b(w)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Oct Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31
30Oct	[redacted]	Epinephrine gtt	06	✓	✓
		Attempt to maintain	18	[redacted]	
		MAP >60			
30Oct	[redacted]	IVF LR @ 150cc/°	06	✓	
			18	[redacted]	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(w)-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

bcw-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 30	31
30 OCT	[redacted]	Condition Expectant	06	✓	
			18	[redacted]	
30 OCT	[redacted]	Vitals per ICU	06	✓	
		protocol	18	[redacted]	
30 OCT	[redacted]	Strict BR Activity	06	✓	
			18	[redacted]	
30 OCT	[redacted]	Diet NPO	06	✓	
			18	[redacted]	
30 OCT	[redacted]	Foley to gravity	06	✓	
			18	[redacted]	
30 OCT	[redacted]	Strict I&O	06	✓	
			18	[redacted]	
30 OCT	[redacted]	Mech Vent settings	06	✓	
		per Anesthesia	18	[redacted]	
30 OCT	[redacted]	NGt to LIS	06	✓	
			18	[redacted]	
30 OCT	[redacted]	NO CPR	06	✓	
			18	[redacted]	
30 OCT	[redacted]	No ALS measures	06	✓	
			18	[redacted]	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

bcw-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

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]

ARRIVAL STATUS

TIME 1726 ☐ IV x 1 ☐ O_2 15 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☑ None ☐ Yes: _____

Allergies: ☐ UKN ☑ None ☐ Yes: _____

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

LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT ____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

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

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☑ Warm ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ _____

☐ Dry ☑ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6

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 ~~☐ Stable~~ ☑ Unstable ☐ _____

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

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

ABDOMEN

☑ Soft ☐ Rigid ☑ Non-Tender

☐ Tender: _____

PELVIS

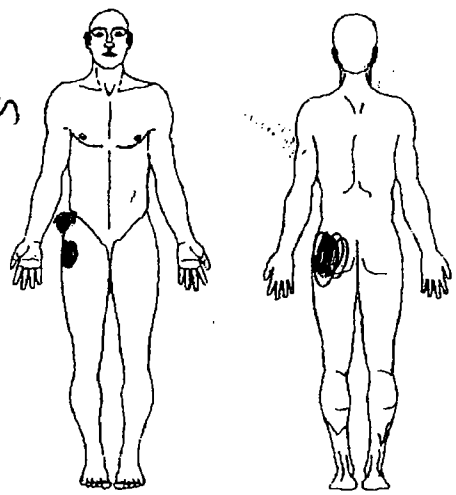
Blood at meatus/vagina: [Y] [N]

Heme +/- Prostate: ☐ WNL ☐ Abnl

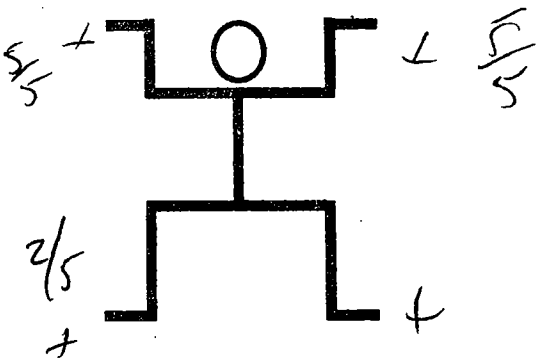
USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(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

Ligr open wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN [redacted] b(6)-2

PHYSICIAN [redacted] b(6)-2

(Continue on reverse)

DEPARTMENT [redacted]

DATE

PA[redacted] *(If typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

b(w)-2 AM

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
8.0 1745	ET Intubation		☒ Oral ☐ Nasal Teeth	Anesth	☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

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

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☐ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☒ T&C x 4
	☐ Tox Screen
	☒ UA ☐ HCG Chem 12
	☐ OTHER
	☐ OTHER

X-RAYS

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

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

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
			Y	N				
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

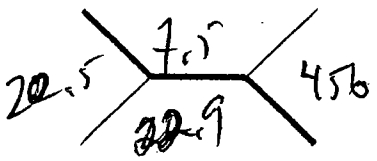
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Succ	1740	100	IV						
Atropine	1741	10	IV						
~~Anesthetics~~									
Versed	1750	3 mg	IV						
Fentanyl	1740	100 mcg	IV						
Etomidate	1801	10	IV						

BLOOD PRODUCTS

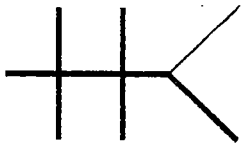
START	#	TYPE	UNIT #	AMT UP	AMT IN	END	WIT
1751	1	O+	[redacted]	1 unit	1 unit	1759	[illegible]
1759	1	O+		1 unit	1 unit		[illegible]
1809		O+					
1809		O+					

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	[redacted]			
Surgeon	DR [redacted]			
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 _____

OK

MEDCOM - 22444 ☐ Stretcher ☐ Wheelchair

Access ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp:

GCS: 15

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
1326	90 50	114	SR	1							
1351	104/80	114	SR								
1354	82 46										
1800	82 46	96	SR	16							
1402	90 50	99	SR	16	96%						
1412	87 50	99	SR	16							

GLASGOW COMA SCALE

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

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

NOTES

Pt is a 39 yo male ♂, came via air 2nd to GSW (R) hip/thigh c̄ (+) Active Bleeding @ multiple sites, Pt awake, (+) pain, (+) answering questions appropriately

PMH ∅
PSH ∅
Meds ∅
All NKDA
(+) tobacco

VS: BP c̄ Manual 80's/40-50's, P 110's
Pen: looking around
CV: (+) Murmur, tachy
Lungs: CTA (B)
Ext: (+) large open wound (R) *Pt Rolled no open wounds on back
*Rectal: ? blood Buttocks/hip c̄ open wound @ (R) prox/ant femur c̄ open wound
All c̄ Active Bleeding. Packed & Pressure.
Neuro: Pen, alert initially, slightly sleep

BSL, ∅ airway
- S/P ET tube
- Sats 98%

4 U ⊖ Blood Pushed in / IVF LR Running
Pt transported to OR.

[redacted]

b(4)-4

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
[redacted]			[redacted]
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays: IRAQ	DATE OF BIRTH Date de naissance	SEX Sexe: [✓] MALE Masculin [ ] FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
[ ] CAUCASOID Caucasique	[ ] SINGLE Célibataire	[ ] PROTESTANT Protestant
[ ] NEGROID Négroïde	[ ] MARRIED Marié	[ ] CATHOLIC Catholique
[X] OTHER (Specify) Autre *(Spécifier)* ARABIC	[ ] WIDOWED Veuf	[ ] JEWISH Juif
	[ ] DIVORCED Divorcé	[ ] OTHER *(Specify)* Autre *(Spécifier)*
	[ ] SEPARATED Séparé	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicilé à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.	GUNSHOT WOUND TO PELVIS	5 HOURS
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	None	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	None	
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]	None	

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée [ ] YES Oui [✓] NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitees par des causes exterieures
[ ] NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
[ ] ACCIDENT Mort accidentelle		
[ ] SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
[X] HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion: [ ] YES Oui [✓] NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*: 2205, 30 OCT 03

[redacted] b(2)-2

I HAVE VEIWED THE REMAINS OF THE DECEA[redacted] DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

[redacted] ou du médicin sanitaire | TITLE OR DEGRE[redacted] b(4)-2

GRADE Grade: 04. b(4)-2 | [redacted] Installation ou adresse [redacted] b(2)-2

DATE Date: 30 OCT 03 | SIGNA[redacted]

[1] *State disease, injury or complication which caus[redacted] of dying su[redacted]*
[2] *State conditions contributing to the death, but [redacted] ease or condition causing [redacted] b(4)-2*
[1] *Préciser la nature de la maladie, de la blessure [redacted] dition qui a contribué à la mort, [redacted] ière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préiser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

b(2)-2

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400. THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL [redacted]

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

IRAQI [redacted]

b(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 2205 30 OCT-2003

3. MEDICAL EXAMINER, CORONER'S CASE: ☐ YES ☑ NO

4. RELIGION

5. CHAPLAIN NOTIFIED: ☐ YES ☑ NO

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

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* GUNSHOT WOUND TO PELVIS	5 HOURS
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) NA	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. NA	
	b. b(6)-2	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTE[redacted]	11. SIGNATURE O[redacted]ENDANCE
30 OCT 03	MAJ/MC	[redacted]

SECTION B - ADMINISTRATIVE ACT[redacted]

TYPE OF ACTION	HOUR	DAY	[redacted]H	YEAR	INITI[redacted]ESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

Admission and Coding Information

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

1. Reporting MTF b(2)-2 [redacted]	2. MTF Loca. IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-2		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1969-05-20	7. Age at Admission 34Y	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 17:38	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS		19. Trauma BC	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICU1		Name / Relationship of Emergency Addressee	
			Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: 0580 [redacted] No Install Provided b(2)-2			Telephone Number of Emergency Addressee	
21. Type of Disposition EXPIRED	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD) 2003-10-30	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From		26. Date this Admission (YYYYMMDD) 2003-10-30	
27. Location of Occurrence IZ	28. MTF of Initial Admission		29. Date of Initial Admission 2003-10-30	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: MULTI GSW TO R THIGH

Procedure Narrative(s):

Cause of Injury Narrative: GUNFIGHT WITH OTHER IRAQIS

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

ming Officer (S[redacted] Admitting Clerk

tomated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

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

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

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICU1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	19:30	AAJ - NEUROLOGY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	EXPIRED	2003-10-30

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-30	[redacted] b(6)-2

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

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: SHOOTOUT WITH 134TH AR.

34. Diagnosis / Operations and Special Procedures:

GSW TO HEAD OPEN SKULL FX.

NONE.

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	1	1

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	1	1

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
[redacted]	b(4)-2 MAJ [redacted]

Automated Facsimile - DA FORM 3647, May 79

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

b(u)-u

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
S1 - [redacted] b(u)-u	CN	CIV	[redacted]

ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	Iraq		☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☐ CAUCASOID Caucasique ☐ NEGROID Négroïde ☒ OTHER (Specify) Autre *(Spécifier)* Iragi	☐ SINGLE Célibataire ☐ MARRIED Marié ☐ WIDOWED Veuf ☐ DIVORCED Divorcé ☐ SEPARATED Séparé	☐ PROTESTANT Protestant ☐ CATHOLIC Catholique ☐ JEWISH Juif ☐ OTHER *(Specify)* Autre *(Spécifier)* Muslim

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicile à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]		Gsw to head	appox 30 min
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☐ NATURAL Mort naturelle ☐ ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès

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

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplôme
[redacted]	MD
GRADE Grade: MAJ b(u)-2	INSTALLATION OR ADDRESS Installation ou adresse: [redacted]
DATE Date: 30 Oct 00	SIGNATURE Signature: [redacted]

[1] *State disease, injury or complication which caused death, but not mere mode of dying.*
[2] *State conditions contributing to the death, but not related to the disease or condition causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préiser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400. THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:
Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.
Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

S1- [redacted] b(u)-4

[redacted]

Iraqi Civilian

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(hour-day-month-year)*: 1940 30 Oct 03

3. MEDICAL EXAMINER, CORONER'S CASE: ☐ YES ☐ NO

4. RELIGION: Muslim

5. CHAPLAIN NOTIFIED: ☐ YES ☐ NO

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

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* GSW to head	approx 30 min
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) GSW to head / open skull fracture	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. b(u)-2	
	b. [redacted]	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. [redacted] ATTENDANCE
30 Oct 03	[redacted]	[redacted]

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

b(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Loc IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-4		4. Pay Grade ~~EON~~	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP ~~99~~ 20	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 19:30	Branch / Corps:
14. Flying Status NO	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU1	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 EXPIRED	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-30		
24. Clinic Svc - Admitting AAJ - NEUROLOGY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-30		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-30		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO HEAD OPEN SKULL FX.

Procedure Narrative(s): NONE.

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

Trauma 9 | Inj 569 | Cause Death #1 | Blood N | Alcohol N

25MD DX: [redacted] b(6)-4

b(6)-2

Admitting Officer (Signature as required) [redacted]

Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

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] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	43Y	X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]						
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Carded for Record Only (CRO)		19:30	AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-03				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-30	[redacted] b(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] b(2)-2			2003-10-30				

31. Selected Administrative Data

Marital Status: Z DoB: 1960-01-07

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: SHOOTOUT WITH 134TH AR

34. Diagnosis / Operations and Special Procedures:

GSW TO R FLANK WITH ILIAC FX

b

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Offic[redacted]

Signature of PAD or Medical Records Officer

MAJ[redacted]

b(6)-2

Automated Facsimile - DA FORM 3647, May 79

b(6)-4

A# [redacted]

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: RPG to Convoy, Ambush

- [ ] 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))
- [X] Other

[ ] Offense against Coalition Forces [check one] If "Other" then describe:

- [ ] 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

Apprehending Unit: 1/34 IN AR	Location Grid:
Date of Incident: (D/M/Y) 30/10/03 to 30/10/03	Time of Incident: 1900 hrs to hrs
Date of Report: (D/M/Y) 30/10/03	Time of Report: 2100 hrs

Detainee # [redacted]	Key Connected Person: [ ] Victim: [ ] Witness
Last Name: [redacted] b(6)-4	Last Name:
First Name: [redacted] Given Name:	First Name: Given Name:
Hair Color: brn	Hair Color: brn [redacted]
Scars/Tattoos/Deformities:	Scars/Tattoos/Deformities:
Eye-Color: brn Weight: lb Height: in	Eye-Color: Weight: lb Height: in
Address:	Address:
Place of Birth: IRAQ	Place of Birth:
Ethn/Tribe/ Sect:	Ethn/Tribe/ Sect:
Sex: [X] M [ ] F	Sex: [ ] M [ ] F
Phone#: DOB D/M/Y: 7/1/60 [ ] Mobile [ ] Regular	Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify)	[ ] Passport [ ] Dr. license [ ] Other (specify)
Document #:	Document #:

Total Number of Persons Involved 2 (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: [redacted] b(4)-2 Email, Phone, or Contact Info.:

Detaining Soldier's Name (Print): MAJ [redacted] Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature: b(4)-2	Signature:
Email: [redacted]	
Unit Phone: [redacted]	Date:

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? fired RPG at Coalition and ran

Who [redacted] or the reason for detention? Give names, contact numbers, addresses. b(4)-2

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

Who was with this person? Iraqi Civilian

What weapons was this person carrying? RPG

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: Fired RPG to Convoy Running from Site and was shot, Ambush Sustained GSW to Buttocks, brought to [redacted] b(4)-2 by 159th Med Evac picked up at Robins airfield

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

43-yo I → s/p GSW / IED to right flank.

PMH – ϕ
PSH – Bladder stone removal
NKDA

PHYSICAL EXAMINATION

P-78 BP- 122/78

awake & alert
abd – soft, ϕ peritoneal signs
entry wound R side, no exit wound
foot drop on R, unable to move R leg, some sensation in foot, lateral lower leg

X ray – bullet in spine, ~L4/L5, shattered thru iliac spine

⊕ rectal tone

PROGRESS (Enter date of discharge and final diagnosis)

A: GSW R side c̄ LE paralysis.
Hemodynamically stable.
P: CT Abd / pelvis.

b(6)-2

SIGNATURE [redacted]	DATE 30 Octo3	IDENTIFICATION NO. 2100	ORGANIZATION
PATIENT'S ID [redacted] ed or written entries give Name last, first, grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

[redacted]

b(6)-4

Transfer Summary – Patient [redacted] b(6)-4

43 yo Iraqi EPW sustained GSW to right flank on 30 October 2003. History of bladder stone removal in the past, otherwise no pertinent medical history, no allergies.

On presentation to ER, had a 2x2 cm entrance wound over the right iliac crest, and able to palpate fragments of the iliac wing through the wound. Also had a right footdrop, decreased sensation in the foot and lower leg. Rectal exam was WNL.

Radiographs revealed a comminuted fracture of the right iliac crest, but a stable pelvis. There was a bullet fragment lodged within the body of L-5.

Neurology consult was obtained. Absent DTR's on right, 0-1 motor on right, and decreased sensation on right only, with intact bulbocavernosus reflex and peroneal sensation. Impression was of a lumbar plexus injury.

CT scan obtained which shows iliac crest fracture, and fragment in canal of L-5. Abdomen without pathology. Neurosurgery consult – no indication for removal of fragment, and concurred with diagnosis of lumbar plexus injury.

Hospital Course – Patient taken to OR on 30 Oct 03, had I+D of right iliac crest, with irrigation with 6 liters, and wound packed loosely. Taken back to OR on 1 November, had wound irrigated. Very loose 2x4 segment of iliac crest excised, and wound closed in layers over a penrose drain.

Plan: Remove penrose drain in 48 hours. Dry dressing changes. Ambulate as tolerated. Currently on Ancef 1 gram Q 8 hours and Gentamycin 400 mg q day.

[redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
31OCT.03 0100	Pt A+Ox3, VSS, speaking arabic + english, LS CTA (B), (+) BS x4, abd soft flat nontender, peripheral pulses +2 equal (B), cap ref < 3sec, dsg (R) flank saturated c̄ blood, reinforced dsg c̄ surgi pads + 4x4's, IV (R) FA intact infusing LR @ 100cc/hr, ∅ s/sx of infex or infiltration, foley to gravity draining c/y urine, NPO, 2 point restraint ∅ s/sx of complications. b(6)-2 [redacted] 9IW
	I Concur with above assess [redacted] CTN
31Oct03 1715	Assume care of PT @ 0600. A+Ox3, VSS Foley to gravity c̄ clear yellow urine. ∅ c/o pain today. Activity consisted of laying in bed. Reinforced dsg to (R) Flank, saturated blood. Pt in 2pt restraint ∅ signs of irritation b(6)-2 Will cont. to monitor. 9IWSPC [redacted]
31Oct03	Surgery Pt. doing very well. No complaints. started diet and have pt. planned for washout tomorrow per Orthopedics b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

LAST NAME	AME		ID NUMBER

DATE	NOTES
31OCT.03 2000	Pt asleep, easily aroused, VSS, dsg + chux pads saturated ≈ blood, Δ'd CDI, wound packed, covered ≈ 4x4's and surgi pads, Ø c/o pain or discomfort, HL IV intact, Ø s/sx of infex, LS CTA (B), (+)BSx4, peripheral pulses +2 equal (B), cap ref <3 sec, 2 point restraint ≈ s/sx of complications. [redacted] SIUN RN
1NOV03 0520	VSS, AO. Pt[illegible] moderate discomfort to (R) flank. Taken to OR [redacted]
1NOV03 1005	Op Note - b(a) - 2 A11 Pre-Op Dx - GSW to (R) ilium Post-Op Dx - same Procedure - I+D, ORC (R) iliac ext GSW Surgeon - [redacted] ASA - III Findings - Wound clean pt dmg. Removed one 2x4 cm retained fragment. Closed in layers over penrose drain. Plan: Remove drain in 48 hours. Mobilize. [redacted]

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 TM
1 NOV. 03 2100	Pt A+Ox3, VSS, peripheral pulses equal (B), (R) flank wound sutures CDI, penrose drain in place draining small amount of blood, dsg Δ'd, Ø c/o pain, LS CTA (B), (+) BS x4, pt consumed most of diet, IV SL flushes well, Ø s/sx of infection, voiding cyu via urinal, 2 point restraint ≅ any complications. [redacted] 9lw
Ø2 NOV Ø3 1300	Rt a10, VSS, LCTAB, (+) BS x4, drsg to (R) flank c̄ scant amt of bloody drainage. Ø c/o pain @ this time. (L) leg c̄ +1 pedal pulses, (R) Leg c̄ +2 pedal pulses. Pt has more strength + movement to (R) leg. Pt unable to wiggle toes to (R) foot. (+) sensation to (B) feet. Pt refused to get OOB because he could not move his (R) foot. Plan: notify MD, PT consult? Will monitor [redacted] 9lwmb.
2 NOV Ø3 2030	Pt A+Ox3, VSS, (R) flank dsg Δ'd, scant blood drainage from penrose drain, sutures + penrose drain intact, Ø s/sx of infex on wound, left LE pulse weaker than RLE, equal (B), Ø c/o pain, pt unable to move toes on RLE, LS CTA (B), (+) BS x4, voiding cyu per urinal, 2 point restraint, Ø complications. [redacted] 9lw I concur with above [redacted]

STANDARD FORM 509 (REV. 5/[illegible]) BACK

USAPA V1.00

#[redacted] b(6)-4

MEDCOM - 22460

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/3/03 1040	A & O. Able to make needs known. VSS. (R) flank drsg Δ done. Wound c̄ sutures & penrose intact. Small amount of bloody drainage noted. HL patent & flushed. O2 pt restraint & compromise to skin or circulation. Medicated c̄ percocet two tabs p.o. in preparation for pain control during transfer to [redacted] Will continue to monitor & provide emo[redacted] [redacted]
11/3/03 1050	Transferred to 21st CSH [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.

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

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: # [redacted] blw-2

CITY: [redacted]

STATE:

ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 30 OCT 03

TIME: 1950

TRANSPORTATION TO FACILITY:

SEX: M

AGE: 43

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. thigh

CATEGORY OF TREATMENT

☐ EMERGENT

☑ URGENT

☐ NON-URGENT

TIME: 1950

INITIALS: M

VITAL SIGNS

TIME	1950				
BP	12V68				
PULSE	72				
RESP	22				
TEMP	97.5				
WT					

LAB ORDERS

✓ CBC/DIFF	ABG	✓ PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	M UA MSCC/CATH		CHEM: 12 c 4yes
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 99% bb-2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2040	fentanyl 100	[redacted]			

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

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

PROVIDER HISTORY/PHYSICAL

43 yr old EPW C GSW to R. ~~thigh~~ hip, Pt A+O X3, vitals stable at present time, PPP, skin cool + dry [redacted] 2 CTA b6-2

Pt is 43yo Iraqi ♂ s/p GSW to (R) flank c̄ obvious ilium Fx, + wound penetrating c̄ ∅ exit wound.

PMH - ∅
PSH - bladder surgery

CV: RRR + (M)
Lys: CTA (B)
abd: soft, NTTP, No Rigidity
Flank: (+) entrance wound, (R) flank, ilium Fx palpated + wound extends ventral + superion. venous drainage, minimal.
Rectal: (−) gross (+) Bulbocavper GS exam
Neuro: (R) Leg ≅ Hip/knee ≅ foot ext/flexion, (+) foot Drop. ∅ DTR (R)
xrays: (+) (R) ilium Fx, (+) Bullet Lodged in L5.

CT Abd/pelvis:
— free air Retroperitoneally
— ∅ in peritoneum.
— open iliac crest Fx.

CONSULT WITH	TIME	ACTION
NS		
GS		
Ortho	2130	admit
Lumbar Plexotherapy.		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] b(6)-2

DIAGNOSIS
— Deficits on (R) to level of L_2 (Lateral pelvis [redacted])
— GSW to (R) flank → stable, lodged in L5.

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 43 HEIGHT: WEIGHT: 60 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): None 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): ??

4. PROPOSED SURGICAL PROCEDURE:
I & D (R) hip

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

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

[redacted]
b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	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. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ 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 [illegible] 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 NU[redacted]LETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 30 0403 DATE

11. POSTOPERATIVE EVALUATION:
Bone pad site clear, dry, intact. Able to move awake, dressing dry clean.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] b(6)-2 DATE: 30 04 03 TIME: 2210	[redacted] DATE: 30 04 03 TIME: 2320

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

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

2. PATIENT IDENT[illegible] REVIEWED AND PROCEDURE VERIFIED BY [redacted] (Emergency)

3. DATE 300503 TIME PATIENT ARRIVED IN SUITE 2213

4. PATIENT IN ROOM TIME 2215 b(6)-2 NUMBER 1 - Emergy

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: able to move UE. awake, alert. NPO p ?? ∅ allergies

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed - on bed, arms on arm sads <90°. Placed in (R) side up. (L) arm on arm board (R) arm across on pillow pillow under & between legs. Strap above knees. axillary roll under (L) axilla. Gel pads

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

8. SKIN PREPARATION free of pressure.

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

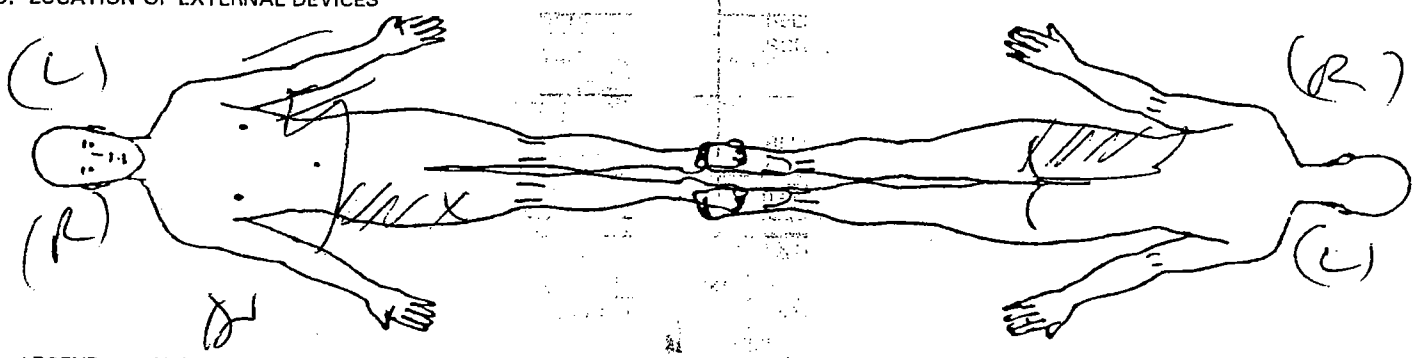
PREP SOLUTION (Specify) Betadine

SITE: (R) Back BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

[redacted]

b(6)-4

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

☒ ESU NO: Valleylab 40 Room 1 Log 20

GROUND PAD: BRAND Kem Polyhesive

LOT NO: 65705 11/2004

☐ 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):
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. 16fr Foley	2. 3/8 Penrose	3.
SITE	1. Bladder	2. (R) hip	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluff
Kerlix
ABD
TAPE

19. ADDITIONAL INFORMATION
S: [redacted] A: [redacted] Type anesthetic: General
blue 2
Bone site clean, debrided pre-prosth SP

20. OPERATION(S) PERFORMED
I&D (R) hip.

21. PATIENT TRANSFERRED TO blue 2 PACU TIME 2316 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

MEDCOM - 22467

REVERSE OF DA FORM [redacted]

USAPA V1.00

b(6)-2 All

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the pro/ agenc the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATI OM
VIA Litter BY Anesthesia

2. PATIENT IDENT. RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 1 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0915 NUMBER 2 # 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* A. lateral on padded OR table position supported by bean bag. Axillary roll (R) Axilla. Pillow between arms and legs.

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

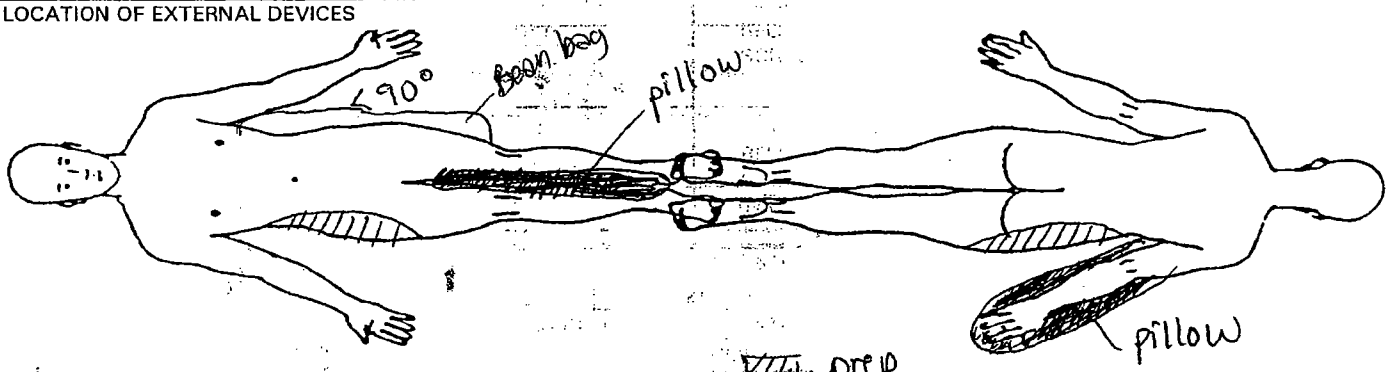
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) hip BY WHOM: ILT [redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

INITIAL: PFC [redacted] ILT [redacted]

C = Correct I = Incorrect

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C	PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

[redacted]

b(6)-4

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

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

[ ] 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 [X]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES [ ] NO [ ]

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs

19. ADDITIONAL INFORMATION WC: IV
Surgeon: Dr. [redacted]
Anesthesia: MAJ [redacted]

b(6)-2
A

20. OPERATION(S) PERFORMED
I&D (R) Hip

21. PATIENT TRANSFERRED TO PACU | TIME See DA7389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

MEDCOM - 22469

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY			31		2/3									
19	HOUR	01	05		20		00								

PULSE (O) / TEMP. F (°)

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

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

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

RESPIRATION RECORD

BLOOD PRESSURE		117/65	117/66	124/75	134/81	140/78	124/73								
		75	83	73	92	88									
		97.4	99	98.8	99.7	100.2									
HEIGHT:	WEIGHT →	98%	98%		96%										
				96%		98%	99%								
						130/74									

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

b(a)-4

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b(6)-2	DATE 30OCT03 / TIME 2002	SSN/DEPENDENT SSN: # [redacted] b6-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
30/10/03 20:15
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER # [redacted] DR #: 000
SERIAL #: b(6) 0000100684

ALB	3.8	3.3-5.5	G/DL
ALP	62	26-84	U/L
ALT	25	10-47	U/L
AMY	37	14-97	U/L
AST	40*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CHOL	♦♦♦	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	199*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
30/10/03 20:14
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: 000010069/

GLU	199*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	441*	39-380	U/L
NA+	127*	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] 66-4	DATE: 30OCT03 TIME: 2002	SSN: [redacted] SSN: 66-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs	85	Mono	3
Bands	4	Eos	1
Lymph	7	Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

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)
Propofol	(mg)
Succ/Vec	(mg)
Fentanyl	(cc)
	( )
Kefzol/Nu	( )
Neostigmine	)
VOLAT AGENT: Forane 2% del	1-2½-1½-1 — 1 cc/hr
% 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		
RgRAc	☐ Warmed	800
20g c 1H	☐ Warmed	400
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS: TOTAL EBL <500; TOTAL URINE 15

FLUIDS - SUMMARY: CRYSTALLOID- 1200; COLLOID-; BLOOD-

REMARKS — Code drugs with numbers, events with letters

(1) V/S Taken
(2) Induced c Lidocaine 20mg Diprivan 170mg Anectine 100mg Intubated
(3) Procedure begun
(4) Procedure ended
(5) Suctioned & cath, extubated To recovery

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 134/76; HR- 77

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME: 2215 30 45 2300 15 30 45 2400 15 30 45 0100 15

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

VENTIL

	2215	2300	2400
VT - ml	830	790	810
f - breaths/min	10	10	10
Peak inf pres / PEEP	23	22	22
MODE - S(pon), A(ssist), C(on)	CV	CV	CV

MONITORS/ACCESSORIES

		2215	2300	2400	
✓ BP/Auto Cuff	✓ ET CO2 (torr)	37	34	33	
BP/oth	✓ FIO2 (Frac or %)	61%	65	62	
ART line	✓ SpO2 (%)	100%	100	100	
Steth- PC/ES	✓ ECG	SR	SR	SR	ST
✓ Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT: PACU ICU ____ (Specify); OTHER ____; CONDITION: Guarded; RESP- 24; SpO2- 100; BP- 177/99; HR- 96

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2130	2214	2325
	Ready	Begin	End
PROC	2232	2246	2303

PROCEDURES and CPT Codes: (1) Wash-out & Packing (2) (3) HIP (4) Wound

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

[redacted] b(4)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen Endo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#8.0 ET tube c #4 MG Blade

SURGEONS: [redacted] b(4)-1

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR

DATE: 30 Oct '03

PAGE 1 OF

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)		30	45	1000									
Lidocaine	( )	100											
Fentanyl	( )	100											
Succ	( )	100											
Fentanyl	( )	100	50										
	( )												
Versed	( )	3											
VOLAT AGENT	Forane % del	2.5	1.5	1.2	X								
	% e.t.												
AIR	L/Min	Ø											
N2O	L/Min	Ø											
O2	L/Min	6	2	2	6								

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

FLUIDS

LINE site (R) Fem		200	#2		700								
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -	1500												

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

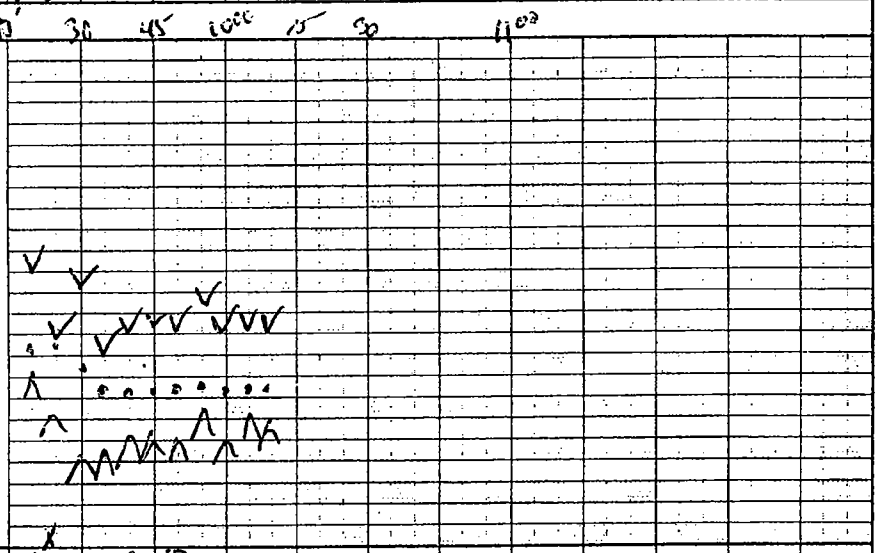
INITIAL DATA: BP- 130/82 HR- 91

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 0 30 45 1000 15 30 1100

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



VENTIL

	0	30	45	1000
VT - ml	1400	780	710	710
f - breaths/min	10	8	8	8
Peak inf pres / PEEP	28	22	22	22
MODE - S(pon), A(ssist), C(on)	S C	C	C	C

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	29	32	33	
BP/oth	✓ FIO2 (Frac or %)	.77	.77	.77	.77	
ART line	✓ SpO2 (%)	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	
Gas analyzer	✓ TEMP-site	Skin	→	→		
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

TOTALS — TOTAL EBL: Ø; TOTAL URINE: 1000

FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters

RECOVERY AT 1018
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION: 96.5
RESP- 16 SpO2-
BP- 132/65 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	915	915	1010
PROC	Ready	Begin	End
	920	937	

PROCEDURES and CPT Codes:
I&D (R) Hip

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*
O ETT MAC 4 Grade I view

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 2-1
DATE: 1 NOV 03
PAGE 1 OF 1

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Oct 03	Neurology Note
2400	43 y/o Iraqi EPW who presents s/p GSW to (R) flank/pelvis with (R) LE plegia. No other reported injuries.
	Focused Neuro exam: awake alert, moving upper extremities purposefully, motor exam: LE's reveals 0-1/5 strength deficit in (R) LE, moves (L) LE well, DTR's → absent (L) knee jerk / (L) ankle jerk, 2+/4 elsewhere, ↓-purpuric rash (R) distal lateral leg / foot, retained perineal sensation intact / urinary incontinence (per EMT)
	CT reveals stable exit fracture with penetrate of canal at L5 level c̄ hematoma
	Imp: (R) lumbar plexus injury / lumbosacral nerve root injury 2° to GSW
	Plan: (1) stabilize reviewed with neurosurgery / Dr [redacted] and no clear role for surgery due to essentially a double crush injury of the plexus / roots [redacted]
	[redacted] b(6)-2

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

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

[redacted] b(6)-4

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Oct 03 2305	Orthopedic Op Note Pre Op Dx - GSW with open (R) iliac fx Post Op Dx - Same Procedure - I+D (R) Iliac Surgeon - [redacted] b(6)-2 CBL, MC Findings - Comminuted iliac crest fracture, but stable pelvis, bruised 6 liters, packed with 4 fluffs. PLAN: Repeat I+D in 48-72 hours. [redacted] CDL RL

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
30OCT03	2250 HOURS	
(1) Admit to Ward		
(2) Staff: Ortho; Alberston; GS		[redacted]
(3) Dx: GSW to R flank & Ilio		Fractured
(4) Condition: stable		
(5) NKDA		
(6) Vitals: q 4° x 2; then q 6°		
(7) Activity: Bed [redacted] rest		

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
(8) Foley to gravity	HOURS	
(9) I+O's		
(10) Incentive Spirometry 10x/hr while awake		
(11) Diet: NPO x ice chips to sips		
(12) IVF: LRO 100cc/hr		
(13) MSO4 2-4mg IV q 2-4hr prn severe pain		
(14) Percocet 1-2 p.o. q4-6° prn pain		
(15) Tylenol 650mg p.o. q6°		

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
(16) Ancef 1 gram IVPB q8°	HOURS	
(17) Gentamicin 400mg IVPB q24° 1st dose in AM (fourhundred milligrams)		
(18)		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF OR[redacted]	
31OCT03	1601 HOURS	
(1) Lovenox 30mg SubQ BID		
(2) TKO IVF		
(3) Advance diet to Regular as tolerated		

[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]

b(6)-4

DATE OF ORDER: 31 OCT 03 TIME OF ORDER: 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) WPD [illegible] b(6)-2
PO [illegible] 1 NOV 03
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] 1 NOV @ 0400 RN 1635

PATIENT IDENTIFICATION

[redacted]

b(6)-4

[redacted]

15-03 NOV 03

DATE OF ORDER: 1 NOV 03 TIME OF ORDER: 1004 HOURS

31 OCT 03

(1) RN Resume previous orders
(2) Regular diet
(3) TBP lock N.
(4) D/C FOLEY
(5) UP to BR with GRUTCHES
OOB to CHAIR T[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

noted

[redacted]

b(6)-2

DATE OF ORDER: 1 NOV 03 TIME OF ORDER: [redacted] 2351

b(6)-2

(1) TRANSFER TO 21ST [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 0500 2 NOV 03

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF OR[redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

b(6)-2

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.	Month Oct/Nov Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (NOV) 30	31	1	2	3	4	5	6	7
31Oct	[redacted]	VS Q4 x2; then	D	/	[redacted]							
		Q6°	N									
31Oct	[redacted]	Activity Bed rest	D	/								
			N									
31Oct	[redacted]	Foley to gravity	D									
			N						/	D/C'd		
31Oct	[redacted]	I & O's	D	/								
			N									
31Oct	[redacted]	Incentive Spirometer	D	/								
		10x/hr WA	N									
31Oct	[redacted]	Diet NPO X ice chips	D	/	D/C 31OCT03							
			N									
31 OCT03	[redacted]	Adv diet to regular	09 13	/								
		as tol.	18 22	/								
1NOV	[redacted]	Up ad lib c̄ Crutches	09 13									
			18 22									
1NOV	[redacted]	OOBTC TID	7	/	/	/						
			14	/	/	/						
			21	/	/							

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: GSW to (R) Flank c̄ Iliac fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

Verity 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
30 Oct	[redacted]	Admit to Ward	30 Oct	0045	—	[redacted]
30 Oct	[redacted]	Staff Ortho [redacted], GS [redacted]	30 Oct	0045	—	[redacted]
31 Oct	[redacted]	Condition Stable	31 Oct	0045	—	[redacted]
31 Oct	[redacted]	NPO pMN 10/31 for Surgery 1NOV03	31 Oct	0010	—	[redacted]
1 NOV ~~31 Oct~~	[redacted]	Resume Previous Orders	1 NOV ~~31 Oct~~	1500	—	[redacted]
1 NOV	[redacted]	D/C Foley ✓	1 NOV	1540	—	[redacted]
1 NOV	[redacted]	Transfer to [redacted] b2-2				

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

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	3
31 Oct	[redacted]	IV LRO 100cc/hr	D	/		DC		
	-----		N	[redacted]				
31 Oct	[redacted]	Tylenol 650mg PO						
	-----	Q6°						
31 Oct	[redacted]	Ancef 1 gram	08	/	[redacted]			
	-----	IVPB Q8°	16	/	[redacted]			
	-----		24	/	[redacted]			
31 Oct	[redacted]	Gentamycin 40mg	X					
	-----	IVPB Q24°	10	[redacted]				
	-----	1st dose in AM	X					
31 Oct	[redacted]	Tylenol 650mg PO	06	/	[redacted]			
	-----	Q6°	12	/	[redacted]			
	-----		18	/	[redacted]			
	-----		24	/	[redacted]			
31 Oct 03	[redacted]	Lovenox 30mg SQ BID	10	/	[redacted]			
	-----		22	/	[redacted]			
31	[redacted]	TKO IVFs	06 18	/	[redacted]	> D/C'd 1 Nov 03		
	-----		18 06	/	[redacted]			
1 Nov	[redacted]	H2IV	6	/	/	[redacted]		
	-----		18	/	[redacted]			

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to (R) Flank & Iliac fx

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 4670 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 22481

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
		D/C'd				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
31 Oct [redacted]		MSO4 2-4 mg IV	D/I	31 Oct 0225 4mg												
		@ 2-4 hr prn	D/I	[redacted]												
		severe pain	I/E													
31 Oct [redacted]		Percocet 1-11	D/I	31 Oct 2												
		p.o Q4-6° prn	D/I	[redacted]												
		pain	E/I													
		~~Tylenol 650 mg~~ Ephnor														
		~~po Q~~														

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 30 Oct 03
Time In: 2320
Allergies:
Pre-op V/S: 134/76 77
Procedures: I&D of Whp
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1200 Colloid
OR Output: UOP 100 EBL 50cc
Meds/Times: Foran Depcovan

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

Pre Op Meds / History

Time																
SaO2	44	100	98	99	98	97	100	98								
FiO2		100	8	8	8	4										
Methods	RA	FM	FT	FM	FM	FM	RA	RA								
240																
220																
200		✓														
180																
160																
140				✓	✓											
120			✓			✓	✓	✓								
100		• ^														
80			•	^ •	^ •	•										
60							• ^	• ^								
40																
20																
RR		18	24	26	28	23	18									
T		97					97									
Time	2330	2350														
Pain (0-10)	0	0														
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2320	NS/LR	100/800	0 FA/0 Foley	[redacted]	200

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	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	0	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	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	4	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)

[redacted] LPN b(6)-2 | DEPARTMENT/SERVICE/CLINIC: ICU3/PACU | DATE: 30 Oct 03

[redacted] written entries give: Name – last, grade; date; hospital or medical facility)

[redacted] b(6)-4

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

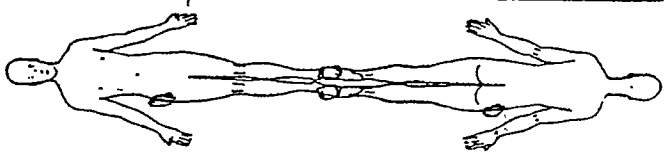
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	R hip	gauze & tape	min
30'	R hip	" "	min
60'	R hip	" "	min
D/C	R hip	" "	min



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
0020	Foley	clear / clear	290

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2320	ST	Ø	Ø

WAMC OP 173-E

NURSING NOTES

2325: Pt arrived to PACU via litter, sole 4L/m room air & oral airway in place. Pt put on 10 L/m non rebreather & Sat 100%. Pt starting to awake, will cont to monitor. [redacted]

2350: Pt on 4 L/m non rebreather & oral airway removed. Pt awake & following command occassionally. Denies pain @ this time. [redacted]

0020: Pt transported to 12W57 via litter in stable condition [redacted]

b/(6)-2

Discharge Criteria:	
Date: 31 Oct Time:	PARS:
BP: 118/67 T: 97.4 HR: 73	RR: 22 Sa02: 100
Pain Level at D/C (0-10): Ø	
Intake: 2400	Output: 290
Additional Data:	
Transferred To: 12W [redacted]	
Report Given To: [redacted]	
Transferred Via: W/C Litter Gurney Ambulance	
Transferred By: SGT [redacted]	
Cleared IAW Recovery [redacted]	
Charge Nurse Signature: [redacted]	

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF [illegible] IZ b(6)-4			
3. Register Number [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1960-01-07	7. Age at Admission 43Y	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP ~~99~~ 20	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 19:30	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS 0	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Carded for Record Only (CRO) 62-2	Ward:	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - [redacted] Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH 21	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-03		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From A 1UA1	26. Date this Admission (YYYYMMDD) 2003-10-30		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-30		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO R FLANK WITH ILIAC FX

Trauma 9 Inj 569

Procedure Narrative(s):

80851
Dx: 9533
39912
3441
Px: 7160

Blood N

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

b(6)-2

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

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register [redacted]	2. Name [redacted] b(6)-2					3. Grade FGN	Admission Remarks
4. Sex M	5. Age 34Y	6. Race X	7. Religion MUSLIM	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [redacted]	13. Organization b6-4				14. Ward ICU2	
15. FlyStatus N/A	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: 19:30	23. Clinic Service -			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-A	26. Date of Disp 2004-01-29			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-30		AdmittingOfficer: [redacted] b(6)-2	
29. ReportingMTF [redacted] b(2)-2				30. Date Init Adm 2003-10-30		32. Units Blood Components	

31. Selected Administrative Data

Marital Status: DoB: 1969-07-11

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: SHOOTOUT WITH 134TH AR

34. Diagnosis / Operations and Special Procedures:

GSW TO BACK

Dx 876.0 E991.2

Px 99.29

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	91	91

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
[redacted]	[redacted]	0	0	91	91

[redacted]

Automa[redacted] DA FORM 3647, May 79

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 Jan 04 @ 0410	Assumed care @ 1900. A&O x3. VSS. afebrile. colostomy bag intact and dry around site. Soft stool. Abscess draining in small amt about bxc since 1900. Skin integrity intact. cls allen to move. Eating and taking Ensure for supplement. Encouraged use of ICS. Voiding clear yellow urine in sufficient amounts. no c/o pain. b (6)-2 [redacted]
27 Jan 04 @ 0605	Bile colored emesis about 100cc. Pt. [redacted] aware. phenergan ordered. Pt. slept well throughout night. VSS. A&O. O2 Sat 99% afebrile voiding clear yellow urine.
27 Jan 04 0814	Assumed pt. VS WNL, IV @ foot, pt. A&O to verbal stimulus, ∅ pain. Will draw labs [redacted], LW
27 Jan 04 1033	Pt. @ foot IV d/c'd, IV in ⓡ wrist and double lumen hep lock in ⓛ forearm flushed c̄ NS & heparin — patent. Will cont. to monitor [redacted] LW
27 Jan 04 @ 2330	Assumed care of Pt @ 1900. VSS. ∅ complaints of pain/discomfort. Colostomy bag intact. Pt A&O x3. 2x2 placed on abd due to minimal oozing of blood. IV in ⓡ arm patent. ∅ skin compromise from restraints. Will continue to monitor — b (6)-2 [redacted]
28 JAN 04	(1630) ASSUMED CARE OF PT AT 0700. VSS A&O x 3 IV [redacted] TO ⓡ ARM INTACT & SIGNS OF INFILTRATION. IV TO ⓛ FORARM. NC'd COLOSTOMY CARE GIVEN & SIGNS OF INFECTION. COLOSTOMY

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
Cont	BAG CHANGE, CLEAN - INTACT. PT UP DDBTC. TOLERATED WELL. [redacted] 91LPN/b
28 Jan 04 2310	Assumed care of Pt @ 1900. VSS. A+O x3. Pt had no pain. IV to (R) arm patent. Colostomy cleaned and changed. Pt turns himself side to side. Restraints intact & skin compromise. Will continue to monitor. [redacted] 91W/f
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0C

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 25 Jan — TIME OF ORDER: 1400 HOURS

Bolus 1L NS over 20
then [redacted] NS @ 75cc/hr

[redacted]

25 Jan 04
1400

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: [redacted] — TIME OF ORDER: [redacted] HOURS

27 Jan 04 — 0600 HOURS

(1) phenergan 12.5 mg IVP Q 8 hr prn nausea/vomiting
(2) CT abd/pelvis ± IV contrast
(3) renal panel, CBC, PT/PTT x 1
(4) T&C x 2 u
(5) NPO p MN
(6) on call to OR 28 Jan 04

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: [redacted] HOURS

[redacted] MAJ MC

28 Jan 04 — 0810

(1) advance diet as tolerated
(2) OR on hold - will reschedule

[redacted]

[redacted] MAJ MC

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 29JAN04 — TIME OF ORDER: 0710 HOURS

NPO

[redacted]

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

☆U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

"USE BALL POINT P[redacted]NT F[redacted] MEDCOM - 22489 [redacted]N PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				24 JAN 04	HOURS	
			1	D/C NPO		
			2	REGULAR DIET c		
			3	ENSURE Q10		
			4	NPO p midnight		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
PATIENT IDENTIFICATION				DATE OF ORDER	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.

☆U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

"USE BALL POINT PEN-PRESS FIRMLY I NO CARBON PAPER REQUIRED"

b(2)-2

1. Reporting MTF	2. MTF Lo	Admission an ding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
[redacted]	IZ		

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

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1969-07-11	34Y	X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] b6-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		19:30	

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

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

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU2	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	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-A		2004-01-29
24. Clinic Svc - Admitting	**25. MTF Transferred From**	**26. Date this Admission (YYYYMMDD)**
-		2003-10-30
27. Location of Occurrence	**28. MTF of Initial Admission**	**29. Date of Initial Admission**
IZ		2003-10-30

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO BACK

T: 1 Dx: 8760
Inj: 450 E9912

Procedure Narrative(s):

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

Admitting Officer (Signature, as required)	S
[redacted] b(6)-2	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

IN. .TIENT TREATMENT RECORD C. .ER 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]	b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	36Y	X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	23:11	AAJ ~~NEUROLOGY~~ Neurosurgery					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	HOME	2003-11-10					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-10-30	[redacted] b6-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 - [redacted] - Iraq b2-2		2003-10-30					

31. Selected Administrative Data

Marital Status: Z DoB: 1967-10-10

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

OPEN DEPRESSED SKULL FX

35. Total Days This Facility

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

35. Total Days This Facility b(6)-2

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

Si[redacted]

[redacted]

MEDCOM - 22492

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 yo ♂ Iraqi s/p ~~motor~~ fragment wound to (R) forehead from attack in Balad @ 1900 this evening. Pt. was awake, alert with CT evidence of ~~bone~~ depressed parietal/Bone fragments for (R) frontal lobe.
No neuro deficit ~~to~~ chronic ipselateral lower facial weakness.

PHYSICAL EXAMINATION
A&O X 3 normal mental

HEAD: (R) forehead open depress skull fx w/ pulsatile CSF Bone / Brain exposed.
Pupil: Bmilly/Reactive/ROMI motor: symmetric/equal no drift
(R) extremity superficial injuries to (R) knee/thigh
Lungs: CTA Heart RRR s murm

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

(1). Open depressed skull fx from penetrating brain injury.

b(6)-2

[redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)	DATE 10/30	IDENTIFICATION NO. 03	ORGANIZATION
		REGISTER NO.	WARD NO.

[redacted]

b(6)4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(2)-2

[redacted] auma Flow Sheet

Time of Arrival 1940
Name/Rank IRAQI #[redacted]
Unit
SSN:
DOB AGE: 40 SEX M
Location of Unit: N/A

Chief Complaint Multiple Shrapnel wounds
Time of C/C: 1945 LOC Duration UNK
Transported by: (Air) Ground Amb Military Vehicle
Medications NONE
Allergies: NKA

Airway ☑ Clear ☐ Obstructed Intubated ☐ Tube size ____
C Spine: ☑ Immobilized ☐ Cleared · Time: 2000
Breathing: ☑ Normal ☐ labored ☐ shallow ☐ assisted ☐ absent ☐ trach deviation
Circulation: IV's on Arrival 18G to (R) AC
Pulses: Upper ☑ Lower ☑ Carotid ☑
Skin: ☑ Cool ☑ Dry ☐ Diaphoretic ☐ pale ☐ flushed ☐ mottled ☐ cyanotic
Chest: Breath Sounds: Clear ☑ R ☑ L
Decreased ☐ R ☐ L Absent ☐ R ☐ L Wheezing ☐ R ☐ L
Rales ☐ R ☐ L Ronchi ☐ R ☐ L
Moves upper Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N
Moves Lower Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N

PROCEDURES
C Collar ☑ Backboard ☐ NG/OG ____ FR Foley ____ FR
CT 2015 FR ☐ L R ☐ Rectal Tone + ✓ – ____
O2 ☑ Device NRB % 10L
Radiology: Time 2010 XRAYS: (Chest) (C Spine)
Other Bil Femur, (R) tib-fib, pelvis
Labs: (CBC) (CHEM 7, Liver Panel) UA T&C Units ____
OTHER TSS
Monitor (+) EKG (+)

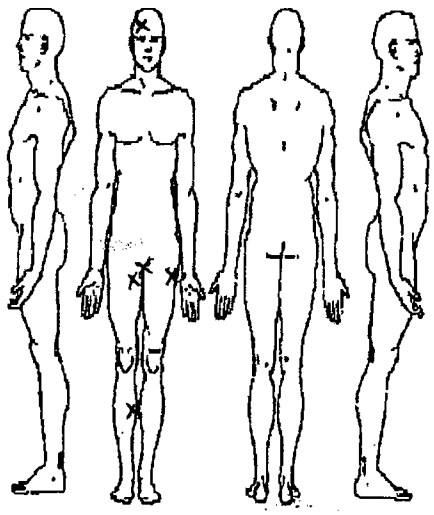
MEDICATIONS/PROCEDURES DONE IN THE FIELD

NONE

MEDS/FLUIDS	TIME	INIT	MEDS/FLUIDS	TIME	INIT
1000cc NS	1950	[redacted]			
~~100~~ 0.5cc TD IM	1985	[redacted]			
Ancef 2gm IV	2045	[redacted]			
Dilantin 1gm IV	2215	[redacted]			
		b(6)-2			

Time	1945	2000	2015	2030	2045	2100	2115	2130	2150	2215
BP	136/90	135/79	147/91	143/87	140/86	142/91	134/81	142/85	136/86	142/87
P	91	87	80	81	91	79	79	77	81	76
R	22	20	20	20	18	18	18	18	18	16
T	97° (R)									
SAO2	100%	97%	98%	100%	100%	100%	100%	99%	98%	98%
GCS	15									

A - Abrasion
AP - Amputation
AV - Avulsion
B - Burn
C - Contusion
DP - Decreased Pulse
E - Ecchymosis
F - Fracture Closed
FO - Fracture Open
IV – IV Lines
GSW - Gunshot Wound
H - Hematoma
L = Laceration
LS - Sutured
P - Pain
SW - Stab Wound
S - Scar
SP - Splint
T - Tenderness
SR - Shrapnel



NOTES

(1940) 40 ♂ Iraqi civilian presented via medevac for multiple shrapnel wounds sustained. Airway patent. 10L O2 via NRB. Lungs CTA. x1 IV present – patent. Wounds to forehead, (L) pelvis, bilateral femurs, (R) tib-fib, and genitalia (+) minimal bleeding. VSS. A:O x3. (+) Calm / cooperative.
(1950) 18Ga #2 placed in (R) AC. Labs to process. (+) pain in neck – ~~cervical~~ c-collar placed. Dressings placed on wounds.
(2010) Pt. transported to XR via gurney. (+) cardiac monitors in place. O2 @ 4L via NC. (+) Condition stable. NAD.
(2055) XR complete. Pt. transported to CT for head/neck studies. Condition stable. (2125) Pt. returned to EMT from CT. (+) Tolerated well. Pt. dx c̄ intracranial injuries 2° to shrapnel. Prepared for evac to [redacted]

CON'T NOTES ON REVERSE SIDE

b(2)-2

GLASCOW COMA SCALE

1. Eye Opening:

Spontaneous	4
To Voice	3
To Pain	2
None	1

2. Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Words	2

3. Motor Response

Obeys Commands	6
Purposeful Movement	5
Withdraws (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	

GCS ON ARRIVAL 15

GLASCOW COMA SCALE (PEDIATRIC)

1. Eye Opening

Spontaneous	4
Speech	3
Pain	2
None	1

2. Best Verbal

Oriented, Smiles, Cries	5
Confused	4
Inapprop/inapprop cry	3
Incomprehensible/grunts	2
No response	1

3. Best Motor b2-2

Spontaneous	6
Localizes Pain	5
Withdraws to Pain	4
Decorticate (Flexion)	3
Decerebrate (Extension)	2
None	1

GCS ON ARRIVAL b6-2

NOTES (CON'T)

↑HOB. IVF ↓. Wounds cleaned and re-dressed. ~~excluding~~ wound to forehead re-dressed. Tolerated well. VSS, NAD.

2215 Dilantin 1gm IV infusion started @ approx. 200cc/hr. 16FR Foley catheter place ē approx. 1200cc return. ⊕ clear/straw colored urine. Pt. tolerated well. VSS. ⊕ cardiac monitors in place.

2230 Pt. prepared for transport to helipad via ground ambulance and air evac to [redacted]. Report called to [redacted] by CPT [redacted] - flight attendant. VSS. ⊕ Cardiac monitors in place. Condition stable. [redacted] T, AN

2230 - 1200 cc removed from foley [redacted] T, AN

2300 - Enroute - P83, Sats 96%, RR 22. Pt stable, Cont. to [redacted]

B(U) - 2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/31/03	Brief OR note
0115	Pre-op Dx: S/P Penetrating Wound to (R) frontal lobe
	Post-op Dx: Same
	Proced: (R) Frontal Craniotomy, Debridement of Depressed Skull fx
	Surg: [redacted] b(6)-2
	EBL: 15 cc
	Drain: Ø
	Anesth: GETA
	Fluids: 1L 0.9NS
	U/O: 300cc.
	b(6)-2 [redacted]

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
31 OCT 0230	Received patient via stretcher from OR. Transferred c̄ 4 person lift to bed. Connected to monitor, temp taken, VSS. Drsg to skull CDI. 2 PIV - (R) AC HL, 18G. (L) AC 18g c̄ D5NS c̄ 20K @ 125cc/h. Foley to gravity, light clear yellow urine. 2 small wounds upper thigh c̄ blooded tinged dressing, Δ @ 0220. Drsg to (B) lower extremities CDI. Will monitor. — [redacted]
0600 31 Oct	Received report from night shift. Pt resting [redacted] comfortably in bed, Ø c/o. Interpreter in for neuro assessment. Pt A&O x3, follows commands, equal strength on both sides of U & L extr, HOB ↑ 30°, tolerating PO sips of water well. Will continue to monitor
1200 31 Oct	Ø significant change in neuro status since this AM, neurologically intact, taking PO well. Will continue to monitor

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.

SI [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/21/03	Neurosurgery POD#1 S/P (R) Frontal Debridement
	& Fan depressed Skull
	Temp: 99.6
	Dressing - clean dry / dressing intact
	Motor - moving symmetrically
	Sensory pupils equally reactive / sensation
	A/B: Adamu diet. Do[redacted] TX obtained of
	ICU [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

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

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MEDICAL RECORD | **PROGRESS N**

DATE	NOTES b(6)-2
1NOV03 @0145	Pt transferred from IAU2 via W/C, placed in bed c̄ 2pt restraints, on s̄ S/Sx of skin/circulation compromise. VSS; Alert, speaks arabic, follows commands, equal strengths BIL LE/UE; PERRLA, Slight (R) sided facial weakness noted. Drsg to head c̄ marked drainage noted. LS CTA, HRR, (+)BS, void per foley. no S/Sx of skin integrity issues. O2 2LNC, Sats 98-99%. Plan: monitor neurological status, pain control, Dilantin as ordered. Will monitor [redacted]
1NOV03@1600	Pt A&O×3, V.S.S. ≠ T-100.2°F, Pt. given T.S., pt. demonstrated correct use, Pt. has productive cough, emesis basin @ bedside, Pt. drowsy, PERRLA, Pt. slurs speech. Pt. tolerating PO fluids well. Bowel sounds hyperactive, Foley draining clear amber urine to gravity, MD Δ'd DRSNG to skull FX c̄ DRY gauze @ 1230, staples intact, MD to Δ DRSNG QD. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted]
2NOV@0280	assumed care of pt @1800. VSS, no c/o. Alert, speaking arabic, slight slurred speech noted c̄ (R) side facial droop/eyelid droop noted; Equal strengths (BIL) UE/LE. Head disg CDI, Δ'd by MD earlier today. LS CTA, (+) productive cough (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR [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)*	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

LAST NAME	ME	MID	ID NUMBER

DATE	NOTES b(6) -2 A-11
2NOV	(CONT) noted. Tol clear liq diet, requesting an apple per interpreter. Foley draining amber urine. IVFS cont to (L) FA IV ⊖ difficulty. 2pt restraints on ⊖ S/Sx skin/circulation compromise. Plan: monitor neuro status, IVFS as ordered, pain control pm [redacted]
2NOV03 @1400	Pt. resting quietly in bed, V.S.S. A&O×3, ⊘ C/O pain. D5NS ≈ 20KCl infusing. Foley to gravity, amber urine. Pt. tolerating liquid diet well. ⊕BS all four quads. BS diminished in lower lobes bilat., I.S. at bedside. Pt. encouraged to deep breath & cough. Pt. has productive cough, dark brown sputum. PERRLA, (R) sided facial droop, slurred speech. MD removed DRSNG to skull FX & incision, stapler intact, edges well approximated, ⊘ drainage. Pt. has superficial shrapnel wounds to (L) thigh, DRY DRSNG applied, scant drainage. Will advance pt. diet to regular for dinner tonight. Pt. in 2-point restraints, ⊘ signs of skin breakdown. Pt. has generalized weakness but is able to Δ position on own. Pt. is on Bedrest. All other assessments WNL. — [redacted] 2LT, AN
2NOV 03 2000	USS alert & oriented. MAE. (R) side facial droop PERRL. Hand grips & foot flexion strength equal. (L) FA IV patent & infusing D5NS ≈ 20mEq KCl/l @ 125cc/hr. Foley to gravity drainage clear amber urine. ⊘% NV. Tolerated regular diet for dinner consumed 60% of meal. Breath sounds diminished in lower lobes. Uses Incentive Spirometer properly @ 900cc/sec. — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 A11
3 NOV 03 0945	VSS. AO. LSCLAB. ⊕ pulses to all extremities. HRR. RS ⊕ x4. S staples to forehead & incision CDI. Cleaned off dried blood from forehead. CNS intact to all extremities. Neuro V's ⊕. PERRLA & tracks well. Slight swelling above ⓡ eye. x1 episode of emesis. Ate small amount of AM breakfast. D5 NS ≈ 20K. [redacted]
3 NOV 03 1930	Pt A+Ox3, VSS, staples to incision on forehead CDI, foley to gravity draining cyu urine, ate most of diet, pt able to move all exts, peripheral pulses +2 equal ⓑ, D5 NS ≈ 20KCL running @ 125cc/hr, ∅ s/sx of infex or infiltration, 2 point restraint ≈ any complications. [redacted]
4 NOV 03 1120	VSS. AO. Sutures & staples CDI and O.T.A. Ambulated x1 to BR ≈ difficulty and performed oral care and washed self appropriately. F/G drainage light yellow urine, BS ⊖ c/o pain @ other time. No s/s infection to wound area on forehead. ⊕ pulses to all extremities. PERRLA and tracks well. CNS intact. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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staples & sutures to small fx "COI 5 1/3 inferior. FTG voiding
light anlen wiwt 5 difficulty. Betty comfortably in bed.

[redacted]

1400 Transferral to ICW-2 per approval from PAD and
determination of civilian status based on medical
record. [redacted]

b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4NOV03 2000	USS, Alert & Oriented Neuro status stable. Staples above forehead intact. Ambulated to BR with assist of walker. Gait unsta without walker. Foley to gravity drain clear yellow urine. Consumed 100% of Regular diet for dinner. (L) FA IV patent & intact infusing D5NS c 20meq KCl @ 125cc/hr. Denies HA, NV or ~~HA~~ Continue care as planned. [redacted] 2C7 [redacted]
4NOV03 0520	c/o pain to (L) FA IV. (L) FA IV site painful to touch, Ø flash back, Ø swelling noted. IV D/Ced. Restarted 18g 1¼ in cath to (R) FA x1 attempt. Will continue care as planned [redacted]
	b(6)-2 AMA

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)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1995)
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USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11/7/03	Nursing Pt cont to do well Plan D/C Foley, IV OOB → ambulation Dress clean dry well approved b(6)-2 [illegible]
	[redacted]
11/8/03	Nursing Pt doing well ∑ (R) shoulder pain staples intact wound healing well A/P: Pt. doing well plan. OOB → Ambulation PT for (R) Shoulder
	[redacted]

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

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

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES: Neurosurgery Narrative Summary / Discharge Note
11/9/03 10:56	Pt. SIP open depressed skull fracture with bone, metal debris into frontal lobe (R) hemisphere. Pt initially came in GCS 15 w/ open wound leaking blood/CSF & was dressed. Pt. was taken to the OR where the skull fragments/hematoma were debrided & injured scalp repaired. Pt. did well post op has been OOB ambulating and doing well. Pt. has tolerated regular diet & activity and normal mentation/speech and level of personal interaction relatively unaffected.
	Dx (1). Open Depressed Skull fracture w/ (R) Frontal lobe Injury Hematoma
	(2). CSF leakage / Scalp Defect Repair
	MEDS (1). Dilantin 300 mg po
	f/Follow-up (2). OPN in one week for suture removal
	[redacted] b(6)-2 [redacted] LTC [redacted] WRA [redacted]
	Neurosurgery 207th CSH Neuro

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 Dilantin

PROGRESS NOTES
Medical Record

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: Transfer from JSCW1 5 Nov 03 Diagnosis: Depressed skull fracture POD: POD:

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	4	Mobility	No limitations	4	4
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4	4	Nutrition	Excellent	4	4
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	4	Friction and Shear	No apparent problem	3	3
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score — *Total Score:* _____

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: Frontal lobe Size: 10 cm Drainage: ∅
Tubes: ∅ Pins: ∅ Appearance: Staples/sutures OTA
Dressing change: ∅

Burn wound (s): Yes__ No X % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes___ No X
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____ Tunneling_____
Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates _____
Type of dressing change: Wet-to-dry_____ Comfeel dressing_____ Carrasyn-V Gel_____ Alginate_____

Physician notified/consulted for wound debridement: Yes___ No X Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes____ No X
Nutrition Referral: Yes_____ No X
Physical Therapy Referral: Yes_____ No X
Action taken:_____ Date & Time 5 Nov 03

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

b(6)-4

[redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 05 NOV 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1355 To ECW2 From ECW1 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis Shrapnel wounds to head & knee B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes Foley

Intake (IV, po) D5N 120K Output (EBL, other) _____ Voided ☐ No ☑ Yes Amount: _____

Medication _____

Other depressed skull fracture, Ambulates c walker

Report From LT [redacted] blue-2 Received By LT [redacted]

VITAL SIGNS

TIME:	0400															
BP ARTERIAL LINE																
BP CUFF	134/80															
TEMPERATURE	98.7															
PULSE	81															
RESPIRATORY RATE	16															
OXYGEN (L/%)																
PULSE OXIMETER	99%															
O_2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1500	0510	0400					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	NA	NA						
RELIEF ACCEPTABLE (Y/N)	MT	NA						

SPECIAL NEEDS

TIME:	1500		2310
*Skin breakdown prevention	NA		NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

NA

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] blue-4

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

IN REQUIRED (Specify): _____

b(6)-2 AM

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley to gravity	☐	☐ Foley to gravity draining clear yellow urine
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Generalized weakness	☐	☐ generalized weakness
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ depressed skull fx c̄ staples to occipit	☐	☐ Staples and sutures to frontal lobe open to air
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS: [redacted]
IV patency ✓ q 6 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr: PRN
IV site care provided:	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RFA / OK	IV Site #1:	IV Site #1: R forearm / Ok
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1500		2310
ID band visible/legible	[redacted]		[redacted]
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h	[redacted]		
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT b(6)-2	BEDREST ~~AMBULATE~~ BSC BRP CHAIR ☐ SELF ☑ ASSIST # TIMES/SHIFT	BEDREST ~~AMBULATE~~ BSC BRP CHAIR ☐ SELF ☑ ASSIST # TIMES/SHIFT b(6)-2

TEACHING

TIME: 1500 INITIALS [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS [redacted]
CONTENT: -Plan of care	CONTENT:	CONTENT: b(6)-2
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C [redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] RT AN	2
	[redacted] RT/AN	3

MEDCOM - 22509

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1500: Awake & alert. Denies pain @ this time. Transferred from ICW1 @ 1400 - ambulatory, VSS, will continue [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 6 DEC 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0000	0400												
BP ARTERIAL LINE																
BP CUFF	127/77	134/[illegible]	126/76	130/80												
TEMPERATURE	[illegible]	98.6	98.6	97.9												
PULSE	75	79	80	94												
RESPIRATORY RATE	16	16	16	16												
OXYGEN (L/%)																
PULSE OXIMETER	95%	97	96%	99%												
O_2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0045	0400						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	X						
RELIEF ACCEPTABLE (Y/N)	NA	NA						

SPECIAL NEEDS

	TIME: 0645		
*Skin breakdown prevention	1h		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Cv [redacted] b/6)-4

DIAGNOSIS: shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

MEDCOM - 22511

b(a)-7 RN

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0645 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ ✗ language barrier	☑ neuro ✓s WNL	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley to gravity	☐ foley to gravity	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Amb ⊼ difficulty	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples / Sutures to frontal lobe intact ∅ drainage	☐ Sutures et staples to frontal lobe intact, DSG ∅ infection	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0645 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q S hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: assess	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1: (R) FA / OK	IV Site #1:
IV Site #2:	IV Site #2: [redacted]	IV Site #2:
Comments: D5½ ⊂ 20Kcl @ 100	Comments: ~~D5½~~ D5NS ⊂ 20K CL @ 125cc/hr	Comments:

b(4)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0645		
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED: 20%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0645 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: plan of care, call for assist	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted]

b(4)-4

INITIALS	b(4)-4 SIGNATURE	SHIFT
[redacted]	[redacted]	1

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0645	Frontal Lobe	Staples/Sutures intact Ø drainage	Assess

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 7 Nov 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2200	0400													
BP ARTERIAL LINE																
BP CUFF	124/86	126/75	124/74													
TEMPERATURE	99.2	98.8	99.5													
PULSE	97	90	75													
RESPIRATORY RATE	16	16	16													
OXYGEN (L/%)																
PULSE OXIMETER	102	98%	96%													
O2 METHOD		RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0835	1200	1530	2230	0400			
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	X N	N	N	N				
RELIEF ACCEPTABLE (Y/N)	N/A	NA	NA	NA				

SPECIAL NEEDS

	TIME: 0835	1530	2230
*Skin breakdown prevention	[redacted]		UO
*Falls prevention protocol		[redacted]	
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C[redacted]

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

blw-2 AM

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0855 INITIALS: [redacted]	TIME: 1530 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ NV✓ WNL	☑	☐ language barrier
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ Foley to gravity	☑ Foley d/c'd	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Sutures / Staples to Frontal Lobe	☐ staples to anterior scalp intact. sm. open sore to penis	☐ Staples & Sutures intact to frontal lobe
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0855 INITIALS: [redacted]	TIME: 1530 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Assess	IV site care provided:	IV site care provided: reassessed
IV tubing changed:	IV tubing changed:	IV tubing changed: not error
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1:	IV Site #1: (R) FA UP / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5 1/2 NS c 20KCL @ 125cc	Comments:	Comments: (1) IV access

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0855	1530	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn		[redacted]	
Turn/reposition q2h		NA	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE TO BR, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0855 INITIALS: [redacted]	TIME: 1530 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: • CALL FOR ASSIST •	CONTENT: Plan of care	CONTENT: call for assistance if needed plan of care
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b/w
AM

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] SPC/SIUMG	1
[redacted]	[redacted]	2
[redacted]	[redacted] 9IWMG SBT	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	Frontal lobe	Staples/sutures intact, drainage	Assess
		penis	sm open sore, min amt bleeding	Cleaned c̄ NS, OTA

SECTION IV - NOTES

1200 Foley DC'd DTV by 1000, pt understands. IV DC'd. sm open sore noted to penis. Sm amt of bleeding. Cleaned c̄ NS. left OTA — [redacted] 1530; Awake + alert, Denies pain @ this time. [redacted] continue to monitor. — [redacted]

b(6)-2

5E

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8 NOV 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 9 | HOSPITAL DAY: 9

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	/	/	/													
BP CUFF	141/85	142/80	129/86													
TEMPERATURE	99.6	99.1	98.6													
PULSE	85	94	71													
RESPIRATORY RATE	16	12	16													
OXYGEN (L/%)	/	/	/													
PULSE OXIMETER	97	98%	95%													
O2 METHOD	/	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0736	1200						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	Y	N/A						

SPECIAL NEEDS

	TIME:		1980
*Skin breakdown prevention			N/A
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted]

b/w-4

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: 30 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

EQUIRED (Specify): _____

MEDCOM - 22519

MEDCOM FORM 689 R (TEST) (MCHO) MAR 88 PREVIOUS EDITIONS ARE OBSOLETE

b(6)-4

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0750 INITIALS: [redacted]	TIME: INITIALS:	TIME: 1930 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ UNABLE TO ASSESS ORIENTATION D/T LANGUAGE BARRIER PT IS ALERT & RESPONSIVE	☐	☐ Pt alert and responsive lethargic
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SCALP LAC ESTAPLES INTACT NO SEPARATION	☐	☐ Staples to frontal lobe intact
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ no c/o pain	☐	☐ a c/o pain
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0740					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0740		1930
ID band visible/legible	✓		[redacted]
Orient to environment prn	✓		
Side rails (2/4) up	✓		
Bed position low	✓		
Call light within reach	✓		

OTHER

Review & post lab results	✓		
Notify MD abnormal labs	✓		
Incontinent urine/stool	✓		
Linen change prn	✓		
Turn/reposition q2h	✓		
ROM q2h if immobile	✓		
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: no complaints	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, ~~AMBULATE~~, BSC, ~~BRP~~, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0730 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: INFORM STAFF OF PAIN CALL FOR ASSISTANCE	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CN b(6)-4 [redacted]	b(6)-2	[redacted]	D 5

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9 Nov 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 10 | HOSPITAL DAY: 10

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0000	2000	0400												
BP ARTERIAL LINE	/	/	/												
BP CUFF	114/79	121/78	126/80												
TEMPERATURE	98.3	98.8	98.4												
PULSE	100	98	88												
RESPIRATORY RATE	14	14	20												
OXYGEN (L/%)	/	/													
PULSE OXIMETER	97%	98	99%												
O_2 METHOD	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	2000							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

DIAGNOSIS: shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: 30 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

MEDCOM - 22522

b(4)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1230 INITIALS:	TIME: 1915 INITIALS [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ A/O x2 ∅ c/o dizziness ∅ vertigo PERRLA/EOM's	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples removed sutures intact ∅ s/sx of infx	☐ Sutures to anterior scalp intact	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

NO ACCESS

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1230	1915	
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	✓		
Bed position low	✓		
Call light within reach	✓		

OTHER

Review & post lab results	✓		
Notify MD abnormal labs	✓		
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h	✓		
ROM q2h if immobile	✓		
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE:	TYPE: Reg
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☑ SELF ☑ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☑ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1230 INITIALS: [redacted]	TIME: 1915 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Orient to staff - wound care - d/c pending	CONTENT: - Plan of care -	CONTENT:
☑ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ P[redacted]erbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION	INITIALS	SHIFT
Civ [redacted] b(6)-4	[redacted]	1
	[redacted] PLT, Ae	5

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1915: Awake + alert, Denies pain or discomfort [redacted] e, Ambulating well. Will continue to monitor. [redacted] Sta

b(4)-2

5E

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 10 NOV 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 11 | HOSPITAL DAY: 11

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0830	1600													
BP ARTERIAL LINE															
BP CUFF	148/77														
TEMPERATURE	98.8														
PULSE	65														
RESPIRATORY RATE	16														
OXYGEN (L/%)															
PULSE OXIMETER	98														
O_2 METHOD	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0705	1600						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	N/A							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0705		
*Skin breakdown prevention	✓		
*Falls prevention protocol	✓		
*Restraint protocol	✓		
*Seizure precautions	✓		
*Isolation precautions	✓		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

b(6)-4

C [redacted]

DIAGNOSIS: Shrapnel wounds to head & knee

DRG: _____ ADMISSION DATE: 30 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

EQUIRED (*Specify*): _____

MEDCOM - 22526

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0715 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ PT NOT VERBALLY RESPONSIVE TO STAFF. DOES COMMUNICATE THRU HAND SIGNALS	☐ b/w = 2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SCALP LACS & STAPLES REMOVED, NO OPENINGS OR SEEPAGE	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ PT DENIES	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0705					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	~~0~~					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	~~0~~					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0705		
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	✓		
Bed position low	✓		
Call light within reach	✓		

OTHER

Review & post lab results	✓		
Notify MD abnormal labs	✓		
Incontinent urine/stool	✓		
Linen change prn	✓		
Turn/reposition q2h	✓		
ROM q2h if immobile	✓		
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE:	TYPE:
PERCENT CONSUMED: 85%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: NO C/O	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(6)-2	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 0710 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: POSS d/c TODAY ALERT STAFF TO ↑ in PAIN CON'T TO MOTOR NEURO;	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	[redacted] SAT, 9/4/06	D
		b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

15NOV03
1335 PT D/C'd TO HOME & FAMILY. DILANTIN & TID SENT [redacted] NEEDS TO F/u IN ONE WEEK. TRANSLATOR SAYS FAMILY HAD Ø QUESTION. [redacted] SGT, [illegible]

V/W-2

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 40 HEIGHT: WEIGHT: 80	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION:
	3. PREVIOUS SURGERY [ ] NO [X] YES (type): LIH

4. PROPOSED SURGICAL PROCEDURE:
Cran, elevate depressed Fx, debridement

NPO SINCE 1800

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition: [illegible]
Tobacco ✓ ppd X___ vrs Body Piercing ✓ Diabetes (Y) (N) ROM [illegible] ASA/Motrin W 72hrs (Y) (N)
ETOH ✓ 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 ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	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. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ___ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	O. Pt. will be able to breath without difficulty during immediate intraoperative 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 intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	O. Pt. will 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 form pooling.

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

[redacted]

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 ____ 4) Safety Devices ____ 5) Hypothermia	~~O 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. ~~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 and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. __X__ Potential Impairment of Mobility due to: __X__ 1) Pain ____ 2) Intra operative Hazzards ____ 3) prosthesis __X__ 4) Positioning __X__ 5) Transfer pt. To/form OR table E.2. ____ Potential Discomfort Due to: ____ 1) Length of Surgery ____ 2) Positioning ____ 3) Arthritis	~~O~~ pt. will be transferred to OR table without difficultly. ~~O pt. will~~ be 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. Bath towel. etc) for positioning.
F. Special Senses F.I. ____ Diminished visual perception due to being: ____ 1) pre-medicated ____ 2) W O GLASSES F.2. ____ Potential for Decreased Communication due to: ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential Injury due to Dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	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. Speak clearly and slowly. O Address pt. from _____ side. O 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.

10. OR [redacted] COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] 30 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 and Title) [redacted]

DATE: 30OCT03 TIME: 2350

13. PREOPERATIVE EVALUATION PREPARED BY (Signature [redacted]

DATE: 31 OCT 03 TIME: 0142

REVERS OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT** — b(6)-2

r use of this form, see AR 40-407, the propo[illegible] [illegible]he office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY ares staff	2. PATIENT IDENTI[redacted]ED AND PROCEDURE VERIFIED BY [redacted]
3. DATE 31 OCT 03 TIME PATIENT ARRIVED IN SUITE 0356	4. PATIENT IN ROOM [redacted] TIME 2358 NUMBER 2 - 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

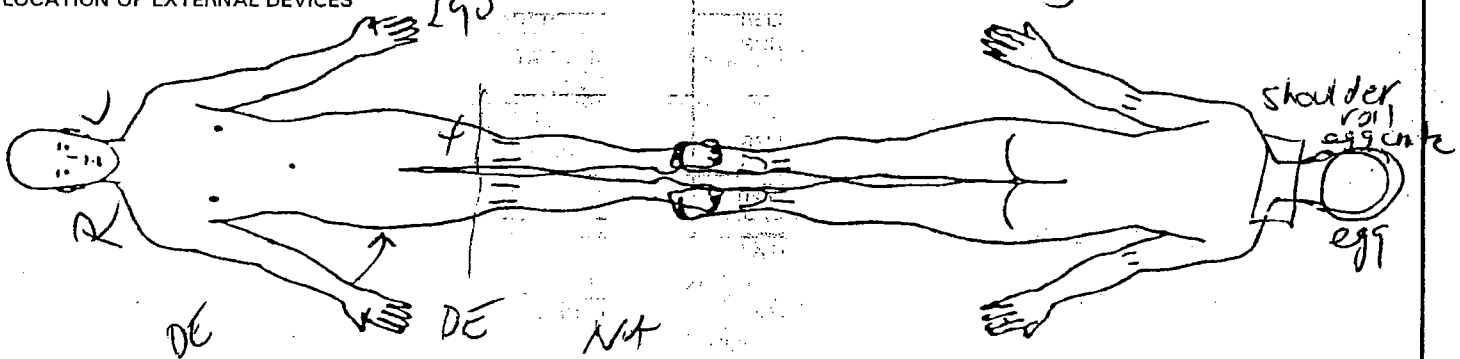
COMMENTS: Pt placed on padded OR table (L) arm extended on armboard @ <90° (R) arm tucked @ sheet

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: forehead to (R) BY WHOM: [redacted]
SITE: ear - shaved hairline BY WHOM:
COMMENTS: Ø pooling b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULAT[redacted]
Sponge	☒ Yes	☐ No	✓	C	C	SGT [redacted]	CPT [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

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 50/50

☒ ESU NO: R8B 10239 S
GROUND PAD: BRAND Valleylab
LOT NO: 7011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: See above - 35

13. PROSTHESIS, IMPLANTS [ ] YES [X] NO IF YES NAME: ID NUMBER, MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Epi 1:100,000 Lidocaine 1% c̄ Epi 1:100,000	10 cc	intraop	inject	[redacted]	[redacted]
gel foam	QS	intraop	topical		
surgicel	QS	intraop	topical		
Thrombin	QS	intraop	topical		

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

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

16. LABORATORY SPECIMENS

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

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

TYPE/SIZE	1. 16 Fr Foley EMT	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform, 4X8, Kelly

19. ADDITIONAL INFORMATION

Surgeon - Dr. [redacted]

Anesthesia - CPT [redacted]

b(6)-2

Foley draining clear light yellow urine

geta

20. OPERATION(S) PERFORMED

Craniectomy depressed fracture c̄ debridement

b(6)-2

21. PATIENT TRANSFERRED TO ICU 1 TIME 0140 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] [redacted] CPT

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 22533 USAPA V1.00

ICU1

Patients Name: [redacted]

Date: 31 OCT

0140 Arrived from OR

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line																								
NBP																				135/68	121/78	129/72	118/65	114/65
TEMP																				98				
HR																				130	95	101	96	97
RR																				25	15	16	13	10
SaO2																				100	4L	4L	4L	
FiO2																				100	100	100	100	95
Source																				NC	NC	NC	NC	NC
MAP																				95	97	92	87	84

Recovery Vitals

NIBP TREND 10/31/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
03:00	101	100	120 / 72	92	16
02:55	99	SRCH	126 / 73	94	14
02:50	96	100	121 / 66	91	11
02:45	92	100	129 / 67	95	15
02:40	101	100	127 / 77	96	19
02:35	99	100	124 / 74	93	15
02:30	97	100	120 / 72	90	18
02:25	98	100	121 / 73	96	14
02:20	99	100	119 / 73	96	18
02:15	95	100	127 / 75	94	15
02:10	88	100	123 / 75	94	12
02:05	101	100	122 / 71	97	14
02:00	95	SRCH	121 / 78	97	15
01:50	103	SRCH	122 / 68	92	24
01:45	130	100	135 / 68	95	25
01:43	IMPI	OFF	ERR# 2		30

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	01	02	03	04	05
IVF															125	125	125	125
IVPB																		
NGT																		
PO																		
Total																		

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																					250	500	400	500	400	1050
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 22534

NEUROLOGICAL ASSESSMENT

			HOURS	02	03	04	05
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4		X	X	X
		TO SPEECH	3	X			
		TO PAIN	2				
		NO EYE OPENING	1				
	BEST VERBAL RESPONSE	ORIENTED	5				
		CONFUSED	4	X	X	X	X
		VERBALIZES	3				
		VOCALIZES	2				
		NO VOCALIZATION	1				
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6				X
		LOCALIZESPAIN	5	X	X	X	X
		FLEXION WITHDRAWAL	4				
		ABNORMAL FLEXION	3				
		EXTENSION TO PAIN	2				
		NO RESPONSE	1				
LIMB MOVEMENT	ARMS	NORMAL POWER					
		MILD WEAKNESS		B	B	B	B
		SEVERE WEAKNESS					
		ABNORMAL FLEXION					
		ABNORMAL EXTENSION					
		NO RESPONSE					
	LEGS	NORMAL POWER		B	B	B	B
		MILD WEAKNESS					
		SEVERE WEAKNESS					
		ABNORMAL FLEXION					
		ABNORMAL EXTENSION					
		NO RESPONSE					
PUPILS	RIGHT	SIZE		3	3	3	3
		REACTION		+	++	++	++
	LEFT	SIZE		3	3	3	3
		REACTION		+	++	++	++
PUPIL SCALE				2	3	4	5 6 7 mm
ICP							
CEREBRAL PERFUSION PRESSURE							

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the tow sides

+ + Brisk
+ Slow
No Response
– Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		02	03	04	05
upper	R	++	++	++	++
	L	++	++	++	++
lower	R	++	++	++	++
	L	++	++	++	++
	R				
	L				
	R				
	L				
	R				
	L				

+ + Normal
+ Weak
– Absent
D Doppler
R Right
L Left

b(6)-4

SI [redacted] 310C

NEUROLOGICAL ASSESSMENT

		HOURS	6	7	8	9	10	11	12	13	14	15	16	17	18
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	4	4	4	4	4	4	4	4	4				
		TO SPEECH 3													
		TO PAIN 2													
		NO EYE OPENING 1													
	BEST VERAL RESPONSE	ORIENTED 5	5	5	5	5	5	5	5	5	5				
		CONFUSED 4													
		VERBALIZES 3													
		VOCALIZES 2													
		NO VOCALIZATION 1													
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	6	6	6	6	6	6	6	6	6				
		LOCALIZESPAIN 5													
		FLEXION WITHDRAWAL 4													
		ABNORMAL FLEXION 3													
		EXTENSION TO PAIN 2													
		NO RESPONSE 1													
LIMB MOVEMENT	ARMS	NORMAL POWER	RL	RL	RL	RL	RL	RL	RL	RL	RL				
		MILD WEAKNESS													
		SEVERE WEAKNESS													
		ABNORMAL FLEXION													
		ABNORMAL EXTENSION													
		NO RESPONSE													
	LEGS	NORMAL POWER	RL	RL	RL	RL	RL	RL	RL	RL	RL				
		MILD WEAKNESS													
		SEVERE WEAKNESS													
		ABNORMAL FLEXION													
		ABNORMAL EXTENSION													
		NO RESPONSE													
PUPILS	RIGHT	SIZE	3	3	3	3	3	3	3	3	3				
		REACTION	+	+	+	+	+	+	+	+	+				
	LEFT	SIZE	3	3	3	3	3	3	3	3	3				
		REACTION	+	+	+	+	+	+	+	+	+				
PUPIL SCALE			2	3	4	5	6	7 mm							
ICP															
CEREBRAL PERFUSION PRESSURE															

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the tow sides

+ − Brisk
+ Slow
− No Response

+ Intact
− Abnormal

VASCULAR ASSESSMENT

HOURS		6	7	8	9	10	11	12	13	14	15	16	17	18
~~07~~ VE	R	++	++	++	++	++	++	++	++	++				
	L	++	++	++	++	++	++	++	++	++				
LE	R	++	++	++	++	++	++	++	++	++				
	L	++	++	++	++	++	++	++	++	++				
	R													
	L													
	R													
	L													
	R													
	L													

+ + Normal
+ Weak
− Absent
Ó Doppler
R Right
L Left

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 19 03 | DAY | HOUR

DAY	1	1	2 NOV		3 NOV 03		4 NOV 03		5 NOV 03		6		7	
HOUR	0	1	2		0		0	2			0		0	
	9	9	0		0		4	3			8		8	
	8	3	0		7		4	0			3		0	
	0	0	0		4		0							
					2		0							

PULSE (O) — TEMP. F (•)

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

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

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

	1	1	2 NOV		3 NOV 03		4 NOV 03		5 NOV 03		6		7	
RESPIRATION	20	18	18					22						

BLOOD PRESSURE

	1	1	2 NOV		3 NOV 03		4 NOV 03		5 NOV 03		6		7	
BP	132/72	134/70	135/80		129/79		121/81	134/78	103/42					
					51		91	80	79					
					96.9		97.9	99.5	98.6					
					98.1		97.1	96%	97.1					
	98%	96%	97%				RA		RA					
	RA	RA												
	99%	95/96%												
	2LNC	RA												

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

1B- [redacted]

b (b)-4

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY																		
MONTH-YEAR	DAY	8		9		10												
19	HOUR	01		02		1												
PULSE (O)	TEMP. F (•)	42		4		6												TEMP. C
	105°	86		0		0												40.6°
180	104°	0		8		0												40.0°
170	103°																	39.4°
160	102°																	38.9°
150	101°																	38.3°
140	100°																	37.8°
130	99°																	37.2°
	98.6°																	37.0°
120	98°																	36.7°
110	97°																	36.1°
100	96°																	35.6°
90	95°																	35.0°
80																		
70																		
60																		
50																		
40																		
RESPIRATION RECORD																		
Record special data only when so ordered: BLOOD PRESSURE																		
HEIGHT:	WEIGHT →																	

(Centigrade Equivalents, for Reference only)

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: ICU1	REQUEST[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 31OCT / TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁹
Hgb		14-18 g/dl (M) 16 g/dl (F)
Hct		
MC		
Plt		
Lym		
(E		
Segs		
Band		
Lym		
Atyp		
RBC Morp		
Spun Hema		
Sed R		
Other		

ID: [redacted] 31-10-03
WB 04:27

			Patient Limits	
WBC	13.0 H	x10^3/uL	4.5	10.5
RBC	4.69	x10^6/uL	4.00	6.00
Hgb	13.3	g/dL	11.0	18.0
Hct	43.1	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	160.	x10^3/uL	150.	450.
LY%	8.2 *L	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A

==== PICCOLO ====
31/10/03 04:30
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100684

GLU	172*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	429*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

nit Crossmatch
TH EVERY UNIT OF BLOOD
ESTED)

PE	CROSSMATCH

REMARKS: CBC Chem 7

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] b/w/ - 2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b/w/ - 4 [redacted]	DATE 31OCT / TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: Chem 7

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)													
Propofol	(ml)	200												
Sux/Ver	(mg)	100	5					50						
Fentanyl	(cc)	2	1	2				200						
Neostigm/Robinul	( )				4/.7									
VOLAT AGENT	Forane % del	1	1.5	1.5	1	1	1	X						
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	2	2	2	2	2	8						

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

FLUIDS

LINE site														
0.9% NS RFA	☐ Warmed	800												
0.9% NS LAC	☐ Warmed	1000			1000									
	☐ Warmed													
	☐ Warmed													

LOSSES

EST BLOOD LOSS														
URINE -					300									

TOTALS	TOTAL EBL
200	~~1000~~
100/5	50
5cc	TOTAL URINE
	300

FLUIDS - SUMMARY

CRYSTALLOID- 1900

COLLOID-

BLOOD-

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 145/77 HR- 80

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME-

TIME 0000 0030 0100 0130

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	940	920	950	840			
f - breaths/min	12	12	10	8	10	12	20
Peak inf pres / PEEP	22	23	23	20			
MODE - S(pon), A(ssist), C(on)	S/A/C	CV	CV	CV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	30	30	37	45	40	45
BP/oth	FIO2 (Frac or %)	.81	.80	.81	.82	.81	.81	.81
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	37.2	37.3	37.1	37	36.8		
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

REMARKS

Code drugs with numbers, events with letters

TO OR #2 - Anesth Prep - Smooth Induction - RSI
0 CP. Esophageal shock, Distant infiltration
0021 Local 1% Lido 20cc
1:200 epi
1:2 dilute injected by surgeon 70cc
0130 Extubation - laryngeal spasm
02 100% mask - Sux 20mg IV
- Assisted vent.
0140 SV O2 100% sat
NC .70 IV

RECOVERY AT Bed 4

PACU (ICU) 2142 (Specify)

OTHER

CONDITION: T-98 2LN

RESP- 22 SpO2- 100%

BP- 110/56 HR- 128

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2350	0358	0150
PROC	Ready	Begin	End
	0005	0022	0120

PROCEDURES and CPT Codes:

Debridement + repair of penetrating skull injury

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

[redacted] b(6)-4 EPW

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* T

GA

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

#8.0 ETT DLX2 (+) VC (+) B=BS (+) ETCO2 @22 on tech

SURGEONS: Armonda

ANESTHETISTS: [illegible]

PROCEDURE LOCATION: OR #2

DATE: 30 Oct 03

PAGE 1 OF 1

MEDCOM - 22541

DA FORM 7280, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: craniectomy depressed fx, debridement
SURGICAL SERVICE: neurosurg
NPO SINCE: 1800

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS: +
TOBACCO: ____
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

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

Ø hematoma, Ø ML shift on CT, A&O X3

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

LIHR

PHYSICAL EXAMINATION
BP 87/72 HR 76 RR 16 T ____
Pain Scale 0-10 3
HEENT - Teeth solid
Trachea ML
TMJ/Neck FROM
Oropharnyx mp II
Nares N/A
CHEST: RRR
CARDIAC: CTAB
EXTREMITIES:
IV Access: AC Bilat
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 1800

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

c-spine clear; DL OK, no need for mannitol/lasix

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

+/- a-line

The patient/legal [redacted] understand and agrees. Questions answered.
Signed: [redacted] Date: 10/30/03 Time: 2330 Hrs

POST-AN[redacted] ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

GSW Rt Frontal ↑ BLEs

Patient Identification: (Ward) ER →
[redacted] EPW

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

CI [redacted]

b(6)-2

NURSING UNIT: ICU1 | ROOM NO.: [redacted] | BED NO.: 4

DATE OF ORDER: 10/31/03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. TX to ICW
2. Dx: s/p Open Depressed Skull Fracture
3. Advance Clears to Reg
4. ~~D~~ D5 0.9 NS w/ 20 KCL @ 125 cc/hr
5. Foley to Gravity
6. Dilantin 300 mg po qhs

PATIENT IDENTIFICATION

8/11/24

DATE OF ORDER | TIME OF ORDER

7. Ancef 1gm IVPB q 8° x 48°
8. Bed Rest. [redacted]

b(6)-2

NURSING UNIT: 24° / 4 Nov 03 | ROOM NO.: 0445 | BED NO.:

PATIENT IDENTIFICATION

DATE OF ORDER: 11/7/03 | TIME OF ORDER: _____ HOURS

1. D/C IV
2. D/C Foley
3. Vitals [redacted]

noted 7 Nov 03 0445

b(6)-2

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

8 Nov 03 | 0215 | [redacted]

1a/An 24° Chart ✓

PATIENT IDENTIFICATION

DATE OF ORDER: 11/8/03 | TIME OF ORDER: 0904 HOURS

1. PT for (R) Shoulder Therapy [redacted]

b(6)-2 noted [redacted] SPC/AMMC 8 Nov 03 0905

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER 10/31/03 TIME OF ORDER 01:15 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU
2. Dx: Open Skull Fracture/
3. STP Debridement Skull Fracture Evacuation Mortar/Metal Frags (R) Frontal lobe
4. VSQ
5. HOB 30°
6. Vitals w/ neuro V's q 1°

PATIENT IDENTIFICATION

NOTED 31OCT 0155 [redacted] ILT/AN

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

7. NPO HOURS
8. IVDs 0.9NS w/20 KCL 125 cc/hr
9. Foley to Gravity
10. Ancef 1gm IVPB q 8°
11. Tylenol Suppository PRN pain q 4-6°
12. Dilantin 100mg q 8°
13. ~~Foley Gravity~~ I/O's
14. CBC, Chem 7 now & in am.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

b(6)-2 [redacted] HOURS

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
24° Chart Check 0300 31OCT [redacted] ILT/AN		

PATIENT IDENTIFICATION

DATE OF ORDER 10/31/03 TIME OF ORDER 1:36 HOURS

1. Advance to Cardiac Diet

[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.

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/w-2				11/9/03 _____ HOURS	
				(1) D/c to home	
				(2) D/c Stanleyville.	
				[redacted]	
				b/w-2	
NURSING UNIT	ROOM NO.	BED NO.			
				24 V 10 NOV 03 0327 [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.			

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

b/(6)-7

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10	11	12
31	[redacted]	DIET: advance	6	[redacted]												
		clears to regular	18													
31	[redacted]	Foley to gravity	6										DC'd			
			18										17 NOV	1150		
31	[redacted]	Bedrest	6													
			18													
31	[redacted]	N10: neurological	6													
		status vs 8/8	18													
06 Nov	[redacted]	Braden Scale q7d	06-18 18-06													
7 NOV	[redacted]	VS QS	D													
			N													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open depressed skull fx

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 - 22546

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
31	[redacted]	TX ICW#1				
8	[redacted]	PT for (R) shoulder therapy	8NOV	~~[illegible]~~		
9	[redacted]	D/C home				
9	[redacted]	D/C staples only				

	----	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. OCT ~~NOV~~ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	01	02
31OCT	[redacted]	VSI	06	/	[redacted]		
			18	[redacted]			
31OCT	[redacted]	Vitals & Neuro ✓ ql°	06	/	[redacted]		
			18	[redacted]			
31OCT	[redacted]	HOB 30°	06	/	[redacted]		
			18	[redacted]			
31OCT	[redacted]	NPO Clear liquids	06	/	[redacted]		
			18	[redacted]			
31OCT	[redacted]	Foley to gravity	06	/	[redacted]		
			18	[redacted]			
31 OCT	[redacted]	I:O's	06	/	[redacted]		
			18	[redacted]			

b(4)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
open Skull Fx
s/P Debridement Skull Fx Evacuation
(Mortar/Metal Frags ® Frontal Lobe)

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

PATIENT IDENTIFICATION:

SI: [redacted] b(4)-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 - 22548

EDITION OF 1 DEC 77 MAY BE USED — USAPA V1.00

Verity 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
31OCT	[redacted]	Admit ICU	31OCT	✓	0140	[redacted]
31OCT	[redacted]	CBC, Chem 7 now	31OCT	✓	OR	[redacted]
31OCT	[redacted]	CBC, Chem 7 in AM	31OCT	0400	0400	[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 *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo.____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8	9	10
31	[redacted]	D5NS c 20KCL @125	[redacted]										DC'd 7 ND 031150	
31	[redacted]	Dilantin 300mg po	[redacted]											
	-----	QHS												
31	[redacted]	Ancef igm IVPB q8°	8											
	-----	x48°	16											
	-----		24	KU										

	-----	b(6)-2												

Completed

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open depressed skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

b/w-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. OCT Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	01	02
31OCT	[redacted]	IV D50.9NS@ 20KCl	06	/	[redacted]		
	-----	@ 125 cc/°	18	[redacted]			
31OCT	[redacted]	Ancef 1gm IVPB q8°	06	/	[redacted]		
	-----		14	/	[redacted]		
	-----		22	[redacted]			
31OCT	[redacted]	Dilantin 100mg q8°	08	/	[redacted]		
	-----		14	/	[redacted]		
	-----		22	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open Skull Fx
s/P Debridement Skull Fx Evacuation
(Mortar/Metal Frags ® Frontal lobe)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

SI [redacted]

b/w-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
31OCT	[redacted]	Tylenol supp PRN Pain q4-6° D/T D/I														

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

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: Iraq Civilian

RANK / GRADE:

☒ MALE / HOMME
☐ FEMALE / FEMME

SSN / NUMÉRO MATRICULE: —

SPECIALTY CODE / GPM: —

RELIGION / RELIGION: —

2. UNIT / UNITÉ: —

FORCE / ÉLÉMENT: [redacted]

A/T	AF/A	N/M	MC/M

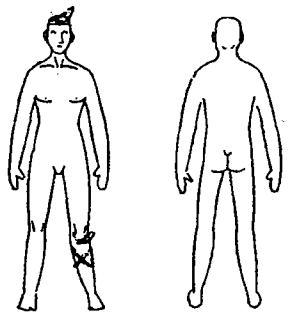
BC / BC: [redacted]

DISEASE / MALADIE: [redacted]

PSYCH / PSYCH: [redacted]

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



- ☐ AIRWAY / TRACHÉE
- ☒ HEAD / TÊTE
- ☐ WOUND / BLESSURE
- ☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- ☐ BURN / BRÛLURE
- ☐ AMPUTATION / AMPUTATION
- ☐ STRESS / TENSION
- ☒ OTHER (Specify) / AUTRE (Spécifier)

multiple shrapnel to head & (L) lower leg

b(6)-2

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: 78 — TIME / HEURE: 1845

6. TOURNIQUET / GARROT: ☐ NO / NON ☐ YES / OUI — TIME / HEURE: —

7. MORPHINE / MORPHINE: ☐ NO / NON ☐ YES / OUI — DOSE / DOSE: — TIME / HEURE: —

8. IV / IV: 18G/L arm — TIME / HEURE: 1850

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

dressing to head and (L) lower leg
L.R 1000 mL
IV started 1851 (L) arm
O2 given 6L/min
1850 = 72/12
1855 = 85/12
1900 = 72/12
1905 = 78/12

10. DISPOSITION / DISPOSITION

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

TIME / HEURE: 1910 hrs

11. PROVIDER: [redacted] 9W18

DATE/DATE (YYMMDD): 380063

DD Form [redacted] of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

DEC 91

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

☆U.S. GOVERNMENT PRINTING OFFICE: 2001–478-671

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89 b(a)-2

SHIFT ASSESSMENT

		TIME:	INITIALS:	TIME: 0200	INITIALS: [redacted]
NEURO	PUPILS			PERRLA 2mm sluggish	
	SENSORIUM			Responds to pain, sometimes to tur	
	EXTREMITY MOVEMENT			moving all extremities	
	SEDATION			ϕ	
	PAIN CONTROL			ϕ	
				Drsg to skull, CDI	
RESP	RESPIRATORY PATTERN			RRR	
	BREATH SOUNDS			CTA (B)	
	SECRETIONS			ϕ	
	O2 SOURCE/FLOW/SAO2			NC 4L 100%	
	VENTILATOR SETTINGS			NA	
CV	CARDIAC RHYTHM			ST S1/S2	
	CAPILLARY REFILL			<3 sec x 4 extremities	
	PULSES			+2 upper +2 lower	
	EDEMA			ϕ	
GI	ABDOMEN			Flat, Soft, Nontender	
	BOWEL SOUNDS			(+)	
	BOWEL MOVEMENT			(−)	
	NGT/OGT			None	
	TUBE FEDDINGS			N/A	
	DRAINS			ϕ	
GU	VOIDING			Foley to Gravity	
	COLOR/CLARITY			Clear Light yellow	
SKIN	COLOR			Normal for Race	
	INTEGRITY			Lac to head - Drsg CDI	
				Lac to (C) thigh - Drsg E S/S drains	
				Drsg to (B) LE CDI	
ACCESS	#1 TYPE/LOCATION/SIZE			PIV R AC 18G	
	DRESSING CONDITION			CDI	
	IV FLUID/RATE			HL	
	#2 TYPE/LOCATION/SIZE			PIV L AC 18G	
	DRESSING CONDITION			CDI	
	IV FLUIDS/RATE			DSNSE 20K @ 125 cc/°	

(Continue on reverse)

PREPARED BY: [redacted] b(6)-2 1LT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 31 OCT 03

PATIENT [redacted] (Where entries give: Name – last, first, middle; [redacted] ility)

NAME: [redacted]

RANK: AGE:

UNIT: b(6)-4

GENDER: (F)

STATUS: US: AD / CIV

IRAQI: CIV (EPW) SI

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 7

USAPPC V2.00

AL RECORD-SUPPLEMENTAL M DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0800 INITIALS: [redacted]	TIME: 1830 INITIALS:
NEURO	PUPILS	Perrla 3mm sluggish [redacted]	PERRLA 3mm Sluggish
	SENSORIUM	(+) color, motion & sensation x 4 ext	Alert Follows simple commands
	EXTREMITY MOVEMENT	MAE	~~sedated & some movements of ext.~~
	SEDATION	Ø A+O x3	~~noted. Propofol, MSO4 mf~~
	PAIN CONTROL	denies	Ø pain or sedation control
			Drsg to head CDI
RESP	RESPIRATORY PATTERN	even & unlabored	RRR
	BREATH SOUNDS	OTA & dim bases	Diminished Bases
	SECRETIONS	Ø cough, Ø secretions	Ø cough or secretions
	O2 SOURCE/FLOW/SAO2	2LNC 100%	NC 2L SaO2 > 95%
	VENTILATOR SETTINGS		Ø
CV	CARDIAC RHYTHM	S1S2 NSR Ø ectopy	RRR SR S1/S2
	CAPILLARY REFILL	< 3 sec cap refill	<3 sec x 4 sec
	PULSES	+2 pulses x 4 ext	+2 upper, +2 lower
	EDEMA	Ø	Ø
GI	ABDOMEN	flat, NT, ND,	Flat, soft, nontender
	BOWEL SOUNDS	hyperactive BS Ø BM	(+)
	BOWEL MOVEMENT		(-)
	NGT/OGT		NA
	TUBE FEDDINGS		None
	DRAINS		None
GU	VOIDING	clear light yellow	Foley to gravity
	COLOR/CLARITY	adequate output	clear light yellow
SKIN	COLOR	normal for race	Normal for Race
	INTEGRITY	multiple shrapnel wounds	shrapnel wounds to head, (L)
		head dressing c̄ blood stain	thigh, (B) LE.
		Ø progression	
ACCESS	#1 TYPE/LOCATION/SIZE	(L) & (R) AC PIV	PIV (L) FA 18G
	DRESSING CONDITION	Ø S/S of infexn,	CDI started 31 OCT
	IV FLUID/RATE		D5NS c̄ 20K @ 125 cc/°
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Sig [redacted] ILT/AN

b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 31 OCT 03

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

NAME: SI [redacted]

RANK: AGE:

UNIT: [redacted]

b(6)-4

GENDER: 07

STATUS: US: AD / CIV

IRAQI: CIV / EPW SI

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU1

Patients Name: [redacted] b(6) 4

Date: 31 OCT

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line			121	118	119	128	127	123	120	122	131	131		123	131	123	119	128							
NBP	116/66	117/65	121/66	118/71	119/69	128/70	127/69	123/72	120/71	122/73	131/80	131/74		123/72	131/74	123/72	119/69	128/69	123/71	149/74					
TEMP			99.7			99.0				99.2															
HR	98	98	88	97	96	90	92	88	92	80	95	91		88	97	80	92	96	86	87					
RR	16	16	15	14	15	18	18	19	18	18	18	18		18	18	18	10	15	16	16					
SaO2	95	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	98	98					
FiO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L					
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC					
MAP	84	85	88	89	88	92	91	93	91	93	100	96		93	100	93	88	91	92	102					

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125						
IVPB									150									100								
NGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
URINE	450/450	225/675	225/900				600/1500					800	2300	125/125	125/250	125/375	125/500	125/625	125/750	200/950						
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 22556

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]

ARRIVAL STATUS

TIME 2311 ☐ IV x 2 ☐ O_2 15 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☑ Yes: Albuterol (given running)

Allergies: ☐ UKN ☑ None ☐ Yes: _____

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

LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY

☑ Natural Patient [Y] [N]

☐ ETT _____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☑ Unlabored ☐ Absent

TRACHEA: ☑ Midline ☐ Deviated [L] [R]

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

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☑ Clear ☐ Muffled

SKIN: ☑ Warm ☐ Cool ☐ Hot

☑ Pink ☐ Pale ☐ Cyanotic ☐ _____

☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6 = 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

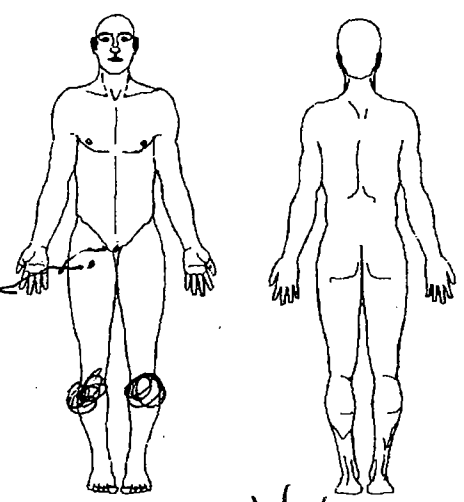
☑ Stable ☐ Unstable ☐ _____

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

Heme +/- Prostate: ☐ WNL ☐ Abnl

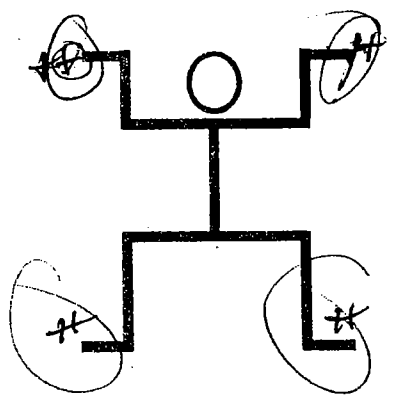
USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(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



b(6)-2

VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN [redacted]

PHYSICIAN [redacted]

(Continue on reverse)

PREPARED [redacted]

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION *(For typed or written [redacted] 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

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
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

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

LABS

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

X-RAYS

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

TIME	PROCEDURE	ACCOMPANED BY	RETURN
1340	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
0335	1	19	Y	N				
existing	1	18	Y	N				
			Y	N				
			Y	N				

MEDICATIONS

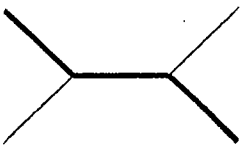
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE

BLOOD PRODUCTS

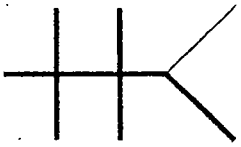
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem: LFTs.



P1/077

UA –

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	[redacted]			
Surgeon	[redacted]		662	
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

Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp: 99

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
2315	153/72	81	SR	N	100%	Ø					

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

2315 40 YBO [illegible] c/o pain to [illegible] forehead pt states he was hit by [illegible] in his head [illegible] LVCG [illegible] to the floor [illegible] bleeding [illegible] dressed, BP regulated [redacted] N [illegible] assuming by Dr [redacted]

b(4) - 2

[redacted] b(2)-2

7 Sept 2003

MEMORANDUM FOR Rear Area Operation Center, Baghdad

Subject: Patient Follow up

1. The following Iraqi civilian was seen at the 28th CSH as a patient and is authorized 1 follow up visit(s) on the date below:

FOLLOW UP VISIT DATE: 17 nov 03

PATIENT NUMBER: 1180

NAME: [redacted] b(4)-4

2. The patient can be escorted to the 28th CSH during regular visiting hours (1000 and 1400) after the necessary security precautions have been performed.

3. The POC for this memorandum is the undersigned at [redacted] b(4)-4

//original signed//
[redacted] b(4)-2
LTC, MC
Deputy Commander for Clinical Services

0580 - 28th CSH -	1Z	For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(4)-2	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1967-10-10	7. Age at Admission 36Y	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] b(4)-4
Organization (Active Duty Only)	13. Marital Status Z	Hour of Admission 23:11	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO
20. Source of Admission Direct from ER b2-2	Ward: ICU1	Name / Relationship of Emergency Addressee Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: 0580 [redacted] - Iraq; No Install Provided		Telephone Number of Emergency Addressee	
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-10	
24. Clinic Svc - Admitting AAJ - ~~NEUROLOGY~~ Neurosurgery	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-30	
27. Location of Occurrence 1Z	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-30	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: OPEN DEPRESSED SKULL FX

Dx: 80389 7194 Px: 0202 8731

Procedure Narrative(s):

Cause of Injury Narrative:

Adm[redacted] Si[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	32Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted]		ICU2

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	A11-ARMY ACTIVE DUTY			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	18:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-04

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-31	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 - [redacted] - Iraq	2003-10-31	

31. Selected Administrative Data

Marital Status: DoB: 1971-01-28

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: IED

34. Diagnosis / Operations and Special Procedures:

SHRAPNEL CHEST, GSW R ARM

Dx 861.31 Proc 87.44
864.10 87.41
E991.9 34.04

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer [redacted] MD

Signature of PAD or Medical Records Officer [redacted]

MEDCOM - 22562

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

32 yo I Detainee s/p I(-) exploration c multiple chest + back wounds

PMH ⊖ PSH ⊖

meds none

PHYSICAL EXAMINATION

PE - VSS
Lungs - clear
Heart - RR
Abd - nontender

chest + flank multiple wounds ⊖ sig bleeding

PROGRESS (Enter date of discharge and final diagnosis)

Imp - 1) I(-) c pulm contusion + liver laceration

Plan - Obs IN ICU, follow H/H + CXR

[redacted]

DATE	IDENTIFICATION NO.	ORGANIZATION
21 Oct		

(Written entries give Name last, first, date; hospital or medical facility)

REGISTER NO.	WARD NO.

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
539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31Oct03 2350	b(6)-2 auscultated lungsounds very diminished throughout. Pt c/o pain to (R) UQ. sats 99%. Ø S/Sx resp distress @ this time. will monitor. [redacted] LTAN
01Nov03 0200	Pt resting HOB ↑ 45° sats 97% on RA Ø S/Sx resp distress noted. LS CTA very dim (B). will monitor. Last H/H 13.4 + 42.2 Ø sig ↓ since previous H/H of 13.9 + 43.4. next draw @ 0245, will compare to results from 0045. [redacted] LTAN
0400	Pt resting HOB ↑ 30° sats 97% on RA Ø S/Sx resp distress, LS ↓ CTA (B). Last H/H from 0045 was 13.3 + 41.2, @ 0250 was 13.3 / 40.2 will cont. to monitor Q2°. [redacted] LTAN
0600	LS ↓ CTA (B) sats 99% on RA Ø S/Sx resp. distress. will monitor. [redacted] LTAN
11Nov03	0700 - pt awake - eyes open upon rounds all ext Ø Resp distress cardiac rhythm - full of chest lungsounds ↓ throughout sats remain 98% on RA - resp. also sq + c/o sudden onset of pain to (R) UQ - staples intact to (R) arm. Wound dressed - 4x4 [redacted]

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

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

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. ICU2

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1NOV03	0700-(R) pectoral area swollen tender to touch bruising noted - afebrile 98.6 - will Report [redacted] CBC
1NOV03	0820- pt c̄ transfer orders to CPW ward [redacted] [redacted] pt asleep
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
01NOV03	(1740) Pt admitted to unit from ICU in stable cond. Ambulatory. Φ c/o pain. VSS. Drsgs to shrapnel wounds to @ arm/shoulder Δd. Small amount sero-sang drainage noted. IVFs infusing into IV in @ dc s̄ S/Sx infection/infiltration. Tol. reg. diet well. voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted] AN
01NOV03 1900	VSS alert & oriented. (R) Ac IV leaking around cath. IV D/Ced & cath intact. Restarted IV (R) FA 18g 1¼ inch X1 attempt. IV infusing LRO 40cc/hr. (R) Arm/shoulder dry dry & intact. SOB → ambs to BR without difficulty. Consumed 70% of Regular diet for Dinner. Will continue care as planned. [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]		

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	M	TIAL	ID NUMBER

DATE	NOTES
11/2	DC SUMM.
	admit 10/31
	d/c 11/2 (pending)
	d/c dx - IED to liver + lung
	operation - Ø
	hx - pt hit c̄ IED to chest + abd. No pneumo or hemo-thorax. Multiple xrays cont ⊖. Abd wound thru liver + observed ⊖ Δ in exam + Hgb stable. DC in good condition
	b/w-2 [redacted]
Ø2NOVØ3	(1125) Assumed care @ Ø600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb well. Drsgs to shrapnel wounds on Ⓡarm/shoulder. Δd. Small amount of sero sang drainage noted. Tol reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
Ø2 NOV03 2000	Temp 100.6 @ 1857hrs. Tylenol PO given. Temp 99.1 @ 2000hrs. Amb to BR Independently. Drsg dry & intact to (R) shoulder/arm. Consumed 70% of Roseberry diet for dinner. Voiding clear amber urine. [redacted]

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

b/w-2

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3 NOV 03 @ 1400	Pt. resting quietly in bed, V.S.S. A&O x3. Ø C/O pain. Pt. in 2 point restraints, Ø signs of skin breakdown. Pt. has superficial shrapnel wounds to chest, No orders for DRSNG Δ.A. DRSNG's intact, Ø [redacted] All other assessments WNL. [redacted] RN
3 NOV 03 @ 2300	assumed care of pt @ 1800. VSS, C/O n/a, Tylenol given c good relief noted. Drsg's to chest wounds CDI. LS CTA @ BS, tol reg diet well, void per toilet c difficulty. + amb c difficulty. Pain monitor drsgs, pain control prn. 2pt restraints m/c S/Sx of skin/circulation compromise. WW monitor [redacted]
3 NOV 03	Surgery [redacted] b(6)-2
4 NOV 03 0700	Assumed care of pt A&O x3. Lungs clear SR/RR. Active BS. Urinating c difficulty ambulates well c diff. Pt for discharge shrapnel wound to @ shoulder and axillary region healing minimal bleeding Afebrile will cont to monitor. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EDW [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 V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11/1/3 0700	Surgery no problems overnight afeb vss Hgb stable ✓ CPR & prob transfer to floor may d/c to camp next 24-48°
	[redacted]
	b/(u)-2

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

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

[redacted] b/(u)-4

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

USAPA V2.00

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

32 yo Iraqi Detainee c̄ IED Explosion c̄ (R) axillary + tricep wounds. Currently 4/10 pain in shoulder

PE: VSS, gen N/AD Sats
CV: RRR ∅ (M)
Lys: ↓BS (R) Base, o/w good air exchange (B).
abd: Benign Chest: (+) hematoma TTP R chest,
Ext: (R) posterior trap + axilla c̄ wounds, open

A/P: shrapnel wounds - (+) intrathoracic
→ CT Abd/chest No intraabd wounds.
→ tetanus
→ Ancef 1gm IM.

CONSULT WITH	TIME	ACTION
GS -		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] MC HS

DIAGNOSIS
Shrapnel Wounds,
(+) intrathoracic Wounds.

CODES b/w-2

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

11

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

038

558-104

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 31 Oct 03 | TIME 1715

TRANSPORTATION TO FACILITY wheel vehicle

SEX M

AGE 32

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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT GSW chest (L) shoulder/(L) arm

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME 1715

INITIALS NJ

VITAL SIGNS

TIME	1715	1811	1822		
BP	114/72	108/71	112/69		
PULSE	108	88	83		
RESP	20	18	18		
TEMP					
WT					

LAB ORDERS

☒ CBC/DIFF | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT

URINE C&S | UA MSCC/CATH | ☒ CHEM: 12 elytes

BLOOD C&S X

☒ CXR

X-RAY ORDERS

CXR PA & LAT/PORTABLE | C-SPINE

ACUTE ABDOMEN | LS SPINE

SINUS | HEAD CT

ANKLE R/L

ORDERS

☒ PULSE OX 98%

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1733	1GM Ancef IV	[redacted]			
1740	.5 / 10mg IM	[redacted]			

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW [redacted]

b(2)-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)

[redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY 01 02 03/4 NOV

19 2003 HOUR 12 1 2 1 2 0800

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 124/66 120/87 114/80 113/61 111/59 105/8

Pulse 124/R 99 101 101H

Temp 100.6 100.3 99.7

HEIGHT: WEIGHT → 97% 97% 98%

97%(RA) 98 97%(RA) N/A

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(4)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(4)-4	DATE: 31Oct03 TIME: 2320	SSN/PSEUDONYM: [redacted] b(4)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted]		31-10-03
WB		23:29
b(4)-4		Patient Limits
WBC	13.2 H	x10^3/uL 4.5 10.5
RBC	4.71	x10^6/uL 4.00 6.00
Hgb	13.4	g/dL 11.0 18.0
Hct	42.2	% 35.0 60.0
MCV	89.7	fL 80.0 99.9
MCH	28.6	pg 27.0 31.0
MCHC	31.8 L	g/dL 33.0 37.0
Plt	440.	x10^3/uL 150. 450.
LY%	16.5 *L	% 20.5 51.1
LYM	2.2 *	x10^3/uL 1.2 3.4
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

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	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PI[redacted] Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI b(6)-4 #[redacted]	310ct03 TIME 2045	SSN/PSEUD[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
W[redacted]		
RE[redacted]		
Hg[redacted]		
He[redacted]		
MC[redacted]		
Plt[redacted]		
Ly[redacted]		
[redacted]		
Se[redacted]		
Ba[redacted]		
Lymph		
Atyp		
RBC Morph		

ID: [redacted] 31-10-03
WB 20:52

			Patient Limits	
WBC	16.9 H	x10^3/uL	4.5	10.5
RBC	4.85	x10^6/uL	4.00	6.00
Hgb	13.9	g/dL	11.0	18.0
Hct	43.4	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	450. H	x10^3/uL	150.	450.
LY%	10.3 *L	%	20.5	51.1
LY#	1.7 *	x10^3/uL	1.2	3.4

Baso			
Imm			

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

Urinalysis

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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

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	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 31 Oct 03	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING P[redacted] DY	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 # [redacted]	12Nov03	TIME 0250	SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	ID: [redacted]	01-11-03
RE	WB	03:01
Hg		Patient Limits
Hc	WBC 11.3 H x10^3/uL	4.5 10.5
M	RBC 4.54 x10^6/uL	4.00 6.00
	Hgb 13.3 g/dL	11.0 18.0
Pl	Hct 40.2 %	35.0 60.0
	MCV 88.6 fL	80.0 99.9
Ly	MCH 29.2 pg	27.0 31.0
	MCHC 33.0 L g/dL	33.0 37.0
	Plt 411. x10^3/uL	150. 450.
	LY% 20.6 * %	20.5 51.1
	LYM 2.3 * x10^3/uL	1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 [redacted]	DATE: [redacted] TIME: 0050	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
ID: [redacted]		01-11-03
WB		01:08
		Patient Limits
WBC	12.6 H	x10^3/uL 4.5 10.5
RBC	4.59	x10^6/uL 4.00 6.00
Hgb	13.3	g/dL 11.0 18.0
Hct	41.2	% 35.0 60.0
MCV	89.9	fL 80.0 99.9
MCH	28.9	pg 27.0 31.0
MCHC	32.2 L	g/dL 33.0 37.0
Plt	451. H	x10^3/uL 150. 450.
LY%	20.2 *L	% 20.5 51.1
LY#	2.5 *	x10^3/uL 1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(4)-2

Ward/Section: GMT | [redacted] PHYSICIAN: | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST: [redacted] | DATE | TIME | SSN/PSEUDO SSN:

b(4)

(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 =======
31/10/03 18:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(4)-2 0000100684

GLU	98	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	133	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

======= PICCOLO =======
31/10/03 18:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(4)-2 0000100697

ALB	4.6	3.3-5.5	G/DL
ALP	72	26-84	U/L
ALT	69*	10-47	U/L
AMY	56	14-97	U/L
AST	64*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
GGT	48	5-65	U/L
TP	7.8	6.4-8.1	G/DL

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

						CL		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

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

b(6)-2

Ward/Section: EMT	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 31OCT	TIME 1802	SSN/SELID/ID SSN: [redacted] b(6)-4

Hematology CBC

ID [redacted]
MB 31-10-03 18:04

			Patient Limits	
WBC	26.2 H	x10^3/uL	4.5	10.5
RBC	5.14	x10^6/uL	4.00	6.00
Hgb	14.9	g/dL	11.0	18.0
Hct	46.2	%	35.0	60.0
MCV	90.0	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	558. H	x10^3/uL	150.	450.
LYX	4.6 *L	%	20.5	51.1
LYM	1.2 *	x10^3/uL	1.2	3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		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	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: DT [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 # [redacted]	DATE 1 Nov 03	TIME 0500	SSN/PSEUD # [redacted] b(6)-4

(Hematology) [redacted]

TEST	RESULT	REF. RANGE
ID: [redacted]		01-11-03 05:43
WB		Patient Limits
WBC	12.1 H	x10^3/uL 4.5 10.5
RBC	4.58	x10^6/uL 4.00 6.00
Hgb	13.4	g/dL 11.0 18.0
Hct	41.2	% 35.0 60.0
MCV	89.9	fL 80.0 99.9
MCH	29.2	pg 27.0 31.0
MCHC	32.5 L	g/dL 33.0 37.0
Plt	406.	x10^3/uL 150. 450.
LY%	20.4	% 20.5 51.1
LYH	2.5 *	x10^3/uL 1.2 3.4
Lymph		
Baso		
Atyp		
Imm		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

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

CSF

Cell Count	
Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<40 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: KW1	REQ[redacted]		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE	TIME 1745	SSN[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted]		4.8-10.8 x 10³
		01-11-03 18:03
		Patient Limits
WBC	13.6 H x10^3/uL	4.5 10.5
RBC	2.42 *L x10^6/uL	4.00 6.00
Hgb	14.3 * g/dL	11.0 18.0
Hct	21.9 *L %	35.0 60.0
MCV	90.3 * fL	80.0 99.9
MCH	58.9 *H pg	27.0 31.0
MCHC	65.3 *H g/dL	33.0 37.0
Plt	220. * x10^3/uL	150. 450.
LY%	16.6 *L %	20.5 51.1
LY#	2.3 * x10^3/uL	1.2 3.4
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
[redacted]		01-11-03 22:34
		Patient Limits
WBC	13.6 H x10^3/uL	4.5 10.5
RBC	4.92 x10^6/uL	4.00 6.00
Hgb	14.3 g/dL	11.0 18.0
Hct	43.9 %	35.0 60.0
MCV	89.3 fL	80.0 99.9
MCH	29.1 pg	27.0 31.0
MCHC	32.6 L g/dL	33.0 37.0
Plt	472. H x10^3/uL	150. 450.
LY%	16.8 *L %	20.5 51.1
LY#	2.3 * x10^3/uL	1.2 3.4
Nit		Negative
Leuk		Negative
HCG		Negative

1CW1

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

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	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4 ICU2				10/31		
				1) admit to ICU		
				2) dx - ICD check abd		
				3) VS q1°		
				4) H/H q 2° call for any sig ↓		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER / HOURS	
[redacted] ICU2				5) LR 125 cc/hr		
				6) NPO		
				7) Tylenol 650 mg PR q4° ≥ cp/KO		
				8) cont pulse ox		
				9) CXR in AM		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER / HOURS	
[redacted] b(6)-4 ICU2				10) chest tube set at bedside		
				[redacted] b(6)-2		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER [redacted]	[redacted] HOURS	
[redacted] ICU2				31Oct03	2120	
				① Activity: Bedrest		
				VO. Dr [redacted] / [redacted]		
				b(6)-2		

Add Orders

Attendings Chart

noted 31 Oct [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] b(6)-4

DATE OF ORDER: 3 NOV 03 TIME OF ORDER: _____ HOURS

To Iraqi hosp today

b(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted] 3 Nov 03 b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 3 NOV 03 [redacted] 00 HOURS

(1) DISREGARD LAST MD ORDER, (TO IRAQI HOSP. TODAY)

N.O. DR. [redacted] 2 CT, AM

b(6)-2

b(6)-2

NURSING UNIT: JAV 0315 4 NOV 03 [redacted] | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 4 NOV 03 TIME OF ORDER: _____ HOURS

to EPW camp

b(6)-2 [redacted] 4 Nov 03 0900

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

PATIENT IDENTIFICATION

DATE OF ORDE [redacted]

b(6)-2

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REP. ES EDITION OF 1 JUL 77, WHICH MAY BE US.

Doctor's Orders

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11/1 | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) ICU → ICW
2) dx - IED
3) VS q4°
4) Gen Diet
5) LR 40 cc/hr
6) Tylenol 650 mg po q4° prn

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

7) Tylenol #3 1-2 po q4° prn severe pain
8) cancel previous lab order
9) CBC at 3 PM call if Hgb < 12.0

NURSING UNIT | ROOM NO. | BED NO.

Noted [redacted] b(6)-3

PATIENT IDENTIFICATION [redacted] b(6)-20945

DATE OF ORDER | TIME OF ORDER _____ HOURS

10) Xray (CXR) 11/2 early AM " fro IED chest
11) Plan transfer to Prison 11/2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11/2 [redacted]
d/c to Prison
d/c heplock
ambulate [redacted] b(6)-2

Noted [redacted] b(6)-3

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4 APR 79 | REPLACES EDITION OF 1 APR 79 | MEDCOM - 22583

DA 4256 03 002

b/w-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 01	02	3	4
01 Nov03	[redacted]	VS q 4°	08	[redacted]			
			18				
			06				
01	[redacted]	en diet	06	[redacted]			
			18				
			06				
01 Nov03	[redacted]	Ambulate	06	[redacted]			
			18				
			06				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: # [redacted]

b/w-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(4)-2 AN

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
01 NOV03	[redacted]	ICU → ICW	01 NOV03	—	—	[redacted]
01	[redacted]	Cancel previous lab order	01	—	—	[redacted]
01	[redacted]	CBC at 3pm	01	1500	1745	[redacted]
01	[redacted]	X-ray (CXR) 11/2 early AM. F/U ED chest	02 NOV03	0	0600	[redacted]
01	[redacted]	Plan transfer to prison 11/2				
02 NOV	[redacted]	D/C to prison				
3 nov	[redacted]	To Iraqi hospital today	3 nov	DISREGARD		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
01NOV03	[redacted]	Call MD if Hgb <12.0 (c̄ CBC @ 3pm 01NOV)														
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

b/w-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2										
31 Oct	[redacted]	V/S Q 1°	06	/	[redacted]											
			18		[redacted]											
31 Oct	[redacted]	H+H Q 2° call for any	06	/	[redacted]											
		Sig ↓	18		[redacted]											
31 Oct	[redacted]	NPO	07	/	[redacted]											
			12	/												
			17	/												
31 Oct	[redacted]	Continuous pulse Ox	06	/	[redacted]											
			18	[redacted]												
31 Oct	[redacted]	Activity: Bedrest	06	/	[redacted]											
			18	[redacted]												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IED chest + abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: # [redacted]

b/w-1

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 - 22586

EDITION OF 1 APR 77 MAY BE USED

USAPA V1.00

b lu)-2 A11

Verity 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
31Oct	[redacted]	Admit to ICU - Dx IED chest + axial	31Oct	—	1930	[redacted]
31Oct	[redacted]	CXR in AM	31Oct	~~0400~~	done	[redacted]
31Oct	[redacted]	Chest tube set c̄ bedside	31Oct	—	done	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo Oct Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2											
31 Oct	[redacted]	LR @ 125cc/hr	00	/													
			18	[redacted]													
31 Oct	[redacted]	Tylenol 650mg PO Q4	04	/													
		c sips H_2O	08	/													
			12	/													
			16	/													
			20	[redacted]													
			24	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IEA chest + abdomen

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

MEDCOM - 22588

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — 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. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 01												
01 Nov 03	[redacted]	LR 4cc/hr	06 18	[redacted]	DIC 02 NOV 03											
	-----		18 06													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
02 NOV	[redacted]	D/C heplock	02 NOV	—		[redacted]
		b(4)-2 AM				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
01 NOV	[redacted]	Tylenol 650mg po 9-4 pm	D/T	02NOV 1740	02NOV 1900	02NOV 2000										
			D/I	[redacted]												
01	[redacted]	Tylenol #3 1-2 po 9 to pm severe pain	D/T	02NOV 0330												
			D/I	[redacted]												

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

b/w-2

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2030	INTILAS		INTILAS	INTILAS
	PUPLIS	2mm brisk reaction				
	SENSORIUM	Alert follows				
		Commands MAE				
		Sport., restraints				
		on (B) arms				
RESPIRATORY	RESPIRATION PATTERN	RR 20's unlabored				
	BREATH SOUNDS	even ↑+↓ (B) LSCTA				
	SECRETIONS	∅ cough/secretions				
SKIN	COLOR	W+D intact, post				
	INTEGRITY	(R) shoulder shrapnel				
		Sm amt drng noted				
IV SITE	LOCATION	18G (L) AC infusing				
	CONDITION	LR @ 125cc/hr ∅				
		S/Sx infection				
		noted				
GASTRO	ABDOMEN	(+) BS x 4 quads				
	BOWEL SOUNDS	abd sft non-tender				
		non-distended				
GU	URINE	void spont.				
	COLOR/CLARITY	∅ UOP @ this time				
CARDIOVASCULAR	CARDIACRHYTHM	SR 80's ∅ ectopy				
		B/P stable 2+ pulses				
		all extrem. ∅ edema				
		noted.				

LEGEND
Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC ICU2

DATE 31 Oct 03

PATIENT'S INDICATIONS (For typed or written entries give: Name --Last, First, middle; grade; date; hospital or medical facility)

b/w-4

[redacted] EPW

32 y.o. ♂

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DATE 31 Oct 03 | DX GSW head/chest (R) arm | HOSPITAL DAY

VITAL SIGNS

TIME	23/24	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	113/69	115/60	107/56	102/62	109/60	113/64	112/63	114/65	112/64	112/69	110/68							
Temperature	99.5							98.9										
Pulse	83	77	83	72	79	79	78	80	74	73	83							
Respiratory Rate	26	18	21	17	8	18	11	14	14	16	12							
Sats	99	97	97	95	100	98	97	99	97	98	99							
Source	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA							

INTAKE

TIME	23/24	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10	11	12	13	14	15	8°T
LR	125	125	125	125	125	125	125	125	125	125	125							
LVPB																		
Blood																		
Bolus																		
TOTALS	125	250	375	500	625	750	875	1000	1125	1250	1375							

OUTPUT

URINE	HOUR / TOTAL		550/650			450/1000				350/1350								
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	07	08	09	10	11	12
BP Arterial Line						
BP Cuff	110/68	113/63				
Temperature	98.6	-				
Pulse	89	78				
Respiratory Rate	18	14				
SaO2	98%	99%				

INTAKE

TIME	07								8° T									8° T
LR	125	125																
Oral	60																	
TOTALS																		

OUTPUT

		HOUR / TOTAL																	
URINE		200																	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

copy for record

[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. 347)
- ☐ 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. 426)
- ☐ 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: KPG + 5m ARMS ATK near ABU on 3/5

- ☐ 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: 4/1 FA		Location Grid:	
Date of Incident (D/M/Y) 31/10/03 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: SAHALE			Last Name:		
First Name: HAMIDE Given Name:			First Name: Given Name:		
Hair Color: BLK	Scars/Tattoos/Deformities:		Hair Color:	Scars/Tattoos/Deformities:	
Eye-Color: BRN	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: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print):	Supervising Officer's Name (Print):
[redacted] Last, First MI	Last, First MI
Signature: [redacted] TL CPT	Signature:
Email: [redacted]	Email:
Unit Phone: [redacted] e / /	Unit Phone: Date: / /

b(6)-2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? [illegible] a list near Abu Ghraib. The hotel detained approached Somali [illegible] weapons & [illegible] Coalition Forces.

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? Hand Guns

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

b(6)-2

Additional Helpful Information: [illegible] [redacted]

[illegible] at [redacted]

b(6)-4

b(2)-2

1. Reporting MTF	2. MTF Loc	Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG
[redacted]	IZ	

3. Registration Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted] b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1971-01-28	32Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		20	[redacted] b6-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		18:00	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78 ~~A11~~ ARMY ACTIVE DUTY	

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

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU2	Address of Emergency Addressee

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

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-04

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-31

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-31

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SHRAPNEL CHEST, GSW R ARM

Procedure Narrative(s):

Cause of Injury Narrative: IED

b(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	[redacted] SPC, 91B10

9	10	11	12	13	14	NAME (Last, First, Middle Initial)

4. PAY GRADE		5. SEX
16	17	18

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

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45

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

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

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

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

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102

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

FOR LOCAL USE

Dx 86131 86410 E9919

Pr 8744 8741 3404

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

[redacted]

b(6)-2

b(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]						3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE 52	6. RACE UNK	RELIGION UNK	LENGTH OF SVC NA	NA	10. PREVIOUS ADMISSION NO	
11. FMP NA	12. SSN [redacted]			13. ORGANIZATION NA		14. WARD ICW1	
15. FLYING STATUS NA	16. DSG	BEN NA		18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from Emt				22. HOURS OF ADMISSION 0240	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK				25. TYPE DISPOSITION 21	26. DATE OF DISPOSITION 01NOV03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 31OCT03	ADMITTING OFFICER b(6)-2 Dr. [redacted]	
29. NAME AND LOCATION OF CIVILIAN TREATMENT FACILITY [redacted]					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: SHRAPNEL WOUNDS

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

52yo ♂ EPW s/p fragment wounds to (R) forearm and lower back. Pt ambulated into EMT.

PMedHx
Asthma NKDA Meds
0

PHYSICAL EXAMINATION BP 167/95 HR 103 RR 16 Ax-96.2 ra

HEENT - clear
CV - RRR
Lungs - CTA (B)
Abd - obese / tender
Back - wound to (L) back

Ext
wound to
(R) forearm
Negative CT scan for intra-abdominal schrapnel

PROGRESS (Enter date of discharge and final diagnosis)

A/P: Schrapnel injury
(1) Admit + observe

b(6)-2

SIGNATURE [redacted]	DATE 31 OCT 03	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

EPW
[redacted]
b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-108

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1NOV03 R1142	Pt. A&O, V.S.S. Ø C/O pain. DRSNGS CDI Pt. to be D/C'd to EDW comp. — [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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTIO

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 OCT 03	52yo Iraqi gr presents c̄ fragment wounds
1715	to (R) FA and lower back. Pt ambulated into
	Cell after being sen (R) Iraqi hosp.
103	CXR PA and LAT & AAS ordered.
16 96% RA	1730 IGM Ancef IM given. .5 of Tylenol SL
167/95	given [redacted] b(6)-2
NKDA	PE: VSS, gen NAD
Ø Meds	Back c̄ Multiple shrapnel wounds
	All c̄ hemostasis, (R) forearm superficial
PMH	CV: RSR Ø (M)
Asthma	Lys: CTA (B)
	abd: soft, NTP, (+)BS, obese
	Ext: Pulses 2+ x4
	xrays c̄? intraabd wound.
	CT (-) for intraabd.
	A/P: superficial shrapnel
	wounds, stable
	- admit for ops, return DEPW in
	am. [redacted]
	b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPA[redacted]
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.)*

GTV EPW

H[redacted] b(6)-4

REGISTER NO. | WARD NO.

MEDCOM - 22601

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

01 NOV 03

0930

Discharge Summary

52yo ♂ EPW, s/p schrapnel injury to (L) back & (R) forearm with negative CT scan for intrathoracic or intrabdominal schrapnel & pt to be returned to EPW camp. Pt requires q 3 day dressing changes to (R) forearm and back & will prescribe 10 days of antibiotics and Percocet for pain.

[redacted] MD

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.

EPW

#[redacted]

b(6)-4

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR OCT	DAY	31														
2003	HOUR	2400														
PULSE (0)	TEMP. F (°)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																
RESPIRATION RECORD																
BLOOD PRESSURE		136/78														
		80														
		96.5														
HEIGHT:	WEIGHT →	151														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

Ward/Section: LMT | REQU[redacted]

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

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 31OCT03 | TIME: 1910 | SSN/[redacted]: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT		REF. RANGE
ID: [redacted]			31-10-03
WB			19:07
			Patient Limits
WBC	14.5 H	x10^3/uL	4.5 10.5
RBC	5.24	x10^6/uL	4.00 6.00
Hgb	14.7	g/dL	11.0 18.0
Hct	46.3	%	35.0 60.0
MCV	88.4	fL	80.0 99.9
MCH	28.1	pg	27.0 31.0
MCHC	31.8 L	g/dL	33.0 37.0
Plt	438.	x10^3/uL	150. 450.
LY%	13.4 *L	%	20.5 51.1
LY#	2.0 *	x10^3/uL	1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
		Negative

icrobiology

	Negative
	Negative

topic Urinalysis

ood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 19:10

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.2 sec.
Ratio = 1.2
Calculated INR = 1.28
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :19:08
Card Lot :080201
Operator : [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 19:16

Patient ID: [redacted]
Test Name :APTT
Test Result:= 24.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :19:14
Card Lot :030201
Operator [redacted]

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	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

Ward/Section: EMT

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

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

DATE: 31OCT03 TIME: 1910

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

[redacted] -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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
31/10/03              19:06
REFERENCE RANGE:       MALE
PATIENT #: [redacted]  b(6)-4
BASIC METABOLIC
DISC LOT #:         3325AA4
OPER #: [redacted] b(6)-2  DR #: 000
SERIAL #:        0000100494
.........................
GLU   238*  73-118    MG/DL
BUN     9   7-22      MG/DL
CA++  9.2   8.0-10.3  MG/DL
CRE   1.0   0.6-1.2   MG/DL
NA+   138   128-145   MMOL/L
K+    4.8*  3.3-4.7   MMOL/L
CL-   ♦♦♦   98-108    MMOL/L
tCO2   27   18-33     MMOL/L

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

CL - 105

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
31/10/03              19:08
REFERENCE RANGE:       MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #:         3153AA7
OPER #: [redacted]  DR #: 000
SERIAL #:        0000100684
.........................
ALB   3.9   3.3-5.5    G/DL
ALP   106*  26-84       U/L
ALT    27   10-47       U/L
AMY    46   14-97       U/L
AST    28   11-38       U/L
TBIL  0.8   0.2-1.6   MG/DL
GGT    24   5-65        U/L
TP    8.7*  6.4-8.1    G/DL

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

tCO₂		18-33 mmol/L

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

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

*U.S. GPO: 1992-316-809/60175

0-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

INATION(S) REQUESTED: CT abd/ Pelvis C̄ IV + oral contrast

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.

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

PREGNANT ☐ YES ☐

TELEPHONE/PA

TOR

DATE REQUEST

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

Rlo intraabd frag. (xray C̄ frag. appearin intra abd

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

LOGIC REPORT

1) (L) flank shrapnel.

2) Else normal.

[redacted] MD

b(6)-2

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

LOCATION OF MEDICAL RECORDS

[redacted]

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 31 OCT 83 TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to
2. Dx - Schrapnel wounds
3. Condition - stable
4. Vitals - per floor routine
5. Allergies - NKDA
6. Activity - OPW partial

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER _____ HOURS

7. Nursing - notify MD for temp > 100.4 / BP > 170/90 or < 90/50 HR > 120 or < 50 RR > 25 or < 10
8. Diet - Regular

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted] b(4)-2

DATE OF ORDER | TIME OF ORDER _____ HOURS

9. IVR ~~[illegible]~~ Heplock
10. LABS - Q
11. Meds - Percocet - 1-2 PO q 4-6 prn
    Ancef - 1 g IVPB q 8° x 3 doses

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER _____ HOURS

12. Wash out [redacted] wounds
    + dress [redacted]
    floor XT [redacted]

b(4)-2

NURSING UNIT | ROOM NO. | BED NO.

24°V INDV @ 0624 [redacted] T/HW

DA FORM 1 APR 79 4256 REPLACES EDITIO[redacted] 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]				8 NOV 03	0930 HOURS	
				(1) D/C IV Abx		
				(2) D/C to OPD w/ consult [redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
b(6)-2 [redacted] 8 NOV 03 0930						
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.

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4									
31	[redacted]	VITALS: routine	6	[redacted]												
			18													
31	[redacted]	ACT: EPW protocol	6	[redacted]												
			18													
31	[redacted]	Notify MD for:	6	[redacted]												
		T > 100.4	18													
		BP > 170/90 < 90/50	/													
		HR > 120 < 80	/													
		RR > 25 or < 10	/													
31	[redacted]	DIET: regular	6	[redacted]												
			18													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Gunshot wounds

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

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
31	[redacted]	admit ICW1, stable				
31	[redacted]	washout wounds & dress on from xt				
01 Nov03	[redacted]	Dc to EPW camp				

	----	b(6)-2				

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

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo.____ Yr.____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3
31	[redacted]	IVF-heplock	6	[redacted]			
			18	[redacted]			
31	[redacted]	Ancef + gm IVPB	6	[redacted]			
		q8° x 3 doses	14	[redacted]			
			22	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
shrapnel wounds

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
01 NOV03	[redacted]	DIC IV ABX	01 NOV03			
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
PRN	[redacted]	Percocet 1-2 po Q4-6° prn	D/T													
			D/T													

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

b(6)-4

[redacted]

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

[X] Offense against Coalition Forces [check one] If "Other" then describe: RPG + 5m ALMS ATK NEAR ABI JN 31 J

- [ ] 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: 4/1 FA		Location Grid:	
Date of Incident: (D/M/Y) 31/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

b(6)-4

Detainee # [redacted]		Key Connected Person: [ ] Victim [ ] Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted] Given Name:		First Name: Given Name:	
Hair Color: BLK	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: BRN	Weight: lb / Height: in	Eye-Color:	Weight: lb / Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: [X] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:		[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	

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

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

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

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature: [redacted] PT A53	Signature:
Email: b(6)-2	Email:
Unit Phone: [redacted] Date: / /	Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? DURING A RIOT NEAR ABU GHARAIB THIS PERSON WAS DETAINED FOR SMALL ARMS ATKS ON US FORCES.

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? SM. ARM (HAND GUNS)

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: ADDITIONAL INFORM CAN BE SOUGHT FROM 4/1 PA AT FOLLOWING CONTACT # 5517129

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 D 1	I 2

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	[redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	5 2 4	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	
NA	2	0240	NA b(4)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O b(2)-2	ICW1	UNK
NAME AN [redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
2 1		0 3 1 1 0 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 1 0 3 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		0 3 1 0 3 1

FOR LOCAL USE

DX: SHRAPNEL WOUNDS

Dx: 879.5
876.0
E991.9

Proc: 88.19
88.01

Inj Trauma
443 1

881.10
876.1
E993

88.01

ADMITTING OFFICER (Signature, as [redacted] b(4)-2 Dr [redacted]

SIGNATURE OF ADMITTING CLERK

DA FORM 2085, MAR 80

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms) [redacted] b(6)-4	GRADE Grade —	BRANCH OF SERVICE Arme —	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation	NATION (e.g., United States) Pays: Iraqi	DATE OF BIRTH Date de naissance	SEX Sexe: [X] MALE Masculin [ ] FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
[ ] CAUCASOID Caucasique	[ ] SINGLE Célibataire	[ ] PROTESTANT Protestant
[ ] NEGROID Négroïde	[ ] MARRIED Marié	[ ] CATHOLIC Catholique
[✓] OTHER (Specify) Autre (Spécifier): Iraqi	[ ] WIDOWED Veuf	[ ] JEWISH Juif
	[ ] DIVORCED Divorcé	[✓] OTHER (Specify) Autre (Spécifier): Muslim
	[ ] SEPARATED Séparé	

NAME OF NEXT OF KIN Nom du plus proche parent

RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit

STREET ADDRESS Domicilé à (Rue)

CITY OF TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.	Gunshot wound to Pelvis	
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Cardiac failure	48 hours
Symptômes précurseurs de la mort. — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès: [ ] NATURAL Mort naturelle; [ ] ACCIDENT Mort accidentelle; [ ] SUICIDE Suicide; [ ] HOMICIDE Homicide	AUTOPSY PERFORMED Autopsie effectuée: [ ] YES Oui [X] NO Non MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
	NAME OF PATHOLOGIST Nom du pathologiste	
	SIGNATURE Signature — DATE Date	AVIATION ACCIDENT Accident à Avion: [ ] YES Oui [X] NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année): 3 NOV 03

PLACE OF DE[redacted] b(2)-2

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDI[redacted]

J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF MEDICA[redacted]cin sanitaire: b(6) [redacted] 2

TITLE OR DEGREE Titre ou diplômé: MD

GRADE: LTC [redacted] b(2)-2

DATE Date: 3 Nov 03

SIGNATUR[redacted] b(6)-2

[1] State disease, injury or complication which caused death [redacted] eath.
[2] State conditions contributing to the death but not related to [redacted] rrêt du coeur, etc.
[1] Préciser la nature de la maladie, de la blessure ou de la compl[redacted] qui a contribué à la mort, ma[redacted]
[2] Préiser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou [redacted]

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA [redacted] ST, 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

record

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400. THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL [redacted] b(2)-2

Instructions - Medical Offi[redacted] in attendance will [redacted]

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or A[redacted]ministrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

[redacted] b(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

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

0054 3 NOV 03

3. MEDICAL EXAMINER, CORONER'S CASE ☐ YES ☑ NO

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☑ NO

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

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Gunshot to Pelvis	
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) cardiac failure	<18 hours
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b. b(6)-2 [redacted]	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIG[redacted] ATTENDANCE
3 NOV 03	[redacted] LTC	[redacted]

SECTION B - ADMINISTRATIVE ACT[redacted]

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	[redacted]SPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

'A FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	25Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
20	[redacted]					ICU1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
NO	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	18:10	ABA - GENERAL SURGERY					
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:				
		2003-10-31	[redacted] b(6)-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] b(2)-2		2003-10-31					

31. Selected Administrative Data

Marital Status: DoB: 1978-07-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: GSW BUTTOCKS

34. Diagnosis / Operations and Special Procedures:

DIVERTING COLOSTOMY/ SUPRAPUBIC TUBE PERUNEAL DRAINAGE

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	3	3

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	3	3

Signature of Attend[redacted]	Signature of TAD or Medical Records Officer
	[redacted]

Automated Facsimile - DA FORM 3647, May 79

b(6)-7

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

IRAQI MALE SIP GSW TO (R) Buttock. C/O (L) hip/leg pain, Ø belly pain.
Alert + Oriented on arrival

PMHx: ASTHMA.
PSHx: Ø
Meds: unknown
All: unknown

PHYSICAL EXAMINATION T- P-135 149/118 12
HEENT - NC/AT PERRLA EOMI
Neck - (-) JVD
Chest - few wheezes to (R) side, Good air entry
CVS - Tachy (-) G/M/R
Abd - Mild distention nontender +BS Ø rebound
Pelvis - tender (L) pelvis / stable Entry wound (R) buttock
Rectal - destroyed rectal vault ~~connecting to~~ Foley catheter felt
(+) blood (-) meaters
Ext - (-)
~~Imp: 6~~

PROGRESS (Enter date of discharge and final diagnosis)

Dx: GSW to perineum
Plan Need emergent exlap for diverting colostomy / suprapubic tube
pelvic washout + drainage
with Urology

[redacted]
MAJ, MC.
[redacted] GENERAL SURGERY

DATE	IDENTIFICATION NO.	ORGANIZATION
31 OCT 03		

[redacted] (Written entries give Name (last, first, date; hospital or medical facility)

REGISTER NO.	WARD NO.

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6)-4

31 OCT 03 2130 PT # [redacted] Bed #2 received from OR intubated. Per anesthesia PT received 2 U PRBC, 10L Crystalloid during operative procedure. Upon transfer to bed PT was monitored. BP 107/59 P. 133 RR 16 Sao2 75-83. PT then connected to ventilator with Sao2 per above, he was immediately suctioned and medicated ☰ morphine 10mg and Sao2 improved to 88-97%. Upon auscultation breath sounds were noted to have Expiratory wheezes. Blood gas was PH 7.170 Pco2 50.3 Po2 45. PEEP ↑ FiO2 ↑ ABG was repeated for verification and PH 7.2[illegible], Pco2 [illegible] Po2 108 Hco3 18 MD at bedside monitoring events. b(6)-2 [redacted] ILT/AN

2330 PT ~~[illegible]~~ hypotensive BP 90/[illegible]. PT received 3L NS bolus. Received orders to transfuse 2U PRBC. Unit #'s 1645515 & 55FH63488 transfused without any RXN. PT still remains with map 265. b(6)-2 [redacted] ILT/AN

0100 5cmg hydrocortisone IV administered. TLC placed to transfuse CVP = 10-13. [redacted] b(6)-2

0130 Albumin 5% ordered with transfuse ASAP [redacted]

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

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0330	ABG & morning Labs Sent. PT still hypotensive. Albumin being transfused at this time. Will continue to monitor BP — [redacted] LT/AN
0430	BP drops to 60's/50's. MD aware and ordered neosynephrine 10mcg/min titrate to effect. Will monitor BP for effectiveness of med. K-Stent
0447	BP to manual cuff Now 103/51 A-line 83/55. Will continue to monitor and titrate Neo accordingly — [redacted]
0450	Albumin 5% completed. [redacted] LT/AN
0452	FiO2 ↓ to 95% — [redacted] LT/AN
0500	Neo titrated down to 7.5mcg/min. Sao2 100% — [redacted] LT/AN
0506	PT restarted on MSO4 2mg & versed 2mg. [redacted]
0510	PT BP dropped to 87/48. Neo drip increased to 25mcg/min. Will continue to monitor. [redacted]
0630	FiO2 ↓ 85% — [redacted]
	b(6)-2 All

STANDARD FORM 509 (REV. 5/1999) BA(
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MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
1700 1 Nov	Daysliff nursing note: Received report from previous nurse. Pt hemodynamically unstable, & acidotic at start of shift. Fluid resuscitated total of c̄ 5% Albumin 1500cc & 1LNS to CVP of 16. Excellent UOP. Neo @ 25 mcg/min titrated to map of 65 now @ 10mcg/min. Pt had episode of hypotension total of 2 amp Cath & 2 Amp of Epi given. Epi gtt started and titrated to SBP > 90 now @ 1028 mcg/kg/min BP - 96/46 (65). Acidosis resolved c̄ a total of 9 amps NaHCO3 & vent changes. Pt now with decreasing O2 requirements. Current vent settings P-5, 50% FiO2, TV-800, SIMV-14, PIP hi 20's, ABG @ 1600 - pH - 7.33, PCO2 - 37.4, PO2 - 181, HCO3 - 20, SaO2 - 100, BE - 6, Plan to keep epi @ current rate for inotropic support & wean neo off. Colostomy beefy red, Ø air in bag. Dressing on Suprapubic cath & JP drain replaced as needed. K = 3.3 replaced c̄ 40 mEq. Vecuronium gtt started @ 7mg/hr, 10 mg Vec IVp loading dose given.

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPARTMENT/SERVICE

HOSPITAL OR MEDICAL FACILITY

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

RECORDS MAINTAINED AT

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
1830 01 Nov 03	Received report on PT 1188, Bed #2 @ unstable BP. PT is medically paralyzed on vecuronium 7mg/hr, Versed - 2mL/hr & MSO4 - 2mL/hr. PERRL @ 2mm sluggish. moderate bloody secretions from nostrils suctioned frequently. PT vented @ ETT #8.5. RR 14 TV 800 PEEP 7 FiO2 50%. Lungs sound coarse with no wheezes. Scheduled neb treatment given. PT Tachycardic 150's. BP 90/30's and continues to slowly trend down. Pulses diminished throughout. JP drain & suprapubic catheter patent and draining. Abd sounds hyperactive. midline incision c/d/I. Will continue to monitor progress. K. Stewart.
1850	CBC/PT/PTT drawn and sent to Lab. ABG by 1 stat @ pH 7.30 PCO2 41.5 PO2 84 HCO3 21 SaO2 95%. PEEP dropped to 5cm/H2O & FiO2 @ 45% per orders to keep PaO2 >65. Received CBC/PTT results @ 2000 out of range and H/H 10.2/17.9. At this time ~~temp~~ BP drop to 72/37. MD notified and ordered 1L LR bolus. Post bolus PT remains hypotensive and neosynephrine ↑ to 15mcg/min with no effect. MD was called STAT to bedside

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.

[redacted]

b7(c)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	and CBC & BP status was brought to his attention immediately. ½ Amp Epinephrine was given, followed by another with adequate results BP 192/74. PT return to hypotensive state shortly after. 4U PRBC was rapidly transfused followed by 4 Amp bicarb, 1 Amp CaCl, 1g mag+ due to acidotic state. PH 7.165 PCO2 48.7 PO2 60 HCO3 18 SaO2 86 BE -11. Subsequently Epi drip was running at 4 mcg/min. PT had echo done at bedside and was shocked with 200J 300J, 360J. Around 1926 BP normalized to 106/41. At 2000 hrs PH 7.251, HCO3 49.5 PO2 215 HCO3 22 [redacted]
2005	Start to wean Epi drip by 0.5cc per 1. Drip weaned to 3 mcg/min. [redacted]
2100	Epi drip wean to 4 mcg/min [redacted]
2200	I stat done ABG WNL. Fio2 ↓ 60%. Epi ↓ 2 mcg/min [redacted] 1LT/AN
2300	Fio2 ↓ 55%. K+ 2.8. received order for 1gm mg+ & 40 KCl. Epi ↓ 2.1 mcg/min. will monitor K+ & repeat 40 meq if K+ < 3.5.
0100	Post K+ run analysis. K+ 4.0 to I stat & 3.8 by chem 8. Will hold 2nd dose of 20 meq KCl X2 as ordered. PH: 7.461 PCO2 32.7 PO2 106. RR ↓ to 6 [redacted] and rate. Will continue ABG Q1H [redacted] 1LT/AN

b(4)-2 A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2 A/1

0300 ABG Sent. Results attached to progress notes. PT continues to have fluctuation in BP map between 60's/65 [redacted]

0440 Dr. [redacted] at bed side. BP drops to 75/50's. HR 150's. IV LR boluses given c̄ minimal effect. Per physician PT is persuasion as evidenced by UOP 700 cc/hr & CVP 13. Will continue to monitor progress [redacted] LT/AN

1000 Pt remain clearly guarded. VS unstable, remain on epinephrine drip titrated to maintain MAP > 65. Increased rate to 3.0 mcg/min @ this time MAP (56) heart rate 144.

1051. ↑ Neo to 15 mcg/min due to MAP 57. BP Now 86/45 MAP 61. Will titrate to effect to ↓ Epi [redacted]

1107 BP 116/62 MAP 82. Neo ↓ 15 mcg/min & Epi 2.5 mcg/min. HR 144. ABG sent. [redacted]

1210 Notified MD for ↓ BP 81/41 MAP < 60. Ordered to titr Neo to 19.5 mcg/min & epi @ 2 mcg/min. UO > 50 cc/hr. May try Dobutamine as a last resort. Continue to closely monitor hemodynamic states. — [redacted] Mj/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.

PROGRESS NOTES
Medical Record

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USAPA V1.00

[redacted]
b(6)-4

b(6)-2 A-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02 Nov 03	Pt received a total of 2L LR, c̄ ⊕ result. BP 88/48
1400	c̄ MAP 64. Epinephrine 1.6 mcg/min. Nalbutamine on hold
1430	per Dr Dixon, norepinephrine 19.9 mcg/hr. Titrate
	downward but keep MAP >60. BP 94/55 (70) - 133 - 16
	SAO_2 96% — [redacted] mj/AN
1615	A new femoral A-line ⓛ started @ 1500, working well.
	Current BP 90/44 - 132 - 16 - 58 - 93% 60%. Bloody secretions
	noted from the nostrils. MD made aware. Albumin
	drip in progress @ 125 cc/hr until complete. T 96.6.
	Neo @ 19.9 mcg/min, epi drip @ 1.6 mcg/min. LE NV sluggish
	but c̄ blood return, cool to touch. Flows red (dark)
	noted "perfusing" putting watery yellow discharge.
	Continue to monitor — [redacted] mj/AN
1700	Albumin drip completed. BP 81/46 - 128-16 - Sat 91%. All
	extremities are edematous + cool to touch. Continue to
	monitor. — [redacted] mj/AN
1805	ABG 1645: pH 7.29, PCO_2 45.1, PO_2 55, HCO_3 22, SAO_2 84%.
	MD notified ordered to ↑ RR 18 + ↑ FIO_2 65% repeat
	ABG in 30 minutes (1835) — [redacted] mj/AN
1850	ABG done PO_2 52. ↑ FIO_2 to 95% [redacted] mj/AN
3Nov3	Code Note
	Pt asystolic, 2 Atropine + 8 epi
	c̄ HCO_3 + Ca ⊖ response c̄
	CPR + bagging. Code called 0054
	[redacted]

[redacted] 9 (REV. 5/1999) BA
USAPA V

[redacted] b(6)-4

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
02 NOV 2003	Received pt # 1188. Bed #4 in unstable
1800	condition. BP 78/47 MAP 56. CVP 10. RR 18 HR 128
	PT is being managed on Epinephrine 2mcg/min
	and neosynephrine 20 mcg/min. PT has
	LR running at 125 cc/hr. and with
	fluid resuscitation & titration of medication
	staff was unable to maintain MAP 760.
	PT at change of shift vented with
	8.5 ETT. 26 cm trp. RR 16 Sao2 91
	PEEP 10 FiO2 55%. ABG was drawn
	and PH 7.356, PCO2 41.7, PO2 52
	& SaO2 85%. Per MD order RR ↑ 18 &
	FiO2 ↑ 65%. PT continues to be watched
	closely through titration of medication
	and respiratory assessment & suctioning of
	thin secretions but large amount of
	bloody secretions nasally. AT 1930
	another ABG was drawn with Chem 8,
	CBC & PT/PTT. ABG shows abnormal
	values of PO2 73 & Sao2 94% . Glucose
	on chem 8 39, K+ 4.8 Cl- 111. PLT 51

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.

EPH [redacted]

b(4)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont	and Coags out of Range for analysis. PT went into respiratory distress with SaO_2 60[redacted] then 40, frothy sputum at mouth and BP in low teens in a rapid period of time. Bagging began immediately and cardiac arrest / respiratory arrest Code called for assistance. Upon their arrival No pulse was confirmed and CPR began followed by drugs according to ACLS protocol. PT received drugs documented on Arrest flow sheet. After regaining pulse & improvement of respiratory status PT was noted to have compartment syndrome to abdomen and transferred to OR for exploration and washout. At 2215 PT returned from OR (see OR flow sheet). PT at this time with SaO_2 92%, Tachycardic & MAP < 60. PT MAP onto 50's & 1/4 Amp of Epi from OR given with temporary ↑ in BP. PT was then restarted on previous medication of 1mcg/min Epi and neosynephrine 20mcg/min. Epi was titrated to 2.5 mcg/min and neo to 30 mcg/min to maintain MAPs. PT then repeated 1st Code episode of rapid desaturation 60's then 50's and likewise reduction in BP rapidly. Labs were

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Nov 03	Brief op Note
2200	Preop: Abdominal Compartment Sx, Necrotic Perineum
	Postop: [redacted]
	Procedure: Irrigation and Placement of Silo Bag
	Irrigation / Debridement Perineum
	Surgeon: [redacted] Asst: [redacted]
	Anest: [redacted]
	EBL: 100 INF: 1500 UO: 250
	Findings - Normal abd. contents
	Necrotic Perineum
	Complication: ø
	Disp to ER Stable c̄ open abd
	[redacted] b(4)-2 A11

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont 2-[illegible]	drawn and PH 7.318 . PCO_2 37.8 PO_2 69 BE -7 SO_2 92 . Late Entry: AT this
(Late Entry)	Gas result MD was on floor and ordered 2 amp bicarb. PT then Cardiac arrest team was called and pt was pulseless, CPR began and ACLS protocol was followed with guidance from physicians in attendance. (Total drugs administered per code sheet). PT expired at 0054. All lines were removed, ABD sutured and face photograph taken. PT then transferred to morgue.

b(6)-2 [redacted] LT AF

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

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

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

510-112

NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 OCT 03			Prop: Perineal GSW c̄ rectal/urethral injury
@ 2100			Postop: Same
			Procedure: Ex Lap & diverting colostomy
			Suprapubic tube & perineal washout
			c̄ placement of presacral drain
			Surgeon: [redacted] b(6)-2
			Asst: [redacted]
			Anest: GETA
			EBL: 500cc 600-700
			IVF: 10L crystalloid
			2 units PRBC
			Findings: disrupted urethra
			- destroyed distal rectum
			Comp: ϕ
			Drains: JP in space of Retzius
			Foley in pelvic wound
			2 Penrose along bladder
			to ICU critical b(6)-2
			[redacted] MAJ, MC.
			~~GENERAL SURGERY~~

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

(Continue on reverse side)

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

ϕ38

MEDCOM - 22631

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

Emergency Case | Pt intubated

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 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Ex Lap

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco_____ppd X____vrs Body Piercing _____ Diabetes (Y) (N) ROM _____ ASA/Motrin W 72hrs (Y) (N)
ETOH _____ 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 ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment _____ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	O Pt. verbalizes any specific anxiety. O Pt. Exhibits relaxed body posture. pt. intubated	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. Parents to stay with pt.
B. AERATION _____ Potential for respiratory dysfunction due to: _____ 1) Positioning ✓ 2) Effects of Anesthesia _____ 3) Medical/Smoking History	O Pt. will be able to breath without difficulty during immediate intraoperative 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 intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement _____ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	O Pt. will 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 form pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name-last, first, middle; grade, data; hospital or medical facility)
[redacted] b(2)-4
[redacted]
31 Oct 03 b(2)-2

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 ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ O. 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. ✓ 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 and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. ✓ Potential Impairment of Mobility due to: ✓ 1) Pain ✓ 2) Intra operative Hazzards 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form OR table E.2. ✓ Potential Discomfort Due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be 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. Bath towel. etc) for positioning.
F. Special Senses F.I. ✓ Diminished visual perception due to being: ✓ 1) pre-medicated ✓ 2) W O GLASSES F.2. ✓ Potential for Decreased Communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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. pt. intubated	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. Speak clearly and slowly. O Address pt. from either side. O 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.

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

[redacted] CPT IAN 31 Oct 03 DATE

11. POSTOPERATIVE EVALUATION :
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☒ Intubated
LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities intubated ☐ Transferred to Litter With roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N) intubated

12. PREOPERATIVE [redacted] PREPARED BY (Signature and Title) [redacted] CPT IAN
DATE: 31 Oct 03 TIME:

13. PREOPERATIVE [redacted] PREPARED BY (Signature and Ti [redacted] CPT IAN
DATE: 31 Oct 03 TIME: 2140

REVERS OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPE[illegible] M
VIA litter BY anesthesia

2. PATIENT I[illegible] IFIE[illegible] [redacted] PROCEDURE
VERIFIED BY CPT [redacted]

3. DATE 31 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1855 [illegible]UMBER 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EMERGENCY CASE S/P GSW
Pt. intubated in EMT

b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	SPC [redacted] (2030-EOC)
ASSIGNED CIRCULATOR	1LT [redacted] 66E (out @ 1930) CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

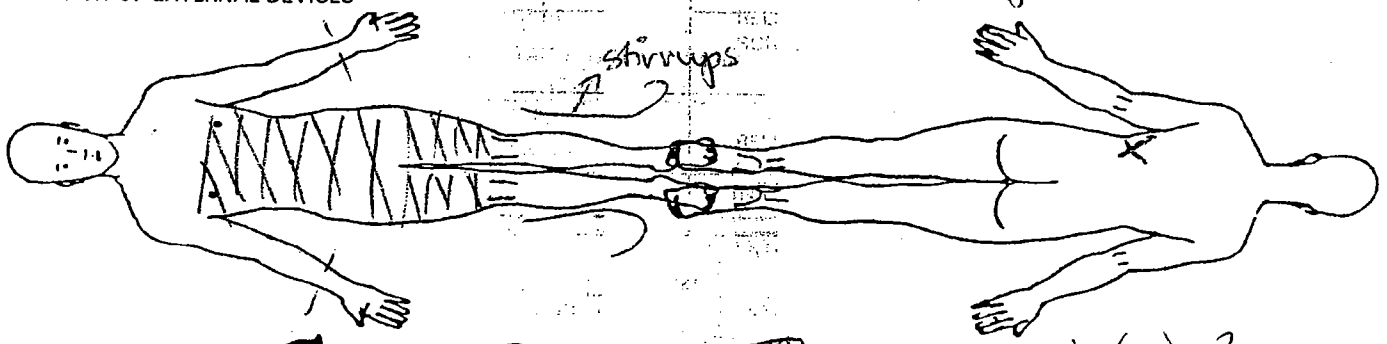
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine Scrub / Betadine Paint
SITE: Nipples to thighs and side to side BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Stra[redacted] = = = Tourniquet [illegible] prep area b(6)-2

Initial: PFC [redacted]
CPT [redacted]

C = Correct I = Incorrect Turnover [redacted]

10. COUNTS

			Turnover Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	C	C	C		
Instrument	☒ Yes	☐ No	C	C	C		
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]
31 Oct 03 b(2)-2

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

☒ ESU NO: VL Force 40 cut: 30 coag: 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 EXP: 2004-11

☐ 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 IF YES NAME: ID NUMBER URER

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		

PHYSICIA[redacted] b(6)-2

15. X-RA[redacted]OM 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)*
4x8
Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE x2	1. 1in Penrose	2. 16 F F/C	3. 10mm JP
SITE	1. Suprapubic	2. (R) Abdomen	3. Rectum

Triple Lumen Sump Drain

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] Dr. [redacted] Dr [redacted] GETA
Anesthesia: MAJ [redacted]
b(6)-2

- DA 5179 Initiated

20. OPERATION(S) PERFORMED
Ex lap; Suprapubic Catheter Placement, Sigmoid Colon Resection, Colostomy, Debridement of Rectum, Presacral Drain Placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1 b(6)-2	see DA 7389	Litter

22. REGISTERED NURSE SIGNATURE
[redacted] N | [redacted] CRT/AN

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT** — b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA letter BY ones

2. PATIENT [redacted] PROCEDURE
VERIFIED BY [redacted] PTN

3. DATE 02 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM [redacted] TIME 2043 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted] Perez b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] Maj [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt placed on padded OR table c̄ arms on armboards @ <90°. Legs frogged secured c̄ 3" silk tape over

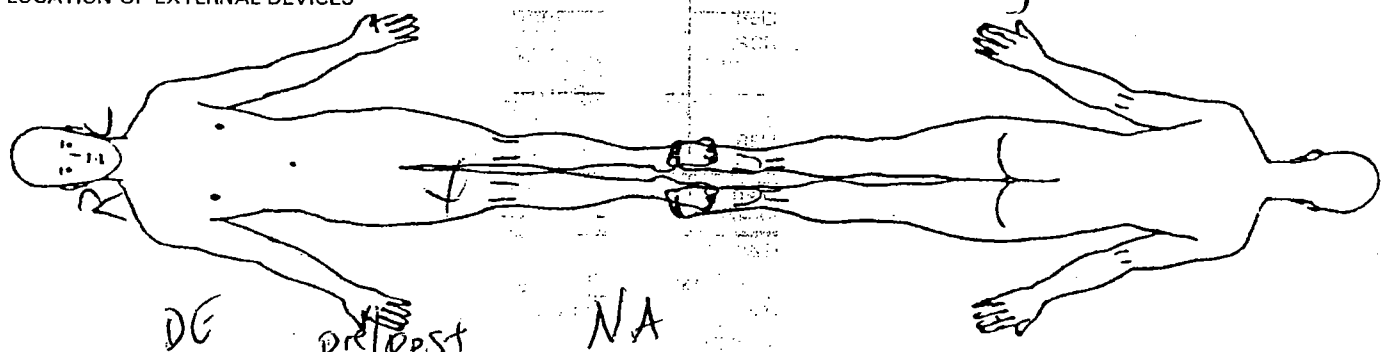
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) betadine
SITE: abd BY WHOM [redacted] chux
SITE: groin - thigh BY WHOM [redacted] position approved surgeon

COMMENTS: ☒ prepping

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap = = = Tourniquet

C = Correct I = Incorrect

b(6)-2

10. COUNTS			Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	C				
Instrument	☒ Yes	☐ No	C				
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: VL Form 40 30/30
GROUND PAD: BRAND RAE 105305
LOT NO: 65706

☐ 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 IF YES NAME: ID NUMBER; JRER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPE[redacted] IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP X 1	2.	3.
SITE	1. a Sd	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
Silo bag
10 BAN
laps
Blue towel
JP X1
Rectal bag

Rectum
1 Lap
4x4
Abd
1 cm 1

19. ADDITIONAL INFORMATION
Boardman
[redacted] b(6)-2
gel
Stas - Cheney - Weber
Foley drawing amber colored urine ☒ difficulty

20. OPERATION(S) PERFORMED
Ex lap c silo-bag placement
I+D Rectal wound c packing

21. PATIENT TRANSFERRED TO b(6)-2 ICU | TIME 2206 | METHOD Intubated Ventilator c O2 monitor

22. REG[redacted] 1A1 AN

b(2)-2

ICU #1

b(2)-2 pt# [redacted]
8.0 ETT
23 cm

[redacted] VENTILATOR FLOW SHEET

GSW thru peritoneum - testicles

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
31 Oct	2200	SIMV	14	700	50	5	37	14	138	95	107/59							BR
	2345	SIMV	14	800	100	5	38	21	146	92	100/55							DOK Atrv
1 Nov	0000	SIMV	14	800	100	5	33	16	144	92	99/56							DOK
	0300	SIMV	14	800	100	5	33	15	144	92	78/55							DOK ↓ 95%
	0600	SIMV	14	800	90	8	26	14	144	100	76/57							DOK Alb+Atro
	0800	SIMV	18	800	50	8	32	18	152	98	82/53							RRA
	1030	SIMV	18	800	50	8	31	18	153	98	80/56							RRA
	1200	SIMV	↓14	800	50	8	33	14	140	100	102/63							RRA
	1400	SIMV	14	800	50	8	33	14	140	100	100/61							RRA
	1800	SIMV	14	800	50	7	31	20	138	100	90/44							BR
	2000	SIMV	14	800	100	5	32	21	128	89	96/52							BR
	2300	SIMV	18	800	50	7	38	18	145	100	78/57							DOK
2 Nov	0000	SIMV	18	800	50	7	40	18	149	100	74/48							DOK
	0100	SIMV	18	800	50	7	42	18	152	100	80/47							DOK Atrov
	0400	SIMV	16	800	50	7	33	16	158	96	105/49							DOK
	0600	SIMV	16	800	55	7	32	16	150	92	100/44							DOK - pt receiving blood
	0800	SIMV	16	800	55	7		16	147	94	52/46							RRA
	1000	SIMV	16	800	55	7	35	16	145	94	50/46							RRA
	1330	SIMV	16	800	↑60	7.8	40	16	135	94	84/46							RRA
	1600	SIMV	16	800	60	8	40	16	136	95	94/52							BR
	1900	SIMV	16	800	60	8	38	16	130	97	96/52							BR
	2000	SIMV	16	800	100	8	41	16	133	94	88/41							BR
	2200	SIMV	18	800	100	10	39	18	123	86	84/32							DOK - Alb + Atro + ABG
3 Nov	2024	— PT		expired														DOK — PT coded @ 2400 - DOK

MEDCOM - 22638

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Istat : ABG's.
	2326
PH	7.318
PCO_2	37.9
PO_2	69
HCO_3	19
BE	-7
SO_2	92
Na^+	148
K^+	3.8
HCT	35
Hb	12
* 2 amps DPCarb	
@ 2346	

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

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

[redacted] b(6)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	ABG Log	PROGRESS NOTES	
DATE	NOTES		
2200	FiO2 100 (T) 96	2300 (T) 99 FiO2 60	0100
PH	7.363	7.399	7.461
PCO2	40.1	35.6	32.7
PO2	297	150	106
BE	-3	-3	-3
HCO3	23	22	23
SO2	100	99	98
Na+	154	153	152
* K+	2.7 *	* 2.8	4.0 LAB 3.8
HCT	40	40	40
Hb	14	14	14

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.	

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1