

REPORTING MTF										LOCATION		ADMISSION AND CODING INFORMATION																	
(b)(3)-1										(State or Country Code)		For use of this form, see AR 40-400; proponent agency is OTSG																	
3. REGISTER NUMBER										NAME (Last, First, Middle Initial)										4. PAY GRADE		5. SEX							
9 10 11 12 13 14 15										(b)(6)-4										16 17		18							
6. DATE OF BIRTH (Y Y Y Y M M D D)										7. AGE AT ADMISSION			8. RACE		9. ETHNIC		RELIGION												
19 20 21 22 23 24 25 26										27 28 29			30		31		BACK-GROUND												
1 9 4 8 0 1 0 1										5 5 4			I																
10. LENGTH OF SERVICE										ETS		11. FMP			12. SOCIAL SECURITY NUMBER														
32 33 34												35 36			37 38 39 40 41 42 43 44 45														
												9 9			(b)(6)-4														
ORGANIZATION (Active Duty Only)										13. MARITAL STATUS										HOUR OF ADMISSION		BRANCH / CORPS							
										46										2 1 0 0									
14. FLYING STATUS										15. BENEFICIARY CATEGORY										16. ZIP CODE OF RESIDENCE									
47 48 49										50 51 52										53 54 55 56 57 58 59 60 61									
17. UNIT LOCATION (State or Country Code)										18. MOS										19. TRAUMA		20. PREVIOUS ADMISSION							
62 63										64 65 66 67 68 69 70										71		YEAR ☐ NO							
																				I N J									
20. SOURCE OF ADMISSION AUTHORITY FOR ADMISSION										WARD										NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE									
72										Direct										F C U S									
																				ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)									
(b)(3)-1																				TELEPHONE NUMBER OF EMERGENCY ADDRESSEE									
73 74										75 76 77 78 79 80										23. DATE OF DISPOSITION (Y Y M M D D)									
																				81 82 83 84 85 86									
																				0 3 0 5 0 8									
24. CLINIC SVC - ADMITTING										25. MTF TRANSFERRED FROM										26. DATE THIS ADMISSION (Y Y M M D D)									
87 88 89 90										91 92 93 94 95 96										97 98 99 100 101 102									
A B A A																				0 3 0 5 0 4									
27. LOCATION OF OCCURRENCE (Battle Casualty Only)										28. MTF OF INITIAL ADMISSION										29. DATE INITIAL ADMISSION (Y Y M M D D)									
103 104										105 106 107 108 109 110										111 112 113 114 115 116									
FOR LOCAL USE										SIP CACMOTOMY DX: V5843										Trauma									
										SIP trach 9985A										9									
										SIP ex tef 85405										Surgery									
										78003										109									
										V440																			
										EB199																			
(b)(6)-2										(red)										(b)(6)-2									
										MTC USA																			

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4926

INPATIENT TREATMENT RECORD COVER SHEET. For use of this form, see AR 40-400; the proponent agency is OTSG

1. REGISTER NUMBER (b)(6)-4		2. NAME (Last, First, MI) (b)(6)-4		3. GRADE		ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. LENGTH OF SVC	8. ETS	10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD CW3	20. TYPE CASE	
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN K-78	18. BRANCH/CORPS	19. UIC/ZIP	23. CLINIC SERVICE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	26. DATE OF DISPOSITION 6 May 03	ADMITTING OFFICER
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Home	28. DATE OF THIS ADMISSION 4 May 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED
29. NAME AND LOCATION OF MEDICAL FACILITY (b)(3)-1						
31.						
33. CAUSE OF INJURY						
34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES Open R Hip Fr, GSW L leg, Peroneal Nerve Palsy 344 g 890.0 ETL 93.5 Dressing						
35. Total Days This Facility						
a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS	
36. Total Days All Facilities						
a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS	
SIGNATURE (b)(6)-2 LTC, MC		SIGNATURE (b)(6)-2		SIGNATURE (b)(6)-2		

DA FORM 3647, MAY 79

EDITION OF 1 AUG 7

MEDCOM - 4927

USAFPC V1.10

PATIENT TREATMENT RECORD COVER SHEET For use of this form, see AR 40-400; the proponent agency is OTSG

REGISTER NUMBER (b)(6)-4		NAME (b)(6)-4		3. GRADE		ADMISSION REMARKS	
SEX	AGE	RACE	RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
FMP		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD CW 3	
15. FLYING STATUS	16. RATING/DSG	17. DEPT/BEN	18. BRANCH/CORPS	UIC/ZIP		20. TYPE CASE IM	
SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE ABAP		
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 6 May 02		
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 4 May 02	ADMITTING OFFICER	
NAME AND LOCATION (b)(3)-1				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE RECORD COMPONENT TRANSFERRED	

39. CAUSE OF INJURY ☐ Check if Continued on Back

40. DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Open R tibia Fr, GSW L leg, Personal Nerve Palsy ~~344.9~~
~~890.0~~ ~~EFT~~

~~93.5 Dressing~~

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
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36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
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SIGNATURE (b)(6)-2

LTC, MC

(b)(6)-2

SIGNATURE OF RAO OR MEDIC (b)(6)-2

DA FORM 3647, MAY 79

(b)(6)-2

EDITION OF 1 AUG

MEDCOM - 4928

USAGM 10-1

MEDICAL RECORD

PROGRESS NOTES

DATE	PRE OPERATIVE EVALUATION		
	General Diagnosis: <u>GSW RVS</u>	Proc. Planned:	Anesth:
	Anesthesiologist:	Surgeon:	
	Anesth. Risk Classification: <u>II</u>		
	Vital Signs: <u>Barrrr</u>		
	Physical Exam Highlights:		
	Procedure & risks discussed with patient: YES <u>NO</u> <u>UNABLE</u>		
	Prognosis: <u>GOOD -</u> <u>IRAGUS</u>		
	<u>RAW</u>		
	<u>R. Femoral Neck Fr</u>		
	Signature		
	POST OPERATIVE NOTE		
	Pre-Operative Dx: <u>GSW R. THIGH, D. THIGH, D. CAUL PERS</u>		
	Post-Operative Dx: <u>SAA E R. Femoral Neck Fr</u>		
	Anesthesia: <u>GENA</u>	Procedure: <u>IAD</u>	
	Surgeon: <u>NOTES / BARNS</u>		
	Findings:		
	1. <u>CLEAN WOUNDS MINIMALLY NEBROSIS,</u>		
	2. <u>PIECES.</u>		
	3.		
	4.		
	5.		
	6.		
	EBL: <u>MIN</u>	I/O:	Tissue sent to lab: <u>Ø</u>
	Prognosis: <u>POOR FOR R. Femoral Neck Fr</u>		
	Plan:	(b)(6)-2	
	<u>DRESSING A'S</u>		
	<u>MEDENAL ASAP</u>		
		Sign	

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

WARD NO.

OTES
rd
(REV. 5-99)
CFR)101-11.203(B)(10)

(b)(6)-4

MEDCOM - 4929

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
4 April 2003	Staff Note
0930	BPW with multiple GSW (3) → one to @ upper inner thigh (large cutaneous defect which is packed & gauze → underlying fo of head of femur noted on X-ray → not amenable to orthopedic surgery at this facility), @ upper inner thigh (cutaneous wound noted which is packed, but no hit wound), @ calf region (5x5 cm cutaneous defect down to muscle which is packed → NO underlying fracture by X-Ray) Pt also has superficial abrasion across top of penis of ? etiology. Remainder of exam WNL. USS - Splenic Lsg: Multiple GSW as stated above @ hip femoral head fracture Plan: Pain Management 1. Ur once / Tent Wound Care To O.K. for I+O today

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI
DEPT./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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 4930

(b)(6)-4

WV

DATE	NOTES
5 April 2003	<u>Staff Note:</u>
0820	Pt stable. Offers no new complaint. Legs clean Leads S.S. NO M G O R old benign ext wounds Dressed, yaws intact USS - ofebule Plan Continue Present Meds + Support Observation Medicare to appropriate facility
6 April 2003	<u>Staff Note:</u> Pt resting comfortably. When asked, he does admit to pain in injuries. ? saying he is doing some old dressing 1015 ⊕BS old soft USS - ofebule Plan: Continue Present Meds + Support VCR Transfer to another facility when available
7 April 2003	<u>Staff Note:</u> 0215 Pt appears to be comfortable but has obvious pain in legs with movement. Pt not eating adequately. old - ⊕BS; soft; legs - clean Leads - S.S.; NO M G O R USS - Trans 1011 Plan: Continue Present Meds + Support Encourage eating

(b)(6)-2

CDR [unclear]

(b)(6)-2

(b)(6)-2

CDR [unclear]

PROGRESS NOTES

DATE

2/8/03
2020

Dr. Michael Siegel

(b)(6)-2

ELW transferred today to
open Rt hip fx, complex wounds
on Rt leg. S/P I&D on 2/4/03,
th the date of injury, or soon there-
after. Age unknown.

Phen Hx: None reported or
documented for Field hospital.

Physical Exam (R) Buttock wound
2 x 3 cm

- (R) groin wound 2 x 2 cm Penile abrasion
 - (L) thigh wound 12 x 6 cm ant-medial
 - (L) calf wound 3 x 4 cm posterior
- distal femoral n. palp. Ventrally
palpable BP pulse on Rt.

Pl To OR for Eval / I&D of wounds.
Hx on chart, will transfuse
Post DPA. Pls for ORIF of hip.

(b)(6)-2

(b)(6)-2

MC USMC

(b)(6)-4

91-248120616

STANDARD FORM 508 BACK (Rev. 11-77)

MEDCOM - 4932

MEDICAL RECORD		PROGRESS NOTES	
DATE			
4/16/63 2040	ORTHO of nte		
	I = DD Rt hip & (L) leg see OR sheet for details. Placed in traction. Ph for ORIF of Rt hip in 48 hours if wound cultures of open fracture are negative.	(b)(6)-2	
			me USMC
9 APR 63 1430	Medical Nutrition Tx O: Do's Open hip fx BSW B thigh Diet Rx Regular. Labs 9 APR Hgb/Hct 9.5/27.9 Wt. estimated @ 70kg. RD offered PT ENSURE - pt. accepted A/P: Kcal needs: 30-35 kcal/kg/day = 2100-2450 kcal/day. Protein needs = 1.5 g/kg/day = 105 g/day Recommend Snacks + ENSURE TID between meals; if pt. not eating meal - offer ENSURE. Recommend MVI q day - will monitor Hain/Hct. F/U q 2-3 days.	(b)(6)-2	MPH, RD

(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.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMP (41 CFR) 201-45.505
509-111

MEDCOM - 4933

MEDICAL RECORD		PROGRESS NOTES
DATE		
4/4/07 2240	ortho	
	seen to translator. age 58. No Atherosclerosis. No blood hx No Meds. feels OK in TX	
	RO 8# TX wound dressed JP to suction	
	Inf Rt T-T. hip fx	
	PL: patient would cutting Pln for ORIF hip fx on Friday (2 days) if Cutting Reg to date.	
	(b)(6)-2	MC BASIK

(Continue on reverse side)

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

middle;

REGISTER NO.

WARD NO.

08APR03

PROGRESS NOTES

STANDARD FORM 508 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRM (41) (R) 20 5.1
508-111

MEDCOM - 4934

PROGRESS NOTES

DATE

9/14/03

NA

Orals

Looks OK

DL for get in AM

for I.E. of wounds

I will try to

close them if I

can

(b)(6)-2

28

PROGRESS NOTES

DATE

4/11/03

Ortho op NGB

1315

RT hip fx ORIF, cleaned th (h) thigh and calf wounds.

PL: Non wt bearing on Rt leg wet → dry dressing changes on left leg. In a few days I will likely be able to close thigh & skin graft calf

(b)(6)-2

(b)(6)-2

LS

MC USNR

PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)</i>	REGISTER NO.	WARD NO.
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b-6-4

MEDCOM - 4937

MEDICAL RECORD	PROGRESS NOTES
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DATE	
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4/15/03	Orthopaedic Surgery
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1240	
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① I debrided both wounds on his left leg. They should get wet to dry dressings for a few days then I can close them and skin graft or close the calf.

② I aspirated the Rt thigh because of pain & generalized swelling. No pockets of fluid identified. I plan to obtain a duplex to go a DVT on the right.

(b)(6)-2

RT McUSAR

4/16/03	Internal Med HTD # 9
---------	--------------------------

0930 s/p DHS Rt hip 4/11 + serial HTD ④ thigh + calf wounds, latest yesterday i plan wet to dry then close or graft as above. Called for possible lesion. Noted by Dr. (b)(6)-2 on admit - specimen today

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; medical facility)	REGISTER NO.	WARD NO.
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(b)(6)-4

PROGRESS NOTES
STANDARD FORM 508 (Rev. 11-77)
 Prescribed by GSA/ICMR,
 FPMR (41 CFR) 201-45.505
 508-111

MEDICAL RECORD	PROGRESS NOTES
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DATE	
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4/16/03 Cont'd Trt. Med. note
 0938 suggest STD vs neoplasm vs
 abscess. On exam ulceration
 to lower border ~ 3 x 3 cm (L)
 side distal shift / circumcised. (P)
 serosity. Non-tender.
 Hx syphilis, chancroid, HSV - neoplasm - tumors
 ✓ RPR, HIV; will do Tzanck
 + GS for N. mening; consider bx
 if late (P).
 Also - pt started on coumadin on
 12th, got 5 mg on 12th + 15th
 but no for PT, no further
 coumadin. LMY ✓ PT / INR now
 + resume coumadin.

(b)(6)-2

16 APR 03 P.T. Note
 Pat seen this P.m. for crutch Trng. Requires hand on
 (A) to ambulate to crutches. Pat does not follow instructions
 and ambulated FUB @ LE. Will cont. crutch Trng until Pat
 is (I)

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade, rank, rate; hospital or medical facility)	(Continue on reverse side)	P.T. Tech
REGISTER NO.	WARD NO.	

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
 Prescribed by GSA/ICMR,
 FIRM (41 CFR) 201-45.505
 509-111

DATE 16 APR 03	Medical Nutrition Tx's
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Medical Nutrition Tx's

O: Ate dinner tonight per RV. Diet Rx: Regular.

Labs 14 APR 03 Hyp/Hot 10.9/13.9/16.1 8.1/3/30.3

ALPs POS intake fair - recommend continue to encourage 'no
'intake = Regular diet + snacks | ENSURE 700.

Hgb/Hkt ↓; malureth UNL - recommend MVT Fe sup.

RD to Ph $\bar{q}$ 2-3 days.

MPH, RD

Orthopaedic Surgery

$T_{m \text{ low}}^{\text{low}}$

Pos: No Δ suddenly or Re

8h local wound care
Surgery in next few days
to close wounds.

(b)(6)-2

25 M. USM

MEDICAL RECORD		PROGRESS NOTES	
DATE 17 APR 03	Medical Nutrition Txs		
1415	O's Hgb/Hct 17 APR Hgb 7.7/1 Hct 22.9/1 MCV/MCH 88.7/29; Diet: Regular. Per nursing - ate lunch today. Meds SMV. AIP. Hgb/Hct ↓; MCV/MCH WNL. Hgb/Hct ↓ since 16 APR. Recommend FeSO₄ ± MVI. Recommend continue to encourage PO intake ± Regular diet + snacks/ENSA. TID. RD to flu q 2-3 days. (b)(6)-2 (b)(6)-2 MPH, RD LT, MSC, (b)(6)-2		
17 APR 03	P.T. attempted to work ± put this PM. Pnt refused upon arrival. will try again in AM. (b)(6)-2 HM - USAF PT TECHNICIAN (b)(6)-2		
4/12/03 1620	Orthopedic Surg Resting comfortably T₁₀/O₈ PE AFO on (2) — Wounds on (2) dry ↓ swelling. (2) dressing intact Weg 7.7 Plan: Transfuse, monitoring, follow fever curve. <i>continue on reverse side</i> don't suspect infection here. PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4 REGISTER NO. (b)(6)-2 WARD NO. 509-111 LINE USAR		

MEDCOM - 4941

PROGRESS NOTES

DATE	
4/18/03	Or Fingard Day
1900	feels OK. 1/2 pi in (R) hip but ↓ AF PS - ↓ Smelly - 2 ΔL Fort drop. R up 2 CT (b)(6)-2 LT MC USMC
4/19/03 0900	Medicine Note - OK +/- Δ - W22 repeat in AM & Start MVI + FeSO4 (b)(6)-2 (b)(6)-2 (b)(6)-2
4/19/03	Or Fw
1920	would look good start showering Personal N. Seems to be returning (b)(6)-2 (b)(6)-2

* U.S.G.P.O. 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4942

MEDICAL RECORD		PROGRESS NOTES	
DATE	4/19/03	(b)(6)-2	CDR
	Verified 0240 4/19/03		
	Urology		
	Penis beginning to granulate c/w healing abrasion.	(b)(6)-2	
19 APR 03	1135		
	P.T. assisted put this A.M. ROM performed @ knee (0-110 deg). Transferred from supine to sit c/min assist x 1, sit to stand c/min assist x 1. Ambulated 30 feet c crutches on flat surface and CGA x 1. Transferred to bedside wc c/min assist x 1. Pnt tolerated session well and improving. Cont P.T. QD.		
		(b)(6)-2	
		HM-USN PT TECHNICIAN	
21 APR 03	1400	(b)(6)-2	
	P.T. Note: Pnt seen this P.M. PT Tech notified by Nurse staff that Pnt ambulated on crutches approx 30 ft c CGA x 1 about one hour ago. Pnt tolerated @ Knee ROM exercise well. Doing well, will be from P.T. assess Pnt in A.M. for (T2) crutch walking.		
		(b)(6)-2	HMUS (R/P) P.T. Tech
(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.	WARD NO.
(b)(6)-4			
		PROGRESS NOTES STANDARD FORM 509 (Rev. 11-71) Prescribed by GSA/ICMR, FIRM (41 CFR) 201-45.505 509-111	

MEDCOM - 4943

PROGRESS NOTES

DATE	
22 Apr 03	P.T. Note Pnt seen this P.M. for catch Tng, ambulated 54 ft on crutches TTWB. Instructed Pnt to ambulate in NWB status, Pnt having difficulty in this gait pattern. Will cont to Train Pnt NWB (b)(6)-2 HMC (CNP) P.T. Tech
23 Apr 03	P.T. Note Pnt cont. to have difficulty w/ bearing status for catch tng. Pnt able to ambulate in CGA TTWB for short distance. Will cont. to tng Pnt on NWB status (b)(6)-2 HMC (CNP) P.T. Tech
24 APR 03	P.T. Note Pnt transferred from sit to stand in assist K1. Ambulated 60 feet in crutches and CGA K1. Tolerated session well in multiple rests during ambulation. Pnt did better today but, still apply at TTWB RLE. Will cont. P.T. as per plan. (b)(6)-2 HMC (CNP) P.T. Tech
24 APR 03	Medical Nutrition Tx F/U 1540 O: Per RN - "eats all of food". Labs 23 APR 03 Hgb/Hct 9.5/42 Diet Rx: Regular. Meds: FeSO ₄ , MVI A/P: Hgb/Hct improving since 4/20 - recommend offer FeSO ₄ & fruit juice to ↑ absorption. PO intake good. RD to FU in 3-5 days. (b)(6)-2 MPH, RD (b)(6)-2 MPH, RD LT, MSC, (b)(6)-2

MEDICAL RECORD		PROGRESS NOTES	
DATE			
4/20/03	Ortho		
1930			
	I don't know if it's wise to do the soft tissue work. With dressings they will take a long time to seal. They are presently clean. I think it is a good idea now. He should be strictly NUB based on his XRay.		
		(b)(6)-2	LT ME USAR
4/21/03	Ortho	(b)(6)-2	
1600			
	Day better BF PS almost all swelling & X Rays collapsed & his but still very heal.		
		(b)(6)-2	

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

(Continue on reverse)

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 4945

PROGRESS NOTES

DATE 21 APR 03
1600 Medical Nutrition Tx/Flu:
TRANS: via translator - ate Breakfast + lunch & ENSURE.
O: Diet Rx: Regular. (b)(6)-2
Labos 20 APR: Hgb/Hct 8.5/24.4 MCV/MCH 88.4/30.8
A/P: PD intake fair. Hgb/Hct ↓, but improving since
17 APR 03. Recommend continue encourage PD intake
& offer FESQ & fruit juice to ↑ Hgb/Hct.
RD to Flu q 2-3 days. (b)(6)-2 MPH, RD
LT, MSC, USNR (b)(6)-2 MPH, RD

4/22/03
1550

Ortho

(A) leg wounds healing
(B) hip wounds healing

Pl. I'll try & close his leg
& skin graft calf.

(b)(6)-2

4/23/03
0830

Medicine Note

Resting comfortably - Δ Percut to PRW.

1130

Burning on urination:-

UA ⊕ WBC, ⊕ Bacteria

P: Septin DS BID x 3 days.

(b)(6)-2

PROGRESS NOTES

DATE

4/23/03 Narrative Summary

1900

Transferred to (b)(3)-1
for treatment of Rt hip fx GSW
Initially placed in traction and
treated with ORIF/IED of wounds.
Comminuted femoral neck fx, complex
soft tissue wounds. Partial Sciatic
Nerve palsy. Recovered well from
Surgery, Partially resolving n. palsy.

Presently being treated for UTI;
should remain numb for 2-3 months
If no signs of healing may require
hemiarthroplasty.

Rt leg wounds being treated by
local wound care and dressing
changes

(b)(6)-2

G. Mc
J. N.

MEDICAL RECORD		PROGRESS NOTES	
DATE			
4/24/03 11A	Ortho		
	(L) leg wounds look very good I will attempt closure in AM		
		(b)(6)-2	MD
		(b)(6)-2	(b)(6)-2
4/25/03 1830	Ortho post op ✓		
	In bed, comfortable		
	AS		
	Bandages intact - (L) leg		
	Try staple post op of skin closure (L) thigh & calf		
	also developing hip flexion contracture - very concerning.		
	will work on this.	(b)(6)-2	ATME USE

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 4949

PROGRESS NOTES

DATE

4/26/03
1640

Ortho

Holding hip flexed;
Dorsalizing flexion contraction

Ph. will ✓ X Rays; Perhaps has DHS
has cut out.

(b)(6)-2

WMC USAK

4/26/03
1505

Internal Med

Acute brachy @ today
4/23. C/A test day, new CT, to i
Septor. Repeat C/A today @ is responded
to Septor. So appears to be confirmed
+ not Acute brachy CT - will do
free snap. started earlier today. Worker
clearly. CBC in Am

(b)(6)-2

PROGRESS NOTES

DATE

4/25/03
0950A

Dr. Flo of MR

I took the opportunity to close the remain open wounds. Have been treated to dressing change and more granulation well to sign of infection. Overall closed easily & absorbable suture.

(b)(6)-2

LT MC VSUR

★ U.S.G.P.O. 1988-103-218/5001

(b)(6)-4

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4951

MEDICAL RECORD	PROGRESS NOTES
----------------	----------------

DATE 26 Apr 03 P.T. Note
 1400 Pat seen this P.M. tolerated Hip ext. well % pain during P.T. session. Ambulated 60ft on crutches part of the way NWB / TTWB (R) LE. Pat requires multiple verbal cues about wt bearing status. Will cont. P.T. QD (b)(6)-2 HuC(RNA) P.T. Ted

27 April 03 Ortho good day
 1040 Feeling ok. up in Bed. Pain as usual. AF
 PS all wounds healing well (b)(6)-2
 Lt hip flexion contracture (b)(6)-2 NLS-20
 X-rays - collapse of femoral neck
 Change from internal study
 Hip screw allowed slight valgus displacement of head which is good.
 Hip - GSW Rt Neck fx
 GSW Lt Spine from wounds
 Pl - work on hip flexion contracture
 NWB to Rt side (b)(6)-2 Lt Nausea

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

(b)(6)-4

(Continue on reverse)

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
 Prescribed by GSA/ICMR,
 FPMR (41 CFR) 101-11.806-8
 509-110

MEDCOM - 4952

PROGRESS NOTES

DATE

27 APR 03

P.T. NOTE

Pnt ind in all transfers. Ambulated approx 100 feet c crutches and SOA X1. (R) hip Flexor stretch performed. Pnt forth a good effort and ind c crutches. Cont Hip flexor stretch AD.

(b)(6)-2

(b)(6)-2

1277

28 APR 03

P.T. NOTE

Pnt at EOB upon arrival. P.T. observed pnt ambulating c Spector using crutches. Pnt did really well and ind c crutches. (R) hip flexor stretch perform. Tolerated session c pain. Will cont P.T. AD for hip flexor stretch.

(b)(6)-2

HM - USN
PT TECHNICIAN

(b)(6)-2

4/28/03

Orthopaedic Surg

Sig ORIF Rt hip fx / Delayed closure of (L) thigh/calf wounds.

1520

AF

Pz all wounds healing

- small central dehiscence of (L) calf wound.

Rec Cont PT to work on Rt hip flexion contracture. Telfa dressing to lt calf until sealed NWB to Rt leg.

(b)(6)-2

WMCUSNR

MEDICAL RECORD		PROGRESS NOTES	
DATE 28 APR 03	Medical Nutrition Tx's FIU's		
1848	S: Per translator 4/27 - Ate 3 meals, 4/28 - Ate Breakfast & Lunch.		
	O: Diet Rx's Regular. Labs 28 APR: Hgb/Hct 8.5/26.6		
	A/P's: Hgb/Hct ↓ - recommend offer FeSO ₄ & Vit. C to ↑ absorption. PO intake good - recommend continue encourage PO intake. RD to Flu 7-35 days.		
	(b)(6)-2	MPH, RD	
	(b)(6)-2	MPH, RD	
29 APR 03	P.T. NOTE	LT, MSC, USNR (b)(6)-2 MPH, RD	
	Pnt seen this PM. (2) hip flexor stretches performed. Pnt ind in ambulation & crutches and good mobility and transfers. Cont P.T. RD.		
	(b)(6)-2	PT TECHNICIAN (b)(6)-2	
29 Apr 03	ORTHO	(b)(6)-4	
	S/P R hip ORIF, soft tissue injuries L post-thigh & leg.		
	Afebrile	(b)(6)-2	
	R hip wounds healed.		
	L post thigh wound healed.		
	L leg - small 2cm area skin open		
	P: allow granulation tissue to form No further st necessary.		
	Daily dressing change - L leg	(b)(6)-2	
(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.	WARD NO.
(b)(6)-4			
PROGRESS NOTES STANDARD FORM 508 (Rev. 11-77) Prescribed by GSA/ICMR FIRM (41 CFR) 201-45.505 GSA GEN. REG. NO. 114			

MEDCOM - 4954

PROGRESS NOTES

DATE 4/30/03	ORTHO POD 19
	Comp
	Afebrile
	P: Continue present care.
	(b)(6)-2
30 APR 03	P.T. NOTE
	Put seen this AM PM. Passive @ hip flexor stretch performed. Put encouraged to lay down in prone position. Cont P.T.
	(b)(6)-2
	(b)(6)-2
	HM - USN PT-TECHNICIAN
1 May 03	ORTHO POD 20
	Comp
	Afebrile
	P: Daily drug As.
	(b)(6)-2
1 May 03	P.T. Note
	(b)(6)-2
	Doing well @ PT sessions. Ambulated 180ft NWS @ LE @ crutches
	①. Tolerated with pain @ Hip Flexion stretches. Cont. PT
	QD
	(b)(6)-2
	HMC(FNF)
	P.T. Tech
1 MAY 03	Medical Nutrition Tbs F/U:
1900	S: Per translator - eating all meals 4/30 + 5/1.
	O: Diet Rx: Regular. Labs 1 MAY: Hgb/Hct 8.6/26.0
	R/P: Hgb/Hct ↓ - recommend offer FeSO ₄ & fruit juice to ↑ absorption. PO intake good - recommend continue encourage. PO intake. RD to PW 7 days.

* U.S.G.P.O.: 1986-491-248/20516

(b)(6)-2

(b)(6)-2

MPH, RP

STANDARD FORM 508 BACK (Rev. 11-77)

LT, MSC, USNR

(b)(6)-2

MEDCOM - 4955

MEDCOM - 4956

MEDICAL RECORD		PROGRESS NOTES	
DATE			
4 May 03 2200	VS 150/90, 112, 98%, 20, 99.4°. PT is 48x3, 0 complaints, drug to (R) hip 101, PT is sleeping 1mg AS ITA. + BSX 4 qeds. Will continue to monitor. (b)(6)-2		Sgt
4 May 2003 2330	VS. 132/62 88, 16, 99.7°. PT Has Several BSXs to check post-op several days to weeks? Sides are clean & s/s of infection. PT c/o generalized discomfort to Sides - in T#3 PO. (b)(6)-2		
0145	Started 20mg IV (R) FH To deliver MSO4 EV as ordered or Med Sect. (b)(6)-2		MMT 111
0200	Pain med effective. (b)(6)-2		MMT 111
0600	PT required MSO4 @ 0445. Pain med effective. PT continue to sleep & complaint. (b)(6)-2		MMT 111
9 May 03	VS. BP 112/59, RR-20, SpO2 95%, T 98.6°		
5 May 03 @ 0910	PT given 5mg IV of MSO4 for c/o pain to (R) thigh. (b)(6)-2		ICR
5 May 03	PT sitting in bed. Alert + Oriented x3. (b)(6)-2		
	Wound to posterior upper left thigh - open to air. Drug to LVE - 400L. R complaint of pain to (R) thigh. Open to air of (R) Hip. Long s/s OIA - Active BS x 4 qeds. Will continue to monitor (b)(6)-2		9/11/03
5 May 03 1540	5mg MSO4 given for pain. (b)(6)-2		

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

REGISTER NO.

PROGRESS NOTES

STANDARD FORM 508 (Rev. 11-77)

Prescribed by GSA/ICMR

FIRM(R41CFR)201-45.505

508-111

MEDCOM - 4957

DATE		PROGRESS NOTES
4 May 03	1540	VS - 120/50 - 82, 98%, 20, T 98.8°, PT is asleep, lungs CTA, +BS x 4 quadrants. Wound to upper @ thigh open to air, & signs of infection. Ace wrap to LEE tube are ODI-MH continue to monitor. (b)(6)-2
5 May 03	2345	U.S. 120/68 99.2 88 16. PT repositioned in bed. PT has post-op surgical wounds to thigh that he is s/s of infection. (b)(6)-2 MAY AM
	0100	PT Medicated for thigh discomfort E 7/ T 3. (b)(6)-2 MAY AM
6 May 03		VS - BP 117/64, HR 64, T - 98.1, SpO2 96% RA (b)(6)-2 SPE (b)(6)-2 PUNE
6 May 03	1320	PT Dcd to home, states understanding of instructions and use of crutches for ambulation and wound care. PT left ambulatory C crutches for assist. (b)(6)-2 Sgt

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 April 2003	<u>Stiff Neck</u>
07205	<u>Spinal Restricting Complaints</u> : Having pain in @ thigh 2° to gunshot wound. No new complaints. Had urinary retention noted yesterday - Foley cath placed. US - epidural Pain Control Patient met & signed Medicare when available
	(b)(6)-2
	CPR Review

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

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	

MEDCOM - 4959

MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

CLINICAL RECORD			NURSING NOTES (Sign all notes)	
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated	
	A.M.	P.M.		
1100			Received for men on sick SPO Schuchman GSE BLE 2pm and GSE. O.L. Sub 928. Sleep 5 oral Adv @ 1000 Dy di @ 1000 2000 sedate. No 1000, 100 122. Fholboks 5000 W. Oz a @ 1000 in P.M.	(b)(6)-2
1245			Orb 2L in hba by	(b)(6)-2
1250			HUSA, O.L. aff. S.H. 966	(b)(6)-2
1256			Unstable ready. Repeat call to L.C.M.	(b)(6)-2
			Now on Adv 2 on sick	(b)(6)-2

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
(b)(6)-4		

NURSING NOTES
Standard Form 510
 General Services Administration and
 Interagency Committee on Medical Records
 FPMR 101-11.806-8—October 1975
 510-109

MEDCOM - 4960

(b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
09 Apr 03	0400		Pt admitted to 5 FWD from PACU. A&O x 3, VSS O ₂ sat 97% 2 LNC. Neuro checks ③ lower ext intact as well as dressings also clean & dry. Denies any SOB & pain at this time. Will continue to monitor. (b)(6)-2 ENS, MC
09 APR 2003 1630			Assumed pt case at 1530. Pt awake, alert. RLE - all wrap to ② hip/thigh. JP drain x 1 with moderate amt serosanguinous drainage. ② hip/thigh disq - CDI. RLE in traction. RLE - warm to touch. ② movement, cap refill < 3 sec, ② +1 edema, color NFR. LLE - all wrap to thigh and calf. Disqs - CDI. LLE - warm to touch, ② movement, cap refill < 3 sec, ② +1 edema, color NFR. Lungs CTAB. CV - RRR. BS - hyperactive LLD, LLD, RLD. BS absent RLD. Foley draining clear yellow urine. NS @ 100 cc/hr. (b)(6)-2
10 Apr 03	0335		Assumed pt case @ 2400. A&O x 3. Dressings & wrap ② & ③ lower extremities c/o/i. N/V okay. JP drain @ thigh mod drainage serosanguinous Foley draining amber color urine sufficient amt. Denies any pain. Pt resting comfortably no complaints. Will continue to monitor status. (b)(6)-2 ENS, MC

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first,
middle, and facility)

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
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510-110

MEDCOM - 4962

NURSING NOTES (Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
13 APR 0930			AM CARE COMPLETED @ BS. FOLEY DRAINING CLEAR YELLOW URINE. WOUNDS TO UE C/D/E. ^{mbh} (L) ANKLE IN SPUNT. (P) CMS. LONG MSD ₄ GIVEN FOR PAIN. PT. NOW BACK TO SLEEP. NS INFUSING C OUT DIFFICULTY. (b)(6)-2
14 APR 03 0215			PT resting. Assumed care @ COS. Left inner thigh dress'd. Pink wound bed, minimal slough tissue noted on dress. N-S wrapped in Kerlix & ace. Joints & darts. (L) arm wrapped in ace & gauze, CHI. Circ/neuro WNL. (R) hip dress. P. scarf shows dress noted. Intact. (R) buttock dress loose; to be reinforced PEN. Circ/neuro WNL. PT currently denying pain. (b)(6)-2 ENS/nc
15 APR 03 0000			PT has pulled out own IV again. ABX S/c'd. Site to be established in UE in AM. (b)(6)-2 ENS/nc
15 APR 03 0247			PT resting. Assumed pt care @ COS. PT dressings to (L) thigh clean dry and intact. (L) leg also C/D/E. Stitches to (R) outer thigh have no drainage and (the tissue is healthy. Stitches in (R) buttock no intact and tissue is healthy (there as well. Splint on (R) LE held on with Kerlix. A lung sound clear with a phlegmy rattle in the throat. S1-S2 present, bowel sounds audible in all 4 quadrants. PT pulses steady and equal. (b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)	
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated	
	A.M.	P.M.		
4/11/03			Change Dressing and page MO. (b)(6)-2	
			② PT TAKEN OF Face MASK O ₂ will monitor for SATs to maintain 95% 1530 Nasal Pharyngeal pulled out by Pt. Pt SATING 98% RA, will cont. to monitor. ③ Otho Tech at bedside posterior Splinting ④ New Dressing changed to ⑤ THIGH serosanguinous moderate amount, ⑥ Buttocks Dressing Slight clear to CDE, Neuro checks done within normal limits ⑦ Pt met pacu + anesthesia discharge criteria. (b)(6)-2	
12 April 03	0542		Assumed care C CCB. Harassed @ 0245. Pt sleeping most of shift. RLE elevated on pillows; in 1/2 cast. R thigh - gauze; tape to lateral aspect. Wrapped in ace. Circ/neuro check WNL. Hemovac to R thigh & serosanguinous drng. LLE circ/neuro WNL. Ace; gauze to calf CHI @ +2 pedal edema. High ace; gauze CDI. ④ BS; lungs CTA. IV restarted b/c infiltrated. Medicated for pain. (b)(6)-2	ENS/NC
12 April 03	0605		Hemovac has come out of site. Dr. (b)(6)-2 to be notified. (b)(6)-2	ENS/NC
13 April 03	0340		Assumed care C CCB. Pt sleeping. IV restarted by Hx13 (b)(6)-2 189 in LFA. Pt SIP Washout on 12 Apr. R hip dressed & gauze, CDI. Pt has half cast on RLE & elevated on pillows. Circ/neuro WNL. +1 edema noted. LLE ace wrap to upper; lower leg CDI. Circ/neuro WNL. (b)(6)-2	ENS/NC

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

REGISTER NO

WARD NO.

(b)(6)-4

NURSING NOTES
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510-110

MEDCOM - 4965

NURSING NOTES

(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
1-7 APR	2350		Pt. received 16 PRBC starting 1754 - VS 128/64-112-20-100.4. Pt. tolerated transfusion with no reaction. Post VS @ 2215 - 128/64-120-20-99.6. Foley output 600cc. Enc. pt. to turn 2h in bed. (B) Legs elevated, (R) foot brace attached. Skin on back, sacrum intact. Penile lesion - dry, excoriated, no purulent discharge - appears to be healing superficially. Pt. sleeping - no c/o pain. (b)(6)-2 [redacted] con, n.c.
18 APR 03 @ 0000			Assumed pt care. Pt resting well c/o c/o pain. VS stable. Pt has sutures to (R) hip, OTA & signs of infection Pt has dressing on (L) calf c/d Pt has dressing around (R) foot, extending past ankle. c/d/t. IV in (R) arm LR100. Will continue to monitor. (b)(6)-2 [redacted] HN
18 APR 03 @ 0445			Pt medicated c/MSO4 for pain & readjusted in bed. Foley still in place. Circ/neuro HNL to all extremities. Pt currently sleeping I concur above statement except drag to R foot is actually a brace. (b)(6)-2 [redacted] ENB/HK
18 APR 03 @ 0700			D. (b)(6)-2 [redacted] notified of pt platelet count of 785 - (b)(6)-2 [redacted]
18 APR 03 @ 1640			Assumed pt care at 1530. Pt resting comfortably at this time. (R) hip c/ ^{sutures} staples OTA. RLE c/ brace in place. (R) c/o pain at this time. NS @ 100cc/hr. Foley draining adequate and clear yellow urine. (b)(6)-2 [redacted] ENB/HK

U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

MEDCOM - 4966

(Reverso)

CLINICAL RECORD			NURSING NOTES (Sign all notes)	
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated	
	A.M.	P.M.		
16 APR 03	0600		Assumed care of pt. Pt c/o pain, 2 Percocets was administered. Pt has Temp. 101.7 and B/P 156/74 all other VS WNL. Pt has dressing to R thigh, c/d/I. Pt has sutures to L thigh, DTA, & signs of infection. IV to R forearm intact. Telex checks WNL. Will continue to monitor Pt. (b)(6)-2 HN	
16 APR 03	0900		Re assessed VS, B/P 120/60, temp. 100.7, will continue to monitor ——— (b)(6)-2 HN	
16 APR 03	0555		Pt currently resting; medicated for pain 6 long/MSY last T. 100.9. Will continue to monitor (b)(6)-2 EN/NC	
16 APR 03	2020		FOLEY WAS D/C ENCOURAGED PT TO DRINK FLUIDS NO S/E OF PAIN or discomfort Will continue to monitor (b)(6)-2 HN	
16 APR 03	2315		14F FOLEY CATH PLACED W/D DIFFICULTY, USED STERILE TECHNIQUE. 300 CC INITIAL OUTPUT (b)(6)-2 HN	
17 APR 03	0600		Assumed care of pt. Pt resting well with c/o pain. VS stable. Pt has dressing LE c/d/I, sutures to R thigh DTA, LR running (b)(6)-2 HN	
17 APR 03	0900		I conc'd E HN (b)(6)-2 Assessment HN EN/NC	

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

REGISTER NO. **WARD NO.**

NURSING NOTES
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 510-109

MEDCOM - 4967

NURSING NOTES

(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	

20 APR 03 @ 2357 Pt has temp of 100.0, IS tx initiated will continue to monitor pt. — (b)(6)-2
concur with above — (b)(6)-2

21 Apr 03 @ 2306 Assumed Pt care no c/os for this pt Slight elevated temp no IS encouraged pt to Deep breath with assess pt. — (b)(6)-2

22 Apr 03 @ 1100 VSS. Resting comfortably. DSS to BLE. claji. Continue to monitor. — (b)(6)-2

NFC THIS PAGE

(b)(6)-4

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MEDCOM - 4968

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD			NURSING NOTES	
DATE	HOUR		OBSERVATIONS	
	A.M.	P.M.	Include medication and treatment when indicated	
18 APR 83	@ 0755		Assumed care of pt. Pt has temp. 101.6 all other VS stable. Foley intact draining cly. Pt has IV site on LUE, intact. Pt has C/D/I dressing around calf of LUE. Dressing to Dinner thigh reinforced w/ gauze & tape. Neuro checks to LE wnl. LE elevated on two pillows. Will continue to monitor. HN (b)(6)-2	
19 APR 83	0220		Concur with above. RLE splint neuro check wnl. HN (b)(6)-2	
19 APR 83	@ 0400		Reassessed pt's temp. 98.2, HN (b)(6)-2 HN	
19 APR 83	1700		OC's Foley NO c/o PAIN HN (b)(6)-2 HN	
19 APR 83	@ 2300		Assumed care of pt. Pt resting well & no complaints at this time. Pt has splint to RLE, C/D/I, neuro checks wnl. Dressing to Dinner thigh c/d/i. Lesion on penis scabbing. VS stable, will continue to monitor pt. IV discontinued. HN (b)(6)-2	
19 APR 83	@ 2320		Pt has temp. 100.2, medicated & peroxide HN (b)(6)-2 HN (b)(6)-2	
20 APR 83	0150		Concur with above HN (b)(6)-2	

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
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MEDCOM - 4969

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	

22 APR 63 @ 2300 Pt has temp 100.6, 18 fx done, will cont to monitor pt. HN (b)(6)-2
 Contact with above (b)(6)-2 BUS, NC

23 APR 63 @ 0300 Pt temp 99.9, all other VS WNL. Will continue to monitor. HN (b)(6)-2
 Contact (b)(6)-2 1515, NC

25 APR 63 2245 ASSUMED C/O PT. PT HAS TEMP OF 100.1. NURSE NOTIFIED. TYLENOL GIVEN. ALL OTHER VS WNL AND STABLE. INSISION SIGHT TO @ LAT. THIGH C/D. ACE WRAPS TO LLE AND BOTH C/D/T. @ C/O PAIN. @ SIGNS OF DISTRESS AT THIS TIME. WILL CONTINUE TO MONITOR. (b)(6)-2

26 APR 63 0130 DISD Contact with above, interpreter paged to explain to PT to lay on stomach, PT not compliant. (b)(6)-2

26 APR 63 0300 RECHECK PT TEMP - NOW 98.8 AND STABLE (b)(6)-2

6/10/63 14306 AWD from 5 Port star board - @ hip - cont. PT here to assist walking. @ culture transferred to @ contact isolation ward. @ per wet retention reflex voided. Pt aware? @ pill in under @ 1/8. (b)(6)-2

PATIENT'S IDENTIFICATION

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

REGISTER NO.

(b)(6)-2

CARD NO.

NURSING NOTES

Standard Form 510

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MEDCOM - 4970

NURSING NOTES

(Sign all notes)

DATE	HOUR		OBSERVATIONS
	A.M.	P.M.	
			Include medication and treatment when indicated
4/26/03	1820		PT EATING well. Ambulating with crutches w/o incident. PT OOB to chair & RLE extended on rack, good strength to lower extremity. PT offers no complaints. (b)(6)-2 LCDR/jc
4/27/03	2045		PT. sitting up in bed intermittently during shift. VSS. A/E - N/V checks normal. Scant amt. of serous drainage from (L) thigh dressing. Reinforced dressing and reapplied ace bandage. Encouraged to lay on abdomen. Will cont. to monitor (b)(6)-2 CDR/NC
4/28/03	1030		PT continues to ambulate well & crutches. Showered this morning & am dry. (R) thigh & (L) calf dressing removed @ 72" postop. (R) thigh sutures intact, wound edges approximated elo, no S/S of infection. Wound left open to air. (L) calf wound & sutures in place. Prime sized gap in wound edges midway between incision. Minimal bleeding with dressing removal. IV hepbloc removed. Site clean & dry. (b)(6)-2 LCDR/jc
28 Apr 03	1730		Assumed care PT 1500, PT sitting in chair, no elo pain, Drsq (L) calf CDI, sutures (Dinner thigh intact & minimal serous drainage no color DTA (b)(6)-2 CDR/NC
29 APR 03	0630		PT. was wakeful during night. No pain (R) leg. Medicated with Tylenol #3 @ 0200 & 0615. VSS. Will cont. to monitor (b)(6)-2 CDR/NC

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NURSING NOTES
Standard Form 610
(Reverse)

(b)(6)-4

MEDCOM - 4971

CLINICAL RECORD			NURSING NOTES (Sign all notes)	
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated	
	A.M.	P.M.		
29 APR 03	0716		VSS no distress noted lying in bed ARO PERIA S.S. RLP BS&X4 lal neg diet. long sanda clear equal bilat. wound to (1) calf VTA gauru / holter dressing cldli incision to (2) chest well healed OTA Will cont to monitor (b)(6)-2	
30 APR 03	0345		Pt. slept well during the night. No complaints noted. Will continue to monitor (b)(6)-2	COR, NC
30 APR 03	0730		VSS no distress noted sitting up in bed ARO PERIA S.S. RLP, lungs clear incisions to BLE E sutures cldli gauru to (1) calf cldli BS&X4 Will cont to monitor (b)(6)-2	
30 APR 03	2000		Assumed care of pt. v.s.s. @ this time. pt is in no apparent distress. Currently pt is in wheelchair conversing w/ other pts and in good spirits. Will continue to monitor v.s. and pain management. (b)(6)-2	Hm3
01 MAY 03	0720		ARO VSS no distress noted PERIA S.S. RLP, lungs clear equal bilat. BS&X4 incisions to BLE E sutures cldli gauru ACE wrap to (2) LE cldli cont to monitor (b)(6)-2	
01 MAY 03	2000		Assumed care of pt. v.s.s. @ this time. pt is sleeping peacefully and is in no apparent distress. Will continue to monitor v.s. and pain management (b)(6)-2	
02 MAY 03	0730		ARO PERIA VSS no distress noted S.S. RLP, long sand clear equal bilat. BS&X4	

Continue on reverse side

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

NURSING NOTES
Standard Form 510
 General Services Administration and
 Interagency Committee on Medical Records
 FPMR 101-11.806-8—October 1975
 510-109

MEDCOM - 4972

(Sign all notes)

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

MEDCOM - 4973

MEDICAL RECORD			VITAL SIGNS RECORD											
HOSPITAL DAY														
POST.	DAY													
MONTH-YEAR	DAY	HOUR												
19			29 APR	30 APR	31 APR	02 MAY	03 MAY	04 MAY	05 MAY	06 MAY	07 MAY	08 MAY	09 MAY	10 MAY
PULSE (C)	TEMP. F (C)													
	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			4	6	4	4	1	2	2	4	6	6	6	6
BLOOD PRESSURE			136/76	144/90	126/80	124/80	146/74	112/60	136/70	144/72	140/70	114/56	134/70	
HEIGHT: WEIGHT:			9870	467	9970	467	9970	467	9970	467	9970	467	9970	
VOP														
215														
675200														
150														
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)														
REGISTER NO.														
WARD NO.														

511-112

VITAL SIGNS RECORD

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

MEDCOM - 4974

VITAL SIGNS RECORD

(b)(6)-4

MEDCOM - 4975

MEDICAL RECORD	OR #	OPERATION REPORT
PREOPERATIVE DIAGNOSIS		

5/11/03 TO BLUE'S AND PENIS & PERMANENT
NECK FX

SURGEON NORRIS	FIRST ASSISTANT (b)(6)-2	SECOND ASSISTANT P	TIME BEGAN: 1050
ANESTHETIST (b)(6)-2	ANESTHETIC (b)(6)-2	TIME ENDED:	TIME OPERATION COMPLETED: 1140
CIRCULATING NURSE (b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN: 1112	

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
--------------------------	-----------------------

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

OPERATION PERFORMED

INCISION, DEBRIDEMENT, IRRIGATION OF PENETRATING
WOUNDS TO LLE, PERMANENT PENIS.

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.) Pre-Operative Nsg Assessment:	PROSTHETIC DEVICES (LOT no.)	DATE OF OPERATION 4/4/03
Dentures: Y	Implants: P	
Allergies: NKA	Foley inserted by: P	
NPO: Y N	Safety Straps: Across Thighs	

Intra Operative Nsg Assessment

Anesthesia: G2	Prep: Betadine
Bovie Equip #: P	Irrigation: NS
Bovie Pad #: P	Medications: P
	/Blood

Post Operative

EBL: M	Packed Wounds
Wound Class: IV	
DSG: PAIN & RELIEF	
U/O:	
Fluids: 700	Report ICU P.O. Order 1132
Counts: Initial	

SIGNATURE OF SURGEON (b)(6)-2	DATE 4 APR 2003
PATIENT (b)(6)-4	REGISTER/I.D. NO. WARD NO.

OPERATION REPORT
Medical Record

1 RADI EPW

FH3
MEDCOM - 4976

STANDARD FORM 516 (REV 5-83)
F by GSA/ICMR
FIRM (41 CFR) 201-45.505

MINIMAL RECORD

PREOPERATIVE DIAGNOSIS

open Rt hip fx ; complex wounds @ thigh & leg.

SURGEON H. [b)(6)-2]	FIRST ASSISTANT [b)(6)-2]	ANESTHETIC General - ETT	TIME 1755
ANESTHETIST LCDR [b)(6)-2]	SCRUB NURSE H/M3 [b)(6)-2]	DATE OF OPERATION 1710 1944	1935
CIRCULATOR LT [b)(6)-2]	OPERATIVE DIAGNOSES [b)(6)-2]		

SAA

DRAIN (Kind and number)

① Buttock - S drain 10mm

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Cultures : ① dermic ② anaerobic } ③ Buttocks

OPERATION PERFORMED

① I & D = Delayed primary closure of open Rt hip fx
② I & D of left leg / thigh wounds ③ Placement of fibular tract retractor

DESCRIPTION OF OPERATION (Kind of surgery, gross findings, etc.)

LCDR [b)(6)-2] 1925 IVF-1400 URINE
EBL - mm 200

PROSTATE (date) 4/8/03

In lateral position open wound on @ buttock debrided / irrigated cultured and closed over suction drain. Ant medial @ thigh wound (2x2) I & D = loose closure over Penrose. Both clean. 5/8" Pin Placed in proximal fibula for skeletal tract.

Rt thigh ant medial wound ~12 x 6 cm debrided / Biopsy sentis / skiner/biopsy exposed. 3x4cm wound in post calf debrided. Plan: local wound care; ORIF

SIGNATURE OF SURGEON

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

[b)(6)-2]

[Signature]

4/8/03

[b)(6)-4]

[Signature]

MEDCOM - 4977

MEDICAL RECORD
PREOPERATIVE DIAGNOSIS

Ⓡ HIP FX

SURGEON DR (b)(6)-2		FIRST ASSISTANT N/A		DATE N/A	
ANESTHETIST DR (b)(6)-2		ANESTHETIC GENERAL VIA GTT		TIME IN 1010	
CIRCULATING NURSE LT (b)(6)-2		SCRUB NURSE RN (b)(6)-2		TIME OUT 1308	

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)

1/8" Hemovac Ⓡ HIP

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

NONE

SPONGES (Type and number)

1 > correct

(b)(6)-2

OPERATION PERFORMED

ORIF Ⓡ HIP DHS
1+D Ⓡ THIGH WOUND

DESCRIPTION OF OPERATION (Type of culture used, gross findings, etc.)

SYNTHES DHS

PLATE: 140° 4 HOLE

SCREW: 90mm (280.90)

SYNTHES LG FRAG screws

4.5mm x 42 x 4 (214.042)

PREEXISTING CONDITIONS

SEE BELOW

DATE OF OPERATION

11 APR 03

UOP: 300

EBL: 200

IV FLUIDS: 1500

COR (b)(6)-2

Lunch break 1100-1130

Details - on fx table;

closed reduced Rt hip fx. Basicervical
communion, 2° to open wound not a
candidate for prosthetic. 4 hole 140° DHS placed
using subvastus approach. Stable & adequate
reduction. Left thigh and calf wounds cleaned
and irrigated and redressed.

(b)(6)-2

ms

4/11/03

(b)(6)-4

MEDICAL RECORD	OPERATION REPORT
-----------------------	-------------------------

PREOPERATIVE DIAGNOSIS

SOFT TISSUE WOUNDS @ THIGH & CALF

SURGEON (b)(6)-2 D1	FIRST ASSISTANT N/A	SECOND ASSISTANT N/A
ANESTHETIST CCOR	ANESTHETIC General via ETT	TIME BEGAN: 1248
CIRCULATING NURSE CORP (b)(6)-2	SCRUB NURSE HM3 (b)(6)-2	TIME ENDED: 1231
OPERATIVE DIAGNOSES SAA	TIME OPERATION BEGAN 1204	TIME OPERATION COMPLETED 1218

DRAINS (Kind and number)

N/A

SPONGE COUNT VERIFIED

(b)(6)-2

DEFERRED

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

(b)(6)-2

N/A

OPERATION PERFORMED

I.D. @ THIGH + CALF WOUNDS

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

HM3 (b)(6)-2 (SCRUB RELIEF) P

PROSTHETIC DEVICES
(Lot no.)

N/A

DATE OF OPERATION

4/15/03

SOLMIN Rm 9
Fluor 900 w/c N/A

Details - in supine position, I debrided the thigh and calf wounds. The thigh is mid-thigh medial 4x6 cm to muscle & copious fibrinous exudate. No abscess infection or necrosis. Thoroughly debrided. Calf wound is posterior mid calf 2x3 & healthy granular tissue. Both irrigated & packed & wet Surg. I next aspirated the Rt thigh, no pockets of fluid identified. to RL in satisfactory condition.

SIGNATURE OF SURGEON (b)(6)-2 MD	(b)(6)-2 LT MC USNR	DATE 4/15/03
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; REGISTER/I.D. NO. (b)(6)-4 C		WARD NO.

OPERATION REPORT
Medical Record

MEDICAL RECORD	OPERATION REPORT
PREOPERATIVE DIAGNOSIS	

① thigh / calf wound

SURGEON DA (b)(6)-2	FIRST ASSISTANT Ø	SECOND ASSISTANT Ø
ANESTHETIST LCDR (b)(6)-2	ANESTHETIC General - LMA	TIME BEGAN: 0820
CIRCULATOR LT (b)(6)-2	SCRUB NURSE HN (b)(6)-2	TIME OPERATION BEGAN 0842
OPERATIVE DIAGNOSES		TIME OPERATION COMPLETED 0925

SAA

DRAINS (Kind and number)	(b)(6)-2	IFIED
MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION		

OPERATION PERFORMED

Wound closure ① Thigh and ② Calf wound

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
	✓	4/25/03

Details: Under LMA

I irrigated both calf & thigh wound on 700

① Leg. thigh wound ~ 12 x 6 cm ± healthy granulation, calf wound ~ 8 x 4 ± healthy granulation. No s/s of infection. Easily mobilized skin and approximated to absorbable suture. Infiltrated to local. To RR in satisfactory condition.

SIGNATURE OF SURGEON (b)(6)-2	DATE
LT MC USMC	4/25/03
grade; date; hospital or medical facility	WARD NO.
(b)(6)-4	

OPERATION REPORT
Medical Record

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation T & D		Age	Weight (kg) 70	Height (in)	ASA Status 2 3 4 5 E	Allergies NKDA
Chemistries	Hematology H / H - Platelets - WBCs -	Coags PT - INR - PTT -	Urinalysis / HCG		NPO - ? Teeth - Airway - MP I / II / III / IV FROM, ___ FB O, ___ FB HM	
Respiratory Cough: > 0 Sputum: > 0 Asthma: > 0 COPD: > 0 Recent URI: > 0 TB: > 0 Lung Exam: Clear but ↓ CXR: > 0	CV HTN: > 0 CAD: > 0 MI: > 0 CHF: > 0 VHD: > 0 Arrhythmias: > 0 Exercise Tolerance: > 0 Cardiac Exam: Rel ECG: Rel	CNS / Skeletal Seizure: > 0 CVA: > 0 LOC: > 0 Neuro: > 0 Muscle: > 0 Skeletal: > 0 Misc		Other Hepatic: > 0 GI: > 0 Endo: > 0 Heme: > 0 EtOH: ? Tobacco: ?		
Previous Anesthetics: ?		Current Medications: 0		Premedication: Ancef + GM Morphine 5mg IV		
Family Hx: ?						
Preoperative Diagnoses GSW's ① Medial thigh ② LE ③ Femoral neck FX ④ Buttock		Vitals BP: 133/89 HR: 113 Resp: 18 Temp: 101.9 FHR: 101.9	Pre-op 133/89	DOS	Day of Surgery ☒ Chart Reviewed / patient examined ☐ Risks / benefits / options discussed with patient ☐ Patient questions answered ☐ Patient / parent / guardian understands and accepts risks ☒ (b)(6)-2 for ___ liq., ___ clears, ___ solids Plan: Staff MD / CRNA signature: (b)(6)-2 Date & Time: 4/8/3	
Evaluator Signature		Date		LCDR/USN ANESTHESIA		
Patient identification (b)(6)-4		Post-operative note No apparent anesthetic complications 4/8/3 MEDCOM - 4981 LCDR/USN ANESTHESIA				

Pre / Post-anesthetic Summary

NRMC 6320/279 (Doc-10)

Age ~40s	Weight (kg) ~70	Height (in)	ASA Status 1 2 3 4 5 E	Allergies NEED
Coags PT- INR- PTT-	Urinalysis / HCG		NPO - PMW Teeth - white Airway - MP I / II / III / IV FROM. ☒ FB O. ☐ FB HM	
CV HTN: CAD: MI: CHF: VHD: Arrhythmias: Exercise Tolerance:	CNS / Skeletal Seizure: CVA: LOC: Neuro: Muscle: Skeletal:		Other Hepatic: Renal: GI: Endo: Heme:	
Cardiac Exam: <u>SINUS TACH</u> ECG: ☒	Misc		EtOH: Tobacco:	
Previous Anesthetics: <u>GA & prob</u>	Current Medications:		Premedication:	
Family Hx: <u>UNK</u> operative Diagnoses: <u>GSW LE</u>	Vitals BP: HR: Resp: Temp: FHR:	Pre-op DOS	Day of Surgery ☒ Chart Reviewed / patient examined ☐ Risks / benefits / options discussed with patient ☐ Patient questions answered ☐ Patient / parent / guardian understands and accepts risks ☒ NPO after _____ liq. _____ clears, _____ solids Plan: Staff MD / CRNA signature (b)(6)-2 Date & Time <u>CRNA 15 APR 03</u>	
Evaluator Signature		Date		

certification
(b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature _____

MEDCOM - 4982

PRE-ANESTHETIC EVALUATION

Date of Surgery 4/4/03

Procedure Debridement of thigh & calf of thigh		Age (M) F	Wt 160 kg lb Ht	NPO after MN Last PO Teeth: Prosthetics: Airway: Mallampoti 1 2 3 4
Surgeon (b)(6)-2		ASA 1 2 3 4 5 E		Neck ROM: Full Limited Allergies: (NKDA) Environmental
LABS UHCG Pos Neg N/A UA: Normal Abnormal N/A				
BP: 155/100 P: 85 Tobacco ? ETOH ? Lungs: CTA Bilat Heart Sounds: RRR Irreg Murmur TESTS: CXR N/A ECG N/A ☐ Stress test ? Echo PFT	Pulmonary No problems ☐ COPD Asthma ? TB URI Other	Cardiovascular No problems ☐ HTN MI ? Chest Pain CHF SOB/DOE Arrhythmia Exercise Tol: Good Fair Poor Other	Other Systems No problems ☐ Skeletal GSWs Anemia Bleeding Liver Renal GI: GERD H/H PUD Thyroid: Hyper ☐ Hypo ☐ Diabetes: NIDDM ☐ IDDM ☐ Other	
Family History: None ☐ Prior Anesthetics/problems: ?		Medications MSO mat Gent		
Preop Diagnosis GSW Bilat IEs		Premed: None ☒ PO Versed _____ mg Zantac Reglan Inhaler (b)(6)-2		
DOS: Plan reviewed. Changes since preop: None ☐ Provider Proceed ☐ Cancel ☐		Evaluator Signature Date 4/4/03 Time 10:		
PostOp Assessment via: Pt interview ☐ Chart review ☐		Primary Plan: (Gen) SAB MAC CLE ISB AXB Bier Alternate Plan:		
Anesthesia related complications reported: None ☐ Entry nude in Progress Notes ☐		☒ Proposed plan reviewed with patient/guardian who communicates understanding of the plan including risks, benefits, and options. All questions answered. ☐ Risks discussed include but are not limited to death, stroke, MI, H/A, aspiration, dental damage.		
Evaluator Signature Date _____ Time _____				

SF 517 (BACK)

nm-English speaking

MEDCOM - 4983

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-18)

Proposed Operation <i>Attempt 2nd closure I + D @ hip Powerleg.</i>		Age <i>58</i>	Weight (kg) <i>70</i>	Height (in) <i>70"</i>	ASA Status <i>1 2 3 4 5 E</i>	Allergies <i>NKDA</i>
Chemistries	Hematology H/H - <i>95/27.8</i> Platelets - <i>915</i> WBCs - <i>8.5</i> RBC - <i>3.2</i>	Coags PT - INR - PTT -	Urinalysis / HCG 1010 WBC - 50-100 RBC - 1-2 Bacterium 3+		NPO - <i>2400</i> Teeth - <i>INTACT</i> Airway - MP I / II / III / IV FROM, <i>3</i> FB O, <i>3</i> FB HM	
Respiratory Cough: Sputum: Asthma: COPD: Recent URI: TB:	CV HTN: CAD: MI: CHF: VHD: Arrhythmias: Exercise Tolerance: Cardiac Exam: ECG:	CNS / Skeletal Seizure: CVA: LOC: Neuro: Muscle: Skeletal: Misc:	Other Hepatic: Renal: <i>+ UTI</i> Endo: Heme: EtOH: Tobacco: <i>+</i>			
Lung Exam: <i>CTA</i>		CXR:				
Previous Anesthetics: <i>multiple 5 yr</i>		Current Medications: <i>MSO4 7 6mg</i>		Premedication: <i>Verbal + myo</i>		
Preoperative Diagnoses: <i>① FX @ Hip ② GSW thigh ③ GSW Buttocks</i>		Vitals BP: HR: Resp: Temp: FHR:	Pre-op 	DOS <i>142</i> <i>64</i> <i>98</i> <i>14</i> <i>100</i>	Day of Surgery ☐ Chart Reviewed / patient examined ☐ Risks / benefits / options discussed with patient ☐ Patient questions answered ☐ Patient / parent / guardian understands and accepts risks SNPO after <i>142</i> <i>2400</i> clears, <i>solids</i> Plan: <i>GFA</i>	
(b)(6)-2		Evaluator Signature <i>[Signature]</i>		Date <i>25 APR 2023</i> <i>0830</i>	Staff MD / CRNA signature <i>[Signature]</i> Date & Time <i>25 APR 2023</i> <i>0830</i>	
<i>Permit implied</i>						

Patient identification (b)(6)-4	Post-operative note ☐ No apparent anesthetic complications
(b)(6)-4	Signature MEDCOM - 4984
	Date

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

DATE REQUESTED

8 Apr 03
DATE AND HOUR REQUIRED

As Upon Request

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

None Known

REQUESTING PHYSICIAN (Print)

(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

(R) thigh GSW

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.

SIGNATURE OF VERIFIER

See Originals

DATE VERIFIED

TIME VERIFIED

VOLUME REQUESTED (If applicable)

250 ML

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? _____

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.

(b)(6)-4

TRANSFUSION NO.

(b)(6)-4

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH

Neg

Comp

PREVIOUS RECORD CHECK:

☐ RECORD

☒ NO RECORD

(b)(6)-2

SIGNATURE OF PERSON PERFORMING

(b)(6)-2

DONOR

RECIPIENT

ABO

O

ABO

O

Rh

POS

Rh

POS

CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4/18/03

REMARKS:

Unit Exp: 17 Apr 03

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)

(b)(6)-2

AT (Hour)

2030

ON (Date)

4/18/03

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.

1st VERIFIER (Signature)

(b)(6)-2

CDR/KC

2nd VERIFIER (Signature)

(b)(6)-2

LTJNC

PRE-TRANSFUSION

TEMP.

98.5

PULSE

112

BP

108/66

DATE OF TRANSFUSION

4/18/03

TIME STARTED

2055 2100

POST-TRANSFUSION DATA

AMOUNT GIVEN

250 ML

TIME DATE COMPLETED

2136 4/18/03

INTERRUPTED

REACTION

☒ NONE

☐ SUSPECTED

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.

DESCRIPTION

☐ URTICARIA

☐ CHILL

☐ FEVER

☐ PAIN

☐ OTHER _____

OTHER DIFFICULTIES (Equipment, clots, etc.)

☒ NO

☐ YES (Specify) _____

SIGNATURE (b)(6)-2

SEX

M

WARD

PACU

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRM (41CFR) 201-45.505
518-122

MEDCOM - 4985

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 8 APR 2003	DIAGNOSIS OR OPERATIVE PROCEDURE ② High SW tractor
	DATE AND HOUR REQUIRED Upon Request	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.
	VOLUME REQUESTED (If applicable) 250 ML	KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify) None Known
REMARKS:	IF PATIENT IS FEMALE, IS THERE HISTORY OF: RHIG TREATMENT? DATE GIVEN: N/A HEMOLYTIC DISEASE OF NEWBORN? N/A	DATE VERIFIED [Signature] TIME VERIFIED

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO. b)(6)-4	TRANSFUSION NO. b)(6)-4	TEST INTERPRETATION ANTIBODY SCREEN Neg	CROSSMATCH Comp	PREVIOUS RECORD CHECK: NO RECORD
PATIENT NO.	RECIPIENT	SIGNATURE OF PERSON PERFORMING TEST [Signature]		
DONOR	ABO O	DATE 4/8/03		
Rh POS	ABO O	REMARKS: Unit Exp: 17 APR 03		
Rh POS	Rh POS			

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA		POST-TRANSFUSION DATA	
INSPECTED AND ISSUED BY (Signature) b)(6)-2	AMOUNT GIVEN 250 ML	TIME DATE COMPLETED 2205 4/8/03	INTERRUPTED
AT (Hour) 2142	REACTION NONE	SUSPECTED	
ON (Date) 4/8/03	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.		
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.	DESCRIPTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER		
1st VERIFIER (Signature) b)(6)-2	OTHER DIFFICULTIES (Equipment, clots, etc.) ☒ NO ☐ YES (Specify)		
2nd VERIFIER (Signature) b)(6)-2	SIGNATURE OF PERSON NOTING ABOVE b)(6)-2		
PR 104	WARD PACU		
TEMP. 99.4	PULSE 113/73	BP	
DATE OF TRANSFUSION 4/8/03	TIME STARTED 2152		
PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.) b)(6)-4			

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRM (41CFR) 201-45,505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

COMPONENT REQUESTED (Check one)

- ☒ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS (Pool of _____ units)
- ☐ CRYOPRECIPITATE (Pool of _____ units)
- Rh IMMUNE GLOBULIN
- ☐ OTHER (Specify) _____

VOLUME REQUESTED (if applicable)

1 unit ML

SECTION I - REQUISITION

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- ☐ TYPE AND SCREEN
- ☒ CROSSMATCH

DATE REQUESTED 17 APR 03

DATE AND HOUR REQUIRED 17 APR 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

REQUESTING PHYSICIAN (Print)

DR.

DIAGNOSIS OR OPERATIVE PROCEDURE

Rhip Fx
SIP I + D LLE

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

SIGNATURE OF VERIFIER

(b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? N/A

DATE VERIFIED

4/17/03

TIME VERIFIED

1645

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.

(b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh Pos

RECIPIENT

ABO O

Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH

Comp.

PREVIOUS RECORD CHECK:

☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON CHECKED

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4-17-03

REMARKS:

EXP: 17 APR 2003 @ 2359

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND APPROVED (b)(6)-2

AT (Hour) 1750 ON (Date) 4/17/03

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.

1st VERIFIER (Signature)

(b)(6)-2

2nd

(b)(6)-2

PRE-TRANSFUSION

TEMP. 100.4

PULSE 112

BP 122/64

DATE OF TRANSFUSION

17 APR 03

TIME STARTED

1754

PATIENT IDENTIFICATION—USE EMBOSSE (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

AMOUNT GIVEN

unit ML

REACTION

☒ NONE ☐ SUSPECTED

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.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

☐ NO ☐ YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE

(b)(6)-2

POST-TRANSFUSION DATA

TIME/DATE COMPLETED/INTERRUPTED

17 APR 03 2215

TEMPERATURE

99.6

PULSE

120

BLOOD PRESSURE

128/64

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 - 4987

Medical Record Conu