INPATIENT TREATMENT RECORD COVER SHEET

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

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

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICU 1

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	1602	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Home	04 MAY 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		~~10~~ 11 ~~APR~~ APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

~~E991.9~~

Shrapnel L Flank S/P BKA

~~897.0~~

879.4

DX: B795
8971
E9654

PPX: 8622
843
8622
8622
843
8669
8669

Trauma
1

Injury
1449

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
23	23				23

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

MAJ, MC, USA

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

EDITION OF 1 AUG [illegible] OBSOLETE

USAPPC V1.10

MEDCOM - 3944

...DICAL RECORD - NURSING DISCHARGE SU...ARY

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

1. Date/Time:

2. Discharge to: ☐ Home (Other (specify)) LOCAL HOSPITAL

3. Mode: ☐ Ambulatory (Other (specify)) AMBULANCE

4. Accompanied by: EMT

5. Activity: AD LIB ☒ Limitations (specify)
- NEED PHYSICAL THERAPY FOR (R) BKA AND PROSTHESIS FITTING
- LIMITED WALKING FOR NEXT 5 DAYS DUE TO SKIN GRAFT.

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☒ No Dietary Restrictions If special, identify - NEEDS HIGH CALORIC / PROTEIN INTAKE FOR ↑ HEALING PROCESS.

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
ATARAX - ORAL	25mg	EVERY 6 HOURS	AS NEEDED FOR ITCHING
BACITRACIN OINTMENT		TWICE A DAY	↓INFECTION ON WOUNDS
MULTI - VITAMIN	1 PILL	ONCE A DAY	COMBAT MALNUTRITION
COLACE - ORAL	100mg	TWICE A DAY	STOOL SOFTNER
PERCOCET	1-2 TABS	EVERY 4 HOURS	AS NEEDED FOR PAIN CONTROL

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:	Patient/S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
CHANGE DRESSING (R) STUMP EVERYDAY	05/03/03	
APPLY BACITRACIN OINTMENT TO WOUND - SKIN GRAFT TWICE A DAY.		

Equipment/Supplies (Specify) PROVIDED 3 DAY SUPPLIES ↓ GAUZE/DRESSINGS AND 3 TUBES OF BACITRACIN

9. Follow-up: You should be seen in LOCAL HOSPITAL clinic in _____ (time period).

FOR DEFINITIVE AND FINAL CARE OF (R) BKA INCLUDING PROSTHESIS FITTING AND PHYSICAL THERAPY. ALSO NEEDS FOLLOW-UP ON SKIN GRAFT HEALING

_____ Patient/S.O. communicates understanding of follow-up instructions.

10. Patient's Condition (Health Status relative to Nursing Care Plan):
VSS, STABLE ↓ MODERATE PAIN SOMETIMES WHEN DOING DRESSING CHANGES. NEEDS PT/OT IN LOCAL HOSPITAL AND DEFINITIVE CLOSURE ON (R) STUMP.

11. Signature (Registered Nurse)
1LT (b)(6)-2

13. Patient Identi

12. Additional Information:
HELP ↓ 3 DAY SUPPLIES OF
- GAUZE - 4x4
- TAPE - KERLEX

MEDICATIONS - 3 DAYS SUPPLIES AS LISTED ABOVE.

COPY 1 - INPATIENT RECORD COPY

DA FORM 3888-3, JUN 91 REPLACES DA FORM 3888-5 (TEST), AUG 85 WHICH IS OBSOLETE. USAPPC V1.00

MEDCOM - 3945

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

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

1. Date/Time:

2. Discharge to: ☐ Home Other *(specify)*

3. Mode: ☐ Ambulatory Other *(specify)*

4. Accompanied by:

5. Activity: ☐ Limitations *(specify)*

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☐ No Dietary Restrictions If special, identify

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

(b)(6)-2,(b)(6)-4

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:

Patient/S.O. observed Demonstrations (Date)

Patient/S.O. Returned Demonstration (Date)

(b)(6)-2,(b)(6)-4

Equipment/Supplies (Specify)

9. Follow-up: You should be seen (b)(6)-2,(b)(6)-4 clinic in _____ (time period).

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

_____ Patient/S.O. communicates understanding of follow-up ir

10. Patient's Condition (Health Status relative to Nursing Care Plan):

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

11. Signature (Registered Nurse)

12. Additional Information:

13. Patient Identification:

COPY 1 - INPATIENT RECORD COPY

DA FORM 3888-3 JUN 04 REPLACES DA FORM 3888-3 OCT 85 WHICH IS OBSOLETE USAPPC V1.00

MEDCOM - 3946

NSN 7540-01-075-3788

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

TEST RESULTS

CBC: WBC / H/H / PLT	SMAC	ABG/PULSE OX: SUP 02 / PH / P02 / PC02 / SAT / OTHER	RADIOLOGY — Check if read by radiologist ☐
PT		U/A: DIP / MICRO	RESULTS
APTT	BHCG / ETOH / GLU		EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

25 yo Iraqi seen & treated c̄ the FST → (b)(3)-1 [redacted] to us. c̄ large necrotic wound. Pt has undergone dressing Δs elsewhere. S/p R BKA

PE: O×3

Lg CTA cor rrr abd soft

c̄ large punctate open areas?

prior I&D (FST) c̄ fibrinous exudate ?pus will take to OR for washout, dressing Δ & wound exploration

Hct 26.5%

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT ... AND STAMP

(b)(6)-2 [redacted]

PR...

DIAGNOSIS

Soft tissue injury (L) flank s/p (R) BKA

CODES

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

(b)(6)-4 [redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-4

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

SEX

AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

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

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 INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

(b)(6)-2

SPO2

VITAL SIGNS

TIME					
BP	131/90				
PULSE	116				
RESP	16				
TEMP	98.4				
	97				

LAB ORDERS

☐	CBC/DIFF	☐	BHCG/URINE/BLOOD/QUANT
☐	URINE C&S	☐	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)*

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-98)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

DATE	NOTES
16Apr03 @0230	Pt voided 525cc clear amber urine via urinal. [redacted] CPT/AN
16Apr03 @0400	VS: P 105, BP 91/48 Map 63, RR 23, Pulse Ox 89% on room air, T 98.7 oral. Encouraged use of Oxygen mask, pt takes it off. Will continue to monitor. [redacted] CPT, AN
16 Apr 03 0600	End of Shift Note: Pt assessment done. Pt A&O, speaks Arabic - translator available. All dressing on flank & and shoulder are clean, dry & intact. No drainage or odor noted. Pt able to move around in bed without assistance. Lungs clear @ bases c scattered rhonchi anteriorly. Abd slightly firm c (+) bs x 4. Pt tolerating PO well. Discussed importance of oxygen with pt, but he refuses to keep it on. Without supplemental oxygen, pt sats in 80s. Will continue to monitor. [redacted] CPT AN
16APR03 0745 (local time)	Nursing: pulse ox 88% RA - At refused O2, BP 106/68, T 99.2 P 85, RR 24; LR infusing to (R) AC @ 150cc/hr (R) BKA ace wrap intact, Yo pain - medicated c 2mg MSO4 IVP; dressing to (L) incep-CDI; +R pulse bilateral upper extremities; dressing to (L) flank - dry, tape falling off - will change when pain is under control; lung sounds - (L) side rhonchi @ bases (R) side clear, (+) BS x 4 quads [redacted] CPT/AN
0905	3Mg MSO4 & 1Mg versed given IVP as pre-med to dressing change; 7mg MSO4 & 4Mg versed IVP given during dressing change @ 0930 [redacted] CPT/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15APR03	Nursing Note
1623 (local time)	T100.8; BP 112/57, R 20, Pulse Ox 82% on Room Air; P111 Pt transferred from ICU #1 [(b)(3)-1] fixed facility to ICU #1 8th CSH (temper); s/p (R) BKA, (L) flank soft tissue injury; pt placed on mask 6L O2 - pulse ox 96%; no c/o pain @ this time; +2 pulses to bilateral upper extremities & (L) LE; dressing c/d/i (L) flank CDI; (L) arm dressing CDI; (R) BKA ace wrap CDI; LR infusing via (R) arm [(b)(6)-2] PT/AN
1900	Pt has taken O2 mask off during shift. explained to pt to keep on; nasal cannula used, pt sat 90% on 3L NC but refuses to wear; sats on RA 80-85% [(b)(6)-2] CPT AN
15Apr03 @2000	Pt voided amber urine 650cc via urinal. [(b)(6)-2] CPT AN
15Apr03 @2200	Pt voided 400cc light amber urine via urinal. Will continue to monitor. [(b)(6)-2] CPT AN
15Apr03 @2201	VS: T100.8 PO, HR 111, BP 106/63 map 79 and Pulse Ox 90% on RA. Attempted to place 4L NC on pt and pt refused oxygen. Will continue to encourage O2 use [(b)(6)-2] CPT AN
15Apr03 @2200	Gave Tylenol 650mg PO x1 for temp 100.8 [(b)(6)-2]

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

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

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

PROGRESS NOTES
Medical Record

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

MEDCOM - 3950
509-114

DATE	NOTES
(cont)	1000cc dark urine output via foley this shift [redacted] CPT/AN
1900	1 Vicodin given for c/o pain [redacted] CPT/AN
16Apr0220 1930	Report received assessment done. VS: T101.2 oral, HR 109, BP 100/52 map 70, RR 23. 650mg Tylenol given PO. Will continue to monitor closely. [redacted] CPT AN
16Apr0320 1930	Pulse Ox 89% on RA, encouraged use of O2. Will continue to monitor closely. [redacted] CPT AN
17Apr0300 1300hrs	VS: T 98.4, oral, Pulse Ox Sat 92% on RA, P91, BP 107/60 map 77, RR 22. Will continue to monitor @ 0600 as ordered [redacted] CPT AN
17 Apr 03 0030hrs	Emptied 1100cc amber urine from foley. Had to lower foley to ground and assist with drainage Pt c/o abd pain - when bladder palpated - found full. After foley drained Pt felt better. Will continue to monitor closely [redacted] CPT
17 Apr 03 @ 0615	Pt continues to rest in bed (WSS. Azebrite). Oriented and follows commands. Pt remains non-compliant with supplement O2 use at times. Currently 91% Sat on RA. Pt flank dressing with some serosanguinous drainage noted - unchanged due to pt returning to DK this AM @ 0715hrs. Pt kept NPO since MN. Palpable pulses x 3 extremities. (R) BKA c drainage on dressing - palp femoral pulse. Lungs CTA c occasional fine scattered rhonchi anteriorly. Abd slightly distended c @bs x 4. DN&V. Foley to gravity. Will continue to monitor level of comfort and VS closely. [redacted] CPT CK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16APR03	Wet to dry dressing change done to ⓛ flank soft
1000	tissue wound; 2 large soft tissue wounds, c multiple smaller wound - some granulation tissue present, 20% slough tissue is in smaller wounds [redacted] [redacted] CPT/AN
1130	Pt OOB to chair for 60 minutes, ate some lunch - tolerate well, pt insisted ne return to bed; dressing to ⓛ flank and ® [redacted] dry & intact [redacted] CPT/AN
1500	Pt c/o unable to void, q void this shift, urethra red, swollen; Dr. [redacted] into assess and cathe patient, over 800 cc out immediately; catheter left in; pt resting comfortably [redacted] KAR
1815	T 100.9 P 119 RR 20 BP 106/62 Pulse ox 96% on RA; Dressing to ® BKA - shadow drainage posterior; Dressing to ⓛ flank shadow drainage posterior; ⓛ arm dressing CDT; unstructed & encourage deep breath and OOB to chair; pt sat at side of bed for dinner; thru translator instructed pt on importance of getting OOB; pt OOB x1 today to chair & ↑ to side of bed x1; urine output total

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

MEDCOM - 3952
509-114

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4/17/03 0000	Emptied 450cc clear amber urine from foley; had to lower bag to ground before it emptied. Will continue to monitor. [redacted] CPT USN
17apr03 0714	Nursing: BP 104/61, T 100.5, P 107, RR 22, pt scheduled for surgery this am, instructed he is NPO, 88% pulse ox on RA - pt refuses O2; dressing to (R) BKA & (L) flank & shawdow drainage - will be changed this am in OR [redacted] CPT/AD
4/17/03 0905	~~Op~~ Op Note Preop Dx: (L) flank wounds (R) BKA Postop Dx: Same Proc: (R) revision BKA & application of skin traction Surgeon: Nilsson Anesth: Gen EBL: Min Comp: ø Drains: Penrose Findings: small subQ fluid collection adjacent to ~~ti~~ tibial stump. Nice granulation. Post comp. shortened.

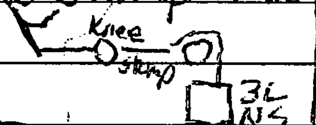
[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SOR'S ID NUMBER
	LAST	FIRST	MI	(SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

[redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
18APR03	0800 hrs Nurses Note: Patient lying in bed sleeping quietly. Easily arousable to verbal expression and tactile reception through motor kinetics. Pupils equal & reactive to penlight luminescense. Intravenous line to right antecubital is size 18 gauge flowing without inhibition c̄ a dial-a flow coupler for accurate accountability of intravenous fluid input. Foley catheter draining bronze colored urine. Foley evacuated p̄ balloon stabilizer depressurized using a 10cc B-D syringe, purulent drainage observed on distal catheter epithelium. Ⓡ stump is to 3L NS traction as diagramed below: Skin Traction
	 Blue chuck x 2 set under serosanguinous draining stump. ⊝ Pussy purulent drainage observed —
	Ⓛ Flank present c̄ multiple confluent schrapnel ulcerations requiring sterile irrigation and wet to dry Δ's 
18APR03	Tolerating PO well. (b)(6)-2 [redacted] KT/AN
1600	Patient received 20 gauge IV to Ⓛ FA. D/C Ⓡ AC IV because of venous swelling & tenderness. Colace prescribed for difficulty c̄ evacuating feces. Monitoring VOP, ⊝ void in 6 hours. Will recath @ 1700 if no void (b)(6)-2 [redacted]
18APR03 1730	Foley catheter started on patient. Dark golden glazed tinged urine evacuated x quantity. (b)(6)-2 [redacted]
18APR 1800	Patient alert & oriented, Able to state name and repeat name of nurse. Fluid ↑ p̄ dark urine emptied and volume of urine borderline. (b)(6)-2 [redacted] KT/AN
18APR03 1918	Pt A+O x 1, VSS - sinus tach, c̄ shrapnel wounds to Ⓛ side + BKA Ⓡ LE. BKA Dressed + wrapped to 3L NS traction. Stump is bloody, draining moderate amounts of blood. Dressing to Ⓛ side is C/D/I. draining small amounts of

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17APR03	(0925) Patient groggy from anesthesia. Vitals stable. Sats 100% ☐ 4L O2 Stump wrapped & intact to traction ☐ 3L bag. Lungs clear to auscultation. ⊖ vomiting. Voiding to foley ☐ gravity clear straw colored urine. Sufficient. Heart rate WNL & skin color appropriate for ethnicity. ⊖ (L) Flank dressing CDI [b)(6)-2]
17APR03	1300 Δ flank dressing. Multiple deep ulcerations packed c Wet-dry. Beefy red appearance. Mild odor. ⊖ purulent drainage. Pre-medicated c 10mg MSO4 & an additional 5mg MSO4 during the procedure. Tolerate PO well. IV t. (R) FA present c ⊖ Redness & swelling. [b)(6)-2]
17APR03 2011	Pt Alert, VSS, PAO2 fluctuates to low 90's / high 80's. Given O2 via simple mask @ 4L/min, ↑ PAO2 to 99%. Dressing to (L) side is covered in gauze / foam tape. Saturating dressing / chux c clear, serous fluid. (R) BKA draining to dressing moderate amt of bloody drainage. Attached to 3L bag of fluid for traction. Slightly elevated. Foley draining clear yellow urine >30 cc hr. Infusing LR to (R) FA @ 125cc/hr. O2 on blow by. [b)(6)-2] 91C3H
2200	Pt c/o nausea / stomach pn. Given 25mg phenergan IV. [b)(6)-2]
0035	Pt removed dressing to (L) side. Replaced dressing + given Vicodin for pain. [b)(6)-2] 91C3H

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	[b)(3)-1]	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[b)(6)-4]

PROGRESS NOTES
Medical Record

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

MEDCOM - 3955
509-114

DATE	NOTES
2130	Wound. Packed c gauze soaked c Dakin's solution. (R) BKA Dressed + elevated c 3L NS to traction. Dressing oozing sero-sanguinous fluid. Premedicated c MSO4; tolerating dressing Δ well. IV of NS @ 200 cc/hr infusing to (R) FA s infiltration. Foley draining clear yellow urine >30 cc/hr. Tolerating PO H2O s N,V. (b)(6)-2 91C3H
2300	Pt c/o (R) thigh pain. Site is warm + dry, ⊖ deformities noted Given 3 mg MSO4. (b)(6)-2 91C3H
0430	Pt c/o pain; offered 2 T3 PO. Pt refused; signed he wants morphine. Tried to explain to pt. MSO4 only for dressing Δ. Will continue to monitor. (b)(6)-2 91C3H
0745	Patient sleeping quietly. Skin traction in place x ⊖ dyspnea, ⊖ Vomiting. Will perform dressing Δ p. Doc early. Dressing c (R) leg Stump presents c breakthrough serosanguinous fluid. (b)(6)-2 LCT/AN
1830	Patient sleeping quietly, Sats transiently dip into the 89% barrier. O2 restores Sats >95% quickly <30 secs. Dressing c (L) stump Δ'd and beefy red granulations. Appetite decreased, ensure utilized to make up calories. (b)(6)-2
1845	Tylenol 650 given for fever (b)(6)-2
2000	Pt A+O x 1, VSS, temp 100.4° F. Premedicated c 10 mg MSO4 prior to dressing Δ. All wounds appear to be healing well s s/s of infection. Redressed and soaked in Dakins solution. (R) BKA Was rewrapped in Coban by a.m. shift, appears dry + intact. Small amounts of sanguinous drainage to chux on bed. Lungs CTA (B), BS active x4, distal neuro-vascular intact x3. NS @ 200 infusing into (R) hand, s s/s of infiltration or infection. (b)(6)-2 91C3H

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 APR 03	serous fluid. Foley catheter draining dark amber
1918	urine. Resting comfortably, tolerates PO s̄ N,V NS @
	200 cc/hr to Ⓛ FA. (b)(6)-2 [redacted], 91C3H
2330	Dressing Δ to Ⓛ side reveals 2 large + multiple
	small wounds all are healing well, s̄ s/s of
	infection. Tiny amount of eschar noted in one wound.
	Dakin's solution used to change Dressing. (b)(6)-2 [redacted] 91C3H
0540	Pt foley drained 1100 cc, extremely odiferous amber urine.
	Intake - 2400 cc NS, 200cc Ancef.
0732	U/A - Glucose - NEG, Bilirubin - Small, Ketone - Large
	SG - 1.020, Blood - Neg, PH - 5.0, Protein - trace,
	Urobilinogen - 1, Nitrite - Neg. (b)(6)-2 [redacted], 91C3H
19 APR 03 0760	Patient alert, tolerating breakfast well. Ⓡ leg to 30 lbs traction
	Plan: Premedicate c̄ MSO4 Δ dressing to Ⓛ flank. (b)(6)-2 [redacted]
0830	Dressing changed to Ⓛ flank. Good pink bed border c̄ small
	blood streams flowing uniformly. Packed c̄ W-Dry Dakins solution. [illegible]
0930	Patient lying in bed. Repositioned for better traction effectiveness.
	(b)(6)-2 [redacted], 1LT / AN
2130	A+O x1, VSS, Lung sounds CTA Ⓑ, BS active x4, Dressing to shrapnel
	wound on Ⓛ side Δ'd. Granulating well, s̄ s/s of infection.
	Small amount of purulent drainage noted on one small

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

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

PROGRESS NOTES
Medical Record

(b)(6)-4 [redacted]

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Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3957
509-114

DATE	NOTES
22 APR 03 2330	patient, and moved pt out of bed to chair for 30min. Attempting to get patient to drink Mag Citrate, tolerates small amounts at a time. (R) BKA redressed during am. shift, small amounts of sero-sanguinous drainage to dsg + dressing. Pt excreting urine via foley >30 cc/hr. NS infusing to (L) FA @ 200 @ [redacted]
22 APR 03 0700	Recieved pt resting in bed. Pt easily arousible. Lungs CTA. S, S, sinustachy. Distent BS x 4. +2 radial pulses. +2 (L) pedal pulse. Cap refil <3 sec. @ 0800 Dr. Petroski preformed dressing A on (L) flank. Pt premedicated c 10mg Morphine 5mg Versed by VO Dr [redacted] Pt tollerated well. After dressing A on flank (R) BKA dressing change done. Area was pink/red. Wet to dry using Jenkins solution. Pt tollerated procedure well. @ 1015 1 enema given. 5 minutes pt placed on bedside commode. With No results @ 1030 2nd enema given. Pt set on commode 15 minutes with no results. Dr [redacted] wrote an order for dulcolax supp q 6° until results. @ 1400 pt has small BM, diarrhea about 50cc. to bedside commode. @ 1630 Dulcolax 10mg Supp given. Pt tollerated well. 1700 pt had appx 300cc diarrhea c formed stool at bedside commode. W/I continue to monitor. Pt did not eat breakfast or dinner, ate 2 pears + crackers for lunch. @ 1700 Dr [redacted] gave VO to dc Foley. Foley DC. Pt has not voided prior to shift change. [redacted]

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 3958

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21APR03 0600	Pt Alert, VSS, T max 98.5° F. Foley output 750cc dark amber urine c trace sediment over 12°. Stump to (R) BKA c small drainage (sero-sanguenous). [(b)(6)-2] q1C3H.
21APR03 0600	Received pt sleeping in bed. Pt easily arousible. Lungs CTA, sinus tachy. Distant BS x4. +2 radial pulses +2 (L) pedal pulses. Cap refill <3 sec. Dressing change to (L) flank done by Dr [(b)(6)-2]. Tissue mostly pink. IV in (L) forarm 200cc/hr NS. Foley to gravity. (R) BKA dressing with clear bloody drainage. 3L bag of fluid used for traction. Will continue to monitor- [(b)(6)-2] 9(c)M
1130	Dr [(b)(6)-2] preformed the dressing change on pt (R) BKA. Pt was pre-medicated c 100mg Demerol & 2mg versed by verbal order of Dr [(b)(6)-2]. Pt tollerated procedure fairly well. Pt was cleaned up afterwards and ate ~~eat~~ half a cup of blueberry sause will continue to monitor- [(b)(6)-2] 9(c)ML
2330 21APR03	Pt Alert, VSS, NAD, presents c shrapnel wounds to (L) side and (R) BKA. (L) side wounds are healing well, tissue is granulating, c s/s of infection. Redressed c sterile gauze soaked c Dakins solution. Multiple small lacerations to (L) arm, back, leg. Performed AM care on

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PROGRESS NOTES
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Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3959
509-114

DATE	NOTES
23APR03	0700 recieved pt resting in bed. Lungs C/T/A. S_1S_2 sinus tachy. BS active x4. +2 radial pulses. +2 (L) pedal pulse. Cap refil <3 sec. Dressing to (L) Flank C/D/I Dressing to (R) BKA has scant amount of clear brown secretions. (R) BKA to traction c 3L NS. @ 0900 Dr [b)(6)-2] preformed dressing change on (L) Flank. Tissue pink/red, healthy looking. Pt was premedicated c 10mg morphine 5mg versed. After dressing Δ to flank, dressing change to BKA. Tissue pink, red, c white throughout. Old dressing has small amount of bloody drainage, yellowish, beige color drainage noted on old dressing. No foul oder noted. Pt tollerated procedure well. @ 1400 PT came by at steer pt up with cruches. Pt tollerated well. Pt became dizzy after standing after about 2 minutes. Pt ate all of breakfast and an apple for lunch. Did not eat dinner. VS within normal limits. Pt has uneventful shift. Will continue to monitor- [b)(6)-2]
23APR03 2156	Pt A+O x 3, VSS, NAD. Shrapnel wounds to (L) side are healing well, granulating c epithelial buds present. Ø S/S of infection seen. (R) BKA covered in dressing, which has a small amount of drainage. IVF of NS infusing to (L) FA @ 200cc QH. Tolerating PO c Nausea / Vomiting. Pt voided, BM x 1 on BS commode approx. 600 cc clear yellow urine. BM was small yellow in color, soft, c formed stool. Pt c/o ph to (R) BKA. [b)(6)-2] 91C3H
24APR03 2400	Assumed care of pt. Report via SSG [b)(6)-2]. Pt resting comfortably. [b)(6)-2] CPT, AN.

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22APR03	1845 Pt penis has purulent discharge. Some redness
	noted. Will continue to monitor — (b)(6)-2 [redacted]
22APR03	pt Alert + oriented x 3, VSS, NAD, c̄ Ⓡ BKA + Ⓛ sided
BP:	Shrapnel wounds. Δ d dressing to Ⓛ side, healing
T: 100.0°	well c̄ epithelial buds, s̄ signs/symptoms of infection.
P: 90	Used 1/4 strength Dakins solution + packed c̄ gauze.
R: 22	Multiple small lesions also appear to be healing
	well beefy red in color, ⊖ purulent drainage, ⊖
	tenderness to palpation, surrounding area is warm +
	natural skin tones. Ⓡ BKA is dressed in stockinette gauze
	+ covered by Coban wrap, c̄ small amount of bloody drainage
	to anterior portion of dressing. Pt voided 850 then an
	additional 500 cc of clear, light yellow urine via
	urinal. Given Ducolax PR x1 s̄ results, although
	pt did verbalize the urge to deficate, and
	sat on B/S commode. Used incentive spirometer c̄
	medium results achieved - approx. 1500 mls of inspiratory pressure.
	Taking PO fluids s̄ nausea, vomiting, BS active x4.
	Lungs sounds CTA Ⓑ. (b)(6)-2 [redacted] 91C3H
23APR03	Gave Dicolax PR s̄ result. Pt voided approx 300 cc
0630	clear yellow urine. (b)(6)-2 [redacted] 91C3H

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(b)(6)-4 [redacted]

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

MEDCOM - 3961
509-114

DATE	NOTES
25APR03 0730	assumed care of pt. pt apont awaken with light touch. PT refused to eat breakfast. pt c/o pain : request MSO4/ LOST MSO4 IVP @ 0300hr. PT response to Commands, PERRL, - ABle to turN : re position Self on bed S assistence. RR 20, unlabored. BS END EXP coarsenes c few wheez @ b/l bases, RA O2SATs , HR 89, S. Sz (PPP X3. @ BKA) SKIN W·D CAP Refill X 3sec. Skin color WNL. ABD SOFT NON tented, B S x 4, has NOT Voided this Shift. DSG L Chest FlanK, Intact, @ BKA Intact (PlaN BACK to OR ON Monday) SM scattered healed / healing (wounds) on L ↑ EXT DSG to be done this AM. IV in L FA, 20g @ S·S infec/infil NS infusing @ 200cchr. (b)(6)-2 maya
25 APR03 0745	pt request IV MSO4/ vs Tylenol 3. for pain 8mg NO given. Instructed by Surg team to inform pt if he continue to refuse to wear his brace on his stump he will be Discharged. (b)(6)-2 mAm
25APR03 0900	DSG D done to L Chest FlanK. by DR [redacted] W-D done c Dr Ken 25%. Two Lg wounds beefy red granulation of edges, Mult SM wounds also. wounds S·S infec, Surg PAD / 2x2, place on wet dsg. PT Tol OK Versed / MSO4 given before procedure. (b)(6)-2 mAm
25 APR03 1400	PT Sleeping off & on Throughout the Shift C/O pain Chest / BKA 03 pt request MSO4 IVP doesn't want Tylenol #3, refused to eat breakfast lunch, voided 1000cc CL amber urine, VS Stable —

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(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0600	Pt c/o pain. Medicated c MS 10mg IV. Pt refused to place amputated leg on traction. after being off for a period of time. [(b)(6)-2] aat RN
24APR03	Recieved pt resting in bed at 0600. Lungs CTA. S1S2 sinustachy. BS Active. +2 radial pulses. +2 (L) pedial pulse. Cap refil <3 sec. (L) flank dressing c/d. Dressing to (R) BKA with scant amount of clear brown drainage. Pt premedicated with 10mg MSO4 & 5mg versed @ 0830. 0845 Dr [(b)(6)-2] changed dressing on (L) flank. Tissue looks healthy pink/red. After flank dressing wet→dry dressing done on BKA. BKA has some bridge yellowish secreasions on bandages. Wet→Dry c dakins solution. BKA pink/red. Pt refusing to have BKA in traction. [(b)(6)-2] 9(6)Pk
24APR03 2200	Pt A+O x3, VSS, presents c (R) BKA / (L) side multiple shrapnel wounds. Dressing d's reveal healthy granulating tissue s signs/symptoms of infection. Ø drainage noted to dressing. IV site d/d to (L) FA, infusing NS @200cc. Pt voiding well via urinal, qs, clear light yellow urine. Pt refusing traction to (R) BKA. [(b)(6)-2] 9, 1C3Pt

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Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3963
509-114

DATE	NOTES
26 APR 03 0800	pt awakened to start IV & am assessment. neuro: pt follow commands, move all ext. Resp: BS CTA, O2 SAT 92% on RA, IS X 10 @ cough, CV S1 S2 SKIN Warm & Dry CAP L3 sec PPP x 4 @ JVD @ 45°. GI, ABD SOFT NT, BS X 4, Last BM 26 APR. hypoactive. GI has not voided this am. SKIN Wounds Chest & Flank, Lg DSG intact @ DSG, @ BKA, DSG intact & old DSG drainage. Plan of Care. D/C to CIV Hosp OR Pt will remain @ mcl Hosp pending skin grafting on Monday [redacted] mgy
26 APR 03 0810	IV placement pending this am, attempts unsuccessful by Off going shift [redacted] mgy
0830	20 g IV placed in L WRIST, LR ↑ @ 125cc/hr
26 APR 03	per D.O [redacted] mgy
0900	DSG & done by [redacted], [redacted] / mgy given by LT [redacted], wound care cont to show signs of healing @ edges & S S S
26 APR 03	infection [redacted] mgy
1315	Hygiene care done by pt & min assistance. Interpreter @ BS. pt received information on the importance of WT on BKA, but he still refuse R/T pain control. Also pt received information of diet intake which is poor, one of the interpreter stated he will bring food ex day for the pt and write a letter to his family. @ D/C assessment [redacted] mgy

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
PONT 1400	pt reported relief from GI upset F 30cc Maalox was given [(b)(6)-2] MSN
25 APR 2200	Pt was A+Ox3 able to full sensation small ext, able to move extremities independently. Lungs CTA. using IS during shift, O_2 sats 93% RA. +2 pulses in all ext <2 sec cap refill ext. Warm and dry. S_1S_2 heard. Patient tolerating regular diet ate 10% of meal this evening. +BS all 4 quadrants ø tend, ø dist. +BM, solid moderate amount. Patient voiding spontaneously in urinal. Clear yellow urine. Wound on @ flank small amount of sanguinous drainage. healthy pink granulated tissue present. (R) BKA: small amount of drainage bloody medicated for pain x3 during shift. VSS. Will continue to monitor. [(b)(6)-2] SCE
25 APR 03 2349	Pt A+Ox3, VSS - +- max 99.6°, Lungs CTA (B), Distal Neuro-vascular intact x3. (R) BKA is wrapped in a stockinette and Coban c a small amount of drainage to the posterior aspect. (R) side is dressed in Gauze + tape; C, D, I. ø Signs + symptoms of infection at either site. Tried to explain to pt that he is leaving tomorrow. c some success. Pt tearful, but responds appropriately to interaction. [(b)(6)-2] 91C3H

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[(b)(6)-4]

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3965
509-114

DATE	NOTES
27APR03 0745	Patient resting quietly. Bandage & (L) flank CDI. Stump & (R) Proximal Tib/Fib Secure & minimal bleed through. (-) dyspnea (-) difficulty urinating. [redacted]
1300	Dressing Δ'd & patients (L) flank. 2 large open wounds healing & secondary intention. Borders present & beefy red interior, small 1cm areas cleaned out. (-) necrosis. IV started & (L) FA. Benadryl given for itchy [redacted]
27APR03	1600 recieved pt resting in bed. Easily arousable Lungs C/T/A. S1S2 NSR. BS. Dressing on (L) flank C/D/I. Dressing on (R) BKA, no drainage noted. VS within normal limits. Will continue to monitor. @2115 pt premedicated & 10mg morphine & 5mg versed @2130 dressing change done on (L) flank wet→dry & NS. Wounds were pink/red. no foul odor noticed. At 2200 dressing Δ done on (R) BKA, yellow bi edge discharge noted on old dressing. Area irrigated & NS. Tissue red/pink. Wet→Dry dressing done. Pt tollerated procedure well. Pt resting comfortable in bed. [redacted]
28APR03 0600	PA A+O×3, VSS, NAD, NPO p MN for skin graft this am. Lungs CTA (B), BS Active×4, Dressing to (L) flank C/D/I (R) BKA has no drainage. Distal Neuro-vascular intact×3. Voiding via urinal 775 cc clear/yellow. tolerated PO @2330 & nausea, vomiting [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 APR 2130.	Pt is AtOx3 has sensation in all ext. pt ambulated with crutches x1. Lungs CTA bilaterally O_2 sats >95% Pt using incentive spirometry accurately. Ø evidence of labored breathing. has +2 pulses all ext. <2sec cap refill ext are warm and dry Ø edema present. Patient tolerating regular diet, last BM on 25 April Ø dist Ø tend. of abdomen, +BS all 4 quadrant. Voiding spontaneously in urinal. clear yellow urine. Pt has (L) wrist PIV 20 gauge C LR @ 125 cc/hr. Wound care done on patient (L) flank wound healthy c pink tissue surrounded by granulated tissue on edges. Small amount of drainage present. (R) BKA has moderate amount of bloody drainage. Pt refuses skin traction at this time. Medicated for pain x1 c dsg D 10 mg MSO4 IVP c relief. VSS Continue to monitor — (b)(6)-2 — VCT, AN
26 APR 03 2350 hrs	Ht Alert, VSS - T-MAX 99.0°F, PAO_2 - 92%. WNL for patient. Lung sounds CTA (B), BS active x4, Distal Neuro-vascular intact x3. IVF of LR @ 125 /hr via IVG ~~or~~ R (L) wrist. (L) Flank dressing C/D/I. (R) BKA has small amount of old bloody drainage. Medicated for pain. Tolerates PO c nausea, vomiting. (b)(6)-2 91C3H

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PROGRESS NOTES
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509-114

DATE	NOTES
29Apr 03 0430	Pt alert and eating crackers/lemonade. Voided 600 cc clear urine. Stated Lt (b)(6)-2 dressing itchy. Administered Ambien for sleep. Chapstick applied to lower lip. DRSG Lt thigh Dry & Intact. Stump sock DRSG Dry VS stable. c/o pain. Adm morphine twice. Patient slept most of the night. IV LR patent Lt forearm IV site ∅ redness or swelling (b)(6)-2 Mg/bm
29APR03 0730	Patient sleeping quietly, arousable on calling. Skin color even and warm. Dressing to (L) flank White, clean, dry & intact. Dressing to (R) DE stump CDI. No dyspnea noted. Will further assess ∅ breakfast. (b)(6)-2
29APR03 1500	Pt resting in bed. Easily arousible. Lungs CTA. S_1S_2 NSR. +2 radial & (L) pedal pulse. Cap refill <3 sec. IV 18G in (L) forarm. BS active (R) upper & lower quad. Unable to access d/t to dressing. Dressing to (L) flank c/D/I Dressing to (R) BKA C/T/I. Pt has no complaints at this time. Will continue to monitor. @1700 pt voided 500 cc clear yellow urine @1800 pt IV would not flush. 18G IV started in (R) forarm. TKO. @2000 pt voided 600 cc clear yellow urine. Pt resting in bed. Will continue to monitor — (b)(6)-2
30Apr03 0545	Patient slept most of the night. Medicated for Lt flank pain tw (x2) with morphine. C/o itching Lt flank. Adm. benadryl x2 (twice). Voided 1000 cc Clear urine. Rt leg stump dressing came off. Abd, kerlix and ace wrap applied. Wound site ∅ drainage ∅ pus. IV Rt forearm patent. Drank 8 oz ensure @ 0550. Applied chapstick and lidocaine (topical) to lower lip. Lt (b)(6)-2 dressing dry & intact. old drainage spot marked. Otherwise dry and intact — (b)(6)-2 m/bm

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28APR03 1500	Pre-op pt. VSS, A+Ox3, abd soft, bs x4 quadrants. Pt urinates via urinal quantity sufficient clear yellow urine. ⊖ drainage from dressing. Ⓒ Flank dressing changed in OR. Post-op pt. VSS. Lung sounds CTA. Pt stating between 90-94% RA, P 123-111, R-20-30 bpm. Pt bite lower lip in OR. Litocain applied, chapstick at pt bedside. IV LR running 125cc/hr in Ⓛ forearm 20G. IV running well no signs of infection. Pt is on strict bedrest skin graft on Ⓒ Flank. Donar site Ⓛ thigh. NO Dressing changes to be done. Diet advance as tolerating. [redacted]
28APR03 1800	Recieved pt on litter resting in bed. Pt is alert Lungs C/T/A. S.S. sinustachy. BS distant x4. +2 radial pulses. +2 pedal pulse. 18G IV in Ⓛ forearm. Dressing to Ⓛ Flank c/d/i. Dressing on Ⓛ theigh c/d/i. Dressing on ⓇBKA c/d/i. Pt has no complaints at this time will continue to Monitor @ 1830 pt voided 900cc clear yellow urine. @ 2000 pt voided 600cc clear yellow urine. Pt tollerating po. IV heplock. Pt ate a banana and drank about 75 cc of ensure. Pt had uneventful evening. Will continue to monitor [redacted]

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[redacted]

PROGRESS NOTES
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DATE	NOTES
30APR03 1616	(B), BS active x4, pt voided 1100cc clear, yellow urine via urinal. IVF of LR @ TKO to (R) FA S signs of infiltration/infection. [redacted], SSG, 91C3H
30APR03 (1800)	Pt. c/o itching. 25mg. Benadryl given IV. [redacted] 91C3H SSG
1800 1 May 03 0615-0	Pt slept majority of the night. c/o pain med 4 times. LT flank dressing dry & intact. Kerlaxon remains on LT thigh. Right stump dressing intact & dry. IV left forearm patent. ϕ urine output during the shift. Continue to monitor for BM. Last BM 25 Apr 03 - [redacted]
0745	Patient sleeping quietly. (L) Flank dressing CDI. Voiding clear straw colored urine. IV Flowing to @ FA ∈ ⊖ redness or swelling. Stump to @ distal extremity CDI. [redacted] LT/AN
1030	Patient itching, gave 50mg Benadryl IV. [redacted]
1110	Dressing changed to patients stump. Circumferential boundry well approximated c pink boundery and red, bleby interior. Premedicated c morph and valium c/o itching → benadryl IV utilized. [redacted]
1120	Got supplies for patient to do personal hygiene. Patient refused. State "pain" in Arabic. Pain medicine given @ 1110. Offered patient water also refused. Took MVI ∈ a small sip. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Apr 03 0640	pt states seeking motion from Rt hip stump - He did it once before my eyes. Adm pain medication for Lt flank pain. VS stable (b)(6)-2 s/a
30 APR 03 0800	Patient alert & oriented. HEENT: No masses, ⊖ JVD, neck soft/supple. ⊖ lesions/drainage. Tongue pink. Pt c/o itching to graft site, benadryl IV administered. Dressing to left flank is bulky, clean & dry. 3" tape intact, ⊖ rashes or redness to taped area circumference. Ⓡ stump unwrapped d/t. Patient frequently asking for pain meds. Will monitor for D/C. Lungs clear to auscultation, ⊕ voids straw colored urine. (b)(6)-2
1155	Bulky dressing removed from donor site & Xeroform left in place to dry. Patient premedicated but still experiencing pain and itching. Translator utilized and patient verbalizes understanding of not to touch surgical sites for possibility of infection. (b)(6)-2 CT/PN
1616	Pt Alert. Dressing to Ⓛ flank C/D/I. Ⓛ leg skin graft covered by Petroleum Gauze bandage which has dry edges but portion covering graft donor site is still wet, ⊖ signs of infection. Ⓡ BKA dressing D/d by a.m. shift, still clean, dry, & intact, FAROM to stump, although pt expresses pain & full extention. ⊕ Distal Neuro-Vascular x 3. (b)(6)-2 CTA

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(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2MAY03	Pt c/o itching, given 50mg Benadryl. Pt c/o dysuria, given urinal, able to micturate 200cc spontaneously. Bladder (-) distention. (b)(6)-2 91C3H
2 May 03 2300	Initial assessment: pt alert. Rt stump wound dry & intact. Lt flank wound dry. Xeroform on Lt thigh in place. Medicated for Lt flank itching (b)(6)-2
3 May 03 0410	Pt took out of Lt flank dressing off while scratching area. Dressing removed and abds x 4 reapplied. Wound site healing. Still had old dressing with old drainage. Not removed. Foam tape applied. Pt told not to scratch area. Benadryl and morphine administered. IV Right forearm patent. (b)(6)-2
3 May 03 0745.	STABLE, PERRLA, A&Ox3, VSS - SEE FLOW SHEET, DRESSING CHANGE ON (R) STUMP DONE, OTHERWISE CLEAR TO D/C BY ORTHOPEDICS STILL FEELING ITCHY ON SKIN GRAFT (L) FLANK - DRESSING D/C BY GENERAL SURGERY LATER IN THE MORNING - 50mg OF BENADRYL IV GIVEN PRN. LUNGS CTA, (+) BS, GOOD PULSES AND CAPILLARY REFILL x 3 ((R) BKA)
1015.	GENERAL SURGERY ARRIVED FOR GRAFT SITE DRESSING D/, WOUND TOOK 95% OF GRAFT, HEALING WELL & NO S/S OF INFECTION, PLAN TO D/C TO HOME HOSPITAL TOMORROW, CLEAR ACSO BY ORTHOPEDIC TEAM AFTER ROUNDS TODAY. CATHETERS 3 DAY SUPPLIES OF DRESSINGS FOR

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
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