b(a)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18										
15 Nov	[redacted]	start dry dressing △	10	[redacted]													
		qD to lower leg															
		wound															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW @ groin / @ leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(a)-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 - 23441

EDITION OF 1 DEC 77 MAY BE USED

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15	16	17	18	19
7Nov	[redacted]	Heparin IV	D	[redacted]												
	-----		N													
7Nov	[redacted]	Ancef 1 gm IVPB	08													
	-----	Q8°	16													
	-----		24													
7Nov	[redacted]	Levaquin 500mg	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	-----	IVPB QD	10	[redacted]												
7Nov	[redacted]	Valium 5mg PO	08													
	-----	Q8° x 48°	16													
	-----	then start	24													
7Nov	[redacted]	Valium 5mg PO Qhs	22													
7Nov	[redacted]	Valium 5mg PO Qshift	22	X	X	[redacted]										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (L) Groin (R) Leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23442

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
		10(u)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
7 NOV	[redacted]	Demerol 50mg IV	D/T													
		Q4° prn Breakthrough pain	D/T													
			E/I													
7 NOV	[redacted]	Percocet ii PO	D/T	7NOV 1030	7 NOV 2030	8 NOV 1400	8 NOV 2000	9 NOV 0300	9 NOV 1400	10 NOV 0155	10 NOV 2130	11 NOV 0840	11 NOV 1000	11 NOV 1920	12 NOV 1200	12 NOV 2000
		Q4° prn pain	D/I	[redacted]												
			E/I				E									
7 NOV	[redacted]	Phenergan 25mg IV														
		Q 6° prn nausea														
7 NOV	[redacted]	Ambien 10mg PO	14 NOV 2100													
		QHS prn insomnia	10mg													
7 NOV	[redacted]	Percoset ii PO q4° prn pain	13 NOV 1640	13 NOV 2045	14 NOV 0100	14 NOV 1115	14 NOV 2015	15 NOV 0500								
			2	[redacted]		[redacted]										

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N]

M/E 36 yo ♂

PSH x-AS child sing to (L) side chest.

ARRIVAL STATUS

TIME: ☐ IV x ___ ☐ O_2 ___ l/min ☐ C-Spine Immob

Meds: ☐ UKN ☒ None ☐ Yes: _____

Allergies: ☐ UKN ☒ None ☐ Yes: _____

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

LMP: ☐

LR (RAC)

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: ☒ [N]
HEART TONES: ☐ Clear ☐ Muffled
SKIN: ☒ Warm ☐ Cool ☐ Hot
☒ Pink ☐ Pale ☐ Cyanotic ☐ _____
☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E ___ V ___ M ___ 15
SPHINCTER TONE: ☒ WNL ☐ None

HEAD
PUPILS: ☒ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R] 4-6
TM: ☒ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ _____ Ø
JVD: [Y] [N]

HEART
RHYTHM: ☒ Regular ☐ _____
PULSES: ☐ Central ☐ Peripheral

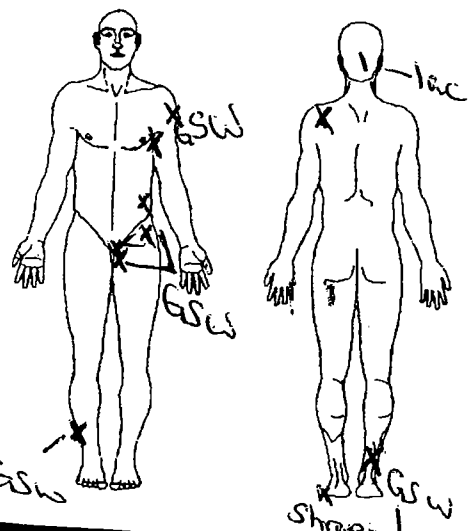
LUNGS
BREATH SOUNDS: ☒ Bilat ☒ Equal ☐ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☒ Soft ☐ Rigid ☐ Non-Tender
☐ Tender: —+—

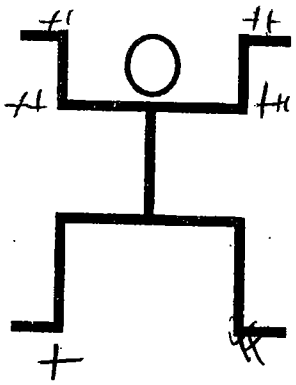
PELVIS
☐ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme + / - Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

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



VASCULAR ASSESSMENT



++ Strong | + Palpable | D Doppler

RN [redacted] blw-2

PHYSICIAN [redacted]

PREPARED BY (Signature & Title)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ER

DATE: 7 Nov 03

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

EPW # [redacted]

blw-4

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

DA FORM 4700

REQUIRED: [illegible]

MEDCOM - 23444

VITAL SIGNS

Rectal Temp:

NC @ 6 liters

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0056	123/71	93		18	97%						
0106	/	99			NC						
0109	138/76	92			100%						
0111	134/62	102		16	100%						
0126	132/60	97		24	100%						
0207	128/77	127	NSR	16	97						
	/										
	/										
	/										
	/										
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GLASGOW COMA SCALE

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

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

NOTES

0055 pt arrived, by helicopter, CH
0126 pt to CT c̄ RN
0209 CT of head, chest, abd., + pelvis done
Pt back to ER,
16 Fr Foley cath placed by Dr [redacted], CH
0215 pt to OR c̄ CRNA

Staff note:

Area xl — mod dist. Good pulses distally xl
[redacted] given BW, Nerve non fixed.
[redacted] obtuse opn [redacted] [redacted] tib/fib,

[redacted] issues

[redacted]

b(6)-2

[redacted]

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
0200	Urinary	16 Fr	☑ Meatus ☐ Supra-Public		[redacted]	☒ Return 800 cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		b6-2	☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:			Comments	

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

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
0108	☒ CBC ☐ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☒ T&C x 4
	☐ Tox Screen
	☐ UA ☐ HCG
	☒ OTHER elec, lact 8
	☐ OTHER

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
0125	☒ Pelvis
	☒ Skull
	☒ R Leg Tib/Fib
	☒ Shoulder

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☒ Contrast Oral		
0138	☒ 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
0102		16	Y	N	LAC	LR		
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

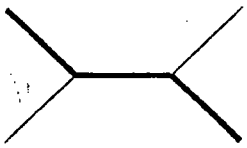
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Morph	0110	6	IV						
Tet	0113	.5	IM						
Ancef	0115	1	IV						
Morph	0122	5	IV	~~Nar 5 IV~~					
Fentanyl	0210	100	IV						
Phenergan	0200	25mg	IV						
Fentanyl	0210	50mg	IV						

BLOOD PRODUCTS

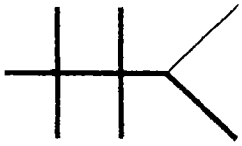
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF LR	2000	Urine	1000
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

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

VALUABLES & CLOTHING

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

DISPOSITION

☐ Home ☐ _____

Admitted to _____ [redacted] b(6)-2

Report Called to _____

Time Transferred _____

Signed By _____

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: 7 NOV
Time In: 0355
Allergies: NKDA
Pre-op V/S: 120/54 99 HR
Procedures: Scrotal/groin repair, head laceration/repair

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

OR Intake: Crystalloid 2300 Colloid
OR Output: UOP EBL <50
Meds/Times: 5fent 150fent 25phen. Bt

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

Pre Op Meds

History

Time	0355	0400	0425	0440	0445	0500	0520	0525	0530	0540	0545	0600	0610
SaO2	98	97	98	98						99	100	100	96
FiO2	RA	RA	RA	RA							RA	RA	RA
Methods													
240													
220													
200													
180													
160													
140													
120													
100													
80													
60													
40													
20													
RR	12	12	12	14	16	12	14	12	12	12	12	14	12
T	97			97			98				99		99

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 NOV 03

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

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

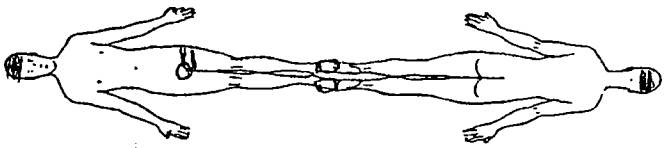
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	head/groin	gauze wrap	Ø/Ø
30'	head/groin	" "	blood to bottom/reinforced
60'	head/groin	" "	same/cl/i
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0400	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

0355 - pt arrived via gurney oral airway in place sats 97-99 on RA all dsgs cl/d/i temp 97.5 Pt winces to pain otherwise Ø response/movement [redacted] LTAN

0410 - pt breathing got labored stridor present. O_2 Sat began to drop. Anesthesia called Sat dropped to 75%. NRB put on pt c̄ 12 L O_2. Sat up. Anest did chin tilt. Sats began to rise to 100% - [redacted] AN

0450 - pt responsive to verbal stim/touch. Sats improving protecting own airway. VSS [redacted] LTAN

b (u) - 2 A1

Discharge Criteria:
Date: 7 NOV **Time:** **PARS:**
BP: 135/77 **T:** 100° **HR:** 92 **RR:** 12 **SaO2:** 96%
Pain Level at D/C (0-10):
Intake: 1000 **Output:** 200
Additional Data:
Transferred To: ICW 2
Report Given To: CN
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: LT [redacted]
Cleared IAW Recovery Room SOP R-3
Charge Nurse Signatu [redacted] A N

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: 8 NOV 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1206

Allergies: NKDA OR Intake: Crystalloid 2200 Colloid

Pre-op V/S: 123/62 101 OR Output: UOP 350 EBL 50

Procedures: IM nailing Meds/Times: 500mcg Fent

washout left groin JP drain levaquin + ancef 500 2gm

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

Pre Op Meds History

Time	1206	1211	1216	1221	1236
SaO2	99	100	100	100	100
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	12	12	14	16	12
T	100				

Time									
Pain (0-10)									
LOS									

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

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
• = Cuff BP
= Pulse

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

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

PA [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 08 NOV 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1220		2mg MSO4	IV			[redacted]
1236		2mg MSO4	IV			
1241		2mg MSO4	IV			

NEUROVASCULAR

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

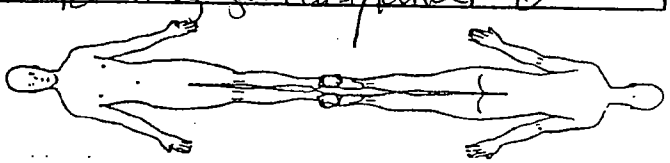
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1206	Rleg groin	cast / Kerlex	0
30' 1236	Rleg groin	cast / Kerlex	0
60'			
D/C 1246	Rleg groin	cast / Kerlex	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symplomatic?	Rhythm Strip Run?
1206	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p IM nailing + ITD of R groin. Pt SpO2 99% RA, pt c/o pain 2mg MSO4 given. 1236 pt still c/o pain 2mg more MSO4 given. Report given to Lt [redacted] — [redacted]

b(6)-2

Discharge Criteria:
Date: 8/5/00 Time: 1246 PARS: 9
BP: 132/79 T: 100 HR: 99 RR: 16 Sa02: 98
Pain Level at D/C (0-10): —
Intake: _____ Output: —
Additional Data: —
Transferred To: ICW
Report Given To: Lt [redacted] b(6)-2
Transferred Via: W/C Litter/Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP [redacted]
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

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

Date: 15 NOV 03
Time In: 1010
Allergies: NKDA
Pre-op V/S: 104/70 90
Procedures: Debrid Primary Closure
Anesthesia Type (Circle): General Spinal Epidural LMA IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP EBL
Meds/Times: 12 Fentanyl

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

Pre Op Meds History

Time	1010	1015	1020	1030	1040
SaO2	100	100	100	100	100
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	12	19	12	20	18
T	96.9	95.9	96.1		
Time					
Pain (0-10)					
LOS	[redacted]				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1010	NS	400	R Arm	[redacted]	600
					b(6)-2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2 b(6)-2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	[redacted] 2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

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

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

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

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

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

(Continue on reverse)

b(6)-2

PREPARED BY: [redacted] LPN
DEPARTMENT/SERVICE/CLINIC: PACU
DATE: 15 NOV 03

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

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	WDM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

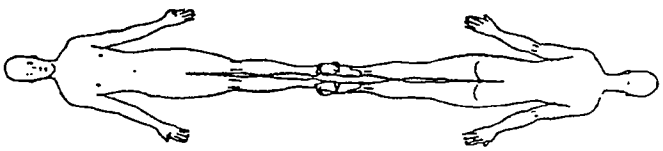
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Kling	∅
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1010	SR	∅	∅

NURSING NOTES

Pt to recovery room from OR s/p [illegible] primary closure (R) leg. Splint to (R) lower leg in place. VSS. Will continue to monitor. [redacted] b(6) -2

Discharge Criteria:
Date: 5 Nov 08 **Time:** 1045 **PARS:** 10
BP: 174/74 **T:** 96.2 **HR:** 82 **RR:** 17 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: 200 **Output:** ∅
Additional Data:
Transferred To: ICW 1
Report Given To:
Transferred V[redacted]urney Ambulance
Transferred By: [redacted] b(6) -2
Cleared IAW Rec[redacted]
Charge Nurse Signature [redacted]

b(2)-2

Admission and Coding Information

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

1. Reporting MTF	2. MTF Location			
[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
1968-06-01	35Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			01:00	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-18		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AGG - FP ORTHOPEDICS		2003-11-07		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-11-07		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P GSW L GROIN R LEG

Procedure Narrative(s):

Cause of Injury Narrative:

878.2
824.9
890.0
880.00
873.0
998.89
E991.2

9	10	11	12	13	14	15

16	17

5. SEX: 18

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

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

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

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

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

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

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

24. CLINIC SVC - ADMITTING: 87 88 89 90

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

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102

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

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

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

FOR LOCAL USE

Dx: 8783
82392
8900
8738
89912

Pr: 613
8345(2)
623
7966
2857
8654

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK
8703

A FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

Inj Trauma
450

To Camp [redacted]

b(a)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

☒ Offense against Coalition Forces [check one]. If "Other" then describe: ESCAPING A RAID

- ☐ 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: 1-34	Location Grid:
Date of Incident: (D/M/Y) 08/11/03	Time of Incident: 0300 to hrs
Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #: [redacted]	Key Connected Person: ☐ Victim ☐ Witness
Last Name: [redacted]	Last Name:
First Name: [redacted] Given Name:	First Name: Given Name:
Hair Color: Black / Scars/Tattoos/Deformities: b(a)-2	Hair Color: / Scars/Tattoos/Deformities:
Eye-Color: / Weight: lb / Height: in	Eye-Color: / Weight: lb / Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/ Sect: / Sex: ☒ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect: / Sex: ☐ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	☐ Passport ☐ Dr. license ☐ Other (specify) Document #:

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

☐ Vehicle Information	Vehicle Number: ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People In Vehicle:
Year:	Names of People In Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:	Model:		Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details: b(a)-2		Where Found:	Owner:

Name: [redacted] 1-34 Armor	Email, Phone, or Contact Info:
Detaining Soldier's Name (Print): [redacted] Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:

Automated Facsimile

ATIENT TREATMENT RECORD - OVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	24Y	X				NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	03:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-13

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-08	[redacted] b(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-08	

31. Selected Administrative Data

Marital Status: DoB: 1979-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P VD R IF DPC OPEN MC FX VD BL LE

DX -	PROV	T	I
81510	8628	1	449
8161H	9354		
8B20	8659		
8910			
E9919			

815.10
894.1
E9919

86.28
93.54
93.57
86.59

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	6	6

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	0	0

b(6)-2

Signature of Atten[redacted]

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 23456[redacted]

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

29 yo Irag: ♂ shot in raid resulting in (R) hand penetrating injury and BL LE shrapnel wounds. Presents for eval Tx. C/O BL LE wound pain & (R) hand pain.

PMHx: Ø

Meds: Ø

PSHx: Ø

All: PCN
Tolerated Amox in E.D.

PHYSICAL EXAMINATION

WD ♂ in NAD
HEENT - WNL
Lungs - CTA
ABD - Benign
EXT. RUE: Penetrating entrance wounds on dorsum of IF MC. Distal LT intact. intact Extension / Flexion. TTP @ metacarpal

RLE: Entrance wounds on the anterior leg. No knee effusion. NTTP & FROM. DNVI.

LLE: Entrance wounds on post. thigh, anterior leg. No effusion. Knee FROM. NTTP. DNVI.

Xrays - (R) IF MC Fx. shrapnel BL LE.

PROGRESS (Enter date of discharge and final diagnosis)

Imp: (R) IF Open MC Fx
BL LE Fragment wounds

Plan: R OR for I+D/ splint (R) IF MC Fx
I+D BL LE wounds

[redacted] b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-108

[redacted]

b(6)-4

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
08NOV03	(1520) Assumed care of pt from ICU3 p̄ surgery via gurney in stable cond. VSS. Pt alert, speaking Arabic [redacted] Ø c/o pain. Drsgs to RUE and LLE CDI. Drsg to RLE c̄ sm. amount sero sang drainage on (R) knee. IVFs SLd in IV in (L) ac p̄ lunch. Ø S/Sx infiltration. Pt tol. reg diet. Voiding s̄ difficulty. Elevated RLE on blankets. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. [redacted]
9NOV03 @0050	Assumed care of pt @ 1800. VSS. No c/o pain. Alert, speaks arabic; LS CTA; (+) BS, tol reg diet well, IV HL'd; voids per urinal s̄ difficulty. RLE drsg CDI, (+) CMS (R) hand. RLE c̄ sm amt yellow drainage noted, o/w CDI, (+) CMS to (R) foot, DP +2, equal (BIL). (L) ac IV flushes well. 2 pt restraints on s̄ S/Sx skin/circulation compromise. Plan: IV abx as ordered, monitor neuro, monitor pain control. [redacted]
9 Nov 03 1000	Assumed care @ 0600. VSS. A&O speaks some English. Able to make needs known. RLE c̄ splint & ace wrap. LLE AC c̄ HL patent. BLE shrapnel wounds redressed. RLE back of thigh wound c̄ small

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
A11

PROGRESS NOTES
Medical Record

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

b(6)-2 An

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont) amount yellow drainage. Open wound wet-dry c̄ Kerlix wrap. Neurovascular intact. Pt medicated c̄ MSO4 2mg IVP for comfort during drsg Δs. Will continue monitoring & keeping RUE ↑. Abx therapy as ordered. 2 pt restraint s̄ compromise to circulation or skin. [redacted] MAS/SON
09Nov03 1500	Pt sleeping c̄ RUE ↑. No acute distress. Will continue to monitor [redacted] MAS/SON
09Nov@2325	Completed DSG Δ to shrapnel wounds. Placed dry 2x2 on superficial wounds. (L) posterior upper thigh had 1"x2" open wound. Packed c̄ wet gauze + covered c̄ 4x4. ⊖ S/Sx ≠ of infection to any wounds. VSS. ⊖ c/o pain at this time. Pt aware not to eat p̄ MN. Sign above bed. Infusing Ancef 1/1 gm as per order. Pt amb to BR x 1 c̄ steady gait. Pt has cast to (R) wrist ⊕ cap refill. Pt able to wiggle fingers. To ~~Start~~ start LR @ 100cc/hr p̄ MN. [redacted] RG/AW
10Nov03	(0915) Assumed care of pt @ 0800. Pt alert, speaking Arabic. VSS. ⊖ c/o pain. IV in (L) ac d/c'd d/t infiltration. 18g IV started in (L) wrist. IVFs infusing s̄ S/Sx infiltration. Drsg/splint to RUE CDI. Pt able to move fingers. Drsgs to BLE CDI. ⊕ pedal pulses equal bilat. Skin warm to touch. Pt able to move toes. Pt remains NPO for surgery. 2 point restraints in place s̄ S/Sx complications. Will cont to monitor. [redacted] MA
	(1105) Pt to OR via gurney [redacted] MA

STANDARD FORM 509 (REV. 5/1999) BACI

USAPA V1.0

[redacted] b(6)-4

b(6)-2
A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11NOV03	(1200) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Drsgs to BLEs Δd. WTD drsgs applied to @ hip/thigh. Bacitracin applied to other wounds. Ø s/sx infection. RUE placed in stocking elevation. Pt able to move fingers. Pt OOB to amb in hallway s̄ difficulty. Favors @ leg. ↑ to chair. SL in @ ac flushes well s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted]
12NOV@- 0020	VSS. Pt Θ c/o pain. A+O. (R) Arm splint + elevated in sock. Θ (+) brisk cap refill. @ hand Warm to touch. Pt completed IV ABX in early AM. Θ maintenance fluids. Tol PO well. urinating s̄ difficulty. Pt asleep in bed at this time. Will continue to monitor. [redacted]
12NOV03	(1130) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway. Steady gait. Drsgs to BLEs Δd. Ø s/sx infection. WTD drsgs applied to @ thigh. Bacitracin applied to other wounds. RUE in stocking elevation. Pt able to move all extremities s̄ difficulty. SL in @ ac dlcd d/t infiltration-

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. KW 1

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Nov 03	ORTHO BRIEF OP NOTE
	Preop Dx - GSW (R) hand, IR wrist fx, LE shrapnel wounds
	Postop Dx - Same
	Proc - I+D (R) hand, Dressing Δ's BL LE
	Surg - White Anesthesia GETA MAI Smith
	EBL - min Fluid 250 cc UOP 8 Urine 8
	Findings - clean wound (R) hand, DPC
	Clean wounds BL LE, dressings Δ's.
	Plan - Splint Δ in 2 days
	Continue daily dressing Δ's.
	Expect D/C in 3-4 days. [redacted] b(6)-2
	WAI [redacted].
10NOV03	(1300) Pt returned to ward via gurney in stable cond. Ø C/O pain. Drsgs to BLE CDI. Pt able to move toes. Skin warm to touch. Splint to RUE CDI. Stocking elevation intact to RUE. Pt able to move fingers. IVFs infusing into IV in @ wrist S SISX infiltration. 2 point restraints in place S SISX complications. Will cont. to monitor. [redacted] WAI
	(1640) IVFs SLd. To PO well. Ø C/O pain. Will cont. to monitor. b(6)-2 [redacted] WAI
10NOV@2340	Pt amb to BR x 2. Pt has mild limp when amb. Ø assistance needed. Δ'ed DSG to (L) thigh. WTD. (R) wrist in splint. (+) brisk cap refill. Pt able to move fingers. (R) wrist elevated in sock. New IV in (L) AC 20 Gauge. Flushes well + (+) blood return. D/C'ed IV fluid 2° to! PO well. Ø C/O pain. [redacted] WAI

STANDARD FORM 509 (REV. 5/1999) BACI
USAPA V1.0

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12NOV03 (1130)	(cont) catheter intact. Pt tol reg diet well. voiding ≅ difficulty. 2 point restraints in place ≅ sx complications. will cont. to monitor. b(6)-2 [redacted] UPAW
12 NOV. 03 1900	Pt A+OX3, VSS, consumed 85% of diet, resting quietly, RUE elevated ≅ stocking, pt able to move exts, (L) thigh dsg CDI, Ø c/o pain, voiding CYU ≅ complications, dsg's to LE x2 CDI, 2 point restraint ≅ any complications. b(6)-2 [redacted] 9W
13 NOV 03 0800	- Assumed care pt. A+O x3. VSS. Denies pain or discomfort. Resting in bed. (R) hand in soft cast elevated ≅ stocking intact Ø drainage noted. Ace wrapped. (L) lateral thigh wound wet → dry lightly packed 4x4 dsg minimal serous drainage. (R) LE surgical wounds scabbing over Ø s/s of infecting. Will cont to monitor b(6)-2 [redacted] SWING

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

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

b(6)-4

[redacted]

REGISTER NO.

WARD NO. KW1

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13 NOV 03	DISCHARGE SUMMARY

Iraqi ♂ detainee with GSW to the right hand and shrapnel wounds to the legs. He has a GSW Index Finger metacarpal Fracture.

Hospital Summary

He underwent operative debridement of the hand and leg wounds x 2 with delay primary closure of the hand wound and radial gutter splinting.

Discharge Diagnoses/Tx.

① Open Rt Hand Index Finger Metacarpal fracture. Treated with I&D and radial gutter splint.

DO NOT REMOVE THE SPLINT

Followup in 10-14 days for splint removal, suture removal and short arm radial gutter cast application.

② Bilateral lower extremity shrapnel wounds. Treated with I&D and wet to dry dressing changes.

These require daily dressing changes with a wet to dry dressings on the left posterior thigh. b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted] S ID NUMBER
	LAST	FIRST	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

1242

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Nov 03	ORTHO OP NOTE
	Prop Dx: (R) IF open mc Fx
	BL LE shrapnel wounds
	Postop Dx: Same
	Procedure - I+D, splint RUE
	I+D BL LE
	Surg - [redacted] Anesthesia - [redacted]
	Fluids - 400cc EBL min.
	Drn - Penrose (R) hand. b (u) - 2 AM
	Plan - Eval (R) hand in 48 hrs
	IV ABX x 48 hrs
	Possible repeat I+D in 2-3 dp.
	[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

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

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) hand; Bic LE

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Surgical Wound
Tobacco_____ ppd X___ yrs Body Piercing ✓ Diabetes (Y) (N) ROM ↓ Extremities 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	∅ Pt. verbalizes any specific anxiety. ∅ Pt. Exhibits relaxed body posture. -pt. Iraqi x language barrier	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	∅ 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	∅ 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)
b(6)-4 [redacted] (SI)
[redacted] b(2)-2
8 NOV 03

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.	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 Left 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.

SP [redacted] b(4)-2 CPT I+N 8 NOV 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) SP [redacted] CPT/MN b(4)-2

DATE: 8 NOV 03 TIME: 0835

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) SP [redacted] CPT/MN b(4)-2

DATE: 8 NOV 03 TIME: 0945

REVERS OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERAT[illegible]M
VIA Litter BY Litter

2. PATIENT IDENTI[illegible] CORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 8NOV03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 0840 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ∅ concerns voiced

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained b(6)-2

8. SKIN PREPARATION

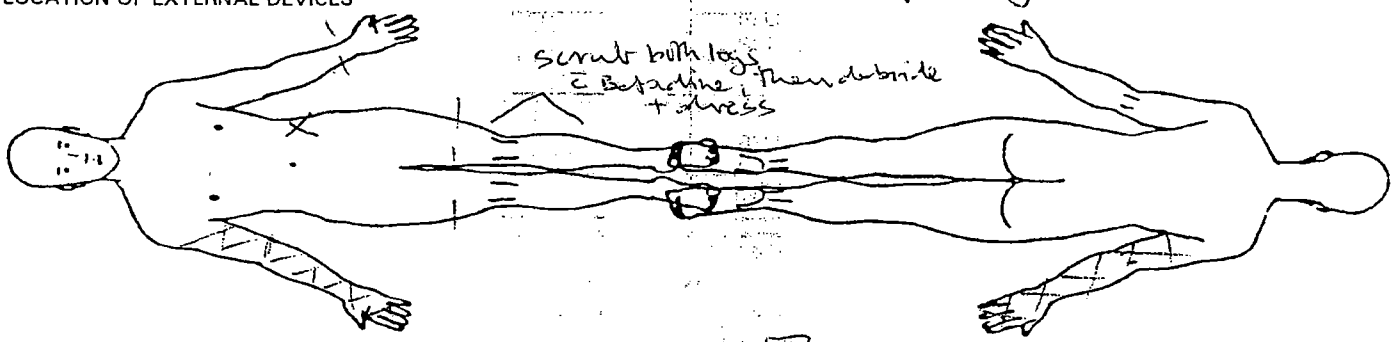
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Scrub / Betadine Paint
SITE: (R) arm BY WHOM: [redacted]
SITE: B/C LE BY WHOM: [redacted]

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect b(6)-2

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;)*

b(6)-4 [redacted] (SI)
[redacted]
8NOV03 b(2)-2

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

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 73538 2005-08

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 in Penrose	2.	3.
SITE	1. (R) hand	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x4 } legs
Kerlix }
Fluffs } (R) arm
Kerlix
Splint

19. ADDIMONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]

20. OPERATION(S) PERFORMED
I+D (R) arm/hand
I+D Bilateral LE

21. PATIENT TRANSFERRED TO ICU3 (PACU) b(6)-2 TIME see DA7389 METHOD Gurney

22. REGISTERED NURSE SIGNATURE
Sally [redacted] CPTION

MEDCOM - 23468

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATI[illegible]M
VIA Stretcher BY anesthesia

2. PATIENT [redacted]IEWED AND PROCEDURE
VERIFIED BY [redacted] CPT/AN b(6)-2

3. DATE 10 Nov 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM [redacted] NUMBER
TIME 1103

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

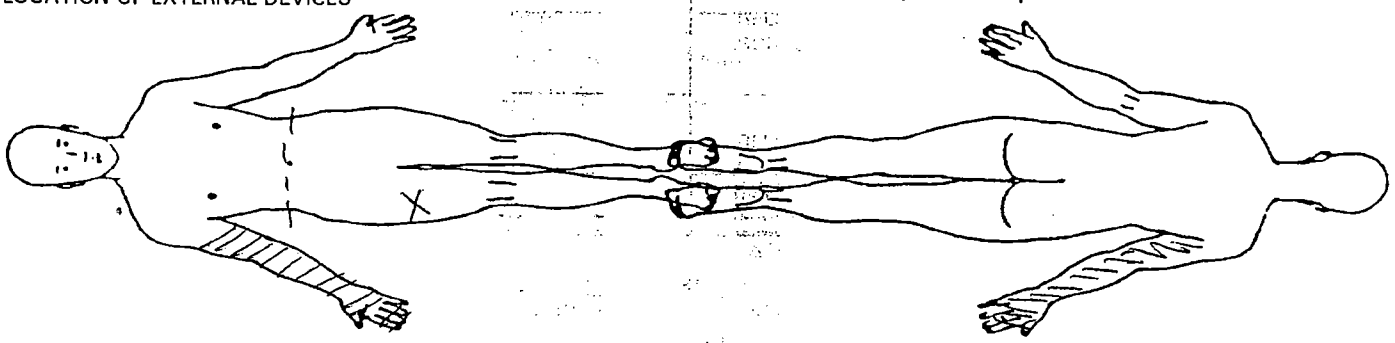
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS: No pooling of fluids b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect Initial C [redacted] b(6)-2

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

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

[redacted] b(6)-4

[redacted] b(2)-2

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

☒ ESU NO: Force 4D R8E 105305 40/40
GROUND PAD: BRAND Valleylab REM
LOT NO: 73538

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ Y ☐ NO IF YES NAME: ID NUMBER JFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE [redacted] b(4)-2

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2's, 4x4's, Kerlix, Tape } B LE

Xeroform, Fluffs, Kerlix, Plaster splint, Ace } Rt. arm

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CENA Anesth. Type: General LMA

b(4)-2

20. OPERATION(S) PERFORMED

1. I & D w/ closure of Rt. hand wound
2. Clean & redress Bil. lower ext. wounds

21. PATIENT TRANSFERRED TO PACU TIME 1201 METHOD stretcher

22. [redacted] SIGNATURE CPT/AN

MEDCOM - 23470

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

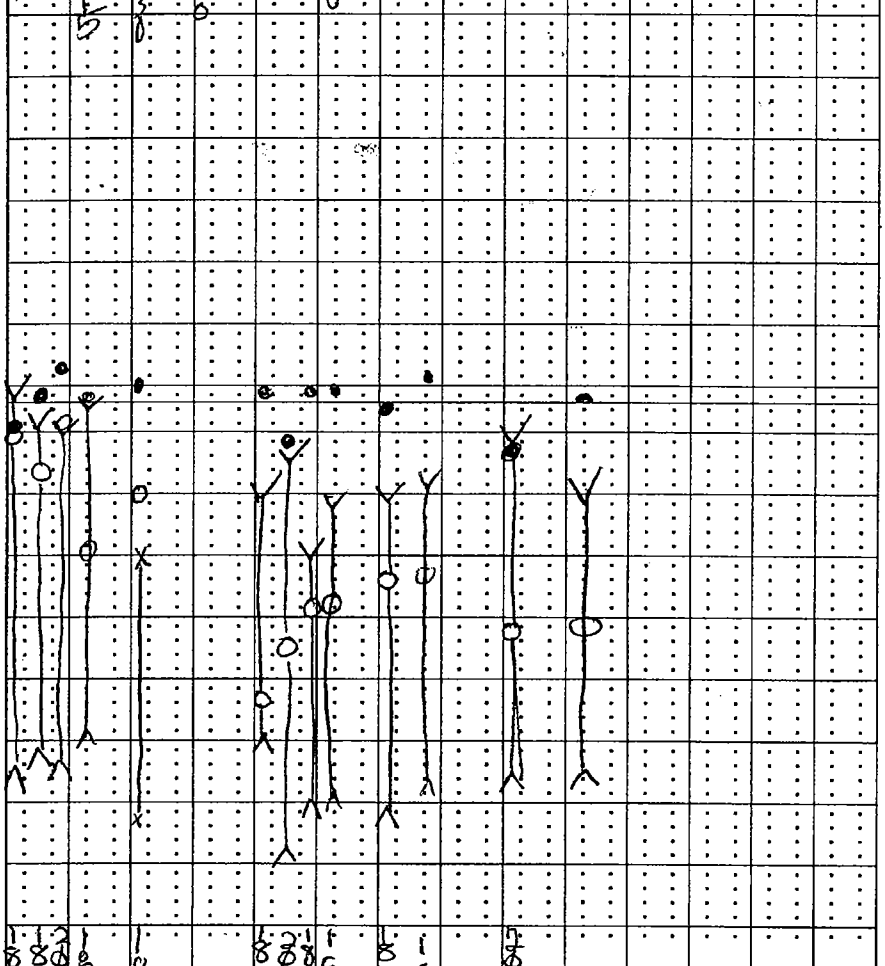
HOSPITAL DAY: 1

POST- DAY

MONTH-YEAR: NOV 2003 | DAY: 08 9 10 11 12

HOUR: 04 07 1 03 12 08 8

PULSE (O) / TEMP. F (•) / TEMP. C



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)

SPIRATION RECORD

BLOOD PRESSURE: 127/65 120/72 100/57 111/65 108/71 108/61 98/59 119/65 108/65; 120/66 110 107 115/53 111/64 88; 119/66 99(R) 109/60 98.8 99.1 98.7

HEIGHT: | WEIGHT →

O2 Sat: 100(RA) 99% RA 97% RA 98(RA) 96% 97(RA) 99(RA) 98%; 99(RA) 95(RA) 97% RA; 98(RA) 97(RA) 91 Pulse 97-P

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

REGISTER NO.

WARD NO. ICW1

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

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)	150													
Fentanyl	(mcg)	150 (100)													
SCH	(mg)	120													
VEC	(mg)		4	2											
	( )														
	( )														
VOLAT AGENT — Iso	% del		1.3	1.3	0.8	X									
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	10	2	2	2	10									

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

FLUIDS

LINE site														
18 (L) AC	☐ Warmed	NS 800	—	—	—	(400)								
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES

EST BLOOD LOSS	
URINE -	Not Measured —

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 80 KG / LB

HEMATOCRIT: 14/45

INITIAL DATA:

BP- 124/76

HR- 115

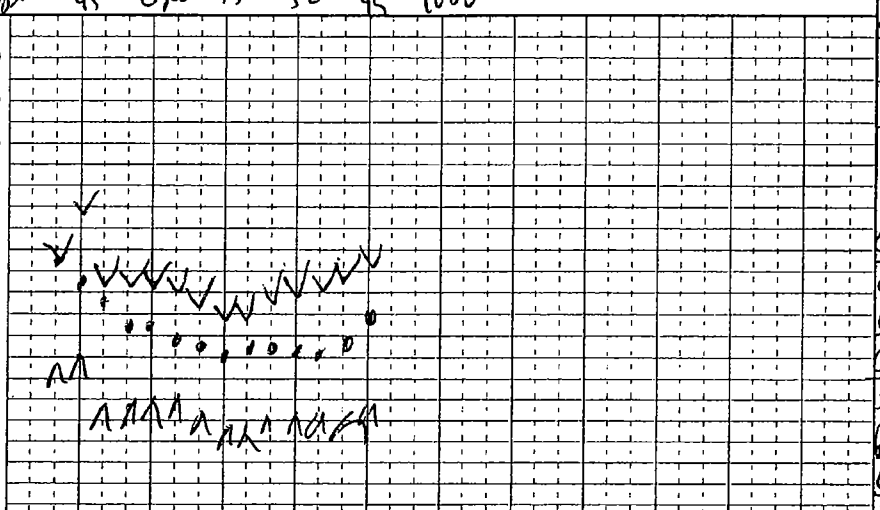
EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? 0830

TIME- Okay

TIME 0830 45 0900 15 30 45 1000

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



VENTIL

VT - ml	—	800	760	760	760	800
f - breaths/min	16	12	10	8	8	16
Peak inf pres / PEEP	—	18	16	16	16	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	(+)	30	32	32	34	34
X BP/oth	X FIO2 (Frac or %)	1.58	58	58	58	58	58
X ART line	X SpO2 (%)	99	99	99	99	99	99
X Steth- PC/ES	X ECG	ST	SR	SR	SR	SR	SR
X Gas analyzer	X TEMP-site Skin						
	N-M Block (T/4)		4/4			4/4	3
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → a-1 → TT 60° → a-1

TOTALS	TOTAL EBL
250	min
	TOTAL URINE
	Ø

FLUIDS SUMMARY

CRYSTALOID- 400cc

COLLOID- Ø

BLOOD- Ø

REMARKS *Code drugs with numbers, events with letters*

0830 Pt. ridin Ent. Chart reviewed, To OR.
0840 In room, ⊕ ventilation, ⊕ O_2, Sat 1
Induction, eyes taped, OG placed, Stomach sxw, Pt. padded, airway < 90°
0915 Procedure started on (R) arm
0925 2ml 4% IV
0935 Reversed c 5mg Neostigmine ⊕ 0.8 Robinul
0940 Pt extubated & left to PU sxw, To PACU stable.
Report to RN

RECOVERY AT 0950

PACU ICU ____ (Specify)

OTHER ____

CONDITION: Stable/Awake

RESP- 20 SpO2 98% RA

BP 125/69 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0840	0935
	Ready	Begin	End
PROC	0847	0900	0945

PROCEDURES and CPT Codes: I&D (R) Leg Wounds

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

#[redacted]

bilat-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique/ components*

NSI (+) cricoid pressure, NL X Tube attempt c MAC 4, #8 ETT, ⊕ BBS ⊕ ETCO2, secure

SURGEON [redacted]

ANESTHETIST/S: [redacted] PT

PROCEDURE LOCATION: OR 2

DATE: 8 Nov 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: _____
NPO SINCE: _____

HABITS:
TOBACCO: Ø
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: _____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): _____ (✓) General: Mask Intubation

INFOR[redacted]NSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and disc[redacted]egal guardian.
b(6)-2
Th[redacted]ems to understand and agrees. Questions answered.
Sig[redacted] Date: 2NOV03 Time: 0830 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

b(6)-4
[redacted]

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.

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

(L) FEMUR
(R) TIB FIB
(R) HAND

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER #
24	M	1242 EPW.	EMT	

FILM NO.

PREGNANT ☐ YES

[redacted] b(6)-2

TELEPHONE

SIGNATURE OF REQUESTOR

DATE REQUE

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

GSW

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, ye

RADIOLOGIC REPORT

PATIENT IDENTIFICATION (Use name or other identifier, if not, use SSN, Medical Facility)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

STANDARD FORM 512
PRESCRIBED BY GSA/ICMR
FPMR (41 CFR) 101-11.6

b(6)-4

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN	WARD/CLINIC	REGISTER
Knee series bilat R-hand series	[redacted]	M	[redacted]	ER	
	FILM NO.				PREGNANT ☐ YES
	REQUESTED BY				TELEPHONE
	SIGNATURE OF				DATE REQU. 8 Nov 08

b(6)-2

SPECIFIC REASON(S) FOR REQUEST (Complaint and Indication)

Shrapnel to R-hand + bilat knees

DATE OF EXAMINATION (Month, Day, Year)	DATE OF REPORT (Month, Day, Year)	DATE OF TRANSCRIPTION (Month, Day, Year)

RADIOLOGIC REPORT

PATIENT IDENTIFICATION (Patient name or Patient number and Name of Medical Facility)	LOCATION OF MEDICAL RECORDS
# [redacted] b(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

STANDARD FORM 513-2
PRESCRIBED BY DEPT OF HHS
FPMR (41 CFR) 101-11.6

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted] b(6)-2

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

LAST, FIRST, MI: b(6)-4 [redacted]

DATE: 8NOV03 TIME: 0315

SSN/PSEUDO SSN: [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____111 mg/dL
BUN_____10 mg/dL
Na_____138 mmol/L
K_____4.0 mmol/L
Cl_____106 mmol/L
TCO2_____28 mmol/L
AnGap_____10 mmol/L
Hct_____43 %PCV
Hb*_____15 g/dL
*via Hct
pH_____7.329
PCO2_____50.7 mmHg
HCO3_____27 mmol/L
BEecf_____1 mmol/L

Sample Type_:

08NOV03 03:53

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
08/11/03 03:51
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

ALB	4.4	3.3-5.5	G/DL
ALP	85*	26-84	U/L
ALT	94*	10-47	U/L
AMY	59	14-97	U/L
AST	55*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	33	5-65	U/L
TP	8.0	6.4-8.1	G/DL

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

(Piccolo) [redacted] 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
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
2		18-33 mmol/l

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT | [redacted] b(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 18NOV03 | TIME: 0315 | SSN/PSEUDO SSN: [redacted] b(6)-4

Urinalysis		Misc. Serology		
RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	N/A	RPR		Negative
	N/A	Mono		Negative
	Negative	**Microbiology**		
	Negative	Source		
	Negative	Gram Stain		
	N/A	Occ Bld		Negative
	Negative	H. pylori		Negative
	N/A	Micro Parasites		
	Negative	Malaria		
	0.2-1.0	O & P		
	Negative	Other		

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 04:09

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 15.2 sec.
Ratio = 1.2
Calculated INR = 1.43
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :04:08
Card Lot :080201
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 04:14

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 31.5 sec.
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :04:10
Card Lot :100208
Operator : [redacted] b(6)-2

ic Urinalysis

d Bank

SF 518 WITH REQUESTED

(MUST SU

OF BLOOD

ROSSMATCH

ID: [redacted] 08-11-03
WB 04:06

			Patient Limits	
WBC	19.1 H	x10^3/uL	4.5	10.5
RBC	5.37	x10^6/uL	4.00	6.00
Hgb	14.6	g/dL	11.0	18.0
Hct	45.7	%	35.0	60.0
MCV	85.1	fL	80.0	99.9
MCH	27.2	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	282.	x10^3/uL	150.	450.
LYM%	11.7 *L	%	20.5	51.1
LYM#	2.2 *	x10^3/uL	1.2	3.4

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

REMARKS:

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	1100	30	50	50
Fentanyl 50µ/cc ( )				
( )				
Norcuron 1mg/cc ( )	7mg			
( )				
VOLAT AGENT: Forane % del	1-3-2¼	1¼		
% e.t.				
AIR L/Min				
N2O L/Min				
O2 -3 L/Min				

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

FLUIDS

LINE site							
☐ Warmed							
☐ Warmed							
RL-200 ☐ Warmed	200				NS	250	
☐ Warmed							

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
	<5
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID- 250

COLLOID-

BLOOD-

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 117 157

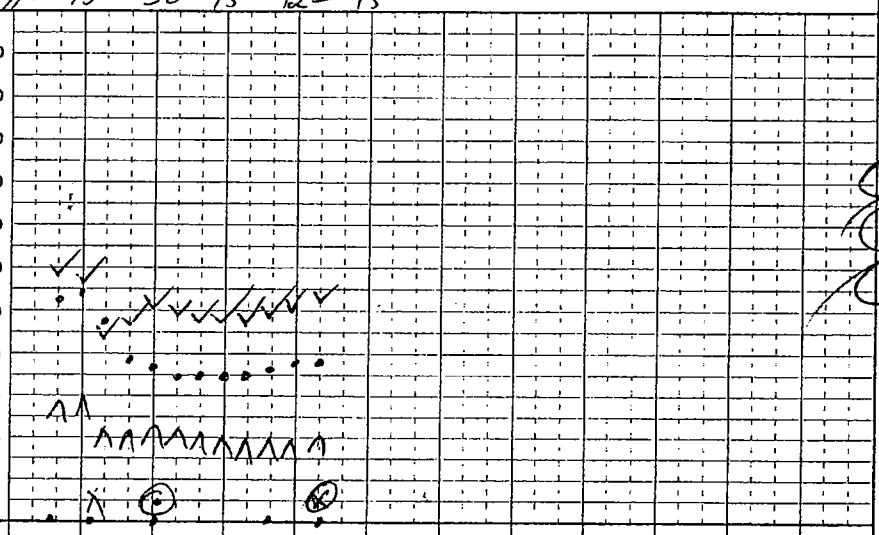
HR- 103 98%

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 1100 15 30 45 1200 15

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



VENTIL

	1100	1130
VT - ml		
f - breaths/min	19	20
Peak inf pres / PEEP		
MODE - S(pon), A(ssist), C(on)	SV	SV

MONITORS/ACCESSORIES

		1100	1130			
✓ BP/Auto Cuff	✓ ET CO2 (torr)		44	47		
BP/oth	✓ FIO2 (Frac or %)		60%	58%		
ART line	✓ SpO2 (%)		100	99		
Steth- PC/ES	✓ ECG	ST	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 1 2 3 4 5

REMARKS — Code drugs with numbers, events with letters

1 I/S taken
2 Induced c̄ Norcuron 7mg, Lidocaine 20mg, DIPRIVAN 160mg, Anectine 100mg, #4 LMA
3 Procedure begun
4 Procedure ended
5 O2 breathing well, suctioned, TO recovery

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 9 SpO2- 96 96

BP- 103/41 HR- 77

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1044	1108	1206
	Ready	Begin	End
PROC	1123	1131	1154

PROCEDURES and CPT Codes: I&D (R) hand c̄ closure • splint

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen c̄ LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#4 LMA

SURGEONS: [redacted] b(6)-2

[redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 10 Nov '03

PAGE 1 OF

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: 8 Nov 03 TIME OF ORDER: 0815 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICW 1 ORTHO DR [redacted] b(6)-2

(2) Dx - (R) Index Finger Open metacarpal Fx
BL LE shrapnel wounds

(3) Cond - stable

(4) Vitals - Q4°

(5) Alt ? PCN allergy - tolerated Ancef in ED

(6) ACT - Bedrest

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(7) IVF - LR @ 100 cc/hr HOURS

(8) NPO - on call to OR

(9) Meds - Ancef 1gm IV Q8°
MSO4 1-10 mg IV Q1° PRN
Reglan 10 mg IV Q6° PRN
Benadryl 25-50 mg IV Q6° PRN

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 Nov 03 TIME OF [redacted] 0950 HOURS

(1) Adm to ICW 1 ORTHO DR [redacted]

(2) Dx - S/P IAD (R) IF Open MC Fx
IAD BL LE

(3) Cond - stable

(4) Vitals - Q4° X3 then Q Shift

(5) Alt ? PCN - No Rxn to Ancef.

(6) ACT - Elevate RUE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(7) Nurs - LR @ 100 cc/hr HL IV HOURS
when tolerating PO well.

(8) Diet - advance as tolerated.

(9) Meds - Ancef 1gm IV Q8°
Reglan 10 mg IV Q6° PRN
Benadryl 25 mg IV Q6° PRN
MSO4 1-10 mg IV Q1° PRN [redacted]

b(6)-2 Noted [redacted] 8 Nov 03 1135

21° / 0200 9 Nov 03

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

b(6)-2 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1	24	10 NOV

DATE OF ORDER: 9 Nov 03 TIME OF ORDER: 1130 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO p MN
2. On call to OR in AM 10 Nov 03
3. Once NPO, start IVF LR @ 100 cc/hr.
4. Daily wet → dry dressing Δ's BL LE wounds. Thanks [redacted] b(6)-2

[redacted] 9 Nov 03 1140

0350 [redacted] WHITE

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 Nov 03 TIME OF ORDER: 12:00 HOURS

1. Admit to PACU → ICW 1
2. Dx - SP 2+D, DPC (R) IP Open Mt Fx
3. Wound - Stable
4. Vitals Q4° x 3 then Q Shift
5. Ant - ? PRN
6. ACT - Steady elevation RUE
7. Nutr - LR @ 100 cc/hr HL IV when tolerating PO well.
8. Diet advance as tolerated
9. Meds - Ancef 1 gm IV Q8° x 3 doses
10. Percocet 1-2 PO Q 4-6° PRN
    MSO4 1-2 mg IV Q 1° PRN Breakthrough
    Phenergan 25 mg IV Q 6° PRN
    Benadryl 25 mg IV Q 6° PRN
    Tylenol 325-650 mg PO Q 4-6° PRN

b(6)-2 Noted [redacted] 10 Nov 03 1200

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

10. Daily dressing Δ's BL LE wound [redacted]
11. b(6)-2 [redacted]

b(6)-2 [redacted]

NURSING UNIT 24 [redacted] 11 NOV 03 @ 0135

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. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 08	09	10	11	12	13	14	15
08 Nov03	[redacted]	Vitals q4° X3	10	[redacted]	/						
			14	[redacted]	/						
		then	18	[redacted]	/						
08	[redacted]	vitals q shift	06 18	/	[redacted]						
			18 06		[redacted]						
08	[redacted]	ct: elevate RUE	06 18		[redacted]						
			18 06		[redacted]						
08	[redacted]	diet: adv as tolerated	06 18		[redacted]	PRE-OP					
			18 06		[redacted]						
09	[redacted]	Daily W-D drsg	06 18	/	[redacted]						
	[redacted]	Δs BL LE wounds	18 06		[redacted]						
10 Nov03	[redacted]	vitals q4° X3	12	/	[redacted]						
			16	/	[redacted]						
		then	20	/	[redacted]						
10	[redacted]	vitals q shift	06 18	/	[redacted]						
			18 06	/	[redacted]						
10	[redacted]	ct - stocking elevation	06 18	/	[redacted]						
		RUE	18 06	/	[redacted]						
10	[redacted]	diet - adv as tol.	06 18	/	[redacted]						
			18 06	/	[redacted]						
10	[redacted]	Daily drsg Δs BL LE	10	/	[redacted]						
		wounds									

ALLERGIES: ☒ YES ☐ NO
? PCN

PRIMARY DIAGNOSIS: DPC
S/P VD @ IF OPEN MCFX
VD BL LE

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
08 Nov	[redacted]	Adm to ICW1 - ORTHO - Dr. White	08 Nov	—		[redacted]
08	[redacted]	NPO - on call to OR	08 Nov	—		[redacted]
9	[redacted]	NPO ā MN	9 nov	2400	—	[redacted]
9	[redacted]	O/C to OR in A.M. 10 Nov 03	10 nov	O/C	—	[redacted]
10 Nov 03	[redacted]	Admit to PACU ⇒ ICW1 - Cond. Stable	10	—		[redacted]

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 02-09-10
08 NOV03	[redacted]	LR @ 100cc/hr · HL IV	08 18	[redacted]
	-----	when tol. po well	18 06	[redacted]
08	[redacted]	Ancef 1gm IV q8°	06	[redacted] PRE-OP
	-----		14	[redacted]
	-----		22	[redacted]

ES: ☒ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D @ IF OPEN MC FX I/D BL LE

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

ENTIFICATION:

[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
	23	24	01	02	03	04	05	06

MEDCOM - 23483

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 11 Yr. 22

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 nov	[redacted]	Once NPO, Start IVF LR@100cc/0	10 nov	2400		[redacted]
		b(6)-2 All				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED													
∅ nov	[redacted]	Reglan 10mg IV q6° pm	D/T														
			D/I														
∅8	[redacted]	Benadryl 25mg IV q6° pm	D/T														
			D/I														
∅8	[redacted]	MSO4 + 10mg IV q1° pm	D/T	[redacted] 0915													
			D/I	2009 [redacted]													

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 09	10
08 NOV 03	- [redacted]	LR w/ 100cc/hr · HL IV	08 18	[redacted]	
	-----	when tol. po well	18 06	[redacted]	
08	- [redacted]	Ancef 1gm IV q8°	06	[redacted]	PRE-OP
	-----		14	[redacted]	
	-----		22	[redacted]	

ALLERGIES: ☒ YES ☐ NO
? PCN
TOL ANCEF IN ER

PRIMARY DIAGNOSIS: S/P VD @ 1F OPEN mc FX VD BL LE

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

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 11 Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 nov	[redacted]	Once NPO, start IVF: LR@100cc	10 nov	2400		[redacted]
		b(w)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
08 nov	[redacted]	Reglan 10mg IV q6° prn	D/T														
			D/I														
08	[redacted]	Benadryl 25mg IV q6° prn	D/T														
			D/I														
08	[redacted]	MSO4 + Ativan IV q1° prn	D/T	[redacted]													
			D/I	1915 2mg [redacted]													

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 8 NOV 03
Time In: 0955
Allergies: PCN
Pre-op V/S: 124/74 115
Procedures: I+D B legs

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

OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL MIN
Meds/Times: 1gm Ancef 250mcg Fent 420fran

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

Pre Op Meds

History

Time	0955	1000	1005	1010	1025										
SaO2	97	97	99	97	99										
FiO2															
Methods	RA	RA	RA	RA	RA										
240															
220															
200															
180															
160															
140															
120	✓	✓	✓	✓	✓										
100															
80	•	•		•											
			•		•										
60	^	^	^	^	^										
40															
20															
RR	14	20	11	11	10										
T	98														
Time															
Pain (0-10)															
LOS															

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

(Continue on reverse)

PA [redacted] b (6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 8 NOV 03

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

Name – last.

[redacted] b (6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

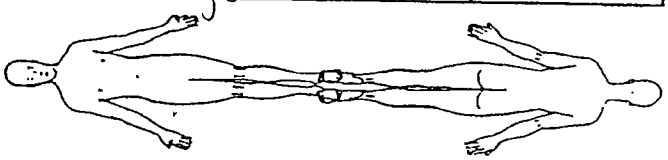
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 0955	Blegs	Kerlex	min
30'	Blegs	Kerlex	min
60'			
D/C	Blegs	Kerlex	min



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0955	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p I+D (B) legs + R hand. Pt SpO2 98% RA, No c/o pain VSS. Report given to Lt [redacted] SpO2 98% RA, No c/o pain Sgt [redacted] LPN

b(6)-2 A11

Discharge Criteria:
Date: 8 NOV 03 Time: 1032 PARS: 9
BP: 116/56 T: 97.1 HR: 77 RR: 9 Sa02: 98%
Pain Level at D/C (0-10): —
Intake: — Output: —
Additional Data: None
Transferred To: ICW 1
Report Given To: Lt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

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: 10 Nov 03
Time In: 1200
Allergies: PCN
Pre-op V/S: 117/57 103
Procedures: 1+D (R) hand, dressing change to legs

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

OR Intake: Crystalloid 250 Colloid
OR Output: UOP 0 EBL 50cc
Meds/Times: Fentanyl

History

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

Pre Op Meds

Time	1200	1205	1210	1225
SaO2	96	95	95	97
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100	V	V	V	V
80	•	•	•	•
60				
40	^	^	^	^
20				
RR	15	=	21	16
T	96			

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1200	NS	250	DR	(L) wrist	250

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] PAL b(6) - 2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 Nov 03

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

[redacted] b(6) - 4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) arm	LROM	+		B	W	PK
15'	B LE	FROM	+	P	B	W	PK
30'							
45'							
60'							
90'							
D/C							

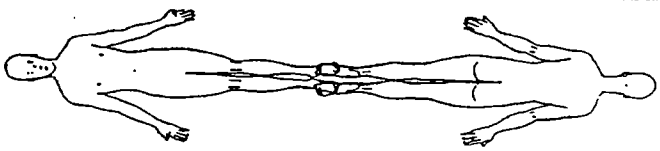
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) arm	splint	∅
30'	B LE	2x2	∅
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1200	SR	∅	∅

NURSING NOTES

Pt to recovery room from OR s/p I&D (R) hand and bil lower extremities dressings. Change. Splint to (R) hand intact. 2x2 to lower extremities also intact. ∅ drainage noted. NV's intact. IV of NS to (L) wrist intact. ∅ s/s of hemorrhage. OR Dwelling to site. VS will continue to monitor [redacted] b(6)-2

Discharge Criteria:
Date: 10/10 **Time:** 1230 **PARS:** 10
BP: 100/70 **T:** 98.2 **HR:** 80 **RR:** 21 **SaO2:** 95
Pain Level at D/C (0-10):
Intake: 200 **Output:** ∅
Additional Data:
Transferred To: ICW1
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] b(6)-2
Cleared IAW Recovery Room
Signature: [redacted]

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
0330	☒ L. femur
0330	☐ R. tibfib
0330	☐ R. hand

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
AW	1		Y	N	(R) AC	SALINE	IL	
0326	2	18	Y	N	LAC	LR	IL	
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef	0315	1gm	IVP						
Tetanus	0326	.5	IM						
Fentanyl	0330	50	IVP						
Fentanyl	0410	75	IVP						
Fentanyl	0515	50	IVP						

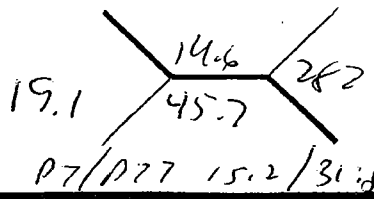
[redacted]

BLOOD PRODUCTS

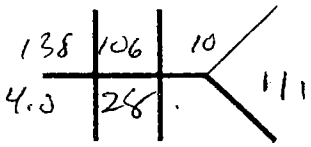
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	RMT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

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

TRAUMA TEAM ARRIVAL

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

VALUABLES & CLOTHING

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

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

By _____

VITAL SIGNS

~~Rectal~~ ORAL Temp: 97.9 SPO2 100 GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0310	136/73	51		10							
0315	136/73	114		20							
0326	137/60	130	SR	30	100%						
0352	122/60	117	SR	22	100%						
0425	128/62	130		19	99% RA						
0800	120/60	82		18	100%						
	/										
	/										
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GLASGOW COMA SCALE

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

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

NOTES

24 y/o Male brought in by Medical, pt. awake + alert, Shrapnel wounds noted to bilat legs + R hand, Skin cool + Dry, Movement to extremities by PPP — [redacted] 20Aug
0350 - pt. taken to Radiology via litter, accompanied by RN + Medic [redacted]

0800 Pt in bed. Denies any pain or discomfort. Ortho with pt — [redacted]

b(6)-2

27 y/o EPW. was running out of a house that US soldiers were raiding near Ramadi tonight. Arrived via medevac.
Pt ambos 3 in pain on arrival
pt denies any pain above wa-zit except for @ hand. NO ABD/chest/back/neck pain.
(R) (B) leg pain.

G: UD, WN, (R) PAIN.

PMH – ∅
PSH – ∅
Tx – ?
All – NKDA
meds – ∅

Ancef / Tetanus / Fentanyl / ortho consult.
2 Y 2 L IVF in ER.

[redacted] b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED *(Date)*
TRAUMA FLOWSHEET The proponent is Dept of Surgery	QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: 0345 UNIT: #1242

MED COM: [Y] [N]

ARRIVAL STATUS

TIME _____ ☐ IV x 1 ☐ O_2 _____ l/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 _____

V _____

M _____

SPHINCTER TONE:

☐ WNL

☐ None

HEAD

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

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☒ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

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

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

ABDOMEN

☒ Soft ☐ Rigid ☒ Non-Tender

☐ Tender: —

PELVIS

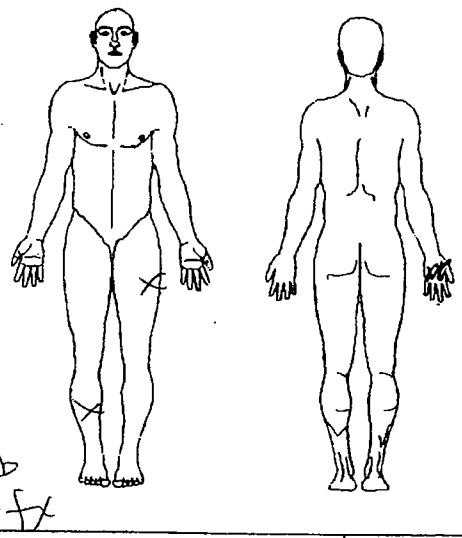
☐ Stable ☐ Unstable ☐ _____

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

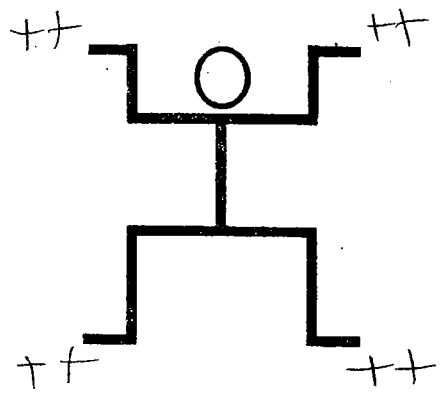
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

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



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

[redacted] b(6)-2

[redacted] *(Signature & Title)*

PHYSICIAN [redacted]

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: EMT

DATE: 8 NOV 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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 Location IZ			
3. Register Number 0015197	Name (Last, First, MI) [redacted] b(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1979-01-01	7. Age at Admission 24Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 03:00	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-13		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-08		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-08		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P VD R IF DPC OPEN MC FX VD BL LE

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Office [redacted]	Signature [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 [redacted] b(6)-2

3. Grade FGN

Admission Remarks

4. Sex M

5. Age 32Y

6. Race X

7. Religion

8. LnthOfSvc

9. ETS

10. PrevAdm NO

11. FMP 99

12. SSN [redacted]

13. Organization

14. Ward ICW1

15. FlyStatus

17. Dept / Ben K78-PRISONER OF WAR/INTER

18. BranchCorps

19. UIC / ZIP

20. Type Case BC

21. Source of Admission Direct from ER

22. Hour Of Adm: 03:00

23. Clinic Service ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee

25. Type Disp TRF-OTH

26. Date of Disp 2003-12-17

27a. Address of Emergency Addressee

27b. Telephone No

28. Date This Adm: 2003-11-08

AdmittingOfficer: [redacted] b(6)-2

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

30. Date Init Adm 2003-11-08

32. Units Blood Components

31. Selected Administrative Data

Marital Status:

DoB: 1971-01-01

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW L BUTTOCKS AND THIGHS

877.0
890.0
276.5
E991.2

86.28
49.21
86.59

35. Total Days This Facility

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

35. Total Days This Facility

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

[redacted] nding Ma[redacted]er b(6)-2 [redacted]

Signature of PAD or Medical Records Officer

[redacted] b(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 23496

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

31yo Iraqi male c̄ multiple GSW to the buttocks 1 hr ago and injuries to the thighs. Presented to the ED c̄ hypotension and hemorrhage from a gluteal wound. Moving all ext and sensory, ~~tact~~.

Ø PMHx PSHx = Ø NKDA

Labs 37.5 > 11.9/464 / 37.4 <
PT/T = 14.1/27.5 INR = 1.26
129/99/11/246
3.4/22/1.2

PHYSICAL EXAMINATION HR = 102 BP = 146/71 Sat = 100% on RA

HEENT = WNL
Lungs = CTA
CV = RRR (tachycardia)
Abd = soft, denies any pain; Ø rebound
GU = WNL; no gross blood in urine
Ext = palpable distal pulses; small medial wound to (R) thigh
Large medial wound to (L) thigh
~~Rectal~~ DRT = No gross blood; GSW to each gluteal area

CXR = WNL
Pelvis = Ø fx
(L) femur = Ø fx

PROGRESS (Enter date of discharge and final diagnosis)

A = GSW to buttocks + thighs
Plan = CT scan of Abd/Pelvis
Washout wounds; may need ex lap; proctoscopy

b(6)-2

[redacted] DATE 8 NOV 03 IDENTIFICATION NO. ORGANIZATION

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

[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

117

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

08NOV03 0730 Recieved pt. from OR via litter. O2@12L per rebreathable mask. CDC's to (R) SC intact & flushes well. IVF: NS c 20MEQ KCL @125cc/hr infusing to site. TPIV to (LB) AC intact & flushes well. Drsg noted to (B) thighs. Drsg also noted to buttock area c packings. FC to BS draining clear yellow urine. SpO2 100%.

Sgt [redacted]

b(6)-2

IBP TREND 11/08/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RI
08:10	92	100	139 / 76	101
08:00	103	100	145 / 84	108
07:50	91	100	141 / 70	103
07:40	94	100	141 / 77	101
07:30	92	100	166 / 77	110
07:20	97	100	139 / 70	96
07:17	97	100	158 / [illegible]	

0843 Nasal trumpet removed. Rebreathable mask replaced with NC ~~@2L~~ O2@2L per NC, @present time. SpO2 100% ~~&~~ distress noted. Will continue to monitor pt. for SSK of distress.

Sgt [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)
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USAPA V1.00

EPW [redacted]

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 NOV 03 0907	Brief Op Note Pre-Op Dx = GSW to bilat. buttocks + thighs Post-Op Dx = SAME Procedure = Flex-Sig / Anoscopy / Debridement + Washout Indications = Mult. GSW Surgeon = [redacted] b(6)-2 Anesthesia = GETA EBL = 300cc Fluids = 4 units PRBCs in ED prior to OR Total of 6 units of crystalloid Specimens = None Drains = None Complications = None No evidence of rectal injury. All wounds washed out + debrided. Packing placed. Return to OR in 24 HR. / [redacted] b(6)-2
	Post Op Labs 139 / 107 / 16 < 190 4.1 / 22 / 0.9 15.9 / 12.4 / 38.6 < 281 7,337 / 41.6 / 114 / 22 / -9 / 98% [redacted]

b(6)-2 A1

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
08NOV03	Pt's condition remains stable. VSS: BP 115/73
0932	HR 105 RR 17 SpO2 100% on 2L O2 per NC. ⊖ complaints of pain voiced @ present time. Pt's AM care completed @ this time. Scant amount of drainage noted to (B) thighs. Will continue to monitor pt. for any S/Sx of distress. — Sgt [redacted]
1002	SpO2 100% RA. ⊖ respiratory distress noted @ present time. Will monitor. — [redacted]
1100	C/O pain. MSO4 4mg given for complaint of (B) thigh pain. Will continue to monitor pt. for S/Sx of distress. — Sgt [redacted]
1115	Incentive spirometry done x3. Pt able to get all 3 balls up c̄ ease. Will encourage pt to cough and do more incentive spirometry. — Sgt [redacted]
1149	Drsg reinforced to (B) thighs. Will continue to monitor. — Sgt [redacted]
1230	⊖ complaints of pain @ present time. Pt. resting in bed c̄ eyes closed, easy to arouse. Will monitor. — Sgt [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | (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.

b(6)-4

EPW #[redacted]

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08NOV03	0 complaints @ present time. Will cont. to
1402	monitor. [redacted]
1428	Pt. to be trasferred to ward. — [redacted]
	b(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 NOV 03 0700	- Assumed care pt sleep yet easily arousable A+O x 3 VSS Remains NPO except sips c meds Medicated c percocet ii tabs c relief. Lungs clear HRRR Active BS. Multiple GSWs to Bilateral LE and buttocks ORDERS to Reinforce dsgs only. Burn pad placed underneath serous drainage to dsg not saturated reinforced as needed. Cont IV ABX Tx will cont to monitor b(6)-2 [redacted] Lurme
9NOV03	Brief Op Note Pre-op Dx = GSW to Thighs + Buttocks Postop Dx = SAME Surgeon = Ellis Anesthesia = G-ETA Indication = GSW EBL = 100cc Fluids = 1 Liter Spec = Ø Drains = Ø Complications = Ø Healthy appearing tissue. Pulse lavage done. Dressings placed, W.U. return in 2 days for wound out

[redacted] b(6)-2

EPW

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Pt transferred to ICW1 from ICU1 via litter in stable condition; A&O USS, pt A&O speaking arabic; ⊕ CMS throughout, +2 PP, brisk cap ref; S1S2, LSCTA-B; ⊕ BS, abd soft NTTP, FTG patent draining clear yellow urine; pt NPO for on call Sx in AM; dsgs to (B) upper thighs & buttocks CDI, scant drainage noted; (R) SC CL patent infusing D5½ NS c 20 Meq KCL ∃ s/sx infection/infiltration; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor b(6)-2 [redacted]
8NOV03 2000	USS alert oriented. Aware of NPO status & scheduled for OR tomorrow. (R) SC & IV patent & intact infusing NS c 20mEq KCl @ 125c. Lungs clear. Abd soft, non-distended. BS+. Bil thigh dsgs dry & intact. Buttock dry reinforced due to serial c moderate serosang drainage. Uses incentive spirometer properly @ 900-1200 cc/sec. Non productive cough. Peripheral pulses +2. +2 restraints in place with daily frequently to ensure proper circulation & prevent damage to skin integrity [redacted] 24/Th
9NOV03 0545	Reinforced dry to left thigh X2. Foley d/c'd @ 0545 hr. 500cc clear amber urine in drainage bag. Will report to incoming shift — b(6)-2 [redacted] 24/Th

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
		ICW1

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09NOV03 2200	[redacted] Assumed care Pt Alert & Oriented. Resp 20 O2SAT 92% on 2l NC. ~~Lt~~ Lying in bed HB ↑30. Lungs clear. Assist pt OOB to chair. Tolerated well. O2SAT ↑ 96% RA. HR 140's Voiding clear amber urine 175cc @ this time. 189 Dr [redacted] present and was informed of Pt's condition. Received new order for 1 Liter Bolus of NS NOW. Abd soft large non-distended Peripheral pulses +2. Temp 100. oral. BP 104/64 Drsg to Bilateral thighs + Buttocks reinforced dry & intact & no sanguinous drainage. TEMP ↑10 @2100. Received order for Tylenol 2 tabs PO NOW. VS @ 2200 Temp 100.3 - 116 - 18 112/57 O2SAT 97% @ 2l NC Continues to use incentive spirometer properly Q1 @ 1200cc/sec & non productive cough. Consumed 40% of Regular chef for dinner. Will continue to monitor closely [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)*

EPW
[redacted]
b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03	Surgery POD #3/1 washout + Debridement Afebrile Doing well Plan to OR for washout + partial wound closure tomorrow [redacted] b(6)-2
10 nov 03 1300	Pt A&O, VSS, mild c/o pain (although falls asleep too quickly). Resp. even & unlabored O2 sats @ 95% on 1L NC. Will attempt to wean off O2. HOB ↑ 30°. Foley reinserted due to bladder distention. Pt has not voided during this shift. (~~since 0600~~) ERROR [redacted] b(6)-2 Upon insertion voided 1400cc amber urine. Drsgs to bil thighs & buttocks c̄ minimal drainage (reinforced). ABD used hourly. Pt consumed 25% of lunch today. NS c̄ 20 KCL infusing ∅ complication. ⊖ redness or edema @ site. ⊕ SC IV. ⊕ peripheral pulses, brisk cap refill. 2 pt restraints on ∅ compromise to skin or circulation. Will monitor. Plan: Ambulate/OOB to chair, IV ancef, monitor drsgs, pain ctrl, mon. respiratory. Will monitor [redacted] 91WM6. b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11NOV03 1312	Brief Op Note Pre-op Dx = Mult. GSW to thighs and buttocks Post-op Dx = SAME Surgeon = [redacted] b(6)-2 Indications = Open wounds of buttocks and thighs and Right hip Fluids = 2400cc EBL = minimal Drains = Penrose drains to each thigh and Right buttock wound Specimens = Ø Complications = None Findings = Clean open wounds. drains placed + tissue approximately. [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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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11NOV03 @0030	assumed care of pt @1800. VSS, O2 @1.5LNC for sats 94-96. Pt is mouth-breather & sats ↓ to low 90s when sleeping. LS CTA, slightly tachycardic @110-115. (+) BS, tol 25% of dinner, currently NPO for SX in AM. (R) buttocks wound & (BIL) hip wounds dsgs reinforced D/T excessive sero-sanguinous drainage. Linen & pads Δd. Foley to gravity c̄ clear yellow urine. NSc̄ 20meq KCl infusing, rate 1 @ MN to 150cc/hr. T @ MN 101°, Tylenol 650mg given, will monitor effect. 2pt restraints on S/S/x0 of skin/circulation compromise. Plan: monitor drgs, monitor temp, monitor O2 sats, NPO for SX [redacted]
11NOV03 @0540	PAS 0600 Tagament dose held D/T pt NPO for SX [redacted] b(6)-2
11NOV 03 0800	Assumed care pt. A+O x 3. VSS Remains NPO on call for surgery today. Lungs clear productive cough light green sputum. O2 sat 90-93% RA. Mouth breather desats when sleep O2 @6s. Encouraged to deep breath and vs IS. HRRR Active BS. Urinates per FTG QS, light yellow Urine. (L) subclavian CL intact patent NSc̄ 20meq KCL @150cc/hr. Remains afebrile @ this time 99°. Dressing c̄ serous drainage copious amt. dsg reinforced. Will cont to monitor b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. TCW #1

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 NOV 03 1330	Pt return from OR S/P I&D of bilateral lower extrem and (R) side of buttocks. VSS BP 141/86 HRRR tachy 110-125 bp Denies PAIN or discomfort. Dressings CDI Pts O2 SATS 80-92 on Room air when sleep. Snoring loud & mouth open. When awake encouraged to deep breath and use IS SPO2 rises to 95-98% O2 @ 6s will notify MD. b(6)-2 [redacted] RMC.
1430	- Pt place on 2L per NC O2 88-92% & evidence of SOB or distress noted capillary refill brisk skin color NNL cough productive light green sputum otherwise lung CTA. Will cont to monitor b(6)-2 [redacted] RMC.
11 NOV 03 1900	Assumed care @ 1800 Was reported of need to give Nebs TX K. Pt alert & Oriented. Temp 103.4 pt c/o HA. HR 134/min. Lungs clear Bilaterally. O2SAT 96% on RA. Uses Incentive Spirometer properly @ 1200 sec. Non productive cough @ this time. Tylenol 1gm P.O given. Voiding quantity sufficient yellow clear urine via foley. Peripheral pulses palpable. Capillary refill brisk to fingers & toes. Consumed 40% of regular diet for dinner. (L) SC triple lumen IV patent & intact infusing NS c 20mEq KCl/l @ 100c/hr all ports patent & flushes without difficulty. [redacted] b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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[redacted] b(6)-4

PROGRESS NOTES
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b(6)-2
A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 NOV 03 2300	Temp 101.4 will [redacted] give tylenol for fever HR 127/min O_2SA 96% on 2L NC HOB ↑30°. continue to use Incentive Spirometer properly @ 1200cc/sec Drinking water q.s. Foley continues to draw clear yellow urine q.s. Resting with eyes closed. Will continue to monitor closely [illegible]
12 NOV 03 0400	Temp 98.7 - P 100 - 18 BP 100/60 O_2SAT 97% on 2L Resting comfortable. Tylenol effective for fever. Will continue care as planned & report condition to next shift [redacted]
12 NOV 03	Surgery POM#1 All dressings dsd. Wounds look good c̄ sero-sanguinous drainage. Ø s/s infection Will continue wound care [redacted]
12 NOV 03 0800	Assumed care pt. Sleep yet easily arousable A+O x3. VSS remains afebrile @ this time. lungs clear O2 titrated to keep greater than 95% c̄ SATS 97% on RA IS and deep breathing encouraged pt. not as sluggish today. HOB elevated ~~&~~ evidence of SOB or distress HRRR Active BS Appetite has increased 75% of breakfast. Wound assessment: Bilateral posterior thigh c̄ penrose drains intact wounds closed sutures intact. (L) thigh serous drainage copious amt. Wound to (R) buttock intrance and exit GSW sutures intact wounds closed penrose drain near anus. Burn pad to bed open to air pt positioned on (L) side to facilitate drainage. Cont IV ABX Tx Will cont to monitor [redacted] 9/WMCO

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 NOV 03 1430	- Foley dc'd this AM at 0800. At this time pt c/o pain to abdomen several attempts made to void per urinal states not able to. Positive distention noted. At this time in and out cath and 900cc dark yellow urine. Foley left in clamped to prevent bladder spasm 30 mins later foley unclamped 300 cc output. Pt was relieved of abd. pain Will cont to monitor b(6)-2 [redacted]
1630	- Foley dc'd per MD order. Cont to in and out cath if distention persist. Bladder training cont b(6)-2 [redacted]
1700	- 600 cc per urinal urine out put. [redacted]
12 NOV 03 2000	Alert & Oriented Temp 100.6. Tylenol 650 PO given O2 SAT 96% on RA. Lungs clear Bil Voiding cloudy clear urine without difficulty QS. Consumed 80% of regular diet for dinner (L) SC IV patent & intact. Infusion NS c 2d PRN KCl-l @ 100cc/hr. Other 2 port to SC triple lumen patent & flushes without difficulty. Peripheral pulses palpable +2. Capillary refill brisk to fingers toes. Dry intact to Bilateral thighs & buttocks Will continue care as planned. [redacted] 247 [redacted]
13 NOV @ 0500	Temp 97.1 No distress/discomfort voided on urinal [redacted]

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

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

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

EPW
[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14NOV03	(1300) Assumed care @ 0700. Pt alert, speaking Arabic. VSS. Ø c/o pain. Drgs to rectum / BLEs d/c'd this am. Pt OOB to shower. Pt amb well c̄ assist of walker. Penrose drains intact draining small amount of serosang drainage. Covered c̄ Kerlix drgs. Sutures to incisions intact. Ø s/sx infection @ wound sites. Pt ↑ to chair for 1°. Tol. well. Ø SC TL flushes well s̄ s/sx infection / infiltration. Tol. reg. diet well. Voiding s̄ difficulty Ø BM this am. 2 point restraints in place s̄ s/sx complications. will cont. to monitor [redacted] (1800) Pt OOB to amb in hallway c̄ walker. Tol. well. Ø c/o pain. b(6)-2 [redacted]
14 Nov 03	Assumed care @ 1800. Pt Alert & Speaking Arabic VSS ~~Pt complains of chest pain R/R @ Chest tube site~~ Percocet Administered c̄ little effect. Penrose drain to Anus is CDI. Draining Sero Sang Fluid. Drsg to Anus is Δ. ~~R~~ penrose to ~~Anus~~ posterior upper thighs Draining Sero Sang. Pt Ambulates [redacted] Walker. Will continue to monitor. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15NOV03	Surgery Doing very well. All wounds healing. Some exudate at (L) gluteal wounds. Will continue to monitor. BID showers. Plan to place PIV and d/c central line [redacted] b(6)-2
15NOV03	(1745) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb in hallway c̄ walker. Pt showered before drsg Δs. Penrose drains intact draining sm. amount sero-sang drainage. Sutures intact. Central line d/cd catheter intact. 18g IV started in (R) forearm. Flushes well c̄ s/sx infiltration. 2-point restraints in place c̄ s/sx complications. Will continue to monitor. b(6)-2 [redacted]
2100	assumed care of pt @ 1800. Pt alert + speaking in arabic - VSS. Ø c/o pain @ this time. Pt ambulated to shower well. Conducted drsng Δ's c̄ small amount of drainage. Sutures intact. applied 4x4's to wound, abd. pad placed above + below drains. wrapped c̄ Kerlex. IV (R) FA patent, flushes well c̄ (−) s/sx inf. Two restraints in place. (−) skin breakdown. (+) circulation. Pt. resting in bed @ this time. will cont. to monitor [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16NOV03	(1030) Assumed care @ 0800. Pt alert, speaking Arabic. VSS. Ø clo pain. Pt amb c walker to shower s̄ difficulty. Penrose drains intact to BLE/rectum draining sm. amount of sero-sang drainage. Gauze dsgs applied. Pt OOB in chair for 1°. Tol. well. Using IS correctly. Tol. reg diet well. Voiding s̄ difficulty. IVFs infusing into IV in ⓡ forearm via dial-a-flow s̄ sisx infection/infiltration. 2 point restraints in place s̄ sisx complications. Will cont. to monitor – [redacted] (1750) Pt OOB to amb in hallway. Walked up and down hallway x 1 s̄ [redacted] walker. Amb x 1 c̄ b/w-2 walker. ⊕BM. Ø clo pain. Monitoring – [redacted]
17Nov03 0100	Assumed care of Pt @ 1800. Pt A&O speaks small amount of english. Able to communicate needs. Pt Denies Pain. LS CTA. HRRR. ⊕BS x4 quads. Drsg Δ to thigh and buttock @ 2200 hours. Penrose to thigh ⓡ intact c̄ inflow. Penrose Drain to Buttocks [redacted] intact and sutured to epidermis but out of wound. Dr [redacted] Notified. Dr [redacted] put penrose back into wound. Fluid infusing to IV in R Forarm. Will

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

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

REGISTER NO. | WARD NO. ICW

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16NOV03	(1030) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb c̄ walker to shower s̄ difficulty. Penrose drains intact to BLE/ rectum draining sm. amount of sero-sang drainage. Gauze dsgs applied. Pt OOB in chair for 1°. Tol. well. Using IS correctly. Tol. reg diet well. Voiding s̄ difficulty. IVFs infusing into IV in @ forearm via dial-a-flow s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted] (1750) Pt OOB to amb in hallway. Walked up and down hallway x 1 s̄ ~~x~~ walker. Amb x 1 c̄ walker. APM. Ø c/o pain. Monitoring [redacted]
17Nov03 0100	Assumed care of Pt @ 1800. Pt A&O speaks small amount of english. Ad. to communicate needs. Pt Denies Pain. LS CTA. HRRR. Ø BS x4 quads. Drsg Δ to thigh and buttock @ 2200 hours. Penrose to thigh ® intact e infusion. Penrose Drain to Buttocks [redacted] intact and sutured to epidermis but out of wound. Dr [redacted] Notified [redacted] put penrose back into wound. Fluid infusing to IV in R forarm. Will

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[redacted]		ICW

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NU[redacted]

DATE	NOTES
17Nov03 Cont	continue to monitor [redacted] b(6)-2 [redacted] Sgt 91WM6
17NOV03 @ 1600	Assumed care of pt @ 0600. VSS, [redacted], Ø c/o pain. NS c 20KCl to (R) FA @ 100cc/h. DRSNG's to dorsal thigh & buttock removed, pt to BR, (P) BM & took shower. Pt. ambulated c walker back to bed. MD assessed wounds. Penrose to buttocks removed, wound packed c damp ~~gauze~~ (x1) Kerlex, covered c gauze. Dry dressings applied to thigh, penrose intact. Ø signs of infection, moderate sero-sang drainage to (L) thigh & buttock. Scant drainage to (R) thigh wound. Pt. OOB to chair x 2 this shift. Pt. resting quietly in bed at this time, 2-point restraints. Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] b(6)-2 2Lt, ANC
17NOV03 ~~2000~~	~~Assumed care of pt. PROR c Ø c/o pain at this time.~~

[redacted] b(6)-4

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b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Nov 03 2000	Assumed care @ 1800. VSS Pt Ambulated to BR For shower & Assistance gait is steady c/o dizzyness [redacted] OOBTC For 30 min. Drsg to Buttocks Δ. Drsg to thigh (B) Δd. Tol PO well. Void c/c [redacted] qs. Denies pain @ this time Will cont to monitor. [redacted] 91WM6
18NOV03	(H3P) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt OOB to shower this am. Amb well. Dsgs to BLE Δd. Penrose drains intact c̄ sm. amount serosang drainage. wound to rectum Δd WD. Sutures to BLE/rectum CDI. Pt OOB to chair. Tol. well. IVFs infusing into IV in (R) forearm s̄ sx infection/infiltration. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ sx complications. Will cont. to monitor. [redacted]
18 NOV 03 2000	VSS OOB 7 BR for shower & removing all drsg. Penrose to anal area not noted. Not noted in old drsg. Anal area had gauze packing. Will inform MD for clarification of need for anal pen.

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

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

b(6)-4 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Nov 03 2000	Assumed care @ 1800. VSS. Pt Ambulated to BR for shower & Assistance gait is steady c/o dizziness [redacted] OOBTC for 30 min. Drsg to Buttocks Δ. Drsg to thigh (B) Δd. Tol PO well. Void c/c [redacted] qs. Denies pain @ this time. Will cont to monitor. [redacted] Sgt. 91WM6
18NOV03	(1430) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt OOB to shower this am. Amb well. Dsgs to BLE Δd. Penrose drains intact c̄ sm. amount serosang drainage. Wound to rectum Δd WD. Sutures to BLE/rectum CDI. Pt OOB to chair. Tol. well. IVFs infusing into IV in (R) forearm s̄ sx infection/infiltration. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ sx complications. Will cont. to monitor. [redacted]
18 NOV 03 2000	VSS OOB 7 B/R for shower & removing all dsg. Penrose to anal area not noted. Not noted in old dsg. Anal area had gauze packing. Will inform MD for clarification of need for anal pen.

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORD [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.

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[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continued)
18 NOV 03 (2000)	Penrose to bilateral thigh posterior intact. Suture to incision on thighs bilaterally intact with incisions edges well approximated. (R) FA IV patent & intact infusing NS c 20mEq KCl @ 100 ml/hr. 2 Restraints applied without compromising circulation or skin integrity. Will continue care as planned [redacted]
19 NOV 03	Bariatrical Surgery POD #1 s/p wound closure [redacted] b(6)-2 Pt. doing very well. Wound on Rigt buttock open c 5cm cavity. Brown out. Right hip and Left thigh wound healing well. Other drains in place. Will remove drains tomorrow. Continue dressing Δ's to Rigt buttock wound [redacted] b(6)-2 [redacted]
19 NOV 03	(1125) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt amb in hallway s̄ difficulty. Pt showered prior to dsg Δs. sutures to BLE intact. Penrose drains intact draining sm. amount serosang drainage. Gauze dsgs placed on BLE incisions. WTD dsg placed on [redacted] rectum. wound packed c̄ NS soaked gauze. IV in @ forearm dlcd per MD verbal order. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]

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b(6)-4 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 NOV 03 1900	b(6)-2 VSS. Consumed 80% of Regular diet for dinner. OOB → BR to shower. [redacted] removing dry. Penrose intact to Bilat Posterior Thigh incisions. Sutures intact. [redacted] (R) Buttock with open cavity. OOD packing removed prior to shower. All areas redress as ordered post shower. +2 restraints reapplied without compromising circulation or skin integrity. Will continue care as planned — [redacted] 2EA
b(6)-2	
20 NOV 03	POD #16 Doing well. No new issues [redacted] b(6)-2
20 NOV 03 0600	Assumed care of pt. @ 0600. VSS. A&O. Pt. OOB to shower this AM, ambulates ∓ assistance, steady gait. ⊕BM. ⊘ C/O pain. MD removed sutures from ® buttock & pulled penrose drains out 2-3 cm from bilat. thigh wounds, mod, sero-sang drainage from all wounds. W → D DRSNG Δ to buttock wound, DRY DRSNG & Δ to bilat. thigh wounds. Pt. in 2-point (cont.)

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20NOV (cont.)	restraints, Ø signs of skin breakdown. ~~All other~~ ERROR (MD). Urinal at bedside, tea colored. All other assessments WNL. Will cont. to monitor. b(6)-2 [redacted] 2CT, ADN
20NOV03 2000	USS Temp 100.° (orally) OOB → BR for shower prior to dsg Δs. Penrose drains for (B) thigh drains serosanguinous fluids. (R) Buttock wound with pink moist tissue. Sutures to (B) (1) Thigh incision & (2) buttock incision intact with edges to incision well approximated. Percocet effective for pain management. Encourage pt to ↑ PO fluid intake and C+DB. Lungs clear. Pulse ox 97% on RA. Will monitor Temp. & restraint in place without compromising circulation or skin integrity. [redacted] CTN b(6)-2

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 NOV 0800	- Assumed care of pt. AOX3. VSS Denies having any pain or discomfort. Ambulated to bathroom shower taken. Dressing to (R) buttock D'd slightly pack. Wounds to Bilateral posterior thighs changed dry 4x4's pen rose drain to (L) thigh intact. Small amt of serous drainage sutures remain intact. Lungs clear HRRR active BS urinating spontaneously Afebrile Will cont to monitor b(4)-2 [redacted]
22 NOV 03 0000-0200	Assumed care @ 1800; VSS, pt A&O speaking arabic; ~~D~~ c/o pain; pt OOB, amb to BR for shower; dsg to wound just superior to anus D'd, packed W → D; dsgs to posterior thighs (B) D'd, penrose to (L) LE intact, sutures intact; pt voiding QS per urinal; Restraints in place, (+) circulation, (-) skin lesions K-Y, Cont to monitor b(4)-2 [redacted]
22 NOV 03 0800	- Assumed care of pt sleep yet easily arousable Denies having pain or discomfort @ this time VSS Wound to Bilateral posterior thigh and buttocks. sutures remain intact 4x4 dry dsg and berlin wrap D'd as needed. (R) buttock c̄ tunneling open to air slightly packed. Minimal serous drainage to wounds. Ambulates I d.f.f. Will cont to monitor b(6)-2 [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03	Surgery POD# 12 s/p closure of wounds. Doing very well. All drains removed. No further s/o of infection. (R) buttock wound still open + getting BID dressing Δs. Will be LOC @ least 1-2 more weeks to heal. [redacted]
23NOV03 @0440	Assumed care @ 1800; VSS, pt A&O speaking arabic; pain controlled c̄ percs; dsg Δd to wound superior to anus, packed w→D; minimal drainage noted; dsgs to posterior thighs (B) Δd, dry dsg placed, sutures intact; Pt to OOB to BR for shower; S/L patent, IV abx cont'd; Restraints in place (L) [redacted] (L) skin break ↓; cont to monitor. [redacted]
23NOV03	(1420) NSG.- VSS. Pt amb to BR c̄ steady gait. Pt did own AM care. Δ DSGs. Sutures ~~approapproximated~~. (L) inner thigh sutures 1" not approximated. Minimal amt of serosang drainage. Cleaned area c̄ NS + placed dry dsg. (R) buttock packed c̄ NS soaked gauze. Wound appears pink c̄ small amt of yellow drainage. [redacted] 24/AM
23NOV03 2000	VSS, A+Ox3, OOB → BR, had a shower, dsg's (B) LE Δd, ∅ drainage noted, dsg on center of buttocks Δd, moderate amount serosang drainage, ∅ s/Sx of infex, sutures CDI, pain controlled c̄ percs, ∅ diff voiding. [redacted] 9W

b(6)-2
All

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24NOV03	(1730) NSG. Pt ⊖ c/o pain. Amb to BR + did self AM care. Δ'ed DSGs to B/L inner thighs + buttocks. Sutures to thighs ⊖ signs of infections. buttocks WTD c̄ NS. + covered c̄ dry gauze. Pt t[redacted] PO meds + meals. Urinating clear yellow s̄ difficulty. [redacted]
25NOV03 @0000	assumed care of pt @ 1800. VSS. No c/o pain. LS CTA, ⊕ BS, tol reg diet well, void per urinal qs. Pt ↑ AMB in hallway s̄ difficulty before P.M. shower. Buttocks & bil thigh drsg Δ'd. Buttocks wound WTD ō packing, odor drainage noted. B/L thigh incisions c̄ sutures, covered c̄ dry 4x4s. 2pt restraints on s̄ S/Sx of skin/circulation compromi[illegible] Plan: monitor drsgs, enc AMB, OOB. [redacted]
25NOV03 0900	Surgery Doing Very well. All wounds Healing. Right gluteal / buttock wound still healing well / Likely Leave for 7-10 more days /
	[redacted]
25NOV03	(1310) NSG. VSS. c/o pain. Med c̄ 1/2 percocet + found adequate relief. Pt amb to BR + ward c̄ steady gait. Did own AM care. Completed DSG Δ to B/L inner thighs + ⓡ buttock. →

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont') (R) buttock packed WTD c̄ NS. Tol DSG Δ well. Sutures approximated. Scant amt drainage from ~~sures~~ sutures. Dr. [redacted] spoke to pt c̄ interpreter. Plans to DIC in 7-10 days. Wound healing. ⊖ signs of infection. Wound to (R) buttock pink c̄ [redacted] sm. amt of yellow area. Will monitor. [redacted]
26NOV03 @0200	assumed care of pt @ 1800. VSS, no c/o pain. Pt ↑ to BR for shower, drsgs to buttocks & thighs changed. (R) buttocks wound packed c̄ WTD drsg gauze, B/L thigh incisions covered c̄ 4x4 dry drsgs. Sm amt serosanguinous drainage from thigh incisions noted, sutures intact. LSCTA, tol po well, void qs to urinal, AMBS difficulty. 2pt restraints on S/Sx of skin/circulation compromise. Plan: cont drsg Δs, pain control, enc OOB. [redacted]
26NOV03 @1600	Assumed care of pt. @ 0600. VSS. A&O, ⊘ c/o pain. Pt. OOB to BR for shower. WTD DSG Δ to (R) buttocks, wound briefly med, 6cm deep. Bilat. thigh wounds closed c̄ sutures, scant serous drainage, dry DSG Δ to thigh wounds. Pt. ambulates well in hallway, steady gait. Pt. in 2-point restraints in bed, ⊘ signs of skin breakdown. All other assessments WNL. Will cont. to monitor pt [redacted]
27NOV03 @0100	assumed care of pt @ 1800. VSS. c/o pain @ hs, percocet given c̄ good relief noted. B/L thigh incisions c̄ sutures, sm amt of serosanguinous drainage noted, dry drsgs applied p̄ shower. (R) buttock wound WTD drsg Δd, ⊘ drainage. Pt ↑ AMBS difficulty 2pt restraints on S/Sx of skin/circulation compromise. Plan: cont drsg Δs, monitor drainage, enc OOB [redacted]

b(4)-2 All

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27NOV03	Surgery No new issues. Healing (R) buttock wound 1-2 more weeks [redacted]
27NOV03 1641	Assume care at PT 0600. A+O, USS Ø c/o pain. Ambulate ō assistance. Took shower, Δ'ed drsg's to both inner thighs and (R) buttocks. Inner thigh sutures are intact, CDI, placed 4x4's wrapped in Kerlix. (R) buttocks WTD drsg, minimal drainage. In 2pt restraint ō skin breakdown. Will cont. to monitor. 91WSPC [redacted]
27Nov03 1700	I concur c above assessment [redacted]
28Nov03 0425	Assumed care @ 1800; USS, A+O speaking arabic, pain controlled c percs; pt amb to shower ō assistance; dsg Δd to buttock, w→D, dry dsg placed over sutures to posterior (R) thigh sutures intact to posterior (R) thigh cont PO abx; Restraints in place, (R) circ, Ø skin breakdown, cont to monitor [redacted]

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

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WARD NO.

b(4)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27NOV03	Surgery No new issues. Healing (R) buttock wound 1-2 more weeks [redacted]
27NOV03 1641	Assume care of PT @ 0600. A&O, USS Ø c/o pain. Ambulate ī assistance. Took shower, Δ'ed dsg's to both inner thighs and (R) buttocks. Inner thigh sutures are intact, CDI, placed 4x4's wrapped in Kerlix. (R) buttocks WTD dsg, minimal drainage. In 2pt restraint ī skin breakdown. Will continue to monitor. 91WSPC [redacted]
27Nov03 1700	I concur c above assessment. [redacted]
28Nov03 @0425	Assumed care @ 1800; USS, A&O speaking arabic, pain controlled c percs; pt amb to shower, ī assistance; dsg Δ'd to buttock, w→D, dry dsg placed over sutures to posterior (R) thigh sutures intact to posterior (R) thigh cont PO abx; Restraints in place, (R) circ, Θ skin breakdown cont to monitor [redacted]

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

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28NOV03	Surgery No Δ's he is healing well [redacted]
28NOV03	(1700) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb to BR for a shower this am s̄ difficulty. WTD dsg to rectum Δd. Dry dsg placed on LE. Sutures to incision on BLE CDI. Ø s/sx infection. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted]
28Nov03 0400	Assumed care @ 1800; VSS, pt alert speaking arabic; Ø c/o pain, pt OOB to BR for shower, amb s̄ difficulty; WTD dsg to wound just superior to rectum Δd, dry dsg to LLE; All sutures CDI Ø s/sx infection; pt voids s̄ difficulty; Restraints in place, Ø circ. Ø skin breakdown; Cont to monitor [redacted]
29NOV03	(1310) Assumed care @ 0000. Pt alert, speaking Arabic, VSS. Ø c/o pain. Amb to BR for shower this am s̄ difficulty. Dry dsg applied to LE. Sutures to BLE CDI. WTD dsg to rectum Δd. Wound pink and moist. Skin breakdown noted on Ⓒ buttock above rectum. Covered c̄ dry dsg. Tol reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monito [redacted]
30Nov03 0305	Assumed care @ 1800; VSS, pt Alert speaking arabic, Ø c/o pain, pt OOB to shower; dsg to buttocks Δd WTD, dry dsg over Ⓓ LE, all sutures intact, Ø s/sx infection [redacted] s̄ difficulty; Tol Reg diet; Restraints in place s̄ compromise [redacted]

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
01Dec03	(1020) USS. VSS. ⊖ c/o pain. Pt stated has not had B.M. in 2 days. Will discuss c̄ Dr [redacted] if wants to give anything. Pt Ambs to BR c̄ steady gait. Did own AM care. WTD DSG placed on (R) buttock. ⊖ signs of infection. Sutures on B/L inner thighs. scant amt of serosang drainage from (L) thigh. ⊖ signs of infection. [redacted]
1Dec03	2030 - USS ATO assumed care of pt @ 1800. LS CTA (B), Resp. even unlabored. BS x4. pt. ambulated in hallway x 15mins + amb. to shower prior to dsg Δ. dressing Δ completed. packed buttock with WTD Gauze. ⊖ s/sx infection. sutures intact. cleaned sutures to (L) thigh c̄ 1/2 NS + 1/2 peroxide. pt. has ⊘ c/o pain @ this time. Voiding c̄ u̲ per urinal. pt. in bed @ this time c̄ two pt. restraints in place ≤ compromise to skin. will cont. to monitor pt [redacted]
2Dec(03)	Surgery No Changes Sutures Removed Will stay until wounds healed [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30NOV03	(1300) NSG. VSS. ⊖ c/o pain. Voiding clear, yellow urine ⊖ difficulty. DSG Δ completed. WTD DSG: Sutures intact ⊖ signs of infection. Pt amb to BR ⊖ steady gait. Did own AM care. Tol PO well. Consumed ~75% meal.
30NOV03	Surgery No complaints Wound Healing Will remove future [redacted] b(6)-2
	(cont) Pt asleep at this time. [redacted]
2315-	VSS - A+O ⊖ c/o pain @ this time. LS CTA ⊖ Abd soft non tender BS x4. voiding cyst per urinal. Pt. ambulated to shower completed dressing Δ. Packed buttock WTD. Removed sutures from (R) thigh: Pt. tolerated well. Pt. resting @ this time ⊂ two pt. restraints in place ⊖ skin breakdown (+) circulation will cont. to monitor pt. b(6)-2 [redacted] Foley care assessment [redacted]

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

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

REGISTER NO. | WARD NO.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2 DEC 2003@1330	Assumed care of pt @ 0600. VSS, A+O, C/O constipation. MD informed, pt. given M.O.M. 30cc PO & Colace 100mg PO BID@ 0900. Ø BM as of yet. Abdomen soft, non-distended, ⊕ BS all four quads. MD removed sutures to (L) thigh this AM, assessed other wounds. Pt. OOB → shower, ambulates well w/ assistance. DRY DSG applied to (L) thigh, Ø drainage noted. (R) thigh wound open to air, Ø drainage, edges well approximated. WTD DSG Δ to buttock, 4cm deep, 1-2cm wide, 1-2cm height. Small amount sero-sang drainage. Pt. is 2-point restraints, Ø signs of skin breakdown. All other assessments WNC. Will cont. to monitor. — [redacted] LT, A
2 DEC 2003@1600	Pt. given Dulcolax suppositor pr rectum x1. Pt. reported small BM & some relief of constipation. Will cont. to monitor pt. [redacted] 2LT, AN
2145	Assumed care of pt. @ 1800. VSS - Pt ambulated to shower + in hallway x15 mins. Completed WTD dsg Δ to buttock. Packed c̄ 4x4's. Pt. tol. well c̄ Ø c/o pain. Incision to (L) medial thigh cleaned c̄ 1/2 NS + 1/2 peroxide. Bacitracin applied to area + re-applied. Pt. in two pt. restraints ∑ compromise to skin. Will cont. to monitor pt — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		
	LAST	FIRST	MI
	Fermin	Calixto	[redacted] 2nd

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

b(6)-4 b(6)-2
#[redacted] (ERROR) [redacted]
EPW# [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
3DEC03@1700	Assumed care of pt. @0600. VSS. A&O. Ø C/O pain. WTD DSG Δ'd to ® buttocks, minimal sero-sang drainage, Ø S/Sx of INFX. Dry dsg. applied to ® thigh incision, scant sero-sang drainage, Ø S/Sx of infx. Pt. OOB to BR for shower, ambulates ī difficulty. Pt. in 2-point restraints, Ø S/Sx of skin breakdown or vascular compromise. All other assessments WNL [redacted] 2LT AN b(6)-2
4Dec03@0600	Assumed care @1800; VSS, pt alert speaking arabic; pain controlled ī percs; @ OOB → BR for shower, amb ī difficulty; dsg to buttocks Δ'd w/ [redacted] Ø dry dsg to L thigh ī bac. ointment; Ø S/Sx infection; pt tol Reg diet; voiding ī difficulty; Restraints in place ī compromise to skin/circ; Cont to monitor b(6)-2 [redacted]
4DEC03@1500	Assumed care of pt. @ 0600. VSS, A+O, Ø C/O pain, WTD DSG Δ this AM to ® buttock, mod. serosang drainage to old DSG, Ø S/Sx of infx. Dry dsg Δ to ® thigh, scant serosang drainage, Ø S/Sx infx. Pt. OOB to shower this AM, ambulated in hallway 10 minutes, steady gait. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL, will cont. to monitor. b(6)-2 [redacted] 2LT, AN
5DEC.03	0730-assumed care of pt. @1800. VSS-A+O. pt. ambulated to shower. dsg Δ completed. woundpacked ī WTD gauze Ø S/S/S inf. Pt. C/O pain. medicated ī ii percs. ⊕ relief. Bacatrin applied to ® ue incision + dry bandage. Ø S/S/S inf. Pt. voiding cyc per urinal ī difficulty. Pt in bed @ this time ī two pt. restraints in place. Will cont. to monitor pt. b(6)-2 [redacted]

[redacted] (PROR) M.D.
b(6)-4

STANDARD FORM 509 REV. 6/2002, EXCEL USAPA V1.00

MEDCOM - 23531

b(6) -2 AY

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06DEC03	(0915) Assumed care of pt @ 0600. Pt alert, speaking Arabic VSS. Ø c/o pain. Pt OOB to shower this am. Amb ~~s~~ difficulty. Rectal wound packed c̄ NS soaked gauze. Wound pink and moist ~~s~~ s/sx of infection. Skin breakdown noted on buttock above rectum. Dry dsg applied. Tol. reg. diet well. voiding ~~s~~ difficulty. 2-point restraints in place ~~s~~ s/sx [redacted] complications. Will cont. to monitor. — [redacted]
7DEC03 @0100	assumed care of pt @ 1800. VSS. no c/o pain. Pt T AMB to BR for shower, dsg Δ completed, wound healing to ® buttock; beefy red / pink tissue noted, Pt T AMB, tol reg diet well, voiding ~~s~~ problems. 2 pt restraints ~~s~~ s/sx of skin compromise. Plan: monitor dsg, monitor pain control, encourage TC / AMB, encpo. — [redacted]
7DEC03 @1517	Assumed care of pt. @ 0600. VSS. A&O. Ø c/o pain. Pt. OOB → shower, WTD DSG Δ to ® buttocks, 3cm deep, mod. serosang drainage, Ø s/sx of infx. Small amount of skin breakdown noted on ® buttock, above ® butt wound, scant drainage, dry 2x2 applied. Pt. encouraged to Δ position in bed Q 1-2° on side. Pt. sitting in chair at this time. Pt. ambulated in hallway 3 times this shift, 10-20 minutes at a time. Pt. in 1-point restraints in chair, 2-point restraints in bed Ø s/sx of skin breakdown. All other assessments WNL. [redacted] CT, AW

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5DEC03	Surgery No complications. (R) gluteal wound healing To prior comp. Once healed All other wounds healed [redacted]
05DEC03	(1210) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt OOB to shower this am. Amb well. Dsg Δd to rectum. Wound packed c̄ NS soaked gauze. Dry dsg applied to skin breakdown above rectum on (L) buttock. 0 S/Sx infection. Incisions on BLE well healed. Tol. reg diet well. voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted]
6DEC03 @ 0245	Assumed care of pt @ 0800. VSS. no c/o. Pt ↑ BR to shower, dsg WTD Δ'd. ∅ drainage noted, healing red tissue noted. LS CTA, ∅ BS, tol reg diet well, voiding s̄ difficulty. 2pt restraints on s̄ S/Sx of skin/circulation compromise. Plan: monitor dsg, inc OOB, inc po intake, inc Amb. Will monitor. [redacted]

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

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

REGISTER NO. | WARD NO. ICW1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20
USAP.

#[redacted]
b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 DEC 03 0030	assumed care of pt @ 1800. VSS. No c/o pain.. Pt ↑ AMB to BR for shower, AMB x 30 minutes, then returned to bed for drsg Δ. Buttock's wound healing, beefy red ↓ drainage. WTD drsg completed, using minimal amt of tape DT + skin shear around wound. All other assessments within normal limits.. 2pt restraints on ↓ S/Sx of infection. LOK in compromised pain - encODB, enc position Δ, encpo, cont po Abx as ordered, pain control. [redacted] b(6)-2
8 DEC 03	Surgery Doing Very Well Right Gluteal Wound almost healed DC to camp when completely healed 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]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (1967)
Prescribed by SECNAVINST 5212.5C

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 Dec 0900	VSS Alert & Orient. OOB → BR for shower. Sluted wound repacked as ordered. Tissue of wound pink & moist. Consumed 40% of Breakfast. Ø C/O pain or discomfort @ this time. 2 point restraints in place without compromising circulation or skin integrity. Will continue plan of care. [redacted]
8 Dec Ø3	VSS A&O. OOB To BR. BMx1 this pm. Void spontaneously ~~5~~ difficulty. Tol PO well. Ambulates c steady gait. Drsg to Buttocks Ad, ~~Ø~~ ~~PAT~~ Tissue in wound is pink moist granulated. No S/Sx of infection. Pt Denies Pain @ this time. Tape to buttocks has caused skin to peel from Butto[redacted] Dry dressing covers .5 cm of open Abrasion to ® [redacted]ttocks check. Will cont to monitor. [redacted] WMM
9 Dec 03 @ 1100	Assumed care of pt @ 0600. VSS. A&O. Ø C/O pain. WTD DSG Δ to ® buttocks, mod. sero-sang drainage to old DSG, wound improving, granulated tissue. Pt. OOB → shower this afternoon ⊕ BM, ⊕ BS all 4 quads. Ulcer @ bedside → CYU. BS clear bilat. Pt. in 2-point restraints, Ø S/Sx of infx. All other assessments WNL. [redacted] RCTAN
9 Dec 03	Assumed care of pt @ 1800. VSS A&O. OOB T BR Ambulated for 30 minutes. Drsg to Buttocks Ad. No S/Sx [redacted]fection. Pt Denies pain @ this time. Pt consumed 70% of [redacted] this PM. LS CTA ®, ⊕ BS x4 quads. HRRR. Will cont t[redacted]onitor. [redacted] Spec 9 WMB

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10DEC03@	Assumed care of pt. @ 0600. VSS. A&O; Ø c/o pain.
1700	Pt. OOB → SHOWER, ambulated in hallway 30 min.
	Pt. OOB → chair @ this time. DSG Δ'd to buttocks, WTD,
	Ø S/Sx of infection, 3cm deep. Pt. tol. reg. diet well, ate
	100% breakfast & lunch. ⊕ BS all 4 quads. ⊕ BM in
	afternoon. Pt. in 2-point restraints. Ø S/Sx ~~of infection~~ Cerno
	of skin breakdown. All other assessments WNL. [redacted] 2CT, AN
10Dec03	Assumed care of Pt @ 1800. Temp 99°F(⊕) All other
	VSS. A&O. Pt Ambulated For 30 min. Showered and
	Drsg to Buttocks Δ'd. Cont Tagamet PO. Temp
	↓ 98.7 after Drsg Δ. Pt void CYS [redacted] difficult
	Will cont to monitor. — [redacted] pc 9 WN
11Dec03@ 1700,	Assumed care of pt. @ 0600. VSS, A&O, Ø c/o pain, Pt OOB
	to BR, ambulates well in hallway, steady gait. Pt. took
	shower & shaved face. WTD DSG Δ to buttocks ⊽ shown.
	min. sero-sang drainage to old DSG, Wound 1-1.5cm
	deep, Ø S/Sx of infx. Pt. ate 50% of lunch & breakfast
	Pt. encouraged to eat more. ⊕ BS all 4 quads, visual @
	bedside, CTU. Pt in 2-point restraints in bed,
	Ø S/Sx of skin breakdown. All other assessments WNL.
	Will cont. to monitor. — [redacted] 2CT, 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

STANDARD FORM 500 (REV
Prescribed by DD/MOIR DFMS (41CFR) 101-11.3

[redacted] b(6)-4

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11Dec03	Assumed care @ 1800. Pt VSS A&O Denies Pain @ this time. LS CTA (B) (+) BS x4 quads HRRR. Voids c/o gs ≤ difficulty. Drsg to Buttocks I'd. Wound approx [redacted] cm deep. Will cont to monitor. — [redacted] Spc 91WM6
12Dec03 1000	VSS. Pt OOB → Showers [redacted] to Dry. (A). (P) Buttock ≈ < 1cm x < 1cm opening. Wound pink + moist. Pack ≈ NS moist gauze. Closed. Consumed 50% of Breakfast. Voiding without difficulty. 2 point restraint in place without compromising circulation or skin integrity. Will continue care as planned [redacted]
12Dec03 1100	Surgery Awaiting wound closure. Pt. ≈ well-healing R buttocks wound, now ~ 1cm, with healthy granulation tissue. Anticipate closure and subsequent discharge home within a week. Otherwise without complaints. [redacted] MA
12Dec03 2012	Assumed care @ 1800. VSS A&O. Denies pain. Pt ambulated 45 min this PM. LS CTA (B) HRR (+) BS x4 quads. Drsg to Buttocks [redacted] DI. Will cont to monitor. — [redacted] Spc 91WM

STANDARD FORM 509 (REV. 5/1969) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13 Dec 03 0800	VSS Consumed 50% of Breakfast. Denies pain @ this time Will have pt shower prior to dry & to (R) Buttocks. Peripheral pulses +2. Urinary clear amber urine. 2 point restraints implace without compromising circulation or skin integrity. Will continue care as planned. [redacted] 2LT NC
14Dec03	(0400) VSS. Ø C/O pain. Voids clear, yellow w̄ difficulty. Amb c̄ steady gait. Med DSG to (R) buttock + covered c̄ b(6)-2 opsite. Wound appears to have Ø signs of infection. [redacted] Tol Powell. 2 restraints c̄ Ø signs of skin compromise
14 Dec 03 0730	VSS A&O 50% of Breakfast Consumed. Ø C/O pain or discomfort noted or noted. Will have pt shower prior to dry & to (R) buttocks Peripheral pulses palpable +2. OOB → BRP (I) with NP supervision. 2 point restraints implace without compromising circulation or skin integrity. Will continue plan of care. b(6)-2 [redacted] 2LT NC

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.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by OSD/DMR FPMR (41CFR) 101-11.2
USA

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	IS NUMBER

DATE	NOTES
15 Dec 03	(0135) VSS. ∅ c/o pain. Δ'ed DSG to (R) buttock. WTD. Wound pink c̄ ∅ signs of infection. Placed 2x2 + covered c̄ opsite. Pt Amb to BR c̄ steady gait. Voids clear, yellow urine s̄ difficulty. BS CTA, BS (+) & 4 quads. Will continue to monitor. [redacted]
15 Dec 03 @ 0920	Assumed care @ 0700. VSS. No c/o pain. LS CTA, (+) BS, tol regular diet well, void s̄ difficulty. Pt ↑ Amb to BR for shave s̄ difficulty. MD @ BS to see wound. Drsg Δ'd. No other issues. Spt restraints m s̄ s/sx of skin/circulation compromise. Plan: enc po, enc oob, monitor wounds. [redacted]
16 Dec 03	(0005) VSS. ∅ c/o pain. Amb to BR c̄ steady gait. Δ'ed DSG to buttocks. Wound pink c̄ ∅ signs of infection. Packed lightly c̄ 2x2 WTD. Pt to D/C to camp. Voids s̄ difficulty. [redacted]
16 Dec 03 0820	Summary Pt s/p multiple GSW to thighs and buttocks on 8 Nov 03. His wounds were debrided on multiple occasions and then closed subsequently. One small wound on his right buttock was allowed to close on its own. Currently that wound is closed with ~1cm of skin defect. Given antibiotic ointment and encouraged to keep clean until skin covers the area. Will discharge to prison camp today. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
16DEC03 @0915	Assumed care of pt @0900. VSS. No issues. awaiting D/C. Instructions given for drsg Δ. Pt tmb S difficulty. Pt restrained on S/Sx of skin/circulation compromise. Plan: enc po, enc tmb, await for D/C. [redacted]
16Dec03 (2320)	VSS Ø c/o pain. Pt did own DSG Δ to (R) buttock. Applied Bacitracin + 2x2. Awaiting ride to camp 17 Dec. Will monitor. [redacted]
17DEC03@1000	Assumed care of pt. @0600. Pt. OOB to shower. DSG to buttocks Δ'd, Ø S/Sx of infx. VSS, A+O, Ø c/o pain Pt. D/C'd to camp. [redacted] b(a)-2 +11 5

SPONSOR'S NAME

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

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by COMMANDANT (PERS)

[redacted] b(a)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 8 | 9 | 9 | 9 | 10 | 10 | 10 | 11 NOV

19 | HOUR: 12 | 2 | 0 | 0900 | 1530 | | | 12 | 0 | 0700

PULSE (O) | TEMP. F (•) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 19 | 18 | 18 | 88 | 18 | 18 | 10 | 10

BLOOD PRESSURE: 118/70 | 105/65 | 119/64 | 123/78 | 118/70 | 104/64 | 114/57 | 104/51 | 113/60 | 123/66 | 138/60

H 114 | H 114 | 110/62 | 126/74 | H 107

131/75 | T 98.6 | T 98 | 105/60 | Temp 100.5 | 100.8 | 99.4

95% | 93% | 101.1 | 100.3

HEIGHT: | WEIGHT →

02 6A7

99% RA | 97% | 96% | RA | 96% | 96% | 96 | 95% | 95% | 96%

97% | 2L O2 | 2L | 2L | 95% | 97% | 2L

121 MAP | 110 | NC

94% 14

on 1L NC

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

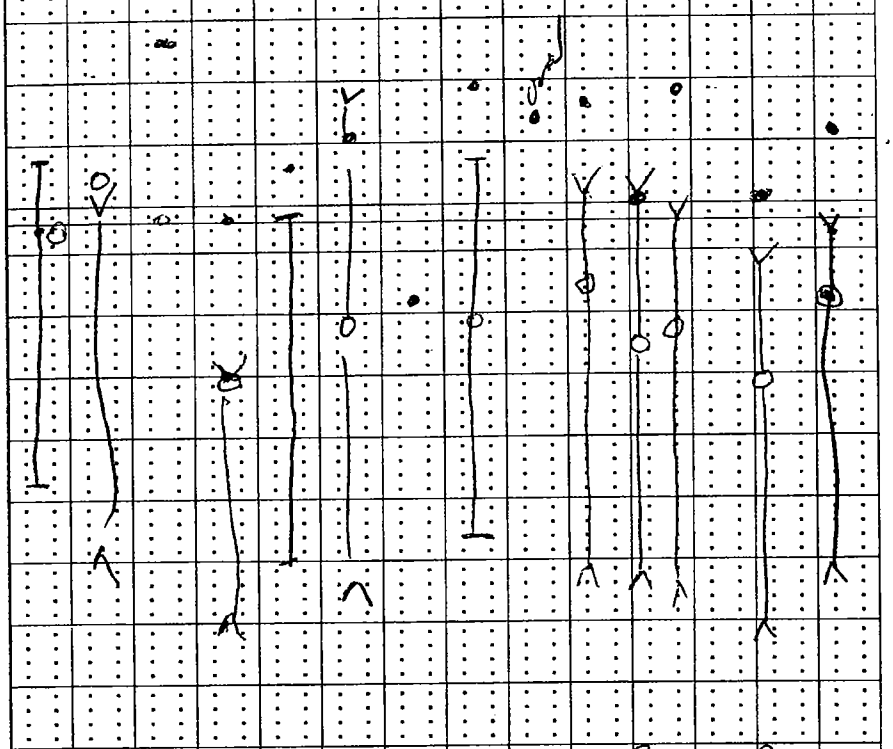
POST-OPERATIVE DAY

MONTH-YEAR: 11 NOV | 12 | 13 | 14 | 15

DAY

19 HOUR: 1930 | 1 | 2 | 0 | 0800 | 2 | 0 | 0800 | 1730 | 1 | 2 | 0 | 0 | 2

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



RESPIRATION RECORD

BLOOD PRESSURE

	1930	1	2	0	0800	2	0	0800	1730	1	2	0	0	2
Resp	22	22	8	18		8		18		20	18		20	
BP	137/83	130/73			128/70			137/74		132/69	132/67		117/60	123/68
	#124			120/60	H 105			#104			129/67			
	T 98.4				T 99.0			T 100.9	to AA	100.7				
										P 109				
					96%					93%	98% (RA)		97% (RA)	97%
	O2SAT	96	96	97%	2L	96%		96%			97% RA			RA
		2L	2L	3L	NC	RA		RA	Pulse 114		100.9F Temp			

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

#[redacted] b(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 16 17 18 19 20 21 21 22

19 HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER 19 2003

DAY	22	23	24	25	26	27	28
HOUR	1	7	7	1	0	7	1
TEMP. F (°)	99.0	99.0	99.0	99.0	97.3	98.0	100.0
PULSE (O)							
RESPIRATION RECORD	16	14	16	18	18	16	18
BLOOD PRESSURE ①	115/64	116/64	115/59	114/60	100/58	104/61	118/63
②		81		97.2	96.8		99.1
① TEMP	97.6	98.1	99.0	99.1	78	81	99.3
HEIGHT: WEIGHT ② TEMP							
① O_2 Sat	96%	96%	98%	98%	97%	95%	98%
SOURCE	RA	RA	RA	RA			RA
② O_2 Sat SOURCE					114/62		

DAY	29	30	31
HOUR	1	7	1
TEMP. F (°)	100.0	98.0	98.0
PULSE (O)			
RESPIRATION RECORD	20	18	18
BLOOD PRESSURE ①	120/62	124/61	
②	99.1		
① TEMP	77	99.1	114/63
HEIGHT: WEIGHT ② TEMP			
① O_2 Sat	96%	96%	98% (RA)
SOURCE	RA		97% RA
② O_2 Sat SOURCE			

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY 29 30 1 1 2 Dec 3 Dec 4 Dec

HOUR

PULSE (O) — TEMP. F (•) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 122/59 | 118/62 | 108/59 | 118/62 | 108/59 | 116/65

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec 2003 | DAY: 5, 06, 7DEC, 08DEC, 9DEC, 10, 11 | HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

108/54	122/80	117/66	112/60	101/49		108/60	113/64		114/57	113/50	111/60	109/62
97.5							78		13		55	78
53							98.5		98.4	97.3	99	98.6

HEIGHT: WEIGHT →

O2 SAT: 95% (RA) | 98% RA | 97% (RA) | 98% RA 98% RA | 99% 99% | 99% RA | 97% | 97% RA | 99% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU1

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 12 Dec | 13 Dec | 14 Dec | 15 | 16 | 17

19 HOUR: 0 1 0 1 0 2 0 1 0 1 0

PULSE (0) / TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE: 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: 18, 24, 18, 20, 18, 18, 18, 18, 18

BLOOD PRESSURE: 112/62, 110/66, 111/66, 122/63, 118/68, 116/64

71, 73, 63, 73

98.4, 98.3, 98.3, 98.4

98.7%, 98.0%, 99.1%, 99.4%, 98.6%, 99.2%, 99.5%

RA, RA, RA, RA, RA, 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)*

[redacted]

b(6)-4

REGISTER NO.

WARD NO.

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

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

4. PROPOSED SURGICAL PROCEDURE:
I+D Buttock wound (Thigh wound + Upper)

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition _____
Tobacco _____ ppd X ___ yrs. 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 X potential for anxiety related to: X 1) Surgical Procedure& Operating Room Environment X 2) Separation Anxiety (Child) X 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 X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 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 X Potential Impairment of Skin Integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids X 4) Prosthesis X 5) Pooling of Prep Solutions	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] 1 (W) -4

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 X 3) Existing Disease X 4) Safety Devices X 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 X 2) Intra operative Hazzards X 3) prosthesis X 4) Positioning X 5) Transfer pt. To/form OR table E.2. X Potential Discomfort Due to: X 1) Length of Surgery X 2) Positioning X 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. X Diminished visual perception due to being: X 1) pre-medicated X 2) W O GLASSES F.2. X Potential for Decreased Communication due to: X 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential Injury due to Dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	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 NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6),2 08 Nov 03 DATE

11. POSTOPERATIVE EVALUATION :
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ 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)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 08 Nov 03 TIME: 0430

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 08 Nov 03 TIME: 0508

REVERS OF FORM 5179, JUN 91 USAPA V1.0

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 OPERATING [illegible]M
VIA Litter BY EMT

2. PATIENT IDENTIFIED [illegible]ORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b(6)-2

3. DATE 08 NOV 2003 TIME PATIENT ARRIVED IN SUITE 0434

4. PATIENT IN ROOM TIME 0434 NUMBER 2 Cor #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: 31 y/o male.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL [illegible]
Initial position ☒ R side up, Pillow between legs & between arms. Patient then positioned supine ☒ both arms on arm boards @ <90°.

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

COMMENTS: legs frog-legged to expose inner thighs.

8. SKIN PREPARATION

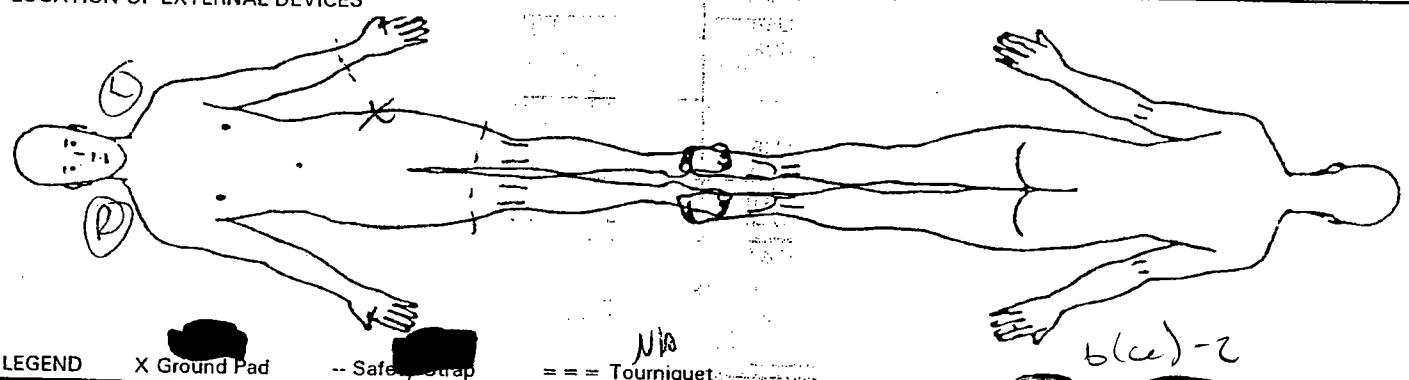
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint
SITE: R hip / buttocks BY WHOM: MDJ [redacted]
SITE: bilateral thighs BY WHOM: CPT [redacted] b(6)-2

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

N/A b(6)-2

10. COUNTS

C = Correct I = Incorrect

Initial count SPC [redacted] CPT [redacted]

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

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

[redacted]

b(6)-4

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

☒ ESU NO: R8B 102395
GROUND PAD: BRAND Valleylab
LOT NO: 73538

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

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): 6,9 gms

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	NAME

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kelly	2.	3.
SITE	1. Buttocks / Thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
DBO & Tape

19. ADDITIONAL INFORMATION
Surgeon Dr [redacted]
Anesthesia - CRT [redacted] called

20. OPERATION(S) PERFORMED
Flexible sigmoidoscopy / I&D (R) hip wound / I&D Bilateral Buttocks / I&D Bilateral Thigh

21. PATIENT TRANSFERRED TO ~~PACU~~ RTS ICU, TIME 0705 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] blue-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

b(6)-2 unless noted diff.

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA ~~Litter~~ gurney BY Anesthesia
2. PATIENT IDENTIFIED [redacted] AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 9 Nov 03 TIME PATIENT ARRIVED IN SUITE 1045
4. PATIENT IN ROOM TIME 1045 NUMBER 2-2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: N/A

6. NURSING PERSONNel

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed Head on foam doughnut for #1005. #1 supine for 3 human + Frog legged for Thigh wash out. Arms ∠90° to ☐ AP secured

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

COMMENTS: to padded armboards c safety straps, pillows under lateral side of knee gel pad under ankles. Rolled to (L) lateral for 2nd part, pillow between legs (knees + ankles) Lie on padded armboard c pillow on top + RUE on top of pillow arms secured. Bean Bag used. Correct Body Alignment Maintained.

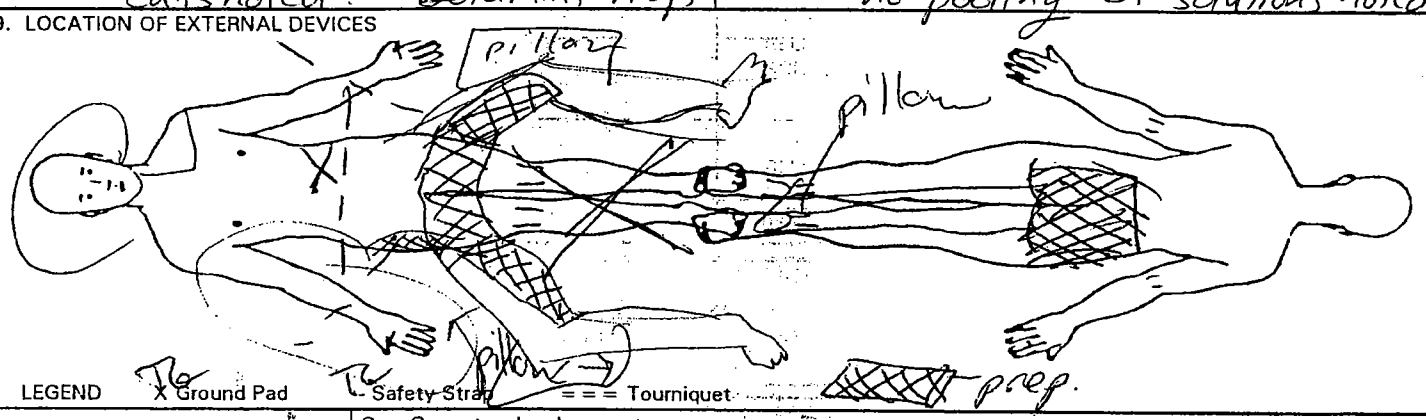
8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR By Dr [redacted] ☐ CLIP
(L) subclavian area

PREP SOLUTION (Specify) Betadine scrub solution
SITE: Bilat Medial Thighs + groin BY WHOM: CPT [redacted]
SITE: (R) hip + Buttock (as below) BY WHOM: CPT [redacted]

COMMENTS: no nicks or cuts noted. c Betapaint Prep
COMMENTS: no pooling of solutions noted

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	CIRCULATOR
Sponge	☑ Yes	☐ No	C		C	PFC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No	C		C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

[redacted] b(6)-4

b(2)-2

9 Nov 03 [redacted]

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

☑ ESU NO: RPB 102395
GROUND PAD: BRAND Valleylab
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 ☐ ☒ NO IF YES NAME: ID NUMBER; TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

0.9% NaCl - QS (>15,000cc)

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlex NaCl	2.	3.
SITE	1. Buttocks + Bilat Thigh wounds.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlex Rolls, Kerlex Fluffs ABD pads, ACE to legs. Silk tape to Buttocks.

19. ADDITIONAL INFORMATION

WC - IV

Surgeon: Dr [redacted]

anes: CPT [redacted] CRNA - Gen/Endo

Bovie pad site pre-op - CDI post-op CDI

b(4)-2 A11

DA 5179 previously done

20. OPERATION(S) PERFORMED

Washout of gluteal wounds and thigh wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1310	Litter

22. REGISTERED [redacted] CPT/AN

b(w)-2 A11

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Amb. BY anesth.

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

3. DATE 11 Nov 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM [redacted] TIME 1054 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: tired from amb. up stairs w/ crutches

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	Maj. [redacted] (1120-1254)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

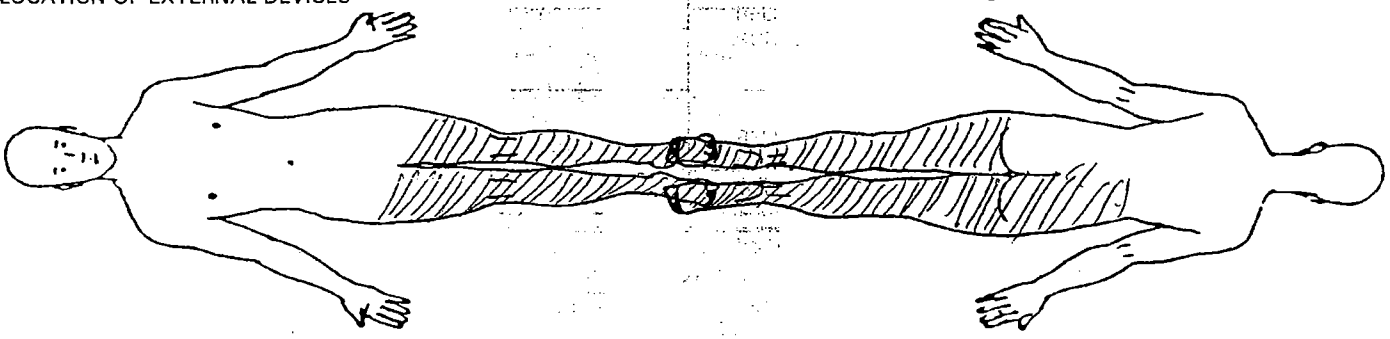
COMMENTS: Bean bag for positioning to safety strap across legs
Pillows between legs, axillary roll, pillow between arms in lat. position

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Rt. leg BY WHOM [redacted]
SITE: Lt. leg BY WHOM: [redacted]
Buttocks
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS

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

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

[redacted]

b(w)-4

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

☐ ESU NO: 30/30
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YE[illegible] ☐ NO IF YES NAME: ID NUMBER; [illegible]

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICI[redacted]

15. X-RA[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. 3/8" Penrose	2. 1" Penrose	3. 1" Penrose
SITE	1. Rt. thigh	2. Lt. Thigh	3. Rt. Buttocks

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, ABD's, Kerlix, Ace } Bilat. LE

Fluffs, ABD, 4x4, Tape } Buttocks

19. ADDITIONAL INFORMATION

Surg. [redacted] Anesth: Sarafin, CRNA Anesth Type: General

6 (u) - 2 A1

Foley in place PTA

20. OPERATION(S) PERFORMED

1. I & D Rt. & Lt. Legs w/ closure of wounds
2. I & D Rt. Buttocks w/ closure of wounds

21. PATIENT TRANSFERRED TO: PACU TIME: 1323 METHOD: Stretcher

22. [redacted] CPT/AN / [redacted] (NA) AN

REVERSE OF DA FORM [redacted], OCT 87

MEDCOM - 23555

USAPA V1.00

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____190 mg/dL

BUN_____10 mg/dL

Na_____139 mmol/L

K_____4.1 mmol/L

Cl_____107 mmol/L

TCO2_____22 mmol/L

AnGap_____15 mmol/L

Hct_____34 %PCV

Hb*_____12 g/dL

*via Hct

pH_____7.325

PCO2_____39.2 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

Sample Type_:

08NOV03 08:14

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

---

i-STAT EG6+

Pt: [redacted]

Pt Name:_____ b(6)-4

Na_____139 mmol/L

K_____4.1 mmol/L

TCO2_____24 mmol/L

Hct_____35 %PCV

Hb*_____12 g/dL

*via Hct

At 37C

pH_____7.337

PCO2_____41.6 mmHg

PO2_____114 mmHg

HCO3_____22 mmol/L

BEecf_____-4 mmol/L

SO2*_____98 %

*calculated

At Patient Temp

pH_____7.334

PCO2_____42.1 mmHg

PO2_____115 mmHg

Patient Temp: 99.0F

Sample Type_: ART

08NOV03 08:12

Oper: [redacted]

Physician: b(6)-2

Ser# 42011

Ver: JAM5046A
CLEW A93

---

i-STAT CREA

Pt: [redacted] b(6)-4

Pt Name:_____

Crea_____0.9 mg/dL

Sample Type_:

08NOV03 08:19

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAM5046A
CLEW A93

---

*CBC (10-4cd)

b(6)-2

Ward/Section: ICU1	REQUE[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRS[redacted] b(6)-4	DATE 8 NOV	TIME 0733	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WE		
RB		
Hgt		
Hct		
MC		
Plt		
Lyr		
C		
Seg		
Bar		
Lyr		
Atyp		Imm
RBC Morph		

ID: [redacted] 08-11-03
WB 08:52

			Patient Limits	
WBC	15.9 H	x10^3/uL	4.5	10.5
RBC	4.23	x10^6/uL	4.00	6.00
Hgb	12.4	g/dL	11.0	18.0
Hct	38.6	%	35.0	60.0
MCV	91.1	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	281.	x10^3/uL	150.	450.
LY%	9.4 *L	%	20.5	51.1
LY#	1.5 *	x10^3/uL	1.2	3.4

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

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: ERAT | REQUEST: [redacted]

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

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 8 Nov 03 | TIME: 0320 | SSN/PSEUDO SSN: [redacted] b(6)-4

CBC

TEST	RESULT	REF. RANGE

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	mod	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Nonreactive

ID: [redacted] 08-11-03
WB 03:31

			Patient Limits	
WBC	37.5 H	x10^3/uL	4.5	10.5
RBC	4.01	x10^6/uL	4.00	6.00
Hgb	11.9	g/dL	11.0	18.0
Hct	37.4	%	35.0	60.0
MCV	93.3	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	464. H	x10^3/uL	150.	450.
LYZ	11.9 *L	%	20.5	51.1
LYN	4.5 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 03:20

Patient ID: [redacted] b(6)-2
Test Name :PT
Test Result:= 14.1 sec.
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :03:18
Card lot :080201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 03:22

Patient ID: 1243
Test Name. :APTT
Test Result:= 27.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time
Card lot
Operator [redacted] b(6)-2

CSF

Cell Count	

Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

T+C 6 units

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-2 [redacted]	DATE: [illegible] TIME: 0829A	SSN/PSEUDO SSN: [redacted] b(6)-2

(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) Metabolic Panel

TEST	RESULT	REF. RANGE
ALB		73-118 mg/dl
ALP		7-22 mg/dl
ALT		8.0-10.3 mg/dl
AMY		0.6-1.2 mg/dl
AST		128-145 mmol/l
TBIL		3.3-4.7 mmol/l
BUN		98-108 mmol/l
CA++		18-33 mmol/l
CHOL		
CRE		
GLU		
TP		

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		
CL-		
tCO2		

======= PICCOLO =======
08/11/03 03:16
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 269 DR #: 000
SERIAL #: 0000100494

GLU	240*	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	711*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 3+, ICT 0

======= PICCOLO =======
08/11/03 09:10 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100684

ALB	3.1*	3.3-5.5	G/DL
ALP	89*	26-84	U/L
ALT	41	10-47	U/L
AMY	36	14-97	U/L
AST	42*	11-38	U/L
TBIL	1.0	0.2-1.6	MG/DL
GGT	51	5-65	U/L
TP	6.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 3+, ICT 0

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)	200											
Succ/Zemuron	(g)	120	40	10									
Fentanyl	(cc)	2			1	1	1						
Neostigmine/Robinul								2/0.3					
Haldol	(mg)				.65								
	( )												
VOLAT AGENT: Forane	% del		1	1	1.5	1.5	1.5	1.5	1.5	1			
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8	2	2	2	2	2	2	6	8			

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

FLUIDS

LINE site												
LR 18G	☒ Warmed	JS #1		#2		#3		#4				
0.9% NS L AC	☐ Warmed	#500										
0.9% NS R AC	☐ Warmed	600										
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE -			200			200/400	150/500					

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: ≈ 90 KG LB

HEMATOCRIT: 11.9/37.4

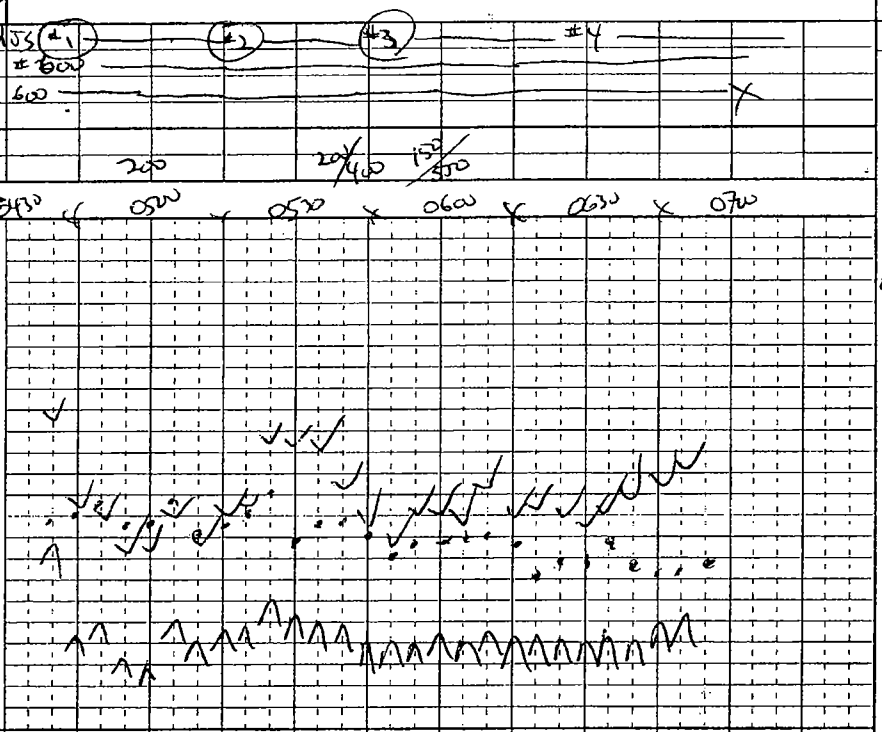
INITIAL DATA: BP- 145/89 / HR- 98

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? ✓ TIME-

TIME 0430 0500 0530 0600 0630 0700

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



VENTIL

VT - ml		880	980	1070	910	900	850			
f - breaths/min		10	10	8	8	8	8	16	18	20
Peak inf pres / PEEP		23	23	24	22	22	21			
MODE - S(pon), A(ssist), C(on)	S/A/CV	SV	CV	CV	CV	CV	CV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		35	30	32	34	36	34	47	46	50
BP/oth	FIO2 (Frac or %)	.61	.58	.58	.59	.59	.59	.58	.58	.58	.58
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site SKIN			96	96	96	96	96	96	96	96
	N-M Block (T/4)			4/4	4/4	4/4		Smart Relax			
Warming blkt											
Conv warmer											

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

TOTALS	TOTAL EBL
200 / 120/50	200
5cc / 2/0.3 / .65	TOTAL URINE 550

FLUIDS - SUMMARY

CRYSTALLOID- ~~3800~~ 3800

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Id'd in ER. To OR. 2 units PRBC's infused. VSS. Monitor. O2. Smoothers: c/o Eyes tired shut. OGT to low-suction. Sx. OGT d/c. Extubated = (+) pain to low-moderate. TO ICU pSR. SaO2/HR monitor. O2. VSS. Uneventful Transport.

RECOVERY AT PACU ICU (Specify)

OTHER

CONDITION:

RESP- 20 SpO2- 97%

BP- HR- 128

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0420	0434	0710
	Ready	Begin	End
PROC	0445	0450	0550

PROCEDURES and CPT Codes:

Colonoscopy; D&B Buttocks, L THIGH + R THIGH

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

OLT-T MAC #8.5 ET (+) B=BS (+) ET CO2 @ 23 cm (+) UL Atraumatic

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

b(6)-4 [redacted]

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: OR 2-1

DATE: 7 NOV 03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	0												
fentanyl	(µg)	150/100		100			150							
ondansetron	(mg)	(4)/100												
succ	(mg)	120												
norcuron	(mg)			4										
	( )													
	( )													
VOLAT AGENT 150	% del		1 →	→	→ (.4)	→	→	→	→ (X)					
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	10 → (2)	→	→	→	→	(3) →	→	→	→				

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

FLUIDS

LINE site		0												
(R) SC	☐ Warmed	(1) →	→	→	→	(2)								
(L) SC TLOL	☐ Warmed						→	→	→	→	→			
	☐ Warmed													
	☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 100 (KG) LB

HEMATOCRIT: 35

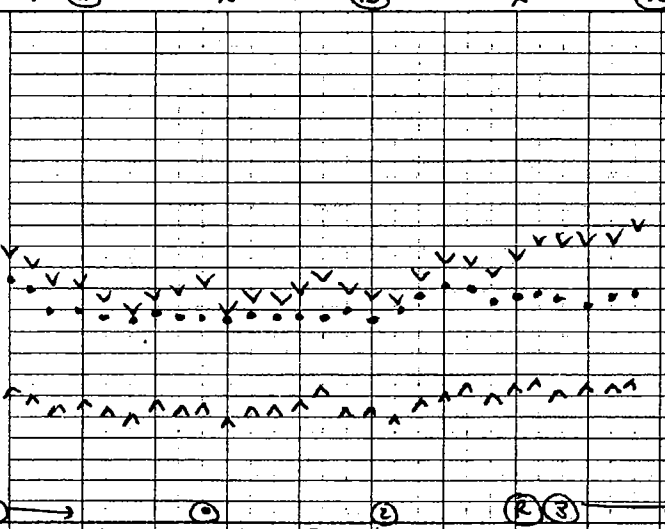
INITIAL DATA: BP- 126 / 65; HR- 112

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1047

TIME → 10 (11) • x • (12) • x • (13)

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



VENTIL

	0	1	2	3	4	5	6	7
VT - ml	SV	880	880	880	870	2000	600	600
f - breaths/min	-	14	12	12	12	8	8	16
Peak inf pres / PEEP	-	20	21	21	21	-	-	-
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S/A	S	S

MONITORS/ACCESSORIES

		0	1	2	3	4	5	6	7
BP/Auto Cuff	ET CO2 (torr)	-	34	29	30	29	44	57	44
BP/oth	FIO2 (Frac or %)	80	71	71	71	71	71	70	70
ART line	SpO2 (%)	97	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	SR	SR	SR	ST	ST	ST
Gas analyzer	TEMP-site E	-	37.6	37.7	37.5	37.5	37.6	37.7	37.8
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (S), BUE on boards <90° c shoulder, pulse ↑

TOTALS	TOTAL EBL
	1000
	TOTAL URINE
	N/M

FLUIDS - SUMMARY: CRYSTALLOID- 1000; COLLOID- Ø; BLOOD- Ø

REMARKS

Code drugs with numbers, events with lettters

(1) IV'd, chart review. Room/O2/monitors. SIVI, eyes taped, easy mask. DVLx1 → OETT A/T → (+) ETCO2 x BBS. (L) SC TLOL placed ∓ sterile prep/drape → Ø complications, (+) heme return x 3 pt. (2) pt to LLD position. (B) on flat, Ø awaken. (3) pt turned supine, intubated. To PACU 1, report

(R) neostig 3 µg / robinul 0.4 µg / IV

RECOVERY AT 1310

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 14 SpO2- 100%

BP- HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1040	1044	1310
	Ready	Begin	End
PROC	1050	1125	1250

PROCEDURES and CPT Codes: I+D (B) leg/buttocks

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

EPW [redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #8.0 OETT, 23 @ lip, A/T, Mac 3

SURGEONS: [redacted] b(6)-2

ANESTHETISTS:

PROCEDURE LOCATION: 2

DATE: 09 NOV 03

PAGE 1 OF 1

MEDCOM - 23561

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)	200												
[Sub] ZEMURON	(mg)	[200]	40											
FENTANYL	(cc)	2	2											
MORPHINE	(mg)			4	6			2	2		2	2		
	( )													
	( )													
VOLAT AGENT — Forane	% del	1.5	2	2.5	2.5	2	1.5	1.0	1.0	1				
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	2	2	4	4	4	4	4	4	8	10		

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

FLUIDS

LINE site												
LR 1000 + [illegible]	☐ Warmed	#1		#2			#3					
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE -						400						

PHYS STATUS 1 2/3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

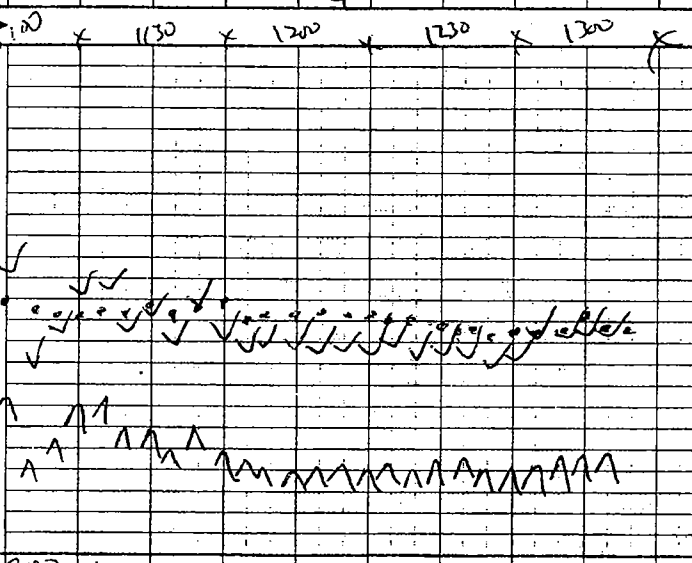
INITIAL DATA: BP- 131/75 HR- 180

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME-

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

TIME → 1100 x 1130 x 1200 x 1230 x 1300 x



VENTIL

VT - ml		900	1.0							
f - breaths/min		10	8	20	21	20	16	20	15	A
Peak inf pres / PEEP		22	24							
MODE - S(pon), A(ssist), C(on)		S/CV	CV	SV	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	28	31	39	37	39	40	39	39	39
BP/oth	FIO2 (Frac or %)	.81	.80	.81	.80	.81	.80	.81	.81	.80
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site SKIN		95	95	95	95	95	95	95	95
	N-M Block (T/4)	4/4	3/4	4/4				Supt. tet		
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine — Lat Decub (+) B=85

TOTALS	TOTAL EBL
200	
122	
5cc	TOTAL URINE
20mg	

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Ambulated w/ assist. TO OR #2. Monitors Anesth. Induction. Eyes taped shut.

1215 Sec. Extubat (+) pres to 10 cm H2O - mask.

RECOVERY AT: 1320

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- 135/67 HR- 111

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1052	1330
PROC	Ready	Begin	End
	1103	1112	1311

PROCEDURES and CPT Codes: LTR

Washout / Partial closure of Thigh / Buttock wounds

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* 24 cuff ETT #8.0

OLYG Miller #2 (+) VC (+) B=85 (+) ETCO2 Atraumatic - easy

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

[redacted] b(4)-4

SURGEONS: [redacted] b(4)-2

ANESTHETISTS:

PROCEDURE LOCATION: OR #2

DATE: 11 NOV 03

PAGE 1 OF 1

MEDCOM - 23562

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 08NOV03 **Diagnosis:** GSW to Buttocks & thighs **HD:** _____ **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	**Mobility**	No limitations	4
	Slightly limited	3		Slightly limited	3
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	4	**Nutrition**	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	1
Activity	Walks frequently	4	**Friction and Shear**	No apparent problem	3
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Add the total score

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

Total Score: 13

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

Surgical wound (s): Yes__ No__ Location: GSW to Buttocks + thighs

Procedure: Flex-Sig | Anoscopy | Debridment + wellox

Size:_____ Drainage: _____

Tubes:_____ Pins:_____ Appearance:_____

Dressing change:_____

Location:_____

Size:_____ Drainage: _____

Tubes:_____ Pins:_____ Appearance:_____

Dressing change:_____

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Pressure Ulcer (s): Yes___ No___

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____ Date/time MD notified _____

CNS notified/consulted for Stage II and greater: Yes____No_____

Nutrition Referral: Yes_____ No_____

Physical Therapy Referral: Yes_____ No_____

Action taken:_____

Date & Time_____

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

PLAN OF CARE FO[illegible] KIN BREAKDOWN AND WOU[illegible] NAGEMENT

PROGR[illegible] NOTES

MEDICAL RECORD

Admission Date: 08NOV03 **Diagnosis:** OSW to Buttocks + thighs **HD:** _____ **POD:** _____

Date: 08NOV03 Time: 1022 RN Signature: _____

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

Wound type: Surgical wound (s) Location: _____

Size: _____ Drainage: _____

Diabetic ulcer Tubes: _____ Pins: _____ Appearance: _____

Venous stasis ulcer Dressing change: _____

Other _____ Describe _____

Burn wound (s): % BSA _____ Partial _____ Full _____

Location: _____ Size _____

Appearance: _____

Dressing change: _____

Pressure Ulcer (s):

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

Location: _____ Size: _____

Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____

Tunneling_____ Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instructions.

Please check the appropriate dressing Change:

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

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

Select the appropriate products used:

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

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d
- ☐ qd

MD Signature and Date: _____

CNS Signature and Date: _____

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

Medical Record, SF 509

NSN 7540-01-185-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR			[redacted]	ICW-1	
	FILM NO. b(6)-4				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR Dr. [redacted] b(6)-2				DATE REQUESTED

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

For CL placement

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
b(6)-4 [redacted]	[redacted] b(2)-2
	LOCATION OF RADIOLOGIC FACILITY [redacted]
	SIGNATURE [redacted] b(6)-2

MEDC[illegible] 23565 [illegible]ATION [illegible]T

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

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

☒ RED BLOOD CELLS (Crossmatch not performed)

☐ OTHER (Specify) _____

☐ THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED:

ALANINE AMINOTRANSFERASE — RETROVIRUS TESTS
CYTOMEGALOVIRUS TEST — SYPHILIS SEROLOGY TEST
HEPATITIS TESTS

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE: [redacted] b(6)-2 — DATE: 8 Nov 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER	RECIPIENT ABO/Rh	INSP[redacted]re)	INDIVIDUAL ACCEPTING COMPONENTS
		[redacted] b(6)-2	[redacted] MAJ An
		AT (Hour) [redacted] 0325	8 Nov 03

UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
11 NO [redacted]	O pos	[redacted]		8 Nov 03	8 Nov 03	1U	NO
11 NO [redacted]	O pos	[redacted]		8 Nov 03	8 Nov 03	1U	NO
b(6)-4		b(6)-2					

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

1. Discontnue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. DO NOT disgard unit. Return Blood Bag, Filter Set and I.V. solution to the Blood Bank.

Description

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER _____

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.)

☑ NO ☐ YES (SPECIFY) _____

PRE-TRANSFUSION

TEMP: 97.8 PULSE: 112 B/P: 144/72

SIGNATURE [redacted] b(6)-2 2LT An

PREPARED BY (Si[redacted]) [redacted] b(6)-2 2LT An

W[redacted] CMT

DATE: 8 Nov 03

PATIENT'S IDENTIFICATION (NAME- LAST, FIRST; SSN)

[redacted] b(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

☒ RED BLOOD CELLS (Crossmatch not performed)

☐ OTHER (Specify) _____

☐ THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED:

ALANINE AMINOTRANSFERASE — RETROVIRUS TESTS
CYTOMEGALOVIRUS TEST — SYPHILIS SEROLOGY TEST
HEPATITIS TESTS

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE [redacted] b(6)-2 — DATE 8 NOV 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER	RECIPIENT ABO/Rh	INS[redacted]UED BY (Signature)	INDIVIDUAL ACCEPTING COMPONENTS
		[redacted] b(6)-2	[redacted]
		A[redacted] 0313	8NOV03

	UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
11NOV	[redacted]	O pos	[redacted]	[redacted]	8NOV03	8 NOV03	1U	ND
11NOV	[redacted] b(6)-4	O pos	[redacted]	[redacted] b(6)-2	8NOV03	8NOV03	1U	NO

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

1. Discontnue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. DO NOT disgard unit. Return Blood Bag, Filter Set and I.V. solution to the Blood Bank.

Description

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER _____

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.)

☒ NO ☐ YES (SPECIFY) _____

PRE-TRANSFUSION

TEMP: 97.8 PULSE: 128 B/P: 72/31

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

b(6)-2 [redacted] — DATE 8NOV03

PA[redacted]ME- LAST, FIRST; SSN)

[redacted] b(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NOTED 2 DEC 2003 @ 0900 [redacted] LT, AN b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 2 DEC 03 TIME OF ORDER: 1 HOURS — LIST TIME ORDER NOTED AND SIGN

1. MOM x 1 30cc
2. Colace 100mg p.o. BID [redacted] b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 2 DEC 03 @ TIME OF ORDER: 1500 HOURS

1. DULCOLAX SUPP. PR x 1 NOW.

V.O. DR [redacted] / [redacted] LT, AN [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24°V	3 DEC	@ 0300 [redacted] LT, AN

PATIENT IDENTIFICATION

b(6)-4 [redacted]

Noted 8 DEC 03 0830 [redacted] b(6)-2

DATE OF ORDER: 8 Dec 03 TIME OF ORDER: 0830 HOURS

1. VS Q shift
2. Shower QD
3. D/C PO Cipro
4. Drsg Dcontinue BID

V.O Dr [redacted] LT, AN

NURSING UNIT	ROOM NO.	BED NO.
b(6)-2 [redacted]		

PATIENT IDENTIFICATION

DATE OF ORDER: [redacted] b(6)-2

@ new orders 15 Dec 0205

b(w)-2 All unless noted diff.

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(w)-4

DATE OF ORDER 8 NOV 83 TIME OF ORDER 0700 HOURS

LIST TIME ORDER NOTED AND SIGNED

1. Admit to ICU from OR, Dr. [redacted]
2. Dx: GSW to both flocks + thigh
3. Condition = stable
4. NKDA
5. Activity = Bedrest
6. Vitals = per routine
7. Incentive Spirometry 10x/hr while awake
8. Foley to gravity
9. I+Os
10. O2 per NC or Face Mask to keep Sat% ≥ 95%
11. 0730 CXR on arrival
12. Diet = NPO ± meds c̄ sips
13. IVF = NS c̄ 20 MEQ KCl / Liter @ 125 cc/hr
14. Tagamet 300 mg IVPB q 6°
15. Heparin Sub Q 5000 Units BID
16. 0730 Ancef 1 gram IVPB q 8°
17. MSO4 2mg - 8mg IV q 2° prn severe pain
18. Percocet 1 - 2 p.o. q 4-6° prn pain
19. Re-enforce dressings prn
20. If soiled c̄ stool Δ outer dressing
21. 0730 CBC, Chem-7 and ABG on arrival to ICU

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU1		1

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9 NOV 03 TIME OF ORDER 1250 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Return to Ward [redacted]
2. Dx = GSW to buttocks & thighs
3. Condition = stable
4. NKDA
5. Vitals = q 8°
6. Activity = OOB to chair & ambulate
7. Incentive Spirometry 10x/hr
8. Diet = Advance to regular as tolerated
9. IVF = NS c 20 MEQ KCl/Liter @ 75cc/hr
10. Tagamet 400mg p.o. q 6°
11. Heparin Sub Q 5000 units BID
12. Ancef 1 gram IVPB q 8°
13. MSO4 2-4mg IV q 2-4° prn severe pain
14. Percocet 1-2 tab p.o. q 4-6° prn
15. Re-catare dressings as needed
16. If dressing soiled c stool, change the outer dressing
17. Post-op CXR for Line Placement [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted] b(6)-2 [redacted] 9 NOV 03 1300

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted] b(6)-2 [redacted] noted 10 NOV @ 0830

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10 NOV 03 TIME OF ORDER 0830 HOURS

1. Tylenol 1 gram p.o. q 4-6° prn pain

[redacted] b(6)-2

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

NOV 11-9-03 @2100

[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11-9-03 TIME OF ORDER: 2100 HOURS

Tylenol #2 po now

[redacted]

b(6)-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24	0020	11NOV03

DATE OF ORDER: 10NOV03 TIME OF ORDER: 0900 HOURS

(1) NPO at MN tonight

(2) 1 IVF to 150cc/hr @ MN tonight

[redacted]

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 Noted [redacted]

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

DATE OF ORDER: 11 NOV 03 | TIME OF ORDER: 1628 | HOURS | LIST TIME ORDER NOTED AND SIGN

1. CXR Now, r/o PTX/pneumothorax
2. Albuterol neb x1, now
3. Titrate O2 to Sat % ≥ 95

b(6)-2 [redacted]

PATIENT IDENTIFICATION

24° V @ 0320 on 13 Nov 03

DATE OF ORDER: 13 NOV 03 | TIME OF ORDER: 2000 | HOURS

1. May ambulate c crutches
2. OOB to chair, TID
3. Once a day shower starting tomorrow AM

b(6)-2 [redacted]

NURSING UNIT: 24° V | ROOM NO.: @ 0030 | BED NO.: 14

None [redacted] 22 Nov

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted]

NURSING UNIT [redacted] | BED NO. 125

DATE OF ORDER: 14 NOV 03 | TIME OF ORDER: [redacted] | HOURS

1. Pt. needs to shower BID c Dressing Δ's. Be sure, lifted area is clean prior to dressing
2. Be sure to place a gauze (kerlix) above + below the drains, so they are not touching the skin

[redacted] b(6)-2

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted]

NURSING UNIT [redacted] | BED NO.

DATE OF ORDER: 15 NOV 03 | TIME OF ORDER: 1600 | HOURS

1. Place PIV
2. Once PIV in, N/C central line

[redacted] b(6)-2

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: 11 NOV 03 TIME OF ORDER: 1315 HOURS

LIST TIME ORDER NOTED AND: [redacted]

1. Return to Ward from OR Dr.
2. Dx: GSW to thigh & buttocks
3. Condition = stable
4. NKA
5. Vitals = q6° b(6)-2
6. Activity = Bedrest
7. Foley to gravity

NURSING UNIT: 1CW1 ROOM NO. BED NO.

PATIENT IDENTIFICATION:

DATE OF ORDER: TIME OF ORDER: HOURS

8. DC foley in AM
9. Diet = Regular
10. IVF = ~~D5 ½ NS~~ NS c 20 mEQ KCl per Liter @ 100cc/hr
11. Vagamet 400 mg p.o. q6°
12. Heparin Sub Q 5000 units BID
13. Zosyn 3.375 grams IVPB q6°
14. Cipro 500 mg ~~IVPB~~ p.o. BID

NURSING UNIT: ROOM NO. BED NO.

PATIENT IDENTIFICATION:

DATE OF ORDER: TIME OF ORDER: HOURS

15. MSO4 2-5 mg IV q2-4° PRN and for dressing Δ's
16. Percocet 1/1 p.o. q4-6°
17. BID Dressing Δ's and as often as needed if soaked. May change entire dressing
18. Tylenol 1 gram p.o. q6° prn temp ≥ 100.5°

NURSING UNIT: ROOM NO. BED NO.

PATIENT IDENTIFICATION:

DATE OF ORDER: TIME OF ORDER: [redacted] b(6)-2

NURSING UNIT: ROOM NO. BED NO.

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

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

b(6)-2 [redacted]

NURSING UNIT: ICW1 240V | ROOM NO.: 3 | BED NO.: B

DATE OF ORDER: 19 NOV 03 | TIME OF ORDER: 0828 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Hep Lock IVF

(2) D/C Zoryn

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE [redacted] ORDER

HOURS

(1) Pt. may ambulate to and from the bathroom

(2) q day dry dressing Δ to Right thigh donor site. Do Not pull off the Xeroform on the donor site ONLY trim the edges

(3) q day dressing Δ to Right lower leg skin graft with Xeroform & dry dressing Xeroform only on the graft

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 NOV 03 | TIME OF ORDER | HOURS

(1) Remove all sutures except from Left Medial Thigh wound

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.: 24V 0300 2DEC03

b(6)-2 [redacted]

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

b(6)-2 A11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23
11/11	[redacted]	Vitals q 6°	06	[redacted]												
			12													
			18													
			24													
11/11	[redacted]	Activity: BRest	06													
			12													
			18													
			24													
11/11	[redacted]	Foley to gravity	06													
			12													
			18													
			24													
11/11	[redacted]	Diet: Regular	06													
			12													
			18													
			24													
11/11	[redacted]	BID Dressing Δs	10													
		and as often as	20													
		needed if soaked.														
		May Δ entire drsg.														
11/13	[redacted]	May ambulate c	06													
		crutches	12													
			18													
			24													
11/13	[redacted]	NWB to chair TID	06													
			12													
			18													
			24													
11/13	[redacted]	Once a day shower	06													
		starting tomorrow	12													
		AM	18													
			24													
14 NOV 03	[redacted]	pt needs to shower	10													
		BID c drsg Δs. Be sure	22													
		gluteal area is clean														
		prior to dressing														
14	[redacted]	be sure to place gauze (KEIN)	10													
		above and below the drains so	22													
		they are not touching the skin														

DIC SEE BELOW

D/C 12 NOV 03

SEE Δ BELOW

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thigh & buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

SPN # [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 A-1

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
11/11	[redacted]	Return to ward from PR Dr Ellison	11/11		1415	[redacted]
11/11	[redacted]	Condition Stable	11/11	noted		[redacted]
11/11	[redacted]	D/C Foley in AM	11/12	am		[redacted]
11 NOV 03	[redacted]	CXR non-to PTX/pneumonia	11 NOV 03	done		[redacted]

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

b(4)-2 All

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 [redacted] 28	29	30	1	2	3	4	5	6
11NOV	[redacted]	VS Q6°	6	[redacted]								
			12									
			18									
			24									
11NOV	[redacted]	Reg diet	6									
			18									
11NOV	[redacted]	OOBTC. TID, AMB	6									
			18									
14NOV	[redacted]	Shower BID & drsg	10									
		Δs. Be sure glutea	22									
		area is clean prior	1									
		to drsg Δ.	1									
4DEC	[redacted]	NIO: BRADEN SCALE	06									
		Q7 DAYS	18									

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [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

b(6)-2 All

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11/12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30ND	[redacted]	Remove all sutures except from left medial thigh wound.	30ND			[redacted]

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

b(6)-2 All

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19
11 Nov 03	[redacted]	S q6°	[redacted]						
			18						
			24						
11	[redacted]	Reg diet	06 18 18 06						
11	[redacted]	DOBTC TID, Amb	06 18 18 06						
14 Nov 03	[redacted]	Shower BID & dsg Δs	10						
		Be sure gluteal area is	22						
		clean prior to dsg Δ							
04 Dec	[redacted]	N10: Braden scale q	06 18						
		7D	18 06						
8 Dec	[redacted]	VS @ Shift	06 15						
			18 06						
8 Dec	[redacted]	Shower @ D	10						
8 Dec	[redacted]	Drsg Δ BID Be	10						
		sure gluteal area	22						
		is clean prior to							
		drsg Δ							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

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 - 23579

b(6).2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16	[redacted]	DIC to prison camp	16 DEC			

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

b(6)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12									
08NOV	[redacted]	NF: NS + 20 meq	06	[redacted]													
	------	KCL (Liter @ 125cc/hr)	18														
08NOV	[redacted]	Heparin Subq. 5000	10	[redacted]													
	------	units BID	22														
08NOV	[redacted]	Tagamet 300mg	06	/													
	------	IVPB Q6°	12	[redacted]													
	------		18														
	------		24														
08NOV	[redacted]	Ancef 1 gram IVPB	08	[redacted]													
	------	Q8°	16	[redacted]													
	------		24														

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: GSW to buttocks + thighs

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ 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														
08/NOV	[redacted]	MSO4 2-8mg IV	08 NOV 03 1100 4mg														
		Q2° prn Severe															
		pain	[redacted]														
08/NOV	[redacted]	Percocet 1-11 po															
		Q 4-6° prn pain															
		b(w)-2 Atl															

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11
08 09 NOV 03	[redacted]	IVF: NS c 20meq KCl/	08 18	[redacted]			
	-----	Liter @ 75cc/hr	18 06	[redacted]			
08	[redacted]	ngamet 400mg po	06	/	[redacted]		
09	-----	q6°	12	/	[redacted]		
	-----		18		[redacted]		
	-----		24		[redacted]		
08	[redacted]	Heparin SubQ 5000	10	/	[redacted]		
	-----	units BID	22		[redacted]		
08	[redacted]	Ancef 1 gm IVPB	08	/	[redacted]		
	-----	q8°	16		[redacted]		
	-----		24		[redacted]		
10	[redacted]	IVFs NS c 20meq KCL/L	6	/	/	[redacted]	
	-----	↑ to 150cc/hr	18	/	/	[redacted]	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW TO BUTTOCK/THIGHS

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23583

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Nov Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/9	[redacted]	Tylenol ⅓ P.O NOW	9NOV	21W	21W	[redacted]
10	[redacted]	↑ IVF to 150cc @ MN tonight	10	24D	24D	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
08NOV	[redacted]	MSO4 2mg IV q2-3 pm severe pain	D/T	8NOV 1740	8NOV 2000	9NOV 0430											
			D/I	8mg	8mg	2mg	[redacted]										
10	[redacted]	Percocet 1 tt po q4-6° pm pain	D/T	8NOV 1610	9NOV 0800	9NOV 1730	10NOV 1500	10NOV 2130									
			D/I	tt	tt	tt	2	4po	[redacted]								
10NOV	[redacted]	Tylenol 1gm Q4-6° PRN pain	D/T	11NOV 0005													
			D/I	1gm	[redacted]												
		b/w-2 AM															

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

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. 11/12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	1	2	3	4	5	6	7	8
11 NOV	[redacted]	Tagamet 400mg po	6	[redacted]													
	-----	Q6°	12														
	-----		18														
	-----		24														
11 NOV	[redacted]	Heparin SQ 5000units	10														
	[redacted]	BID	22														
11 NOV	[redacted]	Cipro 500mg po BID	10														
	-----		22														
2 DEC	[redacted]	COLACE 100mg PO BID	10							/							
	-----		22							/							

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW thigh/buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

Rewritten

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	------	M.O.M. x 1 30cc	2DEC	0910	0910	[redacted]
2DE[redacted]		Dulcolax supp PR x 1 now	2DEC	NOW	1600	[redacted]

	------	b(co)-2 A1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
11/11	[redacted]	Rewritten: MSO4 2-5mg IV q2-4°	D/T														
		prn + for DSG Δ's	D/I														
11/11	[redacted]	Percocet 1-11 p.o.	D/T	25NOV 0700	26NOV 0900	26NOV 1300	27NOV 2215	28NOV 2000	4DEC 0100	4DEC 2000	6DEC 2000						
		q4-6	D/I	[redacted]													
11/11	[redacted]	Tylenol 1 gram p.o.	D/T														
		q 6° PRN temp ≥ 100.5	D/I														

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

b(6)-2 Ally

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 09	10	11	12	[redacted]			17
11 Nov 03	[redacted]	Tagamet 400mg po	06	[redacted]							
	-----	q6°	12								
	-----		18								
	-----		24								
11	[redacted]	Heparin SQ 5000U	10								
	-----	BID	22								
02 Dec 03	[redacted]	Colace 100mg po	10								
	-----	BID	22								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

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. 12 Yr. 98

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		DIW) - 2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 NOV	[redacted]	MSO4 2.5mg IV q2-4° pm & for dsg cs	D/T													
			D/I													
11	[redacted]	Percocet 1-2 po q4-6° pm	D/T													
			D/I													
11	[redacted]	Tylenol 1 gram po q6° pm temp ≥ 100.5	D/T													
			D/I													

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

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11/11	[redacted]	NS c̄ 20 meq KCl	06 18	[redacted]									DC	19	NOV		
	[redacted]	per liter @ 100cc	06														
11/11	[redacted]	Zagamet 400mg	06														
	[redacted]	p.o. q 6°	12														
	-----		18														
	-----		24														
11/11	[redacted]	Heparin SQ 5000U	10														
	[redacted]	BID	22														
11/11	[redacted]	Zosyn 3.375 grams	06														
	[redacted]	IVPB q 6°	12														
	-----		18										DC	19	NOV		
	-----		24														
11/11	[redacted]	Cipro 500mg p.o.	10														
	[redacted]	BID	22														
11 NOV 03	[redacted]	titrate O2 to keep	06 18														
	-----	sat % ≥95	18 06														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thigh & buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW #[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
11 NOV 03	[redacted]	Albuterol neb X 1 now	11 NOV 03	—	1930	[redacted]	
15 NOV 03	[redacted]	Place PIV	15	—	1100	[redacted]	
15	[redacted]	once PIV in, d/c central line	15	—	1100	[redacted]	
19 NOV	[redacted]	Heplock IVFs	19	—		[redacted]	
19	[redacted]	D/C Zosyn	19	—		[redacted]	
		b(6)-2 th1					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11/11	[redacted]	MSO4 2-5mg IV	Date	11 NOV	11 NOV											
		q 2-4° prn and	Time	1920	2340											
		for drsg A's	Dose	5mg	5m	[redacted]										
			I/E	E												
11/11	[redacted]	Percocet 1-11 po	Date	12 NOV	12 NOV	14 NOV	14 NOV	14 NOV	22 NOV	22 NOV	23 NOV					
		q 4-6°	Time	2140	1600	0440	0215	2330	0600	2130	0700					
			Dose	2tb	II	II	II	II	III	II	II	[redacted]				
			I/E													
11/11	[redacted]	Tylenol 1 gram	Date	11 NOV	12 NOV	12 NOV	13 NOV	14 NOV	1 NOV							
		p.o. q 6° prn temp	Time	1930	0010	2000	1930	2130	1530							
		≥ 100.5	Dose	1gm	1gm	1gm	1gm	1gm	1gm							
			Init	[illegible]	[illegible]	[illegible]	[illegible]	25	[illegible]							
			I/E	E	E											

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

b(6)-2 A11

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
0310	Urinary	16Fr	☑ Meatus ☐ Supra-Public	SGT [redacted]	☑ 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_____
0304	☑ CBC ☑ Chem ☐ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
0304	☑ OTHER T+C 6 units
	☐ OTHER

X-RAYS

TIME	LABS
0304	☑ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
0304	☑ Pelvis
0304	☑ (L) femur
0304	☑ abdomen
	☐

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	(R) arm	LR		
central line			☑	N	(R) sub	LR		
0310		18ga	☒	N	(L) AC	NS		
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
fentanyl	0329	100mg	IV						
O^2 via NRM	0320	15L	NRB						
Ancef	0320	1gm	IV						
Tetanus	0325	1ml	IV						
Fentanyl	0400	100mg	IV						

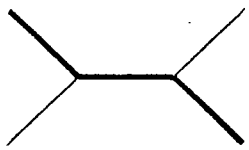
66-4

BLOOD PRODUCTS

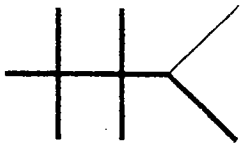
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT
0310		O Pos	[redacted]		1u		
0312		O Pos	[redacted]		1u		
0325		O Pos	[redacted]		1u		
0325		O Pos	[redacted]		1u		

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				
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 _____

Transferred By _____

Via: ☐ Stretcher ☐ Wheelchair

VITAL SIGNS

Rectal Temp:

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0305	72/31	125	NSR	40							
0311	85/65	153	NSR		100						
0317	/	128	NSR		100						
0321	126/65	118	NSR	44	100						
0327	146/71	121	NSR	62	98						
0330	146/71	101	NSR	22	100						
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GLASGOW COMA SCALE

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

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

NOTES

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: 0304 ETA: 1 min UNIT: _____
MED COM: [Y] [N]

ARRIVAL STATUS

TIME 0304 ☑ IV x 1 ☐ O_2 _____ 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: [X] [N]
HEART TONES: ☐ Clear ☐ Muffled
SKIN: ☑ Warn ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic ☐ _____
☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E _____ 15 V _____ M _____
SPHINCTER TONE: ☑ WNL ☐ None

HEAD
PUPILS: ☑ Equal ☐ Fixed ☑ React ☐ Dilated [L] [R]
TM: ☑ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: ∅ [Y] [N]
Pain @ _____
JVD: [Y] [N]

HEART
RHYTHM: ☑ Regular ☐ _____
PULSES: ☑ Central ☑ Peripheral

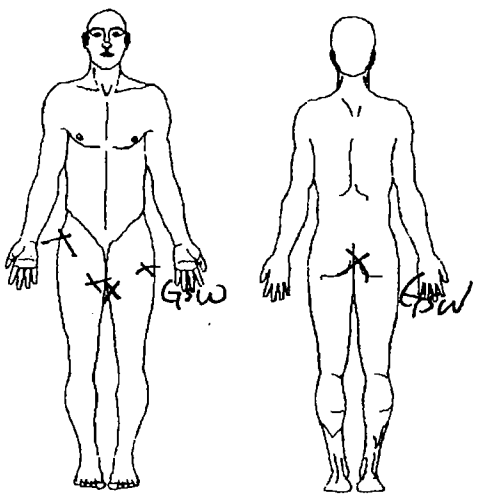
LUNGS
BREATH SOUNDS: ☐ Bilat ☑ Equal ☑ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☑ Soft ☐ Rigid ☑ Non-Tender
☐ Tender: _____

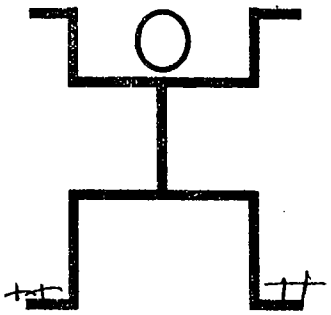
PELVIS
☑ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme +/- Prostate: ☑ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

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



VASCULAR ASSESSMENT



+ + Strong [redacted] Palpable D Doppler

RN [redacted]
PHYSICIAN [redacted]
(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(4)-2
DEPARTMENT/SERVICE/CLINIC Fam
DATE 8 Nov 03

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

SJ [redacted]
31 y/o b(4)-4

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

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

SHIFT ASSESSMENT b(6)-2

		TIME: 1000 INITIALS [redacted]	TIME: INITIALS:
NEURO	PUPILS	3mm PERL	
	SENSORIUM	alert	
	EXTREMITY MOVEMENT	limitation to (B) thigh	
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	~~HR 123~~ RR 16	
	BREATH SOUNDS	CTA	
	SECRETIONS	nonproductive cough noted	
	O2 SOURCE/FLOW/SAO2		
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	HR 123	
	CAPILLARY REFILL	+ <3sec refill	
	PULSES	(+) pulses	
	EDEMA	(-)	
GI	ABDOMEN	firm + nondistended	
	BOWEL SOUNDS	(+) bowel sounds Q4 quadrant	
	BOWEL MOVEMENT	1 stool in OR this AM	
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	FC to BS	
	COLOR/CLARITY	pale yellow	
SKIN	COLOR	normal for race	
	INTEGRITY	GSW to buttock + (B) thighs	
		Deg to thighs + buttock	
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis (RJ) SC.	
	DRESSING CONDITION	Changed this AM	
	IV FLUID/RATE	NS @ 20 MEDICAL @ 125cc/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE

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

NAME: RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ 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] (5) 2

Date: 08/NOV/03

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		120	145																							
NBP		158/58	145/64	139/46	114/70	107/60	120/62	119/64	114/70																	
TEMP		99.9	99°	99.7	99°	99.6	100.1	100.0	100.0																	
HR		109	103	121	117	106	100	102	108																	
RR		24	18	41	13	18	18	35	20																	
SaO2		100	100	100	100	99	100	99	99																	
FiO2		—																								
Source		RBM	NC	NC	RA	RA	RA	RA	RA																	
		12L	2L	2L	—	—	—	—																		

TAKE	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
		125	125	125	125	125	125	125	125																	
		50					100																			
		OR																								
PO																										
Total																										

TPUT	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		550/550	1000/1550	200/1750	150/100	190/2120	165/2285	140/2425	225/2650																	
NGT																										
STOOL		1																								
DRAIN																										
EBL		200																								
		OR																								
Total																										

MEDCOM - 23595

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: 11/09/03
Time In: 1310
Allergies:
Pre-op V/S: 12 [illegible] 12 112
Procedures: [illegible] BOTH

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP EBL 0
Meds/Times: FENTANYL 150 mcg, IMDO 40 mg. CELLS + BUTTOCKS SIP GSW TO THIGHS BOTH BUTTOCKS

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

Pre Op Meds

History

Time	1310	1325	1334	1335	1350	[illegible]	[illegible]	1430	1930
SaO2	100	67	88	98	96	97	93	95	
FiO2	10		10	NC	NC	60			
Methods	RA	RA	[illegible]	[illegible]	[illegible]	[illegible]	RA	RA	
240									
220									
200									
180									
160									
140	142								
		133	135	134					
120					120		122		
						112		105	
100									
80									
	71		75	78			71	76	
60		66			66	65		60	
40									
20									
BP	141	133	122	115	117	123	122	123	
RR	19	12	10	12	16	16	15	16	
T									

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1310	RL	250	TL (2) Clav	IV	250
1350	RL	1000	TL (2) Clav	IV	50

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/09/03

PATIENT [redacted] (For typed or written entries give: Name – last, first, m[redacted]ate; hospital or medical facility)

EPW [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	B/L LEGS	+	+	P	B	W	PK
15'	B/L LEGS	+	+	P	B	W	PK
30'							
45'							
60'							
90'							
D/C							

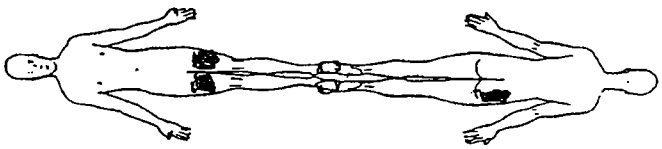
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1310	BK THIGHS. ACE + KUNG.		(-)
30'	BK THIGHS	ACE + KUNG.	(-)
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1310	SR		MESENT

NURSING NOTES

1310 Pt accompanied on stretcher from OR, accompanied by anesthesiologist. Pt set at 100% RA. Pt has nasal airway, pt aroused with deep physical stimuli - pinch to ear lobes. Pt has dressing @ both thighs and (R) buttocks. Pt thrashes around in bed [redacted]
1325. Pt set designs for foley. RN administered with 6L of O2. Pt sat climbed to 98%. Pt encouraged to deep breathe and cough x 3. [redacted]
1340. Pt [redacted] responsible to light touch, verbal stimuli - encouraged to deep breath and cough.
1410. Pt able to cough and deep breathe effectively. [redacted]
1430 Pt alert and oriented x 2 [redacted]
Pt c/o stable & transferred to TCU [redacted]

b (6)-2 A11

Discharge Criteria:

Date: 11/9/03 Time: 1430 PARS: 10
BP: 155/60 T: 98.4 HR: 123 RR: 16 Sa02: 95%
Pain Level at D/C (0-10):
Intake: 250 [redacted] Output:
Additional Data:
Transferred To: TCU
Report Given To: SPC [redacted]
Transferred Via: [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Reco[redacted] SOP B-3
[redacted] e Signature:

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: 11 Nov 03
Time In: 1340
Allergies: NKA
Pre-op V/S: 131/75 120
Procedures: 1415 L ureteroscopy, Rt stent, bl retrograds
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2400 Colloid
OR Output: UOP 400 EBL
Meds/Times: MSO4, Fentanyl

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

Pre Op Meds

History

Time	1340	1345	1350	1355	1400
SaO2	98	98	99	99	93
FiO2		10	10		
Methods	BB	A	M	RA	BB
240					
220					
200					
180					
160					
140			✓		✓
120	✓	✓		✓	
100		•	•	•	•
80	•				
60				^	
40	^	^	^		
20					
RR	14	18	22	22	22
T	97				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1340	LR	600	L SC	OR	400

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	—		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	8	9

Codes

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

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

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

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

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

PRE[redacted] LPN bl(e) 2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11 Nov 03

P[redacted] written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

#[redacted]

bl(e) -4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L leg	Rlm	+	1	B	W	Pk
15'	R leg	Rlm	+	1	B	W	Pk
30'							
45'							
60'							
90'							
D/C							

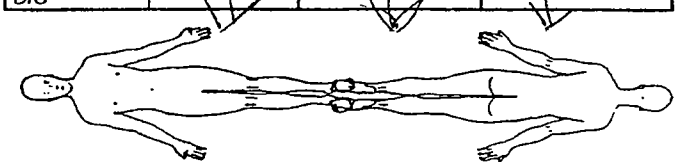
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L leg	Kilix Cap	∅
30'	R leg	Kilix Cap	∅
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1340	ST	∅	∅

NURSING NOTES

Pt to recovery room from OR s/p I&D bil. lithemitrec, washout medium. Bil dressing to both lower lithemitrec. Dressing intact. IV of LR infusing into (L) subclavian. ∅ s/s of [illegible]. Will continue to monit[redacted] [illegible]
blue-2

Discharge Criteria:
Date: 11 Nov **Time:** 1415 **PARS:** 9
BP: 155/90 **T:** 97 **HR:** 122 **RR:** 20 **Sa02:** 93
Pain Level at D/C (0-10):
Intake: 200 **Output:**
Additional Data:
Transferred To: ICW
Report Given To: [redacted]
Transferred Via: [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery R[redacted]
Charge Nurse Signature: [redacted]
blue-2

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: ENEMY WA

RANK / GRADE

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

MALE / HOMME

FEMALE / FEMME

RELIGION / RÉLIGION

2. UNIT / UNITÉ

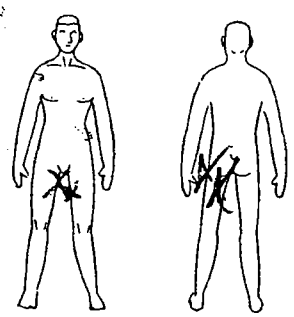
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK ARRIÈRE



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

654 (2) buttocks

4. LEVEL OF CONSCIOUSNESS NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE A LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE

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

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

8. IV / IV: 1000 | TIME / HEURE

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

120, 112/70, 20
A1 patent B 20, CTA (B)
C 112/70, 120 distal pulses +2
D A&O

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ
- DECEASED / DÉC[redacted]

TIME / HEURE: 0200

11. PROVIDER / UNIT / OFFICIER MÉDICAL[redacted]

DATE / DATE (YMMDD): 11/8

DD Form 1380, DEC 91

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

[redacted]S. FIELD MEDICAL CARD
[redacted]ALE DE L'AVANT ÉTATS-UNIS

blue - 2

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.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A			b(6)-2 [redacted]	17	m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 1 0 1 0 1	27 28 29	30	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 9 9	37 38 39 40 41 42 43 44 45: 0 0 0 0 0 1 2 4 3

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: K 7 8	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 (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 1 2 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 1 1 0 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

Dx: 8770
8900
E9912

Pro: 8659 (2)
8628
8345
4524
4921
8801
9904 (2)
8962

Inj Trauma
4150 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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 Location: IZ

3. Register Number: [redacted]

Name (Last, First, MI): [redacted] b(6)-4

4. Pay Grade: FGN

5. Sex: M

6. DoB (YYYYMMDD): 1971-01-01

7. Age at Admission: 32Y

8. Race: X

9. Ethnicity: 9

Religion:

10. Length of Service: ETS

11. FMP: 99

12. Social Security Number: [redacted]

Organization (Active Duty Only):

13. Marital Status:

Hour of Admission: 03:00

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: ICW1

Name / Relationship of Emergency Addressee

Address of Emergency Addressee

Telephone Number of Emergency Addressee

Name and Location of Medical Treatment Facility: [redacted] b(2)-2

21. Type of Disposition: TRF-OTH

22. MTF Transferred To:

23. Date of Disposition (YYYYMMDD): 2003-12-17

24. Clinic Svc - Admitting: ABA - GENERAL SURGERY

25. MTF Transferred From:

26. Date this Admission (YYYYMMDD): 2003-11-08

27. Location of Occurrence: IZ

28. MTF of Initial Admission:

29. Date of Initial Admission: 2003-11-08

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW L BUTTOCKS AND THIGHS

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required)

[redacted] b(6)-2

Signature of Admitting Clerk

[redacted] b(6)-2

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]	b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	27Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
20	[redacted]					ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	10:35	ABD - NEUROSURGERY					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-11-~~14~~ 13					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-~~14~~ 8	[redacted] b(6)-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] b(2)-2		2003-11-~~14~~ 8					

31. Selected Administrative Data

Marital Status:

DoB: 1976-08-19

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L FACAIL HEMOTOMA, L SHOULD SHRAPNEL,R HIP SHRAPNEL

873.41
880.10
890.0
877.0
E993

35. Total Days This Facility

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

35. Total Days This Facility

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

[redacted] b(6)-2

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

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

39 yo/m EPW S/P IED explosion and sustained shrapnel injuries to left cheek, left shoulder and right hip.

PMH
PSH
aller
meds } denies

CV: RRR
Lungs: CTA (B)
abd: soft NT ND (+) BS
ext: (L) shoulder shrapnel wounds
(R) hip shrapnel wounds

Xrays
(+) shrapnel
- L face
- L shoulder

CT scan
(+) shrapnel
(L) face c̄ free air + hematoma
(L) shoulder c̄ shrapnel

PHYSICAL EXAMINATION

Heent A/O x3 mod distress
Perrl EOMI
(+) palpable facial/mand fx's
uvula patent
tm's clear (B)
(+) trismus
(L) cheek hematoma (+) active bleeding
neck supple

consults
OMFS
Neuro sx
ortho

PROGRESS (Enter date of discharge and final diagnosis)

A/P S/P IED c̄ shrapnel wounds to (L) cheek, left shoulder + (R) hip
(1) Admit for obs
(2) consider ever of hematoma

SIG [redacted] b(6)-2 | DATE 8 NOV 03 | IDENTIFICATION NO. | ORGANIZATION

PAT[redacted] (For typed or written entries give Name last, first, middle; 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

117

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 NOV 03 1506	VSS. A&O. Received from EMT @ 1505. PERRLA. HAR. LSCTAB. BS(+)x4. c/o pain to (R) hip: DSG CDI to large laceration from injury & to (L) shoulder laceration. Severe weakness to (L) arm from shoulder to distal carpals. Weakness grip @ (L) hand. CMS intact. Severe hematoma to (L) mandible region. Cleared by MD & CT scan. Able to tolerate PO. Scanty light yellow urine @ this time, as (+) pulses to extremities. Started IV AB per orders. Pertly in bed. [redacted] b(6)-2
8 NOV 03 2200	VSS A&O. HRRR, LSCTA(D), (+)BS x4 quads. c/o pain. MSO4 administered. (R) side of face edematous due to shrapnel. (L) shoulder ≅ puncture wound. Drsg Δ'd wound actively bleeding ~~[illegible]~~ when old Drsg removed. Drsg to (R) hip Δ. small puncture wound. W→D. (+) Pulses in all extremities. (L) hand weaker than ~~Left~~ Right. Skin warm & Dry to palpation. Cap refill [redacted]. Will continue to monitor [redacted] b(6)-2 [redacted] 91WM6
9 NOV 03 (1200)	Pt A&O, VSS, c/o pain earlier to (L) shoulder. 2 mg MSO4 given c̄ noted relief. Drsgs Δ'd. to (L) shoulder & (R) hip. minimal drainage (bloody). Pt c/o pain to (L) hip, redness noted. Will notify MD. (L) side of face edematous. limited ROM to (L) arm/shoulder d/t pain. Pt NPO for OR today. NS @ 125cc/° to (R) AC ō S/Sx infection/infiltration. 2 pt restraints on ō compromise to skin/circulation. Will monitor [redacted] 91WM6

STANDARD FORM 508 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 23605

[redacted] b(6)-4

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10Nov03 0300	[redacted] Assumed care of Pt @ 1800. A&O, c/o Pain MSO4 administered. LS CTA (B) HRRR (+) BS x4 quads. Drsg to (L) Anterior Shoulder Δ'd. [redacted] No Drainge noted from wound. Drsg to (R) Hip Δ'd. moderate amount of Sero Sang Drainage to old Drsg noted. Will continue to monitor. b(6)-2 [redacted] Spc 91WM6
10NOV (1200)	Pt a/o, VSS, c/o pain to (L) shoulder & arm. drsg (2x2) applied to shoulder c̄ scant amt drainage. (R) hip c̄ minimal bloody drainage (duoderm noted in wound) no order to remove duoderm). Will discuss c̄ MD when avail. Pt c̄ c/o pain to (L) hip also (redness noted). ambulating to BR ō difficulty often. (B) cheeks appear edematous. (L) more than (R). Pt is NPO, d/t shrapnel in (L) cheek. Will notify MD of need for NPO re-eval. 2 pt restraints on while in bed ō compromise to skin/circulation. (R) AC IV infusing NS @ 125cc/o ⊖ edema or redness @ site. Will monitor — [redacted] 91WM6. b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW #1

PROGRESS NOTES
Medical Record

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

#[redacted]
b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Nov 03 (0107)	Assumed care @ 1800. VSS. C/o pain to (R) buttocks & (L) cheek. MS04 given c̄ good relief noted. LS GTA, sats 98% on RA, ∅ resp distress; (+) BS, tol regular clear liquids well; voids per urinal s̄ difficulty; ↑ amb s̄ assistance. (R) buttocks wound, small c̄ serosanguinous drainage, iodoform packing noted. (L) shoulder wound c̄ sm amt serosang drng noted, dry dsg ad. new 20G IV to (L) AC, IVFs cont, can HL in AM. 2 pt restraints on s̄ S/Sx of skin/circulation compromise. Pt ↑ amb to BR s̄ difficulty. Plan: monitor pain, monitor drgs, ↑ amb s̄ po. Addendum: (L) jaw edematous, sm poss shrapnel wound OTA, ∅ drainage, inside cheek edematous also, but ∅ difficulties c̄ breathing or swallowing, except pain c̄ jaw movement. Will cont to monitor. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Nov 03	ORTHO CONSULT

Called to eval (L) Shoulder Pain. Pt has shrapnel wound (⊗) (L) Posterior lateral deltoid region. Has 4/6 GSW to same shoulder from Iran-Iraq war. Previously shoulder was pain free & full function.

PE: Entrance wound post shoulder with slight swelling around wound. Minimal TTP in region of wound. Non-tender at anterior shoulder.

FFlex 120 active, 180 passive

ER 45 active 45 passive

IR L2 active

Rot Cuff 4/5 strength. (−) Drop Arm Test.

Xrg - AP Shoulder. Shrapnel at lateral margin of humerus.

Imp: Deltoid muscle injury. No evid. of intearticular injury or rotator cuff tear.

Plan: Encourage shoulder use and ROM. No intervention required.

b(6)-2

[redacted] WHITE, DANIEL ORTHO

Addendum:

Evaluated shrapnel wound (R) Buttock. Wound clean.

Instructed nursing staff to do daily wet → dry dressing Δ's

[redacted] ORTHO

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11NOV03	(CONT) Voiding's difficulty. IV HL'd in (R) AC, flushes well. IV Abx cont. 2pt restraints m/s s/sx of skin/circulation compromise. Plan: cont IV Abx, monitor drsgs, pain control. [redacted]
12NOV03 1230	VSS. AO. Mild c/o HA this afternoon and provided 2 tylenol. Ambulated well to shower this AM and performed self care. DSG d/d to (R) hip WTD 5 difficult c/o pain. ¢ s/s infection to wound site. Moderate amount of serosang drainage noted. ¢ odor. IV started @ (R) AC region and HLIV. (L) shoulder wounds OTA. Voiding light yellow urine, BS [redacted] Appt
12NOV03 0745	assumed care of pt @ 1800. VSS. No c/o pain. (R) hip drsg AD, serosang drainage noted on drsg, wound packed c̄ moist 2x2, erythemic around wound entrance, can still palpate shrapnel (?) approx 2in away from wound toward groin. (L) shoulder wound OTA, (L) cheek wound OTA, both c̄ old drainage noted. Tol mech soft diet c̄ difficulties; void per urinal c̄ difficulty. IV Abx cont. Plan: pain control, IV Abx, monitor drsg. 2pt restraints m/s s/sx of skin/circulation compromise. [redacted]
13NOV03 1230	VSS. AO. WTD DSG d/d c̄ c/o pain. ¢ c/o HA, SOB or dizziness. Ambulated on own to BR. Transferred to EPW comp. [redacted] Appt

b(6)-2 A11

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 NOV 1330	Pt a/o, VSS, c/o pain to (R) shoulder, ~~medicated~~ ERROR [redacted] Pt fell asleep before able to be medicated. Drs to (R) shoulder s/d, ø drainage, drsg to (R) hip c̄ minimal sero-sang drainage, iodoform removed). repacked loosely c̄ gauze (moist & applied 4x4. IV HL'd, Tol PO fluids well. cont. clear liquid diet c̄ difficulty. (L) cheek edema ↓ slightly. Pt able to move arm & shoulder (causes pain) with encouragement. voiding cyu via urinal, had BM x1, amb-ulated x3 today. Ancef cont per orders. Will monitor c̄ [redacted] 91WM6
11 NOV 03 @ 2230	assumed care of pt @1800. VSS. c/o pain, medicated c̄ percocets c̄ good relief noted. (L) shoulder wound OTA, limited ROM to (L) shoulder & arm. (R) buttocks wound approx 3.0cm x 3.0cm, approx 3.5cm deep, packed c̄ moist gauze; sm amt of drainage noted from old drsg. approx 3 inches from wound skin is erythemic & warm, small hard "knot" area felt. Will notify MD. (L) cheek shrapnel wound OTA, old drainage noted, ↓ edema noted, cont c/o pain c̄ swallowing/opening mouth. Pt advanced to regular diet as tolerated. (CONT)

head

(R) side

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SP[redacted]
	LAST	FIRST	MI	(SS[redacted]

b(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

#[redacted]

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Nov 03	ORTHO CONSULT

Called to eval (L) Shoulder Pain. Pt has shrapnel wound (@) (L) Posterior lateral deltoid region. Has H/O GSW to same shoulder from Iran-Iraq war. Previously shoulder was pain free & full function.

PE: Entrance wound post shoulder with slight swelling around wound. Minimal TTP in region of wound. Non-tender at anterior shoulder.

FFlex 120 active, 180 passive

ER 45 active 45 passive

IR L2 active

Rot cuff 4/5 strength. (-) Drop Arm Test.

Xrg - AP Shoulder. Shrapnel at lateral margin of humerus.

Imp: Deltoid muscle injury. No evid. of intearticular injury or rotator cuff tear.

Plan: Encourage shoulder use and ROM. No intervention required

[redacted]

Addendum:

Evaluated shrapnel wound (R) Buttock. Wound clean. b(6)-2

Instructed nursing staff to do daily wet -> dry dressing Δ's

[redacted]

ORTHO

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.

AUTHOR[redacted] REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
11/11/03 1830	Tonsillectomy Pt. Continues to improve. Tolerated clear liquids. Notes decreased trismus and able to open mouth. Tongue is midline w/ protrusion & Nasolabial fold mild flattening likely related to edema (L) angle of jaw edema decreased. Swelling progressively reduced over past 48° A/P: Conservative management as long as remain APBS w/ ↓ swelling. [redacted] b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME — LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

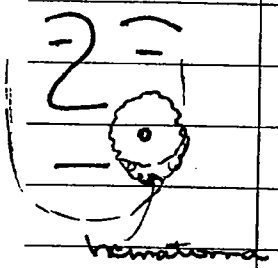
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

OMFS eval

8 NOV 03 @ 1129 Called to eval an 39yo Iraqi male S/P IED c̄ shoulder shrapnel and left cheek shrapnel c̄ left cheek hematoma.

PMH:
PSH:
MEDS:
Aller:
} Denies



HEENT: NC PERRL, EOMI
Ø palpable facial steps or crepitus
nares patent (B)
TM's clear (B)
max & mand stable c̄ trismus
(L) cheek / angle hematoma

Plain films shows a piece of shrapnel in soft tissue of left cheek.

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)*
	CT Scan:
	shows shrapnel in anterior left cheek.
	free air and hematoma collection in left cheek.
	∅ disruption of carotid vessels per CT scan.
	Neurosurgery consult c̄ Dr. [redacted] recommends no neurosx tx @ this time and recommends delayed tx of hematoma once more solidified
A/P	S/P 2ld ED c̄ left facial shrapnel and hematoma
	① admit for observation + IV Abx
	② will consider evacuation of hematoma @ later date.
	[redacted] MAJ/OC
	b(4)-2 OMFS

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 8 NOV 03 | TIME: 1030

TRANSPORTATION TO FACILITY: Air

SEX: M

AGE: 39

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: Pt.

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ancef - 1gm - field

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: shrapnel injuries / Fb's fragments Ø past Med Hx

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1025

INITIALS: NV

VITAL SIGNS

TIME	1025	1090	1100		
BP	154/85	140/97	124/81		
PULSE	105	93	109		
RESP	19	20	18		
TEMP	98.7	98.8			
WT	100%	100%	98%		

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: 12 + lytes
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100% ☒ MONITOR ☐ ECG

TIME	ORDERS	[redacted]BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1105	Morphine 5mg	[redacted]			
1100	2L bolus NR		b(6)-2		
1100	Td + Sc. PM				

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 ☐ DETERIORATE

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]

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC	9.5		139	100	7	SUP 02	PH	PO2	RESULTS	
H/H	10.6/35.5				157				~~[illegible]~~	
PLT			4.8	29	1.7	PCO2	SAT	OTHER		
PT						U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU			MICRO			

PROVIDER HISTORY/PHYSICAL

39 y/o ♂ shrapnel injuries to Lt side of the face / Rt buttocks & Lt arm. ∅ respiratory distress ∅ CP/SOB

Arrived given PTA @ 0935 ⅔ Ⓛ shoulder pain

PMH NR
PSH Ⓛ arm

D: A&O x4 [illegible] mm dilated, JVD
Head: atraumatic, neck: supple, NT
Pupils equal
Face: ⊕ lg hematoma Ⓛ face ⊕ laceration @ Ⓛ mandible angle ∅ palpable mass
Chest: CTA⊕, full symmetric breaths
CV: RRR ∅ M/R/G
Abd: ⊕ BS, NT
Back: ⊕ shrapnel wound,
Ext: ⊕ GSW post Ⓛ shoulder ↓ ROM, 2° pain ∅ active bleed

Xrays:
⊕ shrapnel Ⓛ face
⊕ shrapnel Ⓛ hip superficial

Ap Ⓛ Admit Abx / obs / OMF c/s

CONSULT WITH	TIME	ACTION
OMF		
Surg		

RESIDENT/MEDICAL STUDENT SIGNAT[redacted]

PROVIDER SIGNATURE A[redacted]

DIAGNOSIS
1. Ⓛ face shrapnel c̄ lg hematoma
2. Ⓛ shoulder shrapnel, stable
3. Ⓛ superficial hip soft tissue shrapnel

CODES b(6)-2

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

b(6)-2

[redacted]

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 11-8-03 Diagnosis: (L) Shoulder Shrapnel (R) Facial Hematoma (R) Hip Shrapnel HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	Mobility	No limitations	4
	Slightly limited	3		Slightly limited	(3)
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	(4)	Nutrition	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	(1) (NPO) X3days)
Activity	Walks frequently	(4)	Friction and Shear	No apparent problem	(3)
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Add the total score

Total Score (19)

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 or equal to 15 indicates HIGH RISK –Requires immediate Ulcer prevention program.

(Shrapnel)
Surgical wound (s): (Yes) No Location: (L) Shoulder (R) HIP Size: 2 cm (each) Drainage: min. bloody
Tubes: Ø Appearance: red, healthy tissue.
Dressing change: dry drsg applied BID

Pressure Ulcer (s): Yes (No)
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: _____ Size: _____
Wound character: Pint _____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough _____
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 _____
CNS notified/consulted for Stage II and greater: Yes _____ No _____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes _____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO. | WARD NO.

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

PROGRESS NOTES

b(6)-4

#[redacted]

Medical Record
STANDARD FORM 509

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

8 NOV 03 | 9 | 9 NOV | 10 | 11 NOV | 12 NOV 03 | 13 NOV 03

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

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:44

Patient ID: [redacted] b(a)-4
Test Name :PT
Test Result:= 14.0 sec.
Ratio = 1.1
Calculated INR = 1.25
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:42
Card Lot :080201
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:48

Patient ID: [redacted] b(a)-4
Test Name :APTT
Test Result:< 15 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:46
Card Lot :100208
Operator [redacted]
b(a)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:50

Patient ID: [redacted]
Test Name :APTT
Test Result:= 19.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:48
Card Lot :100208
Operator [redacted]

ID: [redacted] 08-11-03
WB 10:36

			Patient Limits	
WBC	8.5	x10^3/uL	4.5	10.5
RBC	4.87	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	35.5	%	35.0	60.0
MCV	72.7 L	fL	80.0	99.9
MCH	21.7 L	pg	27.0	31.0
MCHC	29.9 L	g/dL	33.0	37.0
Plt	294.	x10^3/uL	150.	450.
LY%	19.2 L	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

ID: 001244 09-11-03
WB 06:06

			Patient Limits	
WBC	5.8	x10^3/uL	4.5	10.5
RBC	4.64	x10^6/uL	4.00	6.00
Hgb	10.2 L	g/dL	11.0	18.0
Hct	33.9 L	%	35.0	60.0
MCV	73.1 L	fL	80.0	99.9
MCH	22.0 L	pg	27.0	31.0
MCHC	30.1 L	g/dL	33.0	37.0
Plt	269.	x10^3/uL	150.	450.
LY%	34.8	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

i-STAT EG6+

Pt: [redacted]
Pt Name:_____

Na_____138 mmol/L
K_____4.3 mmol/L
TCO2_____28 mmol/L
Hct_____37 %PCV
Hb#_____13 g/dL
*via Hct

At 37C

_____ .552
PCO2_____47.0 mmHg
PO2_____31 mmHg
HCO3_____26 mmol/L
BEecf_____1 mmol/L
sO2*_____55 %
*calculated

Sample Type_:

08NOV03 10:56

Oper: 0

Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

Ward/Section: TCU1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE 9 Nov	TIME 0500	SSN/PSEUDO SSN [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. 1244	DATE 8 Nov 03	TIME 1030	SSN/PSEUDONYM: [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		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		Negati

Blood B (MUST SUBMIT SF 5

UNIT		

Misc. Serology

TEST	RESULT	REF. RANGE
		Negative

======= PICCOLO =======
08/11/03 10:39
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

GLU	157*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.7*	0.6-1.2	MG/DL
CK	163	39-380	U/L
~~NA+~~	~~129~~	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
~~tCO2~~	~~21~~	18-33	MMOL/L

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

NA - 138
CO_2 - 28

H

H

REMARKS:

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

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
skull series
[redacted]
pelvis
Rt shoulder/Rt humerus
Rt hand
Rt arm

AGE | SEX | SSN (Sponsor)

WARD/CLINIC: EMT

REGISTER NO.

FILM NO.

b(6)-2

PREGNANT: ☐ YES

REQUESTED: [redacted]

TELEPHONE

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

39 y/o ♂ shrapnel injuries

DATE OF EXAMINATION (Month, day, year): 8 Nov 03

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION (Last name, first name, middle, Medical Facility)

b(6)-4

[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

STANDARD FORM 513-2
PRESCRIBED BY OSD/TOMR
FDMR (41 CFR) 101-11.504

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 — TIME OF ORDER — HOURS — LIST TIME ORDER NOTED AND SIGN

8 NOV 03 @ 1239

b(6)-2

1. Admit to ICW 1 - Dr [redacted]
2. Dx: Left facial hematoma
   Left shoulder shrapnel
   Right hip shrapnel
3. cond: Stable
4. Vitals: Per routine

PATIENT IDENTIFICATION

b(6) Noted [redacted] 08 NOV 03 1340

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

DATE OF ORDER — TIME OF ORDER — HOURS

5. aller: NKDA
6. activ: Ad lib
7. Nurs: HOB ↑30°
8. Diet: Soft diet
9. IV: NS @ 125 cc/hr and heplock when taking PO
10. meds: Ancef 1gm IV q 8°
    MSO4 2-4 mg IV q 1° pm pain
    Tylenol 650 mg PO q 4° pm temp >101
11. Labs CBC in Am (9 NOV 03)
12. Dressing Δ's to (L) shoulder and (R) Hip BID

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

[redacted] MAJ/JDC

DATE OF ORDER — TIME OF ORDER — HOURS

08 NOV 03 1620

NPO

NO. Dr [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
4° ✓	0500 9 NOV 03	

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: CWH 1 | ROOM NO.: 24 | BED NO.: 03000 [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10 NOV 03	1630 HOURS	
N/O: clear liquid diet		
Dr. [redacted]		noted
		[redacted]
b(6)-2		10 NOV 03 1630

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4			11/11/03	HOURS	
			(1). Admission Diet as tolerated		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
1CW#1					

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted]			11NOV03	1845 HOURS	
			(1) D/C morphine b(6)-2		
			(2) Vioxx 50mg po BID.		
			(3) Percocet 1-2 po Q4-6° PRN		
			severe pain		
NURSING UNIT	ROOM NO.	BED NO.	b(6)-2 [redacted]		
1CW#1	242/2	BD 1 IN			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			[redacted]	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 All

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 08	9	10	11	12	13	14
08 NOV	[redacted]	Vitals per routine	08	[redacted]						
			18							
08	[redacted]	Activ. - ad lib	08							
			18							
08	[redacted]	Nurs: HOB ↑ 30°	08							
			18							
08	[redacted]	Diet - soft diet	08							
			18							
08	[redacted]	Dsg Δs to (L) shoulder	10	[redacted]						
		and (R) hip BID	22							
08	[redacted]	NPO	08							
			18							
10NOV	[redacted]	Clear liquid diet	06							
			18							
11NOV	[redacted]	ADV diet as tolerated	6							
			18							

DNC 08NOV03

D/C'd

DNC 11NOV03

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
(L) FACIAL HEMATOMA
(L) SHOULDER SHRAPNEL
(R) HIP SHRAPNEL

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 A1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
08 NOV	[redacted]	Admit to KW/ - Dr. Armandz	08 NOV03	—	—	[redacted]
08	[redacted]	Cont. - stable	08	—	—	[redacted]
08	[redacted]	Labs: CBC in am	09 NOV03	08:00	—	—

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12	13	14	15
08 NOV	[redacted]	NS @ 125cc/hr and	06	[redacted]							
	-----	HL when taking po	12								
08	[redacted]	Ancef 1gm IV q8°	08								
	-----		16								
	-----		24								
13 NOV	[redacted]	Vioxx 50 mg po BID	10	/	/	/					
	-----		22	/	/	/					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
① TACRAL HEMATOMA
② SHOULDER SHRAPNEL
③ HIP SHRAPNEL

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
8 NOV	[redacted]	MSO4 2-4mg IV q1°	D/T	8 NOV 0900	8 NOV 1500	8 NOV 1625	8 NOV 1930	8 NOV 2230	9 NOV 1800	9 NOV 1000	9 NOV 0055	9 NOV 1700	10 NOV 0030	10 NOV 0200	10 NOV 2130	11 NOV 0250
		prn pain	D/I	4	4	4mg	4mg	4mg	2mg	2mg	2mg	4mg	4mg	2mg	2mg	2mg
8	[redacted]	Tylenol 650mg po q4°	D/T	12 NOV 1200												
		prn temp >101	D/I	650												
8	[redacted]	MSO4 2-4mg IV q1°	D/T	11 NOV 0940												
		prn pain	D/I	2mg BR												
19	[redacted]	Percocet-II po q4-6°	D/T	11 NOV 2050	12 NOV 2030											
		prn severe pain	D/I	II po	II po											

D/C'd 11 NOV 03

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

1. LAST NAME, FIRST NAME / NOM, PRÉNOM: IRAQI PRISONER

RANK / GRADE: #12.44

MALE / HOMME

FEMALE / FEMME

SSN: [redacted]

SPECIALTY CODE / SIM: b(6)-4

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT

NATIONALITY / NATIONALITÉ

AIR | ARMY | USMC | MOAA

BC / BC

NBC / BAC

DISEASE / MALADIE

PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE

AIRWAY / TRACHÉE

HEAD / TÊTE

WOUND / BLESSURE

NECK/BACK INJURY / BLESSURE AU COU/AU DOS

BURN / BRÛLURE

AMPUTATION / AMPUTATION

STRESS / TENSION

OTHER (Specify) / AUTRE (Spécifier)

SHRAPNEL INJURIES

IED

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: [illegible]

TIME / HEURE: 0900

6. TOURNIQUET / GARROT: NO / NON

YES / OUI

TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON

YES / OUI

DOSE / DOSE

TIME / HEURE

8. IV / IV: [illegible]

TIME / HEURE: 0855

9. TREATMENT / OBSERVATIONS: CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTES)
TRAITEMENT / OBSERVATIONS: PRÉSENTE MÉDICATION / ALLERGIES / ANTIDOTES

[redacted] b(6)-4

BP 137/87
P 97

Pulse Ox
98 RA

10. DISPOSITION / DISPOSITION

RETURNED TO DUTY / RETOUR À L'UNITÉ

EVACUATED / EVACUÉ

DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

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

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

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.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A		[redacted]	[redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19760819	27Y			b(6)-4

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
			[redacted]

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
		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 (YYYYMMDD)
		20031113

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
		20031108

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)

FOR LOCAL USE

Dx: 88010
8901
87351
920
E9919

Pr: 8703

Inj Trauma
443 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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

b(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Location IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1976-08-19	7. Age at Admission 27Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 10:35	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS		19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICW1		Name / Relationship of Emergency Addressee	
			Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: [redacted] b(2)-2			Telephone Number of Emergency Addressee	
21. Type of Disposition TRF-OTH	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD) 2003-11-14	
24. Clinic Svc - Admitting ABD - NEUROSURGERY	25. MTF Transferred From		26. Date this Admission (YYYYMMDD) 2003-11-14	
27. Location of Occurrence	28. MTF of Initial Admission		29. Date of Initial Admission 2003-11-14	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L FACAIL HEMOTOMA, L SHOULD SHRAPNEL,R HIP SHRAPNEL

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitt[redacted]

[redacted]

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	27Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	10:35	-					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-11-11					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-08					
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] b(2)-2		2003-11-08					

31. Selected Administrative Data

Marital Status: DoB: 1976-08-19

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

SHRAP INJURY L CHEST

877.0
876.0
875.0
E993

87.79
93.57

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

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

Automated Facsimile - DA FORM 3 [redacted] b(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

S: 29yo male EPW, s/p IED injury to (L) chest c resultant superficial schrapnel injury to (L) chest & (R) other injuries.

(P) Med Ho (P) Surg Ho (A) Tab
(2) ORIF knee
d

PHYSICAL EXAMINATION

BP-130/68 HR-93 RR-22 T-99.1

A+OX4
HEENT - Clear
CV - RRR
Lungs - CTA (B)
Abd - benign

Ext - (R) injuries
Back/chest - superficial schrapnel to level T-11

PROGRESS (Enter date of discharge and final diagnosis)

A/P: Schrapnel injury to (L) chest
(1) Admit
(2) Obs / Abx

b(6)-2

SIGN[redacted]	DATE 8NOV03	IDENTIFICATION NO.	ORGANIZATION
P[redacted] (If typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

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

117

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 NOV 03 1424	Assume care of PT @ 0600. C/O dizziness problem solved without meds. Aed drsg to (L) chest CDI and drsg to buttocks (R), CDI. Ambulate enough to exercise in hallway. Speaks good english. In 2pt restraint without any skin irritation. Will continue to monitor. 9/W SPC [redacted]
1719	PT c/o not recieving enough food and juice. Nothing else major has occured, will cont. to monitor. 9/W SPC [redacted]
09 NOV 03 2000	VSS Alert & Oriented. OOB → AMB Ad lib. (L) Chest wound 3cm c̄ scant amt of serosanguinous drainage noted. Tissue to wound freshly red. Buttock ~~an~~ superficial wound to (R) buttock <0.5cm ∅ drainage noted left open to air. Excoriation <0.5cm noted to weight area. Cleaned c̄ NS (sterile). Sterile dry applied. ∅ c/o pain. Consumed 80% of my diet for dinner. Will continue care as planned [redacted] 7 PM
10 NOV 03 1410	Assume care of PT @ 0600. VSS, A+OX3 Ambulate in hallway. Conducted personnal hygeine today. ∅ c/o pain. Drsg Δ to (L) chest, area CDI c̄ minimal blood leakage. (R) buttocks CDI. In 2pt restraint without any skin irritation. Will cont. to monitor. 9/W SPC [redacted]
	b(6)-2 A11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
08NOV03	(1515) Assumed care of pt from EMT in stable condition via gurney. Pt amb to bed. VSS. ϕ c/o pain. Drsg to @ side of chest c̄ sm. amount sero.sang. drainage. ϕ c/o SOB. Tol. reg diet well voiding s̄ difficulty. IVFs s/Ld in IV in @ upper arm – ϕ s/sx infiltration. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted] (1615) Drsg to @ chest shrapnel wound ad. ϕ s/sx infection monitoring. b(6)-2 [redacted]
~~08NOV 03~~	
08NOV03 2000	VSS. Alert & Oriented. OOB > AMB (I). Drsg to (L) chest & (R) buttock dry & intact. (R) upper arm saline lock patent & intact. Consumed 80% of Regular diet for dinner. Ind. s̄ difficulty speaks some English. Peripheral pulses palpable +2. Lungs clear Bilaterally. 2+ restraints in place. Will check periodically to ensure circulation & prevent damage to skin integrity. [redacted] 247 AZ 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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10NOV.03 2030	Pt A+Ox3, VSS, voices ø c/o pain or discomfort, dsg to (L) chest + (R) buttock d'd, ø s/sx of infex, tender around wound area, HL IV (R) arm intact, ø s/sx of infex, 2 point restraint, ø complications. [redacted] 9tw
	b(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

[redacted] b(6)-4

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 8, MONTH Nov, YR. 03 — TIME 1035

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: Ø

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

HOME TELE. NO. (Inc. area code)

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

SEX: ♂ AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ARR

VITAL SIGNS			
TIME	1010		
BP	130/68	129/	
PULSE	93	85	
RESP.	22	14	
TEMP.	Ø	—	
WT. (Child)			

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

ORDERS	INITS.	TIME
CBC/UA/Chem 12 lytes		
CXR/AMS/KUB	[redacted]	
Td 5cc im		1145
Anef Tg IV		1145

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

29 y/o ♂ c/o (L) side, IED

O: A & O x 4 — NAD. VSS

Chest: CTA(B); full symmetric breths equal

ass: RM, Ø left

Abd: soft, Ø BS, WT

(+) (L) small shaped wound (L) mid axilla T-11 level

PMH: Ø

PSH: (L) ARTH knee

(+) tbc

CXR

(+) symmetrical shaped soft tissue

ASSESSMENT/DIAGNOSIS: Shaped (L) chest wound

A/P (1) (2)

→ Admit obs / ABX b(6)-2

[redacted]

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

CONDITION UPON RELEASE
- ☒ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications o[redacted]ns and follow-up plans)

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 11-8-03 Diagnosis: Stroke/injury (L) chest HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		Mobility	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4		Nutrition	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4		Friction and Shear	No apparent problem	3	
	Walks occasionally	3			Potential 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 or equal to 15 indicates HIGH RISK –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location:_____ Size: _____ Drainage: _____
Tubes: _____ Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes No
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough_____
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_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO. | WARD NO.

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

PROGRESS NOTES

Medical Record
STANDARD FORM 509

[redacted]

b(6) -4