INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 34	6. RACE O	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION IRAQ		14. WARD OR	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS CIV	19. UIC/ZIP	20. TYPE CASE INJ	Dob 19690101 K78 20
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION 0323	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE (b)(6)-4				25. TYPE DISPOSITION TRANS	26. DATE OF DISPOSITION 28 MAR 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 27 MAR 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION 27 MAR 03		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX. MULTIPLE SHRAPNEL WOUND

CODING INFORMTION: 959.7

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	2

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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 27, MONTH 03, YR. 03 — TIME: 0315

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [X] AMBULANCE [ ] OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: [ ] PATIENT [X] OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): (b)(6)-4

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Shrapnel injuries to (R) lower ext.

SEX: M

AGE:

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 0315

VITAL SIGNS

TIME	0320	0440	0555
BP	142/92	144/92	134/66
PULSE	115	95	102
RESP.	28	20	16
TEMP.	98.4		
~~WT. (Child)~~ SpO2	96%	95%	3%

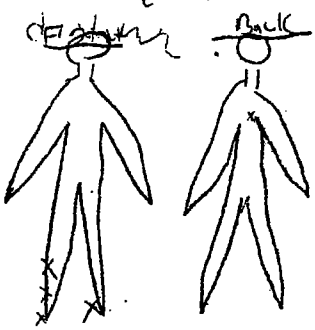
CATEGORY (See reverse)

- [ ] EMERGENT
- [X] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
2mg IV	[illegible]	0340
Ancef 1 gm IVPB	AL	0335
Tetanus .5 mg IMX	[illegible]	[illegible]
Filing Cath	AS	0350
IV x 2 Insert	AS	0350

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)

34 year old local national who was hit by indirect fire has shrapnel injury bilateral lower extremities. Pt not speak English (R) calf injury with devitalized tissue as well as (R) distal tib/fib and (R) heel as well. Pt given morphine 10mg Eq-Iv with washed out. On arrival EMT awake, alert. No acute distress.



PMH: unknown but noted

Allergies: NKDA per report

Meds: Morphine

VS per chart

Heart: PMRL, EOMI

Resp: [illegible] Equal BS

Cardiac: RRR w/o S1, S2

Neuro: CN 2-12 intact w/o [illegible] GCS 15

Abdomen: Soft

Extrem: ⊕ DP pulse, 2+ Rt [illegible] with multiple fragments to calf exposed bone, large defect Rt heel ⊕ fragments with color warm. Left foot - laceration over 3rd to 5th toe

A/P

ASSESSMENT/DIAGNOSIS: Multiple shrapnel wounds Rt calf, Rt heel, posterior back

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: ICU

CONDITION UPON RELEASE

- [ ] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

TIME OF RELEASE: 0600

(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 TREAT-

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2

INSTR any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

MEDCOM - 2661 Copy

STANDARD FORM 558 (REV. 6-82)
Prescribed by GSA and ICMR
FIPMR (41 CFR) 201-45.505

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	(b)(3)-1
MTF LOCATION (State or Country Code)	
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19 69 07 01
7. AGE AT ADMISSION	34
8. RACE	
9. ETHNIC BACK-GROUND	
RELIGION	Mus
10. LENGTH OF SERVICE	
ETS	
11. FMP	26 CIV
12. SOCIAL SECURITY NUMBER	(b)(6)-4 (b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	M
HOUR OF ADMISSION	0323
BRANCH / CORPS	
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	K 7 4 CIV
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	INJ
PREV. ADMISSION	YEAR ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	EMT
WARD	OR ~~ECHZ~~
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	(b)(6)-4 (BROTHER)
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	(b)(6)-4
21. TYPE OF DISPOSITION	Transferred
22. MTF TRANSFERRED TO	(b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D)	03 03 28 1850
24. CLINIC SVC - ADMITTING	
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (Y Y M M D D)	03 03 27

FOR LOCAL USE

Multiple chronic wound
- Rt leg Inj Trauma
- Left foot 443 1
- posterior Back

DX
8911
8921
8931
8761
E9919

Proc: 9659

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

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

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

MEDCOM - 2662

INPATIENT TREATMENT RECORD COVER SHE.

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	23	O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
		IRAQ	OR

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0300	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	TRANS	27 MAR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
BAGHDAD	(b)6-4 (b)(3)-1	27 MAR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	27 MAR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: DESJASION

CODING INFORMATION: 821.10

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

(b)(3)-1

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 9 1 1 0 1	27 28 29: 2 3 Y	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER (b)(6)-4
32 33 34		35 36: 2 0 EPW	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
(b)(3)-1	46: S	0300	n/a

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: R 7 8 EPW	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: Inj	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: GMT	OK	(b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4 (b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 | TELEPHONE NUMBER OF EMERGENCY ADDRESSEE (b)(6)-4

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: Transfer	75 76 77 78 79 80 (b)(3)-1	81 82 83 84 85 86: 0 3 0 3 2 7 1130

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 3 2 7 0300

FOR LOCAL USE

Dx 82110 99912

Inj 450 Trauma 1

ADD (b)(6)-2 (b)(6)-2 atc, mo, usa.

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

DA FORM 2985, MAR 89 EDITION OF MAY 79

MEDCOM - 2664

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE O	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION IRAQ		14. WARD ICU1	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS EPW	19. UIC/ZIP	20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT					22. HOURS OF ADMISSION 0400	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE (b)(6)-4				25. TYPE DISPOSITION TRANS		26. DATE OF DISPOSITION 27 MAR 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 27 MAR 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION 27 MAR 03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GUN SHOT WOUND LEFT ELBOW

CODING INFORMATION: 991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	MUS
1 9 7 2 0 1 0 1	3 1 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0 CPW	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	04:00 HRS	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU 1	(b)(6)-4 (FATHER)
0 EMT		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79	81 82 83 84 85 86
2 1 Transfer	BRO	0 3 0 3 2 7 1130

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 3 2 7 0400

FOR LOCAL USE

GSW (L) ELBOW – Dy 88101 E 99112

Injury Trauma 450 1

(b)(6)-2

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

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2666

INPATIENT TREATMENT RECORD COVER SHE.

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	43	O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	~~(b)(3)-1~~ b(6)-4	IRAQ	ICU1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0400	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	TRANS	27 MAR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
	b(6)-4 (b)(3)-1	27 MAR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 IRAQ	27 MAR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GUN SHOT WOUND LEFT HIP

CODING INFORMATION: 991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
1959 01 23	43			Islam

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	M	04:00	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	ICU 1	(b)(6)-4
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE (b)(3)-1 (b)(6)-4

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
Transfer	(b)(3)-1	03 03 27 1130

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		03 03 27 0400

FOR LOCAL USE

GSW Chip Dx 8900 E9912 Dry Training 450 1

AD (b)(6)-2 required) SIGNATURE (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SFX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	50	O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20 1178	(b)(6)-4	IRAQ	ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0011	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TRANS	28 MAR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		28 MAR 03	

29. NAME AND LOCATION OF MORAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	28 MAR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GUN SHOT WOUND ABD

CODING INFORMATION: 868.00

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
1	9	5	3	0	7	0	1	5	0	Y			Mus

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
				2	0	(b)(6)-4								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: M	0011	EPW

14. FLYING STATUS			15. BENEFICIARY CATEGORY				16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52		53	54	55	56	57	58	59	60	61
			K	7	8	EPW									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION		WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72			
0	EMT	1CW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1			TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)						
73	74	75	76	77	78	79	80	81	82	83	84	85	86	
Transfered							(b)(3)-1	0	3	0	3	2	8	1850

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116
								0	3	0	3	2	8

FOR LOCAL USE

DX: GSW ~~ABD~~

Dx 8792
E9912

Inj 450

Trauma 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	Spc (b)(6)-2

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

MEDCOM - 2670

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			(b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 30	6. RACE O	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP 20 1578		12. SSN (b)(6)-4		13. ORGANIZATION IRAQ		14. WARD ICU3	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS EPW	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION 0011	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION TRANS	26. DATE OF DISPOSITION 28 MAR 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 28 MAR 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION 28 MAR 03		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GUN SHOT WOUND ABDOMEN

CODING INFORMATION: 868.00

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
1973 01 01	30			MUS.

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		0011	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	ICW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOC (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
TRANSFERED	(b)(3)-1	03 03 28 1850

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		03 03 28 0011

FOR LOCAL USE

Dx: GSW ABD

Dy 8792
E 9912

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	SP (b)(6)-2

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

MEDCOM - 2672

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 59	6. RACE O	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP 20 K78		12. SSN (b)(6)-4		13. ORGANIZATION IRAQ		14. WARD ICU3	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS EPW	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION 0011	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION TRANS	26. DATE OF DISPOSITION 28 MAR 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 28 MAR 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION 28 MAR 03		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GUN SHOT WOUNDTO RIGHT BUTTOCK

CODING INFORMATION: 959.1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

MTF LOCATION (State or Country Code)

3. REGISTER NUMBER — (b)(6)-4

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

4. PAY GRADE — 16 17

5. SEX — 18: M

6. DATE OF BIRTH (Y Y Y Y M M D D) — 19 20 21 22 23 24 25 26: 1 9 4 4 0 7 0 1

7. AGE AT ADMISSION — 27 28 29: 5 9 Y

8. RACE — 30

9. ETHNIC BACKGROUND — 31

RELIGION: MUS

10. LENGTH OF SERVICE — 32 33 34

ETS

11. FMP — 35 36: 2 0

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS — 46: M

HOUR OF ADMISSION: 0011

BRANCH / CORPS: EPW

14. FLYING STATUS — 47 48 49

15. BENEFICIARY CATEGORY — 50 51 52: K 7 8 EPW

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: ERA

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE — (b)(6)-4 BROTHER-IN-LAW

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) — (b)(6)-4

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE — (b)(6)-4

21. TYPE OF DISPOSITION — 73 74: Transferred

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

23. DATE OF DISPOSITION (Y Y M M D D) — 81 82 83 84 85 86: 0 3 0 3 2 8 2300

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: 0 3 0 3 2 8 0011

FOR LOCAL USE

Dx: Gunshot wound to Right buttock

Dx 8770 E9412

Inj Trauma 450 1

(b)(6)-2

ADMIT

SIGNATURE OF ADMITTING CLERK

Doc (b)(6)-2

DA F

EDITION OF MAY 79 IS OBSOLETE.

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	29	O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4	IRAQ	ICU3

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0011	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	28. DATE OF DISPOSITION
(b)(6)-4	XFR	28 MAR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		27 MAR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	27 MAR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: HAND FRACTURE FINGER AMPUTATION

CODING INFORMATION: 814.10

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	2

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1

MTF LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15): (b)(6)-4

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

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 19 21 22 23 24 25 26 = 1 9 7 4 0 1 0 7

7. AGE AT ADMISSION (27–29): 2 9 4

8. RACE (30):

9. ETHNIC BACKGROUND (31):

RELIGION: MUS

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36): 2 0

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

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46):

HOUR OF ADMISSION: 0011

BRANCH / CORPS: EPW

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K 7 8 EPW

16. ZIP CODE OF RESIDENCE (53–61):

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

18. MOS (64–70):

19. TRAUMA (71): I INJ

PREV. ADMISSION: YEAR ☐ NO

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

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: (b)(6)-4 BROTHER

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY:

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: (b)(6)-4

21. TYPE OF DISPOSITION (73–74): XFR

22. MTF TRANSFERRED TO (75–78): (b)(3)-1

23. DATE OF DISPOSITION (Y Y M M D D): 0 3 0 3 2 8 2300

24. CLINIC SVC - ADMITTING (87–90):

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102):

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

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

29. DATE INITIAL ADMISSION (Y Y M M D D): 0 3 0 3 2 7 0011

FOR LOCAL USE

Dx: HAND fx FINGER Amputation

Dx 81500
8860
E9289

Inj Trauma
969 ?

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

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

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

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP		12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT/ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		EPW K 78 20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1700	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XR	(b)(3)-1	0 3 0 3 3 0 06303

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		0 3 0 3 2 9

FOR LOCAL USE

(R) lower extremity traumatic amputation

Dx: 89714
E9289
Trauma 9
Injury 999

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

DA FORM 2678, EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2678

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2679

.NPATIENT TREATMENT RECORD COVER SHEE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4			13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN EPW K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

(b)(6)-4

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See SF558
Bp Notes on back

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	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.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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 29, MONTH 03, YR. 03 — TIME 1630

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

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW AB, (R) Leg FX

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME			
BP	124/68		
PULSE	90		
RESP.			
TEMP.			
WT. (Child)			

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

ORDERS	INITS.	TIME
Ancef 1g IV		
MSO4 2mg IV		
(R) femur A/P		

ASSESSMENT/DIAGNOSIS

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)

SpO2-98

EPW s/p GSW abdomen and (R) leg. GSW goes through to back. (R) leg thigh.

Abd- 2 gunshot wounds anterior-exit in back.

Ext- good femoral pulses good ROM.

A/P- To OR for exploration possible ex-fix (R) femur

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:

(b)(6)-2

(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).

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M. (In)	HOUR P.M. (Out)	OBSERVATIONS Include medication and treatment when indicated
29Mar03 2045		~~2045~~	Rec'd from OR S/P x-lap (⊖ findings) + External fix to (R) femur. pt intubated on RA - POX 98%. See assessment on Med. Care Record Sheet — [redacted] CPT
2300	300		VS B/P 137/78 HR 105 R 22 Pulse Ox 98 pt N/G to LIS
IV amb.	100		c̄ min drainage. Pt to evac within next
IV fluid	1000		2-3 hrs — [redacted] CPT/AN
0015 30 Mar			2mg MSO4 IV for % pain — [redacted] CPT/AN
30 Mar 0200		725 urine	pt awake on + off, follows some commands communication diff d/t lang barrier. T 99.3 oral, O2 Sat 94, P 109, B/P 138/75, R 20 LS clear but diminished esp. bases, N/G to LIS c̄ brownish drainage, pt remains restrained abd drg intact c̄ sm. amt. drainage noted (R) leg external fixator c̄ ace wrap intact + pp (R) + (L) — [redacted] CPT
0400 30 Mar 03			pt % pain 4mg IV MSO4 given as ordered — [redacted] CPT
0600	100 IV		

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

RN ASSESSMENT

	ADMISSION ASSESSMENT TIME: 2100	DISCHARGE ASSESSMENT TIME:
RESP	Airway: patent / unassisted / chin lift / jaw thrust / sniff position tube Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Rhonchi Oxygen by: simple mask / nasal canula / BB / RA / other:	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:
CV	Monitor: sinus rhythm / RRR by pleth / other: ST Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:
NEURO	LOC: A V P U Oriented x 3 / other: pt sedated Movement: grasps & plantar-dorsiflexion strong and equal: Yes / No / N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes No/ N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:
GI/GU	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:
PSYCHO-SOCIAL	Affect: calm and appropriate / cooperative / other: Sedated Language: English / other: Interpreter present: Y / N / NA "Special Needs": N/A / identified: Other:	Patient informed of present condition: Yes / No Family updated on patient condition: Yes / No Other:
IV	None: Gauge: 14G Location: R AC Condition: patent / no redness / no edema Other: Solution: LR Rate: Amount remaining: 1/2	None: Gauge: Location: Condition: patent / no redness / no edema Other: Solution: Rate: Amount remaining:
DSG	None: Type: 4x4 & tape & abd & 2x2 Location: R leg & ace wrap dry & external fixator Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:	None: Type: Location: Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:
SAFETY	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:
PEDS	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A
OTHER		
	RN Signature (b)(6)-2 CPT/AN	RN Signature:

PATIENT TEACHING IN PACU (circle all that apply)

D=demonstrated V=verbalized

Topic	Level of Involvement	INIT
Pulmonary Toileting: Importance of / Cough-deep breathing exercises / incentive spirometer / ABD splinting / Other:	D / V	
Wound care: ice compress / heat application / extremity elevation / signs of compartmental syndrome / Other:	D / V	
Pain management: Medications: type, dose, route, indications, side effects / positioning / activity restrictions / pm Rx requests on ward / Other:	D / V	
Surgeons and Anesthesia post-op orders	D / V	
Pediatric: safety: padded sides, IV armboard / monitoring equipment / staff-parent at BS at all times / pediatric post-op agitation vs pain / Other:	D / V	
Spinal anesthesia: use nursing assistance first time OOB, avoid pressure points while numb / Fundal massage / lochia and pad count / Other:	D / V	
Post cardiac cath: signs of bleeding / apply pressure over site when coughing, sneezing, or vomiting / lie flat with leg straight / use of sandbag / Other:	D / V	
MISC: Elevate HOB / avoid eye strain / wire cutter worn around neck / Oral intake restrictions Other:	D / V	

NURSING NOTES

Pt arrived from OR still intubated & sedated & occasional blow by O2 to Keep Sats >93%

DISCHARGE NOTE: This patient meets criteria for discharge from the PACU or has been cleared by the anesthesia provider indicated on MCEUL OP 501: Anesthesia Record.

Nursing Care Plans remain open: #

Report called to: Ward: Via: At: hours.

(b)(6)-2

(RN Signature) for Anesthesia Services

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General
1. AGE: 22 HEIGHT: — WEIGHT: —	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): UNK 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): UNK

4. PROPOSED SURGICAL PROCEDURE:
EX LAP

5. ADDITIONAL INFORMATION:
Refer to DA Form 3888, Medical Record - Nursing History and Assessment. (X those that apply) ☐Family waiting ☐Emergency surgery, unable to obtain data ☐SDS Transfer ☐Additional problems or needs

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

9. PATIENT'S IDENTIFICATION *(For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)*
(b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to positioning and safety straps.	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to SUPO POSN E.2. ✓ Potential discomfort due to SUPO POSN	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being SEDATE F.2. ✓ Potential for decreased communication due to SEDATION F.3. Potential injury due to dentures. NA	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from EITHER side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS / NEEDS. Or continuation of above problems/needs. NA Preop teaching done: Yes/No-Video/Class/Individual/Emergency	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

(b)(6)-2 [redacted] 29 MAR 03 DATE

11. POSTOPERATIVE EVALUATION: (Circle those that apply) VS: stable Dressing: None-Intact-Dry-Splint-Brace-Cast-Drain-Comments:_____ Voiding: Yes/No-Foley-Comments:_____ Tolerating Diet: Yes/No-NPO-Comments:_____ Skin Integrity: Intact-Red-Bum-Blisters-Comments:_____ CNS: Alert-Drowsy-Asleep-Disoriented-Comments:_____ Activity Level: BR-WC-Crutches-Ambulating w/o Assistance Circ: N/A Skin Warm-Appropriate Coloring-Surgical Extremity Pulse Present-Comments:_____ Pain Control: Satisfactory/Unsatisfactory PO Day:___ Informed Nursing Staff of Adverse Findings: Yes/No/NA Patient Available for PO Interview: Yes/No-On Ward/At Appointment/Discharged N/A

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)	13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
(b)(6)-2 [redacted] DATE: 29 MAR 03 TIME: 1715	(b)(6)-2 [redacted] DATE: 29mar03 TIME: 2040

REVERSE OF DA FORM 5179, JUN 9

MEDICAL RECORD — LRMC INTRAOP VE DOCUMENT

For use of this form, see AR 40-4[illegible]7, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM (b)(6)-2
VIA Gurney B[redacted]

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

3. DATE 29 mar 03 TIME PATIENT ARRIVED IN SUITE 1715

4. PATIENT IN RO[illegible] TIME 1715 NUMBER ~~90~~ 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

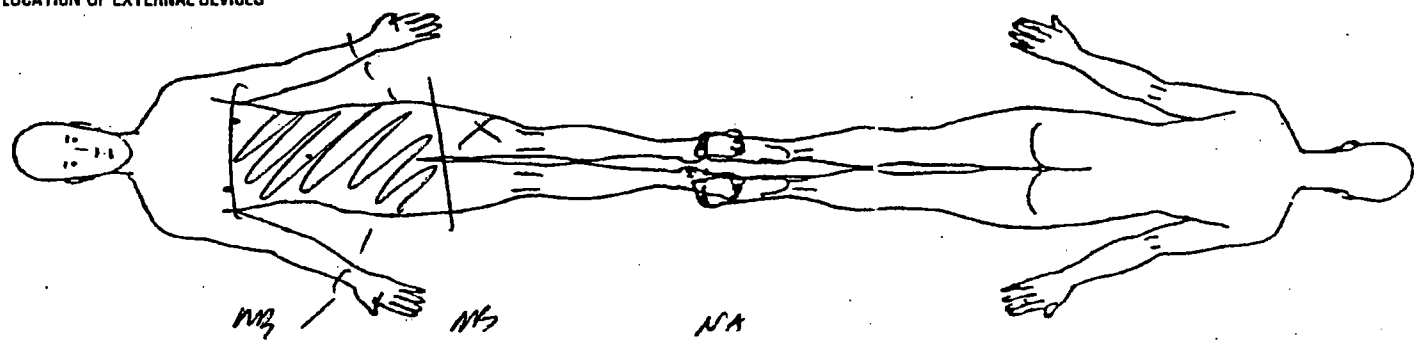
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* BETA / BETA
SITE: ABD BY WHOM: BOT
SITE: BY WHOM:
COMMENTS: NO PADDING

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C – Correct I – Incorrect

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

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

☒ ESU NO:
GROUND PAD: BRAND VARON LAB
LOT NO: VNK 5419 EXP 2003

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME, ID NUMBER, IN NOMENCLATURE

Ex Fix Howmedica Cat no 5129-9-135 Lot Code: VVACA 8929869

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒ ms

TYPE/SIZE	1. 16F Foley	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

Kerlix Xeroform
fluffs 4x8's

19. ADDITIONAL INFORMATION

The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the RIGHT LEG side.

Verified by: Patient/guardian Surgeon (b)(6)-2 CPT CRNA, AN (b)(6)-2 Operating Room Nurse

OPERATION(S) PERFORMED

EX LAP, Right Femur Ex FX

PATIENT TRANSFERRED TO	TIME	METHOD
ICU	2042	litter

REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 MCEUL OP 358, 2 Mar 00 apprvl - 3 Feb 00 USAPA V1.00

(b)(6)-4

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of 1

START	IN OR	ANES. END	DATE
05	1712	2045	29 Mar 03
TOTS	SURG START	DRESSING	OR NO
1720	1733	2030	(b)(3)-1

OPERATION PERFORMED: Exp. Lap. (R) Femur ORIF

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

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [x] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [x] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1710
Cefazolin	1g	IV	1715

Pre-Anesthetic State: [ ] AWAKE [ ] CALM [ ] SEDATE [x] APPREHENSIVE [ ] UNRESPONSIVE

Frogi, EPW - Translator

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [x] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [x] TEMPERATURE Nasal
- [x] WARMING BLANKET [x] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [x] N / G TUBE [ ] O / G TUBE
- [x] IV(s) KBAC #17g
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE Taped
- [x] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL
- [ ] VSS p Induction

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE MAC 3
- [x] ETT SIZE 7.0 [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 8cc ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H20
- [x] ETT SECURED AT 22 CM
- [x] BREATH SOUNDS clear Bilat
- [x] AIRWAY [x] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

	1700		1800			1900			2000			TOTALS
AGENTS												
Propofol (mg)	150		2	70								
Fentanyl (cc)	3		2									
Vecuronium (mg)			5		3							
Sux (mg)		120										
MSO4 (mg)						3	3	4	4	3	3	
ISO	.7	.8	1.0	1.2	1.2	1.1	1.1	1.1	1.1	1.2	1.2	1.2 X
Air (L/min)		.4	.4	.4	.4	.8	.8	.8	.8	.8	.8	.8
N2O L/min												
O2 L/min		.4	.4	.4	.4	.5	.5	.5	.5	.5	.5	.5
FLUIDS												
LR				1000	—	1500	—	2000	—	2200	—	2400
Urine			800				50	850				
EBL				min				20		30		40
MONITORS												
EKG		SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR SR
% O2 Inspired		.42	.41	.42	.41	.41	.42	.42	.42	.42	.45	.5 1.0
O2 Saturation	98	100	100	100	100	100	100	100	100	100	100	100 100
End Tidal CO2	40	33	35	34	34	52	50	50	53	53	58	55 45
Temperature		37.1		37.2				37.3	37.3			
PNS		4	4	4	4	4	4	4				

TIME

PRE-OP VALUES: B/P 122/70; P 92; R 19; SAT 98%; H/H 32.5 Hct

Tidal Volume		750	780	800	790								
Resp Rate	19	10	10	10	10	14	12	14	17				
Peak Pressure		24	23	24	22	30	30	30	30	30	30	30	30
Symbols for Remarks													
Position	Supine					6	1						

SYMBOLS: X ANESTHESIA; OPERATION; B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; PULSE; SPONTANEOUS RESP; ASSISTED RESP; CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

2035 - To ICU SV. Intubated. VSS. Report given.

RECOVERY

TIME IN PACU	CONDITION		
	VSS		
B/P	PULSE	RESP	O2 SAT
	84	14	97

REMARKS | TEMP

REPORT TO: PARRS:

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid 3000	EBL 40	
	Urine 850	
Blood 40 (b)(6)-2	Gastric 25	

(b)(6)-2

CRNA, CPT, AN

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

NAME: (b)(6)-4 SURGEON: (b)(6)-2 Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE | (M) F | HEIGHT | WEIGHT 70 Kg

PROPOSED OPERATION Exploratory Laparotomy

PREOPERATIVE VITAL SIGNS: B/P 122/69 P 92 R 19

PREVIOUS ANESTHESIA / OPERATIONS [✓] NEGATIVE

CURRENT MEDICATIONS [✓] NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS [✓] NEGATIVE

ALLERGIES [✓] NKDA

AIRWAY / TEETH / HEAD & NECK Class I

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD Dyspnea, Pneumonia, Productive Cough Recent cold, SOB, Tuberculosis	[✓]	Tobacco Use: [✓] No [ ] Yes ____ Pack/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF Exercise Tolerance, Hypertension, MI Murmur, MVP, Pacemaker Rheumatic fever	[✓]		EKG NSR
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis Hiatal Hernia, Jaundice, N&V Reflux/Heartburn, Ulcers	[✓]	Ethanol Use: [ ] No [ ] Yes Frequency ____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke DJD, Headaches, Loss of consciousness Neuromuscular disease, Paralysis, Paresthesia Syncope, Seizures, TIAs Weakness	[✓]		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease Urinary retention, Urinary tract Infection, Weight loss/gain	[✓]		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC, Lytes Hct = 32.5 PLT = 227

PROBLEM LIST / DIAGNOSES: GSW abdomen

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

PREOPERATIVE MEDICATIONS ORDERED: Ancef 1g IV slow.

COUNSELING STATEMENT

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

PATIENT'S SIGNATURE ____ DATE ____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 CRNA DATE ____

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

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

DATE: ____

SIGNED: ____ TIME: ____

(b)(6)-4

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
(R) Renal A/P					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUE (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATOR (b)(6)-2			TOR	DATE REQUESTED

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

GSW (R) leg

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
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION RT

MEDCOM - 2691

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

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

29 March Brief Op Note

1822 preop dx: Penetrating injury to abdomen

Postop dx: Same

Procedure: Exploratory Laparotomy

Surgeon: (b)(6)-2

Anesthesia: GETA

Findings: Negative exploration

Complications: None

Disposition: Proceed with management of femur fracture.

(b)(6)-2

29 MAR 03 - Ortho Surg. Op Note

1830

Dx: (R) open femur fx, distal (3) intra-articular extension

procedure: (R) femur D&F; spanning ex-fix.

(deny. - single lung.)

surgeon: Dr. OLSRAN; assistant: Dr (b)(6)-2

(b)(6)-2

TEMPERATURE - PULSE - RESPIRATION						NURSE'S NOTE
DATE AND TIME	T	P	R	STOOLS	WEIGHT	MEDICATION AND NURSE'S NOTES
						anesthesia: CPG (b)(6)-2 (General).
						findings: spinal fracture shaft fx
						c̄ medial wound (proximal).
						amputations: none.
						disposition/post-op plan:
						repeat D&F in 48hr c̄
						adjustment of ex-fix for comfort
						shortening (~2cm) and general
						alignment. ; DVT prophylaxis.
						- A/C to 86+ CXR.

(b)(6)-2

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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: 29 March 2003 TIME OF ORDER: 2020 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit: ICU
Dx: Ex lap / Ex-Fix (R) Femur
Cond: Stable
Vitals: Qroutine
Allergies: NKDA
Act: Bedrest

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO.

DATE OF ORDER: -cont- TIME OF ORDER: HOURS

Diet: NPO
IV: NS @ 120cc/hr
Meds: MSO4 2-4mg IV Q4h PRN
Phenergan 12.5mg IV Q4h PRN
Ancef 1g IV Q8h
Gentamycin 350mg IV QD
Penicillin 2mil u IV Q6h

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: -cont- TIME OF ORDER: HOURS

Lovenox 30mg IV Q12
NGT to LWS to intern
Foley to gravity
Repeat CBC @ 0700 30 March
HOB 30°
Encourage cough and deep breathing.

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29MAR03 TIME OF ORDER: 2230 HOURS

Δ Lovenox to 30mg SC Q12°

(b)(6)-2

(b)(6)-4

Noted 29 Mar 03

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

CLINICAL RECORD	THER[illegible]TIC DOCUMENTATION CARE PLA[illegible]ON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
29	(b)(6)-2	IVF (NS) / LR / D5NS D5 1/2NS To run	07		
		@ 120 cc/hr	19	(b)(6)-2	
29	(b)(6)-2	Ancef 1 GM IV q 8 HRs	07		(b)(6)-2
			15	(b)(6)-2	
			23		
29	(b)(6)-2	Gentamycin [redacted] V Q D	22		
		Cefoxitin 2 gm IV q 8hrs			
		02 titrate to keep SPO2 >	07		
			19		
		Versed gtt 1-10mg/hr titrate to Ramsey	07		
		scale of	19		
		Fentanyl gtt start at 50mcg/hr titrate for	07		
		adequate pain control MAX Dose of	19		
		Vecuronium 1mcg/kg/min	07		
			19		
29	(b)(6)-2	Penicillin 2mil U	06		(b)(6)-2
		IV Q6H	12		
			18		
			24	(b)(6)-2	
29	(b)(6)-2	Lovenox 30mg IV	08		
		Q12°	20	(b)(6)-2	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Treatment Facility: 212th Mobile Army Surgical Hospital

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

Verify by Initialing		THE. EUTIC DOCUMENTATION CARE PL. *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED														
- - - - -	- - - - -	Morphine Sulfate 2-4 mg IV q 4 hr PRN pain	29 Nov 2330 9mg	30 Nov 0015 2mg	30 Nov 0400	30 Nov 0730											
- - - - -	- - - - -	Phenergan 12.5/25mg IV q 4-6 hrs prn N/V	(b)(6)-2														
- - - - -	- - - - -	~~MOM 30cc PRN Gastric Upset~~															
- - - - -	- - - - -	~~NS / LR bolus X ___ liters~~															
- - - - -	- - - - -																
- - - - -	- - - - -																
- - - - -	- - - - -																
- - - - -	- - - - -																
- - - - -	- - - - -																
- - - - -	- - - - -																

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
28	(b)(6)-2	Vital signs q hr / q2hr / q6hr / q8hr /	07	(b)(6)-2	
		q shift	19		
		Cardiac Respiratory monitoring	07		
			19		
29	(b)(6)-2	Diet: NPO / Regular / Soft / Clear	07		
		Liquid	19		
29	(b)(6)-2	Activity: Ad Lib / Strict BR / BR with	07		
		BSC / NWB R or L LE	19		
29	(b)(6)-2	HOB up 30 Degrees	07		
			19		
29	(b)(6)-2	Nursing I/O, CDB / NG to LIS / LCS	07		
		↳ c̄ Foley to Gravity	19		
		Labs: Chem 7 / H&H / PT/PTT /	04		
		CBC q AM / 4 hrs / 8 HRS / BID	08		
			12		
			16		
			20		
			24		
		~~EKG q AM / QOD~~	06		
		~~PCXRAY q AM / QOD~~	06		
		Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07		
		~~q shift~~	19		
29	(b)(6)-2	Vascular checks q 1hr / 2 hr / 4 hr /	07		
		6 hr / q shift	19	(b)(6)-2	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Ex Lap / Ex Fix (R) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Treatment Facility: 212th Mobile Army Surgical Hospital

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 03 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29	(b)(6)-2	Admit Patient to ICU	29Mar			(b)(6)-2
		Diagnosis: Ex Lap / Ex fix R femur				
		Condition: Stable / Serious / Critical				
		Allergies: NKDA /				
29	(b)(6)-2	CBC	30MAR	0700		

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

USAPA V1.00

For: [redacted] CAL RECORD SUPPLEMENTAL MEDICAL [redacted]
(IAW AR 40-66, the proponent agency is the Office of Th[redacted] General)

REPORT TITLE: Medical ~~POST-ANESTHESIA~~ CARE RECORD

OTSG APPROVED (Date):

Time In: 2045

Procedure: Ex lap / External fracture (R) femur

ASA Grade (I – V):

Physician:

Anesthesia Provider:

Pre-Op Vitals: T= P= R= BP= / SaO2=

ANESTHESIA: (General) Spinal Epidural
Sedation Local Nerve Block:
Intrathecal w/ narcotic: time:
Other:

REVERSALS: Narcotic: (No) / Yes time:
Muscle Relaxant: (No) / Yes time:

Allergies: NKA
Latex allergy: N / Y
Medical/Birth Hx:
Complications:
Tourniquet time:

INTAKE: OR / PACU
Crystalloids / ___
Blood Prod / ___
Colloids / ___
Irrigations / ___
Other / ___

OUTPUT: OR / PACU
Urine / ___
EBL / ___
Drains / ___
Emesis / ___
Other / ___

VITAL SIGNS / POST ANESTHESIA RECOVERY SCORE / PAIN ASSESSMENT / OTHER

Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	~~Dem Level~~	~~Dr~~	~~Nurse action~~	Input	Output		Init
2050	127/72	97.9 A	103	20	99%	RA							Sedate	—	(b)(6)-2						
2105	133/77	—	101	20	99%	RA							↓	—							
2118	142/79	—	102	22	97	RA								—	+pp						
2134	132/84	—	106	22	94	RA							Sedate	—	+pp						
2149	129/79	99.2	100	24	93	RA								—							
2205	130/70	—	103	22	93	RA							↓	—	+pp						
2310	134/68		108	20	94	RA															

VITAL SIGNS
BP = blood pressure
P = pulse
R = respirations
T = temperature ax = axillary
SaO2 = oxygen saturation

Activity (Act)
2 = Moves 4 extremities
1 = Moves 2 extremities
0 = Moves 0 extremities

RESPIRATIONS (Resp)
2 = Cough/deep breath
1 = Dyspnea, airway
0 = Apnea

CIRCULATION (Circ)
2 = 20% +/- PRE-OP BP
1 = 20% - 50% +/-
0 = 50% +/-

LEVEL OF CONSCIOUSNESS (LOC)
2 = Fully awake
1 = Verbally aroused
0 = Unresponsive
No nystagmus w/ ketamine

SKIN
2 = Pink
1 = Pale, dusky
0 = Cyanotic

Sxn = suction IS = incentive spirometry C/DB = cough/deep breath HOB = elevate head of bed EE = elevate extremity ICE = cold compress CDI = clean/dry/intact Init = initials
PrT = patient teaching – see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow by Other:
Quality Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp
SL = sleeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:
Location Codes: H = head F = face Fd = fundus Tr = throat N = neck Sd = shoulder B = back Ch = chest ABD = abdomen U = umbilicus UE = upper extremity LE = lower extremity Hd = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

TIME	PROBLEM/COMPLAINT For analgesic include Quality, Intensity (0-10), and Location	MED DOSE/ROUTE	INIT	REASSESSMENT/RESPONSE For analgesic include Quality, Intensity (0 – 10), and Location	TIME	INIT
2330	% pain	2mg MSO4 IV	TP			
0015	" " abd/(R) leg	2mg MSO4 IV	TP			

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or patient location)
(b)(6)-4

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

DA FORM 4700, MAY 78

MEDCOM - 2698

MCEUL OP 45(Rev), 19 Sep 01
[redacted] apprvl - 02 Aug 01

(b)(6)-4

2001705

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial) (b)(6)-4
2. SSN
3a. STATUS
3b. SERVICE
4. PRECEDENCE U P X
5. GRADE
6. AGE: UNK
7. SEX: X Male / Female
8. WEIGHT
9. BLOOD TYPE
10. CLASSIFICATION (1A-5F): AMBULATORY / X LITTER
11. ACCEPTING PHYSICIAN
12. CITE/AUTHORITY NO.
13. APPT/SURG DATE
14a. ORIGINATING FACILITY (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER
15a. DESTINATION FACILITY (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER
16. NUMBER OF ATTENDANTS: 16a. MEDICAL Ø; 16b. NON MED Ø

17. DIAGNOSIS

s/p ex lap for GSW to abdomen
(R) femur fx 2° GSW s/p ex fix

18. X BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.	Ø		AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.		X	AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.		X	EARS/SINUS	j.		X	SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE: 29MAR03
20b. TIME: 2240
20c. ALLERGIES: NKOA

20d. DIET: X REG / SOM-NA / CARDIAC / DIABETIC ____ CALS

ORAL ____ Gm prot ____ Gm Na ____ Mlq K ____ ma PO4
TUBE ____ TYPE ____ ml/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ____ / OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		ORTHOPEDIC BRACES
	NG TUBE		IV PUMP		CHEST TUBE/HEIMLICH
	STRYKER FRAME		TRACH		RESTRAINTS
	INCUBATOR		MONITOR		OTHER (Explain in 23)
			FOLEY		

O2: LITERS: ROUTE:
VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		X-RAYS		FINANCIAL
	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS

Ancef 2gm IV Q8°
Gentamicin 350 mg IV QD
PCN 2 million units IV Q6°
Lovenox 30 mg SQ Q12°

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

EPW s/p GSW abdomen x
(R) femur. Pt. went for ex lap,
& organ damage noted. (R) femur
washed out & ext. fixator
applied. Pt. stable for
X-port to next echelon.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

24. (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 8 2 0 1 0 1	2 2 Y			MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0 EPW	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1700	
	M		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

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 GMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO 86th CSH FWD	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 3 3 0 0630

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 3 2 9

FOR LOCAL USE

Gun shot wound in the right abdomen
Gun shot wound in (R) Leg

DX: 86813
8911
E9912

Injury
4500
Trauma

ADMITTING OFFICER (Signature as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79

MEDCOM - 2700

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(3)-1

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

IPATIENT TREATMENT RECORD COVER SHEI

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDICAL	ABBREVIATED MEDICAL RECORD

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

PHYSICAL EXAMINATION

see SF 558

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

SIGNATURE OF PHYSICIAN	DATE	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.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

Surgery Staff

3 March 03 (b)(6)-4 EPW sustained blunt torso trauma & being run over by a Bradley fighting vehicle. Awake & alert on arrival c̄ obvious open (R) femur fracture c̄ large ST defect on post (R) thigh. Large abrasion over lower (R) chest c̄ ↓ BS. 36 Fr (R) chest tube placed & attached to Heimlich Valve BP 120/71 HR 83. FAST exam ⊖. Pelvis stable but tender c̄ manipulation. ∅ scrotal or perineal ecchymosis, & no prostate on exam. Foley catheter placed easily by me c̄ return of gross blood / hematuria. Only other injuries noted on exam are superficial abrasions vs PNE & (L) ankle wound from failed IV cutdown in field. Moves all extremities.

A: ① Blunt Chest / abdominal trauma
② Open (R) femur fracture
③ Gross hematuria – possible bladder or renal injury
④ Possible pelvic fracture.

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

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

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(?) Broad spectrum IV abx given c̄
ANCEF I	immobilization of femur fracture.
GM 1715	Vigorous fluid resuscitation as needed c̄
2000	monitoring of hemodynamic status.
	Watch urine for clearing of hematuria
UNASYN 3 GM	Chest & abdomen okay for now.
1750 Z	
	(b)(6)-2
MSO4 4MG	
1740	
Albumin 150ml	
1845	MAJ, MC, USA
	General Surgeon
	(b)(3)-1
1855	Blood transfusion started. Patient tachycardic and tachypnic RR 26 BP 122/53 P98 SaO2 99%. Breath sounds equal bilaterally. Chest t̄ drainage. Foley c̄ sanguinous drainage. Abdomen non-distended and nontender to palpation (b)(6)-2 (b)(6)-2
1905	P99 BP 114/62 RR 28 SATS 99% 1920 126/64 P93 RR 26 98%
1910	P92 BP 127/58 RR 26 SATS 98%
1915	P104 BP 143/70 RR 32 SATS 94%
1915	NPO: Pt restraints placed for procedures. NG tube placed 2nd lim. Placement verified by suction of gastric contents. Skin mottled on right arm. Suspect blood infusion
1917 BENADRYL	reaction. 25 mg Benadryl given. (b)(6)-2 (b)(6)-2
1924	Diagnostic Peritoneal lavage started by MAJ (b)(6)-2
	assisted by Dr (b)(6)-2 Pt tolerating procedure well.
	(b)(6)-2 (b)(6)-2

(b)(3)-1

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

Surgery Start

30 March 03 — Some hemodynamic lability last several hrs c̄ widened pulse pressure. Mild tachycardia to low 100's. Repeat FAST performed c̄ optimal windows. Some question of (R) renal laceration by FAST. Urine clearing. Hemodynamic lability tx'd c̄ crystalloid (total 4 liters to this point), colloid (1 unit albumin) & 1 unit PRBC. Due to hemodynamic lability & lack of clear windows on FAST, supraumbilical DPL performed & noted to be grossly (+). Significant improvement in BP & pulse pressure ⊕ transfusion. Urine output adequate to this point. Due to hemodynamic lability of unclear etiology, will hold on I&D of open fracture tonight. Due to weather concerns air evac not possible until ~ 0300Z.

(b)(6)-4

(b)(6)-2

MAJ, MC
General Surgeon

(b)(3)-1

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

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

(b)(3)-1

(b)(3)-1

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Mar 03 2005	Ortho Hx & findings as above. Pt's exam reveals no UE injuries, pelvis stable. RLE ~~[illegible]~~ obvious deformity at distal femoral diaphysis. ≈ 8x10 cm wound on posterior thigh, bruised distal pulses. Pt received IV Anect & Morphine. Will keep wound dressed. Repeat IV abx, pt to be evacuated 0300Z (b)(6)-2 Orthopedic Surgeon
2200 30 MAR 03	N.N.) Patient is deep, easily arousable. Breath sounds diminished on right side. Equal rise & fall of chest bilaterally. Pt tachypneic at 36 RPM. Sats 100% on 6L via NRB. Chest tube in place & heimlich valve attached. Bloody in tube. NSR on monitor. Rate 89 BPM. S1 S2 audible. Abdomen soft & nontender to palpation & distention. Foley to gravity draining bloody urine 200ml out since placement. NG tube to gravity. Dry 4x4's placed on open femur fx. No gross bleeding at site. Dressing on (L) ankle CDI. Bilateral SV's patent. MSO4 2mg for pain. Patient normotensive 117/72. GCS 15 (b)(6)-2
2300	2mg MSO4 IV. 125/65 - 90 - 29 - 98% 6L O2 via FM. ~~[illegible]~~ resting comfortably at this time. (b)(6)-2 (b)(6)-2

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

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

DATE	NOTES
29Apr03	PT arrival
0300	

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2 Apr 03 - 800pm	arrived via Litter, HA by a handlay, ABD upon arrival, Perla, HR 110-120, Distal pulses +3 All ext, BS shallow clear to auscultation, Pulse ox on 80s, Nonrebreather 8L O2, applied, sats came up to 90s, chest tub (R) side to 20 cm pleurovac, (L) Femur Fx, Fixator, Pelvic Fx, and degree burn on (R) Foot. Foley to gravity drank burgundy urine, [redacted] SPC LpN
3 Apr 03 - 0310	- 4 mg morphine [redacted] LpN
3 Apr 03 - 0330	- ancef 1 G gIV [redacted] SPC LpN
0430Z	STABLE VS 8/P 131/53 P-83, SATS 96% ē FM 42/min, RR 36 T° 99.9, GOOD BREATH SOUNDS ON (L), clear on upper lobe (R), ↓ AT middle lobe and bases, ↓BS, GOOD CAPILLARY REFILL AND PULSES x4, chest tube to (R) side ē water seal only, still has +2 EDEMA TO (R) lower extremity ē 2nd burns to ankle area and (R) femur FX ALREADY REPAIRED ē EXT. FIXATORS, GETTING READY FOR TRANSPORT, TRANSLATOR EXPLAINED TO PATIENT TRANSFER PROCEDURE YESTERDAY. HELD X-ray, I STAT 8, PENDING 1 GM OF ANCEF DUE TODAY 15:30 LOCAL TIME
10:00	1 GM OF ANCEF GIVEN NOW, NO CHANGES IN PT CONDITION, ON LITTER WAITING FOR TRANSPORT / TRANSFER

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

DATE	NOTES
3 APR 03 1400 Z	Patient ready for arrival ~~foley~~ 5 Hrs, CT to with seal, 10 Sets of compression (b)(6)-2 (b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surgery [redacted]
	Young Iraqi EPW struck by Bradley on 31 Mar c̄ resulting (R) PTX, (R) femur Fx, Pelvis fracture. Managed c̄ ex fix & foley. On arrival, pt in stable c̄ O2 per FM n=91. sat 98%, lect BP 122/43

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2APR 0615Z	Patient alert to stimuli v/nv. Infusing O+ blood 23/6 c̄ NS. NRB in use @ 10LPM. (R) Femur Fx c̄ ext Fix intact & dressing c̄ mild breakthrough bleeding. Chest tube draining small amount of serosanguinous fluid. Foley draining serosanguinous fluid. RR Tachypnic, febrile 101° approx. [redacted] ILT/AN
0715 2apr03	- PT GCS 9 x 3, Pernrala, BS equal bilat C+A A to B, O2 sats ~~96%~~ on 4L SM via concentrator, Normal Sinus Tachy, B/P WNL, cap ref < 3 secs all distal Pulses +3, PT has Pelvic Fx, (R) Femur Fx, chest tube on (R) side -20 cm via pleure vac, BS hypo active, (R) Foot & ankle 2nd degree burns, Foley to bravity draining clear Yellow U/S, PT has swollen (R) hand Complains of pain [redacted] SPC LPM

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

[redacted]

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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 3 MONTH 03 YR. 03 — TIME 0845

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

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Multiple trauma

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	0800	0900	
BP	134/68	90/52	
PULSE	91	90	
RESP.	36	40	
TEMP.	95.9		
WT. (Child)	5320	9670	

CATEGORY (See reverse)
- EMERGENT
- ☑ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
Chest xray		
Pelvic		
MSO4 4mg IV	(b)(6)-2	0830

ASSESSMENT/DIAGNOSIS
(R) Femur fx
Pelvic fx

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: FEU 3

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0905

TIME SEEN BY PROVIDER

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)

EPW ran over by Bradley fighting vehicle. Patient sustained blunt trauma to chest, (R) thigh, ? renal injury (gross hematuria).
Chest - ↓ BS (R) chest
Abd - DPL incision, soft, ND/NT
Pelvic - pelvic tenderness
Ext - open (R) femur fracture
(R) humerus ~~fracture~~ (deformity ? fx)
Chest Xray - Chest tube (R) chest, No PTX
Pelvis - pubic rami fx on (R)
FAST exam - ? (R) renal laceration → FST
DPL - Grossly negative
A/P - Blunt Trauma, Bradley vehicle
(1) chest - pleurac attached
(2) Local washout to femur fx, traction splint
(3) Plan air evacuat

(CONTINUE ON SF 507, IF NEEDED)

(b)(6)-2

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)

(b)(6)-4

(b)(3)-1

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31Mar03	0015		1000 cc u.o.p. 123/64-101-37-94% 6L O2 via FM. Resp. dance from 24-45. urine amber color c̄ red clots @ times 1000cc output CT 5 drainage. NG patent. LS ⊕ ~~CTA~~. IV c̄d/ as ordered. Resting comfortably @ this time. (b)(6)-2
	0230		125/70-27-94-96% 6L O2 4mg MS04 IV (b)(6)-2
	0245		300cc Sanguinous urine - Foley patent, Chest tube c̄ heimlich valve patent, IV patent. 118/63-91-24-99% 2L O2 via FM Resting comfortably at this time. (b)(6)-2
			500cc bag of NS D5% - (200cc left) - bag from last night. 1000cc↑ (b)(6)-2
	0315		Pt has remained NPO, T 99 PA, 38-98-24/166 (b)(6)-2 PT, AN
31Mar		1900	pt is doing well. V.S. have remained
1Apr02	0700		stable t/o shift. HR in 80s POX 98% on RA Resp Rate - 16, BP normal. UOP good 1600cc for shift. RMA c̄ small amount of sanguinous drainage. Lungs CTA, Heart Sounds normal, BS all quad; +CNS to lower extremities all night. ~~ORCF to ⊕~~ (b)(6)-2
			Ext. fixator to ⊕. pt on Reg diet + eating small amounts. (b)(6)-2
01APR03	0730		Assumed Care c̄ Charge nurse. VSS, Awake and Alert. P/Laws commands appropriately. CT to ⊕, O seal

Cont

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

(b)(6)-4

(b)(6)-2

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 2713

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
~~31~~ 01APR03	0730		Cont NPO ∅ SSK of Infection, Dressing Intact. FTG ⊂ Red/amber urine. O_2 @ 1L NC Sats ≥92%. IVR-LR@120/hr CR Monitor ⊂ NSR 90's. [redacted] 9LWMC 2PW
01APR03	0815		Emptied 225ml Red/amber urine From Foley, beg Pt c/o pain "too much" Referred to SSG Chase For MSO4 Administration. [redacted] 9LWMC 2PW.
01APR03	1020		VS BP 107/56, HR 106, RR-28, SPO2 92% 3L NC Pt NPO to surgery
01APR03	12	1315	Returned From Surg via Litter ⊂ CT to ~~left~~ wall suction, 10L O_2 via FM, Foley to Grav. External Fixation to (R) thigh open, HR 130's BP - 105/78, RR-36, Called for CXR Rev to placement and effectiveness. [redacted] WMC 2PW
01APR03		1900	700ml Red/Amber Urine out of Foley [redacted] 9LWMC [redacted]

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1 APR 03		2157	VS BP 114/59 P 88 R 24 T 98.3 (+) pedal pulses
			(R) leg warm dry cap refill <3 secs pt resting

(Continue on reverse side)

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

(b)(3)-1

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 2715

MEDICAL RECORD	LRMC 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 Cart BY MAJ (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 , CPT

3. DATE 1 APR 03 **TIME PATIENT ARRIVED IN SUITE** 1130

4. PATIENT IN ROOM TIME 1130 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2 CPT AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

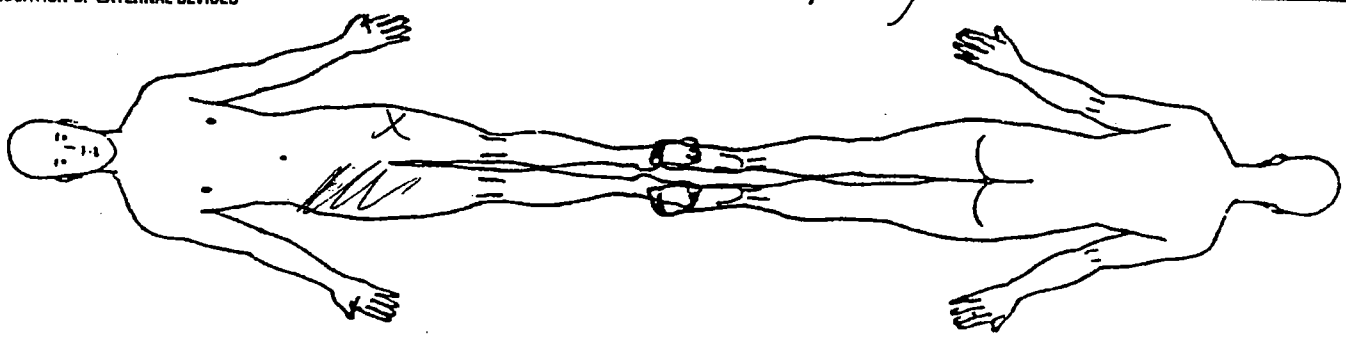
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens
SITE: Right leg BY WHOM: CPT (b)(6)-2
SITE: BY WHOM:

COMMENTS: Ø pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C – Correct I – Incorrect

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

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

EPW # (b)(6)-4

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

[X] ESU NO: Valleylab Force II Serial 30130
GROUND PAD: BRAND E4506
LOT NO: 10527

[ ] 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): .9NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

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)*
Kerlix
fluffs
ABDpad
Xeroform

19. ADDITIONAL INFORMATION
The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the _____ side.

Verified by: NA
Patient/guardian Surgeon Anesthesia Operating Room Nurse

20. OPERATION(S) PERFORMED
Right femur I+D

21. PATIENT TRANSFERRED TO ICU 2 TIME See op rec METHOD Litter

(b)(6)-2

87

MCEUL OP 358, 2 Mar 00
MRRC apprvl - 3 Feb 00

USAPA V1.00

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
1030	1130	1310	1 APR 03
TOTS	SURG START	DRESSING	OR NO.
1140	1215	1300	BD #1

OPERATION PERFORMED: I&D of (R) LE

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [x] QUESTIONING
- [x] CHART REVIEWED [x] NPO SINCE 0500
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
BIGTOP	30gL	PO	1040
VERSED	10g	IV	1040
ZOFRAN	50g	IV	1040
VERSED	3g	IV	1130

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [x] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # V-12 & EQUIP. CHECKED
- [ ] NON-INV. B/P
- [ ] CONT. EKG
- [ ] ESOPH. STETH.
- [ ] PULSE OXIMETER
- [ ] END TIDAL CO2
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [ ] AIRWAY HUMIDIFIER
- [ ] N/G TUBE
- [x] IV(s) 18g (L) UE
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [x] PRESSURE POINTS CHECKED / PADDED

[ ] PNS [ ] V LEAD EKG [ ] PRECORD STETH. [x] O2 ANALYZER [ ] MASS SPEC. [ ] FLUID WARMER [ ] O/G TUBE

ANESTHETIC TECHNIQUE

- [ ] GENERAL [ ] LOCAL / MAC
- [x] REGIONAL [ ] NERVE BLOCK
- [ ] SAB c MARCAINE

INDUCTION

- [ ] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

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

	1130	x 1200	x 1230	x 1300			TOTALS
AGENTS: VERSED	2						
FENTANYL	100						
FENTANYL (SAB)	25						
N2O L/min	—	—	—	—	—	—	
O2 L/min	3 lpm	2	2	3	3	3	
FLUIDS: LR (1°IV)				600		800	
Urine				100		150	
EBL				<50		<50	

MONITORS	1	2	3	4	5	6
EKG	ST	ST	ST	ST	ST	ST
% O2 Inspired	FM	FM	FM	FM	FM	FM
O2 Saturation	100	100	96	95	98	98
End Tidal CO2	(+)	(+)	(+)	(+)	(+)	(+)
Temperature	—	—	—	—	—	—
PNS	—	—	—	—	—	—

TIME: 1130 x 1200 x 1230 x 1300

PRE-OP VALUES: B/P 126/72; P 105; R 16; SAT 97% RA; T 100.2; H/H

RESP	1	2	3	4	5	6
Tidal Volume	—	—	—	—	—	—
Resp Rate	—	—	—	—	—	—
Peak Pressure	—	—	—	—	—	—
	SV	SV	SV	SV	SV	SV

Symbols for Remarks: <A> <B> <C>

Position: SUPINE

SYMBOLS: X ANESTHESI; ⊙ OPERATIO; V ^ B/P CUFF PRESSURE; ⊥ T ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS RESP; Φ ASSISTED RESP; ⊗ CONTROLLE RESP; T TOURNIQUE; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION		
1305	SOMNOLENT		
B/P	PULSE	RESP	O2 SAT
107/52	114	28	99
REMARKS Pt Stable			TEMP

REPORT TO: CPT (b)(6)-2

REMARKS: [ ] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation. <A> To OR, monitors on, IV Decd, monitors on, <B> SAB placed, VSS. <C> VSS, to ICU 3 for Post op Care, VSS, report given.

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid 800	EBL 150	
Blood 150	Urine 150	
	Gastric 0	

(b)(6)-2

MD, CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION: (b)(6)-4 (b)(3)-1

SAB TIME 1130 SAB SOLUTION 15g (2cc). SPACE L3/4 25% Wexbrie 3 dn

NAME: (b)(6)-4 SURGEON: (b)(6)-2 Planned Surgery Date: 1 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

AGE	HEIGHT	WEIGHT	
PROPOSED OPERATION: I & D (R) LE	PREOPERATIVE VITAL SIGNS: BP 126/72	P 88	R 16 SaO2 97%

PREVIOUS ANESTHESIA / OPERATIONS: ☑ NEGATIVE

CURRENT MEDICATIONS: ☐ NONE
ANCEF 1gm q 8hrs
LOVENOX 30mg SQ BID

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS: ☑ NEGATIVE

ALLERGIES: ☑ NKDA

AIRWAY / TEETH / HEAD & NECK
MPT 1 FROM, 3 FB, no loose teeth

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

PROBLEM LIST / DIAGNOSES
1° Dx Open (R) LE Fx
Tobacco Abuse

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

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

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

(b)(6)-2 (b)(6)-2 MD, CRNA 1 APR 03
SIGNATURE DATE

(b)(6)-2 (b)(6)-2 MD, CRNA DATE 1 APR 03
CR

(b)(6)-2 DATE
PH

POST ANESTHESIA VISITS

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

DATE: _____
SIGNED: _____ TIME: _____

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Doctor's Orders
	IV Pt bolus
31 March 03 2030	Dx: ① Blunt chest / abdominal trauma
	② Gross hematuria
	③ Possible pelvic fracture
	④ Open ⓡ femur fracture
	Cond: Serious
	Alt: Chronic
	Vitals, I&O q 1°
	Foley to gravity
	ⓡ CT to thumb lock valve
	NGT to gravity
	~~Call~~ Notify M.D. for SBP < 100 or DBP < 50 on 2 or more consecutive readings, O_2 sat < 95%, HR > 105 or < 60
	NPO
	IVF NS @ 100 cc/h
	~~Call~~ Notify M.D. for UOP < 30 cc/h
	Unasyn 3 gm IV — not available at 1200 z
	Ancef 1 gm IV — Given @ 2400 z
	Morphine 2 mg IV q 3-4° prn pain
31 March 03	Admitted to ICU #32 0815 AM. VS [redacted] MAJ MC USA General Surgeon

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.

#47

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 March 03	96.6°F, HR 89 BP 109/54 (83) O2 sat on RA 82%, placed on 5L NR pt c̄ 100% O2 sat RR 40 (R) lung with coarse crackles, ↓ (R) L.L. (R) CT c̄ good resp. variations. (L) LE immobilized (fracture splint) Denies any neurodeficits, good perfusion. (R) UE c/o pain moving fingers. Denies neuro deficits, good perfusion. lethargic but arousable Abd. soft, nontender, NG (L) arm laceration covered c̄ dressing. Noted multiple scattered skin abrasions. 09:28 MSO4 IV given for pain. 09:56 109/57 (78) 92 HR 92, RR - 36, O2 sat 93%. 10:00 ↑ RR, ↓ O2 sat. MD notified. ↑ FIO2 to 10L NRM. CT = slows. with good effect noticed ↓ WOB, ↑ O2 sat. Will follow
UO - 600cc	closely. 10:10 VSS. started abx. 11:12 (600cc) of concentrated urine, (+) hematuria. VSS. Remains on 10L NRM, CT c̄ good resp-variations. NG changed.
UO - 270cc	12:00 VSS. Pt. resting comfortably. 14:30 109/59 HR-102,
CT - 55cc	96% O2 sat, RR 44, CT c̄ 55cc, pen-long drainage. Resting comfortably. 15:00 Pt. desaturated to 70's. NRM 10L placed c̄ good results (sat 100%) / BP 109/59 (76). RR - 40 bpm, temp 101.7°F, 15:15 107/60, HR-104, 99% Remains febrile. 16:00 3L NP c̄ O2 sat 96%. Denies pain. 16:22 MSO4 IV given for pain. (R) Femoral dressing changed.
	19:30 100.5°F VSS. Resting comfortably O2 sat 97% on 3L NP (R) RE without neuro-vascular deficits (L) LE edema. Good perfusion.

(b)(3)-1

STANDARD FORM 600 (REV. 6-97) BACK

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

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

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

LIST TIME ORDER NOTED AND SIGN

1. Δ chest tube to water seal ✓
2. Tylenol 650 mg p.o. Q6° ✓
3. Lovenox 30 mg SC Q12° ✓
4. Pt. may have sips H_2O. ✓
5. O/C NGT ✓
6. Δ diet to regular ✓

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. Vascular v's (R) foot Q1° ✓

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 APR 03 TIME OF ORDER: 0835 HOURS

NPO

Pre op for Wound Wash

V.O. Dr (b)(6)-2 (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 APR 03 TIME OF ORDER: 1030 HOURS

CT to 25cm H_2O suction

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF ... H MAY BE USED.

MEDCOM - 2722

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

Jan 3

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 March TIME OF ORDER: 0830 HOURS

LIST T ORDE NOTED SIGN

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

13. PCXRAY q AM/QOD
14. IVF NS/ LR/ D5NS/ D51/2NS To run @ 120cc/hr
15. Ancef 1-GM IV Q 8 hrs give Ancef 1g IV 8hr
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs.
18. O2 titrate to keep SPO2 > 92%
19. Versed gtt 1-10mg/hr IV titrate to

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Ramsey Scale of

20. Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of
21. Vecuronium 1mcg/kg/min
22. MSO4 2-4 mg IV q 4 HR PRN Pain 9:23
23. Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24. MOM 30cc PRN Gastric upset

(b)(6)-2

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

(b)(3)-1

MEDCOM - 2723

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER _____ HOURS	LIST TIME ORDER NOTED AND SIGN
			25	NS/ LR bolus X liters		
			26	Neuro checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		
			27	Vascular checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		
				(b)(6)-2		CPG
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
				3 MAR 03	1015	
				Δ chest tube to 25cm		
				with suction		
				(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

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

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

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

(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUM (b)(6)-2 COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

Scw 3 @ 1400 01 APR 03 noted

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1 APR 03	1343 HOURS	
1	Resume previous pain meds & [illegible]	
2	Cont. 350 mg 1493 qday.	

(b)(6)-2

TC, MC, USA
ORTHOPAEDIC SURGERY

PATIENT IDENTIFICATION (b)(6)-2

(b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION (b)(6)-2

(b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

(b)(6)-4

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

DA FORM 1 APR 79 4256 REPLA MEDCOM - 2725 CH MAY BE USED.

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

1 Apr 03 Orthopedic Op Note
1345 dx: (R) open femur shaft fracture,
procedure: (R) femur ORIF, ex-fix,
surgeon: Dr. (b)(6)-2
anesthesia: Dr. (b)(6)-2 (Spinal),
findings: gross ~~[illegible]~~ open femur fx.
midshaft fx c̄ posterior thigh hematoma
(Dupuy ex-fix. 1-bar - 4 pins applied for transport).
post op plan: 48 hr antibiotics, IV
re-secondary of wound in 48 hr
NCWB - (R) LE
PT/OT c̄ SW for definitive fx.
DVT prophylaxis.

TEMPERATURE - PULSE - RESPIRATION						NURSE'S NOTE
DATE AND TIME	T	P	R	STOOLS	WEIGHT	MEDICATION AND NUR

(b)(6)-2

TC, MC, USA
ORTHOPAEDIC SURGERY

(b)(3)-1

USAPPC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

4/2/03 0230 Admit to Surgery
Dx: Blunt trauma - (R) PTX, (R) femur fx s/p ex fix
Condition stable
VS per protocol
NKDA
Bedrest

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Start IVs
Poly trauma
Pleuragode 20 cm H2O - water seal
NPO for now
LR @ 130 cc/hr
MSO4 4 mg IV Q2° prn pain
Phenergan 12.5 mg IV Q4° prn nausea

Noted 2 Apr 03 OPT, AM (b)(6)-2

PATIENT IDENTIFICATION (b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Ancef 1g IV Q8°
O2 2L NC
PE + R now
ABG & H+H
xy (R) femur, pelvis

degree done

(b)(6)-2

PATIENT IDENTIFICATION (b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

2 units PRBC OT now followed by
H+H q 60 min
VO: Dr (b)(6)-2 / LT (b)(6)-2

(b)(6)-2

CXR 1100 2

✓ I stat ✓
Chest tube to water seal

(b)(6)-2

(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			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				3 Apl 2003	0445 Z HOURS	
				I stat 8 ml		
				Chest tube to water seal		
				CXR 1100 Z		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD

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

Mo. March Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (31 / 01 / 02 / 03 / 04)
31 March 03	(b)(6)-2	Admit to ICU (see next	pm	(b)(6)-2
31		Vital signs q shift	07	
31			19	
31		~~Diet~~ NPO	07	(b)(6)-2
31			19	X X } D/C 31 March 03 @
31		Strict BR	07	(b)(6)-2
31			19	
31		HOB > 30°	07	
31			19	
31		O_2 titrate to keep	07	
31 March		SpO_2 > 92 %	19	
		Sips of H_2O.	07	
			19	
31 March 03	(b)(6)-2	Regular diet	07	(b)(6)-2 → Did 01 APR 03 @ 0830
			19	(b)(6)-2 (b)(6)-2
31 March 03		Vascular J's (R) Foot	07	(b)(6)-2
		q 1 h	19	
01 APR 03		NPO ~~to surgery~~ OTC	07	(b)(6)-2
			19	
2 Ap 03		I and O	07	/
			19	/
2 Apr 03		FC to gravity	07	/
			19	/
2 Apr 03		Pleuravac 20 cm H_2O	07	/
			19	/

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) humerus & (L) Femur FX
(L) renal laceration, pelvic - pubis ramus FX
(R) PS S/p Chest Tube placement

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(3)-1

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 2729

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo March/April Yr 05
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
31 March	(b)(6)-2	Admit to ICU	31 March	915	915	(b)(6)-2	
31 March		Dgn: Pedestrian struck	31	915	↓		
31 Mar		Condition stable	31	↓	↓		
31 March		NKDA	31	↓	↓		
31 Mar		CT → 25 cm H_2O suction	31	10AM	10AM		
31		CT → water seal	31	17:00	17:00		
31		D/C NG tube	31	17:00	17:00		
01 APR	(b)(6)-2	Resume Previous Pre op orders	01	Now			
2 APR		PA CXR now	Apr 02	Now	05		
2 Apr		ABG & HH	Apr 02	Now	05		
2 Apr		CXR (R) femur, pelvis	Apr 02	Now	05		

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

☆ U.S. GPO:1997-418-290/55267

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	01	02	03	04	05	06	07
31 March 03	(b)(6)-2	LR @ 120cc/hr IV	07	(b)(6)-2			D/C				
			19								
~~31 March 03~~	(b)(6)-2	Ancef 1 gm IV q8hrs	02	X (b)(6)-2							
01 (b)(6)-2		ZULU TIME	10	(b)(6)-2							
			18	(b)(6)-2							
31 March 03		Tylenol 650mg po	06	X (b)(6)-2							
		Q 6°	12				D/C				
			18	(b)(6)-2							
			24								
31 March 03		Lovenox 30mg SQ	06	X (b)(6)-2							
		Q 12°	18	(b)(6)-2			D/C				
		Gentamycin 350mg	24								
		IVPB QD		/	/						
2Apr03	(b)(6)-2	LR @ 130cc/hr.	07	/	/	(b)(6)-2					
		ZULU TIMES	19	/	/						
2Apr03		O2 @ 2L NC	07	/	/						
			19	/	/						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: MVA, blunt trauma to chest (R) thigh? renal injury (gross hematuria) Femur Fx (R) renal laceration pelvic-pubic rami Fx (R) humerus Fx ↓RBS s/p (R) CT placement

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(3)-1

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
31 March 03	(b)(6)-2	MSO4 2-4mg IV q 4hrs	31 March (b)(6)-2	31 March	1 APR 3mg	2 APR 3mg IV	DC									
				(b)(6)-2	0810	5150 KEN										
2 Apr 03	(b)(6)-2	MSO4 4mg IV q2h prn pain	0200 4mg (b)(6)-2	2 APR	1600 2 APR	2200 4MG 2 APR (b)(6)-2										
2 Apr 03	(b)(6)-2	Phenergan 12.5mg IV q4h prn nausea	2242 Z 12.5MG 2APR													

47

31153MAR03

(b)(6)-4

MEDICAL EVACUATION PATIENT RECORD

Priority

PATIENT IDENTIFICATION

(b)(6)-2

1. NAME (Last, First, Middle Initial): [redacted] Bedford
2. SSN: (b)(6)-4
3a. STATUS: EPW
3b. SERVICE:
4. PRECEDENCE:
5. GRADE:
6. AGE:
7. SEX: X Male / Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): AMBULATORY X / LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1 (Iraq)
14b. ORIGINATING FACILITY PHONE NUMBER: ICU 3
15a. DESTINATION FACILITY: (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER:
16. NUMBER OF ATTENDANTS: 16a. MEDICAL / 16b. NON MED

17. DIAGNOSIS
MVA, Bradley
(R) Pneumothorax
(R) Open Femur Fracture
Pelvic rami fracture
7. (R) Humerus fracture

18. X BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.		X	AMBULATORY
b.		X	CARDIAC HX	g.		X	VISION IMPAIRED	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOMITING PROBLEMS	m.		X	SELF-MEDS
d.		X	RESPIRATORY	i.		X	BOWEL PROBLEMS	n.	X		ADEQUATE SUPPLY OF MEDS
e.		X	EARSHOUR	j.		X	SELF-CARE	o.		X	OTHER

20. PHYSICIANS ORDERS
20a. DATE: 31 March
20b. TIME: 0840
20c. ALLERGIES: NPO
20d. DIET: REG / SOM NA / CARDIAC / DIABETIC ____ CALS
RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4
TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ____ / OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr
20e. IV/BLOOD: LR @ 120 cc/hr
20f. SPECIAL EQUIPMENT:

		TRACTION	X	ORTHOPEDIC BRACES	
	SUCTION	X	IV PUMP	X	CHEST TUBE/HEIMLICH
X	NG TUBE		TRACH	X	RESTRAINTS
	STRYKER FRAME	X	MONITOR		OTHER (Explain in 23)
	INCUBATOR	X	FOLEY		

O2: LITERS: ROUTE: Face Mask
VENTILATOR SETTINGS
20g. ALTITUDE RESTRICTION: None
20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	X-RAYS		FINANCIAL
X	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS
IVF NS @ 1KO
MSO4 2-4mg IV Q4h PRN

(b)(6)-2

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
EPW ran over by Bradley fighting vehicle. Sustained (R) PTX, (R) open femur fx, (R) pubic rami fx, ? (R) renal laceration (FAST), and ? (R) humerus fx. DPL - Grossly negative.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

(b)(6)-2 ATTENDING PHYSICIAN

24. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(3)-1

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (b)(6)-4
4. PAY GRADE (16–17):
5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19750101
7. AGE AT ADMISSION (27–29): 27
8. RACE (30):
9. ETHNIC BACKGROUND (31): 9
RELIGION: MVS

10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 20 EPW
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS (46): M
HOUR OF ADMISSION: 826
BRANCH / CORPS:

14. FLYING STATUS (47–49):
15. BENEFICIARY CATEGORY (50–52): (b)(6)-4
16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–70):
19. TRAUMA (71): B
PREV. ADMISSION: YEAR ☐ NO

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

21. TYPE OF DISPOSITION (73–74): XFR
22. MTF TRANSFERRED TO (75–80): (b)(3)-1 (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 030401 1800

24. CLINIC SVC - ADMITTING (87–90):
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION (Y Y M M D D) (97–102):

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116): 030531

FOR LOCAL USE

How? Does not Know
When?
Where?
(L) foot amputation

Dx: 8960 E9149
Injury 450V
Trauma

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

DA FORM 2666, MAY 85 EDITION OF MAY 7

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
2	1	Y																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	9	6		0																	

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

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

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

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

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

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

MEDCOM - 2735

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b)(6)-1	b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2736

.NPATIENT TREATMENT RECORD COVER SHE.

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(3)-1

REDO

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26 (b)(6)-4	27 28 29	30	31	MUS

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46 M	826	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4	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 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 GMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79 80 (b)(3)-1 (b)(3)-1	81 82 83 84 85 86 ~~0 3 0 4 0 1~~ 1800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 3 3 1

FOR LOCAL USE

When? Two night ago.
How? Bomb from task
Where? City of Caribla
MVA, Bradley vehicle

Dx: 2599
E8109

Injury HSD

Trauma 1

Hostile

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

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

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

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	20 Y					

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW 12-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

(b)(6)-4 ICU3

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 1
4. PAY GRADE (16–17):
5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26: 1 9 8 3 0 9 2 7
7. AGE AT ADMISSION (27–29): 2 0 Y
8. RACE (30):
9. ETHNIC BACK-GROUND (31):
RELIGION

10. LENGTH OF SERVICE (32–34):
ETS
11. FMP (35–36): 2 0 EPW
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46):
HOUR OF ADMISSION: 1440
BRANCH / CORPS

14. FLYING STATUS (47–49): N O
15. BENEFICIARY CATEGORY (50–52): R 7 8 EPW
16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–70):
19. TRAUMA (71): Y
PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): EMT
WARD: ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): XPR
22. MTF TRANSFERRED TO (75–80): (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86: 0 3 0 4 0 1 1800

24. CLINIC SVC - ADMITTING (87–90):
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION (Y Y M M D D) (97–102):

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116): 0 3 0 3 3 1

FOR LOCAL USE
65W (L) HIP
INS @ 0806

Dx: 8901
E9912
Injury 450
Trauma 1

ADMITTING OFFICER (Signature, as required) LTC (b)(6)-2 (b)(6)-2
SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	9	0		0																	

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

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

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

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

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

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

MEDCOM - 2741

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2742

INPATIENT TREATMENT RECORD COVER SHI

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-2	16 17	18
(b)(6)-2			M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		20	(b)(6)-2

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	18:25	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4 (b)(6)-4	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
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	OR	(b)(6)-2
O EMT		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) CALIF
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 0 1

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
	(b)(3)-1	0 3 0 3 3 1

FOR LOCAL USE

GSW buttock

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

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

DA FORM

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

MEDCOM - 2744

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166
		8	7	7		0																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

MEDCOM - 2745

INPATIENT TREATMENT RECORD COVER SH

For use of this form, see AR 40-400; the proponent agency is O1oa

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		

15. FLYING STATUS	16. RATING/ DSG	17. DEPT	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		(b)(6)-4			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	4. PAY GRADE	5. SEX
1 2 3 4 5 6	7 8	9 10 11 12 13 14 15	16 17	18
(b)(3)-1		(b)(6)-4 (b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	Muslim
(b)(6)-4	2 2 4			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1820	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4	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
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XSR	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 4 0 1 1600

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110 (b)(3)-1	111 112 113 114 115 116
		0 3 0 3 3 1

FOR LOCAL USE

Rule out close Head Injury

Dx: 959.0

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

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
143	144	145	146	147	148	149	150
		9	5	9		1	

37. SECOND DIAGNOSIS							
151	152	153	154	155	156	157	158

38. THIRD DIAGNOSIS							
159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS							
167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS							
175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS							
183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS							
191	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS							
199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*							
207	208	209	210	211	212	213	214

45. SECOND PROCEDURE							
215	216	217	218	219	220	221	222

46. THIRD PROCEDURE							
223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE							
231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE							
239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE							
247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE							
255	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE							
263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

MEDCOM - 2748

INPATIENT TREATMENT RECORD COVER SHI

For use of this form, see AR 40-400; the proponent agency is O[illegible]

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-2	(b)(6)-2		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
m						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
2C			

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ REM (b)(6)-2 (b)(6)-2	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

DRAFT

(b)(6)-4

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (b)(6)-2

2. SSN

3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U X R | 5. GRADE

6. AGE 19 | 7. SEX X Male ☐ Female | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A-5F) | AMBULATORY ☐ LITTER X

11. ACCEPTING PHYSICIAN | 12. CITE/AUTHORITY NO.

13. APPT/SURG DATE

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER FCH #2

15a. DESTINATION FACILITY (b)(3)-1

15b. DESTINATION FACILITY PHONE NUMBER

16. NUMBER OF ATTENDANTS | 16a. MEDICAL | 16b. NON MED

17. DIAGNOSIS

(R) open humerus fx
(R) thigh GSW
(R) chest shrapnel WNN c̄ pneumothorax

18. X BATTLE CASUALTY | ☐ ACCIDENT | ☐ NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	j.	X		AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	k.			AMBULATORY AID
c.			DIABETES	h.			HEARING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADDITIONAL SUPPLY OF MEDS
e.		X	EARACHES	j.		X	SELF-CARE	o.		X	OTHER

20. PAROXYSMAL ONSET

20a. DATE 1 APR 03 | 20b. TIME 1045 | 20c. ALLERGIES NKA

20d. DIET ☐ NPO ☐ RENAL ☐ CARDIAC ☐ DIABETIC ☐ CALS

20e. SERIAL ☐ Qm ☐ Qm ☐ Qm ☐ Qm ☐ Qm ☐ mg PO4

20f. TIME ☐ TYPE ☐ 1/4, 1/2, 3/4, FULL STRENGTH

20g. RESTRICTED ADS ☐ OTHER (Specify) ☐

20h. Change to D10 at ☐ cc/hr for max of ☐ days

20i. TUBE FEEDING ☐ at ☐ ☐ cc/hr at ☐ cc/hr

20j. DRAINAGE

20k. SPECIAL EQUIPMENT

SUCTION		TRACTION		ORTHOPEDIC BRACES	
NG TUBE		IV PUMP	X	CHEST TUBE/HEMLICH	
STRYKER FRAME		TRACH		RESTRAINTS	
INCUBATOR		MONITOR		OTHER (Explain in 23)	
		FOLEY			

O2: ☐ LITERS: ☐ ROUTE: ☐

VENTILATOR SETTINGS

20m. ALTITUDE RESTRICTION:

20n. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	X-RAYS		FINANCIAL
X	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20l. MEDICATIONS/TREATMENTS

Tylenol 650m Q6° PRN pain
Ancef 2gm IV Q8°
MSO4 2-4mg IV Q2° PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

19 yo. GSW c̄ mult injuries
(R) humerus fx (R) thigh soft tissue,
(R) chest penetrating trauma
Pt. stable for transport

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

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

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

ADMISSION A..D CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-2	16 17	18 M
(b)(6)-2			

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 8 4 0 1 0 1	1 9 7			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1820	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4 (b)(6)-4	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 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0 EMT	ICU 2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 4 0 2 0410

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110 (b)(3)-1	111 112 113 114 115 116
		0 3 0 3 3 1

FOR LOCAL USE

Dx: (R) femur schrapnel injury
(R) axillary blast injury

Dx: 82110
88012
E993

Injury 450 Trauma 1

(b)(6)-2

SIGNATURE (b)(6)-2

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

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166
		9	0	4		0																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20			

15. FLYING STATUS	16. RATING/ DSG	17. DEPT	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		(b)(6)-4			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
1 2 3 4 5 6 (b)(3)-1	7 8	9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-2	16 17	18 M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1900	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	(b)(6)-4 (b)(6)-4	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 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0 EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79 80	81 82 83 84 85 86 0 3 0 4 0 1 1600

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110 0 3 0 3 3 1	111 112 113 114 115 116 0 3 0 3 3 1

FOR LOCAL USE

BLAST INJURY
BURNS and shrapnel (b)(6)-2

Dx: 88010
88013
E993

Injury
~~HO~~ Trauma
1

S Holder & upper Arm

ADMITTING OFFICER (Signature as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b(3)-1	b(3)-1

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 a			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		9	4	3		0	9			9	5	9		2									

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

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

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

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

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

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

NPATIENT TREATMENT RECORD COVER SH

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

01 Apr 03
1800

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, MI): (b)(6)-4
2. SSN:
3a. STATUS:
3b. SERVICE:
4. PRECEDENCE: U / P / R
5. GRADE:
6. AGE: 23
7. SEX: X Male / Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): AMBULATORY / X LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.:
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER: ICU #2
15a. DESTINATION FACILITY: (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER: (b)(6)-4
16. NUMBER OF ATTENDANTS: 16a. MEDICAL: Ø 16b. NON MED: Ø

17. DIAGNOSIS
Multiple GSW (B) hands
(R) hand open fx
Open skull fx

18. X BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

19. ENROUTE ORDERS

20a. DATE: 1APR03
20b. TIME: 0600
20c. ALLERGIES: NKDA

20d. DIET / RES. / SEMI-RES. / LIMITED / DIABETIC ____ CALS
RENAL ____ Alb ____ Hct ____ Hb ____ BUN ____ Hb PO4
TUBE ____ TYPE ____ SIZE ____ LTD. BR. FEAL STRENGTH
DEHYDRATION ____ DYSTRESS ____
SIGN: Change to D/12 at ____ cells for mark of ____ days
TUBE FEEDING ____ at ____ strength at ____ water
20e. BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		IV PUMP		ORTHOPEDIC BRACES
X	NG TUBE		TRACH		CHEST THERMOMLICH
	STRYKER FRAME		MONITOR		RESTRAINTS
	INCUBATOR		FOLEY		OTHER (Details in 28)

TRACTION

O2: LITERS: ROUTE:
VENTILATOR SETTINGS 55mv @ 16BPM / TV-900 / 30% O2
20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	X-RAYS		FINANCIAL
X	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS
Versed drip 1-10mg/hr titrate for pain
Fentanyl drip same/hr.
Ancef 1gm IV Q8°

10. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES answers in Section 22)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.	X		AMBULATORY
b.		X	CARDIAC HX	g.		X	VISION DEFICIENT	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOMITING PROBLEMS	m.		X	SELF-AIDED
d.		X	RESPIRATORY	i.		X	BOWEL PROBLEMS	n.			ATTENDANT ASSISTANCE
e.		X	EARSINUSES	j.		X	SELF-CARE	o.		X	OTHER

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
23 y.o. ♂ c̄ multiple GSW's (B) hands, open skull fx arrived intubated c̄ GCS 3T. Pt. stabilized here in ICU, ready for X-S Port

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

(b)(6)-2

24. STAMP AND SIGNATURE OF FLIGHT SURGEON

DD FORM 3005, MAR 96

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	NAS
1 9 8 0 0 1 0 1	0 3 4			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1855	
	3		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4 (b)(6)-4	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
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	OR	(b)(6)-4 (BROTHER)
0 EMT		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78	81 82 83 84 85 86
XFR		0 3 0 4 0 2 0410

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
	(b)(6)-4	0 3 0 3 0 3

FOR LOCAL USE

HEAD INJURY
(L) HAND INJURY

Dx: 95901
95914

Injury
45D

Trauma
1

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(6)-2	(b)(6)-1

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 3			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		9	5	9		7				9	5	9		4									

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

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

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

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

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

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

MEDCOM - 2761

INPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is O1...

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 8 0 1 0 1	27 28 29: 3 5 4	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46 M	1915	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: N 7 8 EPW	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 B	YEAR; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LO (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 80: (b)(3)-1	81 82 83 84 85 86: 0 3 0 4 0 1 1600

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110: 0 3 0 3 3 1	111 112 113 114 115 116: 0 3 0 3 3 1

FOR LOCAL USE

~~Other~~ suspected injury to Head

Dx: 95901
E993

Injury 1450 Trauma 1

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b(6)-1	b(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2764

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
3	5	Y																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		9	5	9		0	1																

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

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

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

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

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

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

IPATIENT TREATMENT RECORD COVER SHEE

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. M.. LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6 (b)(3)-1	7 8	9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	18:50	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 (b)(6)-4	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 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0 EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79 80	81 82 83 84 85 86 0 3 0 4 0 1 1600

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110 (b)(3)-1	111 112 113 114 115 116 0 3 0 3 3 1

FOR LOCAL USE

GSW Bu Hock

DX: 8771
89912

Trauma 1

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

(b)(6)-2

FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	23		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
			K-78 CIU		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030401

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030401	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030401	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO LEG/ HAND

CODING INFORMATION: 890.0, 882.0

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	Mus
1 9 7 9 0 1 0 1	2 3 4			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		
	5		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

POW/INT

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	IGV2	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 (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
VFR		0 3 0 4 0 1 1600

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 1

FOR LOCAL USE

GSW to Leg / hand

DX: 8910
8820
Injury 450
E9912
Trauma 1

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

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

MEDCOM - 2769

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
2	3	4																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
137	138	139	140	141	142	143	144
		8	9	0		0	

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152
		8	8	2		0	

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176

41 SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*							
201	202	203	204	205	206	207	208

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b(c)1	b(e)4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2771

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1820z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030402	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030402	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Gun shot wound

HOW:

WHERE: Penetratingwound to abdomen and lower extremity

WHEN:

CODING INFORMATION: 922.3

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	(b)(3)-1
2. MTF LOCATION (State or Country Code)	
3. REGISTER NUMBER	(b)(6)-4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	
7. AGE AT ADMISSION	
8. RACE	
9. ETHNIC BACKGROUND	9
RELIGION	Muslim
10. LENGTH OF SERVICE	
ETS	
11. FMP	20
12. SOCIAL SECURITY NUMBER	(b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	
HOUR OF ADMISSION	1820
BRANCH / CORPS	
14. FLYING STATUS	N 0
15. BENEFICIARY CATEGORY	K 7 8 EPW
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	B
PREV. ADMISSION	YEAR 2003 ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	0
WARD	ICU 3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
21. TYPE OF DISPOSITION	XFR
22. MTF TRANSFERRED TO	(b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D)	0 3 0 4 0 5 0530
24. CLINIC SVC - ADMITTING	
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (Y Y M M D D)	0 3 0 4 0 2

FOR LOCAL USE

Gun shot wound

Penetrating wound to abdomen and lower extremity

Trauma DX: 86813 8911 E9912

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

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

MEDCOM - 2773

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 32y	6. RACE	7. RELIGION Muslim	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR	26. DATE OF DISPOSITION 04032003		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 04032003		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	MUSLIM
1 9 7 1 0 7 0 7	3 2 4			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0 EWP	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	0830	
	S		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8 POW/INT	8 0 1 0 3 0 4 0 3

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
1 2			

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
EMT		

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 0 3 1630

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
1 2		0 3 0 4 0 3

FOR LOCAL USE

SHRAPNEL WOUNDS TO BACK

INJ 030402 @ 1600 By helicopter

Dx: 8761
E9919

Injury
4149

Trauma
1

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

(b)(6)-2

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

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

MEDCOM - 2775

NPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN K-78 (b)(6)-2	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

SHRAPNEL WOUND TO UPPER AND LOWER EXTREMITIES

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	16 17	18
(b)(6)-4		M

(b)(6)-4

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 6 0 0 1 0 1	4 3 4	0	9	Mus.

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1128	
	M		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	X 7 8 EPW	

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	3104	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

(b)(3)-1

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78	81 82 83 84 85 86
XFR		0 3 0 4 0 3 1700

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 3

FOR LOCAL USE

Scrapnel wound to upper and lower extremities

Dx. 8911
8841
89919

~~Trauma~~
~~4149~~
Trauma

ADMITTING OFFICER (Signature, as required)

(b)(6)-2

(b)(6)-2

DA FORM

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2777

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
4	3	Y																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	9	4		0				8	8	4		0									

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

55. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 90		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. DSG		BEN 1K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

ADMISSION AND CODING INFORMATION

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

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4 redacted

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1741	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

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 ERA	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1 redacted	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 (b)(3)-1 redacted	81 82 83 84 85 86
		0 3 0 4 0 3 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 3

FOR LOCAL USE

(L) Timpanic membrane rupture / (R) face laceration

Dx 87261
87340
E9289

Inj Trauma
989 8

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

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

NPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4 (EPW,04)				3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE 50	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Multiple Shrapnel Wounds

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

040012 APR 03

04APR 0130

1. NAME (Last, First, Middle Initial)		3a. STATUS	3b. SERV.	4. PRECEDENCE	5. GRADE
(b)(6)-4	(b)(6)-4			U P R X	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
50	X MALE / FEMALE			X AMBUL / LITTER		(b)(6)-4

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

17. DIAGNOSIS

(L) elbow / face shrapnel WND

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
3APR03	2340	NKA

20d. DIET: REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (*Specify*) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

MSO4 2-4 mg IV Q20 PRN pain

Ancef 1 gm IV Q8

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

~50 y.o. ♂ c mult shrapnel WNDs (L) elbow & face. elbow washed out, XRs ex.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP (b)(6)-2

AF Form 3

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4	16 17	18 M

19	20	21	22	23	24	25	26	27	28	29	30	31
1	9	4	8					5	0	4		

7. AGE AT ADMISSION; 8. RACE; 9. ETHNIC BACK-GROUND

RELIGION: MVS

10. LENGTH OF SERVICE			ETS	11. FMP	
32	33	34		35	36
				2	0

(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46 M	1741	

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
N	O		K	7	5									

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
									B		

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 7	81 82 83 84 85 86
		0 3 0 4 0 3 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 3

FOR LOCAL USE

Multiple scrapnel wounds

Dx. [illegible] Trauma [illegible] 8608 X 2

ADMITTING OFFICER (b)(6)-2

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

DA FO

EDITION OF MAY

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
5	5	4																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	7	9		8																	

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(6)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2786

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	33Y					

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20	(b)(6)-4		

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW K-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

multiple SHRapNeL WOaNdS

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

040012 APR03

04APR 0130

1. NAME (b)(6)-4

3a. STATUS: GPW

3b. SERVICE: BRA-A

4. PRECEDENCE: U | P | R X

5. GRADE

6. AGE: 33

7. SEX: X MALE | FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F): AMBUL | X LITTER

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3

15a. DESTINATION FACILITY (b)(3)-1

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS

16a. MED | 16b. NON-MED

17. DIAGNOSIS

(B) leg shrapnel wounds

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE: 3APR03

20b. TIME: 2330

20c. ALLERGIES: NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

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

PEDIATRIC: AGE | OTHER (*Specify*)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

MSO4 2-4mg IV Q2° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME

21b. TEMP:

21d. RESP:

21c. PULSE

21e. BP

22. BRIEF NARRATIVE

33yo. ♂ c (B) LE shrapnel injuries. Pt. taken for OR washout, stable now for X-Sfer.

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

24. STAMP AND SIGNATURE OF FLIGHT SURGEON (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

(b)(3)-1

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 19700101	27 28 29: 33Y	30	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1900	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K78 EPW	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: GMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78	81 82 83 84 85 86: 0 3 0 4 0 3 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 3

FOR LOCAL USE

Multiple shrapnel wounds

449

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

DA FORM 2965, MAR 69 EDITION OF MAY 79 IS

MEDCOM - 2789

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	7	9		8																	

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b-(6)(a)	b-(6)(a)

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2791

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

(L) eye Rupture, (L) CHeek Lac; (L) Scalp Lac

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

0400|2 APR03 "r" SN TIME 0130

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4	(b)(6)-4	EPW	IRAQI	U P R X	

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11.ACCEPTING MD	12.CITE/AUTH #
~40	X MALE / FEMALE			X AMBUL / LITTER		(b)(6)-4

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

17. DIAGNOSIS

(L) eye globe rupture

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
3APR03	2330	NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify)

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV @ 8°

Percocet 1-11 p.o. Q6° PRN pain

Motrin 800 mg Q8° PRN pain

MSO4 2-4 mg IV Q10 PRN severe pain

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

~40 y.o. ♂ c̄ (L) globe traumatic rupture. Pt. stable for EVac for enucleation.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. S (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
(b)(3)-1		(b)(6)-4	(b)(6)-4 (b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19630101	40Y			

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1741	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
			YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D EMF	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XFR	(b)(3)-1	030403 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		030403

FOR LOCAL USE

Dx: (L) eye ruptwe; (L) cheek lac; (L) scalp lac.

Trauma

Trauma

459

Dx: 8715
87351
8731
E9919

ADMITTING OFFICER (b)(6)-2

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

DA FORM [illegible] OBSOLETE

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	7	1		0				8	7	3		4	1			8	7	3		0	

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(3)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2796

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 35	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETC	10. PREVIOUS ADMISSION
11. FMP 20	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) Open humerus Fx S/p GSW

(R) ~~[illegible]~~ Ps Y/Lite qL GSW c̄ open (L) Knee/tibial/fibula Fx

(R) Flank GSW

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

04001ZAPR07 MSI TIME 0130

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4	(b)(6)-4	EPW	IRAQI	U / P / R X	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
~35	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (R) flank, (R) leg, (L) arm

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
3 APR 07	2320	NKMA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Lovenox 80mg SQ Q12°
ASA 325mg GRD
MSO4 7.40mg IV Q 1° PRN pain
Phenergan 12.5mg IV Q4° PRN nausea
Ancef 1gm IV Q8°
Cefoxitin 2gm IV Q8°

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

EPW S/P GSW (R) flank, RLE, (L) arm. Pt. S/P ex lap, (R) popliteal artery graft. Pt. also c̄ severe trauma to (L) upper arm, wound packed & dressed, pt stable for x-port

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

N

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3039 (455 AES Excel version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(3)-1	

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
1968 06 01	35	0	9	MUS.

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	M	1900	CIV

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N O	K 7 8 EPW	

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
EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
XFR		03 04 03 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		03 04 03

FOR LOCAL USE

(L) Open humerus fracture s/p GSW
(R) popliteal GSW with open Femur/Knee/Tibia/Fibula fracture
(R) Flank GSW.

450

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

SIGNATURE (b)(6)-2

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

MEDCOM - 2799

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
3	4	Y																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
137	138	139	140	141	142	143	144
		8	1	2		5	0

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152
		8	2	0		0	0

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160
		8	2	2		0	0

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168
		8	2	3		8	0

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176
		8	7	9		4	

41 SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*							
201	202	203	204	205	206	207	208

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS (All Facilities)	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2801

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 90		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 20	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	17:05	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 K 7 8 EPW	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 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 D EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79	81 82 83 84 85 86 0 3 0 4 0 3 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 4 0 3

FOR LOCAL USE

Dx: ESW + Abdomen

Dx 8792 E849.0

Ins Trauma

(b)(6)-2

ADMITTING OFFICER (Sign

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

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2803

NPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7.	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW (L) Hand

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

040012 APR03

04APR0130

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial): (b)(6)-4
2. SSN: (b)(6)-4
3a. STATUS: EPW
3b. SERVICE:
4. PRECEDENCE: U P [X] R
5. GRADE:
6. AGE:
7. SEX: [X] Male [ ] Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): [X] AMBULATORY [ ] LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.: (b)(6)-4
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER:
15a. DESTINATION FACILITY: (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER:
16. NUMBER OF ATTENDANTS: 16a. MEDICAL: 16b. NON MED:

17. DIAGNOSIS: Gunshot wound left wrist

18. [X] BATTLE CASUALTY [ ] DISEASE [ ] NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOMITING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			CARDIAC	j.			SELF-CARE	o.			OTHER

20. PHYSICIAN'S ORDERS
20a. DATE:
20b. TIME:
20c. ALLERGIES: PCN
20d. DIET: [X] NPO [ ] SOFT/NA [ ] CARDIAC [ ] DIABETIC ____ CALS
ADVAN ____ Gm prot ____ Gm Na ____ mEq K ____ mg PO4
TUBE ____ TYPE ____ NGT, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: ABS ____ [ ] OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr
20e. IV/BLOOD
20f. SPECIAL EQUIPMENT: [ ] TRACTION [ ] ORTHOPEDIC BRACES
[ ] SUCTION [ ] IV PUMP [ ] CHEST TUBE/HEIMLICH
[ ] NG TUBE [ ] TRACH [ ] RESTRAINTS
[ ] STRYKER FRAME [ ] MONITOR [ ] OTHER (Explain in 23)
[ ] INCUBATOR [ ] FOLEY
O2: LITERS: ROUTE:
[ ] VENTILATOR SETTINGS
20g. ALTITUDE RESTRICTION: Ø
20h. RECORDS TO ACCOMPANY PATIENT
[ ] OUTPATIENT RECORDS [X] X-RAYS [ ] FINANCIAL
[X] INPATIENT RECORDS [ ] OB RECORDS [ ] OTHER (Specify)
[ ] NARRATIVE SUMMARY [ ] DENTAL RECORDS
20i. MEDICATIONS/TREATMENTS
Ancef 1 gm IV Q 8°
MSO4 2-4mg IV Q 20 PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
Gunshot wound at close range to (L) wrist. EVD 4/3/03 Women left open & drain in place. Splinted & placed on IV (b)(6)-2

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

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

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26 1 9 8 1 0 1 0 1	27 28 29 2 2 4	30	31	MWS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1800	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 K 7 8 EPW	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 B	YEAR [Y] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0 EMT	3 ICU	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND L (b)(3)-1 TY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED T (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 2 1	75 76 77 78 79 80	81 82 83 84 85 86 0 3 0 4 0 3 2300

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 4 0 3

FOR LOCAL USE

GSW (L) hand

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

SIGNATURE OF A (b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2806

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
2	2	4																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	8	2		0																	

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
b(3)-1	b(3)-1

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 1			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2808

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. (b)(6)-4		3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 20		(b)(6)-4		13. ORGANIZATION		14. WARD
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-04	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION 03-04-03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 80 11 11	23 Y			Muslim

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1800Hrs	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME OF NEAREST RELATIVE OR GUARDIAN
72 O GMT	7CU3	(b)(6)-4 (Father)

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(6)-4	(b)(3)-1	(b)(6)-4

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XFR	(b)(3)-1	03 04 04 0800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		03 04 03

FOR LOCAL USE

O SPEAKS PERFECT ENGLISH

(L) Knee GSW

89.0
99912

Inj Trauma
450

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

SIGNA (b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2810

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 26	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN		13. ORGANIZATION			14. WARD ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS EPW	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION ERA					22. HOURS OF ADMISSION 1242	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE (b)(6)-4				25. TYPE DISPOSITION XFR		26. DATE OF DISPOSITION 030408		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 030404		ADMITTING OFFICER Maj (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION 030404		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: R flank penetration wound R forearm injury

CODING INFORMATION: 959.3,879.4

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(3)-1	

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
1 9 7 6 1 1 1 1	2 6 Y			MUS

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1242Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	(b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	(b)(6)-4

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XPR	(b)(3)-1	0 3 0 4 0 8 1800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		0 3 0 4 0 4

FOR LOCAL USE

DX (R) FLANK penetration wound (R) forearm injury
DX: 8921
E9112
Trauma

ADMITT (b)(6)-2

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

SPC

HSO

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

MEDCOM - 2812

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	61		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1500	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	XFR	030505

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Yosefia-Alrshid		030404	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to R shoulder + R wrist

CODING INFORMATION: 880.00,881.02

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

[redacted]

T-201. ICU #3

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
[redacted]	[redacted]	[redacted]	[redacted]	U P R ✓	[redacted]

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
6	☐ MALE ☐ FEMALE			AMBUL ✓ LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
	[redacted]	[redacted]	16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER 558-[redacted]	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

(R) shoulder GSW; open clavicle/acromion Fracture

(R) open distal radius Fracture

18. ☐ BATTLE CASUALTY ☐ DISEASE ☐ NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
05 APR 03	0100 Z	

20d. DIET ☐ REG ✓ ☐ 3GM NA ☐ CARDIAC ☐ DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ ☐ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

morphine 1-5 mg IV/IM q 3-4 hrs PRN pain.

phenergan 25 mg IV q 4-6 hr PRN

ancef 2 gm IVPB q 8 hr

21. PRE-FLIGHT VITALS

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

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

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

22. BRIEF NARRATIVE

6 / y.o. Female involved in MVA

GSW to (R) shoulder (open Fx).

and (R) wrist (open distal radius Fx.).

pt is s/p DPI and CSC to (R).

pt. referred to neuro echelon for further care.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING [redacted] M.D.

[redacted]

LTC, MC, USA
ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

✓

(b)(6)-4

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
1 2 3 4 5 6 (b)(3)-1	7 8	9 10 11 12 13 14 15 (b)(8)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 4 7 0 1 0 1	27 28 29: 6 1 Y	30	31	Muslim

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46 M	1500 Z	

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 B	YEAR; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O EMT	ICU 3	(b)(6)-4 (Daughter

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(6)-4	(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74: XPR	75 76 77 78 79 80	81 82 83 84 85: 0 3 0 5 30

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

GSW to (R) shoulder + (R) wrist

1450

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

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

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142
6	1	Y																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
143	144	145	146	147	148	149	150
		8	8	0		0	0

37. SECOND DIAGNOSIS							
151	152	153	154	155	156	157	158
		8	8	1		0	2

38. THIRD DIAGNOSIS							
159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS							
167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS							
175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS							
183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS							
191	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS							
199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*							
207	208	209	210	211	212	213	214

45. SECOND PROCEDURE							
215	216	217	218	219	220	221	222

46. THIRD PROCEDURE							
223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE							
231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE							
239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE							
247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE							
255	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE							
263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	59		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1509	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: multiple GSW lower extremity

CODING INFOMATION: 879.8

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 19 ~~19~~ 4 0 1 0 1	29 ~~29~~ 1	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45 (b)(3)-1

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1509Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 K 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 ERA	ICU 3	(b)(6)-4 (b)(6)-4 (b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (b)(6)-4

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XPR	75 76 77 78 79 80 FWD	81 82 83 84 85 86 0 3 0 4 0 5 1800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 4 0 4

FOR LOCAL USE

DX: Multiple GSW Lower Extremities

DX: 8[illegible]

Trauma

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

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

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

MEDCOM - 2818

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
4	9	4																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
137	138	139	140	141	142	143	144
		8	7	9		8	

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176

41 SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*							
201	202	203	204	205	206	207	208

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

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

MEDCOM - 2819

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2820

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	24		Mus			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78 20			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N					BAT

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1950z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Baghdad, Radwania		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: L head Laceration, L thigh GSW

How: Unknown

Where: Unknown

When: Unknown

CODING INFORMATION: 910, 890

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4		EPW		U P R X	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITIZENSHIP #
	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
	212TH MASH		16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3 558-4987	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS: Laceration of (L) hand / GSW to (L) thigh

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE: 5/18/03 | 20b. TIME: 0630 | 20c. ALLERGIES: NKA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ | OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

NS w 200 cc/hr

~~Ancef~~ 1g IVPB [redacted] (b)(6)-2

Ancef

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

24 yo c laceration of (L) hand / GSW to (L) thigh

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN: (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON: (b)(6)-2

AF Form 3899 (433 AES E

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 9 0 1 0 1	27 28 29: 2 4 Y	30	31	MOS

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1950Z	EPW

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 / [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: ER17	ICU3	~~[illegible]~~ F/[redacted] (b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): BAGDAD ~~[illegible]~~ BADWANIA (b)(6)-4

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XPR	(b)(3)-1 75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 0 5 1800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

① Head Laceration

① Thigh GSW

DX: 8910
8739
E9912

450

Trauma

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

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

DA FORM 2985, MAR 89

MEDCOM - 2823

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N					Bat

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1954z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 Iraq	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to B thighs

How: Unknown

Where: Unkown

When: Unknowns

CODING INFORMATION: 890.0

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4 DISPV

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

(b)(6)-4

2. SSN: EPW

3a. STATUS: EPW

3b. SERVICE

4. PRECEDENCE: U P R

5. GRADE

6. AGE: 27

7. SEX: Male [X] Female

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A-5F): AMBULATORY [X] LITTER

11. ACCEPTING PHYSICIAN

12. CITE/AUTHORITY NO: (b)(6)-4

13. APPT/SURG DATE

14a. ORIGINATING FACILITY

14b. ORIGINATING FACILITY PHONE NUMBER

15a. DESTINATION FACILITY

15b. DESTINATION FACILITY PHONE NUMBER

16. NUMBER OF ATTENDANTS: 16a. MEDICAL 16b. NON MED

17. DIAGNOSIS

s/p GSW THIGH LEFT & RIGHT

18. BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION EXCESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ASSISTANT SUPPLY OF MEDS
e.			EARACHE	j.			SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE | 20b. TIME | 20c. ALLERGIES

20d. DIET: REG | SEMI-NA | CARDIAC | DIABETIC ____ CALS

RENAL ____ Gm prot ____ Gm Na ____ mEq K ____ mg PO4

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

PEDIATRIC: ABS ____ OTHER (Specify) ____

TPN: Change to D10 at ____ cc/hr for max of ____ days

TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		ORTHOPEDIC BRACES
	NG TUBE		IV PUMP		CHEST TUBE/HEIMLICH
	STRYKER FRAME		TRACH		RESTRAINTS
	INCUBATOR		MONITOR		OTHER (Explain in 23)
			FOLEY		

O2: LITERS: ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		X-RAYS		FINANCIAL
	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

(L) GSW (B) THIGH DEBRIDED, WRAPPED OUT

(R) NO FEMUR FRACTURE

23. ASSESSMENT/PROGRESS

DATE/TIME | NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 19 60 10 01	27 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1954z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 EMT	ICU 3	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 (Y Y M M D D)
XFR	(b)(3)-1	0 3 0 4 0 5 0530

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		0 3 0 4 0 4

FOR LOCAL USE

GSW (B) thighs

Dx: 8901
E9912

Trauma

1450

ADMITTING OFFICER (Signature, rank and title)
(b)(6)-2

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

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2826

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	9	0		0																	

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

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

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

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

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2828

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	27	O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
(b)(6)-4			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N					Inj

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	2018z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 / Iraq	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: EX LAP, GSW Abdomen

How:

Where:

When:

CODING INFORMATION: 879.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1830
5APR

1. NAME (Last, First, Middle Initial): (b)(6)-4
2. SSN: (b)(6)-4
3a. STATUS: EPW
3b. SERVICE:
4. PRECEDENCE: U | P ✓ | R
5. GRADE:
6. AGE: 23
7. SEX: MALE ✓ | FEMALE
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A TO 5F): AMBUL | ✓ | LITTER
11. ACCEPTING MD:
12. CITE/AUTH #: (b)(6)-4
13. APPT/SURG DATE: 4APR
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER: FCU #3
15a. DESTINATION FACILITY: (b)(3)-1
15B. DESTINATION FACILITY PHONE NUMBER:
16. # OF ATTENDANTS
16a. MED: Ø
16b. NON-MED: Ø

17. DIAGNOSIS
GSW BACK/FLANK
S/P GX LAP

18. | BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.		✓	Cardiac Hx	j.		✓	Self-care
c.		✓	Diabetes	k.	∞	✓	Ambulatory
d.		✓	Respiratory	l.			Ambulatory Aid
e.		✓	Ears/Sinus	m.		✓	Self-meds
f.		✓	Motion Sick	n.			Adequate Supply of Meds
g.		✓	Vision Impaired	o.			Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS
20a. DATE: 4 APR 03
20b. TIME: 2200
20c. ALLERGIES: NKA
20d. DIET: | REG | 3GM NA | CARDIAC | DIABETIC CALS
NPO
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr
20e. IV / BLOOD
20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:
20g. ALTITUDE RESTRICTION: Yes (No) feet
20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS
CT TO WATER SEAL
NG TO GRAVITY

21. PRE-FLIGHT VITALS
21a. DATE / TIME: 4 APR 03
21b. TEMP:
21d. RESP:
21c. PULSE
21e. BP

22. BRIEF NARRATIVE
RECEIVED S/P GX LAP FOR GSW (L) FLANK 1731, HIS 2 4APR 03. CT PLACED, NG PLACED. POSSIBILITY NOW THERAPEUTIC EXPLORATION

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES
	CHEST TUBE
	NO TUBE
	P/E OTHER AVAILABLE

(b)(6)-2
LTC, MC

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN
(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form 3899 (433 AES Ex

#1 (b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(3)-1	

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 0 0 1 1	27 28 29: 2 8 Y	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	2018Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: (b)(6)-4	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: INJ	YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: ERA	ICU3	
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 80: (b)(6)-4	81 82 83 84 85 86: 0 3 0 4 0 5

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

S/P EXLAP
GSW ABD

Dr. [illegible]
Dr. [illegible]
Injured Trauma
HCP

(b)(6)-2

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

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

MEDCOM - 2831

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
2	7	4																	

36. FIRST DIAGNOSIS (Principal Diagnosis)							
137	138	139	140	141	142	143	144
		8	7	9		2	

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176

41 SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE (Principal Diagnosis)							
201	202	203	204	205	206	207	208

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M 21	O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU3

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N		K78			Inj

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	2050z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030410

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Multiple GSW/ shrapnel injuries

How:

Where:

When:

CODING INFORMATION: 879.8

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4				U / P / R X	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
~20	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS
	(b)(3)-1		16a. MED: Ø / 16b. NON-MED: Ø
	14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3 558-(b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

Multiple GSW's

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
6APR03	1745	NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ | OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°

MSO4 2-4 mg IV Q2° PRN pain

IVF LR @ 125 ml/hr

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

~20 y.o. ♂ S/P GSW (L) arm / (L) leg (R) leg. Pt. S/P washout, stable for x-ray

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2 PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 2 0 1 0 1	27 28 29: 2 1 Y	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 2	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	2050Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 7 8 EPW	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: B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE 442 (b)(3)-1

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 (b)(6)-4	81 82 83 84 85 86: 0 3 0 4 1 0 0420

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

Multiple GSW / Shrapnel Injury

DX: 8799 E9419

Trauma

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

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

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

MEDCOM - 2835

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
2	1	4																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	7	9		8																	

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

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

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

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

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

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

MEDCOM - 2836

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 7			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2837

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE O	7. RELIGION Muslim	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No	
11. FMP K79		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICU1	
15. FLYING STATUS N	16. RATING/ DSG	17. DEPT./ BEN EPW K-78		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE BAT	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION 2135z	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR	26. DATE OF DISPOSITION 030405		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 030404		ADMITTING OFFICER (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 Iraq					30. DATE OF INTIAL ADMISSION 030404		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Grade III with open fracture R BKA

How:

Where:

When:

CODING INFORMATION: 829.1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

05 [redacted] APR 03
0530 (b)(6)-4

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial): (b)(6)-4
2. SSN:
3a. STATUS:
3b. SERVICE:
4. PRECEDENCE: U P R X
5. GRADE:
6. AGE: 35
7. SEX: X Male / Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): AMBULATORY / X LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.: (b)(6)-4
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3
15a. DESTINATION FACILITY: (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER:
16. NUMBER OF ATTENDANTS: 16a. MEDICAL: Ø 16b. NON MED: Ø

17. DIAGNOSIS
S/P (R) leg amputation

18. X BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.	X		AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.		Ø	AMBULATORY AID
c.			DIABETES	h.			VOMITING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARACHE	j.			SELF-CARE	o.			OTHER

20. PHYSICIAN'S ORDERS
20a. DATE: 5 APR 03
20b. TIME: 0030
20c. ALLERGIES: NKDA
20d. DIET: X REG / SOFT-NA / CARDIAC / DIABETIC ____ CALS
RENAL ____ Gm prot ____ Gm Na ____ mEq K ____ mg PO4
TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC AGE ____ OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr
20e. B/BLOOD
20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		ORTHOPEDIC BRACES
	NG TUBE		IV PUMP		CHEST TUBE/HEIMLICH
	STRYKER FRAME		TRACH		RESTRAINTS
	INCUBATOR		MONITOR		OTHER (Explain in 23)
			FOLEY		

O2: LITERS: ROUTE:
VENTILATOR SETTINGS
20g. ALTITUDE RESTRICTION:
20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	X-RAYS		FINANCIAL
✓	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS
Ancef 1 gm IV Q8H
Percocet 1-2 p.o. Q6°
PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
~35 y.o. Iraqi c trauma RLE
S/P (R) BKA prior to X-Sec
to MASH. Pt. stable for
evac.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

(b)(6)-2
24.

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 8 0 1 0 1	27 28 29: 3 5 Y	30	31	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	2135Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K Z 8 EPW	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: B	YEAR / [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFK	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 0 5 0530

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

GRADE III with open fx (R) BKA Dx: 8971 89912

Injury 450 Trauma 1

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

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2

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

MEDCOM - 2840

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT / BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N		K-78			BAT

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	2140z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030406

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 Iraq	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW L Arm

How:

Where:

When:

CODING INFORMATION: 884.0

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

06 0630 Apr 03
0' 1630 Apr 03

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITIZENSHIP #
30	MALE / FEMALE			AMBUL / LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (L) Arm

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
05 April 03	2215 2w/n	NKDA

20d. DIET: ✓ REG | 3GM NA | CARDIAC | DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ OTHER (Specify) ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Clindamycin 600 mg
IVPB q 6°

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

30 year old male GSW (L) Arm superficial of Fracture
n/vtg

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN
(b)(6)-2
1 MD

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(6)-4

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.)
(b)(3)-1	I Z

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19730101	304			

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		2140z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 GPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		B	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
GMT	ICU	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	(b)(3)-1

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
XPR	OMA	030406

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030404

FOR LOCAL USE

GSW (L) Arm

DX: SSCB

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

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

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
143	144	145	146	147	148	149	150
		8	8	4		0	

37. SECOND DIAGNOSIS							
151	152	153	154	155	156	157	158

38. THIRD DIAGNOSIS							
159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS							
167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS							
175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS							
183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS							
191	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS							
199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*							
207	208	209	210	211	212	213	214

45. SECOND PROCEDURE							
215	216	217	218	219	220	221	222

46. THIRD PROCEDURE							
223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE							
231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE							
239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE							
247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE							
255	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE							
263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE O	7. RELIGION Muslim	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No	
11. FMP ~~K78~~ 20		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICU3	
15. FLYING STATUS N	16. RATING/ DSG	17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE BAT	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT				22. HOURS OF ADMISSION 2145z	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR	26. DATE OF DISPOSITION 030405		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 030404		ADMITTING OFFICER (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 Iraq					30. DATE OF INTIAL ADMISSION 030404		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: R facial and R posterior had 2nd Degree burns, R lower extremity shrapnel injury

How:

Where:

When:

CODING INFORMATION: 941.20, 944.28, 904.8

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R ✓	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/AUTH #
	✓ MALE / FEMALE			AMBUL ✓ / LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
(b)(6)-4	(b)(3)-1	(b)(3)-1	16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER: ICU #2 (b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER	Ø	Ø

17. DIAGNOSIS

(R) facial burns 2°
(R) Leg swaddled wwds
(L) hand burns 2°

18. | BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
5 APR 03	0005	NKA

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC | CALS

RENAL Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Silvadene cream BID
Ancef 1 gm IV Q8°
Percocet 1-2 p.o. Q6°
MSO4 2-5mg IV Q1° PRN severe pain

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

	YES	NO	ISSUE		YES	NO	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.			Cardiac Hx	j.		✓	Self-care
c.			Diabetes	k.	✓		Ambulatory
d.			Respiratory	l.		✓	Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.		✓	Other:
h.		✓	Bleeding Prob.				

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

Iraqi ♂ ~35 y.o. c
2° burns to (R) face, ears
& (L) hand & swaddled wwD (R) leg
S/P I&D/WO. Pt. Stable
for x-port.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. (b)(6)-2 ATTENDING PHYSICIAN

25. STAMPED SIGNATURE OF FLIGHT SURGEON

AF Form 3809 (433 AES Excel version)

5 Pu (b)(6)-4

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 8 0 1 0 1	27 28 29: 3 5 Y	30	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	2145	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 7 8 EPW	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; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 EMT	ICU 3	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 (Y Y M M D D)
73 74: XFR	75 76 77 78 79: (b)(3)-1	81 82 83 84 85 86: 0 3 0 4 0 5 0530

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

(A) facial + (B) posterior hand 2nd degree burns
(C) Lower Left shrapnel injury.

Dx: 8911
94420
6807
[illegible]
Dislocation Trauma
9909

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

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

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

MEDCOM - 2847

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		9	4	1		2	0			9	4	4		2	8			9	0	4		8	

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

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

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

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
25	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

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

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

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2849

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
~~K78~~ 20			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N		K78			BAT

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	2350z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 Iraq	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to L neck

How:

Where:

When:

CODING INFORMATION: 874.8

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R X	5. GRADE

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11.ACCEPTING MD	12. CITIZENSHIP #
30	X MALE / FEMALE			X AMBUL / LITTER		(b)(3)-1

13.APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS 16a. MED	16b.NON-MED
(b)(6)-4	(b)(3)-1		Ø	Ø
	14b.ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

GSW (L) neck

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
5 APR 03	0020	NKA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. T / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°

Percocet 1-II p.o. Q6° PRN pain

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

~30 y.o. Iraqi ♂ c GSW

Q neck, s/P washout & wND closure

pt. stable for x-port

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. (b)(6)-2 AN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3809 (433 AES Excel version)

MEDCOM - 2851

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 (b)(3)-1
2. MTF LOCATION (State or Country Code): 7 8 I Z
3. REGISTER NUMBER: 9 10 11 12 13 14 15 (b)(6)-4
4. PAY GRADE: 16 17
5. SEX: 18 M
NAME (Last, First, Middle Initial): (b)(6)-4
6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — 1 9 7 3 0 1 0 1
7. AGE AT ADMISSION: 27 28 29 — 3 0 4
8. RACE: 30
9. ETHNIC BACK-GROUND: 31
RELIGION
10. LENGTH OF SERVICE: 32 33 34
ETS
11. FMP: 35 36 — 20
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS: 46
HOUR OF ADMISSION: 2350Z
BRANCH / CORPS
14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8
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 B
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 0 EMT
WARD: ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
21. TYPE OF DISPOSITION: 73 74 XFR
22. MTF TRANSFERRED TO: 75 76 77 78 79 80 (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 4 0 5 0030
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 — 0 3 0 4 0 4
FOR LOCAL USE

GSW (L) NECK

DX: 8749
E9712
PX: 8628
8659
TRAUMA
1
450

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

EDITION OF MAY 79 IS OBSOLETE.

DA FORM 2985, MAR 85

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS (Principal Diagnosis)	37. SECOND DIAGNOSIS	38. THIRD DIAGNOSIS
137 138 139 140 141 142 143 144	145 146 147 148 149 150 151 152	153 154 155 156 157 158 159 160
8 7 4 8		

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

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

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

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

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

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

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ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

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INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
~~K78~~ 20			ICU3

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N		K-78			BAT

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	2159z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030404	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 Iraq	030404	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: R open tibia fx, L pneumothorax

How:

Where:

When:

CODING INFORMATION: 823.90, 512.8

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4		EPW		U / P✓ / R	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
UNK	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (B) Leg / (D) Chest

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
5 APR 03	0629 Z	NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

CHest Tube	SUCTION		TRACTION		ORTHO BRACES
	NG TUBE		IV PUMP	X	CHEST/HEIMLICH
	STRYKER		TRACH		RESTRAINTS
	INCUBATOR		MONITOR		OTHER (USE 23)

X FOLEY CATH

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

LR @ 125 cc/HR

ALBUTEROL MDI II puffs q4

A-TROVENT MDI II " " q4

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

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

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
5 APR 03	21d. RESP:		

22. BRIEF NARRATIVE

GSW (B) Leg / (D) Chest

seen @ US - ex fix / fasciotomy

Chest tube

H/o ASTHMA

received MDAS

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES
A/E	To Definitive Care -

(b)(6)-2

24. STA[redacted]HYSICIAN

AF For[redacted]

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. (b)(6)-4	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R	5. GRADE
6. AGE	7. SEX ☐MALE ☐FEMALE	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)-- AMBUL / X / LITTER	11.ACCEPTING MD
13.APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY		16. # OF ATTENDANTS	
	14b.ORIGINATING FACILITY PHONE NUMBER	15B. DESTINATION FACILITY PHONE NUMBER		16a. MED	16b.NON-MED

17. DIAGNOSIS

Right open femur shaft fracture
2° GSW

18. ☐BATTLE CASUALTY ☐DISEASE ☐NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES

20d. DIET ~~UREG~~ ☐3GM NA ☐CARDIAC ☐DIABETIC CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ ☐OTHER (Specify) ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or ___ LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS
✓	INPATIENT RECORDS		OB
	NARRATIVE SUMMARY		DENTAL
	FINANCIAL		

OTHER:

20i. MEDICATIONS / TREATMENTS

morphine 1-6mg IV/IM q 3-4hr PRN pain!
Phenergan 25mg IV, 4-6hr PRN
Bncf 1gm IVPB q 8hr
~~Gentamycin 150mg IVP q 8hr~~ (b)(6)-2

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

Thigh EFC fixation GSW
to (R) Fem (2) shaft open fx,
Pt sip DPE Ex-Fix,
Pt upgraded Overall for further care

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2 M.D.
LTC, MC, USA
ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ICU 3

(b)(6)-4

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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
(b)(3)-1	I 2	(b)(6)-4	EPW (b)(6)-4		M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		2 0	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		21:59	(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	N 7 8	

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
EMT	ICU	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XFR	(b)(3)-1	0 3 0 4 0 5 1800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		0 3 0 4 0 4

FOR LOCAL USE

Dx: (R) open thin fx
(L) pneumothorax

Dx 8601

831

(b)(6)-2

(b)(6)-2

MAJ LISA M
Multiples Test Board
DEPT OF OB/GYN

ADMITTING

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

450 1

DA FORM

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2858

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	8	3		9	0			5	1	2		8									

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

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

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

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

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

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