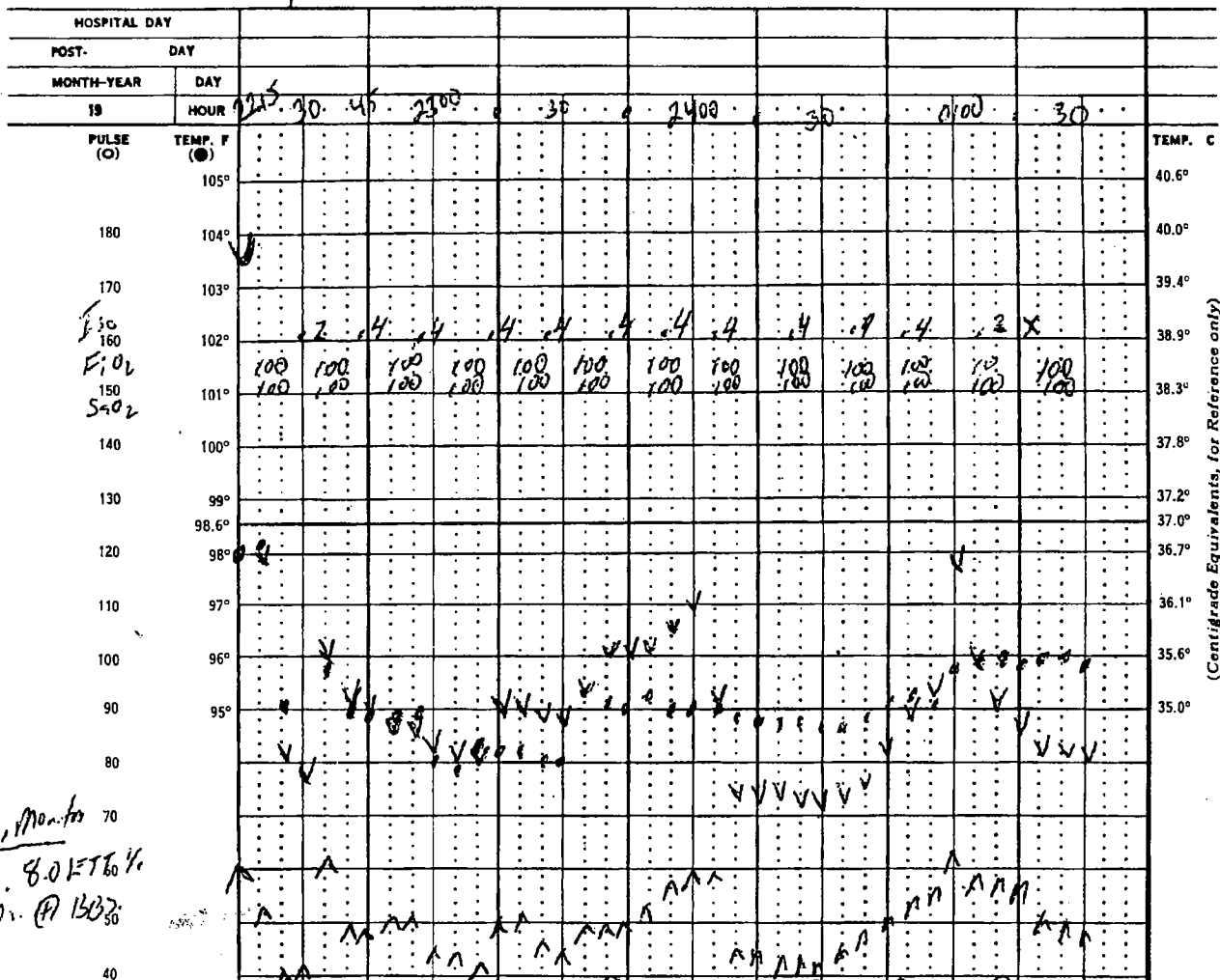


VITAL SIGNS RECORD



Pre-ox, Mon. 70
DLx i. 8.0 FT 60 %
④ FT CO. ④ 133₅₀

[illegible]

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

REGISTER NO. (b)(8)-2	(b)(8)-2	WARD NO. T 31.9
(b)(8)-2	CAVA	FiO2 50%
(b)(8)-2		AL SIGNS RECORD

511-112

(b)(6)-4

$P_T \neq$

Adult, male, Non-English speaker.

Ex-Lop, ~~(12) LF~~ ~~frustration~~
(13) BKA

EBL 1500
L/R 6000
Fluids PRCL 30
A/B 200 25%

WOP 500

OP 500

2448223 PRC 04 UNXm/L 2430 2448236 PRC 0100

1854003

MEDCOM - 3870

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency
Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

29 Mar 03

2448236 PPRC 0100

MEDICAL RECORD				VITAL SIGNS RECORD											
HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY														
19	HOUR														
PULSE (C)	TEMP. F (C)													TEMP. C	
180	105°													40.6°	
170	104°													40.0°	
160	103°													39.4°	
150	102°													38.9°	
140	101°													38.3°	
130	100°													37.8°	
120	99°													37.2°	
110	98.6°													37.0°	
100	98°													36.7°	
90	97°													36.1°	
80	96°													35.6°	
70	95°													35.0°	
60															
50															
40															
RESPIRATION RECORD															
BLOOD PRESSURE															
HEIGHT: 5'11" WEIGHT: 177															
Circumference: 35.0															
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)		REGISTER NO.				WARD NO.									

MEDICAL RECORD		VITAL SIGNS RECORD																						
HOSPITAL DAY																								
POST-	DAY	3/30/03																						
MONTH-YEAR	DAY																							
19	HOUR	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	
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°
120	98.6°																							37.0°
110	98°																							36.7°
100	97°																							36.1°
90	96°																							35.6°
80	95°																							35.0°
70	94°																							MeBxin tye Q8
60	93°																							0200, 1000, 1800
50	92°																							3/30
40	91°																							CBC ☐
																								NO LAB ABIL @ this time
ESPIRATION RECORD		12	12	12	12	12	10	10	14	10	23	23	27		25									
BLOOD PRESSURES, PO2		99	97	98	95	95	89	100	94	90	100	100	100	100	100									
FMD BL PIP		50	30	30	30	30	30	40	30	35	80	75	80	85	85									
HEIGHT: WEIGHT		17	18	23	22	21	20	25	27	27	HL	HL	14		117									
PRBC's		450	450																					
Pleural		0	0	0	0	0	0	20	0															
IUF's		100	100	100	100	100	100	100	100	100	100	100	100	100	100									
UO		50	50	135	150	100	175	100	100	100	100	100	100	100	100									
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.							

(Centigrade Equivalents, for Reference only)

VITAL SIGNS RECORDS

Medical Record

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

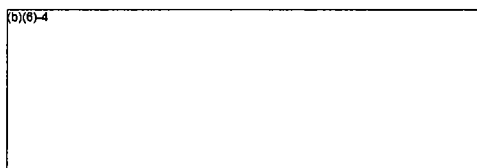
MEDCOM - 3872

MEDICAL RECORD		VITAL SIGNS RECORD											
HOSPITAL DAY													
POST-MONTH-YEAR	DAY												
19	31 MAR	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03	1 APR 03
	HOUR	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600
PULSE (O)	TEMP. F (°)												
	105°												
180	104°												
170	103°												
160	102°												
150	101°												
140	100°												
130	99°												
120	98.6°												
110	98°												
100	97°												
90	96°												
80	95°												
70													
60													
50													
40													
RESPIRATION RECORD													
BLOOD PRESSURE													
HEIGHT: WEIGHT →													
Wt													
Total 570.0													
7A-10													
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.											

(Centigrade Equivalents, for Reference only)

STANDARD FORM 111 (REV. 7-95) BACK

U.S. Government Printing Office: 1995 - 609-021



MEDCOM - 3873

(b)(6)-4

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

Enter in above space REG'D PHYSICIAN'S SIGNATURE		PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REPORTED BY		CHEM 1 URGENCY ☒ BED ☐ ROUTINE ☐ OUTPATIENT ☐ TODAY ☐ NP ☐ PRE-OP ☒ STAT SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)		PAYMENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP		SPECIMEN/LAB. RPT. NO.	
REMARKS		MD DATE TECH 1 APR 63		LAB. ID. NO.		46-107		PATIENT'S MED. RECORD	

MEDCOM - 3875

MEDICAL RECORD		BLOOD OR BLOOD COMPONENT TRANSFUSION			
SECTION I - REQUISITION					
COMPONENT REQUESTED (Check one) ☒ RED BLOOD CELLS ☐ FRESH FROZEN PLASMA ☐ PLATELETS (Pool of _____ units) ☐ CRYOPRECIPITATE (Pool of _____ units) ☐ Rh IMMUNE GLOBULIN ☐ OTHER (Specify) _____		TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.) ☐ TYPE AND SCREEN ☐ CROSSMATCH		REQUESTING PHYSICIAN (Print) Dr. (b)(6)-2	
VOLUME REQUESTED (If applicable) 450 ML		DATE REQUESTED 31 Mar 03		DIAGNOSIS OR OPERATIVE PROCEDURE MULTI TRAUMA - GSW.	
REMARKS:		DATE AND HOUR REQUIRED 31 Mar 03 0800		I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.	
		KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)		SIGNATURE OF VERIFIER	
		IF PATIENT IS FEMALE, IS THERE HISTORY OF: RHIG TREATMENT? DATE GIVEN: _____ HEMOLYTIC DISEASE OF NEWBORN? _____		DATE VERIFIED	
				TIME VERIFIED	
SECTION II - PRE-TRANSFUSION TESTING					
UNIT NO. 4636460	TRANSFUSION NO.	TEST INTERPRETATION		PREVIOUS RECORD CHECK: ☐ RECORD ☒ NO RECORD	
	PATIENT NO.	ANTIBODY SCREEN NA	CROSSMATCH NA	SIGNATURE OF PERSON PERFORMING TEST	
DONOR	RECIPIENT	☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		DATE 31 Mar 03	
ABO O	ABO	REMARKS:			
Rh pos	Rh				
SECTION III - RECORD OF TRANSFUSION					
PRE-TRANSFUSION DATA			POST-TRANSFUSION DATA		
INSPECTED AND ISSUED BY (Signature) (b)(6)-2			AMOUNT GIVEN 450 ML	TIME/DATE COMPLETED/INTERRUPTED 1037 03/31/03	
AT (Hour) 0750 ON (Date) 31 Mar 03			REACTION ☒ NONE ☐ SUSPECTED	TEMPERATURE	PULSE 111 BLOOD PRESSURE 86/50
IDENTIFICATION I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.			If reaction is suspected—IMMEDIATELY: 1. Discontinue transfusion, treat shock if present, keep intravenous line open. 2. Notify Physician and Transfusion Service. 3. Follow Transfusion Reaction Procedures. 4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.		
1st VERIFIER (Signature) (b)(6)-2			DESCRIPTION OF REACTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER (Specify)		
2nd VERIFIER (Signature) (b)(6)-2			OTHER DIFFICULTIES (Equipment, clots, etc.) ☐ NO ☒ YES (Specify) IV line changed to RBICEF		
PRE-TRANSFUSION TEMP. 99.9 PULSE 129 BP 79/48			SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2		
DATE OF TRANSFUSION 03/31/03 TIME STARTED 905					
PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade, room, rate; hospital or medical facility)				Male	WARD ICU I
(b)(6)-4					

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1

MEDCOM - 3876

Medical Record Copy

MEDICAL RECORD		BLOOD OR BLOOD COMPONENT TRANSFUSION	
SECTION I - REQUISITION			
COMPONENT REQUESTED (Check one)		TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)	REQUESTING PHYSICIAN (Print)
☒ RED BLOOD CELLS ☐ FRESH FROZEN PLASMA ☐ PLATELETS (Pool of _____ units) ☐ CRYOPRECIPITATE (Pool of _____ units) ☐ Rh IMMUNE GLOBULIN ☐ OTHER (Specify) _____		☐ TYPE AND SCREEN ☐ CROSSMATCH	Dr. [b)(6)-2]
VOLUME REQUESTED (If applicable) 450 ML		DATE REQUESTED 31 Mar 03	DIAGNOSIS OR OPERATIVE PROCEDURE MULTI TRAUMA GSW
REMARKS:		DATE AND HOUR REQUIRED 31 Mar 03	I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.
		KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)	SIGNATURE OF VERIFIER
		IF PATIENT IS FEMALE, IS THERE HISTORY OF: RhIG TREATMENT? DATE GIVEN: _____ HEMOLYTIC DISEASE OF NEWBORN? _____	DATE VERIFIED TIME VERIFIED

SECTION II - PRE-TRANSFUSION TESTING			
UNIT NO. 4636510	TRANSFUSION NO.	TEST INTERPRETATION	
	PATIENT NO.	ANTIBODY SCREEN NA	CROSSMATCH NA
DONOR	RECIPIENT	PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD	
ABO O	ABO	SIGNATURE OF PERSON PERFORMING TEST	
Rh POS	Rh	☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 31 Mar 03	
REMARKS:			

SECTION III - RECORD OF TRANSFUSION			
PRE-TRANSFUSION DATA		POST-TRANSFUSION DATA	
INSPECTED AND ISSUED BY (Signature) [b)(6)-2]		AMOUNT GIVEN 450 ML	
AT (Hour) 07035		TIME/DATE, COMPLETED/INTERRUPTED 03/31/03 13:20	
ON (Date) 31 Mar 03		REACTION ☒ NONE ☐ SUSPECTED	
IDENTIFICATION		TEMPERATURE 99.6	
I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.		PULSE 112	
1st VERIFIER (Signature) [b)(6)-2]		BLOOD PRESSURE 93/54	
[b)(6)-2]		If reaction is suspected—IMMEDIATELY: 1. Discontinue transfusion, treat shock if present, keep intravenous line open. 2. Notify Physician and Transfusion Service. 3. Follow Transfusion Reaction Procedures. 4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.	
559 9103 MB		DESCRIPTION OF REACTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER (Specify)	
PRE-TRANSFUSION TEMP. 99.4		OTHER DIFFICULTIES (Equipment, clots, etc.) ☒ NO ☐ YES (Specify)	
PULSE 112		SIGNATURE OF PERSON NOTING ABOVE [b)(6)-2]	
BP 87/54		[b)(6)-2]	
DATE OF TRANSFUSION 03/31/03		TIME STARTED 11:05 10/31/03	
PATIENT IDENTIFICATION—USE EMBOSSE (For typed or written entries give: Name—Last, first, middle; grade, rate; hospital or medical facility)		WARD Male ICU I	

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 3877

ACLU-RDI 4739 p.8

DOD 010356

#3

MEDICAL RECORD		BLOOD OR BLOOD COMPONENT TRANSFUSION			
SECTION I - REQUISITION					
COMPONENT REQUESTED (Check one) ☒ RED BLOOD CELLS ☐ FRESH FROZEN PLASMA ☐ PLATELETS (Pool of _____ units) ☐ CRYOPRECIPITATE (Pool of _____ units) ☐ Rh IMMUNE GLOBULIN ☐ OTHER (Specify) _____		TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.) ☐ TYPE AND SCREEN ☐ CROSSMATCH		REQUESTING PHYSICIAN (Print) Dr. [redacted]	
				DIAGNOSIS OR OPERATIVE PROCEDURE	
VOLUME REQUESTED (If applicable) <u>450</u> ML		DATE REQUESTED <u>1 Apr 03</u>		I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.	
		DATE AND HOUR REQUIRED <u>1 Apr 03 0115</u>			
REMARKS:		IF PATIENT IS FEMALE, IS THERE HISTORY OF: RHIG TREATMENT? DATE GIVEN: _____ HEMOLYTIC DISEASE OF NEWBORN? _____		SIGNATURE OF VERIFIER	
				DATE VERIFIED TIME VERIFIED	
SECTION II - PRE-TRANSFUSION TESTING					
UNIT NO. <u>1854363</u>	TRANSFUSION NO.	TEST INTERPRETATION ANTIBODY SCREEN: <u>NA</u> CROSSMATCH: <u>NA</u>		PREVIOUS RECORD CHECK: ☐ RECORD ☒ NO RECORD	
PATIENT NO.				SIGNATURE OF PERSON PERFORMING TEST	
DONOR	RECIPIENT	☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED			
ABO <u>O</u>	ABO	REMARKS:			
Rh <u>pos</u>	Rh	DATE <u>1 Apr 03</u>			
SECTION III - RECORD OF TRANSFUSION					
PRE-TRANSFUSION DATA			POST-TRANSFUSION DATA		
INSPEC [redacted]			AMOUNT GIVEN <u>300</u> ML TIME/DATE <u>1 Apr 03 0238</u>		
AT (Hour) <u>0115</u> ON (Date) <u>1 Apr 03</u>			REACTION ☒ NONE ☐ SUSPECTED TEMPERATURE <u>97.5</u> PULSE <u>100</u> BLOOD PRESSURE <u>102/60</u>		
IDENTIFICATION I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.			If reaction is suspected—IMMEDIATELY: 1. Discontinue transfusion, treat shock if present, keep intravenous line open. 2. Notify Physician and Transfusion Service. 3. Follow Transfusion Reaction Procedures. 4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.		
1st VERIFIER (Signature) [redacted] <u>SPC LPN</u>			DESCRIPTION OF REACTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER (Specify) _____		
2nd VERIFIER [redacted] <u>SPC LPN</u>			OTHER DIFFICULTIES (Equipment, clots, etc.) ☒ NO ☐ YES (Specify) _____		
PRE-TRANSFUSION TEMP. <u>97.5</u> PULSE <u>98</u> BP <u>91/55</u>			SIGNATURE OF PERSON NOTING ABOVE [redacted] <u>SPC LPN</u>		
DATE OF TRANSFUSION <u>1 Apr 03</u> TIME STARTED <u>0131</u>			SEX <u>Male</u> WARD <u>Icu I</u>		
PATIENT IDENTIFICATION—USE EMBOSSE (For typed or written entries give: Name—Last, first, middle initial; date; hospital or medical facility)					

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1

MEDCOM - 3878

Medical Record Copy

MEDICAL RECORD		BLOOD OR BLOOD COMPONENT TRANSFUSION			
SECTION I - REQUISITION					
COMPONENT REQUESTED (Check one)		TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)		REQUESTING PHYSICIAN (Print)	
☒ RED BLOOD CELLS		☐ TYPE AND SCREEN		Dr. [Signature]	
☐ FRESH FROZEN PLASMA		☐ CROSSMATCH		DIAGNOSIS OR OPERATIVE PROCEDURE	
☐ PLATELETS (Pool of _____ units)		DATE REQUESTED		I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.	
☐ CRYOPRECIPITATE (Pool of _____ units)		DATE AND HOUR REQUESTED		SIGNATURE OF VERIFIER	
☐ Rh IMMUNE GLOBULIN		1 Apr 03			
☐ OTHER (Specify) _____		1 Apr 03 1415			
VOLUME REQUESTED (If applicable)		KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)			
450 ML					
REMARKS:		IF PATIENT IS FEMALE, IS THERE HISTORY OF:		DATE VERIFIED	
		RhIG TREATMENT? DATE GIVEN: _____		TIME VERIFIED	
		HEMOLYTIC DISEASE OF NEWBORN? _____			
SECTION II - PRE-TRANSFUSION TESTING					
UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION		PREVIOUS RECORD CHECK:	
1854329	PATIENT NO.	ANTIBODY SCREEN	CROSSMATCH	☐ RECORD ☒ NO RECORD	
		NA	NA	SIGNATURE OF PERSON PERFORMING TEST	
DONOR	RECIPIENT	☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		DATE 1 Apr 03	
ABO O	ABO	REMARKS:			
Rh pos	Rh				
SECTION III - RECORD OF TRANSFUSION					
PRE-TRANSFUSION DATA			POST-TRANSFUSION DATA		
INSPECTED AND ISSUED BY (Signature)			AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED	
[Signature]			450 ML	1850 1 Apr 03	
AT (Hour) 1415 ON (Date) 1 Apr 03			REACTION	TEMPERATURE	PULSE
			☒ NONE ☐ SUSPECTED	98.8	100
IDENTIFICATION			BLOOD PRESSURE		
I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.			130/70		
1st VERIFIER (Signature)			If reaction is suspected—IMMEDIATELY:		
[Signature]			1. Discontinue transfusion, treat shock if present, keep intravenous line open.		
2nd V [Signature]			2. Notify Physician and Transfusion Service.		
[Signature]			3. Follow Transfusion Reaction Procedures.		
[Signature]			4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.		
PRE-TRANSFUSION DATA			DESCRIPTION OF REACTION		
TEMP. 98.8	PULSE 102	BP 113/70	☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN		
DATE OF TRANSFUSION 1 Apr 03	TIME STARTED 1700		☐ OTHER (Specify)		
PATIENT IDENTIFICATION—USE EMBOSSE (For typed or written entries give: Name—Last, first, middle initial; date; hospital or medical facility)			OTHER DIFFICULTIES (Equipment, clots, etc.)		
[Signature]			☐ NO ☐ YES (Specify)		
			SIGNATURE		
			[Signature]		
			SEX	WARD	
			Male	ICU 1	

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1

MEDCOM - 3879

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED (Check one) ☒ RED BLOOD CELLS ☐ FRESH FROZEN PLASMA ☐ PLATELETS (Pool of _____ units) ☐ CRYOPRECIPITATE (Pool of _____ units) ☐ Rh IMMUNE GLOBULIN ☐ OTHER (Specify) _____	TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.) ☐ TYPE AND SCREEN ☐ CROSSMATCH	REQUESTING PHYSICIAN (Print) Dr. [b)(6)-2]
	DATE REQUESTED 1 Apr 03	I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.
	DATE AND HOUR REQUIRED 1415 1 Apr 03	
	VOLUME REQUESTED (If applicable) 450 ML	KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)
REMARKS:	IF PATIENT IS FEMALE, IS THERE HISTORY OF: RhIG TREATMENT? DATE GIVEN: _____ HEMOLYTIC DISEASE OF NEWBORN? _____	DATE VERIFIED TIME VERIFIED

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO. 0758685	TRANSFUSION NO.	TEST INTERPRETATION		PREVIOUS RECORD CHECK:
PATIENT NO.		ANTIBODY SCREEN NA	CROSSMATCH NA	☐ RECORD ☒ NO RECORD
DONOR	RECIPIENT	SIGNATURE OF PERSON PERFORMING TEST		
ABO O	ABO	☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		
Rh POS	Rh	DATE 1 Apr 03 REMARKS:		

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA		POST-TRANSFUSION DATA		
INSPECTED [b)(6)-2]		AMOUNT GIVEN 450 ML	TIME/DATE COMPLETED/INTERRUPTED 1	
AT (Hour) 1415	ON (Date) 1 Apr 03	REACTION ☒ NONE ☐ SUSPECTED	TEMPERATURE 98.2	PULSE 106
IDENTIFICATION		BLOOD PRESSURE 130/77		
I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.		If reaction is suspected—IMMEDIATELY: 1. Discontinue transfusion, treat shock if present, keep intravenous line open. 2. Notify Physician and Transfusion Service. 3. Follow Transfusion Reaction Procedures. 4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.		
[b)(6)-2]		DESCRIPTION OF REACTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER (Specify)		
PRE-TRANSFUSION		OTHER DIFFICULTIES (Equipment, clots, etc.)		
TEMP. 98.8	PULSE 106	☒ NO ☐ YES (Specify)		
DATE OF TRANSFUSION 1 Apr 03	TIME STARTED 1845	SIGNATURE OF PERSON NOTING ABOVE		
PATIENT IDENTIFICATION—USE EMBOSSE (For typed or written entries give: Name—Last, first, middle; grade; rank; rate: hospital or medical facility)		SEX [b)(6)-2]		
[b)(6)-4]		[b)(6)-2]		

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRM (41 CFR) 201-9.202-1

MEDCOM - 3880

Medical Record Copy

MEDICAL RECORD

Doctors Orders ~~PROGRESS NOTES~~29
30 DATE
MAR 03

① Admit to ICU

1230 ② Dxi SLP Ex lap and ligation of bloody vessels in
abd wall, omentum, local exploration and irrigation
of GSW to chest, ② BKA.

③ Condition: guarded

④ Vitals q 1st per routine c continues pulses⑤ Meperin 1g IV q 8th (next @ 0200)

⑥ Nursing:

- Strict I&O's

- Soly to gravity

- Chest tube to -20 cm water suction

- May reinforce BKA and other dressings

⑦ Diet: NPO

⑧ IVs: LR @ 100 cc/hr.

⑨ MSN 2-5 mg IV q 1st per pain → titrate to⑩ Versed 1mg IV q 1st

⑪ CBC in AM

⑫ Vent settings → 100% FIO2 / SIMV / 10 / TV 800 / PEEP 5.

⑬ Call MD for T > 101, R > 40, SBP > 160 < 80, DBP > 110 < 50,

HR > 110, U.O. < 20 cc/hr over 2nd

(Continue on reverse side)

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

REGISTER NO.

(b)(6)-2

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FPMR (41 CFR) 201-9.202-1

PROGRESS NOTES

[illegible]

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			30 MAR 03	1130 HOURS	(b)(6)-2
			① Adminic 1ckl - Gen Surg		
			② SIP Ex Lap / (R) BRK / (L) CT		
			③ Stable		
			④ VS 95°, 2 1/2 O's		
			⑤ NKDA		
			⑥ Bedrest		
NURSING UNIT	ROOM NO.	BED NO.	⑦ RR 18-20 c/min		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
(b)(6)-4					
			⑧ Foley → gravity	HOURS	(b)(6)-2
			⑨ NK to LWS ✓		
			⑩ CT to -20 cm H ₂ O suction ✓		
			⑪ CXR in AM		
			⑫ MSO ₄ 1-2 mg IV q 1-2° PRN pain		
			⑬ Versed 1-2 mg IV q 1-2° PRN sedation		
			⑭ Vent Settings: STIMU Rate 12		
NURSING UNIT	ROOM NO.	BED NO.	TU 700 PEEP 5 FID ₂ titrate for sats > 94%		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
(b)(6)-4					
			⑮ Albuterol MDI PRN per Routs		(b)(6)-2
			⑯ Zantac 50 mg IVB q 8°		
			⑰ Notify MD for T > 102 P > 130 C < 60		
			SBP > 170 < 110 MAP < 30 cc/hr x 2"		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
(b)(6)-4			30 March 2003	1405 HOURS	
			Restraints soft pm		(b)(6)-2
			Vacuum 5-10mg IV q 1-2 h pm agitate		
			Valium 2-5mg IV q 6h pm		
			CXR (PA) in am		
			Zantac		
NURSING UNIT	ROOM NO.	BED NO.	Suction to connector (3) (two) h		
			M-S. 5-20mg IV q 2h pm		

FORM 1 APR 79 **4256**

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

MEDCOM - 3883

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

PATIENT IDENTIFICATION (b)(6)-4			DATE OF ORDER 30 March 2003	TIME OF ORDER 14 07 HOURS	LIST TIME ORDER NOTED AND SIGN noted 31 Mar 03
			① Gentamicin 400mg IV BID ② Ciprof 1 gm IV q 8 x 3 dm ③ if pt is extubated start Albuterol nebs QID ④ Extubate if possible (RT) ⑤ Istat 8 mg qm. ⑥ V.S. 94%		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER 31 March 2003	TIME OF ORDER 1535	LIST TIME ORDER NOTED AND SIGN noted 31 Mar 03
			Δ Gentamicin to 400mg IV qd Continue Ciprof 1 gm IV q 8h x 2 days CXR (PA)		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER Istat 8 mmw	TIME OF ORDER done - HOURS	LIST TIME ORDER NOTED AND SIGN
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER 31 March 03 2000	TIME OF ORDER 18 01 10 HOURS	LIST TIME ORDER NOTED AND SIGN
			① Transfer E to unit of O+ & the rest of the time in one hour later ② Istat 100mg IV qm 2 mmw		
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 4256
1 APR 79

REPLACES EDITION OF 1 JUL 77, WHICH

MEDCOM - 3884

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER 1 April 2003	TIME OF ORDER 0220	HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			③ Subtotal 5mg slow IV ③ Can be repeat every hour per wide complex tachycardia		noted 11APR03 0545 (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER 1 April 2003	TIME OF ORDER 1620	HOURS	
(b)(6)-4			① Clear liquid diet (advised) ② I stat @ 1800 (as tolerated) ③ D/C antibiotics done ④ Transferr 2 unit of O+ blood,		11APR03 noted 1700 (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER 1 April 2003	TIME OF ORDER 1700	HOURS	
(b)(6)-2			DC NG Tube V.D. Dr.		(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER 03 APR 03	TIME OF ORDER 0546	HOURS	
(b)(6)-2			D/C GORDY 1 to PIV D/C Wey, best D/C ALABAMA ↑ Diet as tolerated		(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER 03 APR 03	TIME OF ORDER 0546	HOURS	
(b)(6)-2			NS 1250/L C/LG (b)(6)-2 03 APR 03 / 0546		(b)(6)-2 (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 4256
1 APR 79

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

MEDCOM - 3885

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				MAR Mo. APR Yr. 03	
VERIFY BY INITIALING		INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION					
ORDER DATE	CLERK/NURSE (b)(6)-2	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED			
				30	31	01	02
30 MAR	(b)(6)-2	VS q 4h	03 06	(b)(6)-2			
			07 10				
			11 14				
			15 18	(b)(6)-2			
			19 22	(b)(6)-2			
	(b)(6)-2	Stable	23 02				
			03 07				
		NKDA	07 19	(b)(6)-2			
		Bedrest	07 19				
		Foley → gravity	07 19				
		NG to LTWS	16 19	(b)(6)-2			
			07 19				
		Notify MD for T > 103°	07 19	(b)(6)-2			
		p > 120 < 60, SBP > 170	07 19				
		< 110 UOP < 30cc/hr x 2°					
30 mar 03	(b)(6)-2	I and O	07 19	(b)(6)-2			
			19 07				
30 mar 03	(b)(6)-2	LR @ 125	07 19				
			19 07				
30 mar 03		OT to H ₂ O suction	07 19	(b)(6)-2			
			19 07				
30 mar 03		restraints Soft PRN					

ALLERGIES: ☐ YES ☐ NO

NRDA

PRIMARY DIAGNOSIS:

BP Ep Lap

ADDITIONAL PAGES IN USE:

☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

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

*U.S. GPO: 1998-454-110/95218

[illegible]

*U.S. GPO: 1998-454-110/95218

ACLU-RDI 4739 p.20

DOD 010368

REPORT TITLE

OTSG APPROVED (Date)

TRAUMA FLOWSHEET

INITIAL ASSESSMENT

☐ IMMEDIATE

☐ DELAYED

☐ MINIMAL

Site: _____ Arrival Time: _____ Sex: M F Age: _____ Wt: _____

Allergies: _____ Tetanus Status: UTD Unknown

VP: _____ Last Meal: _____

Chief Complaint: _____

VH: _____ Medications: _____

Current Treatments PTA: _____

VITAL SIGNS: BP: 96/63 P: 103 RR: BVM TEMP: _____ SAO₂: 99

HEENT

TRAUMA ☐ YES ☐ NO

AIN ☐ YES ☐ NO

OB ☐ YES ☐ NO

UNG SOUNDS

R L

☐ CLEAR

☐ WHEEZES

☐ DECREASED

☐ ABSENT

SKIN

☐ WARM

☐ DRY

☐ PALE

☐ DUSKY

☐ MOIST

ABDOMEN

☐ SOFT

☐ DISTENDED

☐ TENDER

BOWEL SOUNDS

☐ YES ☐ NO

GUIAC TEST

☐ POS ☐ NEG

NEURO

PERRL ☐ YES ☐ NO R _____ mm L _____ mm

GLASCOW SCORE: _____

PUPIL SIZE	2	3	4	5	6	7	8	9	
GLASCOW COMA SCALE									
1. EYE OPENING									
Spontaneous	-4								
To Voice	-3								
To Pain	-2								
None	-1								
2. VERBAL RESPONSE									
Oriented	-5								
Confused	-4								
Inappropriate	-3								
Incomprehensible	-2								
None	-1								
3. MOTOR RESPONSE									
Obedient	-6								
Purposeful	-5								
Withdrawal	-4								
Flexion	-3								
Extension	-2								
None	-1								

EXTREMITIES

☐ DISTAL PULSES

☐ RT X 2 ☐ LT X 2

☐ MOVES EXTREMITIES

X 4

☐ NO EDEMA

☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE

PARAMETERS:

TREATMENTS:

2: LPM ☒ NC

TT # MM

MONITOR ☐ Y ☐ N

IG TUBE #

OLEY: #

HEENT TUBE ☐ R ☐ L

BVM MASK

SPLINTS:

ORAL AIRWAY

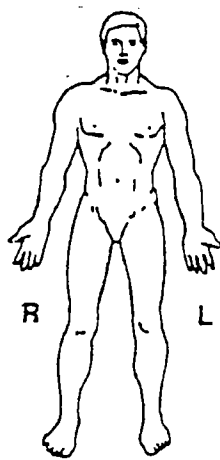
NASAL AIRWAY

☐ N

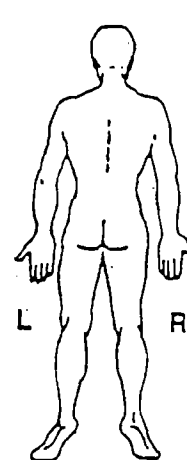
DPL ☐ POS

CM H2O

☐ NEG



FRONT



BACK

A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW (if Stab)
L = Laceration
PW = Puncture Wound
S = Slab Wound
O = Other

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

399th CSH

DATE

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written

entries give: Name - last; first; middle; grade; date;

hospital or medical facility)

[Empty box for patient identification]

☐ HISTORY/PHYSICAL

☐ FLOW CHART

☐ OTHER EXAMINATION
OR EVALUATION

☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

PATIENT EVACUATION TAG – FICHE D'ÉVACUATION DE PATIENT (Attach this tag to patient – Attacher cette fiche au patient)			
FROM (Medical treatment facility) ORIGINE (Installation de traitement médical) (b)(3)-1			
NAME (Last-first-middle initial) <i>07</i> NOM (Nom de famille-premier prénom-initiale deuxième prénom) (b)(6)-4 <i>Elderly Brugis mule</i>			
SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL (Service or employer and nationality) CATÉGORIE DE PERSONNEL (Service ou employeur et nationalité)	
DIAGNOSIS DIAGNOSTIC			
CLASS-CLASSE		DISEASE MALADIE	BATTLE CASUALTY BESSÉ AU COMBAT
1A	2A		
1B	2B		
1C		CABIN OR COMPARTMENT NO. NO. CABINE OU COMPARTIMENT	
3	4	BUNK NUMBER NUMÉRO CQUCHETTE	
VSI TRÈS GRAV. MAL. ☐ Yes ☐ No		BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGE	
DESTINATION DESTINATION		SHIP/AC (Number/type) NAVIRE/AVION (Matricule/type)	
TREATMENT RECOMMENDED EN ROUTE (If no treatment is required a notation to this effect is made) TRAITEMENT RECOMMANDÉ EN ROUTE (Indiquer si aucun traitement n'est nécessaire) <i>(1)</i>			
SIGNATURE (b)(6)-2 SIGNA		DATE DATE	
REGUL RÉGIME NORMAL		REGIME SPECIAL (Description) <i>NO LTC</i>	
SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS			
FROM (Medical treatment facility) ORIGINE (Installation de traitement médical)			
NAME (Last first-middle initial) NOM (Nom de famille-premier prénom-initiale deuxième prénom)			
SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL	
BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGES		DATE OF SHIPMENT DATE DÉPART	
DESTINATION DESTINATION		ARRIVAL DATE DATE ARRIVÉE	
MARKATION TAB – FICHE D'EMBARQUEMENT			

Trauma Resuscitation Form

Name: _____		SSN: _____																					
Date and time of injury: _____		Date and time of arrival: _____																					
Chief complaint: _____																							
Pre-hospital information																							
Mechanism of injury: ☒ Gunshot wound ☐ Stabbing ☐ Burn ☐ Chemical casualty ☐ Other: _____																							
Procedures before arrival																							
☐ Airway: type _____ size # _____ ☐ O ₂ @ <u>4</u> L/min via <u>face mask</u> ☒ IVs: location and # <u>AC Bilat</u> ☒ Chest tube: location <u>C</u> size # <u>36F</u> ☐ Splints: Type _____ ☐ Medications: _____ ☐ Chemical casualty: ☐ Decontamination date/time: _____ ☐ Atropine: <table border="1" style="display: inline-table; vertical-align: top;"><thead><tr><th>Dosage</th><th>Date/time</th></tr></thead><tbody><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></tbody></table> ☐ 2-PAM: _____ ☐ Other: _____ ☐ Other procedures: _____				Dosage	Date/time																		
Dosage	Date/time																						
AMPLE history																							
Allergies: <u>NA</u>																							
Medications: <u>NA</u>																							
Past illnesses: <u>NA</u>																							
Last meal: <u>NA</u> Last Tetanus: <u>NA</u>																							
Events: _____																							
Initial assessment																							
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Airway ☒ Patent ☐ Obstructed Breathing ☐ Normal ☐ Labored ☐ Symmetrical ☒ Asymmetrical Trachea midline? ☒ Yes ☐ No Breath sounds: Right Left Present ☐ ☐ Clear ☐ ☐ Decreased ☐ ☐ Absent ☐ ☐ Rhales/Rhonchi ☐ ☐ Crackles: ☐ Yes ☐ No </td> <td style="width: 50%; vertical-align: top;"> Circulation Skin/mucous membrane color: ☒ Pink ☐ Flushed ☐ Pale ☐ Jaundiced ☐ Ashen ☐ Cyanotic Skin temperature: ☒ Warm ☐ Hot ☐ Cool Skin moisture: ☒ Normal ☐ Dry ☐ Moist Pulses: <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Carotid</td> <td style="text-align: center;">Radial</td> <td style="text-align: center;">Femoral</td> </tr> <tr> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>Normal ☒ ☒</td> <td>Normal ☒ ☒</td> <td>Normal ☒ ☒</td> </tr> <tr> <td>Bounding ☐ ☐</td> <td>Bounding ☐ ☐</td> <td>Bounding ☐ ☐</td> </tr> <tr> <td>Weak ☐ ☐</td> <td>Weak ☐ ☐</td> <td>Weak ☐ ☐</td> </tr> <tr> <td>Absent ☐ ☐</td> <td>Absent ☐ ☐</td> <td>Absent ☐ ☐</td> </tr> </table> </td> </tr> </table>				Airway ☒ Patent ☐ Obstructed Breathing ☐ Normal ☐ Labored ☐ Symmetrical ☒ Asymmetrical Trachea midline? ☒ Yes ☐ No Breath sounds: Right Left Present ☐ ☐ Clear ☐ ☐ Decreased ☐ ☐ Absent ☐ ☐ Rhales/Rhonchi ☐ ☐ Crackles: ☐ Yes ☐ No	Circulation Skin/mucous membrane color: ☒ Pink ☐ Flushed ☐ Pale ☐ Jaundiced ☐ Ashen ☐ Cyanotic Skin temperature: ☒ Warm ☐ Hot ☐ Cool Skin moisture: ☒ Normal ☐ Dry ☐ Moist Pulses: <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Carotid</td> <td style="text-align: center;">Radial</td> <td style="text-align: center;">Femoral</td> </tr> <tr> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>Normal ☒ ☒</td> <td>Normal ☒ ☒</td> <td>Normal ☒ ☒</td> </tr> <tr> <td>Bounding ☐ ☐</td> <td>Bounding ☐ ☐</td> <td>Bounding ☐ ☐</td> </tr> <tr> <td>Weak ☐ ☐</td> <td>Weak ☐ ☐</td> <td>Weak ☐ ☐</td> </tr> <tr> <td>Absent ☐ ☐</td> <td>Absent ☐ ☐</td> <td>Absent ☐ ☐</td> </tr> </table>	Carotid	Radial	Femoral	R L	R L	R L	Normal ☒ ☒	Normal ☒ ☒	Normal ☒ ☒	Bounding ☐ ☐	Bounding ☐ ☐	Bounding ☐ ☐	Weak ☐ ☐	Weak ☐ ☐	Weak ☐ ☐	Absent ☐ ☐	Absent ☐ ☐	Absent ☐ ☐
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Bounding ☐ ☐	Bounding ☐ ☐	Bounding ☐ ☐																					
Weak ☐ ☐	Weak ☐ ☐	Weak ☐ ☐																					
Absent ☐ ☐	Absent ☐ ☐	Absent ☐ ☐																					
Disability Glasgow Coma Scale (circle appropriate scores): 1. Eye opening: Score: Spontaneous <u>4</u> To voice 3 To pain 2 None 1 2. Verbal: Oriented <u>5</u> Confused 4 Inappropriate words 3 Incomplete words 2 None 1 3. Motor: Obey commands 6 Localizes to pain 5 Withdraws to pain <u>4</u> Flexion 3 Extension 2 None 1 Total GCS <u>13</u>																							
Pupillary response <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Pupil reaction: Brisk ☐ ☐ Constricted ☐ ☐ Sluggish ☐ ☐ Dilated ☐ ☐ Nonreactive ☐ ☐ Size _____mm _____mm </td> <td style="width: 50%; vertical-align: top;"> <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td style="text-align: center;">Brisk ☐</td> <td style="text-align: center;">Brisk ☐</td> </tr> <tr> <td style="text-align: center;">Constricted ☐</td> <td style="text-align: center;">Constricted ☐</td> </tr> <tr> <td style="text-align: center;">Sluggish ☐</td> <td style="text-align: center;">Sluggish ☐</td> </tr> <tr> <td style="text-align: center;">Dilated ☐</td> <td style="text-align: center;">Dilated ☐</td> </tr> <tr> <td style="text-align: center;">Nonreactive ☐</td> <td style="text-align: center;">Nonreactive ☐</td> </tr> </table> </td> </tr> </table>				Pupil reaction: Brisk ☐ ☐ Constricted ☐ ☐ Sluggish ☐ ☐ Dilated ☐ ☐ Nonreactive ☐ ☐ Size _____mm _____mm	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td style="text-align: center;">Brisk ☐</td> <td style="text-align: center;">Brisk ☐</td> </tr> <tr> <td style="text-align: center;">Constricted ☐</td> <td style="text-align: center;">Constricted ☐</td> </tr> <tr> <td style="text-align: center;">Sluggish ☐</td> <td style="text-align: center;">Sluggish ☐</td> </tr> <tr> <td style="text-align: center;">Dilated ☐</td> <td style="text-align: center;">Dilated ☐</td> </tr> <tr> <td style="text-align: center;">Nonreactive ☐</td> <td style="text-align: center;">Nonreactive ☐</td> </tr> </table>	Right	Left	Brisk ☐	Brisk ☐	Constricted ☐	Constricted ☐	Sluggish ☐	Sluggish ☐	Dilated ☐	Dilated ☐	Nonreactive ☐	Nonreactive ☐						
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Right	Left																						
Brisk ☐	Brisk ☐																						
Constricted ☐	Constricted ☐																						
Sluggish ☐	Sluggish ☐																						
Dilated ☐	Dilated ☐																						
Nonreactive ☐	Nonreactive ☐																						

ation

Trauma Resuscitation Form

Age (years): _____ Physical examination: _____
 Height (inches): _____ Weight (kg's): _____
 Head, eyes, ears, nose, throat: _____
 Neck: *DM*
 Chest: *GSW @ side, chest tube*
 Back: *NMI*
 Cervical/Thoracic/Lumbar spine: _____
 Abdomen: *hard*
 Perineum and rectum: _____
 Extremity: *Mo pulses R lower ext*
 Skin: *open wound*
 Neurologic: _____
 Other: _____

Diagram for documenting injuries
 (Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)

GSW
GSW
present
Large wound

(With permission from J.B. Lippincott Company. After Denning RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB eds. Surgery: Scientific Principles and Practice. Philadelphia, J.B. Lippincott Company, 1983.)

Trauma Resuscitation Form

[illegible]

1. REPORTING MTF								2. LOCATION		ADMISSION AND CODING INFORMATION																																																									
1	2	3	4	5	6	7	8	(State or Country Code)		For use of this form, see AR 40-400; proponent agency is OTSG																																																									
3. REGISTER NUMBER								(b)(6)-4				4. PAY GRADE				5. SEX																																																			
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6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION				8. RACE		9. ETHNIC		RELIGION																																																			
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14. FLYING STATUS				15. BENEFICIARY CATEGORY				16. ZIP CODE OF RESIDENCE																																																											
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17. UNIT LOCATION (State or Country Code)				18. MOS				19. TRAUMA				PREV. ADMISSION																																																							
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72								ICU				(b)(6)-4																																																							
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(b)(3)-1								(b)(6)-4																																																											
21. TYPE OF DISPOSITION				22. MTF TRANSFERRED TO				23. DATE OF DISPOSITION (YYYYMMDD)																																																											
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24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM				26. DATE THIS ADMISSION (YYYYMMDD)																																																											
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ADA				ADA																																20030330																															
27. LOCATION OF OCCURRENCE (Battle Casualty Only)				28. MTF OF INITIAL ADMISSION				29. DATE INITIAL ADMISSION (YYYYMMDD)																																																											
103				104				105				106				107				108				109				110				111								112				113				114				115				116											
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41519 9 489 (R) BKA																																																																			
ADMITTING OFFICER (Signature, as required)																(b)(6)-2																																																			
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1 2 3 4 5 6 7 8 9 (b)(3)-1										(State or Country Code)																								
3. REGISTER NUMBER										NAME (Last, First, Middle, Initial)										4. PAY GRADE					5. SEX									
9 10 11 12 13 14 15 (b)(6)-4										(b)(6)-4										16 17 18 M														
6. DATE OF BIRTH (YYYYMMDD)										7. AGE AT ADMISSION					8. RACE					9. ETHNIC					RELIGION									
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17. UNIT LOCATION (State or Country Code)										18. MOS										19. TRAUMA					PREV. ADMISSION									
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20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION										WARD										NAME (b)(6)-4														
72										ICU										(SON)														
NAME AND LOCATION (b)(3)-1										TELE (b)(6)-4																								
21. TYPE OF DISPOSITION										22. MTF TRANSFERRED TO										23. DATE OF DISPOSITION (YYMMDD)														
73 74 3 0 2006 APR										75 76 77 78 79 80 0 3 0 4 0 4										81 82 83 84 85 86 0 3 0 4 0 4														
24. CLINIC SVC - ADMITTING										25. MTF TRANSFERRED FROM										26. DATE THIS ADMISSION (YYMMDD)														
87 88 89 90 A R A A										91 92 93 94 95 96 0 3 0 3 3 2 9										97 98 99 100 101 102 0 3 0 3 3 2 9														
27. LOCATION OF OCCURRENCE (Battle Casualty Only)										28. MTF OF INITIAL ADMISSION										29. DATE INITIAL ADMISSION (YYMMDD)														
103 104 I Z										105 106 107 108 109 110 111 112 113 114 115 116										111 112 113 114 115 116														
FOR LOCAL USE																																		
41519 Proc 8415 S/P Fex Lap/ 82380 3401 (R) BKA 9588 3998 Ins Trauma 8750 9671 450 86399 9904(G) Death																																		
ADMITTING OFFICER (Signature, as required)															(b)(6)-2																			
(b)(6)-2 9912 MEDCOM - 3897															(b)(6)-2 MEDCOM - 3897																			

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP		31. AUTOPSY Y/N		32. UNDERLYING CAUSE OF DEATH / SEP		33. RESIDUAL DISABILITY		34. DO NOT USE - DATA FILLER #1				35. CAUSE OF INJURY									
117	118	119	120	121		122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	
		N																			
36. FIRST DIAGNOSIS (Principal Diagnosis)																					
137	138	139	140	141	142	143	144														
			8	9	7																
37. SECOND DIAGNOSIS																					
145	146	147	148	149	150	151	152														
			4	1	5	1															
38. THIRD DIAGNOSIS																					
153	154	155	156	157	158	159	160														
39. FOURTH DIAGNOSIS																					
161	162	163	164	165	166	167	168														
40. FIFTH DIAGNOSIS																					
169	170	171	172	173	174	175	176														
41. SIXTH DIAGNOSIS																					
177	178	179	180	181	182	183															
42. SEVENTH DIAGNOSIS																					
185	186	187	188	189	190	191	192														
43. EIGHTH DIAGNOSIS																					
193	194	195	196	197	198	199	200														
44. FIRST PROCEDURE (Principal Diagnosis)																					
201	202	203	204	205	206	207	208														
45. SECOND PROCEDURE																					
209	210	211	212	213	214	215	216														
46. THIRD PROCEDURE																					
217	218	219	220	221	222	223	224														
47. FOURTH PROCEDURE																					
225	226	227	228	229	230	231	232														
48. FIFTH PROCEDURE																					
233	234	235	236	237	238	239	240														
49. SIXTH PROCEDURE																					
241	242	243	244	245	246	247	248														
50. SEVENTH PROCEDURE																					
249	250	251	252	253	254	255	256														
51. EIGHTH PROCEDURE																					
257	258	259	260	261	262	263	264														
52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES																					
265	266																				
267	268																				
53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES																					
269	270	271																			
54. PRIMARY PROVIDER SPECIALTY CODE																					
272																					
55. BLOOD USAGE Y/N																					
273																					