Ward/Section: ICU	Requesting Physician: Dr. (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	8.4	4.8-10.8 x 10
RBC	5.39	4.7-6.1 x 10
Hgb	15.1	14-18g/dl (M) 12-16 g/dl (F)
Hct	46.7	45-52% (M) 37-47% (F)
MCV	86.7	80-94 fl (M) 81-99 fl (F)
Plt	160	130-500 x 10 Verified
Lymph %	15.9	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	trace	Negative
pH	7.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Inadequate specimen to perform microscopic UA.

Remarks:

R (b)(6)-2	DATE: 20 Aug 03	LAB ID NO:

Ward/Section: SMT	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE / TIME	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	17.8	4.8-10.8 x 10
RBC	5.75	4.7-6.1 x 10
Hgb	16.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	50.4	45-52% (M) 37-47% (F)
MCV	87.7	80-94 fl (M) 81-99 fl (F)
Plt	181	130-500 x 10 Verified
Lymph %	7.0	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Slightly	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	MOD	Negative
pH	5.0	N/A
Prot	Small	~~Negative~~ Small
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk		Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	129	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	241	39-380 u/l (M) 30-190 u/l (F)
NA*	136	128-145 mmol/l
K*	4.1	3.3-4.7 mmol/l
CL*	104	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB	4.3	3.5-5.5 g/dl
ALP	94	26-84 u/l
ALT	22	10-47 u/l
AMY	63	14-97 u/l
AST	32	11-38 u/l
TBIL	1.2	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA**	9.2	8.0-10.3 mg/dl
CHOL	171	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	132	73-118 mg/dl
TP	7.3	6.4-8.1 g/dl

MISC

Results:

(b)(6)-4

J Ra

ID: (b)(6)-4 20-08-03
WB 01:02

			Patient Limits	
WBC	17.8 H	x10^3/uL	4.5	10.5
RBC	5.75	x10^6/uL	4.00	6.00
Hgb	16.2	g/dL	11.0	18.0
Hct	50.4	%	35.0	60.0
MCV	87.7	fL	80.0	100.0
MCH	28.2	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	181.	x10^3/uL	150.	450.
LY%	7.0 * L	%	20.5	51.1
LY#	1.2 *	x10^3/uL	1.2	3.4

Microscopic UA

(b)(6)-2

Rus -
rpt. MOD
at - few

Remarks

Reported by: (b)(6)-2	DATE: 20 Aug 03	LAB ID NO:

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
C-Spine Flex/Ext		M	(b)(6)-4	ICW	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

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

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 REQUEST/REPORT

MEDCOM - 7016 RD

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

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: 20 Aug 03 TIME OF ORDER: 0130 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
2. Dx CHI, Cervical Strain, Belbow Contusion S/p Fall
3. Cond Stable
4. VS q Shift
5. NKDA.
6. Clear Liq Diet.
7. IV NS @ ~~125~~ 200 cc/hr

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8. MSO4 5mg IV q 2-4° prn
9. Neuro ✓'s q 2° Foley, Ice to Belbow.
10. C-Spine Flex/Ext Xrays in AM.
11. UA @ 0800
12. TYL 325 mg T-II po q 4-6° prn

(b)(6)-2

ICU RN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 AUG TIME OF ORDER: 0210 HOURS

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

Phenergan 25 mg IV q 8° PRN nausea

ICU RN

(b)(6)-2 20 AUG 03 0210

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 AUG 03 TIME OF ORDER: 1030 HOURS

1. D/C Foley. CBC XT today

(b)(6)-2

2. Advance diet to regular

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

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

MEDCOM - 7017

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				20 Aug 03	1400 HOURS	
				✓ ① Transfer to ICW		
				✓ ② Resume Previous Orders		
				V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2		noted (b)(6)-2 20 Aug 03 1820
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				21 AUG 03	HOURS	
				D/C		
				MED- MORPHIN, TYLENOL 3		
				ACT- NO DRIVING WHILE TAKING TYLENOL 3		
NURSING UNIT	ROOM NO.	BED NO.				

No test (b)(6)-2 issued

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

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

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21												
20AUG	(b)(6)-2	VS q Shift	06	✓ (b)(6)-2												
			18	(b)(6)-2												
20AUG	(b)(6)-2	CIR liq Diet	06	✓ (b)(6)-2												
			18	(b)(6)-2												
20AUG	(b)(6)-2	Neuro V's q 2°	06	✓ (b)(6)-2												
			18	(b)(6)-2												
20AUG	(b)(6)-2	Foley Care q Shift	06	✓ (b)(6)-2												
			18	(b)(6)-2												
20AUG	(b)(6)-2	Ice to (R) elbow	06	✓ (b)(6)-2												
			18	(b)(6)-2												
20Aug	(b)(6)-2	Advance diet to Regular	06	✓ (b)(6)-2												
			18	✓ (b)(6)-2												

O/c'd @ 1100

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: CHI Cervical Strain, (R) elbow Contusion S/P Fall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 08 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Aug	(b)(6)-2	Admit to ICU	20Aug	20Aug	0210	(b)(6)-2
20Aug	(b)(6)-2	Cond Stable	20Aug	20Aug	0210	
20Aug	(b)(6)-2	C-Spine Flex/Ext Xrays in AM	20Aug	0700	Dm	
20Aug		UA @0800	20Aug	0800	0800	
20Aug		CBC x 1	20Aug	1130	1130	
20Aug		Transfer to ICW	20Aug	1400	1400	
20Aug		Resume Previous orders	20Aug	1400	1400	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

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

Mo. AUG Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				18 30 21
20 AUG	(b)(6)-2	IV NS @ 200 cc/hr	06	(b)(6)-2
			18	(b)(6)-2
21				

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
CHI, Cervical Strain, R elbow Contusion
S/P Fall

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

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20 AUG	(b)(6)-2	MSO4 5mg IV q2-4°	D T													
		PRN pain	Dose													
			I													
20 AU	(b)(6)-2	Phenergan 25mg IV	D T	20 Aug 0210												
		q8° PRN nausea	Dose	IVP 25mg												
			Initial	SL												
20 Aug 03	(b)(6)-2	Tylenol 325mg 1-11	D T	20 Aug 0210	20 Aug 0830	20 Aug 1925										
		PO q4-6° PRN	(b)(6)-2													
			I	SL												

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Pupils 3 mm react.					
	SENSORIUM	AOX 3. Responds to					
		commands appropriately					
		MAE x4. Cpo clear c					
		(c) elbow pain					
RESPIRATORY	RESPIRATORY PATTERN	Even & unlabored.					
	BREATH SOUNDS	Lungs CTA w/ all fields					
	SECRETIONS	∅ crackles on RA 1L/O					
		∅ secretions					
SKIN	COLOR	Pink, No evidence of					
	INTEGRITY	breakdown, ∅ abrasions					
IV SITE	LOCATION	IV #18G to (L)					
	CONDITION	Patent. NSS infusing					
		@ 200ml/hr ∅ infiltration					
GASTRO	ABDOMEN	BS x4 Quadrants.					
	BOWEL SOUNDS	∅ evidence of nausea					
		at this time. No tenderness					
		on guarding & palpation					
GU	URINE	Foley to gravity					
	COLOR/CLARITY	Clear yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus rhythm in 50's					
		PR. 16 by .10 ∅					
		ectopy. Pulses 2+ to					
		all extremities.					

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SaO - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 20 Aug 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | PAGE | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
	BP Arterial Line																	
	BP Cuff	111/44	115/50	118/51	116/45	115/40	112/50	117/40	110/50									
	Temperature	96.4					97.3											
	Pulse	63	66	64	59	63	58	62	71									
	Respiratory Rate	13	13	20	13	13	17	15	18									
	O2 Sat	99%	99%	97%	97%	97%	99%	97%	99%									
	Oxygen	RA	RA	RA	RA	RA	RA	RA	RA									

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
	NS	200	200	200	200	200	200	200	200									
	TOTALS																	

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
	URINE		200/650	150/800															
		sp gr																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

ST-OP DAY

22	23	24	01	02	03	04	05	

22	23	24	01	02	03	04	05	8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME								
		MODE								
		F_IO_2								
		TV								
		RATE								
		PEEP								
	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME															
	MOUTH CARE															
	BATH															
	SKIN CARE															
	FOLEY CARE															
	TRACH CARE															
	ROM EXERCISES															

TURN	TIME															
SUCTION																

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE

INITI

(b)(6)-2

(b)(6)-2

NEUROLOGICAL ASSESSMENT

		HOURS	06	08	10	12	14	16	18
EYES OPEN	SPONTANEOUSLY	4		✓	✓	✓	✓		
	TO SPEECH	3	✓						
	TO PAIN	2							
	NO EYE OPENING	1							
BEST VERBAL RESPONSE	ORIENTED	5		✓	✓	✓	✓		
	CONFUSED	4	✓						
	VERBALIZES	3							
	VOCALIZES	2							
	NO VOCALIZATION	1							
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓	✓	✓	✓		
	LOCALIZES PAIN	5							
	FLEXION WITHDRAWAL	4							
	ABNORMAL FLEXION	3							
	EXTENSION TO PAIN	2							
	NO MOTOR RESPONSE	1							
ARMS	NORMAL POWER		✓	NL		NL	NL		
	MILD WEAKNESS								
	SEVERE WEAKNESS								
	ABNORMAL FLEXION								
	ABNORMAL EXTENSION								
	NO RESPONSE								
LEGS	NORMAL POWER		✓	NL		NL	NL		
	MILD WEAKNESS								
	SEVERE WEAKNESS								
	ABNORMAL FLEXION								
	ABNORMAL EXTENSION								
	NO RESPONSE								
RIGHT	SIZE		4	4		3	3		
	REACTION		++	++		++	++		
LEFT	SIZE		4	4		3	3		
	REACTION		++	++		++	++		
PUPIL SCALE			2	3		4	5	6	7 mm
CEREBRAL PERFUSION PRESSURE									

LEGEND

C Close by swelli

T Trach/Er
S Slurring
D Dyspha
R Receptiv
E Expressi

R Right
L Left

Record separately there is a difference between t two sides.

++ Brisk
+ Slow
- No Respon

+ Intact
- Abnorm

VASCULAR ASSESSMENT

		HOURS	06	08	12	14
Radials	R		++	++	++	++
	L		++	++	++	++
Pedals	R		++	++	++	++
	L		++	++	++	++
	R					
	L					
	R					
	L					
	R					
	L					

LEGEND

++ Norm
+ Weak
- Absen
D Doppl
R Right
L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0230	INITIALS [redacted] b(6)-2		INITIALS		INITIALS
	PUPILS	PERRL					
	SENSORIUM	repetitive questions memory appears short term.					
RESPIRATORY	RESPIRATORY PATTERN	easy, non labored					
	BREATH SOUNDS	clear bilat					
	SECRETIONS	Ø					
		R/A, O2 sat 98%.					
SKIN	COLOR	WNL					
	INTEGRITY	intact					
IV SITE	LOCATION	(R) hand	LAC left elbow				
	CONDITION	dsg + site intact	dsg + site intact				
		NS @ 200cc/hr					
		(+) blood return	flushes easily				
		flushes easily	(+) blood return				
		18 Gauge	18 Gauge				
GASTRO	ABDOMEN	soft flat nontender					
	BOWEL SOUNDS	(+) BS x4 quadrants					
		N/V, Phenergan IV given for emesis.					
GU	URINE:	foley → gravity					
	COLOR/CLARITY	clear yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR ⅰ ectopy					
		(+) pulses x4 ↓					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

PATIENT IDENTIFICATION (If typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

1LT Anv

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19-20 August

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | PAGE | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
	BP Arterial Line																	
	BP Cuff																	
	Temperature																	
	Pulse																	
	Respiratory Rate																	
	O2 Sat																	
	Oxygen Method																	

INTAKE	TIME	06	07	08	09	10	11	12	13	8-7	14	15	16	17	18	19	20	21
	NS																	
	TOTALS																	

OUTPUT		HOUR / TOTAL																
	URINE	10 gr																
		S/A																
	NG	OUTPUT																
		pH																
		GUIAC																
	EMESIS																	
	STOOL																	
	DRAINS																	
	TOTALS																	

(b)(6)-4

ST-OF DAY

ACUITY LEVEL CLASSIFICATION

22	23	24	01	02	03	04	05	
				120/54		119/44	114/41	
				99				
				93	72	73	62	
				18	15	13	14	
				98%	99%	98%	99	
				R/A	R/A	R/A	R/A	
				R/A	R/A	R/A	R/A	

22	23	24	01	02	03	04	05	8° T
				200	200	200	200	
				200	400	600	800	800
								800
					150		925	
					150		1075	1075
				Phenergan 12.5				
				125				125
				Ativan 1 mg				
								1250

RESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
A	pH								
	PCO_2								
	pO_2								
B	HCO_3								
	SAT								
G	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME								
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN	TIME							
SUCTION								

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	800	TOTAL	1200

BALANCE 0400

NURSE'S SIGNATURE [redacted]

INITIALS

062

NEUROLOGICAL ASSESSMENT

		HOURS	02	04
EYES OPEN	SPONTANEOUSLY	4	✓	
	TO SPEECH	3		✓
	TO PAIN	2		
	NO EYE OPENING	1		
BEST VERBAL RESPONSE	ORIENTED	5		
	CONFUSED	4	✓	✓
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1		
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO MOTOR RESPONSE	1		
ARMS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
LEGS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
RIGHT	SIZE		3-4	4
	REACTION		++	++
LEFT	SIZE		3-4	4
	REACTION		++	++
PUPIL SCALE			2	3 4 5 6 7 mm
			N/A	N/A
CEREBRAL PERFUSION PRESSURE			N/A	N/A

LEGEND

C Close by swelli

T Trach/E

S Slurring

D Dyspha

R Recepti

E Express

R Right

L Left

Record separately there is a difference between t two sides.

++ Brisk

+ Slow

- No Respor

+ Intact

- Abnorm

VASCULAR ASSESSMENT

		HOURS	02	04
Radial	R		++	++
	L		++	++
Pedal	R		++	++
	L		++	++
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

++ Norm

+ Weak

- Abse

D Doppl

R Right

L Left

D FORM 1 MAR 63 689

PREVIOUS EDITIONS ARE OBSOLETE.

INDIVIDUAL SICK SLIP

☐ ILLNESS ☒ INJURY

DATE 21 AUG 03

LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT

(b)(6)-4

SERVICE NUMBER/SSN

GRADE/RATE

ORGANIZATION AND STATION

UNIT COMMANDER'S SECTION

IN LINE OF DUTY

REMARKS

SIGNATURE OF UNIT COMMANDER

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY

DISPOSITION OF PATIENT

☐ DUTY ☐ QUARTERS

☐ SICK BAY ☐ HOSPITAL

☐ NOT EXAMINED ☒ OTHER (Specify):

REMARKS NO DRIVING WHILE TAKING CYCLOVR 3. NO PROLONGED DRIVING FOR ONE WEEK

(b)(6)-2

(b)(6)-2 LTC, MC SOIC SERVICE

SIGNAT

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	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 BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29: 2 4 Y	30: X	31: 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34: 2 2 2	b(6)-4	35 36: 9 9	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: U	0050	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: 2 2 2	50 51 52: K 7 ~~0~~ 8	53 54 55 56 57 58 59 60 61: (b)4

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71: 9	YEAR / NO

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
73 74: 0 ~~5~~ 8	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 8 2 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92: A E A A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 8 2 0

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

DX:CONCUSSION
CERVICAL STRAIN
R ELBOW CONTUSION

Dx: 85011
8470
92311
E882

Inj 919

Trauma 8

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

SIGNATURE OF ADMITTING CLERK (b)(6)-2, SSG, PAD, NCOIC

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

MEDCOM - 7032

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGIST (b)(6)-4		2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE X	7. RELIGION ZZZ	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD ICU	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN 91 K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0				22. HOURS OF ADMISSION 1215	23. CLINIC SERVICE ABMA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION DIED		26. DATE OF DISPOSITION 20030826		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 20030825		ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED 0

31. SELECTED ADMINISTRATIVE DATA

PATIENT WAS PRONOUNCED DEAD AT 0512 ON 26 AUG 2003 BY COL (b)(6)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 90% BSA 949.08
TRAMATIC AMPUTATION LEFT HAND 887.0
TRAMATIC AMPUTATION RIGHT HAND 869.0

PROCEDURES: DEBRIDEMENT BURN 86.28
LEFT AND RIGHT BEA 84.03

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

(b)(6)-2 COL, MC

(b)(6)-2 CER SSG, NCOIC, PAD

DA FORM 3647, MAY 79

EDITION OF 1 ...

MEDCOM - 7033

USAPPC V1.10

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

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

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

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

(b)(6)-4

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

2. TIME OF DEATH *(Hour-day-month-year)*: 0512 26082003

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

4. RELIGION: UNKNOWN

5. CHAPLAIN NOTIFIED: ☐ YES ☒ NO

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

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* 90% DEEP PARTIAL & FULL THICKNESS BURN	17 HR
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR [illegible] OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
26 AUG 03	(b)(6)-2 LTC, MC ~~ORTHOPEDIC SERVICE~~	(b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

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

SECTION C - RECORD OF AUTOPSY

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

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

~25 y/o IRAQI NATIONAL c̄ BURNS / BLAST INJURIES IN UXO DECONTRACTION WHILE "SEARCHING BRASS" 1145 TODAY.

PMH
PSH
ALL
MDS
DIABETES
NOS

} UNAVAILABLE - INTUBATED EMERGENTLY

PHYSICAL EXAMINATION ~~INTUBATED ON ANALGESIA O2SAT 75% MANUALLY~~

FULL THICKNESS BURNS ENTIRE ANTERIOR BODY
LUNGS CLR
CVR TACHY NRR
ABD SOFT
GU · GROSS HEMATURIA
EXT BLAST INJ (B) HANDS, (C) MANGLED BEA
(R) · LARGE THIGH DEFECT

PAINS
SCANDS
STS,
ENTER

M 149
M 149
→ 10/28

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

A- >80% ASA
BLAST INJ BUT c̄ OPEN FRS (R) HAND &
(L) BEA
P- ADMIT IN OR. PARKLAND PROTOCOL
FLUID RESUSCITATION

SIGNA (b)(6)-2	DATE 25 AUG 03	IDENTIFICATION NO.	ORGANIZATION
PATI TION (b)(6)-4 *(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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 Aug 03	Time of Burn 1130
11:55	14G IV 1000 ml Lac Ring. 90% Burn
11:55	Tourniquet applied
	144/88 BP 22 Pulse IV Start time 12:30
12:15	10 mg Morphine IV
12:18	Pulse: 75 BP: 71/36 100% RA
12:20	Intubated 8 French
12:20	105/56 BP 97 P
1225	Foley Secured
1229	128/57 BP 85 P 100 RA 2 mg Versed
1230	1000 ml NS. Central line secured
1234	146/64 BP 95 P 100 RA 99.9 T 3 mg Versed
1235	150 m Fentanyl
1235	UA Complete 1000 mL LR
	Bi-lat Pulse (petal) by Doppler
1235	Vecuronium
1239	146/63 BP 89 P 30 R 100 ~~RA~~ 773 Vent
1240	SIMV Rate 16 Tital vol. 700 peep of 5 O2 100%
1242	2g Ancef, 25cc Tetanus 1000 mL LR
1244	121/55 BP 80 P 18 R 100 Vent
1249	169/69 BP 79 P 19 R 100 Vent.
1249	400 mg Gentamicine

TAL OR MEDICAL FACILITY (b)(3)-1

OR'S NAME	STATUS	/SERVICE	RECORDS MAINTAINED AT
			09 08

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

(b)(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
by GSA/ICMR
CFR) 201.9 ...

MEDCOM - 7036

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1254	159/68 BP 77 P 19 R 100% Vent.
1255	1000 ml LR #6
1259	159/76 BP 87 P 19 R 100% Vent
1300	Pulses Bi-lat. pedal By Doppler
1304	142/68 BP 91 P 20 R 100% Vent.
1309	129/68 BP 94 P 19 R 100% Vent
1310	1 unit Blood Transfused
1314	131/83 BP 81 P 19 R 100% Vent
1317	Vecuronium 10mg
1318	1 unit Blood hung
1318	Output 300 cc
1319	1000ml LR #7
1321	2 units of Blood in. (b)(6)-2 ~~9:00~~

STANDARD FORM 600 (REV. 6-97) BACI
*U.S. GPO: 2002 - 491-600/5061

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Aug 03	OP NOTE
1538	PRE-OP DX — 90% FULL THICKNESS BURNS
	POST-OP DX — SP BILAT FOREARM Amputation, Burn Debridement, Bilat LE.
	PROCEDURE — BILATERAL FOREARM AMPUTATIONS, BURN CLEANING
	BILATERAL LOWER EXTREMITY FASCIOTOMIES
	SURGEONS — DRS (b)(6)-2
	FINDINGS — 90% FULL THICKNESS BURNS, BILAT BLAST INJURY to
	BOTH HANDS + Forearms w/ Devitalized Tissue
	DESCRIPTION — GETA. Supraglottal burn wound debridement.
	Bilateral lower extremity Escharotomies, Bilat amputation
	mid forearm performed by Dr. (b)(6)-2. Multiple comorbid
	FX of Both hands and (R) Forearm + Dysvascular. 90% full
	thickness Burns.
	Pt left intubated and transported to ICU —
	Antibio - Ceft 80g, Hrcef 2gm EBL - 200 cc Fluids in 5L
	Uo - 450 cc Drns - NGT/Foley.
	MD
	(b)(6)-2 MAJ, MC USA CHIEF, DOS

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. 5L

(b)(6)-4

PROGRESS NOTES UO 450
Medical Record EBL 200

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1.

LAST NAME | FIRST NAME

DATE	NOTES
25AUG03 1700	GSW Orbit Surg The patient sustained 90% full thickness burns on 12-30 today per exploding ordnance. This is a non survivable injury at this point & will sustain amputee care only. DCCS approved of situation. (b)(6)-2 MD MAJ, MC USA CHIEF, DOS CHIEF, DOS (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Aug 03 @ 1800	Pt Received, Palliative Care Assumed, (L) SC c̄ LR @ 500cc/hr Fentanyl @ 100mcg/hr, Foley to Gravity, Pt Sedated on Vent (b)(6)-2 CPT/AN
2200	Pt Condition unchanged MAP 40-45, Ventilated, Responds to Noxious Stimuli (b)(6)-2 CPT/AN
0100	Pt Condition Unchanged, ⊖ U/O For last 3hrs (b)(6)-2 CPT/AN
0300	Pt B/P Now 40/20's No Response to Noxious Stimuli, ⊖ U/O For last 2hrs (b)(6)-2 CPT/AN
0435	Pt (R) Pupil 5mm + Fixed, (L) 3mm, B/P 32/17 (b)(6)-2 CPT/AN
0508	Pt Fine VF Followed by Asystoly Dr Notified (b)(6)-2
0512	DEATH NOTE CALLED TO SEE PT 2° PEA → VFIB & ASYSTOLE UNRESPONSIVE, PUPILS FIXED DILATED, Ø CORNEAL REFLEX. EKG ASYSTOLE, PRONOUNCED 0512. CAUSE OF DEATH 90% BSA DEEP PARTIAL & FULL THICKNESS BURN. (b)(6)-2 MC ORTHOPEDIC SERVICE

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

PROGRESS NOTES
Medical Record

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

(b)(6)-4

LAST NAME | MIDDLE INITIAL | ID NUMBER

(1 75 kg) 10,500 / 15,100

DATE | NOTES

16 Aug 03 1640 (Received) report on pt, assumed care. Pt admitted to ICU @ 1640 on litter accompanied by ER staff, RN anesthetist, Dr (b)(6)-2, Dr (b)(6)-2. Dopamine infusing @ 5mcg hr / LR @ freeflow. Pt sedated, paralyzed. Intubated, (+) mechanical vent (+) simv; TV @ 700 ml; VR @ 14; FIO2 @ 60% Peep: 5. ETT: 27 @ lip. (+) OGT to LIS. (+) femoral A-Line; (+) foley to gravity. (+) B/L at below elbow amputation. (+) dressing i ace bandages to B/L forearm ext. (+) 2°-3° BSA Burn ≤90% (+) (L) subclavian cath - single lumen c̄ dopamine infusing @ 5mcg/k/min = 7.ml/hr. LR PB'ing Dopamine, (-) evidence of infiltration @ site of insertion. Pain assessments to be notated on DD form 4700.

ER/OR 1800? Grant 7 ER Ancef 1 mg IV Versed - 5mg 200 ESL 450 mini 5000 crystal LR 20 Norm Lab: H: 13.2 H: 40.5

1633 → 1 liter Bolus 69/38 15 kg 1 liter Bolus ↑ Dopa 10 mcg/kg/min 1710 Fentanyl 10cc/hr

1635: Versed 1mg IVP administered. VS unstable. See strip attached c̄ P. Trends. (+) 1 liter Bolus administered per VO Dr Lowry for BP 69/38. No Δ in BP

1706 - Dop stopped 1645: Dopamine ↑ to 10mcg/kg/min. Pressures remain unstable - unΔ'd.

1700: Fentanyl started @ 10cc/hr = 50 mcg/hr. No Δ's in neurologic/cardiac status. Pressures ≤ 50-70 systolically - 40-50's diastolically.

1706: Dopamine stopped per verbal order Dr (b)(6)-2. Pressures remain unΔ'd.

1715: Dr (b)(6)-2, Dr (b)(6)-2 @ BS. No Δ's in plan of care.

LATE PA note: 1700: Burns to face ears lips chest and forearms debrided in OR, (+) silvadene to chest, bacitracin to face. chest open to air, covered only c̄ burn pad.

(b)(6)-2

STANDARD FORM 509 (REV. 5/1999)

USAPA V1.0

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (S): (b)(6)-4

LOG NUMBER

ARRIVAL — DATE: DAY 25, MONTH Aug, YR. 03 — TIME: 1213

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

CURRENT MEDS. (Include immunization and other data): Unk

HISTORY OBTAINED FROM: [X] PATIENT [ ] OTHER (Sp.)

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): (B) Hand Amputation, Burns.

SEX: M — AGE: ~25

POSSIBLE THIRD PARTY PAY: [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 1210

PMHx unk

VITAL SIGNS

TIME	1213	1229
BP	71/36	128/67
PULSE	22	85
RESP.	~30	Bvm
TEMP.	99.9 TM	100%
WGT (Child)	80 RA	~70 Kg

CATEGORY (See reverse)

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

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)

S: Pt is a ~25 yo Iraqi ♂ who was allegedly stealing ordnance that blew up & caught him on fire.
TOI (est) ~1230 Last meal?

O: WD Thin Iraqi ♂ Conversant in mod Resp distress GCS 15 in Severe Dist 2° to burns.
HEENT: NC c̄ Complete S(c)P/face burn. singed mustache. ⊖ Aw burns.
Neck: NT RSM
Chest: Tight Eschar. (D) Bg CTA. Emerg Escarotomy.
Abd: ⊖BS. total Eschar. FAST ⊖
Pelvis Stable NT.
Ext: (R) forearm fx, (L) hand Amp.
LE c̄ (B) ++PP.
90% BSA: sparing (B) feet (4%) ½ (L) UE 6%
+ part of face (1%)

(B) Arm: Comm BB fx + Dra, Rad Base of 5th mt
(L) Arm: Amp @ Carpus
CXR: Tubes in NGT in Esoph. Cent line in ⊖ PTX.
Pelvis: ⊖fx C-spine ⊖fx.

26 | 14.9 / 44.9 | 633
10 / 7.28
7.46/303/68/22/-2/100%
138 | 103 | 10 / 1.4 / 223
Hem 21
CK 15789
Alb 2.4 ↓ TB .8
Ap 52 Cho 70 ↓
ALT 25 TP 5.1 ↓
Amy 5
AST 123

ASSESSMENT/DIAGNOSIS
1) 90% BSA 3° Burn
2) (L) Hand Amp
3) (R) BB FA fx, Thumb fx
4) Rhabdomyolysis
5) Hypovolemic Shock

ORDERS — INITS. — TIME
→ ULR 1800 cc/hr x 7 hr (1230) then 800 cc/hr slow
RSI per Anesth.
Escharotomy.
(L) SC Cent Line
O Neg Trans x 2 u PRBC

CBC, TLC x4, Chem 12, ABG
Foley, UA.
NGT
CXR, C-spine, Pelvis, (R) hand
Ancef 2 gm IV
Td .5 cc IM
Cent 400 mg IV
Vec 10 mg IV

EDC: Scant UO c̄ Red urine that cleared some c̄ IVF resus. Improved BP c̄ Resus p̄ Cent line. Easy to Bag p̄ Escher
Induction Note RSI c̄ Cricoid. # 8.0 ETT @ 24 cm Steth-bed in place on ⊕ETCO2 ⊕BBS. MAC 4 ~~MPII~~ View. Airway edema, swelling
Leading Note (B) Burn (L) IF NEEDED

DISPOSITION (Check all that apply)

HOME	FULL DUTY

QUARTERS: 24 HRS. / 48 HRS. / 72 HRS.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Include clinic): Gen Surg / O Atto.

[ ] EMERGENCY [ ] TODAY
[ ] 72 HOURS [ ] ROUTINE

ADMIT TO HOSP. UNIT/SERVICE: OR → ICU

CONDITION UPON RELEASE

[X] IMPROVED [ ] UNCHANGED
[ ] DETERIORATED

TIME OF RELEASE: 1330

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SS; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

SIGNATURE (b)(6)-2 STAMP: MAJ, MC.

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

To OR.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.)
Prescribed by GSA and ICMR

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: unkn

HEIGHT: "

WEIGHT: "

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION: unknown

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
unknown

4. PROPOSED SURGICAL PROCEDURE:
Burn Debridements, Lt BEA,

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes Intubated	o ~~Pt. verbalizes any specific anxiety~~ Intubated o Pt. Exhibits relaxed body posture. Iraqi civilian Intubated upon arrival to EMT, Emergency Procedure,	o ~~Allow pt. to verbalize feel~~ [redacted] o ~~Explain OR environment a~~ [redacted] questions ~~regarding surgery.~~ o Offer com[redacted]s. (e.g.. warm blanket. touch [redacted] o Explain all nursing procedures before ~~they are done.~~ N/A [redacted] o Remain with pt. whenever possi[redacted] o ~~Maintain family interface.~~ Parents to ~~stay with pt.~~ N/A
B. AERATION X Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase [redacted]	o ~~Offer to elevate head of liner or~~ offer ~~pillow.~~ N/A o ~~Observe pt. while awaiting surgery~~ for ~~signs of distress.~~ N/A JEO o ~~Assist anesthesia during~~ intubation and ~~extubation.~~ N/A
C. INTEGUMENT X Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas [redacted] N/A - Impaired from (burns - entire body) burns	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignm[redacted] Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning X 3) Existing Disease Burns ___ 4) Safety Devices X 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse. (b)(6)-2	o Check for support stockings or wraps. If none, check with doctor (b)(6)-2 o Check that safety straps are correctly applied (b)(6)-2 o Offer pillow for under knees. N/A o Place and take down legs from stirrups with slow bilateral motion. N/A o Check that rings and all body piercing has been removed (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ___ 1) Pain X 2) Intraoperative Hazards ___ 3) Prosthesis ___ 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery ___ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort. (b)(6)-2	o Have sufficient people available for transfer. (b)(6)-2 o Insure proper body alignment (b)(6)-2 o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. X Potential for decreased communication due to: Intubated ___ 1) Diminished Hearing X 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period. (b)(6)-2	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. (b)(6)-2 o Speak clearly and slowly. o Address pt. from ___ side. N/A o Validate pt.'s understanding of verbal communication. (b)(6)-2 o Verify removal of dentures. N/A
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

(b)(6)-2

COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

MAJ AN 25AUG03 DATE

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

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

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

Intubated

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 MAJ AN

DATE 25 AUG 03 TIME: 1320

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 MAJ AN

DATE 25AUG03 TIME: 1535

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT [redacted], CRNA
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] ag
3. DATE 25 AUG 03 TIME PATIENT ARRIVED IN SUITE 1324
4. PATIENT IN ROOM TIME 1324 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt arived to OR intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted], 91D	RELIEF SCRUB	
	PFC [redacted], 91D		
ASSIGNED CIRCULATOR	NLT [redacted] AN, 66E	RELIEF CIRCULATOR	SSG [redacted], 91D
	MAJ [redacted], AN, 66E		

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

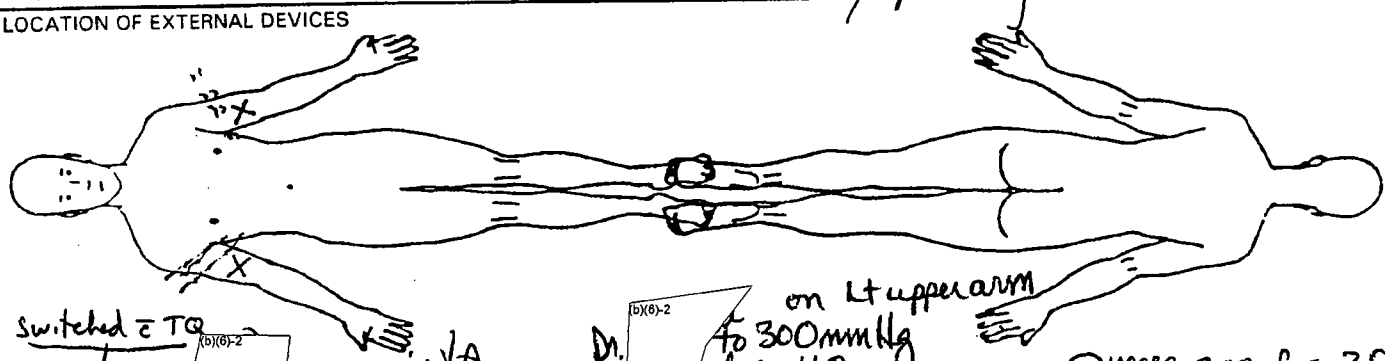
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine BY WHOM: [redacted]
SITE: (B) arms
SITE: Body/legs c̄ Hibiclens BY WHOM: Dr [redacted] / [redacted]
COMMENTS: ∅ pooling or irritation

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				[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted]

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

☒ ESU NO: VL 000442 Set at: 50/50
GROUND PAD: BRAND VL REM
LOT NO: 69671 EXP 2005-04

☐ 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
Silvadene 1% cream	qs 2 bottles	intra-op	topical	(b)(6)-2	(b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Foley	2.	3.
SITE	1. Bladder - pt arrived c̄ in place	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

(B) legs	Abdomen	(B) arms
Fluffs	Burn Pad	Fluffs
Kerlix	Back	Kerlix
Ace Wraps	Burn Pad	Ace wraps

19. ADDITIONAL INFORMATION
Dr (b)(6)-2 / (b)(6)-2 CPT (b)(6)-2, CRNA
CPT (b)(6)-2 CRNA, CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
Lt BEA, Rt BEA
Burn Debridements (B) LE, Abdomen

21. PATIENT TRANSFERRED TO ICU TIME 1535 METHOD gurney

22. REGISTERED (b)(6)-2 arm (b)(6)-2 TIME

REVERSE OF DA USAPA V1.01

MEDCOM - 7046

Ward/Section: EMT	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
0.108	25 Aug 03	1238	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	26.1	~~4.8-10.5 x 10~~
RBC	5.15	4.7-6.1 x 10
Hgb	14.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	44.9	45-52% (M) 37-47% (F)
MCV	873	~~80-94 fl (M)~~ 81-99 fl (F)
Plt	633	130-500 x 10 Verified
Lymph %	9.8	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		~~42-52% (M)~~ 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

MET 8

TEST	RESULT	REF. RANGE
GLU	223 *	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.4	0.6-1.2 mg/dl
CK	1578 *	39-380 u/l (M) 30-190 u/l (F)
NA*	138	128-145 mmol/l
K*	Hem	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	21	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF
PRP		Ne
Mono		Ne

Chemistry 12

Test	Result	Ref.
ALB	2.4 *	3.5-
ALP	52	26-
ALT	25	10-
AMY	5 *	14-
AST	123 *	11-
TBIL	0.8	0.2-
BUN	10	7-2
CA**	7.4 *	8.0-
CHOL	71 *	100-
CRE	1.3 *	0.6-
GLU	229 *	73-
TP	5.1 *	6.4-

MISC

Results:
pH 7.461 HCO3 22
PCO2 30.8 TCO2 23
PO2 68 BE -2
O2 100%

Microscopic UA

K+ 3.6

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 25 Aug 03	LAB ID NO:

14
44
10
219

Ward/Section: ICU	Requesting Physician: Dr. (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 25 Aug 03	TIME 1600	SSN/PSEUDO SSN (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	34.6	4.8-10.8 x 10
RBC	3.78	4.7-6.1 x 10
Hgb	11.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	91.2	80-94 fl (M) 81-99 fl (F)
Plt	242	130-500 x 10 Verified
Lymph %	4.6	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

MET 8

TEST	RESULT	REF. RANGE
GLU	186	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	2216	39-380 u/l (M) 30-190 u/l (F)
NA*	137	128-145 mmol/l
K* ①	4.3	3.3-4.7 mmol/l
CL*	112	98-108 mmol/l
CO2	19	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:
pH 7.346 O_2 100
pCO_2 37.8 HCO_3 21
pO_2 282 TCO_2 22
BE -5

Microscopic UA

Results: ① Hemolysis noted. K+ may be falsely elevated.

Remarks: CBC, Chemistry ABG

Reported by: (b)(6)-2	DATE: 25 Aug 03	LAB ID NO:

Sent
1335

	33.5 H	x10^3/uL	4.5	10.5
	[illegible]	x10^6/uL	4.00	6.00
	11.1	g/dL	11.0	16.0
	40.5	%	35.0	60.0
	90.2	fL	80.0	100.0
	29.4	pg	27.0	31.0
	32.6 L	g/dL	33.0	37.0
	325.	x10^3/uL	150.	450.
	3.0	%	20.5	51.1
	1.3	x10^3/uL	1.2	3.4

pH 7.346
pCO_2 37.8
pO_2 282
BE -5
O_2 100
TCO_2 21
HCO_3 22

pH 7.335
pCO_2 44.5
HCO_3 24
TCO_2 25
O_2 38 H
BE -2

pH 7.329
pCO_2 40.8
pO_2 543
BE -4
HCO_3 21
TCO_2 23
O_2 100
Na 145
K 3.4

(b)(6)-4

======= PICCOLO =======

08/25/03 01:51 PM

REFERENCE RANGE: MALE

PATIENT #: (b)(6)-4

METLYTE 8

DISC LOT #: 3152AA4

OPER #: 600 DR #: [redacted] (b)(6)-2

SERIAL #: 0000100970

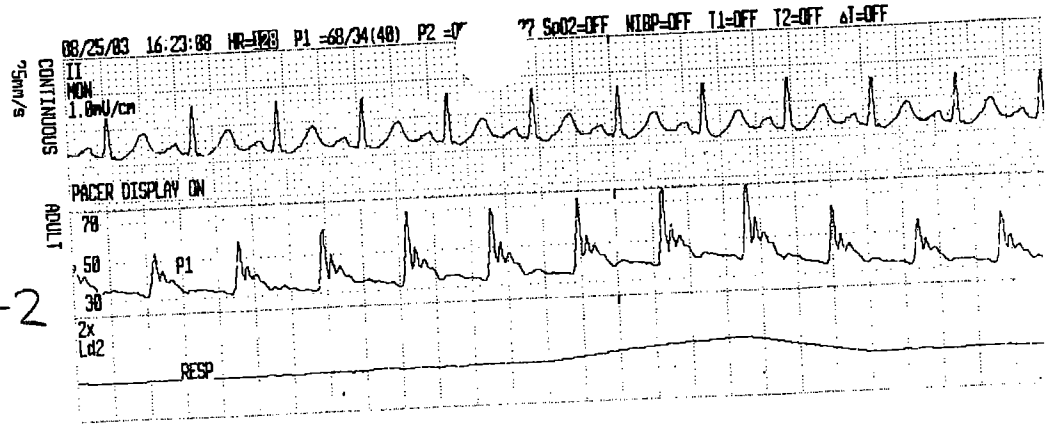
GLU	143*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	1636*	39-380	U/L
NA+	136	128-145	MMOl/L
K+	4.0	3.3-4.7	MMOl/L
CL-	112*	98-108	MMOl/L
tCO2	19	18-33	MMOl/L

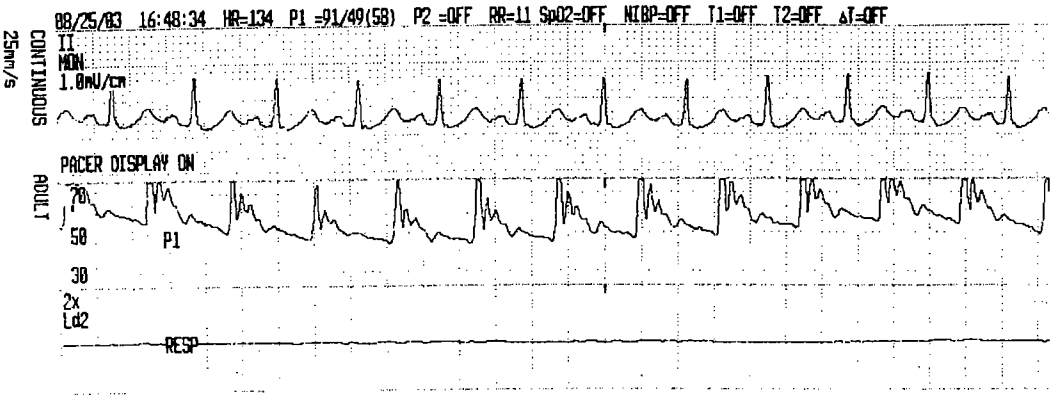
INST QC: OK CHEM QC: OK

HEM 2+, LIP 0 , ICT 0

PT: 18.2

PTT: 70.7





P1 TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
16:12	114	SRCH	61 / 33 [redacted]	OFF
16:10	[redacted]	SRCH	67 / 36 44	25
16:08	[redacted]	SRCH	68 / 36 43	15
16:06	[redacted]	SRCH	69 / 34 41	19
16:04	[redacted]	SRCH	67 / 38 45	14
16:02	[redacted]	SRCH	70 / 39 46	21
16:00	120	SRCH	67 / 38 44	OFF
15:58	[redacted]	SRCH	116 / 46 60	OFF
15:56	112	SRCH	60 / 35 40	15
15:54	119	SRCH	58 / 38 44	13
15:52	[redacted]	SRCH	69 / 43 50	14
15:50	[redacted]	SRCH	70 / 44 52	14
15:48	[redacted]	SRCH	72 / 42 50	14
15:46	115	SRCH	69 / 41 48	10
15:44	[redacted]	STBY	74 / 39 45	14
15:42	121	STBY	72 / 39 45	14
15:40	[redacted]	STBY	64 / 38 44	14
15:38	115	STBY	58 / 35 42	14
15:36	111	STBY	[redacted] / 36 [redacted]	14
15:34	105	STBY	[redacted] / 36 [redacted]	10
15:32	OFF	STBY	NOT ZEROED	OFF

P1 TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
16:48	133	OFF	95 / 49 57	12
16:46	136	OFF	91 / 50 58	18
16:44	135	OFF	82 / 47 56	14
16:42	136	OFF	77 / 43 51	14
16:40	136	OFF	72 / 41 48	14
16:38	134	OFF	78 / 42 48	14
16:36	134	OFF	85 / 46 53	14
16:34	133	OFF	80 / 46 54	14
16:32	132	OFF	80 / 45 54	14
16:30	131	OFF	78 / 42 51	14
16:28	130	OFF	76 / 41 49	14
16:26	[redacted]	OFF	78 / 41 48	22
16:24	[redacted]	OFF	66 / 37 43	13
16:22	[redacted]	OFF	58 / 34 41	12
16:20	[redacted]	OFF	62 / 35 42	OFF
16:18	[redacted]	OFF	63 / 35 [illegible]	5
16:16	[redacted]	OFF	67 / 35 [illegible]	6
16:14	[redacted]	SRCH	64 / 36 [illegible]	13
16:12	114	SRCH	61 / 33 [redacted]	OFF
16:10	[redacted]	SRCH	67 / 36 44	25
16:08	[redacted]	SRCH	68 / 36 43	15
16:06	[redacted]	SRCH	69 / 34 41	19
16:04	[redacted]	SRCH	67 / 38 45	14
16:02	[redacted]	SRCH	70 / 39 46	21
16:00	120	SRCH	67 / 38 44	OFF
15:58	[redacted]	SRCH	116 / 46 60	OFF
15:56	112	SRCH	60 / 35 40	15
15:54	119	SRCH	58 / 38 44	13
15:52	[redacted]	SRCH	69 / 43 50	14
15:50	[redacted]	SRCH	70 / 44 52	14
15:48	[redacted]	SRCH	72 / 42 50	14
15:46	115	SRCH	69 / 41 48	10
15:44	[redacted]	STBY	74 / 39 45	14
15:42	121	STBY	72 / 39	14
15:40	[redacted]	STBY	64 / 38	14
15:38	115	STBY	58 / [illegible] 42	14
15:				

APNEA TICKET (RR) 08/25/03

TIME H:MIN:S	HR/PR BPM	SpO2 %

LAST BREATH:
16:13:48 [redacted] SRCH

RESUMED BREATHING:
16:14:13 [redacted] SRCH

ELAPSED TIME:
00:00:25

NIBP TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM

ADULT

MEDCOM - 7050

MEDICAL RECORD — ANESTHESIA

DRUGS	Dosage						
Vecuronium (mg)		10		10		10	
Neosynephrine (mg)			40	100	(100)	60	
Versed (mg)				2		2	1
Dopamine ug/kg/min				3 — 5	—	5	
VOLAT AGENT	% del / % e.t.	Forane	0.7 .5	.6 — .5	.2 X	.2 X	.3 X
AIR	L/Min						
N2O	L/Min						
O2	L/Min	8	1.5 — 1.5	— 1.5	— 1.5	— 1.5	

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "-"=CONSTANT INFUSION

ANESTHETIC AGENTS AND DRUGS

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

FLUIDS: LINE site LR ☑ Warmed — 1000 — 2000 — 3000 — 4000 — 5000; L SC Cristalloid ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS 3; URINE – bloody 350 100/200 450

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 46.5

INITIAL DATA: BP – 120/75; HR – 80

EQUIP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? (Y); TIME – 1325

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✓; ANES – X-X; PROC – ⊙ – Ø

TIME → 1315 · 0 · 45 · 1400 · 30 · 1500 · 30 · 1600

pH	7.329
PCO2	40.8
PO2	543
BE	-4
HCO3	21
Na	145
K+	3.4
H/H	13.2/40.5
A	18.3
PT	10.7

VITALS: I:E 1:2; VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE – S(pon), A(assist), C(on)

	1315	1400	1430	1500	1530	1600	1630	1700	1730
VT	8	8	8	8	8	8	8	8	
f	820	800	870	870	880	890	890	810	
Peak inf pres / PEEP	30/5	29/5	32/5	33/5	33/5	35/5	35/5	32/5	
MODE	C	C	C	C	C	C	C	C	
ET CO2 (torr)	29	29	30	28	28	27	28	28	29
FIO2 (Frac or %)	.8	.9	.89	.89	.89	.89	.89	.91	.91
SpO2 (%)	100	100	100	99	97	99	99	99	99
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site ESO		36.2	36.3	36.1	36.0	35.8	35.6	35.4	
N-M Block (T/4)		0/4	1/4	2/4	1/4				

BP/Auto Cuff; BP / oth; ART line; Steth- PCIES; Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS: pressure pts padded BUE<90 OR taped & Position → ⊙

TOTALS: 30; 5/0; 200; 450

FLUIDS – SUMMARY: CRYSTALLOID – 500; COLLOID – Ø; BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

(1) from ER → OR; intubated; vent via Ambu bag. (2) → OR table 1-5 pts. assist. (R) by A-line started Dr Dean. fiO2 cent. → 1 OR via stretcher ventilated à Ambu bag. (L) SC TLC patent. Report given.

RUE 300mmHg 1428 ↑ 1503 ↓ 35 min

1334 TQ LUE 300mmHg ↓ 1414 40min

RECOVERY AT 1535; PACU ICU (Specify); OTHER 95.3; CONDITION: N 80/8.6 pp 5; RESP – 8; SpO2 98; BP 71/38; HR – 86

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1200	1324	1545
PROC	Ready 1307	Begin 1347	1530

PROCEDURES and CPT Codes: burn debridement (superficial) (L) BEA (R) BEA escharotomy BE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #8.0 ETT @ 24 cm @ teeth - tied (+) BBS (+) ET CO2

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate. (b)(6)-4

SURGEONS (b)(6)-2

AN (b)(6)-2 CPT

(b)(6)-2

CPT, AN
CRNA

PROCEDURE LOCATION OR 1-1

DATE 25 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7051

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 85 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: burn debridement / BUE amp.
SURGICAL SERVICE: Ortho
NPO SINCE:

ASA Physical State 1 2 3 4 5 E
WT: 75 KG/LB HT: ___ IN.
ALLERGIES: 0

HABITS:
TOBACCO:
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) unknown
( )
( )
( ) gent
( ) ahead ER
( ) 1300

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

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

5500cc LR from ER
Calculated hrly rate per ER 1085 cc/hr

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

unknown

BSA 90%

ASSESSMENT
PAST SURGICAL/ANESTHETIC

?
0

PHYSICAL EXAMINATION
BP 125 HR 85 R ___ T ___
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck
Oropharnyx Intubated
Nares
CHEST:
CARDIAC: #8.0 ETT tied
EXTREMITIES: 24cm teeth
IV Access:
Ulnar Filling:
BACK: (2) SC TC
OTHER: #18 G (2) AC

NPO Since

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ (X) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ar discussed with the patient/legal guardian (b)(6)-2 CPT, AN CRNA

The p (b)(6)-2 to understand and agrees. Questions answered.
Signe CRNA Date: 8/25/03 Time: 1355 Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward)

(b)(6)-4

SEDATION KEY:

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

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: 25 AUG 03 TIME OF ORDER: 1540 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. To ICU - Dr. [redacted] [illegible]
2. DX: SP BILAT FOREARM AMPUTATIONS, BILATERAL LE ESCHAROTOMIES, SWP BURN WOUND DEBRIDEMENT
3. COND - CRITICAL ALL - UNKNOWN
4. VS q 1°, monitor, A-line, Pulse Ox 140

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

5. IV LR TRA 500 cc/hr until 2000 hrs then 800 cc/hr
6. VENT - SIMV - TV - 700 cc R-14, P-5
7. FOLEY to gravity
8. NGT to LIS
9. DOPAMINE gtt to run at 5 mcg
10. FENTANYL gtt - titrate to effect
11. Do Not Resuscitate for ACLS CODE

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

12. CBC, Chem 8, ABG now
13. Call MD for T > 101, PC > 60 or > 120, BP < 100 or > 160, UOS < 30 cc, SaO2 < 92%

(b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 1658 HOURS

1. DC DOPAMINE
2. Will institute comfort care measures only.

Transcribed (b)(6)-2

(b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 Aug 03	(b)(6)-2	DX: S/P Bilateral Forearm Amputations	25 Aug 03	1600	KW	(b)(6)-2
		Bilateral LE Osteotomies, Stump Burn				
		Wound Debridement				
25 Aug 03	(b)(6)-2	Cond: Critical	25 Aug 03			
25 Aug		CBC, Chems, ABG Now	25 Aug	1630	1630	(b)(6)-2
		Call 1				

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

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26											
25 Aug 03	(b)(6)-2	IV: LR @ 500 cc/hr	06	(b)(6)-2											
		until 2000 hr then	18												
		800 cc/hr													
25 Aug 03	(b)(6)-2	Dopamine gtt to Run	06	(b)(6)-2											
		at 5 mcg/kg/hr	18												
25 Aug 03		Fentanyl gtt titrate	06	(b)(6)-2											
		to effect	18												

D/C'd. 25 Aug 03 (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx:- S/P Bilateral Forearm Amputations Bilateral LE Escharotomies, Superficial Burn wound Dehiscence

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

Cond:- Critical

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1690	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	2mm/2mm nonreactive					
	SENSORIUM	comatose ē Ø purposeful response to pain. (+) generalized flaccid posture. versed WI 4mg administered prior to intubat ē 1mg versed admin. upon admission.					
RESPIRATORY	RESPIRATORY PATTERN	Vent ventilated - SIMV FiO2 @ 60% VR @ 14 ē no spontaneous breathing. Peep @ 5 TV @ 700. Breath sounds clear throughout, slightly diminished in bases.					
	BREATH SOUNDS	(+) nasal secretions, small amt, whitish discharge.					
	SECRETIONS	(+) edema noted to nares-anteriorly, (+) burns to lips (+) 3° burns to chest, (+) eschar to chest (+) to bilat lateral aspects of thorax covered ē burn pad					
SKIN	COLOR	90% 2°-3° BSA Burns to face, lips, ears neck					
	INTEGRITY T: 93.5	chest, abd. legs, arms, groin, scrotum & anterior/posterior assessment unable to perform r/t pt status.					
IV SITE	LOCATION	(L) subclavian single lumen - continuing Dopamine					
	CONDITION	@ 5 mg/hr and NSR @ 1250 cc hr. Ø evidence of infiltration @ insertion site.					
	EXTREMITIES: Body	(+) bilat amp Bclow elbows. (+) drainage to (R) stump (-) to left. (+) Bilat lower extremity dressings from thighs/feet. CDI - ore notes stable fasciotomy Bilat LE to lateral aspect.					
GASTRO	ABDOMEN	Ø BS x 4q. Abd-hard/taut Ø abdudention					
	BOWEL SOUNDS	(+) 3° Burns (+) OGT to LIS ē minimal amt of dark brown drainage out.					
GU	URINE:	Foley to gravity. (+) Burns to penis ñ scrotum					
	COLOR/CLARITY	dressed ē gauze Ø bleeding noted; UOP minimal (+) dark tea color, clear.					
CARDIOVASCULAR	CARDIAC RHYTHM	sinus tachy on average ē HR ? 120's					
		BP = 50/70 systolic 40's diastolic/only - Unable to palpate pedal pulses Ø radial pulses r/t BE amput bilaterally					
		Cap refill big toes ~ 3-4 sec, feet cool to touch					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPA (b)(6)-2 [redacted] DEPARTMENT/SERVICE/CLINIC ICU DATE

PATIENT (b)(6)-4 [redacted] (If written entries give: Name—last, first, middle, grade, date, hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line												[illegible]	136/80	90/60	92/40	66/41	59/40
BP Cuff																	
Temperature														92.5			
Pulse												125	136	105	87	94	93
Respiratory Rate												10	19	14	14	14	14
												100%					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
LR									5000				100	250	250	250	250
LR									5000				1000	250	250	250	250
Fentanyl													10	10	20	20	20
													10	20	40	60	80
TOTALS									10500								

OUTPUT

		TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
URINE		HOUR / TOTAL												150/150	30/180	30/210	15/225	—/225	—/225
		10 gr																	
		S/A																	
NG		OUTPUT																	
		pH																	
		GUIAC																	
EMESIS	Blood										250								
STOOL																			
DRAINS																			
TOTALS																			

OST-OP DAY

	22	23	24	01	02	03	04	05	
	61/39	59/37	63/39	59/40	60/38	56/35	39/32	25/15	
	84	86	86	85	87	90	88	57	
	14	14	14	14	14	14	14	14	

	22	23	24	01	02	03	04	05	8° T
	250 7360	250 7500	250 7700	250 8000	250 8250	—	—	—	8250
	250 6200	250 6500	250 6550	250 7000	250 7250	250 7250	250 7300		7300
	30 110	30 140	30 170	40 210	40 250	20 270	20 290		290
	5/230	—	—	—	—	—	—	— 630	28

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

(b)(6)-2

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME									
SUCTION										

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE | INITL

CASALTY FEEDER REPORT
(AR 6[illegible])

CONTROL NO.

CHECK APPLICABLE BOX
☐ HOS[illegible] ACTION
☒ NON[illegible]TILE ACTION

1. LAST NAME - FIRST NAME - MIDDLE [illegible]
b(6)(a)

2. SERVICE NO.	3. GRADE	4. HOUR AND DATE OF INCIDENT
N/A	N/A	1145, 25 Aug 03

5. UNIT	6. GEOGRAPHICAL LOCATION *(nearby town)* AND GRID COORDINATES
IRAQI NATIONAL	LD 6771 0938

7. TYPE OF CASUALTY *(Check applicable box(es))*

	KILLED IN ACTION		MISSING IN ACTION		WOUNDED OR INJURED IN ACTION
	DIED OF WOUNDS OR INJURIES		CAPTURED		LIGHTLY WOUNDED OR INJURED IN ACTION*
	DIED NOT AS RESULT OF HOSTILE ACTION		DETAINED		SERIOUSLY INJURED OR INJURED IN ACTION*
BODY RECOVERED ☐ YES ☐ NO			INTERNED		SERIOUSLY INJURED NOT AS RESULT OF HOSTILE ACTION
BODY IDENTIFIED ☐ YES ☐ NO			MISSING		LIGHTLY INJURED NOT AS RESULT OF HOSTILE ACTION

EVACUATED TO

*To be indicated by medical personnel only.

DA FORM 1156, 1 JUN 66

REPLACES EDITION OF 1 MAY 61, WHICH WILL BE ISSUED AND USED UNTIL EXHAUSTED.

8. WITNESSES WHO SAW INCIDENT OR IDENTIFIED REMAINS. *(Name, grade, service number and unit)*
IRAQI [illegible]TEALING BRASS WHICH 4 A[illegible]D EXPLODED BLOWING UP HIS HANDS & BURNING 90% OF HIS BODY

9. REMARKS *(Additional circumstances, any religious ministration performed, etc.)*

10. FOR USE BY C.O. OR MED. OFF. *(only for casualties not the result of hostile action)* LINE OF DUTY: ☐ YES ☐ NO ☐ UNDETM	AUTHENTICATED BY *(CO or Med. Off.)*	VERIFIED BY *(Pers. Off.)*

UNIT	GRADE	SERVICE NO.
b(6)(a)	CSM	b(6)(a)-2

DATE	SIGNATURE OF P[illegible]SON PREPARING REPORT
25 Aug 03	b(6)-2

U.S. G.P.O.:1998 445-777

MEDCOM - 7059

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)(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: 2 5 4	30: X	31: 9	UNKNOWN

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	b(6)-4	35 36: ~~9 9~~ 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: ~~U~~ Z	1215	

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: ~~0~~ 1	YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICU	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 Y Y M M D D)
73 74: 3 0	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 8 2 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92: A B M A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 8 2 5

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

DX: 90% BSA 949.08
TRAMATIC AMPUTATION LEFT HAND 887.0
TRAMATIC AMPUTATION RIGHT HAND 869.0

PROCEDURES: DEBRIDEMENT BURNS 86.28
LEFT AND RIGHT BEA 84.03

CAUSE: E991

IRAQI WAS STEALING AMMO WHEN ONE EXPLODED ON 25 AUG 2003 @ 1145.

Dx: 887.7 94209 94180 9558 80385 959.8
Pc: 8314 8628 8609 9670 E9228

Death

Trauma

Injury 459

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

SIGNATURE OF ADMITTING CLERK: (b)(6)-2 (b)(6)-2 SPC, 91G10

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	00:40	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-09-15

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-07	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(3)-1	2003-09-07	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: STEALING AMMUNITION

34. Diagnosis / Operations and Special Procedures:

GSW LEFT BUTTOCKS

877.0

IRRIGATION AND DEBRIDEMENT

86.28

35. Total Days This Facility

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

35. Total Days This Facility

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

(b)(6)-2

Signature of Attending Medical Officer

(b)(6)-2 COL, MC

Signature of PAD or Medical Records Officer

(b)(6)-2

(b)(6)-2 SSG, PAD NCOIC

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 7061

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2540 INAQI OF SHOT BY US FORCES 22,55 & 5.56 IN AMMO DUMP, PRESUMABLY FOR PURPOSE OF SECURING EXPLOSIVES. WOUND TO (L) GLUTEUS. NO OTHER INJ.

PMH Ø
PSH Ø
HABITS Ø
NKA
MEDS Ø
ROS NEG

NCVD ANGLE & TOPTOK IN EMT.

PHYSICAL EXAMINATION

NAD
PERIAL COMM NARES & OP CLEAR
CHEST CTA
CON RRR S(1)
ABD NT
EXT WWL E (L) BUTTOCK C
T&T WOUND 5CM DISTAL TO
ILIAC CREST ENTRY ICM ANT EXIT
4CM POST. NVI DISTALLY

140/3.5/16.4
101/27/10.8
UA 1.030 N
228/15.6/46.7/16.2

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

XR - N

A - SOFT TISSUE GSW (L) GLUTEUS, MICROVASCULAR

P - DEBRIDE IN O.R.

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	780203		

r written entries give Name last, first, le; date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15SEP03	NARRATIVE SUMMARY
28TH CSH	ADMITTED 7 SEP 03 D/C'D 15 SEP 03
TIKRIT	DX - GSW (L) GLUTEUS (BUTTOCK)
IRAQ	PROCEDURES - DEBRIDEMENT (L) BUTTOCK GSW 7 SEP 03
	RESUME - 25 Y/O OF SHOT 5.56 MM (L) BUTTOCK JUST DISTAL TO ILIAC CREST WHILE SEEKING ARTILLERY ROUNDS. NEUROVASCULARLY INTACT. WOUND PERFORATING. DEBRIDED EMERGENTLY C̄ FINDING OF ~ 6CM VIOLATION OF GLUTEUS FASCIA & SM AMNT MUSCLE (NONE NON-VIABLE) CLOSED OPEN PRIMARY. 72° PROPELLY KB x. DID WELL. STAPLES OUT & SEEN SEMIPRN TODAY.
	MSPO - D/C TO MP USTOWN
	MEDS - NONE
	FU - WOUND BY INTENSIVE MED PERSONNEL

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

(b)(6)-2 RRC, MC ORTHOPEDIC SERVICE

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

(b)(6)-4

TER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — ~~CHRONOLOGICAL RECO~~ ~~AL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Sep 03	1630 Received pt this pm awake in bed eating. Pt on regular diet tolerates. ⊖ c/o pain at this time. ⊖ SOB ⊖ N/V. Dsg to (R) hip CDI. No s/s infection. Pulses equal and palpable. Lung sounds CTA x4 lobes. Abdomen soft. Pt ambulates to wash. No distress noted at this time will continue to monitor. [redacted]
	2400 Pt sleeping at this time USS No distress noted. Will continue to monitor. [redacted]
	0520 Pt asleep at this time. Dsg CDI. No pain noted at this time. Will give report to oncoming shift. [redacted]
13 Sep 03 1630	Nursing: Shift Note Pt. bright + alert. Able to complete ADL's on his own. (R) hip remains intact c̄ staples. Dressing D+I. Eating + hydrating well. ⊖ signs of respiratory distress. Continue to monitor. [redacted] CPT
13 Sep 03 0700	S NO C/O O VSS DSG DRY A DOING WELL P D/C STAPLES & PT. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV	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.)* [redacted]

REGISTER NO.	WARD NO.

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sep 03 1850	Nurses Notes: Assumed care of Pt AFO. Pt able to answer appropriately to questions asked c̄ head or verbally yes/NO. Breathing intact c̄ SOB or Labored breathing. Ø IV access. Dressings dry and intact c̄ bleeding or obvious drainage. Pt Ambulates to Bath Room on outside. Tolerates it well. Abd Soft and non tender. Tolerated Regular diet - ate approximately 85% of meal. Ø N/V Voids spontaneously able to move all extremities without complaint or complications c̄ complaints of pain at this time will Continue to monitor — (b)(6)-2 Corporal
11 Sep 2003 0900	Nursing Assessment: Pt awake, Ø C/O pain. Pt alert, Lungs CTA, O2 sats 98% on RA. HR 86 reg, Ø IV access, Ø edema to extremities. Abd soft, nontender, (+) BS x4. Pt. tolerate reg diet. Pt ↑ to latrine outside c̄ KP as COA. Drsg to (L) buttock c̄ small amt. of serous shadowing, drsg intact. ↑ OOB amb S assist — KP (b)(6)-2

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

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

REGISTER NO.

WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Sep 03 1900	Nurse Notes: Assumed care of Pt A&O x3. ~~Ø~~ c/o pain or discomfort. Pt sometimes sits up in bed. tolerated regular diet Ø N/V. abd soft and nontender. Marked area on R flank c̄ drainage dried Ø obvious bleeding or drainage. Breathing intact Ø SOB or labored breathing. Pt ī IV access will continue to monitor — (b)(6)-2
12 Sep 03	S NO CHO O VSSA WOUND ī erythema or fluctuance BSC c̄ scant drainage A doing well P D/C when wound dry (b)(6)-2
12 Sep 03 1450	Nursing: Pt awake, Ø c/o pain. Restraints in place x2. Pt has new drsg to (R) buttock CDI. Strip-strips placed to open area between staples c̄ sm. amt drainage. bump CDI, O2 sat 98% on RA. HR 80, Ø edema noted. Ø IV access. Abd soft, nontender, pt tolerating reg diet well. ↑ CCB and to BL outside ō eschar. Pt to be D/C once wound drainage is decreased — (b)(6)-2 JM

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)*
10 Sep 03 –	Assessment – 1930 – Alert, Oriented, Lungs CTA Bilat, S1-S2 strong and reg, (+) BS x4, Abdo S.O.I., Ø % Pain, 002 to BP, Restraints, Tourniquet per order, Continues IV Ancef q8. Will continue to monitor – [redacted]
10 Sep 03	POD 5 S No c/o O VSSA Wound clean & dry, serous drainage A Doing well P D/C Abx D/C to care when wound dry.
	[redacted]
	LTC, MC ORTHOPEDIC SERVICE
10 Sep 03 1848	Nurses Notes! Assumed care of Pt A+O. Breath intact ϕ SOB w labored breathing. abd soft and non tender. Pt tolerated regular diet ate small portion ϕ N/V. dressings dry and intact able to move all extremities. will continue to monitor – [redacted]

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sep 03 2252	Nursing Note: Assumed care of Pt @ leg but easily aroused. Breathing intact Ø SOB or labored breathing. Ø IV access. Vitals stable. dressings dry clean and intact. will continue to monitor [redacted] 15/AN
14 Sep 2003 0855	Nursing Assessment: Pt awake, Ø c/o pain at present. Pt alert. Lung CTA, Ø SOB apparent, O2 sats 98% on RA. HR 76, reg, Ø edema to extremities. Ø IV access. Abd soft, nontender, BBSx4. Pt tolerated reg breakfast. Pt ↑ COB to BR c̄ NP @ COA 5 difficulty. Drsg to (R) buttock CDI. Wound has staples intact & steri-strip x7. Small amt. drainage present on drsg. ~~Wound~~ [redacted] 1LT AN
14 Sep 03 1850	Nursing Notes: Pt Alert and Oriented Ø c/o pain or discomfort. Tolerated regular diet. Vitals Stable Ø IV access pt ambulates stc. Ø increased blood or drainage to wound dressings. Ø odor or other signs of infection. will continue to monitor status [redacted] CG 102
15 Sep 03 @ 1130	Nursing Assessment: Drsg change performed @ 1130. pt tolerated drsg change. Small amount of drainage approx the size of a dime. New drsg CDI. Wound appears to be healing. Drsg was a 4x4 and tape. [redacted] 9LWO

STANDARD FORM 600 (REV. 6-97) BACK

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8SEP03	POD 1
	S NO C/O
	O VSSA
	LUNGS CLEAR, BSO C̄ MOD STRIDOR
	DRAINAGE, PENROSE OUT.
	A DOING WELL
	P 72° IN ABD, TREN TO CARE WHEN WOUND DRY
	(b)(6)-2
8 Sep 03 20:50	Received care of pt. @ 18:00. Pt. lying in bed comfortably. 20:50 initial assessment - Awake and Alert. Restraints x2 to (R) wrist/(L) ankle. Skin warm, dry, intact. PERRLA (+) WNL. Lungs clear to auscultate throughout (B). Heart rate regular S1 S2 WNL. Bowel sounds (+) x4 quadrants. Soft and non-tender. (+) Radial pulses (+) 2 (B). Hx to (L) forearm patent and intact ∓ s/s infection. Dressing to (L) Hip clean, dry, intact. ∅ complaints of pain @ this time. Will continue to monitor — (b)(6)-2
2153	Vital signs WNL per flowsheet. — (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 Sep 03	Assessment - 1400 AAO x3, Perrla, Lungs CTA Bilat, S1 S2 strong and regular, (+) BS x4. Abdo G.D.I, IV Anef tgm continues. Ø c/o pain. OOB w/ BR Restraints, Guard posted. Tolerated Reg Diet. Will continue to monitor throughout. (b)(6)-2 SGT USA
9 Sep 03 1700	S NO PAIN O VS SA DSG Dry & intact A DOING WELL P IV ABX until tomorrow D/C if wounds ok tomorrow (b)(6)-2 (b)(6)-2
9 Sep 03 20:31	Received care of patient @ 1800. Awake and alert in bed. VS @ 1400 WNL. Restraints x2 (2) wrist/(2) ankle. Skin warm/dry/intact. Buccal mucosa moist/pink. PERRLA (+) WNL. (+) EOM WNL. Lung sounds clear to auscultate throughout (B). HR regular S1S2 WNL. Bowel sounds (+) WNL x4 quadrants. Dressing to (2) hip/buttocks clean/dry/intact. No staining noted & odor noted. (+) Radial pulses (B) 2. & c/o pain. Will continue to monitor. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Sept 03	S) PT (b)(6)-4 25yrs old was shot time of Injury 2355. (L) hip
0135	I.V. Bolus 0137. There is an exit wound to
BP 130/78	PT Foley was given 0130 . the upper Left Gluteus Maximus
P 93	PT recieved a Sonogram @ 0142
Temp	ancef 1gm Piggyback I.V. 0136 PT was shot. after
RR /le	Morphin 10mg 0135 he was shot PT went
P.Ox 02 99	Tetanus 0.5 I.M. Running.
0136	BP 134/95 I.V. bolus (L) arm L.R. 2 bags.
NKDA	P 84
PSHX Ø	RR
PMHX Ø	Pox 90
Med Ø	
LMI 2200 ~~1000~~	
49 kg	
tob Ø	

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.)*

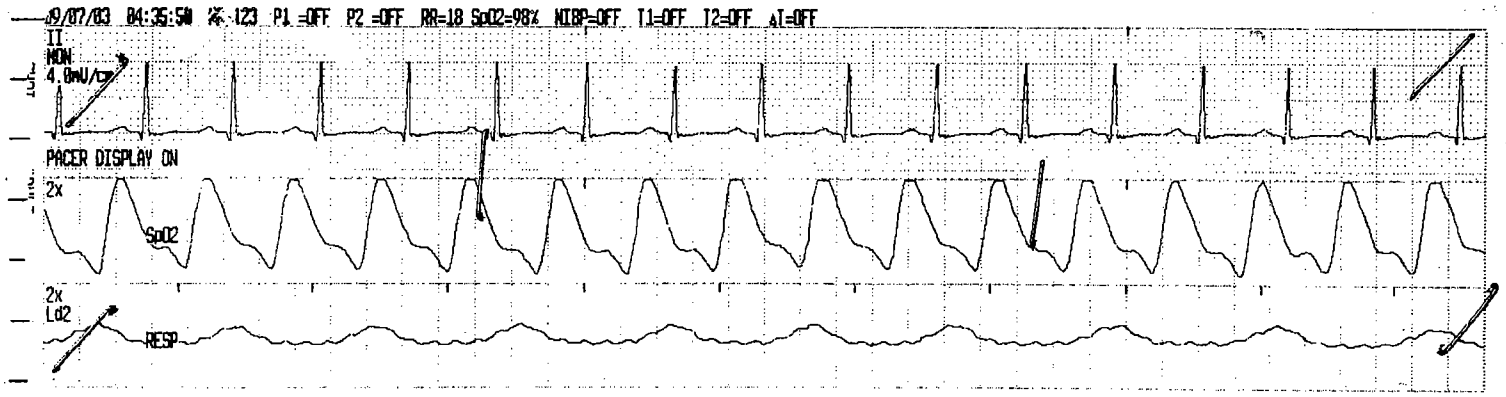
(b)(6)-4

REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0330 Sept 7, 03	Pt arrived to ICU via gurney c̄ guard - alert & cooperative - Bulky dsg to (L) buttocks moderately soaked c̄ blood - dsg reinforced on arrival IV 18G L AC infusing NS @ 200 ml/hr via pump Pt c̄ positive ⊕2 pedal pulses bilat - able to move all extremities - lungs CTA bilat hyporactive BS x4 quads - Foley to Gravity draining dark yellow urine - abd soft non-distended - Pt medicated c̄ 5mg IV MSO4 for pain - will continue to monitor (b)(6)-2



0530	Pt. resting c̄ complaints. LSS seg flow chart Dsg to (L) buttock c̄ no significant Δ's

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7Sep03 0630	Report received from SGT Love, pt lying in bed awake, follows commands, moves all extremities, lungs CTA bilaterally, resp even & unlabored, rate 13-16, sats 97% on RA, heart sounds audible, sinus tachycardia, all pulses palpable, BS(+) x4 quads. NPO, entry & exit wounds to (L) hip dressing soaked through c blood. Awaiting transport to OR. [redacted] (b)(6)-2 SGT/LPN
0745	Pt taken to OR for debridement of wound via litter. [redacted] (b)(6)-2 SGT/LPN

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7 80803 OP NOTE
PREOP DX GSW (L) BUTTOCK
POSTOP DX SAME
PROCEDURE DEBRIDEMENT (L) BUTTOCK WOUND
SURG GMANDUNE
ANES SCHMABEN GEN
FLUIDS 300 LR EBL MIN UO 175
DRAINS PENROSE SKIN & CAP
FINDINGS - 7MM ENTRANCE, 4CM
POST EXIT WOUNDS GLUT DISTAL TO IUNC
CREST 15CM WOUND TRACK, 1° SUBQ
GLUT DEEP FACIAL VIOLATION C ACM
SUPERFICIAL GLUTEAL MUSCLE INJURY.
NO DEVITALIZED MUSCLE OR FB.
TO ICU TO NEUROSURG STABLE

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME | FIRST NAME

DATE	NOTES
7Sep2003 1040	Nursing: Admit Note: Pt received from ICU via stretcher. Pt begins to vomit before transfer to bed of ~100cc mucoid, tan emesis. Pt given 25 mg Phenergan IV. LT (b)(6)-2 AN
7Sep03 1105	Nursing: Assessment: Pt sleeping, briefly aroused to tap on shoulder. Lungs CTA, O2 sats 97% on RA. Pt is tachycardic, c HR of 109, ∅ edema to extremities. IV to Bac c KL @ 75. Abd soft, ∅ indication of pain on palpation. Hypoactive BS x4
7Sep03 1655	Nursing: Pt has ∅ void in 6.5 hours. Bladder c some distension on palpation. MD in OR, will consult for NO cath. LT (b)(6)-2 AN
7Sep03 1705	Nursing: MD in to eval pt bladder, wants to allow pt 2 hours to void LT (b)(6)-2 AN
7Sep03 1750	Nursing: Void - Pt has 750 cc of clear yellow urine out. Pt as LT (b)(6)-2 AN
7SEP03	PT awake, REERLA, BBS CTA, PPP x 4 ext, ∅ complaints, will continue to monitor (b)(6)-2 [illegible]
8 Sep 03	1130 - Assessment A&O x3, PERRLA, Lungs CTA BILAT, S1 S2 strong and reg, (+) BS x4, ∅ ∅ pain. IV Antibiotic therapy continues, VSS Telemetry reg sinus. Will continue to monitor (b)(6)-2 [illegible]

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

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY No. (b)(6)-4

LOG NUMBER 128

ARRIVAL — DATE: DAY 07, MONTH Sep, YR. — TIME 0115

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

CURRENT MEDS. (include immunization and other data): 0

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW to (L) hip — Last Meal 2200

SEX: M — AGE: 25

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0116

VITAL SIGNS

TIME	0115		
BP	130/78		
PULSE	93		
RESP.	16		
TEMP.			
WT. (Child)	94 kg		

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

ORDERS	INITS.	TIME
I.V. Bolus	2	0130
Morphine 10mg	10mg	0135
Tetanus I.M.	5	0136
Ancef piggyback	1gr	0135

ASSESSMENT/DIAGNOSIS: G.S.W. to (L) buttock.

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): Ortho

☐ EMERGENCY ☒ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 0230

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)

S) PT (b)(6)-4 GSW to (L) hip. Time of Injury 2355

I.V. Bolus 0137. PT was given Foley 0130. there is an exit wound to the Upper buttocks. PT recieved Sonogram for further injuries.

Ancef 1gr piggy back I.V. 0136

Morphin 10mg 0135

Tetanus .5 I.M 0136. (b)(6)-2 9MM10

PSLTX ∅
PMLTX ∅
LMI 2200
TOb ∅

S: PFC a 25 y.o. Iraqi who was stealing Ammo from a US guarded Ammo dump for the presumed purpose of making IEDs. Pt sustained GSW to (L) buttocks & was still able to Run p injury. ⊖ weakness, ⊖ Numbness, ⊖ Other injuries. Occurred Near Samarra

O: Man in mod dist 2° to GSW to buttocks, ~~CVS: ⊖ Resp: distress Nutrition~~

HEENT: Atraumatic

COR: RR ⊖ (b) Lungs (B) CTA

Abd: ⊖ BS, S, NT non-tender. FAST ⊖

Pelvis stable ⊖ Crepitus

Ext: ++ pp. NL motor NL sens.

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SS; 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 DATE (b)(6)-2 (b)(6)-2

INSTRUCTIONS (Include follow-up plans): To ICU.

EMERGENCY CARE AND TREATMENT — Medical Record Copy

STANDARD FORM 558 (Rev. ...) Prescribed by GSA and ICMR

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: 25

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
[X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD
REACTION:

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
DAI, Lt GSW buttocks.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Info from Chart and ICU nursing staff Arabic-speaking.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ___ Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. Semi-Emerg	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 integrity due to: ___ 1) Intraoperative Immobility ___ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ___ 5) Pooling of Prep Solutions	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

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P JG 0130 (ER arrival) ! Contacts Removed
! NPO Since 7 SEP 03 ! Jewelry Removed
! ~~UHCG/LMP~~ N/A ! Body Pierce Remove
! Consent/Blood Transfusion
~~Signed/Witnessed/Dated~~ N/A
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! ~~Family/Friend:~~ N/A

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION Potential for inadequate tissue perfusion due to: 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. Axillary o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed. [illegible] (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. Potential impairment of mobility due to: 1) Pain 2) Intraoperative Hazards 3) Prosthesis 4) Positioning 5) Transfer pt. to/from OR table E.2. Potential discomfort due to: 1) Length of Surgery 2) Positioning 3) Arthritis	o Pt. will be transferred to OR table without 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, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. Diminished visual perception due to being: 1) Pre-Medicated 2) W/O Glasses F.2. Potential for decreased communication due to: 1) Diminished Hearing 2) Language Barrier F.3. NA Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from [illegible] side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] CRNA 7 SEP 03 DATE

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

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

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liner with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] MAJ/AN

DATE: 7 SEP 03 TIME: 0705

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] CRNA

DATE: 7 SEP 03 TIME: 0955

MEDICAL RECO

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERAT[illegible]M
VIA litter BY OR Staff

2. PATIEN[illegible] (b)(6)-2 VERIFIED B[illegible] AND PROCEDURE MAJ, AN

3. DATE 7 SEP 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0745 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert, Arabic speaking.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC	(b)(6)-2	910	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CP-7	(b)(6)-2	66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Bean Bag Axillary pad arm 90° b/l.

8. SKIN PREPARATION

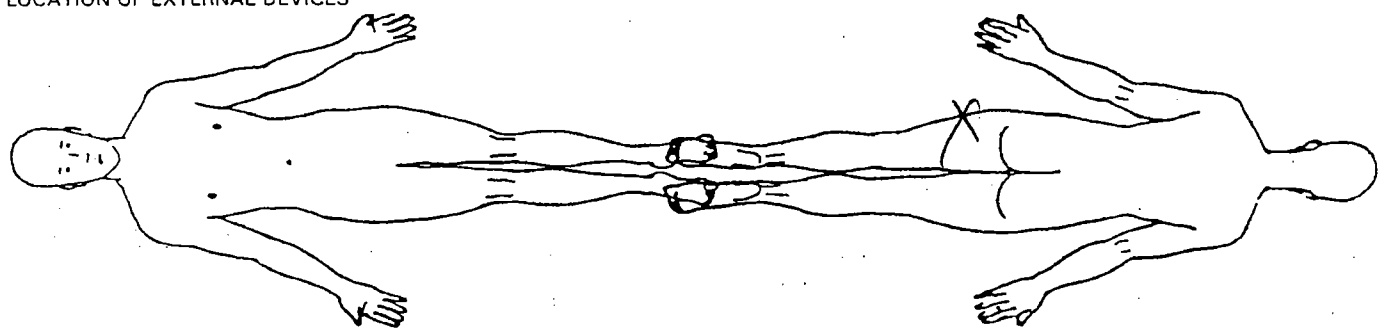
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: buttocks BY WHOM: CRNA G
SITE: ∅ BY WHOM: ∅

COMMENTS: ∅ prep

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: 1-1
GROUND PAD: BRAND Valley Lab 30/30
LOT NO: 69263 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 7079

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): NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. (L) buttocks area	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluff
tape
abd pad

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

DS I & GSW buttocks

21. PATIENT TRANSFERRED TO ICU TIME 0955 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CRN

REVERSE OF DA FORM 5179-1, C 17 USAPA V1.01

MEDCOM - 7080

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY			8		9													
POST- DAY			7		8													
MONTH-YEAR Sep	DAY		14		15													
19 2003	HOUR		0	8	1	4												
PULSE (O)	TEMP. F (°)		6	6	6	8												TEMP. C
	105°		0	14	0	0												40.6°
180	104°																	40.0°
170	103°																	39.4°
160	102°																	38.9°
150	101°																	38.3°
140	100°																	37.8°
130	99°																	37.2°
	98.6°																	37.0°
120	98°																	36.7°
110	97°																	36.1°
100	96°																	35.6°
90	95°																	35.0°
80																		
70																		
60																		
50																		
40																		

(Centigrade Equivalents, for Reference only)

ESPIRATION RECORD

Record special data only when so ordered																		
	BLOOD PRESSURE		108/52	108/72	103/49													
			100/39															
	HEIGHT:	WEIGHT →	98½	96½	98													
			97½		96½													

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 4 5 6 7

POST-DAY: DOS 1 2 3 4 5 6

MONTH-YEAR: Sep 19 2003 — DAY: 7 8 9 10 11 12 13

HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

SpO2

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Iraqi EPW

Ward/Section: ICU	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE 7 Sept 03	TIME 0511	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.2	4.8-10.8 x 10
RBC	5.24	4.7-6.1 x 10
Hgb	15.6	14-18g/dl (M) 12-16 g/dl (F)
Hct	46.7	45-52% (M) 37-47% (F)
MCV	89.1	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10 Verified
Lymph %	9.2	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 07 Sep 03	LAB ID NO:

Ward/Section: ENT

Requesting Ph (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name (b)(6)-4

Date: 7 Sep

Time: 0115

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	164	73 - 118 mg/dL
BUN	10	7 - 22 mg/dL
Creat	0.8	0.6 - 1.2 mg/dL
Na	140	128 - 125 mmol/L
K	3.5	3.3 - 4.7 mmol/L
Cl	101	98 - 108 mmol/L
tCO2	27	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	191	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	Yellow	N/A
App	clear	N/A
Glu	NEG	Negative
Bili	neg	Negative
Ket	TRACE	Ace: NEG Negative
SGav.	1.030	N/A
Bld	SMALL	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	Negative

Micro UA
WBC 3-5
RBC 15-20
EPZ 10-15
MUCUS MOD
AMORPH MOD
BACL LIGHT

Venous Blood Gas

ph	7.306	7.31 - 7.45
PCO2	64.5	35 - 45: Art
PO2	—	80 - 105
HCO3	32	22 - 26
TCO2	34	23 - 27
BE	6	(-2) - 3
sO2	72	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	17.3	4.8 - 10.8 x 1E3
RBC	5.56	4.7 - 6.1 x 1E6
Hgb	16.4	14 - 18 g/dL (M); 12-16 (F)
Hct	50.6	45 - 52% (M); 37 - 47% (F)
MCV	91.0	80 - 99 fL
Plt	292	130 - 500 1E3
Lymph%	22.6	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

AB POS

Additional Instructions:

Reported By (b)(6)-2

Date 7 Sept 03

Lab ID # ~~[illegible]~~

Ward/Section: EMT

Requesting Physican: (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 7SEP03

Time:

Patient #

Chemistry 7		
Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT		
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)		
Test	Result	Ref. Range
WBC		4.8 - 10.8 x 1E3
RBC		4.7 - 6.1 x 1E6
Hgb		14 - 18 g/dL (M); 12-16 (F)
Hct		45 - 52% (M); 37 - 47% (F)
MCV		80 - 99 fL
Plt		130 - 500 1E3
Lymph%		20.5 - 51.1 %

Hematology Manual Diff.	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

WASTE:
① fentanyl 100mg
② STP 250mg

MEDICAL RECORD — ANESTHESIA

DRUG	(Route)	
midazolam	(mg)	2
fentanyl	(mcg)	100 50
STP	(mg)	250
Succ	(mg)	100
	( )	
	( )	
VOLAT AGENT 150	% del	2 – 1.7 – 1.7 – X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	B-2 – 2 – 2 – B – B

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

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

TOTALS	TOTAL TIME
2mg	Min
150 mcg	
250mg	TOTAL URINE
100mg	
X	175

FLUIDS – SUMMARY
CRYSTALLOID– LR = 300 cc
COLLOID–
BLOOD– X

FLUIDS

LINE site		
LR (cc) 18g LA	☐ Warmed	300
	☐ Warmed	
Ancef 1gm in 100 NS	☐ Warmed	X — X
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 49 (KG) LB

HEMATOCRIT: 46.7

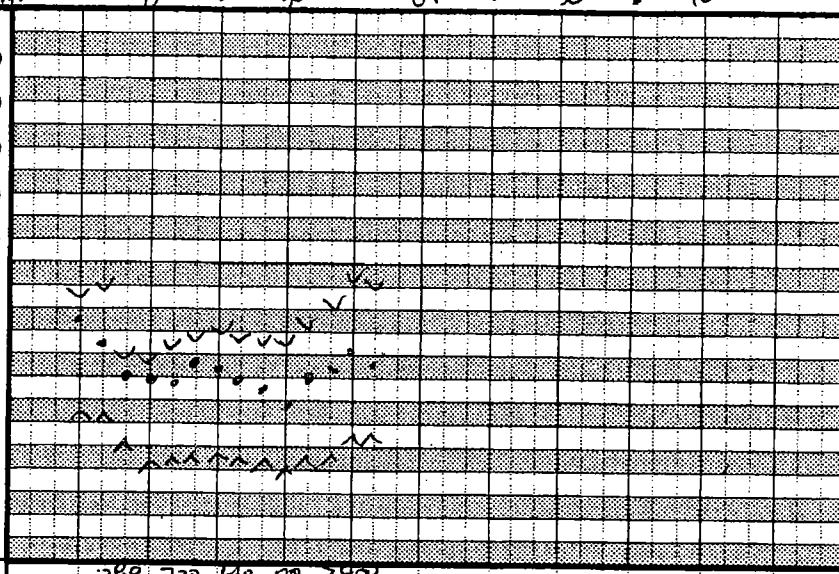
INITIAL DATA: BP – 115 / 63; HR– 108

SOUP CHECK: OK? – (Y) N

PATIENT RECORDS: OK for PROCEDURE – Y/N; TIME – 0740

TIME → 0730 0800 30 0900 30 1000

SYMBOLS:
(R) arm BP by cuff — V Reg, Λ Cuff
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ⁄
ANES– X-X
PROC– ⊙ – Ø



VENTILATION

I:E = 1:2 VT – ml		780	720	640	500	400
f – breaths/min	14	8	8	6	6	12 12
Peak inf pres / PEEP		20	20	20	–	
MODE– S(pon), A(ssist), C(on)	S	C	C	C	A	S S

MONITORING & ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕	34	31	34	48	
BP / oth	✓ FIO2 (Frac or %)	.87	.87	.88	.88	.89	.7/21
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
~~CO2~~ analyzer	TEMP- site Axill						
	N-M Block (T/4)	4/4	4/4				
Warming blkt		✓✓					
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS

Position → OR (R) LD → → → OR

(R) arm (90°) secured to padded armboard / (L) arm supported on pillow / secure AX roll in place.

REMARKS – Code drugs with numbers, events with letters

0740 Greeted pt. Proc. Loss reviewed. ⊕ ID
GETA discussed via interpreter; Ø questions
0745 → In OR 1-1 via lift
Pre O2. Monitors on.
IV induction; eyes tape shut; see Airway note below.
0752 → moved to RLD by
All pressure pts va/pad → Turned supine
0845 Resp event Reg.
opens eyes. Airway reflexes intact. Oral stim. Extubated ⊕ pts. pressure breathing
0850 Resp event Reg.
To ICU for recovery.
VSS. Report to SGT (b)(6)-2
pt stable.

RECOVERY AT 0850
PACU ICU_____ (Specify)
OTHER F296²
CONDITION: SBZ 3/4 O2 Fm 112
RESP– 12 SpO2– 100%
BP 120/55 HR– 86

ANESTHESIA & PROCEDURE TIME

	Start	Room	End
ANES	0730	0745	0100
PROC	Ready	Begin	End
	0752	0807	0838

PROCEDURES and CPT Codes
Debridement / Irrigation (L) gluteal wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
RSI ⊕ cricoid pressure. DL x1 ⊕ MAC 3 grade I view VC. ⊕ stylet
BAO ETT placed & secured @ 23cm @ teeth. ⊕ ETCO2 sustained ⊕ BBS: ⊕ soft Pak block

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CRT/CRNA

PROCEDURE LOCATION: OR 1-1
DATE: 7 SEP 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 9

MEDICAL RECORD – ANESTHESIA

MEDCOM - 7086

U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE / PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: debridement (L) fulbers wound
SURGICAL SERVICE: ortho
NPO SINCE:

ASA Physical State 1 2 3 4 5 E
WT: 49 KG/LB HT: 69 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: denies
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Keflex - ER - 0136
( )
( )
( )
( )
( )

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

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

27.8 / 15.6 / 46.7 / 11.2
140 | 101 | 10
3.5 | 27 | 0.8 / 164

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Obtained history from mother, father speaks Spanish

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 117/61 HR 112 R 18 T ____
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx 3.5 mm
Nares
CHEST: CTA (B)
CARDIAC: S S
EXTREMITIES:
IV Access: 18 G IV
Ulnar Filling: (L) wrist
BACK:
OTHER:

99%

NPO Since ____

* apparently trying to steal ammo-fragment wound to (L) fulbers

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

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

(b)(6)-2

Th[redacted]rees. Questions answered.
Sig[redacted] Date: 9/7/03 Time: 0730 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward)

(b)(6)-4

RADIOLOGIC CONSULATION REQUEST

PATIENTS NAME: (b)(6)-4

SSN:

UNIT:

PROVIDER/ CLINIC: EMT

DATE REQUESTED: 7 Sep 03

EXAMINATION REQUESTED:

SPECIFIC REASON(S) FOR REQEST:

RADIOLOGIC REPORT:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10 SEP 03 TIME OF ORDER: 0800 HOURS

D/C ANCEF, MS, PENICILLIN & DIFFICEN

LIST TIME ORDER NOTED AND SIGN: noted (b)(6)-2 10 SEP 03 1615

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2d chart 10 Sep 03 @ 950

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 15 SEP 03 TIME OF ORDER: 1330 HOURS

D/C TO MPS
MED NONE
F/U CAMP PENDLETON

(b)(6)-2

LTC MC ORTHOPEDIC SERVICE

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.

Last May 22.00

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

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
7 Sep 03	0200		
(1) Admit to ICU			
(2) Dx GSW (R) Gluteus			
(3) Cond Stable.			
(4) NKDA.			
(5) BR, C Armed Guard			
(6) NPO			
(7) IV NS @ 200 cc/hr			

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
(8) MSO4 5-10 mg IV q 2-4° PRN		
(9) CBC @ 0500		
(10) Ancef 1gm IV q 8°		

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

~~2ND 7SEP03 0000~~ TOTAL

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
7SEP03	0800	
ADMIT ICU LOCMANVILLE		
DX (L) BUTTOCK GSW		
COND STABLE		
NS NOVLINE		
ACT BR - DECAMPED STATUS		
BRP WHEN COMMANDED		
NKA		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
NEG BLEY		
LR @ 75cc/HR, HOLDER WHEN PO C		
D/C FOLEY		
ANCEF 1GM IV Q8°		
MS 2-4MG IV Q15' PRN UPTO 20MG/4		
PENICILLIN 1 PO Q 4° PRN		
PHENERGAN 12.5-25MG IV Q8°		
IS Q1°, W/R		

D/C'd ICU 1015

NURSING UNIT | ROOM NO. PR803 | BED NO.

(b)(6)-2

LPG, MC
ORTHOPEDIC SERVICE

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

8 Sep 03 @ 0400

MEDCOM - 7090

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11	12	13	14
7SEPT03	(b)(6)-2	Cond: Stable	06	✓	(b)(6)-2							D/C
			18	(b)(6)-2								
7SEPT03	(b)(6)-2	BR c armed guard	06	✓	(b)(6)-2						(b)(6)-2	
			18	(b)(6)-2								
7SEPT03	(b)(6)-2	NPO	06	✓	SS		D/C'd					7 Sept 1000
			18	82								
7 Sept	(b)(6)-2	Vital Signs: Routine	06	✓	✓							
			14	✓								
7 Sept	(b)(6)-2	DIET: Regular	06	✓	✓	(b)(6)-2				(b)(6)-2		
			11	✓								
			18	✓	c					(b)(6)-2		
7 Sept	(b)(6)-2	ACTIVITY: BR	06	✓							(b)(6)-2	
		detainee status	18	✓	(b)(6)-2					(b)(6)-2		
		BRP when that										
7 Sep	(b)(6)-2	VS: routine	06	✓	(b)(6)-2							
			14	✓		✓	(b)(6)-2					
			22	✓	(b)(6)-2							

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW ⓛ foot

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7SEPT	(b)(6)-2	CBC @ 0500	7SEPT	0500	0515	(b)(6)-2
7sep03		Admit to ICU	7sep03	/	0300	
7sep03		Dx GSW (L) Gluteus	7sep03	/	0300	
7Sept		Admt to ICU c/o Granville	7Sept			
		Dx (L) Buttocks GSW				
	-----	Condition: Stable				
7Sep	(b)(6)-2	NIO DTV by 1900	7Sep			
7Sep		D/C Heplock	10Sep	1500	1615	(b)(6)-2

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

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED												
				06	07	08	09	10	11	12						
7 SEPT	(b)(6)-2	IV: NS @ 200 cc/hr	04		(b)(6)-2		D/C									
			18	(b)(6)-2												
7 SEPT	(b)(6)-2	ancef 1 Gm Q8°	08													
			14													
	(b)(6)-2		22													
7 SEPT 03		Ancef 1GM	08	/												
		Q8°	16	/												
			24	/												
7 Sept	(b)(6)-2	IVF: LR ~~75cc/hr~~	04	/	(b)(6)-2											
		~~keep back when PO intake~~	15	/												
7 Sept		ANCEF 1gm IV Q8°	08	ok												
			16													
			24													
7 Sep		Ancef 1 gm IVQ8°	08	/	(b)(6)-2											
			16	/												
			24	/												

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) Glut

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing

THE, EUTIC DOCUMENTATION CARE PLA
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
7 Sept 03	(b)(6)-2	MSO4 5-10 mg	7 Sept Sing @ SL					D/C		1000 AM 7 Sept						
		IV Q 2-4° prn														
7/Sept	(b)(6)-2	MSO4 2-4 mg IV														
		q 15' PRN ~~up to~~						D/C		1050 03 1800 MC						
		20 mg Max														
7 Sept	(b)(6)-2	Percocet ÷ tabs														
		PO Q 4° PRN														
7 Sept	(b)(6)-2	Phenergan 12.5-	7 Sep 1145 25 mg IV pm					D/C		1800 1050 03 MC						
		25 mg IV q 8°														

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0330	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Perr - 2-3 mm brisk					
	SENSORIUM	alert - Quiet					
		Cooperative					
RESPIRATORY	RESPIRATORY PATTERN	RLR					
	BREATH SOUNDS	CTA bilat					
	SECRETIONS	ϕ cough ϕ secretion					
SKIN	COLOR	normal for race					
	INTEGRITY	intact					
IV SITE	LOCATION	LAC PIV 18 G					
	CONDITION	NS infusing @					
		200 cc/hr					
GASTRO	ABDOMEN	soft - non distended					
	BOWEL SOUNDS	hyp-active BS					
		x4 quads					
GU	URINE:	Foley to Gravity					
	COLOR/CLARITY	dark yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR					
		NSR					

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PR (b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU

DATE 7 SEPT 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line																		
BP Cuff		117/61																
Temperature																		
Pulse		109																
Respiratory Rate		17																

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IV	200	200																
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	HOUR	400															
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITALS	22	23	24	01	02	03	04	05	
						115/68		127/65	
						97.4		97.6	
						110		123	
						20		16	

	22	23	24	01	02	03	04	05	8° T
						200	200	200 600	600
								800	800

ARTERIAL BLOOD GAS		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	(b)(6)-2	(b)(6)-2
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA

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

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

OTSG APPROVED (Date)

Date: 7 Sep 03
Time In: 0855
Allergies: NKA
Pre-op V/S:
Procedures: Debridement of (b)(6) buttock GSW

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300cc Colloid
OR Output: UOP 175cc EBL min
Meds/Times: 1gm Ancef (0845) 2mg Versed 150mcg Fent + Thiopental & succ for intubation

Drains: Hemovac, NG, JP, Tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	0855	0900	0905	0910	0915	0920	0925	1000
SaO2	100	100	99	99	99	99	99	99
FiO2 mod	RM	RM	RM	RM	RM	RA	BB	NK
Methods	15L	12	15L	15	15			
240	14	55	%					
220								
200								
180								
160								
140								
120	V					121	121	
100			113	104	112		116	
80	0	45	•	•	•	•	•	
60						58		
40	^	42	50	49	49		59	49
20								
HR		83	86	89	86	74	77	79
RR	18	14	12	12	13	12	12	11
T	97.4	96.8			96.4			96.5

Time								
Pain (0-10)								
LOS								

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
		Ø			

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	11	12	12

Codes

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

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

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

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

PREPARED: b(6)-2 SGT/LPN
DEPARTMENT/SERVICE/CLINIC: ICU
DATE: 7 Sep 03

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

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

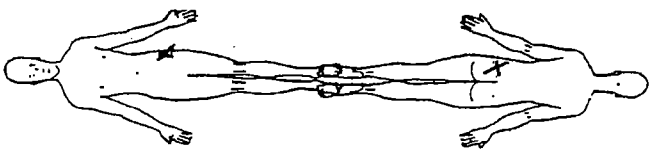
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	Foley	clear light yellow	

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

0855 - Pt arrived from OR via litter. Asleep but arousable c̄ difficulty to voice, on 5 l/pm venturi mask sating 99%.

0915: Physical Assessment — Neuro: sedated c̄ aversed, moves spontaneously c̄ environmental, verbal stimuli, @ this time, (+) sleepy, ∅ fully awake. Pupils 3mm/3mm, Pearl, moves all extremities, (+) sensation, toilet c/o sat. [redacted]; LS clear throughout. (+) Venturi mask 4-5 l/pm SaO2 [redacted] RR - 12-14 BPM. CV: NSR - BP HR WNL ∅ peripheral-dependent edema, cap refill ≤3 sec (R) thumb and (L) toe, good pulses radial, pedal 2+. [redacted] (+) BS x4 q. ∅ abd distention, ∅ abd pain [redacted] (+) Foley to gravity, clear yellow out. — [redacted] (+) PIV to (L) AC, LR infusing TKO ∅ evidence infiltration — [redacted]

0930: VM d/c'd — [redacted] RR [redacted] 99% RR - 11-14 BPM ∅ evidence resp distress, difficulties — [redacted]

0900: Pt awakes spontaneously to verbal stimuli, oriented x3 asking questions in gradually about wnd. Pt sleepy, returns to rest. — [redacted]

Discharge Criteria:
Date: 7 Sept 03 Time: PARS: 12
BP: 116/49 T 96.5 HR: 81 RR: 14 SaO2: 98%
Pain Level at D/C (0-10):
Intake: ∅ Output: 100cc - Foley d/c'd 1015 c/out problem
Additional Data:
Transferred To: ICW
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] CPT
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

WAMC OP 173-E

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.)
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 9V	18 m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26 [redacted]	27 28 29 2 6 Y	30 X	31 9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	b(6)-4	35 36 9 9	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 2	0200	

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63 [redacted]	64 65 66 67 68 69 70	71 1 BC	YEAR b(6)-4 NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 C	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74 4 1	75 76 77 78 79 80	81 82 83 84 85 86 87 88 2 0 0 3 0 9 1 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92 A B A	93 94 95 96 97 98	99 100 101 102 103 104 105 106 2 0 0 3 0 9 0 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108 I Z	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

GSW (A) Buttocks
877.0
I+D
86.28

Dx 877D
Proc 8628
Trauma 9
Inj 569 B9E
(Stealing Ammo)

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

1. Reporting MTF	2. Location	Admission and Coding Information
(b)(3)-1	IZ	For use of this form, see AR 40-400; the proponent agency is OTSG

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

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	(b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	00:40	

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

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

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW	Address of Emergency Addressee
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 (YYYYMMDD)
TRF-OTH		2003-09-15

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-09-07

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-09-07

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW LEFT BUTTOCKS
877.0

Procedure Narrative(s): IRRIGATION AND DEBRIDEMENT
86.28

Cause of Injury Narrative: STEALING AMMUNITION

(b)(6)-2

Admitting Officer (Signature, as required)

Signature of Admitting Clerk

(b)(6)-2

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

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 7101

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X	UNKNOWN			No

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICU

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	14:20	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	DUTY	2003-09-17

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-09	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(3)-1	2003-09-09	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: Sustained injury while stealling ammunition on US compound

34. Diagnosis / Operations and Special Procedures:

GSW to neck

S/P neck exploration gor zowell GSW

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of A

(b)(6)-2 MAJ,MC

Signature of PAD or Medical Records

(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION

Unknown age young male drugs shot by US Forces today in North. Reportedly sent to US Forces when approached.

All - NKDA

MEDS	PMH	PSH
?Ø	?Ø	?Ø

TOB ?

GTW - ?

PHYSICAL EXAMINATION (b)(3)-1

Gen Thin male in AD. Usual, alert & responsive
HEAD - Ø EYES - PERRLA, EOMI. EARS - Ø NOSE Ø Throat Ø
NECK Two penetrating wounds through platysma Zone II (L)
CHEST - Ø LUNGS Ø HEART Ø GI - Ø MS - No deformity
Neuro intact.

PROGRESS (Enter date of discharge and final diagnosis)

A: GSW Left Neck
P: To OR for Neck exploration

(b)(6)-2 , MD
MAJ, MC USA
(b)(6)-2 09 Sept 03

IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION	REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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MEDICAL RECORD | **CHRONOLOGICAL REC D MEDICAL CARE**

DATE	MS, DIAGNOSIS, TREATMENT, TREAT. ORGANIZATION *(Sign each entry)*
9 SEP 03	Pt presents c̄ GSW to neck. 1416 IV
1413	bag Changed. 1416 pulse 73 bpm. 1418 tracheal
	deveation. 116/90 BP. 1420 R 16. 1420 fem
Al: NKDA	stick performed. Rox 100%. – (b)(6)-2
SHx: None	

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.)* (b)(6)-4 (b)(6)-2

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
09Sep03	PRE-OP DX – ZONE II Neck injury
1623	POST-OP DX – ZONE II neck wound –
	PROCEDURE – LEFT NECK EXPLORATION
	SURGEON – Dr. (b)(6)-2 / (b)(6)-2 GEN (b)(6)-2
	FINDINGS – Bullet fragments at (L) side C5 Body, wound probe in soft tissue.
	Description: GEN. Incision made slightly parallel to Left SCM – Dissection made infront the carotid sheath. Tract posterior to carotid sheath ending at (L) side of C5 Vertebral Body. Carotid sheath spared – Vagus Nerve & Carotid Artery examined – No evidence of injury. Trachea & esophagus distinct from injury. Posterior wall entry 3 cm inf to Mastoid tract tunneled posteriorly and transversely in soft tissue. wound copiously irrigated w/ NS. Thin wound closed, SCM approx. w/ sing 3-0 Vicryl followed by closure of Platysma w/ sing 3-0 Vicryl. Skin edges approx w/ Running subcut w/ 4-0 Vicryl/Benzoin/Steri-Strips. 2 entire wound, packed w/ iodoform gauze. Pt tol procedure/anesthesia/extubated and transported to ICU in stable cond. COND-Stable CMP-0
550	IV Fluids in 900 cc LR UO-550 cc
550	
100	Antibiotics: Ancef 1 gm EBL-100 cc

(b)(6)-2 (b)(6)-2 MD

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			NUMBER
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 Sept 2003	EPW S/P (L) neck exploration c̄ debridement c̄ removal of foreign body + hemostasis. Discovered around arrow during firing upon US Soldiers. (L) tracheal deviation upon arrival to ER. Gen anesthesia 2mg Versed, 20mg Pentothal, received 9W in LA, U.O. 550cc, 10W in EBL. 1 BG to (L) A/C, 1 BG to (R) Hand, (R) Radial A line placed by SGT [redacted] in the OR. (b)(6)-2 Returned to ICU @ 1630, transferred to bed c̄ assist of four. A bird placed c̄ excellent waveform. 1 BG to (R) Wrist placed c̄ LR KVO 100 cc/hr. 1 BG Heparinized, flushed + patent. Oxygenated 55% Venturi, well mean pattern as tolerated to maintain adequate 92%. Assessments as follows: Neuro, Pupils 3mm bilat, able to move all extremities, resting comfortably c̄ complaints of pain. Resp: Even + unlabored, diminished CTA on upper fields, diminished in the bases, O2 sat 100% on 55% Venturi. GI: Abdomen flat c̄ distention, BS hyperactive + 4 quads. GU: Foley to gravity, clear yellow urine. CV: Pulses 2++ to all extremities, skin cool to touch temp 95°, covered c̄ blankets. SR 5 ectopy (V) ~70's. Cap refill brisk. Skin: Noted bandy dressings (L) neck site, dry + intact, well sensorium pain, medicated for pain, Code 50 for difficulty c̄ airway, diminished breath sounds on increased breathing due to hematoma. (b)(6)-2 [redacted] MD

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

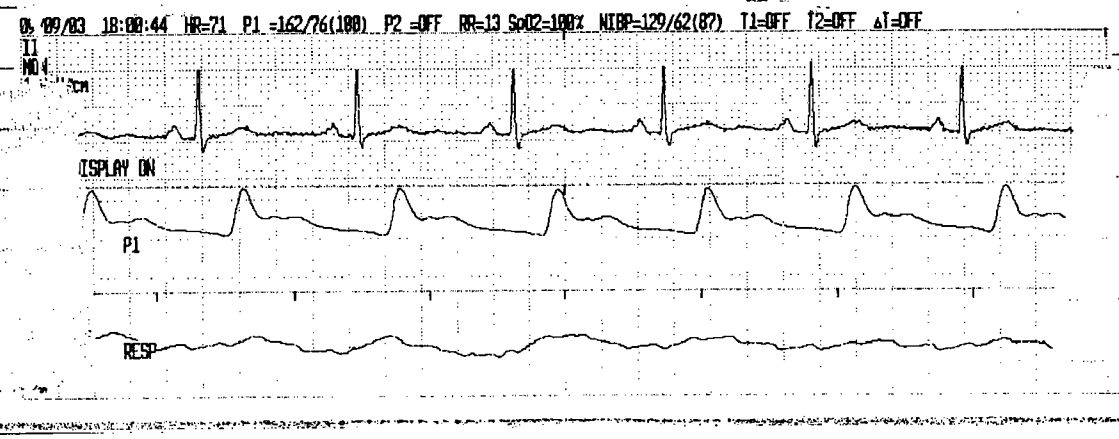
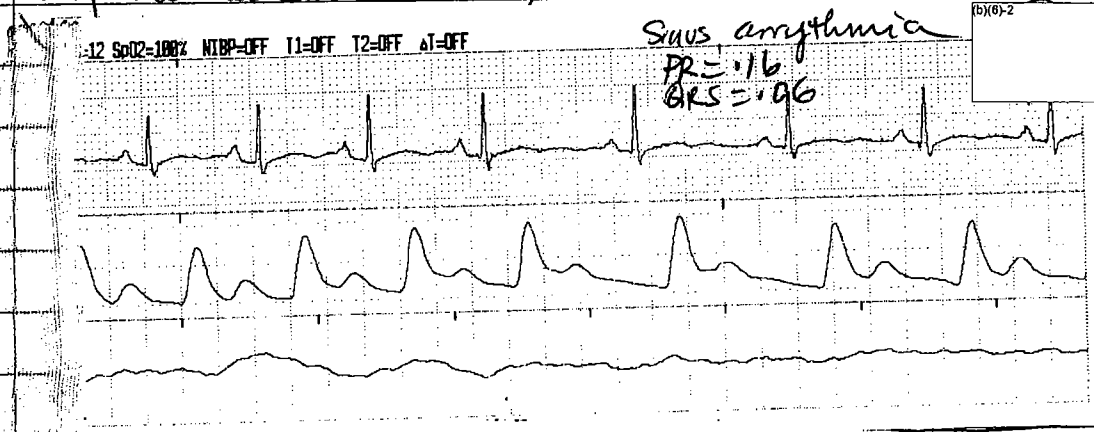
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	
9 Sept 2003	PR. 14 QRS. 08. Patient remains in NSR. U+ Rales on room AR 1W%. Drsg to Neck Dry + Intact. Reports given to ILT [redacted] Patient reporting pain medication. Will notify Dr. [redacted] [redacted]
9sep03 1800	Report received from day shift. Client in bed connected to cardiac monitor. IVF infusing via (R) hand PIV, foley patent and draining, drsg to (L) neck D+I. [redacted]
1815	Client c/o pain to (L) neck, medicated c̄ 5mg Morphine via IVP. [redacted]
1900	Complete assessment done, see DA form 4700. [redacted]
	 [redacted]
2000	client asleep at this time. [redacted]
2200	client asleep in NAD, Drsg D+I. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Sept 03 1900	OP NOTE PRE-OP DX – OPEN GSW to (L) Neck POST-OP DX – Same PROCEDURE – I & D wound (L) neck SURGEON – Dr [redacted] GSTA – Anesth – Gen [redacted] FINDINGS – No evidence of injury but damaged Pseudoaneurysm. Description – GSTA – Removed Iodoform gauze – Pseudoaneurysm OK – No hemorrhage or edema – Clamped w/ HIBCLAMPS – Angiogram w/ 2L NS has probed carotid & distal segments (8 hrs) of the two entry wounds. Dye injected pt tol. procedure well → Anesthetized & extubated then transferred to ICU in stable condition. Dx – Early Ailenia
mef 1 gm Ancef 3 gm 600 cc LR 500 cc	

[redacted] MD
MAJ, MC USA
CHIEF, DOS

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0900	Pt bathed & Ad. 2 pt restraints on (R) hand & (R) leg - MP guard @ bedside. VSS, pt denies pain. [redacted] SGT/LPN
1100	Pt c/o dizziness, HOB Ad to 45° pt now resting comfortably. [redacted] SGT/LPN
1300	Pt still c/o dizziness, will notify MD. [redacted] SGT/LPN
1330	Pt c/o pain - 3mg MSO4 given. Will monitor. [redacted] SGT/LPN
1600	Pt c/o pain to neck - 3mg MSO4 given. Dressing beginning to drain through. Dressing Ad, pt now resting [redacted] SGT/LPN
	Sign SLR
12 Sept 03	S: Pt Oper no Complaint
	O: Alert, VS noted
2248	161 / 11.6 / 35.4 / 302 — 129 / 100 / 26 / 0.5 / 120 / 43
	Neck - No active bleeding. No tracheal deviation. No hematoma.
	A: POD # 1 Neck exploration
	P: will take back to OR tomorrow for washout and DPC
	[redacted] MD MAJ, MC USA CHIEF, DOS [redacted]

STANDARD FORM 509 (REV. 5/1999) B
USAPA

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 Sep03 2300	Assessment done, no changes from previous assessment. Client c̄ c/o pain to neck, medicated c̄ 5mg MSO4 IV P. at this time. (b)(6)-2
2300	Right radial art line intact c̄ good waveform on monitor zeroed and calibrated. (b)(6)-2
2400	Client asleep in NAD (b)(6)-2
10Sep03 0200	Assessment done, no changes from previous. (b)(6)-2
0210	Client c̄ c/o nausea, medicated with 25mg phenergan IVP. (b)(6)-2
0220	Neck dsg saturated, old dsg removed, steri-strips intact, sterile 4x4's applied, ABD pad then kerlex c̄ tape to secure. good results from phenergan, denies nausea (b)(6)-2
0400	Medicated c̄ 4mg morphine IVP for pain (b)(6)-2
0515	Labs drawn from (R) radial art line and sent for analysis — SG
0600	Report given to SGT (b)(6)-2 - client in bed asleep in NAD connected to cardiac monitor, LR infusing @ 100 cc/hr via (R) hand PIV, site intact + patent. (R) radial art line c̄ good waveform on monitor, dsg + site intact. Foley patent + draining clear yellow urine (b)(6)-2
0700	Pt resting in bed - refused breakfast. Assessment performed (see DA4700) - Will monitor. (b)(6)-2 SGT/LCN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Sep 03 0100	Client in bed, asleep, connected to monitor in NAD [redacted] (b)(6)-2 LT A
0300	No changes in assessment. [redacted] (b)(6)-2 LT A
0330	Medicated with 3mg morphine IVP for pain [redacted] (b)(6)-2 LT A
0500	client in bed asleep, in NAD [redacted] (b)(6)-2 LT A
0530	client c/o pain to (L) neck area, medicated c̄ 3mg MSO4 IV for pain [redacted] (b)(6)-2 LT A
0610	Received report on pt from LT [redacted] (b)(6)-2 Assumed care. Pt a a supine in bed. O2 per RA Sao2 @98% RR 11. Ø audible distress or resp. discomfort. UR emptying to (R) bend @ 125 cc Ø evidence infection or infiltration. (+) PIV to (L) AC sl'd, (+) dried blood around catheter tip, insertion site cleaned redressed. (+) flush, (+) BR, (+) SL to (R) radial art. transduced, clear good wave form. (+) NIBP cuff to (R) brachial. Cont. A-line monitoring, NIBP x1 q hr. (+) correlation. (+) foley to gravity clear yellow urine. Pt resting c̄/out evidence pain or discomfort. (+) Pt leather (error sp pt to) restraints, 1st to (L) wrist, 2nd to (R) ankle. Guard @ BS. Pt speaks arabic, understands some English as reported by LT [redacted] (b)(6)-2 Monitoring to cont. Plan: Cont. Cardiac Resp monitoring via A-Line, f/u. c̄ PO. Monitor for airway disturbances, and damage from wound site. Prep for OR I & D in and closure for later this AM.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

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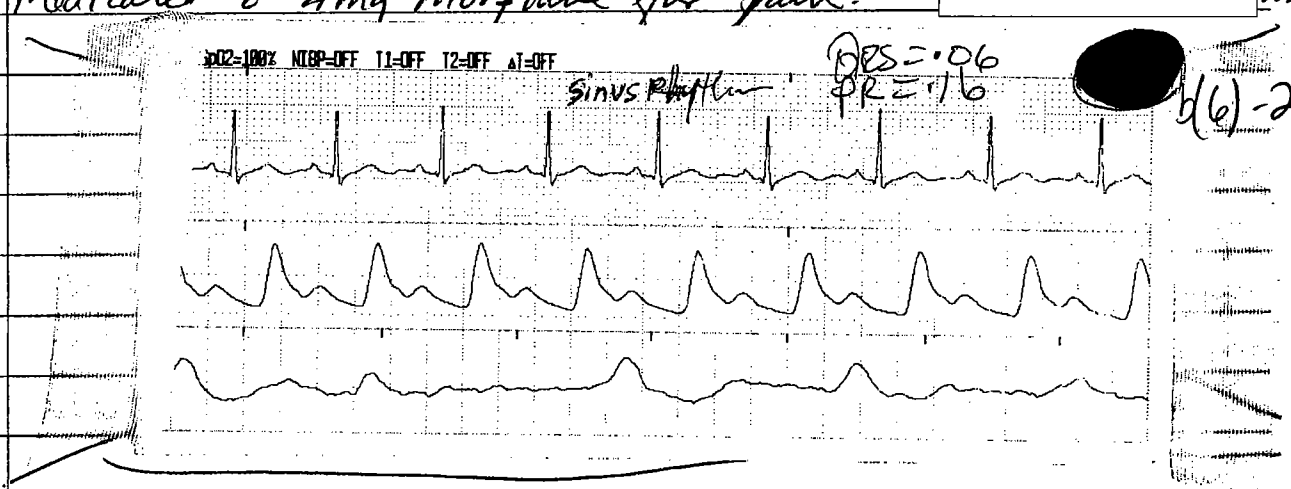
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16 Sep 03 1800	client in bed connected to cardiac/resp monitor, awake + alert. IVS infusing via (R) hand PIV @100cc/hr. Foley patent + draining. Art line to (R) radial site intact c̄ good waveform on monitor — (b)(6)-2 LCT
1900	Assessment done see DA form 4700. — (b)(6)-2 LCT
2000	client asleep at this time, in NAD — (b)(6)-2 LCT
2200	Complete bath given, Foley care done c̄ soap and water. Drsg change done to (R) neck, old drsg c̄ small amt of bloody drainage, sterile 4x4's applied c̄ ABD Pad and Kerlex and tape to secure. New gown and linen changed. Medicated c̄ 4mg Morphine for pain. — (b)(6)-2 LCT



(b)(6)-2

2300	Dr Lowery @ bedside, IVF rate ↑ 125cc/hr, aware of decreased appetite. Plan for OR in Am. — (b)(6)-2 LCT

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD	PROGRESS NOTES

DATE | NOTES

Nursing cont. 11 Sept 03 0700.

0700 (Pleur-cont.) Cont monitoring I/O's; ✓ pain management, and ABX tx. (b)(6)-2

0750 Pt prepped for OR. Report on pt status provided to CPT [redacted] (b)(6)-2 Pt transferred to OR on litter w/ LR infusing, foley, urinary to gravity, O_2 per RA. Pt accompanied to OR per staff x2 - no problems on transfer (b)(6)-2

0910 Pt returns from OR on stretcher accompanied by staff x2. O_2 per RA. SpO_2 98% RR 10. Ø evidence resp difficulties. Pt A&O, oriented, moves all extremities, good sensation throughout. NSR BP 158/96 via A-Line, 134/77 via NIBP - HR 71. T = 97.1. A-line zeroed, leveled, Ⓟ good waveform. Dressing to left CCI, Ø drainage. Monitoring to cont. (b)(6)-2

Arline NIBP
7 15: 152/75 73 98% RR 12 133/75 74
1920 152/73 73 99% RR 13 134/77 72
1925 156/76 74 99% RR 12 137/78 74

0930 UOP: = 75cc out. 0930: BS = Rhonchi throughout. Will encourage IS. SpO_2 = 97-98% RR 13-14 BPM (b)(6)-2

0940: LATE NOTE - 0915: 2 PT RESTRAINTS placed - one to Ⓛ wrist, 2nd Ⓛ ankle. Guard @ BS. (b)(6)-2

0945 IVF's ↓ 100 cc/hr per MD order. IVF to Ⓡ wrist w/ Ø evidence infection/infiltration. (b)(6)-2

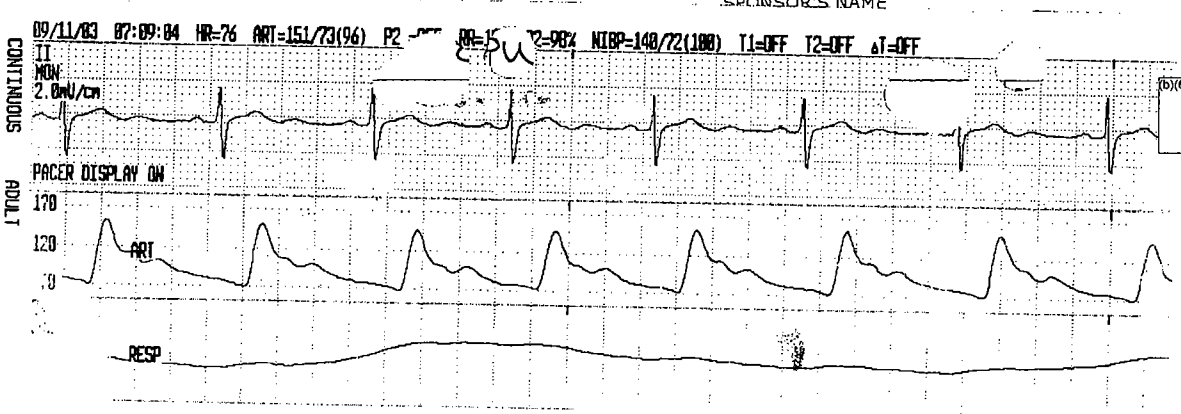
1145: Translator, Salem @ BS translating plan of care to pt. All questions & concerns addressed. Pt denies pain @ this time (b)(6)-2

SPONSOR'S NAME

SPONSOR'S ID NUMBER (SSN or Other)

(b)(6)-4

WARD NO. ICU



ESS NOTES
cal Record

STANDARD FORM 509 (REV. 5/199
ed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1

USAPA V1.(

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Sept 03 1230 -	HR - 120's - 130's BP - 150-160 systolically - 80's 90's diastolically. Pt c/o headache - Percocet II PO administered. Pt offered PO intake - H_2O & food - declined solids - consumed 120 cc H_2O & soda. (b)(6)-2
- 1300	24/7 136 HR MAS 91. Pt cont. to complain of headache to (L) side - temporal region, rated 6/10 on pain scale. MSO_4 3mg SIVP administered. Eval pending (b)(6)-2
1320:	MSO_4 2mg IVP administered s/p pt c/o headache VS unΔ'd c̄ HR ↑ 120. Dr. Lowry notified MSO_4 administered. Eval pending (b)(6)-2
1320	
128/70 112 HR	- 1400: Pt denies pain, states feeling comfortable. Ref. lunch - solids & purees, tolerated 240 cc's Instant breakfast. Pt continues to cooperate c̄ IS attaining 1200 cc/sec x 4 breath. & 900 cc/sec 8-10 breaths. Dressing to neck saturated c̄ serous drainage. Dressing Δ'd. Incl cont to monitor.
RR 17	
SaO_2 98%	
	- 1500-1630 Complete head-to-toe bath, shampoo, shave, ADLS - encouraged and completed. VS remain unchanged c̄ HR @ 120's 130's - BP 130's systolically 78-80's diastolically. Pt denies pain. Dr (b)(6)-2 notified of VS. No new action taken. (b)(6)-2
	1630: Tohey d/c'd. Pt up ambulating around ward. Continued practicing w/ incentive spirometer.
PO intake this shift = 700 total	1705: Pt Back to Bed (R) PIV 16g infiltrated - D/c'd. IVF-LR @ 100 cc/hr started in (L) AC 18g. A-line zeroed, good wave form - leveled. Pt encouraged PO intake & tolerated - 240 cc's of fluids. 2 pt restraints placed
UOP = 1195	to (L) UE, 1 to (R) LE skin color good, pulses 2+, Pt resting quietly in bed VS then noted on DA Form 4700 - Physical assessment noted on same DA Form. Report given to on coming shift 1st (b)(6)-2 (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) E

USAPA V1.0

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

11 Sep 03
1800 Report received from CPT [redacted] b(6)-2 client in bed awake + alert. follows commands, connected to cardiac resp monitor, (R) radial art line c̄ drsg + site intact, good waveform on monitor. LR infusing @ 100cc/hr via (R) AC PIV. [redacted] (b)(6)-2 LT HA

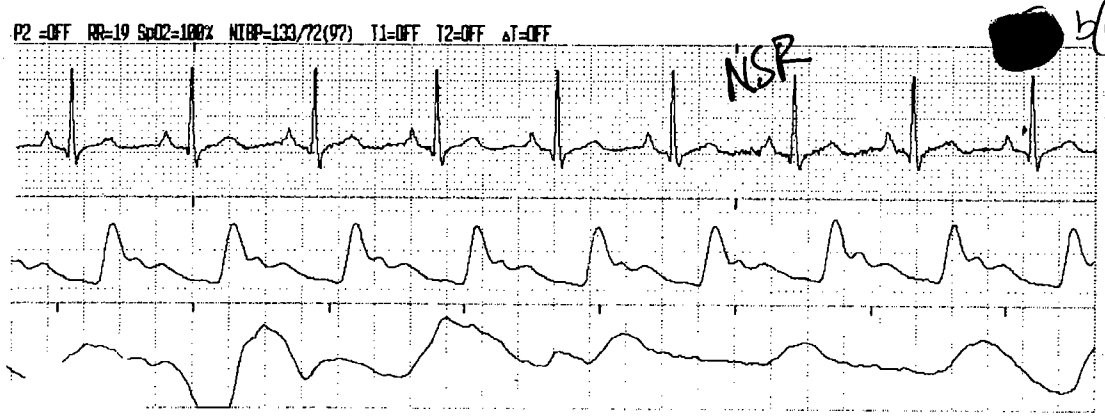
1900 Assessment done, see DA form 4700. [redacted] (b)(6)-2 LT

2000 Medicated per order c̄ Unasyn IV, explained to client via interpreter that it is important for him to void soon due to foley being d'c'd on previous shift. [redacted] (b)(6)-2 LT

2030 Client up OOB, ambulated well to bathroom with escort, unable to void at this time. Drank 500 ml H_2O, tolerated well and back to bed. [redacted] (b)(6)-2 LT

2100 Art line zeroed and calibrated, good waveform on monitor VSS. [redacted] (b)(6)-2 LT HA

102) P2 =OFF RR=19 SpO2=100% NIBP=133/72(97) T1=OFF T2=OFF ΔT=OFF



[redacted] b(6)-2

RELATIONSHIP TO SPONSOR

LAST	FIRST	MI	(SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2230	375 cc of dark yellow urine D ambulating to bedside commode — (b)(6)-2
2250	Medicated c̄ 5mg MSO4 for pain to O neck + head. — (b)(6)-2
2355	Client c/o HA, Pupils round, reactive, medicated c̄ ii percocet PO for HA. — (b)(6)-2 ILT AN
2400	Dr [redacted] notified of client c/o HA. Ordered toradol IV now. MD twice of client getting percocet for pain. — (b)(6)-2
2400	Client on NPO status for surgery in Am. — (b)(6)-2 ILT AN
12 SEP 03 0050	Medicated c̄ 25mg Phenergan for nausea — (b)(6)-2 ILT AN
0300	Client asleep w/ NAD. — (b)(6)-2
0500	Blood drawn from (R) radial art line and sent to lab for analysis. — (b)(6)-2 ILT AN
0600	Client up to commode, voided 400 cc clear yellow urine ambulated well. Report given to SUT (b)(6)-2 & client back to bed on cardiac monitor, A-line intact LR @ 100 cc/hr, Drsg to neck D+I. — (b)(6)-2
0625	Assumed care of pt. Rcvd report from ILT (b)(6)-2 pt in bed c̄ HOB ↑ 45° angle LR infusing @ 100cc/hr to 18g IV (L) AC. A-Line to (R) wrist zeroed does not correlate c̄ NIBP, restraints on / — (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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PROGRESS NOTES
Medical Record

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

(b)(6)-4

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12Sept03	OP NOTE
0930	PRE-OP DX - DPOW NECK mass
	POST-OP DX - Same
	PROCEDURE - I+D, DPC
	SURGEON - Dr. [redacted] Anesth - CPT [redacted]
	FINDINGS - Clear margins
	DESCRIPTION - GETA - neck clean & DC - Normal packing - drainage w/ 2 x NS - Undermine both edges - undermine, muscle fascia approx. w/ 3-0 Vicryl. Skin on 2 only sides. Area closed w/ interrupted vertical mattress sutures of 3-0 Nylon. Neo-Poly-Bacin applied on dressing. Dry compress. Pt tolerated procedure well → Awakened & Extubated & xported to PACU w/ stable cardiac. IV fluids in - 250cc LR Antibiotics - UNASYN 3 gm IV - MA → No Drains. [redacted] MD
	[redacted] MAJ, MC USA CHIEF, DOS
	[redacted]
	[redacted]
	[redacted]

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12Sept03 0630	Pt in bed. Initial assessment complete Neuro/ alert & oriented, easily arousable c̄ verbal stimuli. (+) movement to all extremities. Resp/ RR 10 SAO2 98% non labored even ↑↓ Chest LS: CTA & SOB noted Cardiac/ HR 71 NSR S¹ S² normal & extra sounds & murmur noted. (+) peripheral pulses x4. A-Line → (R) wrist zeroed poor wave-form does not correlate c̄ NIBP Gastro/ Abd. flat, soft, non-distended. (+) BS x4 quad (-) BM noted GU/ Pt able to urinate → urinal & urine this shift. W/ 18g IV (L) AC infusing LR @ 100cc/hr & S/S infiltration, redness +/- Plan: Pt back to surgery this Am. Will monitor pt. / [redacted] (b)(6)-2 SGT USA [redacted]

[redacted] (b)(6)-2

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12SEP03 -	1130 - ADMISSION - 25 y/o ♂ RECEIVED FROM ICU VIA LITTER. - Dx: I&D / DPC NECK WOUND. COND: STABLE. PT ALERT, PERRLA, LUNGS CTA BILAT & SYMMETRICAL. RISE AND FALL ON CHEST. HYPERACTIVE BOWEL SOUNDS x 4. S1-S2 STRONG AND REGULAR. PULSES PALPABLE IN ALL EXTREMITIES. CAP REFILL <3. WILL CONTINUE IV ANTIBIOTIC THERAPY (UNASYN 3gm). WILL REINFORCE MEALS WITH ENSURE/CARNATION. IV LR @ 100cc/hr. WILL CONTINUE TO MONITOR THROUGHOUT. (b)(6)-2 SEIZLAN
	1630 Received pt this pm awake eating. Pt on regular diet. Dsg to (L) side of neck. CDI. ⊖ Drainage noted. No c/o pain at this time. ⊖ SOB ⊖ N/V. Lung sounds CTAX4 lobes. Chest expansion full and equall. Pulses equall and palpable. Pt voids via urinal. No distress noted at this time will continue to monitor - (b)(6)-2 glumo SPC USA
	2030 - Pt c/o H/A Ti Percocet given will monitor (b)(6)-2
	2400 Meds given Pt easily arousable No distress noted will continue to monitor (b)(6)-2 glumo SPC USA
	0530 Pt sleeping easily arousable. Meds given for 0600 IV site patent No distress noted will give report to oncomming shift (b)(6)-2 glumo SPC USA

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

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

[redacted] (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sep 03	Nutrition Note
1030 S:	Nursing staff reports pt eating approximately 50% of meals and drinking a total of 2 carnation instant breakfasts everyday.
O:	Diet: Regular c̄ Ensure supplements
A/P	Pt tolerating regular diet and staff is encouraging use of supplements. agree c̄ current diet and will encourage use of supplements as PO intake improves. [redacted] MAJ, SP RD/LDN
13 Sep 03	1100 - AAO x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG REG, (+) BS x4. Ø % PAIN. CONTINUES IV ANTIBIOTIC THERAPY. OOB TO BR. ATE 30-50% OF DIET BOTH BREAKFAST + LUNCH. CARNATION x2. WILL CONTINUE TO MONITOR. [redacted] SOLC
14 Sep 3 1900	Nursing Notes: Assumed care of Pt Sleepy but easily aroused. Pt had no c/o pain received IPD toradol. Pt able to ambulate to BR without complaint or complication steri strips on wound at (L) side of neck clean dry and intact Ø obvious odor or drainage Ø S/S of infection at this time. Wounds showing Ø S/S of infection at IV site. Will continue to monitor Stats [redacted] MCK
15 Sep 03	Nursing: Shift note Pt. bright + alert speech clear, poor appetite, slight cough + tickling in his throat. Upper Resp. wheezing. Given IS 930 min (cat)

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)*
15Sep03 1725	Nursing Cont. Explored diet preference this shift. Pt. prefers strawberry carnation & fruits. Pt. states he is use to native food. Pt. additionally states that he is getting negative / bmats remarks of some type from guards. Will inform ISG of escorting unit that EPW's are patients. Continue access. [redacted] CPT AN
15Sp03 2001.03	Pt. sleeping in bed easily awakened to verbal stimulus. Skin warm/dry/intact (+) PERRLA WNL. (+) EOM WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4. Abdomens soft/nontender. (+) Radial pulses (B) (+) 2 strength. Steri-Strips / Sutures to (L) side neck c/D/I. S s/s infection. pt. c/o pain to sacral area & noted redness. PIV (L) AC patent infusing LR @ 100cc/hr. Will continue to monitor [redacted] LT/AN
2206	Pt. c/o pain to Sacrum. ii Percocet given [redacted] BN
16Sep03	ASSESSMENT – 1340 – A&O x3, PERRLA, Ø % PAIN. STERI STRIPS TO NECK L,D,I. TOLERATES 100% OF REG DIET. IV CR CONTINUES OOB TO BR. WILL CONTINUE TO MONITOR [redacted] SGT LAN

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

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

[redacted]

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)*
16 Sep 03 1900	Nurses Notes: Assumed care of Pt AT0. breathing intact Ø SOB or labored breathing Pt able to move all extremities ī pain or complication. Tolerated regular diet OK Ø N/V. wound in neck ī steri strips clean dry and intact Ø bleeding Ø drainage Ø odor. Pt voids spontaneously. Ø c/o pain at this time. Will continue to monitor status — (b)(6)-2 [redacted] cpur
2300	changed IV tubing. IV infusing ī blockage — (b)(6)-2 [redacted] IV/A
17Sep03 1445	Nursing ~~Shift~~ Discharge Pt. bright + alert. tolerating p.o., speech clear in native tongue. Sutures removed from neck line + steri-stripped. Pt. pain meds given to escort. X-ray given also Pt escorted off ward by responsible unit — (b)(6)-2 [redacted] 1971 AN

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)*
17 SEPT 03	NARRATIVE SUMMARY Origin male DPW
1430	who was shot in (L) side of the Neck
	on 09 Sept 03. He underwent Left Neck
	Exploration on 09 Sept 03 w/ Nonoperative removal.
	Exploration revealed no injury to vital
	structures. 2 penetrating bullets underwent
	delayed primary closure 11 Sept 03. He had
	initial course of 3 days w/ Unasyn.
	Currently being visual pain, ambulating and
	tolerating regular diet.
	NKDA PMH/PSH: Asthma (-)
	MEDS: 1) MOTRIN 800 po TID w/ food 2) PERCOCET
	1 po q 4' PRN/PAIN
	DIET: Regular
	ACTIVITY: Ad lib
	A: SP NECK EXPLORATION FOR ZONE II GSW
	P: DISCHARGE TO MPS.
	(b)(6)-2 (b)(6)-2 , MD
	MAJ, MC USA
	CHIEF, DOS
	(b)(6)-2

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

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

REGISTER NO.	WARD NO.

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 09, MONTH 09, YR. 03 — TIME 1413

TRANSPORTATION TO HOSPITAL (or enroute clinic): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT CONDITION: ⊖

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA.

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 to Neck. TOI 1300.

SEX: M AGE: ~25

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1413

VITAL SIGNS			
TIME	1413		
BP	116/90		
PULSE	73		
RESP.	18		
TEMP.	⊖		
WT. (Child)	RAPO 100%		

CATEGORY (See reverse)
- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: GSW to ⊕ Neck Zone 2.

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): Gen Surg.
- [X] EMERGENCY — TODAY
- 72 HOURS — ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: IMPROVED — UNCHANGED — DETERIORATED

TIME OF RELEASE: 1417

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)

S: Pt is ~25 yo Iraqi ♂ EPW who was shot to ⊕ neck by M-16 from US forces whom he was firing upon at an ammo storage site N. of Tikrit. C/o Hoarseness to voice.

PMH: ⊖
PSH: ⊖.

O: WDWN in mod-sev dist ♂ to GSW. GCS 15 min. Resp dist ⊕ hoarseness.
HEENT: NC/AT PERRL EOMI ⊖ Blk in Alw.
Neck: ⊕ Tat neck - Thru/thru GSW c̄ Tracheal deviation to ⊕
⊖ Stridor ⊖ SQ emphy. ⊕ mod swelling to ⊕ neck.
Chest: ⊕ eq CTA
Cor RRR ⊖
Abdo ⊕ BS, S, NT ND ⊖ Alw
Ext: ⊖ NT from Mvintact
Neuro: I ⊖ intact 5/5 Motor, moves all 4 Ext

142 | 1.0 | 8 / 4.1 | 03 | .4 / 102
17.8 | 12 / 36 | 266
PT/PTT: 15/39 INR 1.59
Tox Scrn:
C-spine: ⊖ fx
⊕ mult frags to to ⊕ neck.
⊕ Ant Spinal ST swelling
Intubated.

EDC: Initiated RSI for Emergent A/w control due to Expanding ⊕ Neck Hematoma → Pack Dem Brought to OR for Intubation + Surgical A/w back up.

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SS; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

SIGNATURE

(b)(6)-2

INSTRUCTIONS (Medication prescribed, any limitations and follow-up plans)

To OR for Intubation with Surgical Backup

EMERGENCY CARE AND TREATMENT — Medical Record Copy

STANDARD FORM 558 (Rev. ... Prescribed by GSA and ICMR

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: unknown
   HEIGHT:
   WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
   ☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
   REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
   Lt neck exploration

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
   Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
   ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
   Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes X language barrier	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Emergent ~~GSW to~~ erron YES Nickel-size wound and Quarter-size wound at Lt neck region.	o Allow pt. to verbalize freely (b)(6)-2 o ~~Explain OR environment and~~ answer questions regarding surgery. N/A o Offer comfort measures. (e.g.. warm blanket. touch). o ~~Explain all nursing procedures before they are done.~~ N/A o Remain with pt. whenever possible. o Maintain family interface. Parents to ~~stay with pt.~~ N/A
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. (b)(6)-2	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. (b)(6)-2 o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas). (b)(6)-2	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment (b)(6)-2 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

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP_____ ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated EMERGENCY
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	IENT GOALS AND EXPECTED OUTCOM	NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning ____ 3) Existing Disease X 4) Safety Devices ____ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse (b)(6)-2	o ~~Check for support stockings or ace wraps. If none, check with doctors.~~ N/A o Check that safety straps are correctly applied. (b)(6)-2 o ~~Offer pillow for under knees.~~ N/A o ~~Place and take down legs from stirrups with slow bilateral motion.~~ N/A o Check that rings and all body piercing has been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery X 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. (b)(6)-2 o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. (b)(6)-2 o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. X Potential for decreased communication due to: ____ 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR tabl (b)(6)-2 o Pt. will be able to understand instruction o Minimize danger of injury during intrao period.	o Introduce self. Keep pt. informed where he/she is and what is happening (b)(6)-2 (b)(6)-2 o Inform pt. in which direction to move d assist if necessary (b)(6)-2 o ~~Speak clearly and slowly.~~ N/A o ~~Address pt. from ____~~ N/A o ~~Validate pt.'s understanding of verbal communication.~~ N/A o ~~Verify removal of dentures.~~ N/A
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES: Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2

9 SEP 03 DATE

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

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

LEVEL OF ACTIVITY: X Moves All Extremities ☐ Moves Upper Extremities

☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) none

DATE: 9 SEP 03 TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (b)(6)-2 MAJ, AN

DATE: 9 SEP 03 TIME: 1632

REVERSE OF FORM 5179, JUN 91

MEDCOM - 7126

USAPA V1.0

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

For use of this form, see AR 40-66, the prop[illegible] agency is the [illegible] General.

PATIENT TRANSPORTED TO OPERATING [illegible] litter BY CPT [redacted], CRNA

2. PATIENT IDENTIFIED RECORD RE[illegible]URE VERIFIED BY [redacted] [redacted]

DATE 9 SEP 03 — TIME PATIENT ARRIVED IN SUITE 1417

4. PATIENT IN ROOM TIME 1417 — NUMBER [illegible]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted], AN, 66E MAJ [redacted], AN, 66F	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

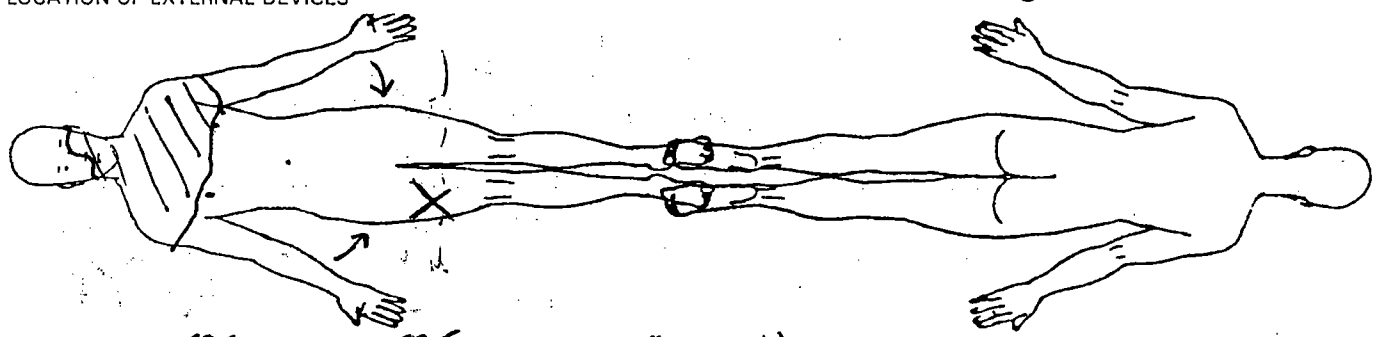
COMMENTS: arms tucked; head on foam

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine & Betadine
SITE: ⓒ neck - nose to nipples BY WHOM: 1Lt [redacted]
SITE: - to ⓡ ear BY WHOM:
COMMENTS: No pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (ESC) -- Safety Strap (ESC) = = = Tourniquet (NA) \\\ = prep

10. COUNTS — C = Correct I = Incorrect — Count by [redacted]

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

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

[redacted]

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

☒ ESU NO: Selling 30/30 VL 000442 Force II
GROUND PAD: BRAND VL REM
LOT NO: 69671 Exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.01

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
Tetanus Toxoid 0.1mm	0.1 mg	1435	IM	EMT Staff	Dr. (b)(6)-2

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

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIA (b)(6)-2

15. X-RA

YES ☒ NO ☐ IF YES, SITE Neck + head

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☐ NAME (A) foreign bodies, Lt neck (s) given to surgeons NAME

FROZEN SECTION (FS) YES ☐ NO ☒ NAME NAME

CULTURE (C) YES ☐ NO ☒ NAME NAME

NAME NAME NAME

NAME NAME NAME

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley 16 FR	1/4" Iodoform Gauze	
SITE	leladder	Lt neck wound	

18. DRESSING/IMMOBILIZATION (Specify)

Bemjorin
Steristrips
4 x 8 dressing sponges
Towel
Coverall

9. ADDITIONAL INFORMATION

Dr. (b)(6)-2 CRT (b)(6)-2 CRNA

. OPERATION(S) PERFORMED

Lt neck exploration, D+I, and foreign body removal

. PATIENT TRANSFERRED TO ICU TIME 1630 METHOD Litter

REGISTERED NURSE SIGNATURE (b)(6)-2 (b)(6)-2

USAPA V1.01

MEDICAL RECORD — **INTRAOPER[illegible] DOCUMENT**

For use of this form, see AR 40-66, the [illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN[illegible] VIA letter BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTIFI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 MAJ, AN

3. DATE 11 SEP 03 TIME PATIENT ARRIVED IN SUITE 0803

4. PATIENT IN ROOM TIME 0803 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert, Arabic-speaking. See previous pre-op NPO status maintained

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Beach chair. Back elevated to 30°. Pillow under knees. Knees bent. ~~at~~ (B) arms abducted less than 30° at side of bed on padded armboards.

[ ] 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

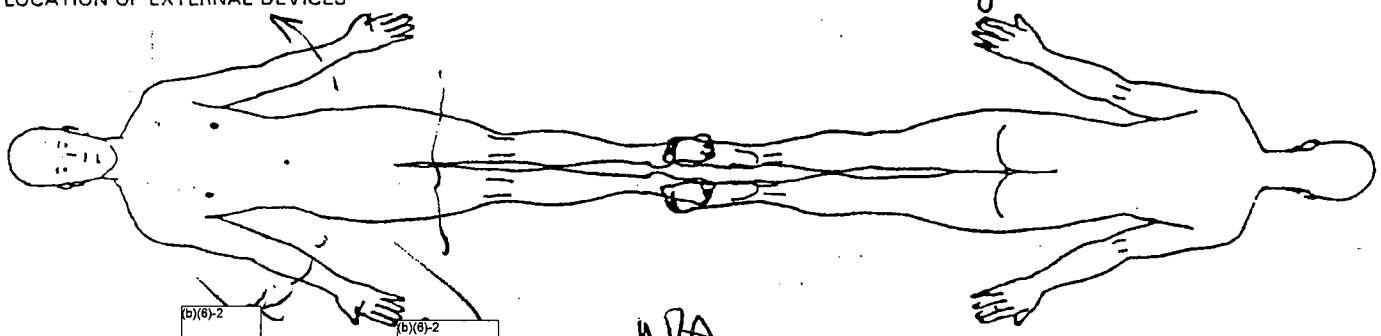
COMMENTS:

PREP SOLUTION (Specify) Betadine SITE: Lt face/neck BY WHOM: (b)(6)-2

SITE: Lt shoulder BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 N/A === Tourniquet

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

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

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

(b)(6)-4

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

Settings 20:20

[X] ESU NO: VL 000442 Force II

GROUND PAD: BRAND VL REM

LOT NO: 69671 EXP 2005-04

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUMB 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): NSS
Beticlens + NSS - wounds by Dr. (b)(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1/4" Iodoform Gauze Packing		
SITE	Lt neck wounds		

18. DRESSING/IMMOBILIZATION (Specify)
Benzoin / Steris
4X8 dressing sponges
Kerlix

19. ADDITIONAL INFORMATION
Dr. (b)(6)-2 CPT (b)(6)-2 CRNA

Foley (from ICU)

20. OPERATION(S) PERFORMED
Debridement + Irrigation, Lt neck wounds.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	0905	letter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 7130

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY anesthesia

2. PATIENT IDENTIFIED PROCEDURE VERIFIED BY (b)(6)-2 Lt/m

3. DATE 12 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IDENTIFICATION TIME 0815 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: (L) arm tucked, head on pillow

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

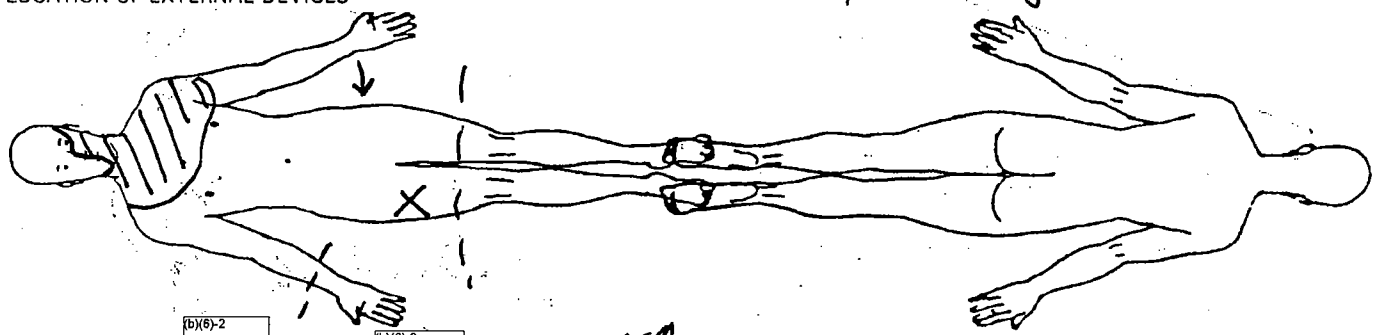
PREP SOLUTION *(Specify)* Beta / Beta

SITE (L) neck to Right neck BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet N/A \|\|\| = prep

10. COUNTS — C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: #1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

LOT NO: 69671 exp 2005-04

☐ 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 ☒ (b)(6)-2

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Surgicel	QS	I/O	Topical	MFR	(b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
1) NSS
2) Hibiclens

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Benzoin
Steri Strips
4x8
coverall

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

maj (b)(6)-2 CRNA / CPT (b)(6)-2, CRNA / SSG (b)(6)-2, RT

20. OPERATION(S) PERFORMED
I+D, DPC (L) neck wounds

21. PATIENT TRANSFERRED TO ICU TIME 0935 METHOD litter

22. REGISTERED NURSE SIGNATUR (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 0

USAPA V1.01

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		12Sep03															
MONTH-YEAR	DAY	Friday															
19	HOUR	06	07	08	09	10	11	12	13	14	15	16	17	18	19		

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	12														
BLOOD PRESSURE NBP	129/73														
Heart rate	72														
~~Temp~~ A line (MAP)	154/77														
HEIGHT: WEIGHT →															
O2 Sat	98%														
LR	100/100														
PO															
Urine	400/400														

INPUT

OUTPUT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 ~~4~~ 5

POST- DAY

MONTH-YEAR Sep 03 | DAY: 12 13 14 ~~15~~ 14 15 16 17

19 | HOUR

PULSE (O) | TEMP. F (°) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
~~60~~	H20	600	600
	mi:N	250	850

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1100	1L	LR	1L	1830	1000
1200	100	uni:Syn	100		1100
1830	1000	LR			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

106

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1400	400	400			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* ..	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL.....	240
COFFEE CUP	160	LARGE WATER GLASS...	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) JUL 72 WHICH MAY BE USED. USAPPC V1.00

Ward/Section: ICU	Requesting Physician: DR (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE: 9 Sept 03 / TIME: 1800	SSN/PSEUDO SSN: -

Hematology (CBC)

TEST	RESULT	REF RANGE
WBC	19.3	4.8-10.8 x 10
RBC	4.09	4.7-6.1 x 10
Hgb	11.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	35.6	45-52% (M) 37-47% (F)
MCV	87.2	80-94 fl (M) 81-99 fl (F)
Plt	272	130-500 x 10 Verified
Lymph %	7.5	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

[redacted] Chem 7

TEST	RESULT	REF. RANGE
GLU	126	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
[redacted]		
NA*	129	128-145 mmol/l
K*	3.7	3.3-4.7 mmol/l
CL*	104	98-108 mmol/l
CO2	23	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 10

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

CBC, Chem 7

Remarks:

(b)(6)-2 | DATE: 9 Sept 03 | LAB ID NO: (b)(6)-4 [redacted]

Ward/Section: ENT	Re[illegible] Physician: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Name: (b)(6)-4	Date: 9Sep03	Time: 1421	Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	102	73 - 118 mg/dL
BUN	8	7 - 22 mg/dL
Creat	0.4	0.6 - 1.2 mg/dL
Na	142	128 - 125 mmol/L
K	4.1	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
tCO2	23	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	17.8	4.8 - 10.8 x 1E3
RBC	4.07	4.7 - 6.1 x 1E6
Hgb	11.8	14 - 18 g/dL (M); 12-16 (F)
Hct	35.8	45 - 52% (M); 37 - 47% (F)
MCV	87.5	80 - 99 fL
Plt	266	130 - 500 1E3
Lymph%	15.1	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	16.0	9.8 - 13.6 sec
aPTT	~~39.0~~ 51	21 - 34 sec
INR	~~39~~	N/A 1.59

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions: Type + Cross, PTPTT

Reported By (b)(6)-2	Date 9Sep03	Lab ID # 007

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST, FIRST, MI		TIME	SSN/PSEUDO SSN:
(b)(6)-4	10 Sep 03		(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.1	4.8-10.8 x 10
RBC	4.03	4.7-6.1 x 10
Hgb	11.6	14-18g/dl (M) 12-16 g/dl (F)
Hct	35.4	45-52% (M) 37-47% (F)
MCV	87.7	80-94 fl (M) 81-99 fl (F)
Plt	302	130-500 x 10 Verified
Lymph %	10.1 %	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU	122 *	73-118 mg/dl
BUN	5 *	7-22 mg/dl
CRE	0.5 *	0.6-1.2 mg/dl
[redacted]		
NA*	129	128-145 mmol/l
K*	4.3	3.3-4.7 mmol/l
CL*	100	98-108 mmol/l
CO2	26	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	(b)(6)-2	DATE: 10 Sep 03	LAB ID NO:

Ward/Section: ICU	Requesting Physician: DR (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE: 11 Sept 03	TIME: 0945	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.3	4.8-10.8 x 10
RBC	3.95	4.7-6.1 x 10
Hgb	11.5	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	87.1	80-94 fl (M) 81-99 fl (F)
Plt	307	130-500 x 10 Verified
Lymph %	9.4	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

Chem 8 [redacted]

TEST	RESULT	REF. RANGE
GLU	16.3 58	73-118 mg/dl 98
BUN	3.95	7-22 mg/dl 6
CRE	0.4	~~0.6~~-1.2 mg/dl
[redacted]		
NA*	128	128-145 mmol/l
K*	4.1	3.3-4.7 mmol/l
CL*	100	98-108 mmol/l
CO2	26	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

b(6)2 **Malaria Smear**

Results:

Microscopic UA

Results: CBC Chem 8

Remarks:

Reported by: (b)(6)-2	DATE: 11 Sept 03	LAB ID NO: 007

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST, FIRST, MI		TIME	SSN/PSEUDO SSN
(b)(6)-4	12 Sep 03	0455	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	9.9	4.8-10.8 x 10
RBC	3.45	4.7-6.1 x 10
Hgb	10.1	14-18g/dl (M) 12-16 g/dl (F)
Hct	30.0	45-52% (M) 37-47% (F)
MCV	87.1	80-94 fl (M) 81-99 fl (F)
Plt	265	130-500 x 10 Verified
Lymph %	22.7	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU	91	73-118 mg/dl
BUN	5 *	7-22 mg/dl
CRE	0.4	0.6-1.2 mg/dl
[redacted]		
NA*	134	128-145 mmol/l
K*	3.9	3.3-4.7 mmol/l
CL*	97	98-108 mmol/l
CO2	25	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	(b)(6)-2	DATE: 12 Sep 03	LAB ID NO:

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)									
Midazolam	(mg)	2								
fentanyl	(mg)	150				50				
STP	(mg)	250								
Succ/Zem	(mg)	100	30	20		10	10			
Neostigmine/glycopyrolate	(mg)							4/0.6		
VOLAT AGENT: Sevo	% del	1.5	1.5	1.0	1.7	1.5	1.5	1.5	0.6	X
	% e.t.									
AIR	L/Min									
N2O	L/Min									
O2	L/Min	8 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 8 - 15								

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION

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

FLUIDS		
LINE site LR (cc) 18g UR ☐ Warmed		150 — 200 — 350
☐ Warmed		
LR (cc) 16g RH ☐ Warmed		100 — 200 — 850
RA (cc) 16g 1m 20mg NS ☐ Warmed		X — X
LOSSES: EST BLOOD LOSS		350 — 100
URINE –		350 — 350

TOTALS	
2mg	
200 mcg	
250 mg	
100 / 70 mg	
4/0.6	
TOTAL FLUID	100cc
TOTAL URINE	550cc

FLUIDS – SUMMARY
CRYSTALLOID – LR 900cc
COLLOID –
BLOOD – X

PHYS STATUS: 1/2 3 4 5 (E)

BODY WEIGHT: 350 KG LB

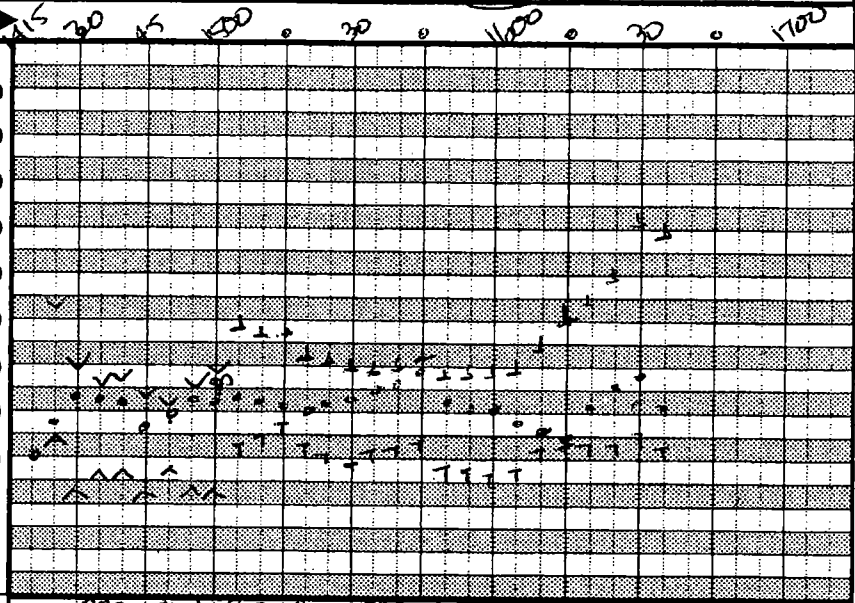
HEMATOCRIT: 35.8

INITIAL DATA: BP – 124, 69 HR – 60

COMP CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE? Yes TIME – 1417

SYMBOLS: (R) arm BP by cuff; ∨ Peq ∧ Adult; Heart rate ●; Resp rate; (R) Radial BP (transduced); ⊥ T; TOURNIQUET T – ✗; ANES – X-X; PROC – ⊙ – Ø



I:E = 1:2 VT – ml		820	840	820	830	830	820	600	>400	
f – breaths/min	16	10	8	6	6	6	6	6	14	26
Peak inf pres / PEEP		17	18	17	17	17	17	14	—	
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	#	33	28	31	32	31	30	35	40	—
BP / oth / ✓ FIO2 (Frac or %)	.85	.85	.84	.85	.85	.85	.85	.85	.85	.21
✓ ART line (R) / ✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth – PC/ES / ✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
✓ Gas analyzer / TEMP – site Axil										
N-M Block (T/4)	4/4	0/4	4/4		1/4		1/4		4/4	ET
Warming blkt		✓✓								
Conv warmer										

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → D ⊥ → → → →

(D) arm tucked/padded (R) arm <90° secured on padded Armboard.

REMARKS – Code drugs with numbers, events with letters

1410 → In ER, greet pt c̄ GSW to (D) neck. Tracheal deviation to (R) noted c̄ mild bleeding noted @ site. SpO_2 100 on RA. Mild stridorous upper airway noises noted upon auscultation of lungs. To OR → immed.

1417 In OR 1-1. Pre O_2. Monitors on. See airway note below. IV induction, eyes taped, intut.

1425 (D) hand 16g IV placed. (R) radial line placed under sterile technique.

1628 Resp even/reg, TV > 400. Airway reflex intact. Opens eyes. Oral Sxn. Extubated, pos pressure breath.

1630 → ICU via litter. Pt stable. VSS. Report to MAJ Walker RN.

RECOVERY AT 1632
PACU (ICU) _____ (Specify)
OTHER Tz 95F Tymp
CONDITION: Stable
RESP – 26 SpO2 – 100% 15L FM
BP – 159/63 HR – 84 (SR)

ANES	Start	Room	End
	1410	1417	1645
PROC	Ready	Begin	End
	1421	1430	1625

PROCEDURES and CPT Codes
(D) neck Exploration of debridement & irrigation of (D) neck GSW c̄ removal of foreign body

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA O_2 / Sevo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
RSI c̄ cricoid pressure. IV x 1 c̄ MAC 3. Grade I view VC. 8.0 OETT placed easily & secured @ 22cm @ teeth. (B) skilet (B) sustained ETCO2 (B) BBS = (B) BS

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

SURGEONS: (b)(6)-2
AN (b)(6)-2 CRNA

PROCEDURE LOCATION OR 1-1
DATE 9 SEP 01
PAGE 1 OF 1

16.1 / 11.6 / 35.4 / 302 129 | 100 | 3 / 4.3 | 26 | 0.5 / 122 Ancef LD 0200
NKDA ASA I - s/p GSW to ⓛ MSO4 LD 0530

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage						
midazolam (mg)	(2)						
fentanyl (mg)	100	25		25			
Propofol (mg)	140						
succ / zem (mg)	100 / 20						
neostig / glyco (mg)				3/0.4			
( )							
VOLAT AGENT: Sevo % del	1.0	.8	.4	1.5	X		
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	8-2-2-2-2-6						

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

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

TOTALS	TOTAL MIN
2mg	Min
150mcg	
140	TOTAL URINE
100 / 20	500cc
3 / 0.4	

FLUIDS — SUMMARY
CRYSTALLOID– LR = 600
COLLOID–
BLOOD– X

FLUIDS: LINE site LR (c) 16g 4H ☐ Warmed — 300 — 600; ☐ Warmed; Ancef 1g in 50cc NS 10 min ☐ Warmed; Unasyn 3g in 100cc NS 10 min ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE – Min 500

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: N 45 (KG) LB

HEMATOCRIT: 35.4

INITIAL DATA: BP – 131, 69; HR – 90

COMP CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE (Y) N; TIME – 0745

TIME → 0700 • 30 • 0900 • 30 • 1000 • 30 •

SYMBOLS: (1) Arm BP by cuff; V Reg ^ Adult; Heart rate ●; Resp rate; BP (transduced) ⊥ (P Read); TOURNIQUET T – ⁄; ANES – X-X; PROC – ⊙ – Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

I:E, I:2 VT – ml	720	720	700	>750	720
f – breaths/min	8	8	8	15	13
Peak inf pres / PEEP	17	17	17		
MODE – S(pon), A(ssist), C(on)	C	C	C	S	S
✓ BP/Auto Cuff / ET CO2 (torr)	(P) 30	31	30	48	—
BP / oth / FIO2 (Frac or %)	.89	.90	.90	.90	RA
✓ ART line (P Read) / SpO2 (%)	100	100	100	100	99%
Steth- PC/ES / ECG	ST	ST	ST	SR	SR
✓ Gas analyzer / TEMP- site Axill					
N-M Block (T/4)	4/4	0/4	4/4	3/4	4/4 ST
Warming blkt	✓				
Conv warmer					

REMARKS – Code drugs with numbers, events with letters

0745 Greeted in ICU. ⓛ NPO verified. Non-Eng speaking. No change in preop since 9/9/03. VS: ⓡ radial Aline et Bilat arm IVs patent. —

0803 to OR 1-1 via litter. Lifted to bed by 3. Monitors on. Pre O_2. See Airway note below.

0905 Resp even / Reg. TV 700. MAE. Airway reflexes intact. Oral Sxn. Extubated c̄ pos pressure breath. Spont resp returns.

0910 To ICU via litter. VSS. Report to CPT A. Pt stable

RECOVERY AT 0910
PACU (ICU) (Specify)
OTHER Tc 97.1 Ax.
CONDITION: Stable
RESP-13 SpO2-99% RA
BP-155/74 HR-71

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	0730	0803	0915
PROC	Ready	Begin	End
	0810	0832	0902

Mark with letters & symbols, explain under REMARKS — EVENTS: Arms near torso bilat (90° secured on padded armboards) Position → OK → OK → OK

PROCEDURES and CPT Codes: (1) Neck wounds debridement + irrigation ~~c̄ delayed primary closure~~ (b)(6)-2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA (O_2 sevo)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 c̄ MAC 3 Grade 1 view UC B.D OETT placed + secured @ 22cm @ tech. @ stylet @ sustained $ETCO_2$ @ BBS = Soft bite block placed.

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: (b)(6)-4

SURGEONS: (b)(6)-2
ANESTHETIST: (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION: OR 1-1
DATE: 11 SEP 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 3 REVISED 1 Jan 3.

MEDCOM - 7143

*U.S. GPO: 2002-729-180/40137

Sep pre-op 9/11/03 NKDA

9.9 / 10.0 / 50.0

134 | 97 | 5
3.9 | 25 | 0.4 (91

(R) radial a-line DC'd c̄ pressure x 5 min.

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION		
DRUG	(Right)	
versed	(mg)	2
fentanyl	(ug)	100 25
STP	(mg)	325
Sch	(mg)	100
	( )	
	( )	
VOLAT AGENT Forane	% del	
	% e.t.	1.0 .8 .6
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 2 2 8

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

TOTALS	TOTAL MIN.
2	Min
125/125	

TOTAL URINE: ϕ

FLUIDS – SUMMARY
CRYSTALLOID– 250
COLLOID– ϕ
BLOOD– ϕ

FLUIDS		
LINE site	☐ Warmed	
OR ↑ 350	☐ Warmed	250
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 45 KG

HEMATOCRIT:

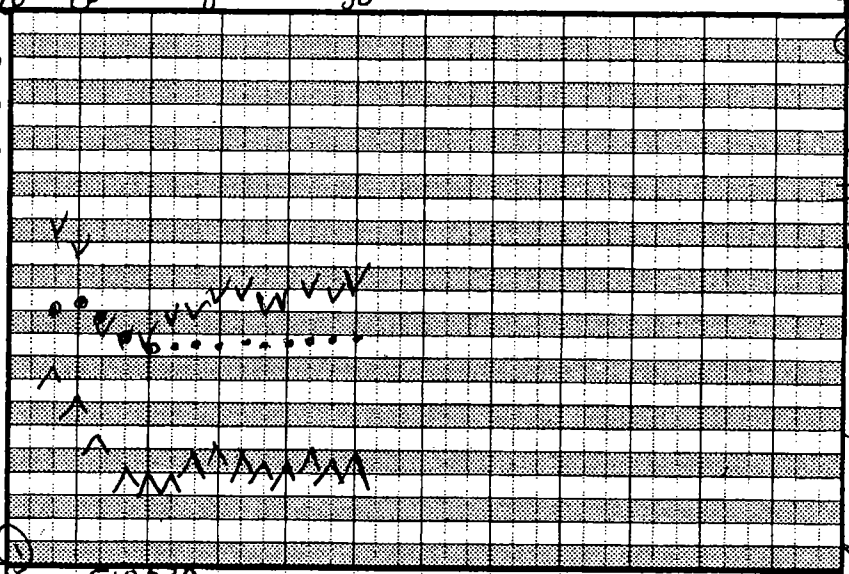
INITIAL DATA: BP – 142, 84 HR – 110

EQUIP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? (Y) TIME – 0823

TIME → 0815 0820 0825 0830

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES – X-X; PROC – ⊙ – Ø



VENTILATION						
	VT – ml		510	530		
	f – breaths/min		6	6	12	12
	Peak inf pres / PEEP		13			
	MODE– S(pon), A(assist), C(on)		S	C	C	S	S
BP/Auto Cuff	✓	ET CO2 (torr)	7	46	51	53	51
BP / oth	✗	FIO2 (Frac or %)	.26	.85	.85	.89	.89
ART line	✗	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✗	ECG	ST	SR	SR	SR	SR
Gas analyzer	✗	TEMP- site		98.6		98.6	
		N-M Block (T/4)	0/4	4/4			
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS: pressure p's padded but <90. Position → ⊙

REMARKS – Code drugs with numbers, events with letters

(1) → OR from ICU Pre-O2 / monitors - I.V.

(2) Sx'd / extubated c̄ r.p. p̄ SV, TV > 5 c̄ c̄ kg SaO2 99%. → ICU for recovery I.V. patent. Report given

RECOVERY AT 0934
PACU (ICU) (Specify)
OTHER 97.4
CONDITION: sleepy, ICU
RESP– 16 SpO2– 98%
BP– 132/75 HR– 92

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	0820	0822	0940
	Ready	Begin	End
PROC	0834	0850	0924

PROCEDURES and CPT Codes: DPC neck wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: mil #2 8.0 ETT @ 22 cm @ lip ⊕ ETCO2 ⊕ BBS. Atraumatic. (mf) ↑ re-intubation by SSG (b)(6)-2 ERT

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: (b)(6)-4

SURGEON (b)(6)-2

ANESTHE (b)(6)-2 Cogan

(b)(6)-2 CPT, AN CRNA

PROCEDURE LOCATION OR 1-1

DATE 12 Sep 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7144

*U.S. GPO: 2002-729-180/40137

13 Sep 03 – post-op [illegible]

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: N 25 HRS DAYS MOS YRS SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Neck Exploration SURGICAL SERVICE: GS - (b)(6)-2

ASA PHYSICAL STAUS (1) 2 3 4 5 (E)
WEIGHT: N 45 (KG)/LB HEIGHT: ____ IN.
ALLERGIES: NKDA

HABITS:

TOBACCO: Ø
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:

([ ]= ordered as premed)

[ ] Ø
[ ]
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:

None Yes (@ ____ Hrs) /OC
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A: ____
OTHER:
17.8 / 11.8 / 35.8 / 266

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:	Hypertension	N	Y
	Angina	N	Y
	MI	N	Y
	CVA	N	Y
	Other	N	Y
Pulmonary System:	Asthma	N	Y
	Bronchitis/URI	N	Y
	COPD	N	Y
	Other	N	Y
Renal System:	Acute/Chronic RF	N	Y
Gastrointestinal:	Hepatitis	N	Y
	Hiatal Hernia	N	Y
	PUD	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	(Y) Gun to (R) neck
Familial HX		(N)	Y ____

Denies
(via interpretor)
Emergent nature
Trachea deviation to (R)

PAST SURGICAL/ANESTHETIC HISTORY

Ø

PHYSICAL EXAMINATION

BP ____ HR 90 RESP ____
HEENT - Teeth Intact
Trachea Deviated to (R)
TMJ/Neck FROM
Oropharynx II
Nares Patent
CHEST: CTA (B) Upper airway stridor
CARDIAC: S1 S2 RRR
EXTREMITIES: ____
IV Access: LAC 18g
Ulnar Filling: ____
BACK: ____
OTHER: ____

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): ____ (X) General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wih the patient/legal guardian. The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: (b)(6)-2 CPT/CRNA DATE: 9 SEP 03 TIME: 1415 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____

VITAL SIGNS: BP ____ HR ____ RESP ____ SuO_2 ____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level ____

REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

(X) NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER
c/o dizziness

CPT/CRNA
Sign (b)(6)-2 DATE: 10 SEP TIME: 1200 Hrs

PATIENT IDENTIFICATION: (Ward: ____)
(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 09 Sept 03 TIME OF ORDER: 1633 HOURS

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. Z PKU - Dr.
2. AL - SP (L) Neck exploration
3. Cul Spital AN ?
4. VS q 1, FEO, A-line, Morton
5. ACT/MT - Bedrest, elevate HOB
6. Diet - Clear liquids
7. IV LR TKO 100 cc/hr

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(b)(6)-2

8. ANCEF 1 gram IVPB q 6°
9. Incentive Sp, Resume 10-20 x/hr
10. Repeat Lat Cervical Spine
11. CXR
12. CBC, Chem NOW and IN AM
13. Pray Chya Neck hemorrhage
14. Call MD for T > 101° or LEO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

2110, SBP < 100 or > 160, UO < 30
Pulse Ox < 92 %, Expansion
Neck hematoma.

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 09 Sept 03 TIME OF ORDER: 1800 HOURS

1. MORPHINE 2-6 mg IV q 2° PRN
2. PHENERGAN 25 mg IV q 4° PRN/Nausea

Noted 09 Sep 03 at 2100 hrs

(b)(6)-2

(b)(6)-2

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

MD

(b)(6)-2

10 Sep 03 @ 0220

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10SEPT03	1700 HOURS	
① NPO ~ MN		10Sep 1700 SS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 (b)(6)-2 MD

MAJ, MC USA

CHIEF, DOS

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10Sep 03	2247 HOURS	
① ↑ Immodium N ~ 125cc/hr		noted 10Sep03 (b)(6)-2

(b)(6)-2

MD

MAJ, MC USA

CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ @11Sep03 @0340 (b)(6)-2 ILT XN

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 - 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: 11 Sep 03 TIME OF ORDER: 0900 HOURS

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

1. To ICU - Dr.
2. Dx - SP I+D Neck wound
3. cond - Stable NKDA
4. VS q 4°, I+O, A-line, monitor, SpO
5. ACT + Bedrest, Elevate HOB
6. DIET - Regular
7. NPO p MN

PATIENT IDENTIFICATION

Transoral cath (b)(6)-2 0945 11 Sept 03

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. IV LR TKO 100cc/hr
8. UNASYN 3 grams IVPB q 6°
9. INCENTIVE SPIROMETRY 10-20x/hr
10. PERCOCET - I-II po q 4° PRN/pain
11. PHENERGAN 25 mg IV q 4° PRN/nausea
12. MORPHINE 2-10 mg IV q 2° PRN/pain
13. CBC, chem 8 NOW and in AM

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

14. Call MD for T > 101°, P < 60 or > 110, SBP < 100 or > 160, UO < 30cc/hr, SpO < 92%
15. Pt chg Neck drains if > saturated

(b)(6)-2 (b)(6)-2 , MD

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 Sep 03 TIME OF ORDER: 2355 HOURS

1. PRADUL 30mg IV now please — noted 2400

(b)(6)-2 OTAN

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

24 12 Sep 03 0100 14 hr

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 7148 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 12 SEP 03 TIME OF ORDER 0935 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. To ICU then ICW - Dr.
2. DX - SP ETD/DPC Neck wound
3. Cont Stable, NKDA
4. VS q 4°, I-O
5. ACT - up in chair QID, Ambulate w/ assistance QID
6. DIET - REGULAR - Supplement w/ ENSURE (EQUIN) 1-2/meal

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2

7. N LR TKO 100cc/hr
8. UNASYN 3 gm IVPB q 6°
9. PERCOCET - Give 1-II po q 4° prn pain
10. TORADOL 30 mg IV q 6°
11. ZANTAC 150 mg po BID
12. TCDB q 1°, INCENTIVE SPIROMETRY 10-20x/hr

12 Sep 03 1140

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

13. MULTIVITAMIN - 1 po q Day
14. Call MD for T > 101, PR < 60 or > 110, SBP < 100 or > 160, or HR < 60.

(b)(6)-2 (b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

DLP done

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 13 Sep 03 TIME OF ORDER 1720 HOURS

1. DC UNASYN

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

14 Sep 03 @ 0145/0

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				17 Sep 03	17 00 HOURS	
			(1)	DC TO MPJ		
				(b)(6)-2	(b)(6)-2 MD MAJ, MC USA CHIEF, BOS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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. Sept Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11
9Sept 03	(b)(6)-2	VS: Q 1°, I+O	06		(b)(6)-2	
		A line, Monitor, Pulse ox	18		(b)(6)-2	
9Sept 03		Act: Bedrest, Elevate HOB	06			
			18		(b)(6)-2	
9Sept 03		Diet: Clear Liquids	06			
			18		(b)(6)-2	
9Sept 03		Incentive Spirometer	06			
		10-20 times/HR	18		(b)(6)-2	
9Sept 03		May change Neck	06			
		Dressing if saturated	18		(b)(6)-2	
9Sept 03		Call MD for T>101	06			
		P<60>110, ~~SBP<100>160~~	18			
	------	SBP<100 ~~Sys>160~~				
	------	U.O<30cc/hr, Pulse ox<92%				
	------	Neck Hematoma				
9Sept 03	(b)(6)-2	Call MD for T>101	06		(b)(6)-2	
		P<60>110, SBP<100 >160,	18			
	------	U.O.<30cc/hr, Pulse ox				
	------	<92%, Expanding				
	------	Neck Hematoma				

D/C'd S/P I&D and new orders 11 Sept 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Dx: S/P (L) Neck Exploration
Cond: Stable

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

PATIENT IDENTIFICATION:
Dx: S/P (L) Neck Exploration
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing

RA[illegible]IC DOCUMENTATION CARE PL[illegible]
(NON-MEDICATION)

Mo _____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9Sept	(b)(6)-2	To ICU → Dr (b)(6)-2	9Sept	1630	1630	(b)(6)-2
9Sept		Dx: S/P (1) Neck Exploration; Cond Stable	9Sept	1630	1630	
9Sept03		Repeat Lateral Cervical Spine	9Sept03			
9Sept03		C-Xray				
9Sept03		CBC, Chem, Now	9Sept03			
9Sept03		CBC, Chem, 1:1 AM	10 Sept	0400	0515	(b)(6)-2
10 Sept03		NPO p MN	10 Sep	p MN	2400	

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15
"Sept	(b)(6)-2	Vital Signs q 4°	06	(b)(6)-2				
		8-hrs, PO monitor	18					
"Sept		Intake & Output q 8°	06					
			18					
"Sept		ACTIVITY = Bedrest	06					
		Elevate HOB	18					
"Sept		DIET: Regular	06					
			18					
"Sept		Insertion Barometer	06					
			18					
"Sept		Vital Sign Parameters	06					
		NHO: T > 101°, P < 60	18					
		or > 110, SBP < 100 > 160;						
		UOP < 30cc/hr SaO2 < 92%						

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
© Neck GSW S/P I&D

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing

T .P IC DOCUMENTATION CARE P
(NON-MEDICATION)

Mo Sept Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 Sept	(b)(6)-2	Admit to ICU. Dr (b)(6)-2	11 Sept	0930	0930	(b)(6)-2
		Dx - Sp I&D Neck ; cond: stable				
		NKDA.				
11 Sept		NPO e MN	11 Sept	2400°	2400°	
11 Sept		CBC/Chem 8 x 1 now	11 Sept	0930	0930	
		CBC/Chem 8 x 1 12 Sept 0500	12 Sept	0500	0455	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
11 Sept	(b)(6)-2	Δ Neck dressing, if														
-----	-----	saturated, ϕ touch iodo-														
-----	-----	form in wnd.														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-[illegible]
he proponent agency is the Office of The S[illegible]

Mo. ____ Yr. ____

VERIFY BY INITIALING | *INITIAL PROH[illegible] OLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17
12Sep	(b)(6)-2	VS Q4°	10	(b)(6)-2					
			14						
			18						
			22						
			02						
			06						
12Sep	(b)(6)-2	I+O's	06	(b)(6)-2					
			18						
12Sep	(b)(6)-2	PCT: UP IN CHAIR QID,	06	(b)(6)-2					
		UP & ASSISTANCE QID,	18						
12Sep	(b)(6)-2	DIET: REG - SUPPLEMENT	06	(b)(6)-2					
		& ENSURE 1-2 /MEAL	12	(b)(6)-2					
			18	(b)(6)-2					
12Sep	(b)(6)-2	TCDB & IS 10-20x	06	(b)(6)-2					
		PER hour	18						
12Sep	(b)(6)-2	CALL MD FOR T>101,	06	(b)(6)-2					
		P<60 OR >110, SBP <100	18						
		OR >160, NO VOP IN 6°							

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

S/p I+D / DPC NECK WOUND

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12Sep	(b)(6)-2	To ICU -2 Turn ICW D.R. (b)(6)-2	12Sep	0930	1100	(b)(6)-2
12Sep		S/P I&D / DPC Neck wound	12Sep			
12Sep		Cond: stable	12Sep			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
13Sep	(b)(6)-2	Call MD for														
		T>101, P<60 >110														
		SBP 400 >160 a														
		U.O. in 6														

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12									
9 Sept 03	(b)(6)-2	IV: LR TKA 100cc/hr	06	/	(b)(6)-2		D/C									
10 Sep 03		↑ maintenance IV to 125 cc/hr.	18		(b)(6)-2											
9 Sept 03		Ancef 1 gram IVPB Q6°	02	/	(b)(6)-2		D/C'd									
			08	/												
			14		(b)(6)-2											
			20													
11 Sept 03	(b)(6)-2	IVF: LR @ 125 cc/hr	06	/	/	(b)(6)-2	D/C'd									(b)(6)-2
			18	/	/											
11 Sept		IVF: LR @ 100 cc/hr	06	/	/	(b)(6)-2										
			18	/	/											
11 Sept		UNASYN 3g IVBP q 6°	02	/	/											
			08	/	/	(b)(6)-2										
			14	/	/											
			20	/	/	(b)(6)-2										

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Dx: s/p Neck Exploration
COND: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing

APEUTIC DOCUMENTATION CARE
(MEDICATIONS)

Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11 Sep 03	(b)(6)-2	Tomadol 30mg IV now	11 Sep 03	Now	2400	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
9 Sep 03	(b)(6)-2	Morphine 2-6mg	DATE	9 Sep 03	9 Sep 03	10 Sep 03	10 Sep 03	10 Sep 03	10 Sep 03	11 Sep 03	11 Sep 03	11 Sept 03	11 Sep 03			
		IV q2° PRN/Pain	TIME	1815	2300	0400	1330	1100	2200	0330	0530	1300	2250			
			DOSE	5mg	5mg	4mg	3mg	3mg	4mg	3mg	3mg	3mg	5mg			
			Initial	SG	SG	SG	SS	SS	SG	SG	SG	SG	SG			
9 Sep 03	(b)(6)-2	Phenergan 25mg	DATE	12 Sep 03	12 Sep 03											
		IV q4° PRN/Nausea	TIME	0210	0050											
			Initial	SG	SG											
11 Sept	(b)(6)-2	Percocet 1-11 tabs PO	11 (2) PO 11 Sept 1230													
		q4° PRN pain	Headache Sep 9E													

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18
12 Sep	(b)(6)-2	IVLR @ 100 cc/hr	06	(b)(6)-2						
			08							
12 Sep	(b)(6)-2	UNASYN 3gm IVPB q 6°	06	(b)(6)-2						
			12	(b)(6)-2						
			18							
			24							
17 Sep	(b)(6)-2	TORADOL 30mg IV q 6°	06	(b)(6)-2						
			12							
			18							
			24							
12 Sep	(b)(6)-2	ZANTAC 150mg PO BID	6	(b)(6)-2						
			22							
12 Sep	(b)(6)-2	MULTIVITAMIN 1 PO q day	10	(b)(6)-2						
FORWARD	(b)(6)-2									

D/C'd 13 Sep 00 1720 (b)(6)-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/P HD / DPC NECKWOUND	PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
12Sep	(b)(6)-2	Percocet - Give	12Sep 1115	12Sep 2020	13Sep 0545	13Sep 1715	13Sep 1540	14Sep 0800	14Sep 2205									
		1-2 po q4° prn/pain	1 TK	2 CM	2 po CM	1 TK	1 TK	1 LCC	2 po CM									

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1630	INITIALS	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3mm Round, MRE		PERRLA			
	SENSORIUM	X4. Oriented connected		Sleeping but wakes up			
		interpreter help. Denies		to tactile stimulus			
		pain at this time.		MAE X4. in NAD.			
RESPIRATORY	RESPIRATORY PATTERN	Even + unlabored		easy, nonlabored.			
	BREATH SOUNDS	Lungs CTA in all lobes		clear bilat.			
	SECRETIONS	denuded in bases		O2 Sat 100% on			
		O2 Sat 100% on 35%		R/A			
		Venturi mask.					
SKIN	COLOR	Normal for race		WNL			
	INTEGRITY	(L) Neck Dressing D+I		(L) Neck drsg D+I.			
IV SITE	LOCATION	16G to (R) Hand: LR		(R) HAND PIV	(L) AC heplock		
	CONDITION	@ 100cc/hr. Site S/S		patent + clear	patent + clear		
		on dressing. 18G to (L) AC		intact. LRD	+ site intact		
		Heplocked.		@ 100cc/hr			
				infusing			
GASTRO	ABDOMEN	Abdomen Flat & distended		Flat, nontender			
	BOWEL SOUNDS	BS hyperactive x 4 quads		(+) BS x 4 quads			
				appetite poor			
GU	URINE:	Foley to gravity, clear		Foley → gravity			
	COLOR/CLARITY	Yellow Urine		clear yellow			
				urine			
CARDIOVASCULAR	CARDIAC RHYTHM	SR PR. 16 BP. 08		Sinusarrhythmia			
		Rales LLS - 2 LS. Edema		pulses palpable to			
		2+ to all extremities		bilat radials + pedals			
		Cap refill less than 3					
		seconds					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 MSPA

DEPARTMENT/SERVICE/CLINIC ICU

DATE 9 Sept 2003

PATIENT'S ID (b)(6)-4 (In entries give: Name—last, first, middle; grade, date, hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line												157/65	134/70	114/75	163/78	156/76	157/81	
BP Cuff												135/65		130/85	125/69	124/66	137/69	
Temperature												95.5	98.4			99.6		
Pulse												82	63	84	91	94	89	
Respiratory Rate												24	17	18	12	19	18	
SaO2												100%	100%	100%	100%	100%	100%	
Method														R/A	R/A	R/A	R/A	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR												100 100	100 200	100 300	100 400	100 500	100 600	
OR									400 900									900
IVPB																50 50		
PO															150 150			
TOTALS																		

OUTPUT

		06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR / TOTAL											500 / 500		200 / 700			550 / 1250		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	EBL												100					100
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05
V	159/81	154/83	144/78	141/74	159/77	161/86	154/85	169/81
	144/76	139/78	130/65	138/69	134/69	141/74	144/75	138/72
T		99.4			99.1			
P	97	86	0	96	98	98	94	85
R	20	18		19	20	18	14	16
	100%	100%		99%	99%	99%	99%	99%
	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A

	22	23	24	01	02	03	04	05	8° T
	100	100	100	100	100	100	100	100	
	700	800	900	1000	1100	1200	1300	1400	1400
									900
					50 100				100
		300 1550		100 1630	50 1680			275 1955	2400 195
									100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
ARTERIAL	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	2400	TOTAL	2055

BALANCE 345

NURSE'S SIGNATURE | INITIALS

(b)(6)-2 | (b)(6)-2

MEDCOM - 7163

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0615	INITIALS SS	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	3mm & PERLA		PERRL			
	SENSORIUM	asleep but arousable, follows commands, moves all extremities		Awake + Alert (+) commands, MAE's x 4.			
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored		even, non labored			
	BREATH SOUNDS	CTA bilaterally		clear bilat.			
	SECRETIONS	Ø noted		N/A			
				O2 sat 99% on Room air.			
SKIN	COLOR	normal for race		WNL.			
	INTEGRITY	surg incision to (L) side of neck, dsg CDI		drsg to (R) neck D+I.			
IV SITE	LOCATION	(R) FA, (L) AC heplock		(R) HAND PIV	(L) AC heplock		
	CONDITION	infusing LR @ 100 cc/hr - patent		site + drsg intact. LR @ 100 cc/hr infusing - patent & flushes easily	small amt of dried blood at insertion site patent & flushes easily		
GASTRO	ABDOMEN	soft, non tender		soft, flat, non tender			
	BOWEL SOUNDS	(+) x 4 quads, little to no appetite		(+) BS x 4 quad. poor appetite.			
GU	URINE:	Foley to gravity		Foley → gravity			
	COLOR/CLARITY	clear, yellow		clear yellow urine			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR - all pulses palpable - (R) radial A-line		Sinus rhythm + ectopy. Pulses palpable x 4. (R) radial art line intact & good waveform on monitor, zeroed + calibrated			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 10 Sep 03

(PRINT OR STAMP NAME of typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 10 Sep 03 | DX S/P (L) Neck Exploration | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	167/84	163/85	153/74	165/79	165/78	169/82	158/78	144/70	134/76	148/73	142/75	157/75	153/74	160/78	161/79	152/76
BP Cuff	137/71	139/77	142/76	142/71	139/75	139/74	135/65	137/81	139/67	143/66	143/68	131/68	131/72	136/69	144/72	139/70
Temperature	98.7					98.4								99.2		
Pulse	83	78	76	76	79	75.	78	75.	81	81	91	76	78	84	92	91
Respiratory Rate	23	20	18	15	17	19	16	18	19	15	25	17	11	19	22	19
O2 Sat	98%	100	100	100	100	100	100	100	100	98	99	98	97	99%	99%	100%
Mode	R/A	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	R/A	R/A	R/A

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100 100	100 200	100 300	100 400	100 500	100 600	100 700	100 800		100 100	100 1000	100 1100	100 1200	100 1300	100 1400	100 1500	100 1600	
IVPB			50							50 100						50 150		
PO															100 100			100
TOTALS																		

OUTPUT

		TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE		HOUR / TOTAL	50/50	50/100	100/200	100/300	100/400	100/500	500/1000	500/1500	150/2450	100/2550	100/2650	100/2750	400/3150		150/3300	
		SP GV																
		S/A																
NG		OUTPUT																
		pH																
		GUIAC																
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY 1

	22	23	24	01	02	03	04	05
	145/64	160/80	162/79	152/80	158/82	162/86	167/85	152/70
	133/73	137/70	140/70	144/70	124/80	141/83	136/68	138/72
	98					98		
	89	85	76	94	97	98	83	79
	26	17	15	19	25	19	16	15
	99%	98%	98%	97%	97%	97%	97%	97%
	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A

	22	23	24	01	02	03	04	05	8° T
	100	125	125	125	125	125	125	125	
	1700	1825	1950	2075	2200	2325	2450	2575	2575
					50				
					200				200
									100
									2875
	150	150		200		250	100		
	2450	2600		2800		3050	4150		4150

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	2875	TOTAL	4150

BALANCE 1275

NURSE'S SIGNATURE (b)(6)-2 INITIALS (b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS	1900	INITIALS		INITIALS
NEURO	PUPILS		2mm / 2mm reactive		PERRLA			
	SENSORIUM		knows all extremities		A+O x3 MAE x4.			
			(+) sensation throughout		in NAD			
			good strength ē bilat					
			↓ OP to U/L ext.					
RESPIRATORY	RESPIRATORY PATTERN		unlabored, even		easy, non labored.			
	BREATH SOUNDS		clear throughout		clear bilat.			
	SECRETIONS		Ø —		none			
			SaO2 99% RR 14-16 BPM		O2 Sat 98% on RoomAir			
					good effort ē incentive spirometer			
SKIN	COLOR		NFR		WNL			
	INTEGRITY		(-) Gauze to neck Ø drainage		(-) neck drsg D+I			
			ecchymosis					
IV SITE	LOCATION		PIV to (R) hand, LR @ KVO		(-) AC PIV			
	CONDITION		(-) evidence infiltration		intact			
			(+) 18g PIV to (L) AC - SL'd		LR @ 100 cc/hr infusing			
			(+) flush (+) SR.		flushes easily			
			(+) AL to (R) radial					
			secured, leveled, (+) good waveform					
GASTRO	ABDOMEN		(+) BS x 4q. (-) distention		(+) BS x4 quadrants			
	BOWEL SOUNDS		(-) tenderness. Pt NPO for procedure at 0700 later this AM		soft, nontender appetite poor			
GU	URINE:		(+) foley to gravity, clear yellow urine out.		Foley D/C'd on previous shift + has not voided yet.			
	COLOR/CLARITY		Ø drainage (-) edema from thighs/genitalia					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR HR 50-90's.		NSR, Rate 98.			
			BP 150's systolically 70's diastolically		(+) pulse to all extremities.			
			A-line secured (+) NVSP to (L) UA.					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

1LT AN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 11 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TF MENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line	155/78	154/75		147/71	154/74	138/75		159/89		127/70	139/81			131/75			160/79
BP Cuff	135/66	140/72		137/68	138/82			159/89						127/68			120/72
Temperature	98.7	98.8		97.1						100.0	98.6			97.8			99
Pulse	77	79		74	92			126		123	125			114			89
Respiratory Rate	12	15		14	15			22		18	9			18			14
O2 Sat	97%	98		99%	98%			99%		97%	96%			99%			100%
Method	R/A	RA		RA	RA			RA		RA	RA			RA			R/A
MAP		96		98	96			100		82	105			95			
IS								+		+	+					10X	
							Removed 11	MSO4-3mg		MSO4 2mg							
										Unasyn						Unasyn	

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
LR	125 / 125	250 / 125	250 / 100	975 / 125	1075 / 100	1175 / 100	1275 / 100	1375 / 100		1475 / 100	1575 / 100	1675 / 100	1775 / 100	1875 / 100	1975 / 100	2075 / 100	2175 / 100	
1UPB										100 / 100						100 / 200		
PO									PO	120 / 120	120 / 240	120 / 360	120 / 480	Ø / 600			300 / 1200	1200
P.O	NPO	NPO		Ø	Ø	Ø				120 / 120	240 / 240	120 / 480	120 / 600	600 / 600	600 / 600	600 / 600	1200 / 1200	
TOTALS																		

OUTPUT

		TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE		HOUR / TOTAL	40 / 40	100 / 140		75 / 215						875 / 1075	50 / 1125	Ø / 1075	Ø / 1125			
		sp gr											16:30 Foley d/c				2030 F. to Same D/C Foley	
		S/A																
NG		OUTPUT																
		pH	N/A															
		GUIAC																
EMESIS				Ø														
STOOL				Ø														
DRAINS			N/A															
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITALS	22	23	24	01	02	03	04	05
		146/81	142/89	144/88		139/77	146/89	
		140/66	145/76	139/79		135/72	131/67	
							97	
		88	93	94		82	74	
		14	17	12		12	12	
		97	99	95		97%	96	
		R/A	R/A	R/A		R/A	R/A	

Unasyn

	22	23	24	01	02	03	04	05	8° T
	100	100	100	100	100	100	100	100	
	2275	2375	2475	2575	2675	2775	2875	2975	2975
					300 100				
					300 100				300
								PO	1200
									4475
375									
1570									1570

BASPDIAT ATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE	0700								
	TRACH CARE	N/A								
	ROM EXERCISES									

TURN	TIME									
SUCTION										

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	4475	TOTAL	1570

BALANCE 2905

(b)(6)-2

INITIALS (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D.

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

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

OTSG APPROVED (Date)

Date: 12 Sept 03 Anesthesia Type (Circle)): General Spinal Epidural
Time In: 0940 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 250 Colloid Ø
Pre-op V/S: 142/84 HR 110 OR Output: UOP Ø EBL Ø
Procedures: Drl wound neck Meds/Times:

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

Pre Op Meds History

Time	0930	0945	1000	1015	1030	1045	1100	1115
SaO2	98	99	99	99	99	99	99	100
FiO2								
Methods	J	J	J	J	J	J	J	J
240								
220								
200								
180								
160								
140								
120	V	V	V	V	V	V	V	V
100	•	•	•	•	•	•	•	•
80	^	^	^	^	^	^	^	^
60								
40								
20								
RR	12	12	16	12	14	12	13	13
T	97.4	97.5		97.5			97.8	

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0900	UR	100	O/A	DS	100
1000	UR	1000	O/A	DS	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	11	11

Codes

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

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

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

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

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

(Continue on reverse)

(b)(6)-2

	DEPARTMENT/SERVICE/CLINIC	DATE
Gwm 6	ICU	12 Sept 03

PATIENT IDENTIFICATION (Or types or write entries given first, middle; grade; date; hospital or medical facility) Name – last,

(b)(6)-4

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

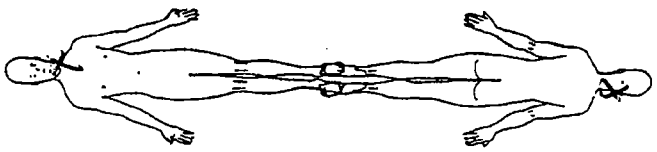
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) neck	Gauze & tape	CDI
30'	(L) neck	" "	CDI
60'	" "	" "	" "
D/C	" "	" "	" "



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

0940 Pt transfer to ICU for recover s/p DPC back board. Monitors on USS noted on reverse side. Pt appear to be sleeping, lethegic Drsg on (L) side neck gauze & tape. CDI. 18g IV infusing @ 100cc/hr = difficult. Ø SOB SaO2 99%-100% on RA. — SGT [redacted]

1035 Pt on litter arousable to verbal & touch stimuli able to move extremities x 4 Drsg CDI — [redacted] SGT

1050 Report given to SGT Clifford, LPN Pt read for transport — [redacted]

1100 Pt transfer via litter to ICU & transfer into bed w/ difficulty [redacted]

Discharge Criteria:
Date: Time: PARS:
BP: 126/75 T: HR: 74 RR: 10 Sa02: 100%
Pain Level at D/C (0-10):
Intake: 200cc Output: Ø
Additional Data:
Transferred To: ICU
Report Given To: SGT [redacted] LPN
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B.3
Charge Nurse Signatur [redacted]

WAMC OP 173-E

1. Reporting MTF	2. MTF Location	Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
(b)(3)-1	(b)(3)-1		
3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
(b)(6)-4	(b)(6)-4	CIV	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	Z	UNKNOWN

10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	(b)(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	14:20	

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

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

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU	Address of Emergency Addressee

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 (YYYYMMDD)
DUTY		2003-09-17

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-09-09

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-09-09

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW to neck

Procedure Narrative(s): S/P neck exploration gor zowell GSW

Cause of Injury Narrative: Sustained injury while stealling ammunition on US compound

(b)(6)-2

Admitting Officer (Signature, as required)	S
See DA 3647 (b)(6)-2	

ADMISSION A[illegible]ODING INFORMATION

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

1. REPORTING MTF	2. [illegible]ATION (State or Country Code.)
1 2 3 4 5 6 (b)(3)-1	7

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 CIV	18 M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9	27 28 29	30: X	31: Z	UNK.

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 99 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: Z	1420	

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: [redacted]	64 65 66 67 68 69 70	71: b(6)-4	YEAR / NO: b6-4

b(3)-1

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	1C4	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 9 1 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A B A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 9 0 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: [redacted]	109 110 111 112 113 114	115 116 117 118 119 120 121 122

b(6)-4

FOR LOCAL USE

GSW to Neck

S/P Neck exploration gon 20well GSW

DX-8748
Trauma-1 E9912
Injury-450 PR-8605
8622

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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

MEDCOM - 7173