b(6)-2 All

CLINICAL RECORD

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

Mo. 03 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10
5	[redacted]	D5½ NSS 20 meq KCl @ 125 cc/hr	05	/					
			13	[redacted]					
			21						
			/						
5	[redacted]	Cipro 400 mg IVPB q8h	06	/					
			14	/					
			22	[redacted]					
			/						
5	[redacted]	Gentamycin 120 mg IVPB q16h	04	/					
			10	/					
			16	[redacted]					
			22						
			/						
5	[redacted]	Pen G 4 million units IVPB q6h	06	/					
			12	/					
			16	[redacted]					
			24						
8 Aug	[redacted]	Saline Lock	5	/	/	/	/	[redacted]	
			13	/	/	/	/		
			21	[redacted]	/	/	/	[redacted]	
			/						
~~9 Aug~~	[redacted]								

DC'd 9 Aug 03 BRS

DC'd 9 Aug 03 BRS

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of R IF

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE [redacted]

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 15841

Continuation Sheet

[redacted] [redacted]

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	
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....	b(4)-2 +11					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
..5.	[redacted]	Percocet 1-2 q4° pr- pain	5Aug 1850 PAS +PO (+1)	[redacted]	[redacted]	[redacted]	6 Aug 1145 +po	6 Aug 1630 [redacted]	6 Aug [redacted]	7Aug 0952 +po	7Aug 1515 [redacted]	7Aug 2030 [redacted]	8Aug 0000 [redacted]	8A 1230 +po	8Aug 2030 [redacted]	9Aug 1217 +po	12Aug [redacted]
.....	.....	pr- pain															
.....	.....																
..5.	[redacted]	MSO4 2-5mg IV q2° pr- pain (breakthrough)															
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																

USAPA V1.00

[redacted] b(6)-2 A11 [redacted]

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MED[illegible]TIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Y. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13
9	[redacted]	Keflex 500mg PO QID	06	/	[redacted]			
			12	/				
			18					
			24					
				/				
9	[redacted]	Cipro 500mg PO BID	08	/	[redacted]			
			20					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of (R) index finger I&D of (R) hand

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

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 15843

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

66-4 [redacted] Asthma

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

OTSG APPROVED (Date)

Date: 7 Aug 03
Time In: 1437
Allergies: NKDA
Pre-op V/S: 132 67
Procedures: R hand debridement & closure

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 650 Colloid
OR Output: UOP 85 EBL Min
Meds/Times:

250 Fent versed

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

Pre Op Meds History

Time	SaO2	FiO2	Methods	240	220	200	180	160	140	120	100	80	60	40	20	RR	T
1437	97		RA													15	96A
1442	96															16	
1447	95															11	
1452	95															14	
1457	97															15	
1502	96															16	98A
1507	97															19	
1512	96															20	
1517	96															22	
1522	96															22	
1527	96															19	
1532	96															19	99A
1537	96															17	
Time																	
Pain (0-10)																	
LOS																	

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	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	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	10

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

[redacted] b(a)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 Aug 03

Name – last, [redacted] tries give:
[redacted] b(a)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDCOM - 15844

ACLU-RDI 1634 p.4

DOD-029233

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1515	/	Percocet 5/325	po	/	E	[redacted]

NEUROVASCULAR

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

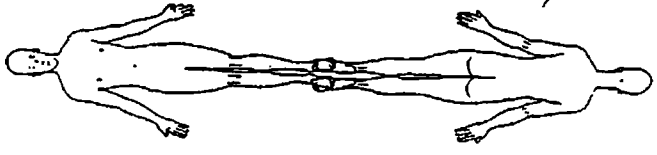
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1427	(R) hand	Kerlix & Ace	0
30' 1457	R hand	Kerlix & Ace	0
60' 1527	(R) hand	Kerlix & Ace	0
D/C 1536	(R) hand	Kerlix & Ace	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC-OP 173-E

NURSING NOTES

1427 Admitted from OR to PACU. Pt arousable to verbal stimuli. Able to move all 4 extremities, then aroused. IV (D) AC, 3 4/50 infusing. Noted. Will cont. to monitor. [redacted]
1445 Pt more arousable & trying to stay awake. [redacted]
1500 Pt fully awake. Can move all 4 extremities. D5 ½ NS c 20 KCl @ 125 cc/hr via (D) AC. [redacted]
1531 Transferred to ICU 2 by litter per [redacted] & CPT [redacted]

Discharge Criteria:
Date: 17 Apr 03 Time: PARS: 10
BP: 145/[illegible] T: 99 HR: 75 RR: 17 Sa02: 96
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data: SMOKER
Transferred To: ICU 2
Report Given To: CPT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 5 AUG 03
Time In: 1500
Allergies: NKMA
Pre-op V/S: 125/67 – 82
Procedures: Removal (R) Finger GSW

Anesthesia Type (Circle): (General) Spinal Epidural
IV Sedation Nerve Block – 20mg MSO4
OR Intake: Crystalloid 800 ml Colloid
OR Output: UOP 0 EBL 150 – 2 UNITS PRBC
Meds/Times: – 5mg VERSED

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

Pre Op Meds

History: ASA II smoker

Time	1500	1505	1510	1515	1520	1525	1600	1615
SaO2	96	97	95	94	89	94	96	94
FiO2	RA	RA	RA	RA	4L	4L	RA	RA
Methods					NC	NC		
240								
220								
200								
180								
160								
140					V			
	V	V	V	V		V	V	
120								V
100								
80				•	•	•	•	
	•	•	•					
	^	^	^					
60				^	^			
						^	^	^
40								
20								
RR	32	22	8	10	28	17	15	17
T	98				99		99	99
Time	1505	1530	1615					
Pain (0-10)	9/10	1/10	2/10					
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1615	D5½ 20K	80 cc	(E) FA	CR	[redacted]

b6-2

X-rays: N/A Labs: N/A

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

[redacted] CPT/AN b(4)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2 (PACU)

DATE: 5 AUG 03

PA[redacted] (IDENTIFICATION) ...ed or written entries give: Name – last, first, middle; grade; date; ...edical facility)

[redacted] b(4)-4

- [ ] HISTORY/PHYSICAL
- [ ] FLOW CHART
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] OTHER (Specify)
- [ ] DIAGNOSTIC STUDIES
- [ ] TREATMENT

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

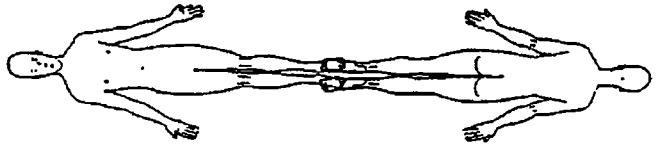
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) HAND	BULKY ACE WRAP	(-)
30'	" "	" "	(-)
60'	" "	" "	(-)
D/C	" "	" "	(-)



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1615	Ø	Ø	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1500	NSR	—	

WAMC OP 173-E

NURSING NOTES

(1505 hrs) Pt arrived to PACU on gurney c 2 person asst. Drowsy, but arousable. Seems to understand a good amount of English. (R) Hand in bulky ace wrap dressing. (R) index finger remained in splint. Moves all other digits in (R) hand on command & noted limitations due to dressing. Able to palpate radial pulse just below the ace wrap dressing; brisk capillary refill < 3secs. (Neuro, CV, lungs, GU all unremarkable.) - Lvl I continuous recovery per PACU protocol. [redacted] CA/An

(1530 hrs) SaO_2 ↓ 87%. Unable to T by cough & deep breath measures. Placed on 4L O_2 via NC. Continue to monitor & recover. [redacted] CA/An

(1615) No D in neuro checks to (R) hand. RA SaO_2 94%. (L) FA PIV (# 18 ga) c D5½c 20KCl @ 125 cc/h patent. Ready for transfer to ICW #2. Will give report and transfer now. [redacted] CA/An

b(6)-2 All

Discharge Criteria:

Date: 5 AUG 03 Time: 1615 PARS: 9
BP: 124/55 T: 99 au HR: 110 RR: 17 Sa02: 94%
Pain Level at D/C (0-10):
Intake: 80cc Output: Ø
Additional Data: Ø
Transferred To: ICW
Report Given To: [redacted]
Transferred V[redacted] Gurney Ambulance
Transferred [redacted] CA/An
Cleared IAW Re[redacted]
Charge Nurse Signat[redacted]

MEDCOM - 15847

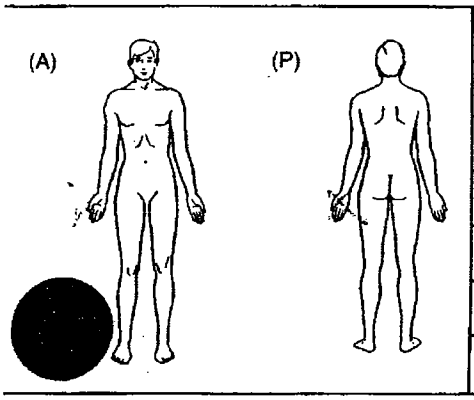
DELAYED A789849

2nd PRIORITY **MODERATE** A789849

A789849

DECEASED A789849

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997



TIME			
AGE		SEX	M
LUNGS			
PULSE	80		
RESP.			
B.P.	120/80		
A	V	P	U

Patient Name (if known) [redacted] b(6)-4

Notes/Treatment GSW (R) hand
old Dressing is adhere to infected
dead skin, removing with sterile
water pass cause more injury

To be given to:
TRANSPORTATION OFFICER

TAG# A789849

Priority #		2		D
Primary Injury/Illness				
E.M.S. Unit				
Depart Time				
Hospital				

MEDCOM - 15848

~~3rd~~ PRIORITY ~~DELAYED~~

2nd PRIORITY MODERATE

[redacted]

DECEASED

Minor Injuries/Illness: _____

Moderate Injuries/Illness: _____

2

Life Threatening Injuries/Illness
☐ co-worker injured
☐ uncontrollable emotional disorder

D ☐ OBVIOUSLY DEAD (D.O.A. - D.A.S.)

Mass Casualty Incident Tag

Developed for
Triage and Patient Management

(610) 820-9212

Additional Information: PT has controll
a second PT [illegible] Skin
and motion of [illegible]

MEDCOM - 15849

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.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	EPW # [redacted] b(6)-4	EPW	M

3. REGISTER NUMBER	6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
00141807	ZZZZZZZZ	27Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1140	b(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		9	YEAR / X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
8 b(2)-2	ICW2	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030813

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030805

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

gsw & open fx ® hand

DX
81611
E9[illegible]9
b(6)-2

PROC.
7914
7933
8401
9357

Inj. Trauma
599
9

b(6)-2

ADMITTIN[redacted] as required) b(6)-2

[redacted]

DA FORM 2095, MAR 80

MEDCOM - 15850

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1 REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
0014195	EPW # [redacted]	EPW	

4 SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. [illegible]	10. PREVIOUS ADMISSION
M	23	—	—	—	—	ND

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	btw-4	ICU #2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1730	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	26	15 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK		6 Aug 03	b(6)-2 DR [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (L) Knee / (L) patellar open fx

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	9	9

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
		b(6)-2			

SIGNATURE OF ATTENDING MEDICAL [illegible] | [redacted] MEDICAL RECORDS OFFICER

Dr [redacted]

DA FORM 3647, MA[illegible]

MEDCOM - 15851

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

See [redacted] b(6)-4

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN

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

[redacted]

b(6)-4

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

539-108

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
8/6/03	ORTHO Staff Triage detained/EPW arrived aeroevac c no hx. Unresponsive initially c elevated temp 103 & tachycardia. Some hx of OSW (L) knee of indeterminate age. Evaluated by Neurology for MS Rx. Hydration & cooling c improving MS. Ext: (R) knee c small effusion. No erythema, purulence, PROM, palpable patellar defect, entire joint smooth w/ full medial knee and quadriceps AROM c stellate patella fx WBC 8.0 IMP: ~~open~~ patellar fx w/pt c knee injury Plan: Cont MS Rx's, continue hydration when stable → to OR for I+D, IV ABX [redacted] b(6)-2

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

8/6/03

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Neurology Consult

6 Aug 03 1605 HPI Mid 20-ish Iraqi ♂ EPW, brought in by MP's for altered mental status thought to be related to a GSW to the (L) patella. Very little hx is known and only a brief note accompanied the pt. Pt's temp was 103.4 rectally on arrival & he was agitated and intermittently combative. He has been cooled since arrival c water/ice/fan and his MS has progressively improved as his temp has dropped. His core temp was 100.8 rectally by the time I finished my exam, and while he would follow commands & tell his name, he would give no further hx but this may have been intentional.

PMH Unknown meds Unknown Allergies Unknown.

PE 148/92 103 26 100.8 (R)

GEN Thin Iraqi ♂ c IV's in either arm, foley cath, wet on a stretch, awake & calm c a (L) knee wound

HEENT (L) frontal minor abrasion c min ecchymosis & no swelling. No fx's at the site on palpation/inspection of skull ? (R) infraorbital bruise. Canals somewhat occluded by cerumen but no hemotympanum or d/c noted. No raccoon eyes or

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EPW [redacted] b(6)-4

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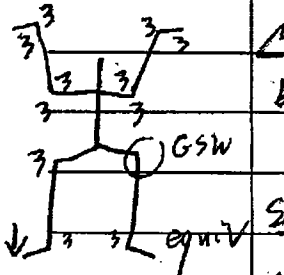
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Neuro (2)
6 Aug 03	Battle signs, sinuses NT to pal/p, oro clear
	Neck full passive ROM, Ø meningismus
	HT RRR S (w), full pulses
	Skin no rashes noted
	MS Awake + alert S stim. Pt will occasionally attend to me (Chalter is Iraqi translator). He follows verbal commands via translator consistently + quite well but seems a little obstinate at times. He would verbalize his name only, clear enough to anticipate me examining his 2nd ear + rotating his head to allow that S command. Pt is calm + mostly cooperative
	CN VF - Attends to stim in all 4 quads, Fundi - benign + sharp disc + no hemy PERRLA $\frac{5}{5}$ > 3, Ø APD, EOMI, Ø ptosis, intact MSM + NFE, hearing grossly intact, intact + sym gag, sym shrug, midline tongue.
	Motor NL tone + bulk, full strength (S/S formally in UE's + (R) LE but formal testing not done in wounded (L) LE. Sym forearm roll. No abn movements
	Sensory pt would not answer sensory questions but did respond to tactile stim (B)
	Coord Good F→N + RAM's (H→S not tested)
	Gait not tested



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[redacted]

6 Aug

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
6 Aug 03	Neuro (3) ~~Extrem~~ Old ecchymosis of (R) posterior shoulder + (R) posterior subAxillary region. Extrem + ap/t GSW of (L) knee of dime/nickle size draws @ same time Piccolo / Islet Labs 133 | 103 | 10 / 4.3 | 25 | 0.9 — 132 | 109 | 15 / 3.8 | 28 | 1.0 — 8.0 | 10.4 | 259 / 34.6 / LKOP CK - 2449 AST 72 U/A - dark yellow, clear, gluc⊖, bili⊖, Ket 1+ >160, 1.020, bld⊖, pH 6.0, prot⊖ uro - 0.2, nit⊖ Assessment 1. Resolving Altered Mental Status - pt seem to be improving in parallel c his drop in core body temp. He is nearly A&O now (has to tell b/c it appears he is deliberately not speaking to us. His neuro exam is non focal. I see no evidence of intracranial pathology, meningitis, or a progressive encephalopathy. I suspect heat injury c dehydration. Recommendations 1. Observation. b(6)-2 [redacted] LTC [redacted]

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[redacted] b(6)-4		

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
7 Aug 03 0800	Neurology · Pt not very responsive over past 12+ hrs. Pt mainly sleeping + yawning when more awake. Pt did awaken this morning to verbal stim. No asymmetries in motor activity noted, no SZ's, no Δ's/variations in vitals (still AP) PE 129/74, 70, 16, 97.8 Pt very sleepy. Will open eyes to tactile stim + a little to verbal. Localizes to sternal rub. Verbalizes a few arabic words. Moving all 4 well, no facial asymmetry, yawns frequently. Conjugate versions. Fundi - suboptimal exam 2° to eye movement but no gross papilledema. Medial L/L bruising on (L) more noticable on arm (R) knuckle bruising. Assessment ANS, fluctuating - it is possible pt is developing some cerebral edema from a possible CHI (has head/orbital abrasions + ecchymosis, pt is mild). Edema may peak 2-5 days out. Pt has (L) knee surg plan for this pm. Exam is non focal. Recommend Would get a CT head if ours were working. Would use short acting agents, usually benzo's in surgery but do not see specific reason to cancel surgery

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
06Aug03 1830	NN: Patient arrived from ER on litter @ 1800. Neuro: Patient confused, intermittenly aggitated and combative. Pupils 2-3mm reactive. Moves all extremities spontantously, occasionally follows commands. Restrained x 3pt, released/checked Q 2°. Resp: lungs clear, resps even and unlabored Sats 100% on RA, Ø cough. CV: HR 60-70's BP stable, pulses palpable, afebrile. GI: BS ⊕ x4, Ø stool, Ø N/V/D, Ø distention. Will try sips of H_2O advance to regular diet when more awake. GU: foley draining clear yellow urine approx 100cc/°, Ø bladder distention. Lines: 18g ② AC c NSC 150cc/°, 18g Ⓐ wrist HL. Meds: Ancef Q 6°, tylenol prn. Plan: monitor neuro status. Skin: Multiple small bruises and Scrapes, ISW to Ⓐ knee c small amount serosang drainage, approx 1-2cm wound, dog bite on arrival, Will go to OR for I+D in AM. Will continue to monitor [redacted] CPT AW

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

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EPW # [redacted] b(6)-4

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06Aug03 2200	NN: Patient resting, occasionally agitated. Follows commands thru interpreter. Will continue to monitor [redacted] CPT/AN
06Aug03 0200	NN: Ø change to patient status, continues to awaken spont., pupils 2-3mm reactive to light, follows some commands, difficult to ~~dot~~ determine confusion vs non compliance (willful). Will continue to monitor [redacted] CPT/AN
07Aug03 0430	NN: Labs done, patient bathed, linen changed. Dsg to knee L'ed, continues to have sensang drainage. Patient responds to stimuli; loud voice, firm touch, still appears confused, occasionally combative. Pupils unchanged reactive to light [redacted] CPT/AN
07Aug03 0530	Received report from outgoing shift. Pt Resting c eyes closed on backside HOB ↑ 45°. Responsive to loud verbal - opens eyes pupils 2-3mm reactive to light, appears confused then closes eyes again. ⊕ Ecchymosis purple sm amt noted under eyes ⊖ battle Signs noted ⊕ abrasion (L) frontal head noted ⊖ drainage ⊖ edema ⊖ erythema ⊖ ecchymosis. LS - 12 Sat O2 100 RA CTA shallow. even unlabored ABD - Flat Soft hyperactive x 4 ⊖ rigidity noted ⊖ response to palpation. (L) knee bulky dsg intact mod amt

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07Aug03 1830	Assumed care of patient @ 1700. Neuro: Patient continues to be confused, slightly combative. Trying to get OOB, follows some commands. Pupils 3-4mm, brisk reaction to light. Moves all extremities well. Resp: lungs clear, breath sounds even and unlabored, sats 99% on RA. Ø cough. CV: Skin warm and dry, afebrile. Pulses palpable. HR 80-100, BP stable. GI: BS ⊕ x4 quads, Ø N/V/D, tolerating sips of clear liquids. GU: foley draining approx 100cc clear yellow urine an hour. Ø bladder distention. Skin: Multiple areas of bruising and scraping. Ace wrap to (L) patella. CDI. Lines: (L) AC 18g c NS @ 125cc/°, (R) wrist 18g HL: patent, Meds: Ancef Q 8°. Plan: monitor neuro status, N/V status of (L) E. Will continue to monitor [redacted] CPT/NP
07Aug03 2230	NN: Slightly less agitated. Following more commands, seems to speak some english. Continues to restrained, V's Q 2°. Pupils remain 2-4mm brisk reaction to light. Ø other A's. Ancef given. Will continue to monitor [redacted] CPT/NP

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08Aug03 0230	NN: Ø Δ in mental status. Pupils 2-3mm brisk reaction, awakens to stimulation. moves all extremities. CMS ✓ to (L) LE intact, pulse +2, Ø drainage on dsg. Will continue to monitor b(6)-2 [redacted] CPT AN
08Aug03 0430	NN: Bath given, linen changed, patient trying to get OOB, follows some commands. Dressing to knee CDI b(6)-2 [redacted] CPT AN
08Aug03 0600 T- 97.8	VS 127/64 P 68 R 15 SaO2 100% RA R-even unlabored Shallow LS CTA color good pupils 2cm brisk awakens to verbal & touch opens eyes b(6)-2 [redacted] talks. Interpreter present "states ~~not~~ pt mumbling" "makes no sense". holds hand if hand touched. Skin warm to touch cap refil brisk Drg (L) leg bulky c ACE CDI pedal pulse strong able to move extremity. NVI. IV (L) AC patent Running NS @ 150cc/Hr ⊖ S+S infiltrate or infx. foley to gravity draining amber (light) urine sm amt sediment noted. Occasionally sits up in bed seems confused then lies back down ABD soft BS hypoactive x 4 ⊖ facial grimacing

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EBW [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 Aug 03 0600	cont to restlessness during palpation will cont to monitor [redacted] 91MMG
08Aug03 0800	PT breakfast held, PT awakened eyes opened unable to keep PT awake BST [redacted]
1230	PT lunch held PT awakened eyes opened unable to keep PT awake [redacted] MMG
08Aug03 BSU	restless moving about in bed VSS Skin hot, dry afebrile PT diaphoretic AC ineffective pt hospital cooled c Waters + Washcloths ice unavailable [redacted] 91MMG
b(6)-2	
08Aug03 1830	NN: Assumed care of patient. Neuro: Pupils 3mm brisk reaction to light, follows some commands, trying to get out of bed, out of restraints. Moving all extremities well, equally strong. Resp: lungs clear, resp even and unlabored, sats 98-99% on RA. Ø cough. CV: HR in 80-90's, BP stable, skin warm and muddley sweaty, pulses palpable, afebrile. GI: abd soft, flat, N/T. BS ⊕ x4 Ø stool. Tolerating clears, will be NPO p MN for surgery in AM. GU: foley draining clear yellow urine, 50-100cc/h. Skin: multiple contusions and abrasions, dressings to knee CDI, C/Vs to distal limb intact. Lines: 18g ⊕ AC c D5½NS c 40K @ 175cc/h. Ancef Q 8h. Will continue to monitor.

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b(6)-2 [redacted]

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PROGRESS NOTES

DATE	NOTES
7 Aug 0530	cont serous drg. (+) pedal pulses skin warm to touch noted ecchymosis c edema b/l AT knuckles. multiple abrasions (L) leg (+) bowel sounds noted (small) (L) hip. moves in bed IV 18G (L) AC c NSS 150cc/hr patent SL (R) EA patent foley to gravity draining 50cc amber urine sm amt sediment will cont to monitor SGT [redacted] 91WMC
07 Aug 0618	noted pt Resting appears to be sleeping yawns on occasion NAD SGT [redacted]
07 Aug 0730	pt breakfast held not able to awake SGT [redacted] 91WMC b(6)-2
8 [illegible] 7(J	Pre Op Dx: Open (L) patella fx (age unknown) Bmp Type & Hold Post op Dx: same Procedure: I+D @ open patella fx Surgeon: Olivera Anesthesia: General LMA EBL: min Fluids: 800cc Urine: 1" clear yellow Drains: 1 medium JP Dressing: Soft Bulky Complications: none Condition: stable Plan: PT/OT WBAT (L) LE Pain control DVT prophylaxis Abx x 24 hrs Wound care Foley to gravity Monitor I/O Monitor labs Monitor vitals Monitor neuro status Monitor pain control Monitor wound Monitor drains Monitor foley Monitor IV Monitor labs Monitor vitals Monitor neuro status Monitor pain control Monitor wound Monitor drains Monitor foley Monitor IV

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b(6)-4

EPW # [redacted]

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A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8Aug03 2100	NN: Patient medicated ē 4mg Ativan per Dr [redacted] for restlessness. Minimal improvement. Neuro V's remain the same. Will continue to monitor [redacted] CPT1 RN
8Aug03 0130	Patient continues to be intermittenly agitated Gave 2mg Ativan IVP. Neuro states unchanged. [redacted] CPT1 AN
9Aug03 0300	Patient bathed, clean gown. Restraints checked. Dressing CDI, distal CMS √ intact. Will continue to monitor [redacted] CPT1 RN
09 Aug-03 0530	Assumed care of Pt. VS 98.4 - 132/90 - 88-20-79% FiO_2 on RA. Pt has ↓ LOC, responds to tactile stimuli, sits up at times but does not open his eyes, his pupils 3-4mm brisk, PERRLA, Lungs CTA (3), resp even + nonlabored, CV-S1,S2, NSR, 18g Rt/o wall in Q AC, GI-BSx4, NO, NT, , foley to gravity clear amber urine, Ø BM. Will monitor [redacted] RN/CNS
09 Aug-03 0903	NPO TO OR (Neuro) [redacted] RN/CNS
9 AUG 03 (1130hrs)	Returned from OR via litter. Drowsy, but responds to tactile stimuli. Pupils 2-3mm ē sluggish response to light. Moves all extremities spontaneously x 4. On (A) IV RT AC wrap dressing & Knee brace (Lungs): CTA all lobes ē SaO_2 @ 98-100% on RA; Ø SOB/difficulty breathing. (CV) +2-2 pulses palpable in all extremities ē brisk capillary refill < 3 secs. Color good, skin warm to touch [redacted] CPT

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#[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8/9/03	Pre Op Note Pre Op Dx: Open patellar Fx Post Op Dx: Same Procedure: I+D, ORIF ⓒ Patella Surgeon: [redacted] b6-2 Anesthesia: GOETA EBL: ⓒ Fluids: 1100 TT: 105 @ 300mm Hg Findings: Comminuted patella Fx, many medial patella Cx: ⓒ b(6)-2 Drains: Hemovac. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 AUG 1130hrs (Cont'd)	S1,S2 50@. B/P stb. T @ systolic of 130's-140's/90's. (GI/GU): abd soft, flat non-distended ± hyperactive bowel sounds in all quads. Foley cath ± 125-150cc/hr urine output, otherwise unremarkable. (Lines): PIV #1 (L) FA #18ga ± NS @ 150cc/hr → will Δ to D5½ ± 20K@150 per MD's order. JP #1 to (R) knee draining bloody fluids into collection container. (Plan): Complete recovery and transfer to ICU #2.
9 AUG 03 (1325hrs)	PACU post-surgery recovery complete. IV NS Δ to D5½ ± 20K @ 150cc. Report given to CA Spears (ICU #2). To transfer to ICU #2 via litter & two persons. OSS to further hospital care.

D(4)-2
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RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9Aug03 1530	received pt. from ICU 2@~1400 - VSS - D5½ NSc 20meqKCl@175cc/hr infusing into (R) AC, site patent - foley to gravity, amber Colored urine - (L) leg & ace wrap, knee immobilizer in place, hemavac in place - no drainage, [redacted] (+)2 pedal pulse in (L) foot - (+)2 peripheral pulses - pt. does not respond to commands, sits up at random, pulling @ restraints occassionally - PERRLA - pt. will lie back down c a hand lightly placed on chest - responds only to painful stimuli - restraints placed on (B) wrists and (B) ankle - lungs CTA (B) - (+) BS - 2mg ativan given IVP @1400 for agitation, pt. continues to sit up and pull @ restraints [redacted]
9Aug03 2040	labs drawn, Dr. [redacted] aware of results - pt. continues to fight restraints, attempting to pull out foley, open leg brace, sit up, pull IV - IV restarted in (L) FA - Dr [redacted] aware of pt's activity and status — [redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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EQW [redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Aug 03 0250	Pt care assumed @ 2100. VSS, lung sounds clear, bs x4, pulses @ x4. Pt is not orientated or alert, only responds to painful stimuli, has not opened his eyes once this shift. Eyes perrla. Pt on 40 meq KCL in 250cc NS @ 63cc/hr, IV site intact, IV ABx. Dsg on lle col, hemovac draining little amount of blood. Pt very combative although not appearing concious. Has epic restraints on BUE, RLE, and across chest. Keeps moving all extremeties, and sitting up in bed. Dr [redacted] saw pt, new orders ē labs @ 1800. Will continue to monitor. b(6)-2 [redacted] alumo
0400 0725	Hemovac emptied 60cc blood. [redacted] alumo Pt. restless in bed ē HOB @ 45°, restraints x 4. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Foley draining clear, orange tinged urine, insertion site ē white milky fluid draining. IV in (L) FA infusing [redacted] NS ē 40 meq KCl @ 62cc/hr ē s/s of infection or infiltration. Hemovac to (L) LE draining dark blood tinged drainage. Immobilizer to (L) LE intact, pedal pulse palpable, ≤ 3sec cap refill. Pt. ē decreased LOC, pupils equal & reactive to light, pt. responds to voice & painful stimulation. VSS, slight temp of 100.4, ē tylenol dosed in H2O & given to pt. All other assessment findings WNL. Will continue to monitor. [redacted] PFC [illegible] b(6)-2

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ĒF [redacted] b(6)-4

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510-112

NSN 7540-00-634-4123

MEDICAL RECORD

progress notes ~~NURSING NOTES~~ (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17Aug03	0625		Assume pt care @ 0500. Pt sleeping. Responds to touch and verbal stimuli. While awake pt moves back and forth yelling. VSS. D5NS c 20 kcl @ 125cc to central line blue port. Red and white port @ flush @ bld return c white port. Dsg reinforced c tape. CD+I. Jevity plus @ 50cc/hr to G-tube c difficulty. Dsg CD+I. Foley to gravity c dark clear yellow UOP. Pt restrained @ this time to prevent pulling out G-tubes and lines. @ knee dsg and brace CD+I. @ movement @ pulse below splint. Will continue to monitor [redacted]
	1300		Dsg Δ done @ 0845. packed c gauze & soaked in Betadine solution. Area pink, foul odor noted prn rose drain intact. MD request to be @ next dsg Δ. [redacted]
17Aug03		1630	assumed care @ 1300 - VSS agitated, yelling, biting anything he can get near his mouth, pulling @ restraints - central line patent - Foley to gravity - Jevity plus purg - tube @ ~60cc/hr - @ knee dsg Δ done, Dr. [redacted] unable to be found for dsg. Δ - pt. scheduled to go to civilian hospital in Am -

(Continue on reverse side)

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

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WARD NO. ICU 2

CIV [redacted] b(4)-4

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Medical Record

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

MEDCOM - 15869

b(6)-2 All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 Aug cont			Dr. [redacted] saw Knee wound, good granulation tissue noted, some small areas of black tissue, periwound intact, old dsg [redacted] moderate amt. of seroSang. drainage [redacted]
17 Aug 03		2200	VSS - Remains confused to person, place, time. At time Knows who he is but is intermittent. Pearl 94% Lungs CTA Bil Resp even Reg - HR-NSR BS (+) x4 quads Abd soft NT. Pedal and Radial pulses +3. dsg to (R) Knee dry and intact brace is in place. IV of D5NS @ 20 cc/hr KVO @ 125 ml/hr is patent to central line all 3 ports ACP patent. IV Cleon x can cont
			2 soft restraints. Restraints to UE and LE in place and secure; [redacted] 8/17/20
18 Aug 03	0430		Dsg to (R) Knee D/I by MD moderate amt of bloody drng to dry noted. wound looks clean & Redness drainage noted. Re-wrap c Kerlix and Ace bandage. brace put back on. MSO4 given for pain control. Resting quietly c Pleasant. woke up from 10 min restfully out in Acuity. Restraints to UE and LE in place and secure. [redacted]
1805-30 Aug 03	———		Nursing Assessment: Asleep, Arousable c stimulation. AAOx1 c stimulation. Airway intact, breathing even & unlabored, LS CTAB. Abd soft, nontender, c BS in four quads. Foley to gravity - clear, dark urine. Jevity @ 50 cc/hr continues. Foley to gravity - clear, dark urine. FROM and symmetrically intact to (R) UE and RLE limited ROM and symmetrically intact to LUE 2° splint/brace. 4-point restraints. C-line dsg D/I c diffusion Hg. C-line not stitched into place at this time. [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 15870

ACLU-RDI 1634 p.30

DOD-029259

6 Aug 03

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1320	
110/90	S - detainee brought in - [illegible]
P-115	escort guard stated wound to ①
R-18	knee
	& mental status
O2-92	Head - Rapid - Agitating
	Head - abrasion ① forehead
	Eyes-PERRL
	Neck - normal - normally no pain
	Chest - no trauma
	Back - ①
	Lungs - B.S. all ausc
	Heart - RR -
	Abd - soft - no tenderness
	① knee - [redacted]
	[redacted] DO
	Neuro - response & circulation -
	[illegible]
A -	Gunshot wound ① knee
	multiple abrasions
	Chain of Custody
P -	Treated & Released

66-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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] 66-4

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
USAPA V2.00

EPW

MEDCOM - 15871

NSN 7540-00-634-4176 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Aug03 1830	assumed care @ 1300 - VSS - D5½ NS @ 20 mEq KCl @ 175 cc/hr infusing into (L) PA IV - 4 point restraints on pt. for most of shift - pt. reaches for certain things & a purpose, combing himself, removing clothes - PERRLA - responds only to painful stimuli, does not noticeably respond to commands - Foley draining dk. amber urine, JPS - Hemovac drain - minimal output, ace wrap and knee immobilizer in place on (L) leg. neuro's WNL in (L) foot [redacted] AW
10 Aug 03	HD # 5 6 SW (L) knee / MS Δ b(6)-2
	- 6 SW opened / splinted & drain by Ortho. doing well.
Anref	- MS Δ's. No improvement; still moving all ext. equally & purposely. (pushing away during eye exam). No PO intake.
DS NS @ 20K @ 125 cc/hr	Na initially 141 ↓ 127 → 129 @ D5 NS @ 20K; K+ wnl
foley in	BUN/Cr wnl; LFT's wnl except mild ↑ AST & ALT & 3.1
	Plan: Zantac ulcer prophylaxis
	Lovenox 30mg SC. q12° DVT prophylaxis.
	500 cc bolus; Plan NL on D-feeding tomorrow
	[redacted] / [redacted] b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW b(6)-4 [redacted]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 15872

STANDARD FORM 600 (REV. 6-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 2244.	Pt. care assumed @ 2100. MD informed of labs. BP 150/100 and temp 100.1. NS bolus 500cc ordered and given. Pt. ~~inf~~ given Tylenol supp. for low grade temp. HR Reg, lungs CTA, BSE X4. Foley to gravity draining CYU. Knee brace to (L) LE intact, hemovac intact. (R) ft c Brisk cap refill, pulse 2+. Pt. restrained X4. HOB ^ for comfort. Will cont. to monitor. b(6)-2 [redacted]
0345	10cc bright red bloody drainage out by hemovac [redacted]
110530 Aug 03	NURSING ASSESSMENT: Assumed pt care. Pt appears to be asleep but is not arousable to painful stimuli. Pt has no response to deep painful stimuli or arm drop to bed. Pt does have sporadic, spontaneous verbalizations and movements. The movements typically seem to be the pt's attempt to get up out of bed. Airway intact, breathing is even and unlabored, LS: CTA (B). Some diminished noises to bases of lungs but clears c spontaneous coughing. Abd soft, nontender, ~ distention. BS (B) x4. Voiding per foley, clear, yellow urine. Pt is (R) UE, (R) LE, and all extremities are neurovascularly intact. LLE in leg brace c ACE wrap beneath brace, hemovac coming from knee. Dsg is CDI, hemovac has small amount of serosang drng. IV to (R) AC is ~ s/s of infiltration/inflammation but area is very positional. Pt has not eaten since admission to hospital. Medicine team aware. Will be reminded today. b(6)-2 [redacted]
111200 Aug 03	NURSING NOTE: Dobhoff 12Fr feeding tube placed in (L) nare. Lubricated c water-based jelly prior to insertion. Insertion point marked c black permanent marker, approx 1cm beyond single-lumen ~~tube~~ manufactured mark of tube. Placement verified via auscultation c good gastric bubble & fluid returned upon aspiration. Pt didn't cough throughout the procedure. Gastric air bubble auscultated at epigastrium. Tube secured @ 10 cm/hr initially to tube. [redacted]
111200 Aug 03.	NURSING NOTE: Hemovac DC'd by MD intact. [redacted] b(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 15873

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	assumed care @1300 [redacted] - dobhuff tube
1350	in (R) nare c 1/2 strength ensure infusing ~~into~~ @10cc/hr, tube taped to nose and forehead - IV in (L) FA c D5NS c 20meq KCl @125cc/hr, site patent - foley draining dk. amber/orange urine QS - (L) leg in ace wrap c Knee immobilizer in place, neuro V's WNL in (L) foot/toes - pt. c restraints on ankles (B) & upper arms (B) & sheet at pt's waist - pt. resting at moment, occassionally lifting head, pulling @ wrist restraints - PERRLA - pt. does not purposefully respond to sternal rub but resisted dsg Δ and dobhuff placement b(4)-2 [redacted]
11Aug03	temp @1400 102.7°F, pt. will not take PO
1445	tylenol, 650mg tylenol given PR @1445, will monitor results [redacted]
2132	Pt. care assumed @2100. Pt. febrile @ 101.°A 650 mg Tylenol given PR. HR Reg, lungs sounds CTA bilat. BS (+) bothyperactive. Lower ABD firm. Foley: 7 gravity draining amber/orange color urine. Pt. restrained X5 pts. Dobhuff tube in place infusing 1/2 strength ensure @ 10cc/hr. IVF infusing c difficulty. Pulses 2+ x 4 ext

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. BCW2

EPW b(4)-4 [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

MEDCOM - 15874

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	ē brisk cap refill. Knee immobilizer in place. NV checks @ LE WNL. Pt. fighting against restraints, grabbing @ Foley, sheets, people near bed. ~~Pt. movements don't~~ b(6)-2 [redacted] Pt. doesn't respond purposely all the time, but reacted to Lovenox shot. Will cont. to monitor. b(6)-2 [redacted] /LTJA
120530 Aug 05	Nursing Assessment: Assumed pt care. Glascow coma scale of 7/15 (eyes ① no response to painful stimuli; flexes ④ away from painful stimuli; ② incomprehensible verbal responses - non spontaneous). Airway intact, breath sounds clear bilateral, LS clear @. Abd soft, nontender, ī distention. BS @ x 4. Voids per foley to gravity (urine clear, ~~yellow~~ orange). Dobhoff tube to @ nares. Tube has come out & now a little bit. Advanced to marking on tube ī difficulty ~~d~~ retained. Feeding on hold for OR today. Plan and reasonably what to B/E and RLE. @ LE in knee brace ī ACE wrap RLE. Toes warm, good pulses to LLE. IV to @ RA flushes well & ī s/s infection or infiltration. b(6)-2 [redacted] /LTJA

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 15875

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 07	Neurology The pt has had essentially no clinical change over the past several days. He remains mostly somnolent, unable to follow any commands, briefly agitated when uncomfortable manuevers are done but verbalizing only a few brief words/sounds. He is unable to feed or toilet himself + has tube feedings. Pt's BP has been a little labile but pt has been AF. (E) Somnolent but briefly arousable c non-painful stimuli. Blinks to threat ? (B). Fundi reveal flat disc. Pt has roving eye movements at times + does not seem to direct gaze ? rarely when agitated. I could not get him to track objects, PERRL, conjugate, no ptosis, no facial Asymmetry, sym + ↑ tone movement of all 4 limbs. Tone is now spastic. ? Movement on this (D). He is hyper-reflexic c extensor toes. He responds to noxious stim. (B). Assessment 1. Encephalopathy, may be permanent 2° to brain stroke given his lack of improvement + global spasticity. I have

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
[redacted]			b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO	LTC K.R. [redacted]

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

REGISTER NO.	WARD NO.

[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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Aug 03	Neuro ②
	This mainly on his Temp @ presentation. Less likely but also possible is diffuse axonal injury 2° to CHI. This is possible but his forehead abrasion + cheek ecchymosis WERE quite minor.
	Plan
	1. Continue tube feedings + DVT prophylaxis (Lovenox)
	2. Placement in IRaqi facility
	b(6)-2 [redacted]
	LTC [redacted]
12AUG03	Brief op note
	Indication ① infected ② knee
	③ Encephalopathy
	Procedure - ① I+D ② knee
	③ open Arthrotomy.
	Anesth - GEM
	Fluids - 1L LR UO 500
	EBL min.
	Findings - G Tube placed on Ant surface of stomach near Greater Curve & complication: Necrotic tissue subQ & fascia c purulent arthritis
	b(6)-2 [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 15877

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03	CXR done x ®FJCVL confirmed correct placement no evidence of pneumothorax ® x ©. [redacted] CRNA/ME b(6)-2
12Aug03 1500	assumed care of pt. @ 1315 on pts return from OR S/P knee washout & gastrostomy - VSS BP 150/90 - ⓔBS, hypoactive - lungs CTA ⓑ ®IJCVL patent x3 ports c blood return x3 ports - g-tube to gravity drain, minimal reddish/brown output - foley to gravity draining ⓟS amber urine - IVSD - dobhoff tube remains in ®nare, pt. NPO & present - ⓓknee c ace wrap and immobilizer in place, neuro V's WNL in ⓓfoot - pt. b(6)-2 sleeping calmly & present [redacted] on
12Aug03 1930	pt. became very agitated @ ~1730, pulling at various tubes, restrained @ that point @ ⓑ wrists and ⓔ ankle - ensure ½ strength infusing @ 20cc/hr into dobhoff tube - pt. seemed to be moaning and was grabbing ⓛleg, medicated c 2 mg MSO4 for pain - [redacted] on b(6)-2

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EPW# [redacted] b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03	WSS - Not A but to person, place, time. W of LR @125 to central line is patent o s/s infiltration saline load to (R) arm is patent o s/s infiltrat. dobhoff NG patent ~~exam of~~ ensure @ 20cm ½ strength Runny. Foley patent draining dark yellow urine. CT dsg dry and intact CT take to gravity draining dark brown. Accuwrap to (R) leg dry and intact splint in place. lungs CTA BIL Resp even Reg. Pearl 3mm BS (R) x 4 quads. Radial and pedal pulses +3 CMS to upper and lower extremities 2-3sec. heart Asou - S1 S2 o ectopy NSR. Restraints to upper and lower extremities in place and secure [redacted]
12Aug03	NG feeding stopped @ 2400 per MD order - [redacted] b(6)-2
8/17/03	[redacted] b(6)-2 Pre OP Dx - Infected (R) knee Post OP Dx. SAME Anesthesia - Regional ITD Surgeon: [redacted] Fluids - ~~crystal~~ 2000cc LR EBL: minimal Post Op Plan: Cont ABX [redacted]
8/17/03	PT received from OR for TBO of (R) knee. PT fluids ok to infuse ordered. PT initially debilitated. PT bathed and NG/NJ tube, tube secured. to xray for placement. Follow up for placement. PT (R) knee CT [redacted] DSG of (R) knee intact, CT draining dark brown drainage as well. [redacted] b(6)-2 in medical distress [redacted]

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STANDARD FORM 600 (REV. 6-97) B[redacted]

MEDCOM - 15879

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 1300	Pt stable but agitated. Pt making purposeful movements and attempting to speak. Will open eyes partially to verbal and tactile stimuli. Given 4mg MSO4 for post op pain. NG tube to (R) nare intact, (R) nare 5 redness or inflammation. CL to (R) IJ CDI. 3 ports functioning properly. IV to (R) arm removed. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. G-tube placed yesterday, dsg CDI, draining dark green bile. Brace to (L) leg intact. Strong pulses and brisk cap refill to bilat LE. b(6)-2 [redacted] LT/BR
1330	Pt resting calmly on his side. ∅ agitation noted. Loose Kerlix restraints to wrists. Will cont T pain management b(6)-2 [redacted] LT/
1500	Pt alert and awake. Speaking to translator at bedside to give name and some info, still confused about details of injury. Dophoff removed. Pt drinking water and juice. MSO4 controlling pain and agitation. Pt loosely restrained. Will monitor [redacted] LT/BR

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW# [redacted]

b(6)-2

RECORDS MAINTAINED AT: b(6)-2

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 15880

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0145 14 Aug 03	Pt care assumed @ 2100. BP slightly elevated, other VSS. Lung sounds CTA, pulses +x4, BS(+). LLE dsg CDI, pulse and capillary refill(+), (1) foot edema. G-tube site on abd c dsg CDI, draining bile to gravity. Triple lmen to (R) IJ intact, all 3 ports working. LR A'd to DSNS c 20meq KCl @ 125 cc/hr. IV ABX running IVPB. foley catheter intact, draining CYU. 2mg MSO4 given for pt moaning "elam" @ 0130. Pt slowly being able to verbalize words, occasionally opening eyes and making eye contact. Interpreter spoke c patient, patient not verbalizing anything understandable, pt later heard to speak c nurse. Will continue to monitor [redacted] b(6)-2
14 Aug 03 0655	Pt care assumed @ 0600. VSS T temp of 100.2 Pt restless trying to verbalize. Pulses +x4 G Tube draining bile to gravity Foley draining dark amber urine DSC 20 meq KCl running. PT sitting up c ASSISTANCE will continue to monitor [redacted] b(6)-2
0645	Central line to (R) IJ intact (+) flush x3 (+) blood return c dsg CDI. LR running. Lungs CTA Abd. BS x4 G tube dsg CDI. Tylenol 650mg given for temp [redacted] pt NPO for breakfast. b(6)-2
14 Aug 03	OP Note Pre op dx: Septic Arthritis (L) knee Post op dx: same Procedure: Debridement I+D (L) knee Surgeon: [redacted] — b6-2 — [redacted] 23L Cefazolin Fluids: 300cc

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03	1245 Pt returned from ICU3 p recovery from Ex-lap of (L)LE. VSS. G-tube in place. Foley to gravity. Central line c NS c 20KCl @ 125cc/hr. Dsg Δ'd - Ond intact. Dsg and brace to (L)LE, CD+I. pt restless. @ this time moving up and down. b(6)-2 [redacted] Shumpert
14Aug03 1445	assumed care @1300 - VSS BP 160/96 - Central line patent x 3 ports c blood return - g-tube clamped - Foley draining clear urine QS - ace wrap on knee, knee immobilizer in place on (R) leg + pl. Sleeping @ present, (R) wrist restraints in place - lungs CTA (B) - (+) BS, hypoactive - pt. making limited eye contact and asking questions in Arabic, Still acting confused as he is occassionally pulling @ Foley and central line b(6)-2 [redacted] ChrA
14Aug03 2100	Osmolite 1 N/tubefeed started @ 10cc/hr via Kangaroo tubing, Dr [redacted] aware of tubefeed type Δ - Jevity plus will be used when rate reaches 30cc/hr [redacted] ecp b(6)-2

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

H [redacted]

b(6)-4

REGISTER NO.

WARD NO. ICU2

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

MEDCOM - 15882

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14Aug03	VSS - is confused as to person, time, place. IV 20mK NS Running to central line is patent @ s/s infil. trunk. Pearl. Lungs CTA Bil. Reg even. HR - WSR - BS ⊕ x 4 ea. Lads: Ace wrap and brace to ⊕ leg leg in place. +1 edema to ⊕ foot. OS molite HN. Running to AT ↑ 10u to 20ml is patent ⊕ Residuals Restraints to UE and LE in place and secure. Lying quietly w/ eyes closed @ present. — S/T [redacted] q1 cath b(a)-2
15 14Aug03	Assumed PT care at 0545. PT sleeping has wrist restraints & R leg restraint. central line Patent w/ NS 20 KCL running. Foley Draining Amber urine. G-Tube w/ water & nocyte Lungs CTA w/ even breathing b(a)-2 LLE in brace PT due to OR this AM —— Pt [redacted] after
14Aug03	PT bathed w/ all lines FLushed osmolyte stopped at 0700 due to NPO MD. order or not freed. — [redacted] given at
15Aug03	PT awake spoke to staff and Transfer.
15 Aug03	OPNote Preop Dx: Infected ⊕ knee Postop Dx: same Procedure: I&D ⊕ knee Surg: [redacted] Fluids: 1500cc Patient: TID wet to dry Contact Ax [redacted] b(a)-2
15Aug03 1640	assumed care upon pt's return from ⊕ knee w/ short ~1500 - VSS - pt. very agitated & c/o pain, restrained ⊕ wrists & ⊕ ankle, given 5mg MSO4 for knee pain IVP - pt. slept for ~30 minutes and is now very agitated again [redacted] b(a)-2 CHAN

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STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug03	USS - Becoming more Alert to person, Still confused as to Place, time. IV of D5NS @ 125 ml/hr to central line is patent @ S/S of infiltration. Brace and Ace wrap to (R) leg in place and dry and intact. GT in place and patent. Pearla 4mm - HR - NSR - Lungs CTA B/L - BS (+) X4 Quads, Pedal and Radial Pulses +3. foley to gravity urine clear yellow. Restraints to UE and LE in place and secure. b(6)-2 SGT [redacted] USMC
16Aug03 0320	PT Agitated and confused most of Pm. Quieted down @ 2Am. has been awake intermittently but falls back Asleep. IV D5NS @ 125 ml/hr to central line is patent S S/S infiltration. Tube feeding Osmolyte HW @ 20 ml/hr @ Restful @ 2400 TOL well. Restraints to UE and LE in place and secure. b(6)-2 SGT [redacted] USMC
16Aug03 0745	Pt. awake & restless in bed, pulling @ lines & intermittently yelling in Arabic. HR Regular, lungsands clear bilat, bowel sounds (+) X4 quads. Central line in place (R) EJ, D5 ½NS @ 20 kcl meq @ 125cc/hr infusing into proximal port, medial port flushed well @ 3cc NS @ good bld return, distal port flushed well @ 3cc NS & bld return. G tube in place & leakage around insertion site, Osmolyte HN ~~flowing~~ infusing @ 20cc/hr. Foley draining clear orange tinged urine. (L) LE DSG D/d by MD, warm to (L) knee @ foul odor & (+) S/S of infection. Wound irrigated @ ½% Dakins soln. & ABD pads, wrapped @ kerlex & ace wrap. All other assessment findings WNL. (L) LE pedal pulse palpable, cap refill <3sec, (+) sensation, full ROM

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. CCR

EPW [redacted] b(6)-4

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

MEDCOM - 15884

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16Aug03	in digits & ankle. Will continue to monitor. [redacted] T/AN
16Aug03 1720	assumed care @1300 - VSS - very restless & agitated, restrained (B) wrists & (R) ankle - left leg in immobilizer, dsg Δ dove, 4x4's & Kerlix c large amount of drainage, wound bed c a red moist appearance, no pus or drainage in wound bed, penrose drain in wound, neuro's WNL in (L) foot - Jevity plus tube feed begun @ 40cc/hr via g tube, residuals < 2cc - central line patent x3 ports, blood return x2 ports, D5NS c 20meq KCl @ 125cc/hr - foley draining amber urine QS - pt. continues to be confused and disoriented, follows simple commands infrequently [redacted] R.AN
16Aug03 2130	VSS - Remains confused as to person & times, place, time. IV to central line D5 NS c 20meq q K @ 125 cc/hr, is patent & site is free from infiltration. foley to gravity is patent draining clear straw colored urine. Pearla 3mm - Lungs CTA Resp - even Reg. HR - NSR. BS @ x4 quads. Radial and pedal pulses +3. Pressure @ Knee dry and intact brace in place. Restraints to UE and LE dsg in place and secure. Awake & present yelling out in [redacted] SGT [redacted] C-6
16Aug03 2330	Dsg Δ to (L) Knee dsg mod amt of bldy drainage noted. wound looks clean & free of redness or discharge. penrose drain in place & dry. Repacked c super sponges and covered c Abd pad. Rapped c Ace wrap. brace in place [redacted] C-5

558-104 b(2)-2 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]
RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS
CITY | STATE | ZIP CODE

ARRIVAL
DATE *(Day, Month, Year)* | TIME
TRANSPORTATION TO FACILITY: AS

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
?	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: ?
ALLERGIES: ?

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT
DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS
DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW 6SW (L) knee ↓ mental status

CATEGORY OF TREATMENT
☐ EMERGENT
☐ URGENT
☐ NON-URGENT
TIME: 1405
INITIALS:

VITAL SIGNS

TIME	1405		1605			
BP	131/74		148/92			
PULSE	102		103			
RESP	20		20			
TEMP	102.3	103.4 rectal 100.8 axill				
WT			100 w/o splint			

LAB ORDERS
☒ CBC/DIFF | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT
URINE C&S | UA MSCC/CATH | CHEM: 8, LFTS (1 stat)
BLOOD C&S X

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

ORDERS
☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1405	X-RAY (L) KNEE				

DISPOSITION: ☐ HOME ☐ FULL DUTY
MODIFIED DUTY UNTIL
DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS
RETURN TO DUTY
PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
ADMIT TO UNIT/SERVICE
TIME OF RELEASE
REFERRED ▶ TO | WHEN

I have received and understand these instructions.
PATIENT'S SIGNATURE

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

[redacted]
b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 15886

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

TEST RESULTS

CBC: WBC 8.0; H/H 10.4/34.6; PLT 259

SMAC: CK 2449 H; 139 | 103 | 15 / 25 | 0.9 | 103

ABG/PULSE OX: SUP O2 | PH | PO2 | PCO2 | SAT | OTHER: ABG 7.4e7 39.9 76 24 4

RADIOLOGY: Check if read by radiologist ☐

RESULTS: (L) patellar fx Skull cap WNL Reviewed c Dr. Brennan

EKG INTERPRETATION: WA neg blood (ge Rebow

PT | APTT | BHCG | ETOH | GLU | U/A: DIP | MICRO

PROVIDER HISTORY/PHYSICAL

S: EPW presents c GSW to (L) knee O2 Sat 96% on RA - not responding to verbal commands Axillary temps 102. Wound to (L) knee 1cm around bleeding controlled. Hardened area above knee non-tender

O: VS noted Tachycardic BP WNL Pt not responding to verbal commands or deep pain Trauma. Spontaneous resp (+) gag, Sabellan Opens eyes spontaneously GCS -9 Eyes PERRL Optic discs clear Ears TM's gray flat Mouth OP WNL + gag membranes moist Heart RRR Tachycardic Lungs CTA Chest even excursion Lower (L) knee trauma Upper Palpable patellar fx Back Skin intact & negative abrasion wounds Rectal - normal tone Prostate WNL (+) gag response (+) response to pain A: (L) Knee trauma altered mental status

CONSULT WITH	TIME	ACTION
Oliveira Ortho	1	
Command Neuro		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] STAMP Capt MC

DIAGNOSIS A: (1) Altered mental status, prob heat injury/stroke R(6)-2

(2) Fx patella (L) knee c effusion

P: Admit

CODES

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

#[redacted] (6)-4

EMERGENCY CARE AND TREATMENT (Doctor)
Medical Record

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

MEDCOM - 15887

[redacted] 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: 20's
HEIGHT: } unknown
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: s/p GSW
open patellar fx (L) knee. MS Δ

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition multiple bruises & scratches
Tobacco ? ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM _____ ASA/Motrin w/72 hrs (Y) (N)
ETOH ? Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ancef

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ 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	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted]

b(6)-4

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

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	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. o Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ 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 – Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ 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 INTERVENTION S NOTED.

[redacted] 117 AN b(6)-2 7 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: b(6)-2 (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 117 AN
DATE: 7 Aug 03 TIME: 0755

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Tit[redacted] 117 AN
DATE: 7 Aug 03 TIME: 0925

b(6)-2 A11

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: Cart BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] b(6)-2 A11

3. DATE 7 Aug 03 — TIME PATIENT ARRIVED IN SUITE 0817

4. PATIENT IN ROOM TIME 0817 — NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: S/P GSW (L) knee. MS △. NPO p MN. Patent Foley cath

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded arm boards <90°.

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

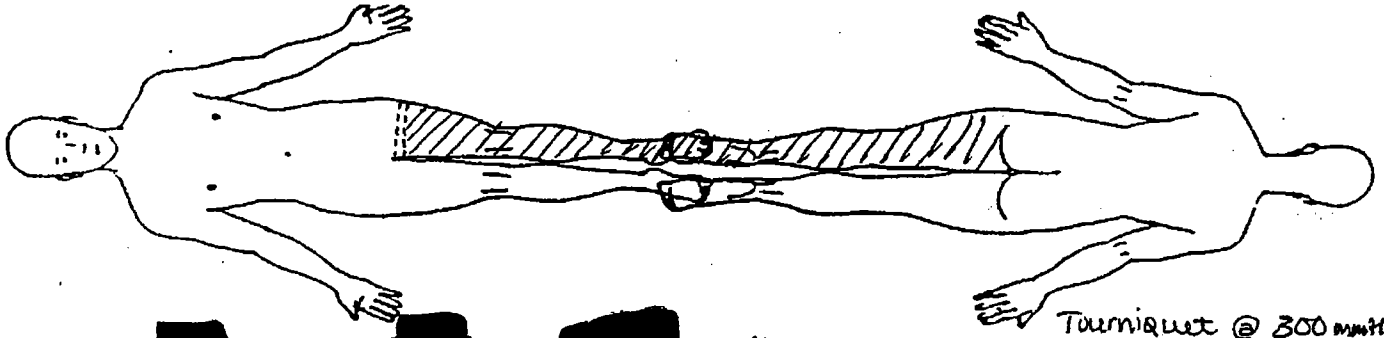
HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP Left Knee

COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify)
SITE: Left leg BY WHOM: ILT [redacted]
SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = Tourniquet ☑ - prep

Initial: SGT [redacted] ILT [redacted]

C = Correct I = Incorrect

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

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

[redacted]

P(6)-4

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

☒ ESU NO: #3 Cut 30 Coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 Exp 2005-03

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN [redacted] b(6)-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs, Kerlix, ABD, ACE

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Penrose Drain 1"		
SITE	Left knee		

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] b(6)-2 GETA
Anesthesia: CPT [redacted]

DA 5179 initiated

20. OPERATION(S) PERFORMED
I&D © knee wound / Left open patella Fracture

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	0925	Litter

22. REGISTERED NURSE SIGNATU [redacted] b(6)-2 RN

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

MEDCOM - 15891

b(4)-2 All

MEDICAL RECORD — INTRAOPERA[illegible] 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/RNurse

2. PATIENT IDENTIFIED, R[illegible]D PROCEDURE VERIFIED BY: LT [redacted]

3. DATE: 9Aug03 TIME PATIENT ARRIVED IN SUITE: 0900

4. PATIENT IN ROOM TIME: 0900 NUMBER: 2-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) SR #9

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

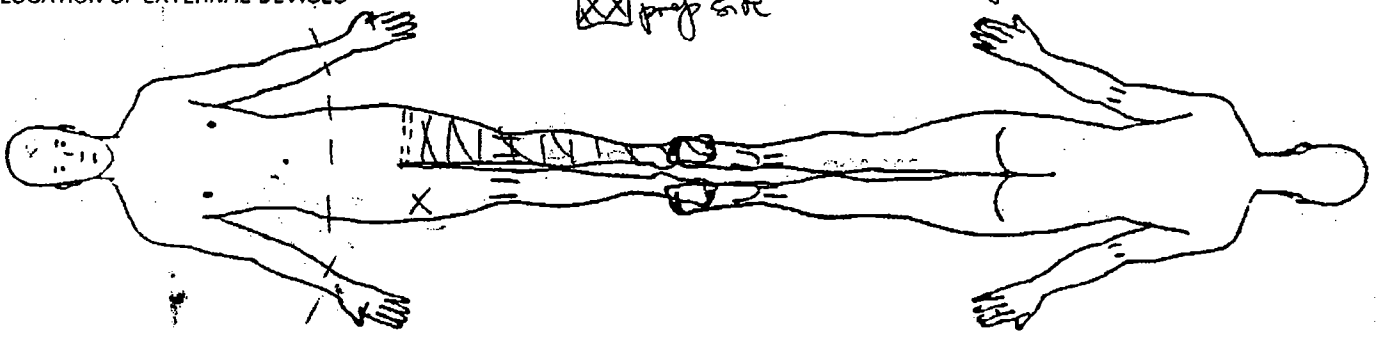
COMMENTS: proper body alignment maintained, head on foam donut, arms extended less than 90° on padded armboards, position approved by surgeon/anesthesia

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Beta
SITE: L leg BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Str[redacted] = = = Tourniquet (placed by surgeon over velcro)

C = Correct I = Incorrect Initial: [redacted]

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

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

[redacted]

ICU2 b(4)-4

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

☐ ESU NO: VL Force 2#3 (000417)
GROUND PAD: BRAND Vl Rem Polyhesive II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Small Frag Set cms #0921501
4.0mm Cancellous Screws
~~15x~~ 40x2 35x1
219.98 Washer x3

20g Wire cms # 0522101
x1

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

b(6)-2

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ☒ YES ☐ NO — IF YES, SITE (L) knee C-arm

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION (Specify)
Fluffs Xeroform
Kerlix ABD
Acewrap
Immobilizer

17. TUBES, DRAINS/PACKING ☒ YES ☐ NO

	1.	2.	3.
TYPE/SIZE	400ml Hemovac		
SITE	(L) knee		

19. ADDITIONAL INFORMATION

Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]

Tourniquet ↑ 0925
↓ 11
Bone not used

- DA 5179 in chart

20. OPERATION(S) PERFORMED
I+D (L) knee
ORIF (L) patella

21. PATIENT TRANSFERRED TO ICU b(6)-2 — TIME set DA7389 — METHOD litter c safety

22. REGISTERED NURSE SIGNATURE [redacted] TIAN

REVERSE OF DA FORM [redacted] USA 1.01

MEDCOM - 15893

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPER[illegible]TING ROOM
VIA Litter BY Anesthesia/OR nurse

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

3. DATE 12 Aug 03 TIME PATIENT ARRIVED IN SUITE 1020

4. PATIENT IN ROOM TIME 1020 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

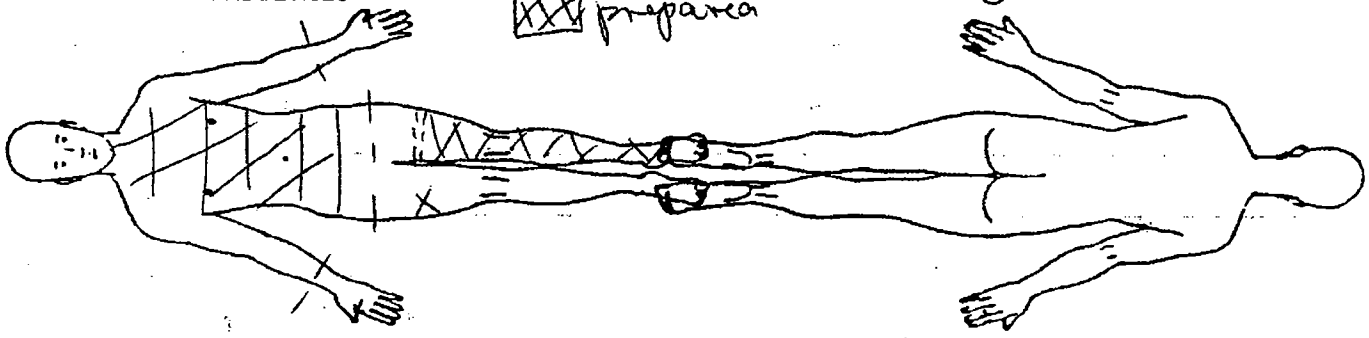
COMMENTS: Proper body alignment maintained, head on foam donut, arms extended at less than 90° on padded arm boards, position approved by surgeons and anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Betal Beta #19
SITE: L leg BY WHOM [redacted]
SITE: clavicle to symphysis pubis BY WHOM [redacted]
COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad SM – Safety Strap SM === Tourniquet placed by Dr. [redacted]

10. COUNTS			C = Correct I = Incorrect: Initial Count / Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	C	C	C
Needle Sharp	☒ Yes	☐ No	C	C	C
Instrument	☐ Yes	☒ No	NA	NA	NA
Other	☐ Yes	☒ No			

SCRUB: Treadwell NA

CIRCULATOR: b(6)-2 [redacted]

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

[redacted]
ICW2 b(6)-4

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

☒ ESU NO: VL Force 2 # 4
GROUND PAD: BRAND VL Rem Polyhesive II
30130 LOT NO: 68936 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 - 15894

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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	18. DRESSING/IMMOBILIZATION (Specify) 4x8 + Tape (Abdomen) Fluffs ABD pads Kerlix ~~Ace wrap~~ Ace wrap Knee Immobilizer

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	24 F Malecot	1 in Penrose	
SITE	1. G-tube Abdomen	2. (L) knee	3.

19. ADDITIONAL INFORMATION
WC ~~III~~ IV
Surgeons: [redacted]
Anesthesia: [redacted]
Anesthesia Type: general
66-2
30130
Bovie Pad site intact pre-op ✓; post-op _____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op ✓: post-op ✓
Tourniquet Time: Up 1056 Down 1144

20. OPERATION(S) PERFORMED
CL insertion, G tube placement, arthrotomy left knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
Recovery	DA7389	Litter c safety strap on

22. REGISTERED NURSE SIGNATURE
[redacted] AN

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

b(4)-2

MEDCOM - 15895

b(6)-2

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 gurney BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED B [redacted] CPT AW

3. DATE 13AUG03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0617 NUMBER 2-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

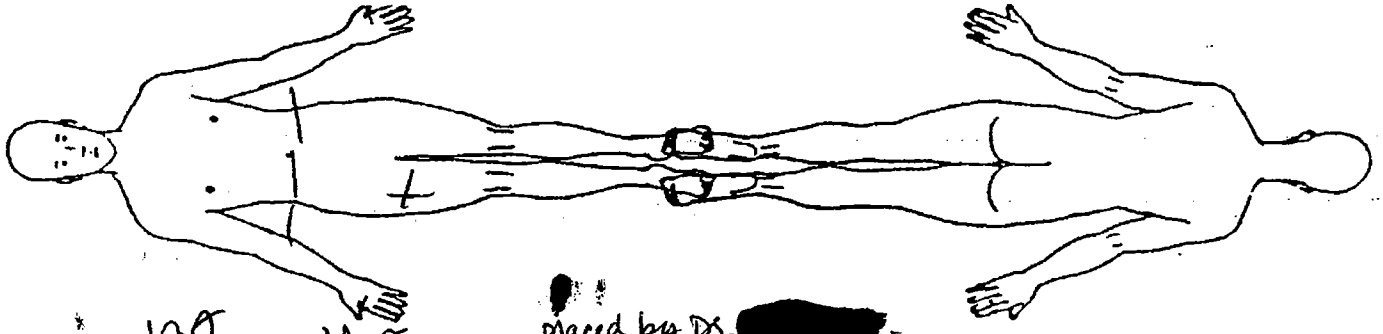
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta / Beta
SITE (L) leg BY WHOM: CPT Eades / CPT Holder
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ± Safety Strap === Tourniquet

YNP YNP placed by Dr. [redacted] TT1 – 14Mins @ 200mmHg

10. COUNTS		C = Correct I = Incorrect: Initial Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2 [redacted]	CIRCULATOR CPT [redacted]
Sponge	☒ Yes ☐ No	C		C	SPC	
Needle Sharp	☒ Yes ☐ No	C		C		
Instrument	☐ Yes ☒ No	1	1	1	1	1
Other	☐ Yes ☒ No					

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

CIV [redacted] b(6)-4

[redacted] b(2)-2

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

CUT 30 COAG 30

☒ ESU NO: Valleylab #2-1
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 15896 4 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

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATI[redacted] IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify)

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 1" Penrose	2.	3.
SITE	1. ©Knee	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
- fluffs
- Kerlix
- ABD pads

19. ADDITIONAL INFORMATION
WC
Surgeons: DR [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: Gen b(c)-2 All

Bovie Pad site intact pre-op CI ; post-op CI Bovie Settings: Coag/Cut 30-40/30-40

20. OPERATION(S) PERFORMED
I & D left Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	0710	gurney

22. REGIST[redacted] -AD [redacted] AD

REVER[redacted] USAPA V1.01

MEDICAL RECORD — **INTRAOPER/ DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

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

3. DATE 14AUG03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ... TIME 0933 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] AN	RELIEF CIRCULATOR	CPT [redacted] (0945-1000)

7. POSITION AND POSITIONAL AIDS (Specify)

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

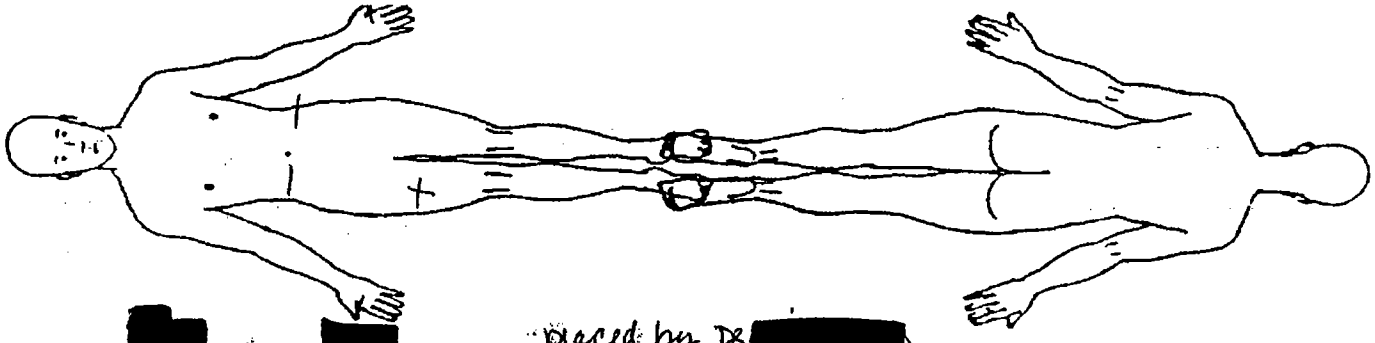
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta / Beta
SITE: (L) Leg BY WHOM: CPT [redacted]
SITE: — BY WHOM: —
COMMENTS: No pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Strap === Tourniquet placed by Dr. [redacted] b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Count Other**	First Closing Count	Final Closing Count
Sponge	☐ Yes ☐ No	C		C
Needle Sharp	☐ Yes ☐ No	C		C
Instrument	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

SCRUB: PFC [redacted] b(6)-2 / PFC [redacted]
CIRCULATOR: CPT [redacted] / CPT [redacted]

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

CIV [redacted] b(6)-4

[redacted] b(6)-2

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

☒ ESU NO: CUT Valleylab E7507 / COAG #21
GROUND PAD: BRAND Valleylab / NA
LOT NO: 68938 2005-03

☐ ESU NO: —
GROUND PAD: BRAND —
LOT NO: —

☐ BIPOLAR NO: —

DA FORM 3179-1, OCT 87 REPLACES DA MEDCOM - 15898 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

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATUR[redacted] b(6)-2

15. X-RAY IN OPERATI[redacted] IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- Kerlix
- ABD pads

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

19. ADDITIONAL INFORMATION
WC
Surgeons: DR [redacted] b(6)-2 Anesthesia: CRT [redacted] b(6)-2 Anesthesia Type:

Bovie Pad site intact pre-op [redacted]; post-op [redacted] Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
I & D (L) [redacted] Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3 / b(6)-2	1045	gurney

22. REGISTERED NU[redacted]IRE
[redacted] CPT ~ 66E

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

MEDCOM - 15899

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

b(6)-2

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 Gurney BY Anesthesia

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

3. DATE 13 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN R... TIME 1318 NUMBER 1-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1300-1330

7. POSITION AND POSITIONAL AIDS (Specify) Bilateral arms on padded arm board <90

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

COMMENTS: b(6)-2

8. SKIN PREPARATION

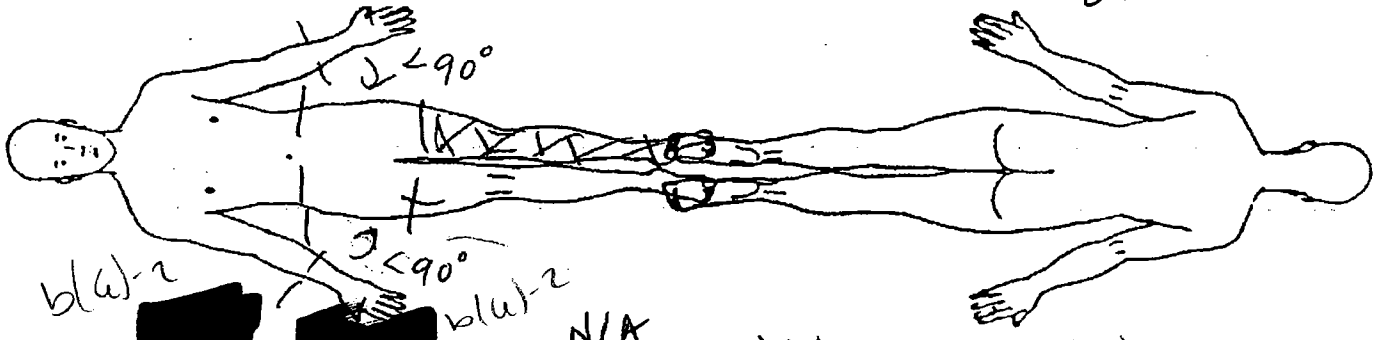
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta/Beta
SITE: L Knee BY WHOM: CPT [redacted]
SITE: BY WHOM: CPT

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted] b(6)-2 [redacted] N/A

LEGEND: X = ... === Tourniquet XXX prep b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No	C		C	SSG [redacted]	CPT [redacted]
Needle Sharp	☐ Yes ☐ No	C		C	SSG [redacted]	CPT
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;)

EPW [redacted] b(6)-4

[redacted] b(2)-2

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES ... MEDCOM - 15900 ... CH 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
Dakins Sol. 1/4	QS	Intraop	Soak	Pharm.	Dr. [redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NACL b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

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

- fluffs
- kerlix
- ace Wrap

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] b(6)-2 Anesthesia: CRNA [redacted] esthesia Type: gen.

Bovie Pad site intact pre-op [redacted]; post-op [redacted] Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
I & D Left knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU b(6)-2	1415	gurney

22. REGISTERED NURSE SIGN [redacted] PT AN

[redacted] DA FORM 5179-1, [redacted] USAPA V1.01

MEDCOM - 15901

7 Aug 03

Date: 06 Aug 03 Bed#: 7

Patients Name: U EPW #[redacted]

Time	01	02	03	04	05					14	15	16	17	18	19	20	21	22	23	24
														Admit						
BP	113/61	121/72	112/67	118/66										120/73	111/68	120/62	115/63	135/68	119/66	111/61
TEMP		979												991				988		
HR	61	80	66	68										72	66	69	63	69	63	60
RR	15	19	13	15										12	10	17	10	12	17	15
SAO2	100	100	100	100										100	100	100	100	100	100	100
FIO2	RA	RA	RA	RA										RA	RA	RA	RA	RA	RA	RA
INPUT																				
PO																				
IV NS	150	150	150	150										150	150	150	150	100	100	150
NGT																				
IVPB														50						50
TOTAL	150	150	150	150										200	150	150	150	150	150	150
Balance	(1300)	(1450)	(1600)	(1750)										(200)	(250)	(500)	(650)	(800)	(950)	(1150)
OUTPUT																				
URINE		250*												400				500*		
NGT																				
STOOL																				
TOTAL		250		250										400				500		
														(400)				(900)		
BALANCE		(1150)		(1400)																
Restraint ✓																				
~~TEMP~~ Q 2		✓		✓										✓		✓		✓		✓

[redacted] b(3)-4

Date: 07 Aug 03 Bed#: 7
Patients Name: ERU # [redacted] b(3)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP	116/63	118/71	129/74	O	O	124/85	118/83	141/81	131/76	122/72	137/70	125/80	127/57	126/69	135/62	141/73	153/73	130/74	142/75	142/78
TEMP	97.3		97.8			97.6			97.6		100.8					98.8				97.9
HR	60	64	70	R	R	48	62	55	59	66	91	116	117	100	118	86	70	68	69	78
RR	12	10	16			13	14	14	14	16	24	18	24	26	27	22	19	19	16	15
SAO2	100	100	100			100	100	98	98	98	97	98	98	96	99	98	99	99	100	100
FIO2	RA	RA	RA			RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																				
PO	0	0	0	800																
IV	150	150	150	0	0	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT	N/A	N/A	N/A			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
IVPB		50								50								50		
				R	R															
TOTAL																				
OUTPUT																				
URINE	50	45	50	300			300	150	225	125			550			450				450
NGT	N/A	N/A	N/A			N/A	N/A	N/A	N/A	N/A										
STOOL	0	0	0	0	0	0	0	0	0	0										
TOTAL	50	45	50		300															
BALANCE	(50)	(95)	(145)		(445)		(745)	(895)	(1120)	(1245)			(1795)			(2195)				(2645)
TURN Q 2																				

511–119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY — 08 Aug 03

19 HOUR — 01 02 03 04 05 06 07 08 09 10 11 12 13 14

PULSE (0) — TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

17 15 18 17 14 15 15 15 16 18 18 15

BLOOD PRESSURE

144/75 134/73 140/74 137/72 125/65 127/64 129/64 123/67 122/71 133/74 126/66 126/78 136/90 129/60

O2 sats

100 100 100 99 100 100 100 100 100 100 100 100 100 100

HEIGHT: WEIGHT →

Input total — 125 125 125 125 125 125 125 125 125 125 125 125 125 125

Output total — 320 430 610

total IN — total out

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.

MEDCOM - 15904

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY | POST- DAY | MONTH-YEAR | DAY | 19 | HOUR

NIGHT 08 Aug | DAY 09 Aug | NIGHT 09 Aug | 10 | 11 | 12

HOUR: 18 22 02 06 10 14 18 22 02

PULSE (O) | TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)

OR / RECOVERY

RESPIRATION RECORD

BLOOD PRESSURE

Sats

HEIGHT: | WEIGHT →

Input: IV / PO

Output - foley

	18	22	02	06	10	14	18	22	02						
BP	129/67	124/83	130/63	132/80		135/78	144/70			138/70	159/82	130/70		124/82	150/90
Sats	99	99	100	98	96		96			93			98	98	96
Input IV	300	700	700	0	150										
Input PO		50		400	—										
Output - foley	240	520	500		950										

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. TCW2

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 15905

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 17
POST- OP DAY: POST
MONTH-YEAR: Aug 2003
DAY: 12 13 14 15 16 17
HOUR: 2100

PULSE (O) / TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 136/80 | 146/98 | 130/90 | 136/98 | 150/90 | 113/64 | 144/84

	97		96	95	96		98	98	96			98	98	
HEIGHT:	WEIGHT →	21	22	23	24	01	02	03	04	05	06			
IV LR 125/hr		125												
ensure 60 bid 2 c/m		20												

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)

EPW [redacted]

REGISTER NO.

WARD NO. LCW2

VITAL SIGNS RECORDS
Medical Record

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

MEDCOM - 15906

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug DAY 15 18

HOUR 05 21

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

BLOOD PRESSURE 134/82 120/68

100 97

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

511-114

MEDCOM - 15907

Ward/Section: CW2 | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 11AUG | TIME: 0300 | SSN: [redacted]

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
11/08/03 03:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100676

GLU	103	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	314	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

Na -134

REMARKS:

REPORTED BY: [redacted] b(6)-2 | **DATE:** 11 Aug 03 | **LAB ID NO.:**

Ward/Section: 12W2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 11AUG	TIME: 0900
SSN/PSN: [redacted]		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	17.2	9.8-13.6 secs
APTT	32.1	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Microbiology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]

DATE: 11Aug03

LAB ID NO.:

Ward/Section: Echo 12	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8/11	TIME: 2328
		SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

ID: 000538
WB

WBC	8.5 *	x10^3/uL	4.5 10.5
RBC	4.03	x10^6/uL	4.00
Hgb	12.3	g/dL	11.0 16.0
Hct	38.2	%	35.0 50.0
MCV	94.7	fL	80.0 99.9
MCH	30.5	pg	27.0 31.0
MCHC	32.2 L	g/dL	33.0 37.0
PLT	420.	x10^3/uL	150. 450.
LYM	7.6 *	%	20.5 51.1
LYM	0.6 *	x10^3/uL	1.2 3.4

Bands		Baso	
Lymph		Imm	
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
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]

DATE: 11 Aug 03

LAB ID NO.:

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

REQUESTING PHYSICIAN: b(6) - 2

DATE: 9 Aug 03 TIME: 1515 SSN/PSEUDO SSN:

ID: 000538 09-08-03
UB 15:57

				Patient Limits	
WBC	12.3	H	x10^3/uL	4.5	10.5
RBC	4.36		x10^6/uL	4.00	6.00
Hgb	12.4		g/dL	11.0	18.0
Hct	41.2		%	35.0	60.0
MCV	94.5		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	30.0	L	g/dL	33.0	37.0
Plt	175	*	x10^3/uL	150.	450.
LY%	27.1	*	%	20.5	51.1
LY#	3.3	*	x10^3/uL	1.2	3.4

CBC

REF. RANGE
4.8-10.8 x 10^3
4.7-6.1 x 10^3
14-18 g/dl (M) 12-16 g/dl (F)
42-52% (M) 37-47% (F)
80-94 fl (M) 81-99 fl (F)
130-500 x 10^3 verified
20.5-51.1%

Differential

Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	N	Negative
Bili	N	Negative
Ket	Lge	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	7.0	N/A
Prot	Neg	Negative
Urob	8	0.2-1.0
Nit	N	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

AcbTest: Lge
Bact: Moy
Mucus: Mod
WBC: 5-10

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6) - 2

REPORTED BY: [redacted]

DATE: 9Aug03

LAB ID NO.:

b(6)-2

Ward/Section: 7CW2 | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 9Aug03 | TIME: 1506 | SSN/PSEUDO SSN:

b(6)-2

(i-STAT)

TEST	RESULT	REF. RANGE
		mmol/L
		mol/L
		bol/L
		Hg (art)
		g (ven)
		Hg (art)
		/L (art)
		/L (ven)
		/L (art)
		/L (ven)
		pl/L
		mmol/L
		g/dL
		/dl
		CV
		NGE

i-STAT 6+

Pt: [redacted] 66-4

Pt Name:_____

Glu_____126 mg/dL

BUN_____5 mg/dL

Na_____127 mmol/L

K_____3.0 mmol/L

Cl_____106 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

Sample Type_:

09AUG03 16:01

Oper: 7702

Physician:_____

Ser# 40763

Ver: JAM5046A
CLEW A93

(Piccolo) Chemistry 12

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

PICCOLO

09/08/03 15:34

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METHYL: 8

DISC LOT #: 3111AA4

OPER #: 702 DR #: 000

SERIAL #: 0000100684

GLU	132*	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	554*	39-330	U/L
~~NA+~~	~~+++~~	~~128-145~~	~~MMOL~~
~~K+~~	~~4.1~~	~~3.3-4.7~~	~~MMOL~~
~~CL-~~	~~99~~	~~98-108~~	~~MMOL~~
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
A++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

Abuse		

REMARKS:

b(6)-2

REPORTED BY: [redacted] **DATE:** 9Aug03 **LAB ID NO.:**

b(6)-2

Ward/Section: ICU2	REQUESTING PHYS: Dr [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: PVT [redacted] b(6)-4	DATE: 7AUG03	TIME: 0400
		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.7	4.5 10.5
RBC	4.23	4.00 6.00
Hgb	12.7	11.0 18.0
Hct	39.7	35.0 60.0
MCV	93.9	80.0 99.9
MCH	30.1	27.0 31.0
MCHC	32.1 L	33.0 37.0
Plt	294.	150. 450.
LY%	18.3 *L	20.5 51.1
LY#	1.6 *	1.2 3.4

ID: [redacted] 66-4 07-08-03
WB 04:35
Patient Limits

Lymph		Baso		
Atyp		Imm		
RBC Morph				

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 7 Aug 03 **LAB ID NO.:**

b(6)-2

Ward/Section: CCU 2 | REQUESTING PHYSICIAN: DR [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 7Aug03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		ABSENT
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
07/08/03 04:37
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

ALB	3.1*	3.3-5.5	G/DL
ALP	59	26-84	U/L
ALT	54*	10-47	U/L
AMY	34	14-97	U/L
AST	58*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CHOL	140	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	97	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

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

Bun 11

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GL		
BU		
CA		
CR		
NA		
K+		
CL		
tCi		
Al		
Al		
Al		
A		
A		
T		
G		
T		

i-STAT EC8+

Pt: [redacted]
Pt Name:_____

Glu_____93 mg/dL
BUN_____11 mg/dL
Na_____141 mmol/L
K_____3.6 mmol/L
Cl_____106 mmol/L
TCO2_____29 mmol/L
AnGap_____10 mmol/L
Hct_____37 %PCV
Hb*_____13 g/dL
*via Hct
pH_____7.419
PCO2_____43.3 mmHg
HCO3_____28 mmol/L
BEecf_____4 mmol/L

Sample Type_:

07AUG03 04:33

Oper: [redacted] 66-2
Physician:_____

Ser# 40763
Ver: JAM5046A
CLEW A93

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 7 Aug 03 **LAB ID NO.:**

b(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)-4	DATE: 8/6/03 TIME: 1830	SSN/PSEUDO SSN: # [redacted]

b 16-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse urine	NEG	

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Laver Panel Plus 11

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

(Piccolo) Electrolyte

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 8/6/03	LAB ID NO.:

EMT

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI		STATUS	RANK	SSN
[redacted]	EPW			

Time called	Called to	Physician	Date

b(6)-4

i-STAT EC8

Pt: [redacted]

Pt Name:_____

Glu_____101 mg/dL
BUN_____15 mg/dL
Na_____139 mmol/L
K_____3.8 mmol/L
Cl_____109 mmol/L
TCO2_____28 mmol/L
AnGap_____8 mmol/L
Hct_____37 %PCV
Hb*_____13 g/dL
*via Hct
pH_____7.515
PCO2_____32.9 mmHg
HCO3_____27 mmol/L
BEecf_____4 mmol/L

Sample Type:

[redacted]AUG03 14:37

Operator

Physician_____

Ser# 49763

Ver: JAM5046A
CLEW A93

~~CKMB~~		
~~Troponin~~		
DOA		
~~Alcohol~~		

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.2-1.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
Leuk		Negative
Microscopic		
hCG		Negative

Hematology

TEST	RESULT	REF. RANGE

66-4

ID: [redacted]
WB 06-08-03 14:29

			Patient Limits	
WBC	8.0 *	x10^3/uL	4.5	10.5
RBC	3.66 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	34.6 L	%	35.0	60.0
MCV	94.6	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.0 L	g/dL	33.0	37.0
Plt	259.	x10^3/uL	150.	450.
LY%	10.1 *L	%	20.5	51.1
LY#	0.8 *L	x10^3/uL	1.2	3.4

Other		
Spun Crit		42-52% (M) 37-47% (F)
~~Man WBC~~		4.8-10.8x10³
~~Manual Plt~~		130-500x10³ verified

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

OTHER:

Ward/Section:

LAST, FIRST, MI.

REQUESTING PHYSICIAN: [redacted] b(6)-4

DATE

TIME

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)
SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Dark Yellow	N/A
App	Clear	N/A
Glu	Yes	Negative
Bili	Yes	Negative
Ket	>160 Large	Negative
SG	1.020	N/A
Bld	Yes	Negative
pH	6.0	N/A
Prot	Yes	Negative
Urob	0.2	0.2-1.0
Nit	Yes	Negative
Leuk	—	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Acetest (ketones) - Large

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 6 Aug 08

LAB ID NO.:

b(6)-2

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

Ward/Section: EM | REQUESTING PHYSICIAN: [redacted] | DATE 6 AUG | TIME 1550 | SSN/PSEUDO SSN:

LAST, FIRST, MI. [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (ar 41-51 mmHg (ven
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%

-2) – (+3)
nmol/L
0-20 mmol/L
.12-1.32 mmol
-26 mg/dl
0-105 mg/dl
.7-1.5 mg/dl
8-51% PCV
2-17 g/dl
try
EF. RANG

i-STAT: G3+

Pt: [redacted]

Pt Name:_____

TCO2_____29 mmol/L

At 37C

PH_____7.447

PCO2_____39.9 mmHg

PO2_____76 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

sO2*_____96 %

*calculated

Sample Type_:

06AUG03 14:40

Oper: 0

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

b(6)-4

======= PICCOLO =======
06/08/03 14:35
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 269 DR #: 000
SERIAL #: 0000100676

GLU	103	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	2449*	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
06/08/03 14:50
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3135BA4
OPER #: 269 DR #: 000
SERIAL #: 0000100684

ALB	3.4	3.3-5.5	G/DL
ALP	60	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	28	14-97	U/L
AST	72*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
GGT	13	5-65	U/L
TP	6.9	6.4-8.1	G/DL

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

Repeated

	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)															
Robinul	(mg)	.2														
Fentanyl	(mcg)	100	50	50	50											
propofol	(mg)	100														
	( )															
MSO4	(mg)			10												
Labetalol	(mg)		15		10											
VOLAT AGENT 1.5	% del	1.5		1.5		.5		.6								
	% e.t.															
AIR	L/Min															
N2O	L/Min															
O2	L/Min	6		3		3		3								

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

FLUIDS

LINE site																
18g (L) ac	☐ Warmed															
	☐ Warmed	NS			500											
	☐ Warmed															
	☐ Warmed															

LOSSES

EST BLOOD LOSS																
URINE -						200										

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 65 (KG) LB

HEMATOCRIT ✓

INITIAL DATA

BP- 137/84

HR- 83

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0822

TIME 0830 0900

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	330	250	370	420	
f - breaths/min	12	15	18	15	
Peak inf pres / PEEP	/	/	/	/	
MODE - S(pon), A(assist), C(on)	S	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	43	41	42	41	
BP/oth	PO2 (Frac or %)	.89	.89	.89	.89	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site	Avail				
	NM Block (T/4)					
Warming blkt						
Conv warmer						

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

TOTALS	TOTAL EBL
12	100
250	
100	TOTAL URINE
10	200
25	

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

0800 pt ID. Form 2400 complete.

0820 Rm. O_2, monitors

0827 LMA insert x1 Atraumatically

0833 ↑ 300 mHg

0906 (T) ↓ 27 min

0927 pt RTC — LMA removed

0936 RPT TO SDT 6 RBCs

RECOVERY AT 0933

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- 15 SpO2- 100 (RA)

BP- 137/84 HR- 88 60

ANESTHESIA / PROC TIMES

	Start	Room	End
ANES	0800	0820	0940
PROC	Ready	Begin	End
	0827	0834	0927

PROCEDURES and CPT Codes:

I & D (L) Leg

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GAT LMA

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

[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* LMA #4 insert x1 atraumatically. soft bite in place, cuff ~25cc air, eyes taped, LMA secured w tape

SURGEONS:

[redacted] b(6)-2

PROCEDURE LOCATION: 2

DATE: 7 AUG 03

MEDCOM - 15919

MEDICAL RECORD - ANESTHESIA

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

→ LOC on wound / responds slowly to pain

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

DRUG (Units)

Fentanyl mcg ( )

Lidocaine (MCG) ( )

Ecotrin (MCG) ( )

( )

( )

VOLAT AGENT Forane % del

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min

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

FLUIDS

LINE site #18 ↓ R ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 37

INITIAL DATA: BP- 118/60 HR- 90

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 0800

TIME → 0730 1030 1130

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL / MONITORS/ACCESSORIES

		0730	0800	0830	0900	0930	1000	1030	1100	1130
VT - ml		500	700	700	800	830	740	750	740	760	780
f - breaths/min		14	10	10	9	8	8	8	8	15	10
Peak inf pres / PEEP		20	20	21	20	21	21	21	21	20	20
MODE - S(pon), A(ssist), C(on)		S	CV	CV	CV	CV	CV	CV	CV	AV	SV
BP/Auto Cuff	ET CO2 (torr)		28	25	26	25	23	25	26	34	35
BP/oth	FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	0.7	.7	.7
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SIC	SIC	SIC	SIC	SIC	SIC	SIC	SIC	SIC	SIC
Gas analyzer	TEMP-site sh	95	95	95	95	95	95	95	95	95	95
	N-M Block (T/4)										
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS — EVENTS Position → O2 b(6)-2

PROCEDURES and CPT Codes: ORIF Ft (c) [redacted]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA, b(6)-2

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rank [redacted]

MANAGEMENT: Intubation route, blade, technique, comments #8.0 ETT NDUAL BL: DS

[redacted]

b(6)-4

TOTALS: TOTAL EBL 250 ABL 20 / 150 / 100 / 640 = 890

TOTAL URINE

FLUIDS SUMMARY: CRYSTALLOID 1100 COLLOID- 0 BLOOD- 0

REMARKS — Code drugs with numbers, events with letters

Oxygen - mouth piece

(E) Sea Belmont

(2) Sedated & Extubated

(4) Tolic 2 → 08/Nov

Transport Time 1106

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: RESP. 12 SpO2. 96% BP- 166/62 HR- 110

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0800	1130
PROC	Ready 0700	Begin 0800	End 1130

PROCEDURE LOCATION: OR

DATE: 7 AUG 07

MEDCOM - 15920

Static encephalopathy 2° to Heat Stroke?

MEDICAL RECORD - ANESTHESIA

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

NYCH

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

DRUG (Units)									
Versed (mg)	Ø								
fentanyl (ug)	250								
propofol (mg)	170								
SCh (mg)	100								
Vecuronium (mg)		3	3	/ Neostigmine/ Glycopyrrolate 5/0.8					
MSO4 (mg)	4	2			3				
VOLAT AGENT % del	TSe								
% e.t.	1.5	2	2	2	2	1	X		
AIR L/Min									
N2O L/Min									
O2 L/Min	6	2	2	2	2	2	10		

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

FLUIDS

LINE site	Warmed		
LR 20G (R) AC	Warmed	700	Fluid 50ii Heparin x3 lumens + asp blood x3
(R) IJ Triple Lumen	Warmed		
	Warmed		

LOSSES — EST BLOOD LOSS; URINE - 300

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT 38.2

INITIAL DATA

BP- 124/87

HR- 98

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 1025

TIME 1030 X 1100 X 30 X 1200

SYMBOLS

BP by cuff V

Heart rate ^

Resp rate ●

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

TO PACU Report Anesthesia recovered @ 1220 x15min BP@1220 148/99

VENTIL

VT - ml		5/800	830	870	860	850	540	250-510	
f - breaths/min		10	10	10	10	6	6	15-20	
Peak inf pres / PEEP			19	20	20	20-17	17	—	
MODE - S(pon), A(ssist), C(on)		S/C	C	C	C	C	C	S	S
BP/Auto Cuff	ET CO2 (torr)	4	25	24	25	26	40	35-40	
BP/oth	FIO2 (Frac or %)	.8	.6	.8	.8	0.87	0.85	0.85	
ART line	SpO2 (%)	99	99	99	99	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site	Avail	Avail						
	N-M Block (T/4)							4/4	4/4

Sux Tet @ 1255sec

MONITORS/ACCESSORIES: Warming blkt; Conv warmer

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

TOTALS

TOTAL EBL	TOTAL URINE
<100	500

250 / 170 / 100 / 10

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Pt ID'd, chart reviewed. Pre-anesthetic assessment done

To OR, monitors applied, smooth induction & intubation.

(L) subclavian CVL attempted by [redacted] @ 1130. 3 attempts.

(R) IJ 3 Lumen placed & difficulty by [redacted] CRNA

All 3 lumens aspirated venous appearing blood & flushed easily.

Labetalol 10 mg IV @ 1200

OP suctioned; Extubated; Stable & awake

RECOVERY AT 1210

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: Stable

RESP- 21 SpO2- 98

BP- 162/97 HR- 91

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1015	1020	
PROC	Ready	Begin	End
	1038	1050	1201

PROCEDURES and CPT Codes:

(L) Knee arthroscopy / 6-4vbr / CVL Placement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA — Eyes Taped — Arms secured & padded

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x 1 c Mac 3 — 8.0 ETT in — (+) ETCO2; equal BS

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

[redacted]

b(6)-4

SURGEON: [redacted] b(6)-2

PROCEDURE LOCATION: 1

DATE: 12 AUG 03

MEDCOM -15921

ACLU-RDI 1634 p.81

DOD-029310

ASA 3

20/m NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)					
MIDAZ	(mg)	3	2			
FENT	(mcg)	50	50			
Propofol	(mg)	100				
	( )					
	( )					
Succ	(mg)	60				
VOLAT AGENT: Forane	% del	1	1	IX		
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	8	2	2	2	8

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

FLUIDS

LINE site (R) IJ 3L ☐ Warmed — LR →

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 (3) 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT:

INITIAL DATA

BP- 128 / 82

HR- 107

EQUIP CHECK (OK?) Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 0619

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

TIME → 0615 30 45 0700 15 30 45 0800 15 30 45 0900

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		800	780			
f - breaths/min	12	10	6	34	28	
Peak inf pres / PEEP		18	19			
MODE - S(pon), A(ssist), C(on)	S	C	C	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	29	34	36	37	
BP/oth	FIO2 (Frac or %)	.81	.81	.81	.81	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site	AXIL →				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

TOTALS — TOTAL EBL: 5 mg / 100 mcg; 100

TOTAL URINE: NA

FLUIDS SUMMARY

CRYSTALLOID- 100 LR

COLLOID-

BLOOD-

REMARKS *Code drugs with numbers, events with letters*

0605 Prep & Drape
(R) IJ 3L

0618 OR #2 monitors placed
PaO2 IND/INT

0700 Suction Agreed to Ext

RECOVERY AT

PACU (ICU 2) (Specify)

OTHER

CONDITION: STABLE

RESP- 12 Room Air SpO2- 97

BP- HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0605	0618	
PROC	Ready 0625	Begin 0637	End 0900

PROCEDURES and CPT Codes:

1 & D (L) KNEE GSW

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

[redacted] ICU3/ICU-3

b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

DLX1/MAC3 & NASAL → VC ± BBS (+), ETCO2 (+) SECURED EYES TAPED

SURGEONS: [redacted] 66-2

PROCEDURE LOCATION: OR #2 28CSH

DATE: 13 AUG 03

DA FORM 7389, FEB 1998 — MEDCOM - 15922 V1.01

NKA ASA II

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	0945 10 X 30 X 1100
Versed	(mg)	3
Fent	(cc)	2 1 1.5
Lido/Propof	(mg)	20/120
Succ	(mg)	20
	( )	
	( )	
VOLAT AGENT	% del	X 1.5 - 1.5 - 1.5 20X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X4 - 2 - 2 - 2 - 10

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

FLUIDS

LINE site		
Twin	☐ Warmed	R 100 →
D5 1/2 NS	☐ Warmed	(250) + 100 → 400
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE - Foley 110

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

INITIAL DATA

BP- 115 / 60

HR- 111

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME- 0935

TIME → 0945 1000 X 30 X 1100

SYMBOLS:

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL / MONITORS/ACCESSORIES

VT - ml		800	680	690	300	600
f - breaths/min		9	8	8	24	15
Peak inf pres / PEEP		18	17	17	-	-
MODE - S(pon), A(ssist), C(on)		C	C	C	A	S
BP/Auto Cuff	ET CO2 (torr)	33	32	31	45	41
BP/oth	FIO2 (Frac or %)	.76	.77	.78	.78	.78
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site					
	N-M Block (T/4)	4	0	4		
Warming blkt						
Conv warmer						

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

TOTALS — TOTAL EBL: 3 / 250ml MIN; TOTAL URINE: Ø 110

FLUIDS SUMMARY

CRYSTALLOID- LR 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Prep, NPO, Id Band Placed IV patent on O2 monitor Stable IV induction post-prep drugs

0955 CPT [redacted] to relieve - report received.

1005 Zofran 4mg IV

1038 POSxNxZ. Pt extubated 5 difficulty TO ICU 3 on stable condition. Report to [redacted] b(6)-2

BP 130/116 hr 103 - Given Fent 1 20mg Esmolol total IV

RECOVERY AT 1043

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 16 SpO2- 98 RA

BP- HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0920	0935	1045
PROC	Ready	Begin	End
	0942	0957	1030

PROCEDURES and CPT Codes:

I & D Lt Knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA RSI & Orbital eyes taped 4/MR O2 x1

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

Grade I view 8.0 ETT @ 21 BS = B + ETCO2

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

[redacted] b(6)-4

SURGEON: [redacted] b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 12/8/2003

DA FORM 7389, FEB 1998 — MEDCOM - 15923 [redacted]

ASA II ♂ NKDA

MEDICAL RECORD - ANESTHESIA

This form, see AR 40-66; the proponent agency is ...

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

DRUG	(Units)	
Versed	(mg)	2.5
Fentanyl	(mg)	150
Propofol	(mg)	140
Lidocaine	(mg)	50
Sch	(mg)	100
	( )	
VOLAT AGENT	150 % del	20 - 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 + 2 + 2 + 10

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

FLUIDS

URINE site	☐ Warmed	
R 15 x 3	☐ Warmed	LR (500) → 150
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS — URINE - Foley (150 cc/hr)

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 KG LB

HEMATOCRIT

INITIAL DATA

BP- 156, 90

HR- 105

EQUIP CHECK OK?- Y N

PATIENT RECHECK

OK for PROCEDURE- Okay

TIME- 1250

TIME → 1305 30 45 1400 15

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

Resp rate

BR (transduced)

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VENTIL

VT - ml	–	740	800	800
f - breaths/min	20	7	7	15
Peak inf pres / PEEP	–	20	20	–
MODE - S(pon), A(assist), C(on)	S	C	C	S

MONITORS/ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	+	32	34	37
☐ BP/oth	☒ FIO2 (Frac or %)	.65	.65	.66	.66
☐ ART line	☒ SpO2 (%)	100	100	100	100
☐ Steth- PC/ES	☒ ECG	ST	ST	ST	ST
☐ Gas analyzer	☒ TEMP-site dch	97	97	97	97
	☐ N-M Block (T/4)				
☐ Warming blkt					
☐ Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0-1 →

TOTALS — TOTAL EBL: n/a — TOTAL URINE: 150

FLUIDS SUMMARY

CRYSTALLOID- 2000cc

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1310 Pt to an ICU
2. Chart reviewed
To OR via litter,
1320 In room. ⊕ monitors
⊕ O2, Sux, Oral ETT under
easy mask ventilation
Padded, eyes taped,
arms < 90°
1337 Procedure started
1410 Procedure ended
1415 Extubated & awake,
To ICU 3 in stable
condition, Report
to RN

RECOVERY AT 1415

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 20 SpO2- 96 RA

BP- 140/91 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1305	1320	1420
PROC	Ready	Begin	End
	1330	1337	1410

PROCEDURES and CPT Codes: I&D (L) Knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

[redacted] blw-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x 1 attempt c MAC 4, #8 ETT, Grade 1 view; + BBS + ETCO2, Secured @ 2

SURGEONS: [redacted] blw-2

PROCEDURE LOCATION: OR 1

DATE: 15 Aug 03

No Δ in Anesthesia evaluation since 14 Aug 03, date of last SX

MEDCOM - 15924

ACLU-RDI 1634 p.84

DOD-029313

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS (YRS) Sex (M) MALE ( ) FEMALE

PROPOSED PROCEDURE:
SURGICAL SERVICE: ORTHO
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 E
WT: 65 (KG)/LB HT: 70 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (0)
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef
( )
( )
( )
( )
( )

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

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

10.4
4.0 259
34.6

139 / 109
3.8 / 28 / 101

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

cleared by neuro for Sx (2° to defect)

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR 81 R 16 T ___ SpO_2 100%
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea midline
TMJ/Neck 3 FB
Oropharnyx MP TL
Nares patent
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES:
IV Access: 18g (U) AC
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

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

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

The patien[redacted] b(4)-2
Signed: [redacted] to understand and agrees. Questions answered.
CRT CRNA Date: 7 AUG 03 Time: 0800 Hrs

POST-ANESTHESIA EVALUA[redacted]AND NOTE (NON ASU)
{ } NO APPARENT ANESTHET[redacted]OMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICU 2

[redacted] b(4)-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.

AMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

PATI[redacted] MEDCOM # 15925 [redacted]COPY

Previous edition is obsolete

ANESTHESIA PLAN OF C — **PROCEDURAL ASSESSMENT (Sedation/Anesthesia)**

Age 20 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: arthrotomy (L) knee; G-tube; CVL placement

SURGICAL SERVICE: [redacted] bb2

NPO SINCE: MN

ASA Physical State 1 2 (3) 4 5 E

WT: 70 KG/LB HT: ___ IN.

ALLERGIES: NKDA

HABITS:
TOBACCO: ___
ETOH: Ø
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) Ancef 1gm IVPB 06-14
(✓) D5 1/4NS + 10meq KCl @ 125 ml/hr
(✓) Zantac 50mg IVPB 08:00 06-24-06
(✓) Lovenox 20mg SC @ 12:00
( ) ___
( ) ___

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

LABORATORY STUDIES:
HB/HCT: ___/___
U/A: ___
OTHER: PT-17.2/PTT 42.1 8-11-03

8.5 | 12.3 | 420
38.2

8-10-03
— | 93 | 5
4.6 | 21 | 0.8 | 120

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

Foley
NG-Tube
feeds

Unresponsive upon admission 7 day 03
Pt. [redacted] bilat breath sounds w. CHI, pt in 4 out of consciousness
STATIC Encephalopathy 2° to Heat Stroke

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 124/72 HR 78 R 16 T 38.6/T-37.0 (O) (P) Tylenol
Pain Scale 0-10 Sa02 96%
HEENT - Teeth intact
Trachea midline
Board TMJ/Neck 3 FB's
Oropharnyx
Nares Patent
CHEST: CTA (B) -
CARDIAC: S1 S2
EXTREMITIES:
IV Access: #18 RFA
Ulnar Filling: ___
BACK: ___
OTHER: Unresponsive during assessment

NPO Since MN

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
Unable to obtain informed consent c interpreter. Pt. unresponsive.
The patient/legal guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] RNA/MA Date: 8-12-03 Time: 0937 Hrs

POST-A[redacted]
} NO [redacted] ANESTHETIC COMPLICATIONS { } OTHER
b(6)-2
Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

#[redacted]
b(6)-1

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.

C Form 2300 (Revised) 15 Mar 01 MCXC-DOS

PATIE[redacted] MEDCOM - 15926

Previous edition is obsolete

ANESTHESIA PLAN OF (PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20's DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 2 (3) 4 5 E

PROPOSED PROCEDURE: arthrotomy (L) knee; G-tube; CVL placed

SURGICAL SERVICE: [redacted] 8-12

NPO SINCE: MN

WT: 70 (KG)/LB HT: ____ IN.

ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) Ancef 1gm IVPB 06-
(✓) D5 1/2NS @ 40 mEq KCl @ 125
(✓) Zantac 50m IVPB 08
(✓) Lovenox 30mg SC q12
( ) ____
( ) ____

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: PT-17.2/PTT 42.1 8-11-03

8.5 / 38.2 | 12.3 | 420

8-10-03
4.6 | 98 / 21 | 5 / 0.8 | 120

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

Pulmonary System: 92 on RA 6-24 06

Renal System: foley

Gastrointestinal: NG-Tube feeds

Neurological: Unresponsive upon admission 7-31-03 [redacted] Pt. found down West Stairs via. CHI; Pt in/out of consciousness STATIC Encephalopathy 2° to Heat Stroke

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 124/82 HR 93 R 16 T 38.6/T-37 @ oral

Pain Scale 0-10 Sat 96%

HEENT - Teeth intact

Trachea midline

Beard TMJ/Neck 3FB's

Oropharynx ____

Nares Patent

CHEST: CTA (B) =

CARDIAC: S1 S2

EXTREMITIES: ____

IV Access: PIV (R) FA 18G

Ulnar Filling: ____

BACK: ____

OTHER: Unresponsive during assessment

NPO Since MN

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

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

Unable to obtain informed consent c interpreter. Pt. unresponsive.

The patient/legal guardian expressed understand and agrees. Questions answered.

b(6)-2

Signed: [redacted] RNA/MA Date: 8-12-03 Time: 0937 Hrs

POST [redacted] SIA EVALUATION AND NOTE (NON ASU)
{ } NO[redacted] PARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted]
b(6)-4

SEDATION KEY:

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

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

Age 20 DAYS MOS (YRS) Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: arthrotomy (L)knee; G-tube; CVL placem
SURGICAL SERVICE: [redacted] p6-2
NPO SINCE: MN

ASA Physical State 1 2 (3) 4 5 E
WT: 70 (KG)LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

(Y) Ancef 1gm IVPB 06-14-06
(Y) D5 1/2NS + 30meq KCl @ 125 q2 hr
(Y) Zantac 50mg IVPB 08 q6-24-06
(Y) Lovenox 30mg SC q PM
( ) ____
( ) ____

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: PT-17.2/PTT 42.1 8-11-03

8.5 | 12.3 / 38.2 (420

8-10-03
— | 98 | 5 (120
4.6 | 21 | 0.8

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	foley
Gastrointestinal:			?
Hepatitis	N	Y	NG-Tube
Hiatal Hernia	N	Y	feeds
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			Unresponsive upon
Seizures	N	Y	admission 7-10-03
Neuropathy	N	Y	Dx: [redacted] Lids opened
Other	N	Y	Pt. [redacted] Blunt Stroke
Gynecological :			w. CHI; Pt in+out
Pregnancy	N	Y	of consciousness
Other Significant Hx:			STATIC Encephalopathy
	N	Y	2° to Heart Stop/Seizures
	N	Y	
Familial HX	N	Y	?

ASSESSMENT
PAST SURGICAL/ANESTHETIC

? ? ? ? ? ? ?

PHYSICAL EXAMINATION

BP 124/82 HR 99 R 16 T 38.6/F-37 C 97.9 P Tyde
Pain Scale 0-10 Sa02 96%
HEENT - Teeth intact
Trachea midline
Beard TMJ/Neck 3FB's
Oropharnyx
Nares Patent
CHEST: CTA (B)
CARDIAC: S1 S2
EXTREMITIES:
IV Access: #1 (R) FA 18G
Ulnar Filling:
BACK:
OTHER: Unresponsive during assessment

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (Y) 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.
Unable to obtain informed consent c interpreter. Pt. unresponsive.
The patient/legal guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] CRNA/MA Date: 8-12-03 Time: 0937 Hrs

b(6)-2

POS[redacted]E (NON ASU)
{ } NO[redacted]RRENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted]
b(6)-2

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

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 6 Aug 03 TIME OF ORDER 1730 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit = ICU 2
Dx = 1. MS Δ 2. (L) patellar open Fx
Cond = Guarded
VS = per protocol
Allergies =
Act = Bedrest c restraints
Nursing = Dress. Δ's (L) knee

PATIENT IDENTIFICATION

[redacted]

b(6)-9

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Diet = Reg
Labs = Chem 12, metabolic, CBC in am
IV = Saline Lock (R); NS @ 150 cc/hr (L)
Special = Urine Drug Screen now
Meds = Ancef 1 gm IV q 6°
Tylenol 325 mg ii po q 4° PRN

NOTED 6 Aug 03 1730

[redacted]

6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 6 Aug 03 TIME OF ORDER 1730 HOURS

038

NURSING UNIT	ROOM NO.	BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1979 O - 289-465 MEDCOM - 15929

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

[redacted] CPT/ANN

BED NO.

2355/07 Aug 03

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
8/7/03	0930		
Post I+D Planes			
Stable			
Routine v. tals			
Bed rest treatments			
Reinforce Dressing PRN			
NS @ 125 cc/hr			
Tylenol #3 q 4 hrs PRN pain			
Ancef 1gm IVPB q8°			
Percocet 1 tab q 4° PRN pain			
1/4 level 1 tab q 4° pain T 99.5			
Demerol 50mg IVP PRN breakthrough pain			
Phenergan 25mg IVP q6° PRN nausea			
Colace 100mg po BID			
Regular Diet			
[redacted]			
D/C Percocet/Tylenol/Demerol phenergan/Colace.			
[redacted]			

DOR 1100 07 Aug 03 SUTWA

[redacted] GTWM6

[redacted] CPT

b(6)-2

24°V

07 Aug 03

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

EPW # [redacted] b(4)-1

URSING UNIT | ROOM NO. | BED NO.

ATIENT [redacted]

b(4)-1

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TI ORDE NOTED SIGN

8 Aug

D5 ½ NS @ 20 tc mEq Dose

@ 175 cc/hr

Bolus [redacted] Physician Dose

[redacted] b(4)-2 allergic

1635

DATE OF ORDER | TIME OF ORDER | HOURS

08 Aug 03 2030

Ativan 2mg IVP Q4° prn agitation

MD: Dr [redacted] b(4)-2

noted b(4)-2

2100 8 Aug 03

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

URSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 8/9/03

TIME OF ORDER: ______ HOURS

LIST TIME ORDER NOTED AND SIGN: Noted @ 1210hrs 8/9/03 [redacted]

- Bedrest
- Routine vitals
- Stable
- Advance Reg diet as tol
- D5½NS c 20meq KCL @ 150cc/hr
- Ancef 1gm IVPB q8°
- Tylenol 650mg po q4°
- Reconsult/report of Dr... q shift

b(6)-2

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER: [redacted] HOURS

b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER: ______ HOURS

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER: ______ HOURS

FORM 4256 APR 79

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE ...

MEDCOM - 15932

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9 Aug 03	1210 HOURS	
1.	Transfer to ICU 2		
2.	CBC / chem 12 / metabolic panel / ½ today.		noted @ 1220 hrs 9 Aug 03

[redacted] b(6)-2 [redacted] b(6)-7 MAJ

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. 21 VS | BED NO. CB30 IVF @ 03

	DATE OF ORDER	TIME OF ORDER	
	10 Aug 03	0200 HOURS	
1.	A IVF to D5 NS c 20 kcl @	125 cc/hr	noted 10 Aug 03 0230
2.	40 meq KCl in 250 cc NS over 4 hrs.		
3.	Metabolic panel 10 Aug @ ≈ 1800.		

[redacted] b(6)-2 MAJ

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO. 21 VS

	DATE OF ORDER	TIME OF ORDER	
	10 Aug 03	HOURS	b(6)-2
1.	500 cc NS bolus IV		
2.	Zantac 50mg IVPB q 8° (1800)		8-16-24
3.	Lovenox 30mg SC. q 12° (1st @ 1800)		
4.	Met panel & ~~CBC~~ q PT/PTT in AM		

noted/sent 8/10/03 2203

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO. 24 VS

	DATE OF ORDER	TIME OF ORDER	
	11 Aug 03	1030 HOURS	b(6)-7
①	[redacted] DHT		
②	start enoxaparin 40 cc/hr		

[redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES [redacted] WHICH

MEDCOM - 15933

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 [redacted]

ULTAN 8-11-03 2300

NURSING UNIT	ROOM NO.	BED NO.
ICW#2		

DATE OF ORDER 8/11/03 TIME OF ORDER 2300 HOURS — LIST TIME ORDER NOTED AND SIGN

- CBC now
- Hold tube feeds 4 hrs

[redacted]

b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER 8/12/03 TIME OF ORDER 1200 HOURS

Admit to ICW 2
Stp knee wkshout 3
Gastrostomy
Cond stable
Vitals Routine
All - NKDA
Act Bedrest

b(6)-2 [redacted] Not [redacted] 1440

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER TIME OF ORDER HOURS

Nurse - Foley to Gravity
G-Tube to Gravity Drain
Central line care
Diet - NPO
IVF - LR @ 125 cc/hr
Meds
Clindamycin 900 mg IVD IV 06-14-22

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER TIME OF ORDER HOURS

Gent 450 mg IV QD 2000
Tylenol 650 mg Per DNT/PR Q6° PRN Fever
MSO4 2-4 mg IV Q1° PRN Pain
CXR on AM 8/13 to rule
ZANTAC 50 mg [redacted] -24

Ø38 b(6)-4

b(6)-2

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

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MEDCOM - 15934

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

EPW [redacted]

NURSING UNIT: ICWZ | ROOM NO. | BED NO.: 1

DATE OF ORDER: 8/13/03 | TIME OF ORDER: 0700 HOURS | LIST TIME ORDER NOTED AND SIGN

① Resume PreOp orders, - meds, diet, fluids, activity [redacted]

② D/C Lorenzo [redacted]

PATIENT IDENTIFICATION

EPW [redacted]

b(4)-4

NURSING UNIT: ICWZ | ROOM NO. | BED NO.: 1

DATE OF ORDER: 13 Aug | TIME OF ORDER: 2200 HOURS

1. D/C LR
2. D5 NS ± 20 KMcq @ 125 cc/hr [redacted] b(4)-2

V.O. Dr. [redacted] / LT [redacted]

(1) Diet AAT, NPO p MN

PATIENT IDENTIFICATION

EPW [redacted]

DATE OF ORDER: 14 AUG 03 | TIME OF ORDER: 8/14/03 0150 HOURS

14 AUG 03 1030

- Resume PreOp orders, meds - activity, diet [redacted]
- NPO p MN

Moved [redacted] 14 Aug 03

NURSING UNIT: ICWZ | ROOM NO. | BED NO.: 1

PATIENT IDENTIFICATION

EPW [redacted]

DATE OF ORDER: 14 Aug '03 | TIME OF ORDER: 1600 HOURS

1. Jevity plus G tube feeding. (1.2 cal/cc
2. Start @ 10 cc/hr
3. Check residuals q 4°
4. Increase by 10 cc/hr up to 100 cc/hr if residuals are less than the last 2 hrs of tube feedings

[redacted]

0038

NURSING UNIT: ICWZ | ROOM NO. | BED NO.: 1

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted] BE USED.

b(4)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-362-710

MEDCOM - 15935

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

CIV

[redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 7

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
14 AUG 03	1920 HOURS	

1. Benadryl 50 mg IV Q6° PRN itching

[redacted] b(6)-2

14 Aug 03

PATIENT IDENTIFICATION

CIV

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 7

DATE OF ORDER	TIME OF ORDER
15 Aug	HOURS

1. Restart tube feedings as previously ordered. c OR

[redacted] b(6)-2

1630

PATIENT IDENTIFICATION

CIV

[redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 7

DATE OF ORDER	TIME OF ORDER
8-15-03	1520 HOURS

- Resume preop Orders, meds, fluids, activity
- Begin twice daily dressing changes TID (0900-1500-2300)
- c Darkins solution begun 8/16/03.

[redacted]

Aug 15 DATE OF OR [redacted] Y-18 033826

HOURS

Transfer to Iraq Hospital

[redacted] b(6)-2

038

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994—383-710

MEDCOM - 15936

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

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

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
6 Aug	[redacted]	VS: per protocol
6 Aug	[redacted]	Activity: Bedrest c restraints
6 Aug	[redacted]	Diet: regular
7 Aug	[redacted]	Nursing: reinforce DRG PRN
7 Aug	[redacted]	Foley to GRAVITY
11	[redacted]	Dobhoff Feeding tube c Ensure 10cc/hr
11	[redacted]	NIO: Δ Ensure tubing & bag q 24 hrs

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

HR	DATE COMPLETED 6 7 8 9 10 11 12 13
05	[redacted]
17	
05	
17	
00	
12	
18	
06	
17	
05	
17	
06	
14	
22	
12	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
MS Δ & ⓛ patellar open fx
S/P I+D(L) knee

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Aug Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6 Aug	[redacted]	Admit ICU 2 - condition guarded	6 Aug	NOW	1730	[redacted]
6 Aug	[redacted]	Labs: Chem 12, metabolic, CBC in AM	7 Aug	DA	done	[redacted]
6 Aug	[redacted]	Urine drug screen now	6 Aug	now	done	[redacted]
7 Aug	[redacted]	Diet regular 0600	7 Aug	06	held - PT not able to ambulate	[redacted]
7 Aug	[redacted]	Admit ICU 2 - stable post I+D OK MW	7 Aug	0930	0930	[redacted]
10 Aug	[redacted]	Metabolic Panel @ 1800, 10 Aug	10 Aug	1800	1830	[redacted]
10 Aug	[redacted]	Metpanel & PT/PTT in AM	11 Aug	0400		[redacted]
10	[redacted]	Place DVT	11	Now	DONE	[redacted]
11	[redacted]	CBC now	11	2300	2328	[redacted]
11	[redacted]	Hold Dobhoff feed p MN	12	0001	0001	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
7 Aug	[redacted]	Reinforce Dressing prn	

USAPA V1.00

b(4) ; 2 A11

CLINI 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. 8 Yr. 03

VERIFY

ORDER DATE | CLERK/ NURSE | RECURRING ACTIONS, FREQUENCY, TIME | HR | DATE COMPLETED (INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION)

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	12	13	14	15	16	17	18
12 13/8	[redacted]	Vitals: routine	05	/	[redacted]					
			13							
			21							
			1							
12 13/8	[redacted]	activity-bedrest	05	/	[redacted]					
			13							
			21							
			1							
12 13/8	[redacted]	Foley to gravity	05	/	[redacted]					
			13							
			21							
12 13/8	[redacted]	g-tube to gravity drain	05	[redacted]	D'd 13 Aug 03 BS					
			13							
			21							
			6							
12 13/8	[redacted]	Diet ~~NPO~~ Clears AM	07	/	[redacted]					
	[redacted]	AAT	11	/						
			17							
			/							
15	[redacted]	W → D dsg Δ TID	07	/	/	/	/	[redacted]		
		C dakin's soln ½%	15	/	/	/	/			
		(Start 16 Aug 03)	23	/	/	/	/			

ALLERGIES: YES [X] NO

PRIMARY DIAGNOSIS: S/P knee washout & gastrostomy

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO

PAGE NO:

PATIENT CATEGORY:

EPW [redacted]

b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM , 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. MEDCOM - 15939 USAPA V1.00

b(6)-2 All (NON-MEDICATION) Mo 8 Yr 03

	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12	admit to ICWZ	8/12		1315	
12	Condition stable	8/12	rule out		
12	CXR on arrival toward	12		1430	
14	NPO p Brkfst	14	AM		
14	NPO p MN	14	MN		
14	Resume preop orders, meds, activity level.	14	0730	1830	
15	resume previous orders, dc	15	1630		

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 6 7 8 9
6 Aug	[redacted]	IV: Saline lock (R)	05	[redacted] Δ 0930 07 Aug 03
		NS @ 150cc/hr (L)	17	[redacted] SGT [redacted] 77mm6
6 Aug	[redacted]	Ancef 1gm IV Q6°	04	[redacted]
			12	[redacted]
		b(4)-2	18	[redacted] Δ 0930 07 Aug 03
			24	[redacted] SGT [redacted] 91mm6
07 Aug	[redacted]	IV: NS @ 125cc/M	09	[redacted] Δ 0945 07 Aug 03 [redacted]
			17	[redacted]
07 Aug	[redacted]	Ancef 1gm IVPB q 8°	06	[redacted]
			14	[redacted] Δ 0945 07 Aug 03 [redacted]
			22	[redacted]
07 Aug	[redacted]	Colace 100mg PO BID	08	[redacted] Δ Med 07 Aug 03
			20	[redacted] 0945 [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: MS Δ 9 (L) patellar open fx S/P I+D (L) knee

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(4)-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

D FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE US UNTIL EXHAUSTED. USAPA V1.00

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
07 Aug	[redacted]	Tylenol 325mg	
-----	-----	2 po Q 4° prn	
-----	-----	T > 100.5	
07 Aug	[redacted]	Percocet 1 po	
-----	-----	q 4° PRN PN	
07 Aug	[redacted]	Demerol 50mg	
-----	-----	IV PRN q (break through pain)	
07 Aug	[redacted]	phenergan 25mg	
-----	-----	IVP q 6° PRN	
-----	-----	Nausea	
-----	-----		
-----	-----	b(6)-2	
-----	-----		

USAPA V1.00

b(6)-2A11

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 7 8 9 10 11 12 13
7 Aug	[redacted]	Ancef 1gm IVPB q 8°	06	[redacted]
			14	
			22	
7 Aug	[redacted]	IV NS @ 125cc/hr	05	[redacted] DC 08 Aug 03 1000
			13	
			21	
08 Aug 03	[redacted]	IV D5 1/2 NS c 20K @ 175cc/° Δ to D5NS c 20 meq KCL @ 125cc/hr	05	[redacted] See below for Δ'd 10 Aug 03
			17	
10 Aug	[redacted]	Zantac 50mg IVPB Q8°	08	[redacted]
			16	
			24	
10 Aug	[redacted]	Lovenox 30 mg SC Q 12°. 1st dose 8 AM lab.	06	[redacted] DC 8 Aug 03
			18	
11 Aug	[redacted]	Ensure 10cc/hr through DHT.	05	[redacted]
			13	
			21	
10	[redacted]	D5NS c 20 meq KCl @ 125cc/hr	05	[redacted]
			13	[redacted]
			21	[redacted]

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
(L) patellar open FX
SP I+D (L) knee

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

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)		Mo. Aug Yr 03		
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
08 Aug [redacted]	Bolus last of NS bag	08 Aug	1600	1615	[redacted]
10 Aug [redacted]	40 meq KCL in 250cc NS over 4 Hrs	10 Aug	0300	0300	[redacted]
10 Aug [redacted]	500 cc NS Bolus x 1 now	10 Aug	2200	2200	[redacted]

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
B Aug	[redacted]	Ativan 2mg IVP Q4°	8/8 2100 / 8/9 0130 / 9 Aug 1400 / 9 Aug 1800 / 10 Aug 1200
		prn agitation	2mg IVP / 2mg IVP / 2mg / [redacted]
10 Aug	[redacted]	Tylenol 650mg po Q4° PRN	10 Aug 0720 PO / 10 Aug 2209 / 11 Aug 1445 / 8-11 2125 650mg PO / 8-12 0430 650mg PO
			[redacted]

b(6)-2

USAPA V1.00

b(6)-2 All medication

CLINICAL RECORD

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

Mo. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12 13 14 15 16 17 18
12	[redacted]	Central line care	05	[redacted]
12/8		Flush QS, Adsg	13	
		q72°(□)-Flush 10cc	21	
		saline q shift on open ports	1	
12	[redacted]	LR @ 125cc/hr	05	
13/8			13	
			21	
			1	
12	[redacted]	clindamycin 900mg	06	
18/8		TID IV	14	
			22	
			1	
12	[redacted]	gentamycin 450mg	20	
13/8		IVPBQD	1	
			1	
12	[redacted]	Zantac 50mg IVPB	08	
13/8		q8°	16	
			24	
		~~Ancef 1gm IVPB q8°~~	~~08~~	
			~~16~~	
			~~24~~	
8/14	[redacted]	D5 NS ē 20meq KCl @	05	X X
		125cc/hr.	13	X X
			21	X [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Knee washout x3 gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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med MEDCOM - 15945

b(6)-2A17

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN ~~(ORDER~~-MEDICATION)					Mo 8 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
12-	[redacted]	~~NPO~~ D					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
12-	[redacted]	tylenol 650mg per	0640
		OUT/PR q6° p.r.n	
		Fever	
12-	[redacted]	MSO4 2-4mg IVP	1320 1530 2015 0149 1515 2109 2210 0149
		q1° p.r.n-pain	
14-	[redacted]	Benadryl 50mg IVP	50mg 2000
		q6° PRN-itching	

USAPA V1.00

b(6)-2 All

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. 8 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18
14	[redacted]	OSmolite HN tube	04		[redacted]			
		feeding @ 10cc/hr	RA Tube		[redacted]			
		-check residuals	residual		0	0	0	0
		q4°, increase by	08		[redacted]			
		10cc/hr up to 100cc/hr	rate		/	30	50	
		if residuals less	residual		/	20	50	
		than the last 2hrs	12		[redacted]			
		of tube feeding	rate		/	50	50	
			residual		/	[redacted]		
			16		[redacted]			
		-once rate reaches	rate		10	20	30	
		30cc/hr tube	residual		50	100	100	
		feed can be	20		[redacted]			
		Δ'd to Jevity plus	rate	10	20	30		
		(1.2cal/cc)	residual	/	30	50		
			24	100	[redacted]			
			rate	30	20	50	50	
			residual	0	10	0	0	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P knee washout & gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

CIV [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 15947

137
84 plo

15

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 07 Aug 03
Time In: 0935
Allergies: NKDA
Pre-op V/S: 107/64/63
Procedures: I+D (R) patella

Anesthesia Type (Circle): General LMA, Spinal, Epidural, IV Sedation, Nerve Block
OR Intake: Crystalloid 500 Colloid 300
OR Output: UOP 200 EBL 100
Meds/Times: MS04 10 Fent 250

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	0935	0940	0945	1005	1015	1030	1045	1100	1115
SaO2	100	100	100	100	100	100	98	98	98
FiO2	60	60	60	60	60	0	0	0	0
Methods									
RR	15	16	17	13	13	15	12	15	13	15
T	96.6				97.4			97.6	
Time									
Pain (0-10)	0	0	0	0	0	0			
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1115	NSS	3750	LAC	—	300

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

Codes

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

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

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

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

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

PREPARED BY (Signature & Title) (Continue on reverse)
b(6)-2 SGT [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 07 Aug 03

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

EPW # [redacted]
b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

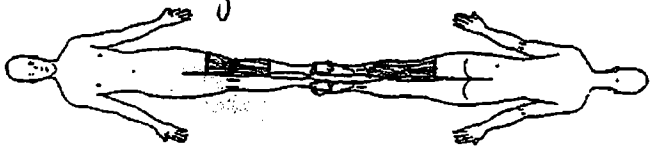
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	bulky/ACE	Ø
30'	(L) leg	" "	Ø
60'	(L) leg	" "	Ø
D/C	(L) leg	" "	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1115	Urine foley	Amber sediment	350

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 173-E

NURSING NOTES

0935 - 20+ 4.0 ETT ♂ transferred via litter to bed from OR to ICU 2. tolerate well. Resting c eyes closed responsive to painful stimuli color good VS - 137/84 P. 105 R. 15 even unlabored shallow SaO2 100% on 6l O2 via face mask. LS CTA. ABD soft + BDN + Rigidity. perla EOM I skin warm to touch T 96.6 pulses present x 4 cap Refill brisk x 4. Dsg bulky & Ace wrap CDI. NVI to painful stimule. IV 18 G (L) AC Rung LR @ 125cc/hr patent. Hep lock LFA sluggish to flush + Inf. Rate will cont to monitor SGT [redacted] MM

1115 - ADMIT ICU 2. PACU D/C VSS SaO2 98% RA. PT sat up spontaneously confused not able to track & eyes. spoke in Arabic. understandable - went back to sleep NAD SGT [redacted]

Discharge Criteria:
Date: 7 Aug **Time:** 1115 **PARS:** 9
BP: 143/88 **T:** 97.6 **HR:** 78 **RR:** 16 **SaO2:** 98
Pain Level at D/C (0-10): unable to evaluate
Intake: 300 **Output:** 350
Additional Data: NPO
Transferred To: N/A
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9-Aug-03
Time In: 1130
Allergies: NKDA
Pre-op V/S:
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1100 Colloid
OR Output: UOP 200 EBL 20
Meds/Times: 250 mg Pent 0940
6mg MS04 1105

Drains: ~~Hemovac~~ ~~Penrose~~ NG ~~JP~~ T-tube Foley TLS

Airway: Nasal Oral ETT Trach Other

Pre Op Meds

History

Time	1130	1135	1140	1155	1220	1225	1230
SaO2	99	100	100	100	100	98	96
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods	FT	FT	FT				
240							
220							
200							
180							
160	V	V	V				
140				V	V	V	V
120							
100							
80							
60							
40							
20							
RR	24	20	22	22	19	18	18
T	96	96.2	96			98.3	98.3
Time	1130						
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1230	NS	150	(L) FA	O.R	150cc

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

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 9 AUG 03

PAT... (If typed or written entries give: Name — last, first ... hospital or medical facility)

#[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) LE	BRACE	N/A	P	B	W	PK
15'	"	"	"	"	"	"	"
30'	"	"	"	"	"	"	"
45'	"	"	"	"	"	"	"
60'	"	"	"	"	"	"	"
90'	"	"	"	"	"	"	"
D/C	"	"	"	"	"	"	"

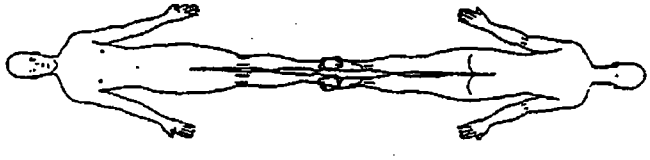
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1130	(R) LE	ACE WRAP	(-)
30' 1200	" "	" "	"
60' —			
D/C 1230hrs	" "	" "	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1230	Urine	yellow/cloudy	150cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
	N/A		

WAMC OP 173-E

NURSING NOTES

See progress note [redacted]

b(6)-2

Discharge Criteria:
Date: 9 Aug 03 Time: 1230hrs PARS: 9
BP: 148/92 T: 98.3 HR: 80 RR: 18 Sa02: 99%
Pain Level at D/C (0-10): Ø
Intake: 150cc Output: 150cc
Additional Data:
Transferred To: PCU #2
Report Given To:
Transferred Via: [redacted] Litter Gurney Ambulance
Transferred By: [redacted] SPC
Cleared IAW Recovery
Charge Nurse Signature [redacted]

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **Post-Anesthesia Care Unit (PACU) Flow Sheet** — Static encephalitis 2° heat stroke Combative

OTSG APPROVED (Date)

Date: 12 Aug 03
Time In: 1320
Allergies: _____
Pre-op V/S: _____
Procedures: L knee arthroscopy, L-tube, CVL in (R) IJ

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

OR Intake: Crystalloid 1000 Colloid _____
OR Output: UOP 1500 cc EBL <100
Meds/Times: 10mg Labetalol 150 Neat 10mg Nbay

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

Needs CXR to verify line placement

Pre Op Meds — History

Time	1320	1323	1325	1345	1410
SaO2	98	98	95	99	97
FIO2	28	28	28	28	28
Methods					
240					
220					
200					
180					
160					
	√	√	√		√
140				√	
120					
100					
	^	^	^	^	^
80	•	•			
60			•	•	•
40					
20					
RR	17	19	20	14	14
T					
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: _____ Labs: _____

Post-Anesthesia Recovery score

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

Codes

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

V/S: X = A-line BP; ° = Cuff BP; ♥ = Pulse

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

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

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

PREPARED BY (Signature & Title): [redacted] PT/AN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 12 Aug 03

PATIENT'S IDENTIFICATION (First, middle; grade; date; hospital number) Name — last,

b(6)-2

[redacted]

#[redacted]

b(6)-4

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

DA FORM 4700, MAY 78 — WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) — Previous edition is obsolete — USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1225		MSO4 2mg	IVP			[redacted]

NEUROVASCULAR

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

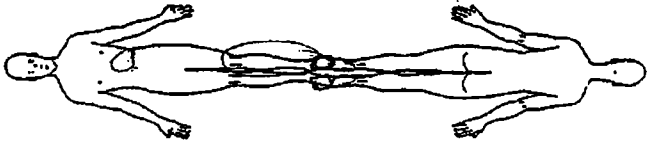
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Clean	ace wrap	none
30'	Clean	ace wrap	none
60'			
D/C	Clean	ace wrap	none



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Received in PACU area very drowsy and slightly agitated. Dsg around G-tube and on (L) knee clean, dry & intact. Ice pack in place. Pt currently calm & VSS stable. Will continue to monitor [redacted] tph

Discharge Criteria:
Date: 12 Aug 03 Time: PARS: 9
BP: 119/98 T: HR: 56 RR: 13 Sa02: 99%
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICU 2
Report Given To:
Transferred Via: W/C Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatur[redacted]

MEDCOM - 15953

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
A	Rt	+	+	P	B	W	PK
1	Rt	+	+	P	B	W	PK
3							
4							
6							
9							
D	Rt	+	+	P	B	W	PK

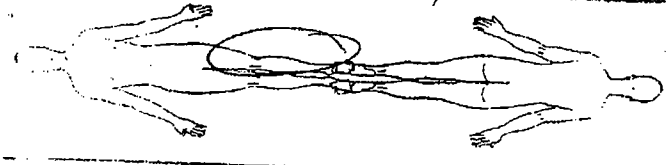
Movement/Sensation: + = present, - = absent Temp: C = Cool
W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height		N/A					
Lochia							
Perineal							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
A	Rt knee	ace wrap	none
3			
6			
D	Rt knee	ace wrap	none



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

Pt received on unit S/P I&D of Rt knee. Alert but not coherent. Resp to voice, clear, dry + intact c brace in place. Foley cath remains in place [redacted] Will continue to monitor [redacted] Pt more agitated, v/s stable. Continue c IVF noted. Will be [redacted] to ICU & [redacted] Pt transferred to ICU2. Pt responsive to verbal and tactile stimuli. Pt very combative, restraints applied. V/S stable. Pt still able to move his legs & his Foley cath pulled out [illegible] tube.

Discharge Criteria:
Date: 13 Aug 03 Time: 0745 PARS: 9
BP: 156/100 T: HR: 102 RR: 12 SaO2: 100 %
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICU2
Report Given To: Sgt [redacted]
Transferred Via: W/C [illegible] Gurney Ambulan
Transferred By: Cpt [redacted]
Cleared IAW Recov [redacted]
Charge Nurse Signatur [redacted]

1040

Post-Anesthesia Care Unit (PACU) Flow Sheet

ASA 3

Date: 13 Aug 03
Time In: 0710
Allergies: NKDA
Pre-op V/S:
Procedures: I+D Ulnar

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 100 Colloid
OR Output: UOP 0 EBL 150
Meds/Times:

100 mcg Fent

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
STT
Trach
Other

Pre Op Meds

History

Time	0710	0715	0730	0745
SaO2	98	97	99	99
FiO2	RA	RA	RA	RA
Methods				
240				
220				
200				
180				
160				
140	124 ✓	124 ✓	✓	✓
120	✓			
100			100	
80	1 92	1 93		
60				
40				
20				
HR	14	18	18	18
T	96.2			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		2	AIRWAY A = Ambu BB = Blow M = Mask FT = Face Tent RA = Room NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1		2	
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2		2	V/S X = A-line & * = Cuff BP = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		1	TEMP S = Skin O = Oral A = Axillary T = Tympan R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2	LOS C = Cervic T = Thorac L = Lumbar S = Sacral
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8		9	

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

b(6)-2

PREPARED BY (Signature) [redacted] RN/BSN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 13 Aug 03

IDENTIFICATION (Print or written entry: last; first; middle; grade; date; hospital facility)

Name – last,

#

b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

MEDCOM - 15955

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 14 Aug 03
Time In: 1047
Allergies: _____
Pre-op V/S: 113/60, 111
Procedures: I&D RLE

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid _____
OR Output: UOP 100 EBL Minimal
Meds/Times: Fentanyl, Versed, Esmalol 30 mg

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

Pre Op Meds _____ History _____

Time	1047	1053	1055	1103	1108	1113	1130	1140	1148	1153
SaO2	97	98	96	96	98	97	95	96	95	94
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	3L	02
Methods										
RR	16	19	15	19	21	20	16	21	17	16
T	98				96			97		
Time										
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1047	LR	450	RLE IV		100

X-rays: _____ Labs: _____

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 14 Aug 03

PATIENT'S IDENTIFICATION (Name – last, first, middle; grade; date; hospital or [redacted]): [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1115	/	MSO4 3mg	IV	/		[redacted]

NEUROVASCULAR

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

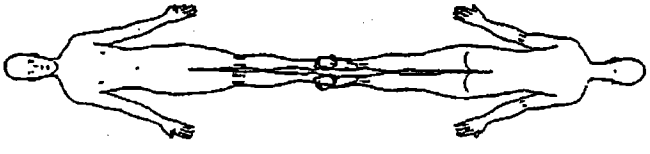
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE, Abd	Ace Wrap	None
30'	LLE	Ace Wrap	None
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1158	Foley	Dark Yellow	300

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1050 - Pt arrived from OR via litter. Airway natural. Receiving UR @ TKO. Dressings to PEG tube & LLE c/o I [redacted] /DJ

1110 - Pt removed PEG tube dressing. 4x4 Dressing reapplied [redacted] /DJ

b(6)-2

Discharge Criteria:
Date: 14Aug03 **Time:** 1154 **PARS:** 9
BP: 148/93 **T:** 96° **HR:** 102 **RR:** 17 **Sa02:** 98
Pain Level at D/C (0-10): —
Intake: 100 **Output:** 300
Additional Data:
Transferred To: ICW 2
Report Given To: CT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Ro[redacted] B-3
Charge Nurse Signature: [redacted] /DJ

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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 15 Aug 03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block

Time In: 1419

Allergies: ——— OR Intake: Crystalloid 200 Colloid ———

Pre-op V/S: 156/90, 105 OR Output: UOP 150 EBL ———

Procedures: I+D (L) Knee Meds/Times: Fent, Versed 150mcg 2.5mg

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

Pre Op Meds History

Time	1419	1429	1439	1449	1459
SaO2	98	99	99	99	98
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	18	20	21	19	21
T	97.4				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1419	NS/LR 20K	200	TLC	———	50

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

Time	Patient teaching done; Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

b(6)-2 [redacted] /AN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15 Aug 03

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

[redacted]

b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

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	Bilat	+	+	P	B	W	PK
15'	Bilat	+	+	P	B	W	PK
30'	Bilat	+	+	P	B	W	PK
45'							
60'							
90'							
D/C	Bilat	+	+	P	B	W	PK

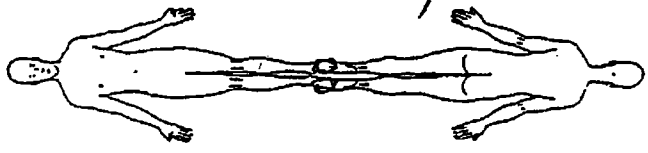
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	Ace Wrap	None
30'	LLE	Ace Wrap	None
60'			
D/C	LLE	Ace Wrap	None



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	Foley		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1419: Pt arrived from OR via litter. Pt moving arms and legs, attempting to pull at lines. Pt uncooperative & does not follow commands. Pt very restless [redacted] and agitated. Requiring 3 staff members to keep pt calm [redacted] b(6)-2

Discharge Criteria:
Date: 15 Aug **Time:** 1457 **PARS:** 10
BP: 150/98 **T:** 97.4 **HR:** 145 **RR:** 22 **SaO2:** 98%
Pain Level at D/C (0-10): —
Intake: 50 **Output:** —
Additional Data:
Transferred To: ICU 2
Report Given To: Cpt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Cpt [redacted]
Cleared IAW Recovery [redacted] B-2
Charge Nurse Signature [redacted]

b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A1(D1	I2	EPW# [redacted] b(6)-4	EPW	M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
0014195	[redacted]		2	2	UO

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	000 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	1730	b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K70	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I2		9	YEAR [ ] [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICU#2	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
26		030815

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		030806

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

FOR LOCAL USE

Dx: GSW to (L) Knee/ L Patellar open fx

Dx: 8221, 34839, 9920, 71100, E9000

Dx: 7966 (7), 7436, 4319

992.0, 348.3, 822.1, 920, 910.0, E991.2, E900.9

79.69, 79.39, 86.28x4, 43.19

ADMITTING OFFICER (Signature as required) Dr [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] b(6)-2

DA FORM [redacted] [redacted] COM - 1596[redacted]

b(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agent;

1. REGISTER NUMBER	2. NA	3. GRADE	ADMISSION REMARKS
00 14200	[redacted]	E4W	

4. SEX	5. AGE	6. RACE	7.	9. ETS	10. PREVIOUS ADMISSION
M	24Y	X	MUSLIM	b(6)-2	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	TAGIT D15631	ICW1

15 FLYING STATUS	16. DSG	BEN	18 BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—		K78	—	—	WIA

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	XFER TO 21st CSH	26 AUG 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	06 AUG 2003	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P GSW TO ABD

DX
86350
8760
8748
99859
99921

V443
E9161
E9912

PROC
8609

863.50
8760
87.4.8
998.59
998.31
569.61
E9912

8/12 93.57
97.83
97.84
8/18 93.57

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	14	14

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	14	14

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR. [redacted]

SIGNATURE [redacted]

DA FORM 3647, MAY 75 EDITION [redacted] USAPPC V1.10

b(6)-2

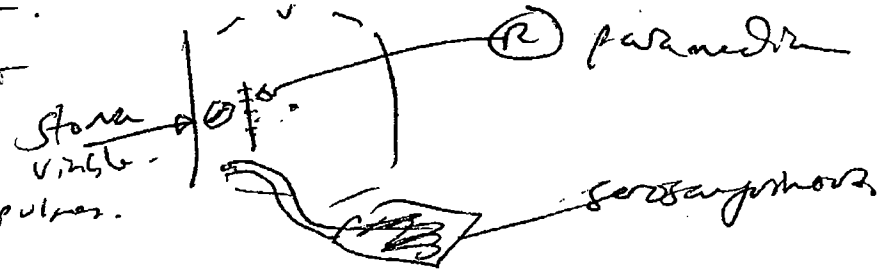
MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 yo. ♂ s/p GSW (L) neck and GSW abdomen/Back yesterday ⇒ Emerg. Hospital Neck not treated (and looks OK) at got Laparotomy for abdomen. T-Colon injury ⇒ colostomy done, Drain placed Back wound closed.

PHYSICAL EXAMINATION

11/5/78 (L) neck & post scar tiny little wound large clear. Abd soft



Ext: normal pulses.

PROGRESS (Enter date of discharge and final diagnosis)

Plan: NPO / Levine / AIGI / Dr. [redacted]

b(6)-2

b(6)-2

[redacted]

IAN [redacted] MAT	DATE 06 AUG 03	IDENTIFICATION NO.	ORGANIZATION
ICA... or written entries give Name (last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

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

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6 Aug 03	24 y/o Iraqi National c 1d hx of RUQ abdominal wound
1530 hrs.	2° to GSW. Pt was shot by Iraqi National while
T: 98.8	working for American (U.S. Army) Logistics Support Co. P.T.
P: 100	was subsequently transported to Al Kasik Hospital Unit per
R: 16	MICU Capability & Monitoring performed.
B/P: 130/90	
PO2: 99%	a.) Stable Unwanted c NAD, WD/WN Caucasian
A: NKDA	HEENT: WNL c exception of dry tube placed in @ nostril
M: Ø	Pul: CTAB s W, RR
P: Ø	CV: CTAB s M, R
I: Last Night 1900h	Abd: + BS, NT, @ TS @ TTP to RUQ @ quadrant to,
E: In Object	Foley bag & drainage bag in place
O: 625ml	Ext: Foley Cath in place
GU: 50ml	
Urine: 200ml	A/P) 1d hx of GSW to RUQ - pt will Medevac to
Vitals @ 1600	28th CSH pia LTC Hoss, 91st FST for
T: 99	continued Care. Pt is unmedicated EPW.
P: 110	• MEDEVAC to [redacted] b2-2
R: 20	• 9-Line MEDEVAC Called @ 1645 b(a)-2
B/P: 112/72	• Δ IV to LA, DC @ [redacted]
PO2: 94%	
	* Ø IV ABX's given, Ø Narcotics [redacted]

PITAL OR MEDICAL FACILITY	STATUS	DEPART./S[redacted]	RECORDS MAINTAINED AT
ISOR'S NAME b(a)-2	SSN/ID NO.	RELATIONSHIP TO SPONSOR	LT 3P PAC
[redacted] ON:	(When written entries, give: Name - last, first, middle; ID No or SSN; Sex; Rank/Grade.)	REGISTER NO.	WARD NO.

2/5/79 M Iraqi National
EPW

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
06 Aug 03 2015	Received pt. from EMT about 1930. Pt. transfered from litter to bed. VSS. Pt. alert & oriented. Pupils equal @ 4mm & reactive. Resp. even, unlabored. Lungs CTA throughout c slight exp. wheeze noted (R) UL, anterior. SpO_2 98-100% RA. HR regular c Ø murmur. ST c ectopy. HR 110's. 2+ pulses x 4. Abd. soft, flat, non-distended. Hyperactive BS (R) UQ, otherwise absent. Colostomy c bag intact. Min. amt. watery stool draining - located (R) UQ. NG tube (R) nare c green drainage. 50cc emptied upon arrival. NGT to LCS. Foley to gravity drainage c dark amber urine. Vertical abd. incision on (R) side of abd. about 12 inches in length c sutures intact. Ø S/S. of infection. 1 Drain located (R) LQ c bloody drainage. 225cc drained/ emptied upon arrival. 18g PIV (R) AC c LR @ 150cc/hr infusing c difficulty. Pt. denies pain @ this time. Will cont. to monitor. [redacted]
06 Aug 03 2100	UOP last hour 20cc concentrated, amber color. Will monitor next hour to see if output ↑. [redacted]
06 Aug 03 2200	UOP to 30cc/hr. Pt. cont. to deny pain at this time. Sleeping c o/o. Will cont to monitor. [redacted]
06 Aug 03 2300	Colostomy bag emptied. Colostomy site pink & beefy c fatty tissue & fascia visible around stoma. Surgeons aware; plan to redo stoma within next few days. Pt. c/o pain around incision/drain site. Medicated c 4mg MSO4 IVP. - giving adequate pain control. [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

bleed - 2 Ab

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07 Aug 03 0015	<15cc drainage from NG noted. Ø fluid replacement given. Pt. sleeping. IV Abx treatment going. VUP cont. @ 30cc/hr. Dressing d/d around drain site. Old dressing saturated c serosanguinous drainage. Drain kept in place c sutures. Site looks good Ø S/S infection. New dressing placed. — bleed [redacted] clan
07 Aug 03 0230	Drainage bag d/d from Iraqi bag to Foley bag because tubing in orginal bag clotted & is unable to be stripped. 200cc bloody drainage emptied from bag. Serosanguinous drainage cont. to leak from site. bleed-2 [redacted] clan
07 Aug 03 0440	Pt. able to sleep through the night ~ c/o. Abx care done. Exit wound to (R) back closed c sutures intact. New dressing applied to site. Ø drainage on old dressing. Dressing @ drain site saturated c serosanguinous fluid. Dressing d/d. Very little bloody drainage noted in tubing. Grimacing noted on pt's face c turning. Pt. medicated c MSO4 4mg IVP. Small wound to (L) neck. Ø drainage through the night. bleed-2 [redacted] clan
07 Aug 03 0445	Pt. guarding (R) LE. States that he is unable to move leg on his own! (+) sensation to leg. Will monitor. bleed-2 [redacted] clan
0530	Assumed care of pt resting in bed. Lipids 3mm + brisk. Groups strong equal bilaterally. HR in high 90's ~ rhythm. Ø palpable pulses in all extremities. IL currently infusing @ 150cc/hr via 18ga @ forearm. Lungs ~ inspiratory wheezing noted bilaterally. O2 sats 97-99% on room air. Color normal for race. Abdomen c incision noted, sutures intact. Colostomy to RLQ c small amt of liquid drainage noted. Absent bowel sounds in 3 quads ~ hypoactive bowel sounds noted in

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 Aug 03 cont	@ LQ. Drain also noted in @ lower quad c small amt of sanguinous drainage noted. Drsg around site c serous sanguinous drainage noted. Drsg D/d, new one applied. NGT to LCS c minimal amt of green drainage to replace c 1/2cc/cc of IV. Foley to gravity draining adequate amt of yellow urine. No problems noted c present time, will continue to monitor [redacted] appl/bn b(6)-2
07 AUG 03 0723	Surgery POD # 2 Doing well. Vitals 60/60/100 = 1 out 3 h. minimal stoma output (6 gut, 5 cm 17-9) NGT lightly SWS - 60cc Drain in pelvis = 0 ⇒ will remove today wound c 10 I, Clear D/C Drain Abd NT, NGT. 0723 [redacted] b(6)-2 NMS
0815	Drain in @ lower quad D/C'd by Dr. [redacted] 4mg MSO4 given prior. Pt. tolerated c difficulty, will continue to monitor b(6)-2 [redacted] appl/bn
0930	Drsg to @ lower quad checked, small amt drainage noted [redacted] appl/bn

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

bled-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7Aug03 1400	Pt up to stand, Afternoon care performed. Stoma c brown edges noted. Small amt of liquid stool noted. 4mg MSO4 given for c/o pain. Weakness noted in @ lower extremity. Pt unable to stand and place pressure on that side. Will continue to monitor [redacted] cont.
1700	Pt continues to rest in bed. Denies any pain @ present. States he has tingling in @ leg. Will continue to monitor [redacted] c/m
7Aug03 1738	Received pt @ 1700. Pt. Sitting ↑ in bed. A+O×3. Weakness to @ LE. Dr. [redacted] notified. Resp. even unlabored. Lungs CTA throughout. SpO2 96-98% RA. ST c ϕectopy. HR 90-110s. 2+ pulses x4 extremeties. NST to LCS c min. amt. green drainage. Colostomy to @ RUQ c dark brown liquid stool. @ BS @ RLQ. Hyperactive to @ quadrants. Foley to gravity c clear amber urine. Abd. incision c sutures intact. ϕ signs of infection. Pt. denies pain @ this time. Will cont. to monitor. [redacted] KTBan
7Aug03 2000	Axillary Temp of 102.° 650mg Tylenol PR given. Pt. c/o being cold. Will monitor [redacted] KTBan
7Aug03 2100	Temp ↓ to 101.8 Ax. Pt. also c/o dry mouth. Assisted pt. in brushing his teeth. ϕ other c/o [redacted] KTBan
8Aug03 0200	NST drained total 10cc green fluid over 8°. Replaced c 10cc maintenance fluid from IV @ 0100. VSS. ϕ other Δ's. Pt. able to sleep c difficulty. [redacted] KTBan
8Aug03 0410	Pt. washed up this Am. Dressing to @ RUQ Δ'd. Old dressing saturated c serosanguinous drainage. Site looks good ϕ redness. Still bleeding from hole. New dressing applied to site. Colostomy emptied. Green/brown stool. T 100.4. [redacted]

ST [redacted] REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
08 AUG 03 0720	Surgery POD#3 Drsn Removed yesterday Tm 102, ↓ after WBC 6.2 NBT 10/12 wound clean staples in place Plan D/C suction if NGT possible D/C NGT today A/C/P: day #2 ⇒ Full 7 days. b(6)-2 will cover every day for now [redacted]
10 AUG 03 0545	Surgery POD#5 Tm 101, afeb now Wound clean dry intact staples & sutures Plan Continue ab b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8Aug03 0900	Pt alert, VSS. T 99.1. Heart sounds S^1 S^2 present. Lung sounds CTA bilaterally. + Bs * 4 Quadrants. Colostomy site draining dark brown liquid stool. UOP sufficient, Foley d/c'd this am @ 0745. Will Monitor urine output. Sutures to (R) side of Abdomen C/D/I ∑ S/S of infection. NG tube to (R) nare taken off Suction @0730 this am. Will Dc if out put < ~~300~~ 100cc/hr. by order of Dr. [redacted] b(6)-2 IV D5½NS + 20K infusing @ 125cc/hr (R) wrist. Site ∑ S/S of infection. Pt c/o Pain this am. Will Continue to Monitor pt. [redacted]
08Aug03 1617	Pt urinating spontaneously in sufficient amounts. NG tube D/C'd. To be advanced to Clear liq diet. Using incentive b(6)-2 spirometer. T 100.5 → 99.5 @1620 po 650mg of Tylenol. C/o [redacted] numbness/tingling in RLE. Will Continue to monitor
8AUG03 1800	Received pt resting in bed w/o c/o@this time. (Neuro) AAOx3, PERRLA, MAE ∑ ↓ ROM ∑ RLE. PT c/o tingling (Per interpreted to RLE. (D)Sensation, slightly ↓ed. PERRLA. (RESP) RR 20's, SpO2-95% RA, even, unlabored, CTA ∑ ↓@bases. (CV) SIS2 NSR (AP) 70's 3+ pulses ∑ CRT<3sec throughout. (MS) extremities warm (GI/GU) SNTND ∑ BC to RLQ-shiteles CD1, OTA. Colostomy to RLQ/RUQ-liquid brown stool in pouch. BSx4Quads. (Integ) cont

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.

H [redacted] b(6)-4

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PROGRESS NOTES
Medical Record

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

b(6)-2 All

LAST NAME	FIRST NAME	MIC	INITIAL	ID NUMBER

DATE	NOTES
cont	(R) Flank = GSW. 2X2 over site - CDI. Warm - dry intact brown in color. (Lines) 22g PW (R) RA/AC area. LR @ 125cc° · Hr when fol. PO well = U/O ↑. POC. IV ABX, drsng Δ as, monitoring — CPT [redacted]
8 AUG 03 2056	Pt given 4 mg MSO4 IVP. ~~Ad~~ clo pn to Abd by pointing and stating "Allium". Awaiting effects — CPT [redacted]
8 AUG 03 2130	(+) Results pt's no longer showing visual S/S of pain: i.e. facial grimaces — CPT [redacted]
9 AUG 03 0100	4mg MSO4 IVP given for Abd pn — CPT [redacted]
9 AUG 03 0130	(+) Results. Ved Physical S/S. of pn. Pt sleeping at this time. — CPT [redacted]
9 AUG 03 0330	2mg MSO4 IVP for abd pn — CPT [redacted]
9 aug 03 0430	Pt resting comfortable in bed @ this time — asleep. NO events throughout pm. IV ABX per schedule = pn management pm. VSS Tylenol 650mg PO given for low grade temp. Cont to monitor = LR @ 125cc. Pt tolerated H20 x3 cups w/o N/V/d - CPT [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
09 Aug 03 0750	Surgery POD # 4 T 100.5, Abds soft Drinking well. Stoma - + Sh.1 ⌀ gas. Incis c/d/I PIV - A/G/F Dsg # 4 + dsg - + I.V.F. + TWF. [redacted] MAT bid(a) - 2 All
9 Aug 03 0900	Alert a+o x 3, VSS, Afebrile this am. Pupils PERRLA. Heart Sounds S^1, S^2 present ∅ murmur. Lung sounds CTA bilaterally + BS x 4 quadrants. Stoma to RUQ Draining Brown, liquid Stool. Sutures to (R) side c/d/I ∅ S/S of infection. Dsg to Drain site RLQ d'd this am. UOP sufficient. Voiding spontaneously. Tolerating Clr Liq ∅ complaint. Will HL IV ~~per MAR~~ [redacted] & advance to Reg diet per MD [redacted] orders. Abx Given as ordered. Will continue to Monitor- [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MI	NITIAL	ID NUMBER

DATE	NOTES
9Aug03 11:30	Pt OOBTC for 45min. Tolerated well. [redacted] c/o pain in back & RLE. Using Incentive spirometer frequently. T @ 10:00 98.4. Tolerating Clr. Liquids 5 Complaint bld-2 vop sufficient. Will Continue to Monitor [redacted] LBM—
9Aug03 15:00	Pt tolerated small amount of reg diet w/ thout Complgt Dsg to back d/d. Afebrile. Will Continue to monitor. [redacted]
9Aug03 16:00	~~Dsg to~~ ~~to~~ IV d/d from (R) Forearm to (L) Bicept. T@ 15:12 100.9 Tylenol given. T° Now 99.4. Pt c/o pain 4my MSO4 given per Dr Rosen's orders. Pain control sufficient. Order to transfer to ICU held due to bed space. Will Continue to Monitor. [redacted] bld-2
17MS	Nursing Note: Pt is A&O; lungs clear; sutures to Ex lap open to air and D+I; colostomy intact. Hyperactive BS; [redacted] c/o pain. IV to (L) Bicep is patent. Pt. on antibiotics. urinating w/o difficulty. ——— CPT [redacted]
24W:	Nursing Note: Pharmacy was out of Ampicillin which was due at this time. Dr. [redacted] notified and gave a verbal order for Unasyn 3gm x 1. ~~He~~ He stated to let the ~~doctor~~ ~~nurse~~ ~~during~~ [redacted] his doctor know of the lack of Ampicillin. ——— CPT [redacted] bld-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Aug 03	Nursing: Pt A&O x 3, VSS. T° @ 11:00 99°. Heart Sounds
12:45	S1, S2 Present ∅ Murmur. Lung Sounds CTA bilaterally.
	+ BS x 4 quadrants. Colostomy in place draining brown
	liquid stool, passing flatus. Colostomy Care done this
	AM. Stoma necrotic looking @ upper & lower edges. Will
	Notify MD. Sutures to abdomen C/D/I. Drsg to drainage
	site d'd. Voiding spontaneously, VOP sufficient. Drsg to
	Lumbar region d'd. Sutures intact, site ∅ S/S of infection.
	IV ② bicept patent & ∅ S/S of infection. IV ampicillian
	2gm q6 d'd to Anvof 1 gm IV q8° per MD orders. Will
	Continue to Monitor. — [redacted] LPN
10 Aug 03	Pt T 100.1 @ 1439. Tylenol given. Incentive Spirometer Encouraged.
1530	OOBTC @ 11:00 x 1 hour. Tolerated well. 15:00 C/O pain
	4mg MSO4 given ∅ adequate relief. Will Continue to
	Monitor. — [redacted] LPN
10 Aug	Dr. [redacted] looked @ Stoma. Stated it looks good.
1600	T° 100° — [redacted] LPN
1745	VS 117/56 78 18 @ 98% RA 37.1 © = 99.8 [redacted] LPN
	ALERT AND ORIENTED. NEURO PUPILS 3MM BRISK BILATERALLY [redacted] CTA
	BILATERALLY EVEN UNLABORED BREATHING. DS TO PERITONEOUS @ 1° PT
	ABLE TO ELEVATE SU 3 BALLS ON DS ∅ GOOD EXCHANGE AND NO FATIGUE.

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

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

REGISTER NO. | WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

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b(4)-2 All

LAST NAME	FIRST NAME	MIDDLE INIT.	ID NUMBER

DATE	NOTES
	CV NSR Ø EDEMA S1,S2 (+) RADIAL 3+ DP 3+ BILATERALLY CAP REFILL BRISK. GI COLOSTOMY PINK/BEEFY C SOME AREAS PURPLISH HUE (+) CAP REFILL BRISK. SOFT AND FORMED STOOL IN BAG, BROWN IN COLOR. GU VOIDING TO URINAL S DIFFICULTY. CLEAR YELLOW URINE. SKIN TO (R) OF MIDLINE SUTURES INTACT, INCISION WELL APPROXIMATED Ø S/S OF INFECTION. BRUISING TO RETROPERITONEAL (L) SIDE BLUISH/REDDISH HUE. TENDER TO TOUCH AND PALPATION. ~~WILL CONTINUE~~ 20G IV HEPLOC TO (L) BRACHIAL. CONTINUE TO MONITOR. [redacted] RN
1800	VOID 375CC TO ~~FOLEY~~ URINAL CLEAR YELLOW. [redacted] RN
1920	PT REQUED 2 TABS PERCOCET FOR PAIN TO ABD. WILL [redacted] RN
1940	VOID 200CC TO URINAL CLEAR YELLOW. [redacted]
2115	VOID 400CC TO URINAL CLEAR YELLOW [redacted] RN
2130	ANCEF 1GM IVPB AND INFUSING TO (L) BRACHIAL PIV [redacted]
2310	GENTAMICIN IVPB AND INFUSING TO (L) BRACHIAL PIV [redacted]
2310	VOID 375CC TO URINAL [redacted]
2355	FLAGYL IVPB AND INFUSING TO (L) BRACHIAL PIV [redacted]
0305	VOID 400CC TO URINAL [redacted]
0310	MEDICATED C 2 TABS PERCOCET FOR PAIN TO ABD. [redacted]
0330	TMAX 98.5. VSS 118/57 81 20@ 99% RA [redacted]
0415	OSTOMY CARE DONE BAG CHANGED C MOD AMOUNT OF SOFT AND FORMED STOOL FROM STOMA. STOMA IS BEEFY RED C SOME DIFFUSE TISSUE TO PERIPHERY BLANCHED/NECROTIC AREAS TO EXCESS TISSUE. STOMA C (+) CAP REFILL. NEW OSTOMY BAG APPLIED ~~RSL TO SHAVE~~ [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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[redacted] b(4)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Aug 03 0600	received report from outgoing shift pt resting c eyes closed easily roused A+O x 3 NAD VSS color good cap refill brisk. NVI. LS CTA even unlabored ABD soft (-) DTN (-) rigidity BS active x 4 sutures intact (-) drainage colostomy site pink some granulation noted dry brown stool formed soft stool. IV (L) upper arm patent flushed c 10cc NSS Amcf 1 gm given per schedule. (-) infiltrate (-) S+S infx. will cont to monitor SGT [redacted] q1hrWMp b(a)-2
11 Aug 03 1000	OOB in chair (+) L leg weakness. drag leg denies pain in leg. tolerated well. SGT [redacted] q1hrWMp.
11 Aug 1200	Back in bed tolerated well. NAD c/o ABD pain given percocet II tabs PO c 180cc H2O. Rest c eyes closed NAD SGT [redacted] q1hrWMp b(a)-2
11 Aug 03 1500	Surgery PO note D/C'ing well Labs Wound c/d/I Staples coming out Abx Day #6

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

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

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

[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

b(6)-2-All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Aug 03 1530	C/o abd pain, reassessed colostomy removed noted SM amt diffuse non bleedy Superficial ulceration on stoma. @ 11:00 (+) erythema noted. liquid stool draining from 11:00. MD notified - (L) + (R) of outside stoma noted necrotic. stoma itself Deep Red. - MD aware came to bedside. Stoma assessed by Dr [redacted] States surround stoma is mucosa can will fall off. BS active (+) RUQ RLQ. SM amt BRN noted (R) side of abd. KUB Ordered; MOM & HS. pt NAD fluids encouraged [redacted]
1630	KUB completed @ bedside Dr [redacted] aware stated KUB is fine. no further intervention necessary. [redacted]
	1745 11 Aug 03 - Pt resting comfortably in bed assessment as follows: FC, purposeful movements (+) for pain; CTA (+) BS use of all 4 Q; No cough [illegible] NSR; +3 pulses equal Extremities warm; S1/S2 [illegible] colostomy in (R) abd. side; necrotic area to outlying; Mucus out of colostomy; Abd soft; no [illegible] of necrotic outlying; (+) tenderness; slight darkness to (R) side; BN; encouraged to ambulate; [illegible] pt voiding spont. [illegible] on to (L) LE. [redacted]

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

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
12 Aug 03	0730 Pt resting c eyes closed, A+Ox3, V/S HR 76 RR 16 Sats 96% BP 136/78 Temp 95.6, Good skin color, cap refill brisk, ø BS x 3 quadrants, LS CTA, Abd soft ø DTN ø Rigidity, Sutures intact ø Drainage, Colostomy site pink drainage brown slightly formed stool, IV (L) Upper Arm ø Signs of infection. Continueing to monitor. SPC [redacted] 91WM6
0730	Pt Complained of pain, gave 2 Percocets per doctors orders. SPC [redacted] 91WM6 b(6)-2
12 AUG 03 1850	b(6)-2 Surgery Eating, Stooling (mon 30 - po's Hts) Ambs: wound c ID I Still slightly tender between stoma and wound but no fluctuance, erythema every other suture removed on abd. + all sutures on back. plan - Local wound care - ø OOB + ambulate b(6)-2 [redacted] MAJ

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
b(6)-4	# [redacted]		

DATE	NOTES
12Aug03	1600 Dr. [redacted] removed the back sutures and everyother suture on the ABD, Then covered c steri strips. SPC [redacted] 91WM6
1830	Pt A+O, gestures c hands. LSCTA RR unlabored, reg. S1S2 ∅murmurs, 2+ pulses all extrem. Abd soft, tender, steri strips intact. @ colostomy draing liquid brown stool. Voiding sufficient amts to void. Ate 1/4 dinner, drinking sufficient amts. Plan to monitor stoma & VS b4 0700. Will monitor [redacted]
2030	Resting comfortably denies any pain discomfort unable to speak English but able to communicate using body language. HOB 130°, able to self position. VIS stable. Temp afeb 99.7. Will continue monitor pain discomfort. [redacted] MWM
13AUG03 0630	Pt sleeping, VSS. Will monitor. [redacted] LTAN
0400	Pt colostomy bag D'd, stoma cleaned. VSS, will monitor. [redacted] LTAN
∅800	Pt resting awakes upon external stimuli. A+Ox3. Pt's colostomy draining soft brown stool. Colostomy bag c/d/I and free of SIS of infection. ∅ Pulses all extremities +2. SPC [redacted] 91WM6
∅810	Pt complained of pain. Gave 2 percocet tabs. SPC [redacted] 91
13 AUG 03 (1015hrs)	Pt continues to do well this a.m. No % discomfort ∅ receiving percocet tabs. Colostomy bag D'd c 0830hrs. Report given to SPC [redacted] Transfer to TCW2 via W/C. [redacted] CRT/LA

[redacted] REV. 5/1999) BACK

USAPA V1.00

b(a)-2 A-11

NSN 7540-00-634-4176 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Aug03 1100	pt transferred from ICU2 via w/c @ 1030. Alert and Oriented. No c/o pain. VSS. HR reg. Lungs CTA Abd ML incision c sutures intact and steri strips. Colostomy to RUQ intact c soft brown stool. BS×4. Wound to lower back c steri strips and 4×4 dsg CD+I. pt has limited ROM to RLE. pt resting @ this time. Will continue to monitor [redacted] 9/WM6
	1115 HL to ⓐ brachial +flush c redness/infiltration [redacted] 9/WM6
13Aug03 1330	Waiting for MD for new orders Assumed pt care @ 1300. VSS pt awake et alert. Lungs CTA, Abd c Midline incision c Sutures et Steri Strips intact Ⓓ s/sx of infection noted. Colostomy bag to RUQ intact, BSⓅ. dsg to V back area CDI. RLE c limited ROM, LLE c full ROM Ⓟ pulses to both. BLE c full ROM Ⓟ pulses, HL to LLE, Ⓓ s/sx of redness/swelling noted. Ⓓ c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted] 9/WM6
18Aug03 21:57	Recd c/o pt @ 21:00. Restraints x2 Ⓑ wrist/Ankle. VS WNL x temp ↑ 100.2. Awake and alert in bed. Skin W/D PERRLAⓅWNL. LCAⓅ. HRRS. S1, S2. BSⓅ×4. ABD soft + non-tender. Colostomy intact, stoma beefy red in color. Ⓟ flatus Ⓢ stool

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

[redacted]

EPW

RECORDS MAINTAINED AT: FCW2

PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 15979

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	⊕PPB. H2 ⓘ R arm ⊗ patent. leaking @ insertion site, will replace. ⊗ c/o pain @ this time. M2 ABD incision c sutures OTA C/D/I. will mon T temp throughout shift [redacted] BET /AW
14 0530 Aug 03	NURSING NOTE: Assumed pt care. AAOx3. Airway intact, breath even and unlabored, LS CTA Ⓑ. Abd soft, nontender to near surgical sites, ± distention, Ⓝ BS(+)x4 but quiet. Midline incision c steri strips & sutures, open to air, well approximated, ± drng, some redness noted. Colostomy to Ⓡ UQ putty/tan light brown, soft stool in flatus. FROM all extremities, intact to Ⓑ UE and Ⓑ LE. IV Hl to Ⓡ FA ± s/s infection/infiltration. [redacted] b(6)-2 A11
14 AUG 03	SURGERY POD #9
0800	T= 100.2, Only well but c/o pain. pain. VSS. Stool in bag pain/incisional — no fluctuance No erythema
	plan/ CBC. continue physical therapy. D/C staples [redacted]
14 Aug 03 1445	pt care assumed @ 1300. pt awake et alert. VSS. lungs CTA, abd c midline incision OTA, steri strips intact, Ⓝ S/Sx of infection noted. Colostomy bag to RUQ intact, draining loose brown stool. RLE c limited ROM Ⓟ pulse. LLE c full ROM Ⓟ pulse. BUE c full ROM Ⓟ pulses. Ⓝ IV access noted. Ⓝ C/O pain/discomfort voiced @ this time. Will cont to monitor, dressing to ↓ back area CDI. — [redacted] 9 WMC

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

b(a)-2 A-4

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 03 22:19	Rec'd c/o pt @ 21:00. VS WNL x temp ↑ 100.8. Awake and alert in bed. Restraints x2 (L) wrist/ankle. Skin w/ DTI PERI-LAB WNL. LCA (+). HRRS, S2. BS (+) x4. ABD soft + non-tender. Colostomy LUQ intact c (+) flatus (+) liquid brown stool. Stoma beefy red in color and firm. ML ABD incision well approx c steri-strips intact. c/o pain @ this time (-) PRN (+). Will cont to mon. ii Tylenol given for ↑ temp. [redacted] RT/AN
14 Aug 03 2230	Pt temp 100.5 @ 2230 — Sgt [redacted]
14 Aug 03	1210 - pt alert & oriented lying in bed VSS, lungs CTA, HR reg, BS (+), pulses (+) x4. Colostomy bag s/d. Stoma beefy red. Midline incision c steri strips intact — (-) s/s of infx. (-) complaints of pain at this time. Will cont to monitor [redacted]
15 Aug 03 1330	Pt awake & alert. VSS. lungs CTA, abd soft, colostomy bag LUQ intact draining brown semi-formed stool @ this time, midline incision c steri strips (-) s/s of infection noted, BS (+) x4. RLE BLE c (+) pulses. BUE c (+) pulses. (-) complaints voiced. Will cont to monitor [redacted] q/wnm

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. ~~VA/DD~~ NO. ECWC

EPW [redacted] b(a)-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

MEDCOM - 15981

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03	Rec'd c/o pt @ 21:00. Pt. motioning for me and holding gauze
21:50	to ABD. ML ABD incision c pinhole dehiscence noted. Beige, milky opaque, watery drainage pouring from wound. Dr. [redacted] notified, and ~~assessed~~ assessed. Packed c iodoform gauze and applied DSD. @ new orders written. per Dr [redacted] will notify surg. MD. ↑ temp 100.6 ÷ Tylenol given. Restraints x1 (Dankle. PERLA Pwr. ICA (+) HRRS, S2. BS (+) x4. ML ABD inc. see above statement. Colostomy bag intact draining liquid brown stool. Stoma beefy red in color PWD (+) PPB. @ further c/o's. will cont to mon. [redacted] RT/AN
20:00	Held MOM d/t colostomy draining very soft stool. Moderate amt [redacted] RT/AN
00:38	Pt. taught via demonstration to empty colostomy bag. Pt performed emptying bag c some assistance ∫ difficulty. [redacted] RT/AN
0248.	Pt ↓ temp 97.8. DSG to ML ABD incision saturated c serosang. drainage & ~~colored~~ error odor noted. Reinforced c DSD. will mon. [redacted] RT/AN
16 Aug 03	1000- Pt Alert & oriented lying in bed. Colostomy intact. Dsg applied to abd wound. VSS, lungs CTA, HR reg, BS (+) x4, pulses (+) x4. Voicing @ Complaints. Will cont to monitor - [redacted]
16 Aug 03	Assumed pt care @ 1300. Pt Awake & Alert. VSS. lungs
1500	CTA, abd c midline incision covered by 4x4 gauzes, drang c/d/I. colostomy bag to RUQ intact, leaking around edges, taped sides until another colostomy bag can be located. ↓ et ↑ ext c (+) pulses. 1430: PT c pt. pt ↑ ambulating in the asile. pt tol well. drang to abd N/d, site c/d/I c active drainage noted. BS (+) x4 quads.

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STANDARD FORM 600 (REV. 6-97) BACK

b(6)-2
All

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
cont'd 16 Aug 1520	① complaints voiced Will cont to monitor [redacted] 9/WM6
2040	abd dsng c mod amt of reddish brown drainage dsng. drainage dsng d/d. Iodoform to 1st pin hole site d/d, site oozing reddish brown drainage hole approx 1" in depth, 2nd pin hole site ① drainage noted. covered sites c 4x4 gauze et secured c silk tape. pt tol well. [redacted] 9/WM6
16 Aug 03 21:49	Rec'd c/o pt @ 21:00. Restraints x 2 ⓓ wrist/Ankle. VS WNL per flowsheet x 1 temp 100.5. II Tylenol given. Skin warm to touch. PERRLA WNL LCAB. BS ⊕ x 4 ML ABD dsg CD/I Colostomy RUQ intact. Stoma beefy red in color. Error [redacted] ~~steel~~ scant amt brown stool noted in colostomy bag. ⊕ PPB. ø c/o pain @ this time. Will cont. to mon. [redacted] 2ND/AN
0335	Pt c/o pain in ⓛ leg II Tylenol given. Colostomy Duoderm adhesive adhering to pt. skin Stool noted under adhesive Error [redacted] and in ward. Bag removed. Stoma care performed. ~~to ⓡ of~~ ② side of stoma necrotic tissue noted. Tissue beneath necrotic tissue, pale pink in color. Several ulcerated spots noted c cleaning stool adhered to stoma. scant amt. bleeding noted. ML ABD dsg. Removed wand packing removed. Iodoform packing replaced. Medial and distal incision pinhole dehiscence noted.

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. ICW2

[redacted]

EPW

b(6)-4

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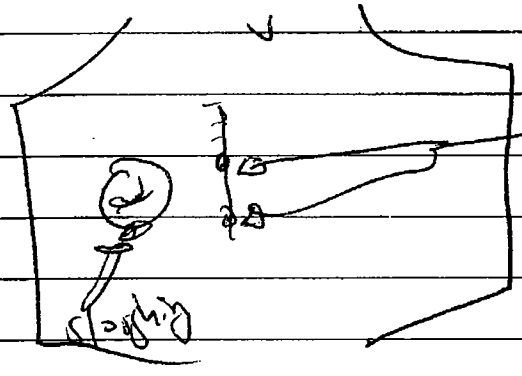
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 15983

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	DSD applied to ML ABD incision C/D/I. Dr [redacted] aware of stoma status and ML ABD incision status. Will mon. [redacted] b(6)-2
17Aug03 0630	Pt awake & alert in bed & complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sands (+) x 4 quads. Colostomy draining soft brown stool, colostomy bag intact, stoma moist & pink. DSG to mid abdominal vertical incision & to mid lower back CDI. All other assessment findings WNL. Will continue to monitor. [redacted] b(6)-2
17AUG03 @1122	Surgery f/u #12 early well, stoma working But wound & drng. Abx.  2 draining areas purulent fusch tissue (looks ok) plan OR for small wound washout / packing. [redacted] b(6)-2

b(a)-2 A11

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03 1337	Pt resting, quietly aroused to verbal stimuli. VSS temp 99.7. Pt is NPO. lungs CTA, abd c midline incision, dressing CDI. Colostomy bag to RUQ intact draining brown semi formed stool. ↓ext ↑ ext c full ROM (+) pulses. abd c BS (+) x4 quads. Dsing to back CDI. c/o complaints voiced. will cont to monitor. Pt is O/C for surgery. [redacted] RN/MC
17 Aug 03 21:53	Reid dopt @ 21:00. Restraints x2 (L) ankle/wrist. Awake and alert in bed. VS wnl. per flow sheet ↑ temp ↑ 100.5. ↑↑ Tylenol given. Will retake temp. in 1°. PERRLA (+) WNL. Skin W/D/I. LCA (+) HRRS, S1, S2. BS (+) x4. Colostomy RUQ intact. Stoma beefy red in color. Pale pink tissue to right and left of stoma noted. @ the distal (L) edge of stoma necrotic tissue remains. Superior (L) of stoma pea-sized ulcer noted and (L) to the ulcer sm. blister noted. a/o pain. M2 NPO dsg C/D/I. will cont. to mon. [redacted] RN/MC
0100	Temp 99.2° (+) Results from Tylenol [redacted] RN/MC
0300	per pt. request colostomy emptied by pt c difficulty some assistance required. Soft & formed lt. brown stool moderate amt noted. Bag cleaned. Will cont to mon [redacted] RN/MC
Addendum	MOM 30cc PO held d/t status of stool [redacted] RN/MC

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. BCWR

b(a)-4 [redacted] EPW

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

MEDCOM - 15985

b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18AUG03 0740	OP Note Wound I+D Surgeon: [redacted] ~~MAC~~ /local anesthesia EBL: ø Findings: Wound opened. Tiny facial dehiscence @ center of wound but everything else felt solid. Despite the small dehiscence, that it is 13 days out from his surgery, everything is tightly sealed in. He is at slight risk for evisceration but more harm than good would be done to try to fix the facial defect now. [redacted]
18Aug03	1230- Pt received from FST via stretcher. Dsg applied to abd incision, ø drainage noted. Colostomy intact. NS @ KVO into (D) arm. On regular diet now. Voiding ø complaints, VSS (Temp CTA, HR reg, BSø, pulses ø x4. Will Case to monitor [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

1st FST

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE

NOTES

18 MAR 03
0740

OP Note b(6)-2 A11

Ward 7D

EPW S/P GSW to back/ASD, treated at Iraqi Hospital = (A) Paramedian incision + colostomy, wound infection on Day #11 - #21)

Surgeon: [redacted]

MAC: [redacted]

EBL: 0

Findings: Small fascial dehiscence but rectus are well together otherwise wound clean + packed

Plan
- Return to 28th CSH
- Dressing D's.

[redacted] MAJ

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. ICW2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 A11

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18Aug03 2040	assumed care @1300-VSS-SL in (L) AC removed as pt. tol. regular diet- lungs CTA (B) - BS x2 quads, minimal output in colostomy bag-abd dsg Δ w→D, small amount of bleeding in wound bed, old dsg c moderate amount of serosang drainage - NO QS - percocet TI q4° x24°, no c/o pain @ this time [redacted]
8-1903 0033	Pt. care assumed @ 2100. VSS. HR Reg lungs CTA BS(+) x4. ML ABD Dsng CDI. Colostomy c min output of soft semi-formed brown stool. Pt c/o ∅ pain. ∅IV access. Will cont. to monitor [redacted]
19 Aug 03	0630-pt alert + oriented lying in bed. VSS, lungs CTA, HR reg, BS(+), pulses ⊕ x4. Dsg to midline incision to abd. Colostomy intact. Voicing ∅ complaints at this time. Will cont to monitor [redacted]
	0800- Dsg d/d to abd wound, wet → dry applied, loosely packed. Crave TI percocet for pain [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. ECW

EQW [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

MEDCOM - 15988

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 1345	pt care assumed @ 1300. VSS. pt awake & alert. lungs CTA, abd c midline incision draing c mod amt of serosang drainage noted. colostomy bag to RUQ intact draining brown semi-formed stool. BS+. pulses +2x4/4 IV access noted. denies c/o pain voiced @ this time. will cont to monitor [redacted] Alwmk
19 Aug	Progress notes D(6)-2 A11 VSS/AFEBS Tolerating PO Ostomy Functioning Pouch Cont hd Dressings Dsg [redacted]
19 Aug 03 1930	Dsing to abd Aid. Site c beefy red, sm amount of oozing red blood noted. denies s/s of infection noted. wound gently packed c gauze wet to dry covered by abd pad. pt to draing. A well- [redacted] Alwmk
19 Aug 03 2345	Recd c/o pt. ~~pain~~ @ 21:00. Restraints x2 D/wrist/ankle. Awake and alert in bed. Skin WDI. LCTA HRRSSa2 BS+x4 ABD soft to palpation. MI ABD dsg intact c serosang and greenish colored drainage noted. ABD pad removed and new ABD applied. Colostomy RUQ intact edges loose + not adhering to skin, reinforced c tape. Stoma beefy red in color. Inferior ~~to~~ section of stoma pale in color. MDs aware. Colostomy draining liquid brown stool. MOM held. +Pedal Pulse. denies pain x1 IPercoset given. VS WNL

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STANDARD FORM 600 (REV. 6-97) BACK

b(e)-2 A11

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	X temp ↑100.8 ii Tylenol given. Retook temp @ approx. 00:00 temp remained @ 100.8. Will cont. to mon [redacted] PD/AD
20 Aug	0900 - Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS@, pulses@ x4. Celostomy bag ΔD, Stoma beefy red. Dsg ΔD to midline abd incision. Voicing ∅ complaints. Will cont to [redacted]
20 Aug 03 1415	Pt awake & alert awaiting transportation to be EVAC. lungs CTA, abd c midline dsg. CDI. colostomy bag to RUQ intact, ⊖ drainage noted @ this time. ↓ & ↑ ext c/ from ⊕ pulses. ⊖ IV access noted. ⊖ c/o pain voiced. Will cont to monitor [redacted] 91 WMD
20 Aug 03 01:59	Rec'd c/o pt @ 01:00. Restraints x2 ⊕ wrist/ankle. VS WNL X ↑ temp 101.5°. ii Tylenol given. Will retake temp throughout shift. Awake and alert in bed. Skin W/D/I. X mL ABD inc. DSG C/D/I. ⊕ L Back. old dsg removed. Green-yellow drainage noted. Ward pink around edges and white in center. cleansed c NSS and new DSD applied and secured c silk tape. RPL HOWR. LCAB HRRSSx. ABD ⊕ BS x4. Colostomy

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. ICU

EPW [redacted]

b(a)-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

MEDCOM - 15990

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	intact. Stoma unchanged. Beefy red in color. ⊕ PP ⊕. Will
	cont. to mon [redacted]
0005	- temp 99. [redacted]
21 Aug 03	assumed care @ 0500 - VSS - no c/o pain @
1330	this time - pt. emptied colostomy bag, liquid
	dk. brown stool - ambulated x 10 minutes -
	abd. dsg Δ'd, w→D, wound bed c some
	granulation tissue, some yellow/green drainage
	on old dressing none noted in wound bed -
	NO QS - ⊕ BS, hypoactive - pt. awaiting
	transport to 21st CSH — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
AUG 26 2003	25 y/o male PJ arrived to Cropper w/ colostomy bag ripped out and wound exposed. Above note Laparotomy wound. Healing bed with healthy granulation Colostomy - sutures still in place. Appears infected Send to CSH for Surgery evaluation (A) Infected colostomy site (P) Refer to CSH Surgery for evaluation - Routine Ambulatory Dr. [redacted] Maj b(6)-2 CoB 109th ASMB

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

EPW

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

CoB 109th ASMB
BIAP IRAQ

MEDCOM - 15992

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Chief Complaint

BP: 103/58
P: 85
R: 15
T: 98.2
3PO2

LHP: PMH: PSH:
Allergies: Meds: Tob:
S: 25yo EPW here for referral "infected Colostomy.

O. 25yo Iraqi, male. Colostomy RLQ - Stoma intact, ∅ signs of infection, patent - ∅ stool formed brown. Skin around stoma intact. Abd incision open, about ½" deep, appx 3" long - minimal amount of thick beige drainage.

A. Open abd wound
Colostomy

P① New colostomy bag
② Wet to dry dressing to abd wound.
③ Colostomy cleansed with soap & warm water b(6)-2 [redacted]
④ RE EPW camp
⑤ RTC PRN

[redacted]
FAMILY NURSE PRACTITIONER
426-98-7439

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.

Name: EPW, [redacted] Age: 25 Rank: EPW
SSN: [redacted] b(6)-2
Init:
DOB:

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
	0400	~~0700~~
Output	400	
HR	88	76
RR	24	16
Sats	100	96%
BP	131/72	136/~~88~~
Temp	99.7	95.6

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.)*

[redacted] b(6)-4

[redacted] 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

MEDCOM - 15994

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
25	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: 0

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?			WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: Abd pain / wound (Colostomy)

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1240

INITIALS: [redacted] bb2

VITAL SIGNS

TIME	1240					
BP	110/70					
PULSE	88					
RESP	18					
TEMP	98.4					
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted] b(4)-4

#[redacted] — [redacted] b(2)-2

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 15995

558-104

b(2)-2

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER TR [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS Fragi -

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 06/08/03 | TIME 1740

TRANSPORTATION TO FACILITY Medevac

SEX M

AGE 24

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

MILITARY STATUS			
ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS ~~Add~~ denies

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME 1740

INITIALS [redacted]

b(2)-2

VITAL SIGNS

TIME	1740	1800	1825			
BP	113/69	116/71	115/78			
PULSE	122	111 ST	105 ST			
RESP	97.7	18	16			
TEMP						
WT	98.7		96.7			

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(a)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL Iraqi shot yesterday - GSW to abd treated in Iraqi hospital Polychanged UOP 500cc - cystostomy performed. NG tube in place. IV infiltrated [redacted] b(a)-2 AAOF3. HRRR. Lungs CTA (3). Abd soft + tender hypoactive BS

CONSULT WITH	TIME	ACTION

DIAGNOSIS

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

CODES

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

[redacted] b(a)-2

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

b(2)-2

ES-104 7540-01-075-3

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

OG NUMBER [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS [redacted] b(6)-4

CITY | STATE | ZIP CODE

SEX: M

AGE: 21

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

ARRIVAL

DATE (Day, Month, Year): 18 AUG 03 | TIME: 0658

TRANSPORTATION TO FACILITY: LITER CARRY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: NONE

ALLERGIES: NONE

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: I&D ABDOMINAL WOUND

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NON-URGENT

TIME: 0658

INITIALS: b(6) [redacted]

VITAL SIGNS

TIME	0658				
BP	108/65				
PULSE	89				
RESP	16				
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

MEDCOM - 15998

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: Surgery - CSA | FROM: (Requesting physician or activity) Dr. [redacted] CoB 109th ASMB BIAP. | DATE OF REQUEST 26 Aug 03

REASON FOR REQUEST (Complaints and findings)

Infected ileostomy site

PROVISIONAL DIAGNOSIS

Abscess

DOCTOR'S SIGNATURE [redacted] b(6)-2 | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

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

b(2)-2

SPN - [redacted]

b(6)-4

[redacted]

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDICAL RECORD — INTRAOPERA[illegible] 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, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN b(6)-2

3. DATE: 18AUG03 TIME PATIENT ARRIVED IN SUITE: 0655

4. PATIENT [illegible] TIME 0711 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 66-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

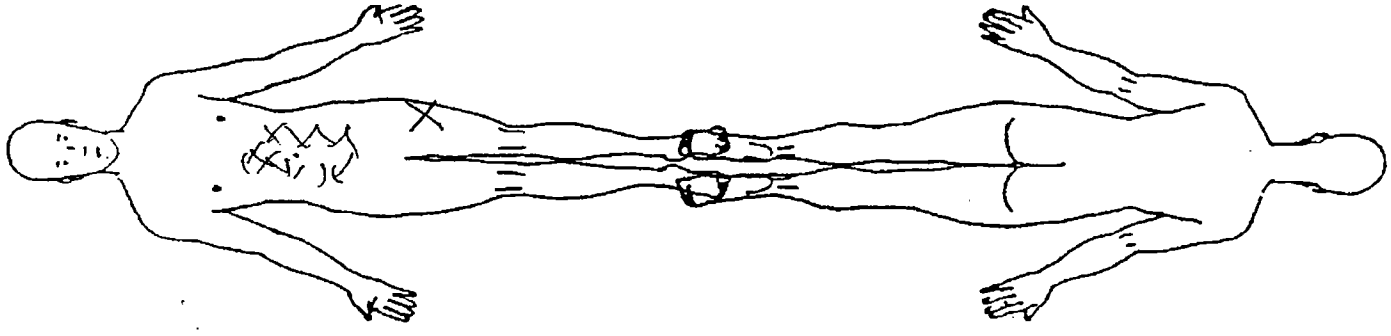
COMMENTS: Proper body alignment maintained, padded arm boards

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine Soln
SITE: Abd. BY WHOM: [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: No pooling of fluids

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					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] b(6)-4

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

☒ ESU NO: #2 30/30
GROUND PAD: BRAND Conmed
LOT NO: 0109221

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 16000 HICH 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 50/50	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine / .5% Marcaine	6cc				[redacted]
					b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

4X4's
4X8s
Tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION

Surgeon: [redacted] b6-2

Anesth: [redacted]

Colostomy on arrival

Sedation/local

20. OPERATION(S) PERFORMED

I & D abd. wound

21. PATIENT TRANSFERRED TO [redacted] b(2)-2 TIME 0740 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/N-1 b(6)-2

REVERSE OF DA FORM 5[illegible] OCT 87 USAPA V1.01

MEDCOM - 16001

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 8 Aug | DAY

19 | HOUR: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04

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: 18 20 20 19 14 — 18 — 24 — 23 — 13

BLOOD PRESSURE

99.4 — 100.3

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16002

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 19 | 20 | 21 | 22 | 23 | 24 | 25

HOUR

PULSE (O) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

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. ICW 2

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

ICW [redacted] b(4)-4

MEDCOM - 16003

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 67 DAY

2007 10 HOUR

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

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

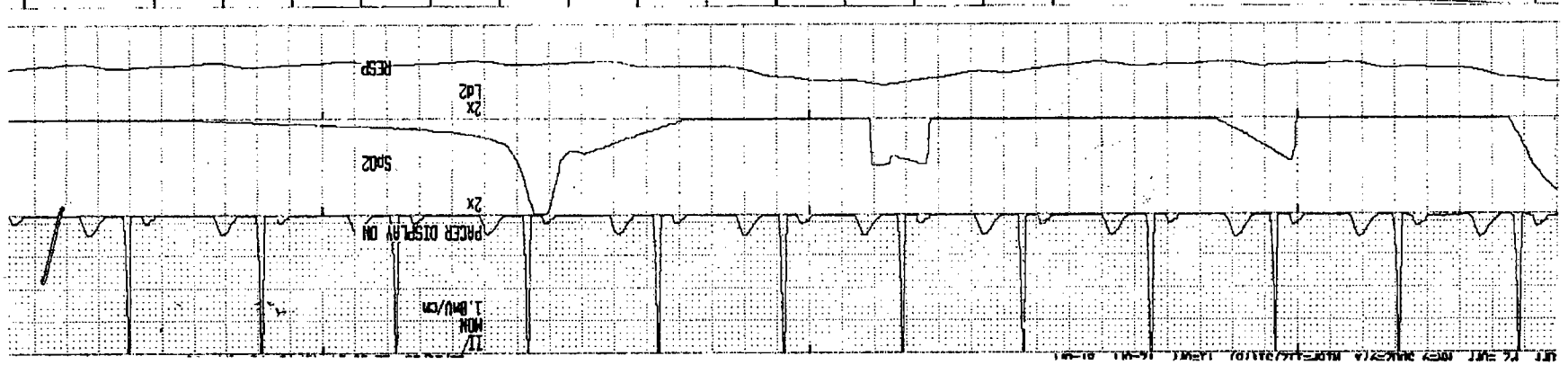
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 16004

Date: 12Aug03 Bed#: 1

Patients Name: [redacted] b(a)-4

Time	05	06	07	08	09	10 4Ø	11	12	13	14	15	16	17 5Ø	18	19	20	21	22	23	24	04
BP			136/78				144/80				144/82					132/70				125/68	128/66
TEMP			95.6				97.2				97.8					99.1				99.2	99.4
HR			76				77				78					72				70	75
RR			16				16				18					12				14	14
SAO2			96%				97				99									96	96
FIO2			RA				RA				RA					KIA				RA	RA
INPUT																					
PO																					
IV																					
NGT																					
TOTAL																					
OUTPUT																					
URINE		350			175	300		1100			2000		75	250					250	200	325
NGT																					
STOOL																					



Date: 11 Aug 09 Bed#: 1

Patients Name: [redacted] b(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP		118/56				122/70				117/68				138/86				122/58		
TEMP		99.6				99				99.4								99.6		
HR		90				88				90				79				92		
RR		16				20				22				20				20		
SAO2		100				100				100				99				99		
FIO2		RA				RA				RA				RA				RA		
INPUT																				
PO			240	240				180	240			240				240		240		
IV		50		50						50										
NGT	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
TOTAL																				
OUTPUT																				
URINE				625				250								450		250	550	
NGT																				
STOOL				X1																
TOTAL																				
BALANCE																				
TURN Q 2																				

Time																								
BP	142/70					140/78																		
TEMP	100				100.1	99.4										99.8		100.4						
HR	88					90																		
RR	20					18																		
SAO2	98%					97																		
FIO2	RA					RA																		
INPUT	180																							
PO						0	0	100	240	0	240	0	0	0	240									
IV	100					0	0	100	0	0	0	0	0	0	100									
NGT						0	0	0	0	0	0	0	0	0	0									
TURN Q 2						self									cadic	self								
TOTAL	280					0	0	200	+340	+440	+680	+680	+680	+680	1020									
OUTPUT																								
URINE	200			175		0	0	100	350	0	100	0	0	400	200									
NGT						0	0	0	0	0	0	0	0	350	0									
STOOL						0	0	0	0	0	0	100	0	0	0									
subtotal	200			175		0	0	100																
TOTAL	200			375		0	0	-100	-450	-450	-550	-650	-650	-1050	-1250									
BALANCE						0	0	+100	-10	-10	+130	+30	+30	-370	-230									

[redacted]

10 Aug

b(6) - 2

MEDCOM - 16007

DOD-029396

ACLU-RDI 1634 p.167

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
		113/59										115/62								
BP																	138/58			
TEMP		97.4				98.6					100.9	99.1			101		101			
HR		87										90					84			
RR		23										18					20			
SAO2		97										97					94			
FIO2		RA										RA					RA			
INPUT																				
PO	Ø	Ø	240	Ø	240	300	Ø	Ø	240	Ø	Ø	240		220						
IV	75	100	Ø	100	Ø	Ø	Ø	100	Ø	Ø	Ø	100		100					100	100
NGT																				
TURN Q 2	Self					OOBTC	Self	Self	Self	Self										
Hourly	75	100	240	100	240	300	Ø	Ø	240	Ø	Ø	340		320					100	
TOTAL	75	175	415	515	755	1055	1055	1055	1295	1295	1295	1635		2105					2205	2305
OUTPUT																				
URINE	Ø	Ø	300	Ø	100	300	Ø	Ø	100	300	Ø	150		200	200		200		200	
NGT																				
STOOL	Ø	Ø	Ø	Ø	100	Ø	Ø	Ø	Ø	Ø	Ø	100								
Hourly	0	0	300	0	200	300	Ø	0	100	300	0	250		200	200		200		200	
TOTAL	0	0	300	300	500	800	800	800	900	1200	1200	1450		1650	1850		2050		2250	
Hourly ±	+75	+100	-60	+100	+40	0	0	+100	+140	-300	0	+90								
BALANCE	+75	+175	+115	+215	+255	+255	+255	+355	+495	+195	+195	+285								

[redacted] b(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP																				
TEMP																				
HR																				
RR																				
SAO2																				
FIO2																				
PN level			(+)																	
MED effects			mod																	
INPUT					(+)															
PO	ø	ø	240	ø																
IV	125	125	125	125																
NGT																				
TURN Q 2																				
TOTAL	—	—	—	1740																
OUTPUT																				
URINE	ø	ø	ø	200																
NGT																				
STOOL	X1																			
TOTAL			200																	
BALANCE																				

Date: 8 Aug 03 Bed#: 1

Patients Name: [redacted] 1600-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP																				
TEMP																				
HR																				
RR																				
SAO2																				
FIO2																				
INPUT																				
PO	NPO																			
IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	240 125	240 125	125	125	125
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	D/C'd												
														100				100		200
Hourly	125	125	125	125	125	125	125	125	125	125	125	125								
TOTAL	125	250	375	500	625	750	875	1000	1125	1250	1375	1500				2340				3380
OUTPUT																				
URINE						280			150	0		100			200			200		600
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	D/C'd	Ø											
STOOL	Ø	Ø	120	Ø	Ø	Ø	Ø	Ø	150	0	0	25								
Foley			300	D/C'd																
Hourly	Ø	Ø	480	0	0	280	0	Ø	300	0	0	125								
TOTAL	Ø	Ø	420	480	420	700	Ø	Ø	1000	1000	1000	1125			1325			1325		1625
BALANCE	125	+~~250~~	-375	+~~50~~	+250	+95	220	+345	+160	+850	+375	+375								+~~1755~~
hourly	+125	+~~125~~	-375	+~~125~~	+125	-155	+125	+125	-185	0	+125	±0								
TURN Q 2	Supine	"	"	"	"	"	"	"	"	"	"	"								

7
3380
1625
1755

Date: 04AUG03 Bed#: 1

Patients Name: EPW [redacted] b(6)-4

Time	1930 05	2000 06	2100 07	2200 08	2300 09	2400 10	01 11	02 12	03 13	04 14	05 15	16	17	18	19	20	21	22	23	24
BP	128/78	122/74	114/70	120/78	120/80	114/76	115/75	115/74	120/72	110/71										
TEMP	99.4									98.8										
HR	110	100	98	101	103	102	99	104	97	101										
RR	21	19	18	18	18	17	17	16	16	17										
SAO2	98	98	99	98	99	99	98	98	98	98										
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA										
INPUT																				
PO	NPO	—	—	—	—	—	—	—	—	—										
IV	150	150	150		150	150		150	150	150										
NGT																				
IVPB				100		100	100													
TOTAL	150	300	450	550	700	850	900	1050	1200	1350										
OUTPUT																				
URINE		100	20	30	30	30	40	40	40	30										
NGT	50																			
STOOL	0																			
JP	225	—	—	—	—	—	—	20												
TOTAL	275	375	395	425	455	485	525	585	625	655										
BALANCE																				
TURN Q 2																				

Date: 07 Aug 03 Bed#: 1

Patients Name: J EPW#: [redacted]

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03
BP	111/68	113/65	108/63	108/61	110/60	107/61	103/59	111/59	109/59	114/64	116/62	122/69	111/57	109/55	107/60	122/67	117/69	111/60	115/61	112/55	117/55	122/64	
TEMP		98.6														102.°	101.8	101.4				101.5	
HR	99	98	96	95	92	91	93	92	101	118	116	119	119	104	113	117	115	95	95	94	93	102	
RR	15	15	14	19	14	16	15	15	17	24	23	26	23	19	23	24	21	20	17	18	18	20	
SAO2	97	98	98	98	98	98	98	98	97	95	96	96	97	96	98	97	95	96	95	95	96	98	
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
INPUT																							
PO																							
IV	150	150	150	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	12
NGT																							
IVPB		100		100				100				100		100				100		100	100		
1Dec/1cc			3	60																			
Subtotal	150	250	150	285	125	125	125	225	125	125	125	225	125	225	125	125	125	225	125	225	225	125	12
TOTAL	150	400	550	835	960	1085	1210	1435	1560	1685	1810	2035	2160	2385	2510	2635	2760	2985	3110	3345	3570	3695	3
OUTPUT																							
URINE	60	60	100	90	90	90	90	70	70	50	50	90	70	100	100	100	75	75	75	100	50	50	1
NGT			60									<50cc								10			
STOOL																							
Subtotal	60	60	160	90	90	90	90	70	70	50	50	90	70	100	100	100	75	75	75	110	50	50	1
TOTAL	60	120	280	370	460	550	640	710	780	830	880	950	1020	1080	1180	1280	1355	1430	1505	1615	1665	1715	1
BALANCE																							
TURN Q 2																							

output 0400 – 100 cc – (1915) out

intake 125 cc – (3945) in

13 AUG 03 [redacted] bed 1

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV																								
BP NIBP			113/66																					
TEMP			99																					
HR			76																					
RR			13																					
SP02			97																					
FIO2			RA																					
INPUT																								
PO																								
IV																								
NGT																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE		350																						
NGT																								
STOOL																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 16013

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 7Aug03	TIME: 1330
		SSN/PSEUDO SSN: [redacted] b(6)-2

(Hematology) CBC

	TEST	RESULT	REF. RANGE
	WBC	4.2	x10^3/uL 4.5 10.5
	RBC	3.28 L	x10^6/uL 4.00 6.00
	Hgb	8.5 L	g/dL 11.0 18.0
	Hct	25.6 L	% 35.0 60.0
	MCV	87.2	fL 80.0 99.9
	MCH	25.9 L	pg 27.0 31.0
	MCHC	29.7 L	g/dL 33.0 37.0
	Plt	138. L	x10^3/uL 150. 450.
	LY%	12.3 *L	% 20.5 51.1
	#LY#	0.8 *L	x10^3/uL 1.2 3.4

ID: [redacted] b64
DOB: [redacted] 07-08-03 13:46

	Lymph		
	Atyp		Imm
	RBC Morph		

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 7Aug03	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 6 Aug	TIME 1750	SSN/P[redacted]N:

(Hematology) CBC

66-2

ID: [redacted]
06-08-03
18:09

				Patient Limits
WBC	12.0 *H	x10^3/uL		4.5 10.5
RBC	4.64	x10^6/uL		4.00 6.00
Hgb	11.9	g/dL		11.0 18.0
Hct	40.6	%		35.0 60.0
MCV	87.6	fL		80.0 99.9
MCH	25.7 L	pg		27.0 31.0
MCHC	29.3 L	g/dL		33.0 37.0
Plt	176.	x10^3/uL		150. 450.
LYM	10.2 *L	%		20.5 51.1
LYM	1.2 *	x10^3/uL		1.2 3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Amber	N/A
App	Hazy	N/A
Glu	1+	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	Large	Negative
pH	6.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA - 14 1-5 EPI
cl. mucus - 1%
40-50 RBC

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 6 Aug 03	LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: EM | REQU[redacted]AN: | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | ATE: 6 Aug | TIME: | SSN/P[redacted]DO SSN: [redacted]

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TE*		
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		
K		3.5-4.9 mmol/L				BUN		
Cl		98-109 mmol/L				CA+		
pH		7.31-7.45				CRE		
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)				NA+		
PO2		80-105 mmHg (art) N/A (ven)				K+		
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)				CL-		
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)				CO2		
sO2		95-98%						
BEecf		(-2) – (+3) mmol/L				TES		
AnGap		10-20 mmol/L				ALB		
Ca		1.12-1.32 mmol/L				ALP		
BUN		8-26 mg/dl				ALT		
GLU		70-105 mg/dl				AMY		
Creat		0.7-1.5 mg/dl				AST		
Hct		38-51% PCV				TBIL		
Hgb		12-17 g/dl				GGT		
						TP		

Misc. Chemistry		
TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

b(6)-4

PICCOLO

06/08/03 17:54

REFERENCE RANGE: MALE

PATIENT #: [redacted]

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER #: 678 DR #: 000

SERIAL #: 0000100684

ALB	2.9*	3.3 5.5	G/DL
ALP	41	26-84	U/L
ALT	89*	10-47	U/L
AMY	13*	14-97	U/L
AST	141*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
BUN	13	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	109	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	117	73-118	MG/DL
TP	5.6*	6.4-8.1	G/DL

INST QC: OK CHEM QC. OK

HEM 2+, LIP 0 , ICT 0

i-STAT EC8+

Pt [redacted] 66-4

Pt Name:_____

Glu_____117 mg/dL

BUN_____19 mg/dL

Na_____137 mmol/L

K_____4.4 mmol/L

Cl_____108 mmol/L

TCO2_____27 mmol/L

AnGap_____7 mmol/L

Hct_____39 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.418

PCO2_____40.6 mmHg

HCO3_____26 mmol/L

BEecf_____2 mmol/L

Sample Type_:

06AUG03 17:52

Oper: [redacted] 66-2

Physician:_____

Ser# 40763

Ver: JAM5046A
CLEW A93

REMARKS:

REPORTED BY: [redacted]	**DATE:** 6 Aug 03	**LAB ID NO.:**

b(6)-2

b(6)-2

Ward/Section: ICU 2	REQUES[redacted]CIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 7Aug03	TIME 1330	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

		REF. RANGE
		0³
		0⁹
		(M) (F)
		M) F)
		M) F)
		10³
		1%
		rential

ID: [redacted] 66-4
MB 07-08-03 13:46

			Patient Limits	
WBC	6.2	x10^3/uL	4.5	10.5
RBC	3.28 L	x10^6/uL	4.00	6.00
Hgb	8.5 L	g/dL	11.0	18.0
Hct	28.6 L	%	35.0	60.0
MCV	87.2	fL	80.0	99.9
MCH	25.9 L	pg	27.0	31.0
MCHC	29.7 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LY%	12.3 L	%	20.5	51.1
LY#	0.8 L	x10^3/uL	1.2	3.4

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 7Aug03 **LAB ID NO.:**

b(6)-2

66-2

MEDICAL RECORD — ANESTHESIA

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

Vec [redacted]
Fent [redacted]
( )
( )
% (de)
% e.t.
AIR L/Min
N2O L/Min
O2 L/Min

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

LINE site [redacted] Warmed
Warmed
Warmed
Warmed

LOSSES: EST BLOOD LOSS
URINE –

VITAL STATUS 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

INITIAL DATA: BP 110 / 72 HR– 81

SKIN CHECK: OK? (Y) N

PATIENT IDENTIFICATION: OK for PROCEDURE ✓ TIME– 0630

TIME → 0515 30 0[illegible]

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml
f – breaths/min
Peak inf pres / PEEP
MODE– S(pont), A(assist), C(on) 5V 5V 5V 5V

✓ BP/Auto Cuff	ET-CO2 (torr)
BP / oth	✓ FIO2 (Frac or %) 1.0
ART line	SpO2 (%)
Steth– PC/ES	ECG 5N 5N 5N 5N
Gas analyzer	TEMP– site
	N-M Block (T/4)
Warming bkt	
Conv warmer	

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

TOTALS: 540 | 250-1000 | 1 | 1214

CRYSTALLOID– 1200
COLLOID– 0
BLOOD– 0

REMARKS: Code drugs with numbers, events with letters
(1) Induction on
(2) To ICU

RECOVERY AT: PACU ICU ✓ (Specify)
OTHER
CONDITION:
RESP– 10 SpO2– 97
BP– 108/57 HR– 76

	Start	Room	End
ANES	0620	0650	0740
PROC	Ready	Begin	End
	0655	0700	0735

PROCEDURES and CPT Codes: I+D Abd Abscess

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 100% NRB MASK

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

[redacted] b(6)-2

[redacted] b(6)-4

PROCEDURE LOCATION: FST
DATE: 18 AUG 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WRAMC OVERPRINT 558
1 OCT 99

MEDCOM - 16018
PATIENT RECORD

b(6)-4

b(6)-2

CLINICAL RECORD · DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

06 AUG 03

Admit to ICU 12
NPO
NGT to LCS
Strict I+O.
LR @ 150 cc/h
Foley to BSD.
Drain in RLQ to BSD

Noted [redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

- empty stat
Ten empty sterile Technique q6h.
Ampicillin 2g IV q6h
Gentamicin 240mg IV qD
Flagyl 500mg IV q8h
Morphine 4mg IV q2h PRN
Tylenol 650mg PR q4h PRN

1935

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Replace NGT Losses
½ cc:cc with LR
q8h.

[redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

07 AUG 03 0723

IVF=) D5½NS +20mEq KCl/L @ 125cc/h
Replace NGT cc:cc q8h with Bolus IVF (D5½NS+20) [redacted]
Drain to be D/C'd by me today.

Noted [redacted]

038

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

☆ U.S. GC MEDCOM - 16019 1-710

b(6)-4

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

07 AUG 03 0841 HOURS

CBC @ Noon.

PSD to drsg site PRN

Aug 03 0850 [redacted]

[redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

28 AUG 03 0720 HOURS

1. D/C Suction and leave NGT to open drainage.
2. IV Lasix <100 q 4h
3. Remove NGT + OOB
4. Incentive Spirometer. Keep NPO

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

5. D/C Foley.

HOURS

08 AUG 03 1800

Clear liquids

Will tolerate well

+ voiding, d/c IVF @ 75 cc/hr

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Chart 0400 q 8h

09 AUG 03

Regular diet

IV Heplock.

b(6)-2
A11

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 09 AUG 03 TIME OF ORDER 1250 HOURS — LIST TIME ORDER NOTED AND SIGN

Transfer to ICU

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 10 AUG TIME OF ORDER 0115 HOURS

V.O.

Give Unasyn 3gm IV x1 now

Dr [redacted]

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

10 AUG 1730 NOTED

DATE OF ORDER 10 AUG 03 TIME OF ORDER 0900 HOURS

① D/C Amp. 2gm

② Start Ancef 1gm IV q8h and continue Gent/Flagyl.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.

10 AUG 1920 NOTED

DATE OF ORDER 10 Aug 03 TIME OF ORDER 1900 HOURS

① D/C Ancef

② Percocet #1 PO q 4° PRN pain

[redacted]

MEDCOM - 16021

b(6)-4 ↓ b(a)-2 ↓

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

11 AUG 03 (1500) HOURS

D/C Abx tomorrow. AM. [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

11 AUG 03 1615 HOURS

① AXR - 1 View AP. √ Done 1630

② MOM 30cc q6hrs 11 Aug [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

12 Aug 03 1550 HOURS

Consult Physical Therapy for ambulate (R) Leg weakness

24° chart √ 12 Aug [redacted]

PATIENT IDENTIFICATION

[redacted]

038

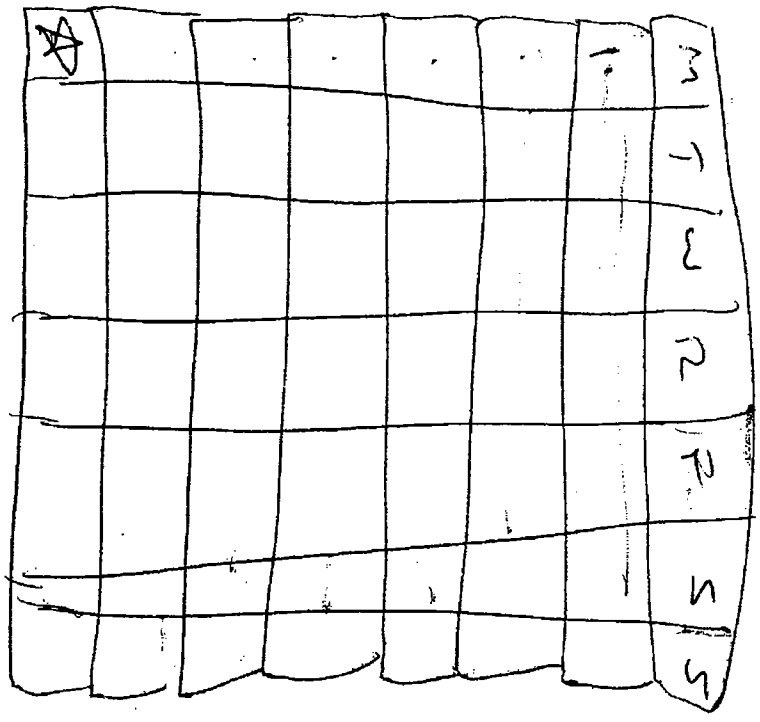
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

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

☆ U.S. GOV MEDCOM - 16022 710



b(6)-2 All

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT: ICU 2 | ROOM NO. | BED NO.

DATE OF ORDER: 13 AUG 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

V.O. from Dr [redacted]
to UT [redacted]

resume all pre-op orders.

[redacted] UT/RN

PATIENT IDENTIFICATION [redacted]

b(6)-4

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME O [redacted] HOURS

ICU orders.
VS Routine
Please D/C all sutures
Steri-strips PRN
Regular diet
ISC to any place

PATIENT IDENTIFICATION [redacted]

NURSING UNIT: ICU2 | ROOM NO. | BED NO. 24 V/dr [redacted]

DATE OF ORDER | TIME OF ORDER

Tylenol 650 mg po q4h PRN HOURS
Percocet #1 tab po q4h PRN
MOM 30 cc po q HS.
Physical Therapy for [redacted] ROM / [redacted]
D/C Heplock

[redacted] 14 Aug 03 0900

PATIENT IDENTIFICATION [redacted]

NURSING UNIT: ICU2 | ROOM NO. | BED NO. 84 V/dr [redacted]

TIME OF ORDER

17 AUG 03 1122 HOURS

NPO, To OR [redacted]
noted [redacted]
17 AUG 03 @ 1645
Regular diet
NPO after midnite
To OR tomorrow [redacted]
@ 1st FST.

[redacted]

038

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

b(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] EPW b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
TCW 2		

DATE OF ORDER 18 AUG 03 TIME OF ORDER 0740 HOURS

LIST TIME DRUGS NOTED AND SIGN

Postop
VS q 4h
Strict I+O
Reg Diet
IV: continue present IVF @ 150 c/h and heplock once tol. po.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Morphine 4mg IV q4h PRN
Percocet 1 tab q 4h start 0245
then PRN.

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68, the proponent agency is OTSG

b(6)-2

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

18 AUG 03 | 0740 HOURS

Postop
✓ VS q 4 hrs
✓ Regular diet
✓ T Oral 650mg tab q 4h PRN
Abdominal Wound Dressing changes BID

PATIENT IDENTIFICATION [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ Use saline moistened gauze + gently pack open wound, cover = DSD + change BID.
✓ Morphine 4mg IV q 4h PRN
✓ Stoma care PRN
✓ IV continue current fluid @ 150cc/h

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF

=) D/C once tole
✓ Percocet 1 tab po q 4h strict x 24h then go PRN.

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 VS

DATE OF | TIME OF ORDER

TAN 8-19-03 0037 HOURS

20 Aug 03

Transfer [redacted]

b(2)

Voided [redacted]

9 Nurse 20 Aug 03

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—403-924

"USE BALL POINT PEN, PRESS FIRMLY [illegible] PAPER REQUIRED"

MEDCOM - 16026

b(6)-2 +1

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

DA FORM 4239-R, OCT 78

ORDER DATE	CLERK NURSE	RECURRING ACTIONS FREQUENCY TIME	DATE COMPLETED
6 AUG	[redacted]	Diet: NPO	05 [redacted] → D/C & Aug 03
			17 [redacted]
6 AUG	[redacted]	NGT to LCS	05 [redacted] Add Aug 03
			17 [redacted]
6 AUG	[redacted]	Strict I & O's	05 [redacted] Copy forward 9 Aug
			17 [redacted]
6 AUG	[redacted]	Foley to BSD	05 [redacted] Add Aug 03
			17 [redacted]
6 AUG	[redacted]	Empty drain in	06
		RLQ to BSN	12 → rewritten below
		sterile technique	18
		q 6hr	20
6 AUG	[redacted]	empty drain in RLQ	02
		to BSD sterile	08 [redacted] Add Aug 03
		technique QL6°	14
			20
8 Aug	[redacted]	D/C suction and leave	05 [redacted] → D/C Aug 03
8 Aug	[redacted]	NGT to open drainage	17
8 Aug	[redacted]	If NGT drainage ≥100cc/4hr	05 [redacted] → D/C Aug 03
8 Aug	[redacted]	Remove NGT keep NPO	17
8 Aug	[redacted]	OOB	05 [redacted] → Copy forward to 9 Aug
8 Aug	[redacted]	Encourage ambulation	09 [redacted] → Copy 9 Aug
			17 forward
8 Aug	[redacted]	Diet: [illegible] (thrush)	05
8 Aug	[redacted]	Liberalize to soft, bridge → IV	17 [redacted] → D/C
		PLAX	

ALLERGIES: ___ YES ___ NO PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: X YES ___ NO

PAGE NO:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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 4239-R, OCT 78 EDITION OF DEC 77 IS OBSOLETE USAPA V1.00

MEDCOM - 16027

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Aug Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Aug	[redacted]	Admit to ICU #2			DONE	[redacted]
6Aug		Drain in RLQ to BSD	6Aug		1930	
		empty NOW				
7Aug		Drain to be D/C'd by MD today	7Aug		0830	
7Aug		CBC @ Noon	7Aug	0500	1500	
8Aug		D/C Foley	8Aug		0745	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
7Aug	[redacted]	Drsg Δ to Drain site PRN	0500 8/7	0600 8Aug	Copied Forward											

USAPA V1.00

b(6)-2 ALL

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 09	10	11	12	13	14
6 Aug	[redacted]	Strict I&O's	05	[redacted]					
			17						
8 Aug	[redacted]	OOB	05						
			17						
8 Aug	[redacted]	Incentive spirometer	05						
			17						
9 Aug	[redacted]	Regular diet	07						
			12						
			18						

ALLERGIES: ☐ YES ☐ NO — NKA

PRIMARY DIAGNOSIS: S/P GSW to Abd

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 02

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 16029

b(6)-2 A11

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
6 Aug	[redacted]	Admit to ICU #2				
9 Aug	[redacted]	Transfer to ICW				
12 Aug	[redacted]	Consult PT for ambulation (R) leg weakness				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
7 Aug 03	[redacted]	Disg A to drain	
		site PRN	

USAPA V1.00

b(6)-2 & 11

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

ORDER DATE	CLERK NURSE	RECURRING MEDICATIONS DOSE FREQUENCY	HR	DATE DISPENSED
6AUG	[redacted]	LR @ 150cc/hr	05	Adm 7Aug03 [redacted]
			12	
6AUG	[redacted]	Ampicillin 2gm IV	06	
		q 6h	12	
			18	DC'd DAC 03
			24	
	[redacted]			[redacted] DC'd 12Aug03
	[redacted]			
6AUG	[redacted]	Replace NGT losses	08	
		1/2cc: cc @ LR	16	Adm 7Aug03 [redacted]
		q 8 hr.	24	
7Aug03	[redacted]	D5 1/2 NS @ 20cc @ 125cc/hr	05	DC
			17	
7Aug	[redacted]	Replace NGT loss,	08	
		cc:cc @ base IVF	16	DC'd 8Aug03
			24	
8Aug	[redacted]	IVF @ to 75cc/hr when	05	DC'd 9Aug03 [redacted]
		tolerate PO & + BOP	17	
				[redacted] DC'd 12Aug03

ADDITIONAL PAGES IN USE — YES — NO — PAGE NO.

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIME

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	2
N	23	24	01	02	03	04	05	0

[redacted] b(6)-4

DA FORM 4078, 1 FEB 79 — EDITION OF [illegible] MAY BE USED UNTIL EXHAUSTED

MEDCOM - 16031

b(6)-2 A11

THERAPEUTIC DOCUMENTATION / CARE PLAN

SINGLE ORDER PRE OPERATIVES

Order Date	Clerk Nurse		Date to be Given	Time to be Given	Time Given	Initials
[redacted]						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED	
6Feb	[redacted]	Morphine 4mg IV q 2hr PRN	[redacted]	DC'D 192

MEDCOM - 16032

C[illegible] RECORD

THERA[illegible] EUTIC DOCUMENTATION CARE PLAN *(M[illegible] ATIONS)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon Gen[illegible]

Mo Aug Yr. 03

INITIAL PROPER COLU[illegible] *LOWING EACH ADMINISTRATION*

VERIF		RECURRING [illegible]EDICATIONS, DOSE, FREQUENCY	HR	[illegible]E DISPENSED										
ORD DA	RK/ SE			13	14	15	16	17	18	19	20	21	22	23
13Aug	[redacted]	IV HL	06	/	[redacted]			DC'd						
			13	/				14Aug 03						
			21	[redacted]										
11	[redacted]	MoM 30 cc PO, HS	21	[redacted]	Held	Held	Held	Held	Held	Held	Held			
18	[redacted]	IV NS @ 150 c/hr	05						/	[redacted]				
		then HL	17							X				
The Aug	[redacted]	Percocet TT Q4° x 24°	12 Am							X				
		then PRN	16							X				
			20							X				
			24							X				
			04						X		X			
			08						X	[redacted]	X			

b(6)-2
A11

[illegible] NO | PRIMARY DIAGNOSIS: S/P GSW to Abd

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PA[illegible] GE [illegible]N:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA F[illegible] FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	SINGLE ... ER, PRE-OPERATIVES	...en	Time to be Given	Time Given	Initials
	b(a)-2 AR				

Order/ Expir Date	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
13 Aug [redacted]	Tylenol 650mg q4° PRN	13 Aug 2150 15 Aug 2140 PO; 16 Aug 0214 PO; 17 Aug 0835 PO; 17 Aug 21:59 PO; 20 Aug 0:20 PO; 20 Aug 0145 PO; [redacted]
13 Aug [redacted]	Percocet ½ tabs q4° PRN pain	20 Aug 0000 PO (H); 21 Aug 1430 [redacted]
18 Aug [redacted]	MSO4 4mg IV Q4° PRN	

USAPA V1.00

[redacted] b(a)-4

MEDCOM - 16034

b(4)-2

ECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surge
Mo. 8 Yr 03

VER. | INITIAL PROPE... | MN FOLLOWING EACH COMPLETION

	RK/ SE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13 14 15 16 17 18 19 20 21 22
BAMG	copied [redacted]	Regular Diet	06 12 17	[redacted]
12	[redacted]	Consult PT for ambulation @ leg weakness	08	[redacted]
14	[redacted]	Vitals routine	06 14 22	[redacted]
18 Chg Dr	[redacted]	Abd. Wound Dsg D's BID wet → Dry gently packed	08 20	/ / / / / / [redacted]

ES ☐ NO | PRIMARY DIAGNOSIS: S/P GSW to abd | ADDITIONAL PAGES IN USE: ☐ YES ☐ NO | PAGE NO: _____

ION:

EPW #[redacted] b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

b(6)-2 A 11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 03

	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted] DC all sbl wound sutures	14	Today	0930	[redacted]
14	[redacted] CBC today	14	AM	093	[redacted]
17 Aug	[redacted] NPO to OR	17 Aug	NOW	CX	
17	[redacted] NPO after MN - TOOR if FST; Am	18 Aug	0000	0000	[redacted]
20	Transfer to [redacted] b(2)-2				

	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
14	cd Stoma Care prn	17 Aug 0153 [redacted] see note

USAPA V1.00

. RECORD—SUPPLEMENTAL MEI ...A

For use of ... AR 40-68; the proponent agency is the Offic... ...geon General.

REPORT TITLE

POST-ANESTHESIA CARE UNIT (PACU) FLOW SHEET

OTSG APPROVED (Date) 8/18/03 Aug 18 03

DATE: 08/18/03

TIME IN: 7:40

PROCEDURE: I&D OBD INCISN.

TYPE ANESTHESIA: GEN SAB EPIDURI

NERVE BLOCK (IV SED) MAC.

OR INTAKE: (Crystalloid: 250 Colloid

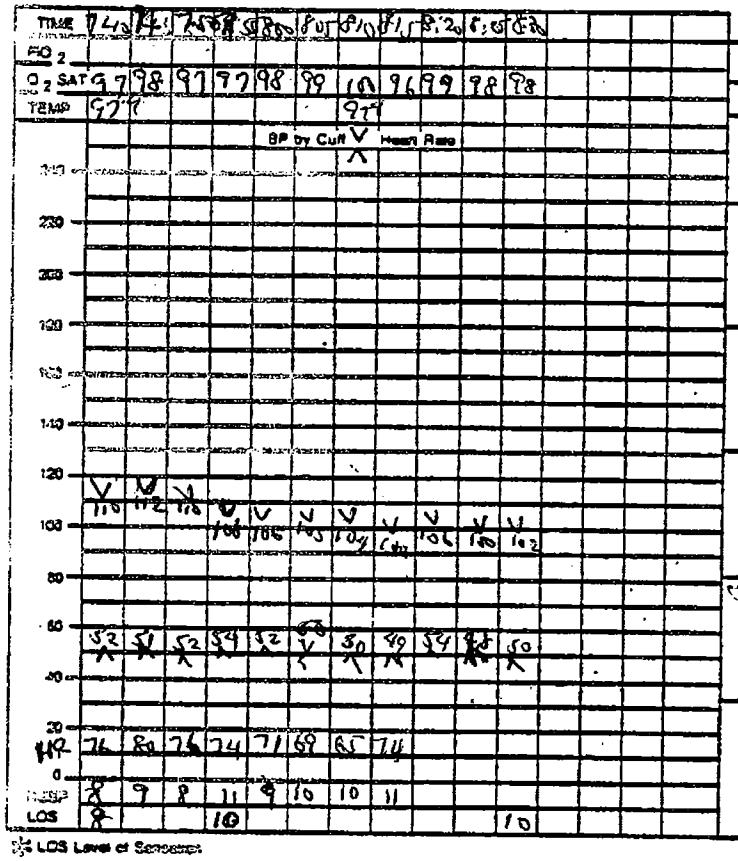
OR OUTPUT: Urine Output EBL

b(6)-2

INTAKE					OUTPUT				
TIME	SOLUTION	Amt Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM.	RL	800	LA	[redacted]					

X-RAYS DONE:

LABS DRAWN:



REACT SCORE			IN	30 Min	OUT
ACTIVITY	SCORE				
(R)espirations:	0	Ventilator essential	2	2	2
	1	Spont. resp.; <10/min: airway essential			
	2	Spont. resp.; no support: >10/min			
(E)nergy	0	Does not move legs	2	2	2
	1	Moves legs, cannot sustain head lift			
	2	Sustains head lift, moves legs			
(A)lertness	0	Awakens only with vigorous somulation	1	2	2
	1	Awakes only when somulated gently			
	2	Awake, seldom dozes			
(C)irculation Adults	0	BP 20% pre-anesthesia level	2	2	2
	1	BP 20-50% pre-anesthesia level			
	2	BP 50% pre-anesthesia level			
Infants	0	Carotid-only regular pulse palpable			
	1	Axillary pulse felt most but not wrist			
	2	Pulse can be felt easily at wrist			
(T)emperature	0	Axillary temp. <95 F	1	2	2
	1	Temp. 95-98 F			
	2	Temp. >98 F			

* LOS Level of Sensorium

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] RPT 8/18/03 b(6)-2

DEPARTMENT/SERVICE/CLINIC 1ST FST WARD 2-D

DATE 18 Aug

(For typed or written entries give: Name—last, first, middle; ... hospital or medical facility)

[redacted] CPW.

b(6)-4

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

DA FORM 1 MAY 78 4700

MEDDAC FBg OP 173 (Revised) 1 Nov 89 (HSXC-NU)

MEDCOM - 16037

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS:
Alert
(Responsive)
Unresponsive

AIRWAY:
Nasal
(Oral)
Endotracheal
Tracheostomy

OXYGEN
Hudson Mask 40%
Oxygen Mist
Nasal Cannula
(Room Air)

DRAINS
Hemovac
Jackson-Prat
N/G
Foley

SIGNATURE [redacted] b(6)-2

MEDICATIONS

ALLERGIES:

Time	Medication/AMT	Route/Site	BY

DRESSINGS

	SITE	TYPE	DRAINAGE
	MIDLINE ON R SIDE OF ABD	STERILE GAUZE.	NO

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN	RL 100 cc	URINE OUTPUT	
COLLOID IN		EMESIS	
P.O		NG TUBE	
		JP DRAIN/HEMOVAC	
TOTAL INTAKE	150	TOTAL OUTPUT	

TO ICU 2

DISCHARGE CRITERIA Time: 8 20 hr Date: 8/18/03

REACT Score:
VS: BP 152/50 R 11 HR 72 T 97.4
Cleared according to
WARD 2-D SOP C-2
Charge Nurse Signature: b(6)-2 [redacted]

NURSES NOTES:

7:45 Pt easily arousable & verbal and follows commands. Pt received 15 mg of MSO4 and 250 mcg of fentanyl also 200 mL of crystalloid via OA. Pt has OSA & mid abdominal post incision on R side of abdomen. Pt has abdominal bag. Pt put on room air 99%. 800 Pt allowed to eat for preoperation bowel sounds present and flatulence in abdominal bag. Pt has bounding radial and pedal pulses bilaterally Pt opens eyes spontaneously and understands verbal commands. Pt D/C discharge to ICU 2. S1, S2 present, voiding clear pink tinged urine. Received IVF via RL. Pt remains alert and oriented x3. Sat 99% Pt transfer via stretcher to 2 C for Dr Adam. Report given to [redacted]

MEDCOM - 16038

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. ...r LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	[redacted] b(6)-4 UNK IRAQI	E4W	M

3. REGISTER NUMBER	6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	19 N K	24Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99 b(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—TAGit [redacted] b(6)-4	U	1330	—

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
—	—	1	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21		030820	

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030806

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

DX: S/P GSW TO ABD

ADMITTING OFFICER (Signature as required)

DR [redacted] b(6)-2

SIG [redacted]

MEDCOM - 16059

b(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 00 14205	2. NAME (Last, First, M): EPW# [redacted]			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 26	6. RACE: —	7. RELIGION: —	8. LENGTH OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: NO					
11. EMP: 99	12. SSN: [redacted]		13. ORGANIZATION: —		14. WARD: ICW#2
15. FLYING STATUS: —	16. DSG: —	17. DEP'T/BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP: —	20. TYPE CASE: WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 1240

23. CLINIC SERVICE: AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25. TYPE DISPOSITION: 50

26. DATE OF DISPOSITION: 18Aug03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.: —

28. DATE OF THIS ADMISSION: 7 aug03

ADMITTING OFFICER: DR [redacted]

28. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

30. DATE OF INITIAL ADMISSION:

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED:

b(2)-2

b(6)-2

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to (L) Leg & Elbow S/P I&D (L) Leg.

825.31
881.01
875.0
873.8
E.991-2

79.67

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
Ø	Ø	Ø	Ø	11	11

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

NATURE OF ATTENDING [redacted]

DR [redacted]

RDS OFFICER

FORM 3647, MAY 75

EDITION OF [redacted]

b(6)-2