(b)(3)-1

TIENT TREATMENT RECORD COVER SHEE

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 M	5. AGE	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION N/A			14. WARD ICW	
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPT./BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE BC	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0	22. HOURS OF ADMISSION 0615	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION XFER EPW HOLD	26. DATE OF DISPOSITION 06 SEP 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 08 JUL 03	ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
959.1 903.3

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	62	62

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
		0	0	62	62

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

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

DA FORM 3647, MAY 79 MEDCOM - 6411 USAPPC V1.10

TIENT TREATMENT RECORD COVER SHEE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION N/A			14. WARD ICW
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE BC

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0	22. HOURS OF ADMISSION 0615	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION XFER EPW HOLD	26. DATE OF DISPOSITION 06 SEP 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 08 JUL 03	ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
959.1 903.3

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	62	62

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		0	0	62	62

(b)(6)-2

(b)(6)-2 COL, MC

(b)(6)-2

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

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 6412

.TIENT 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): (b)(6)-4
3. GRADE:
4. SEX: M
5. AGE:
6. RACE: X
7. RELIGION: UNK
8. LENGTH OF SVC: N/A
9. ETS: N/A
10. PREVIOUS ADMISSION: NO
11. FMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION: N/A
14. WARD: ICW
15. FLYING STATUS: N/A
16. RATING/DSG:
17. DEPT./BEN: K78
18. BRANCH/CORPS: N/A
19. UIC/ZIP:
20. TYPE CASE: BC
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: 0
22. HOURS OF ADMISSION: 0615
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
25. TYPE DISPOSITION: XFER EPW HOLD
26. DATE OF DISPOSITION: 06 SEP 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
27b. TELEPHONE NO.:
28. DATE OF THIS ADMISSION: 08 JUL 03

ADMISSION REMARKS:

ADMITTING OFFICER: DR (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
30. DATE OF INITIAL ADMISSION:
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

FRACTURE E991.2

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ LEFT PROXIMAL ULNAR ~~E922.3~~

959.1 903.3

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	62	62

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		0	0	62	62

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

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

DA FORM 3647, MAY 79 MEDCOM - 6413 USAPPC V1.10

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

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

c 40 yo ♂ s/p GSW Abdomen
BIB A/E - Awake, alert HD stable c/o Abd pain

No sig PMHx
PSHx: (R) hip replacement
ø fbs

PHYSICAL EXAMINATION

116/60 P80
NAD
Chest: CTA
CV: RRR
Abd: ⊕ peritoneal signs
Ext: (L) UEx wound

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

A/ GSW Abd / (L) Arm

P/ Emergent OR

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	7/4/03		

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

REGISTER NO.	WARD NO.

MEDCOM - 6414

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Sept 03 1500	NARRATIVE SUMMARY 50 yo IRAQi male civilian who suffered gunshot wound to the (L) elbow & abdomen as a bystander 08 JULY 2003. He suffered fracture of the Left olecranon and small bowel perforations requiring partial small bowel resection on Exp LAP w/ ORIF Left Olecranon. He developed an abdominal wound dehiscence 13th July 03. He was treated w/ an open abdomen with retention sutures and allowed to heal by secondary intention. He developed a grade IV Sacral Decubitus ulcer requiring operative Debridement and is currently undergoing BID wet-to-dry dressing changes.
	ALLERGIES - None MEDS PMH
	TOB Ø CELEXA 20 mg QHS Depression
	PSH
	(R) Hip replacement
	VS ↓ BP- 130/82 97.8°F T.
	ACTIVITY - AMBULATES WITHOUT ASSISTANCE
	DIET - REGULAR w/ Supplements

ELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

EPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
8 July 03	Time arrived to ER @ 0617	
	arrived c̄ O^2 @ high flow	
0613 38 124/81	4 (GSW) to Lt ↓ quad	
pulse ox 99%	1 (GSW) to Lt elbow	
	~~foley cath~~ (b)(6)-2	
P 116/68 @0625	Chest + abd X-Ray ordered @ 0614	
pulse @ 90	(b)(6)-4	
O^2 @ 98	IV 9% Sodium Chloride (R) arm	(b)(6)-2
	Type + Cross, blood gas ordered	
	femoral stick for bloodgas @ 0620	
	labs drawn @ 0620, CBC, Chem 12, ~~ETT~~ lytes, ABG, Type + Cross	
	patient (b)(6)-4	
	(L) elbow splinted @ 0620	
	0624 pt put into trendelburg	
	taken to OR by anesthesia	
	@ 0631	
	elbow X ray @ 0628 lateral	
	ABG results – PH 7.332	
	CO^2 38.7 PO^2 251 Bicarb HCO^3 21	
	BE -5 SO^2 100% @ 0630	
	.5cc tetanus given @ 0630 IM	
	to OR @ 0631 1 gram ANCEF IV @ 0630	

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

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

(b)(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 6416

NSN 7540-00-634-4176

~~AUTHORIZED~~ FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 JUL 03	PREOP DX Ⓛ OLECRANON GSFX
	POST OP DX SAME c̄ CORONOID FX
	PROCEDURE ORIF
	SURG (b)(6)-2 ANES (b)(6)-2
	~~TOTAL~~
	FLUIDS →
	EBL 650 CRYST 3500 HESP 500 2U PC TT 106 @250mm
	IMPLANTS 2X 0.062 K-WIRES TENSION BAND
	& CIRCLAGE c̄ #2 STERNAL WIRE STRANDS
	BRAIDED
	FINDINGS - COMMINUTED OLECRANON FX c̄
	EXTENSION RADIALLY INTO CORONOID PROCESS
	GROSS CONTAMINATION FROM MULTIPLE BULLET
	FRAGMENTS. NO NOTABLE SOIL CONTAMINATION
	CASE FOLLOWED EX LAP c̄ SB RESECTION X2
	TO ICU FOR RECOVERY
	(b)(6)-2 (b)(6)-2 (b)(6)-2
	LTC, MC
	ORTHOPEDIC SERVIC

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

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

(b)(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 6417

MEDICAL RECORD | **PROGRESS NOTES**

DATE

8JUL 1300 Admitted to ICU 50 yo Iraqi male c̄ dx of Ex lap, ORIF Ⓛ elbow & bowel resection. Transferred from OR. Pt sedated but is Alert to verbal & tactile stimuli. Pupils pinpoint at this time 2mm c̄ ⊕ reaction. Resps even unlabored c̄ O_2 @ 15L via nonrebreather mask. Lung sounds diminished bilat bases. SpO_2 100%. Color WNL skin warm/dry to touch. Mid abdominal incision covered c̄ DSD Ø drng noted. Drsg to LLQ c̄ bloody drng, mod amt. S_1 S_2 c̄ NSR. Peripheral pulses ⊕2 cap refill < 3 secs. Arterial Line inserted in Ⓡ radial artery, zeroed on admission, line patent. 20 G IV in Ⓡ AC Ø s/s infiltration line patent. Ⓛ arm wrapped c̄ gauze & ACE wrap, Ø s/s bleeding. BS ⊖ all quads, 18 Fr Foley catheter inserted drng dark amber urine. Moves all extremities. Will monitor per ICU protocol. —— (b)(6)-2

1315 4mg MSO_4 given IV for pain. —— (b)(6)-2

1330 Labs drawn via A-line & sent to lab. —— (b)(6)-2

1340 NG tube inserted, placement verified via gastric aspiration & air bolus. Hooked up to low intermittent Sx. —— (b)(6)-2

1415 2mg MSO_4 given IV for pain —— (b)(6)-2

1430 Pt becoming more Alert. Opens eyes to verbal stimuli

(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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
cont	ā tactile stimuli ——— (b)(6)-2 cr
1515	4 mg MSO4 given IV for pain ——— (b)(6)-2 cr
1530	O_2 has been weaned ↓ to 7LPM via mask. SPO_2 remained 100% throughout. Will switch to N/C @ 6LPM at this time, Continue to monitor SPO_2 ——— (b)(6)-2 cr
1615	4 mg MSO4 given IV for pain. O_2 ↓ to 4LPM via N/C @ 1615. SPO_2 remains 100% ——— (b)(6)-2 cr
1830	Pt. resting quietly in bed, NG tube flushed c̄ 30cc H_2O, A-line zeroed, LR @ 150cc/HR to Ⓡ AC, Ⓛ arm in splint, DRSG to Ⓛ ABD has blood soaking through, midline ABD DRSG is CDI, O_2 @ 4LPM to NC, SaO_2 100%, am ↓ O_2 to 2LPM, will monitor. ——— SPC (b)(6)-2
2030	NG flushed c̄ 30cc H_2O. Pt. sats have stayed >98% c̄ 2L via NC. Will titrate to RA. Will continue to monitor. ——— SP (b)(6)-2
2235	500cc bolus of LR started for ↓ urine output. SaO_2 has remained > 95% on RA. SP (b)(6)-2
9/21 0045	Pt. given 30cc H_2O via NG, SaO_2 has remained >96% on RA ——— SPC (b)(6)-2
0300	Pt resting quietly in bed, responds to verbal stimuli. VSS. SPC (b)(6)-2
0400	Pt. given 30cc H_2O via NG tube ——— SPC (b)(6)-2
0410	100cc output from NG over the nite of a lite-brown color ——— SPC (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE	
7/9/03 0500	Assumed care of patient. labs sent c̄ 0530. assessment done see critical care flowsheet. Will continue to monitor ——— (b)(6)-2 CPT/AN
7/9/03 1200	2mg MSO4 given for pain. Small amount of drainage noted to Ⓛ elbow. CMS √s WNL. Will continue to monitor ——— (b)(6)-2 CPT/AN
7/9/03 1300	4mg MSO4 given for pain c̄ mild increase in HR. ——— (b)(6)-2 CPT/A
7/9/03 1600	4mg MSO4 given for pain, patient [illegible] is well c̄ encouragement ——— (b)(6)-2 CPT/A
7/9/03 1700	Report given to oncoming shift ——— (b)(6)-2 CPT/A

(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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6420

MEDICAL RECORD | **PROGRESS NOTES**

DATE

9/2/03 1830 Received pt this pm in bed. Responsive to touch.
Assessment done see DA 4700. NGT flushed c̄ 30cc
water. SaO2 96% ~~c̄ 2L NC.~~ Foley to gravity. IV site
patent c̄ LR @ 150cc/hr. A-line good waveform. will
continue to monitor (b)(6)-2 91WM6 SPC 2000 pt
is sleeping. No distress noted at this time. SaO2 95% c̄
2L NC. Unasyn started 3gm in 100ml ns IVPB. IV site
patent. Will continue to monitor (b)(6)-2 91WM6 SPC
2100 Unasyn infusion complete. pt is sleeping at this time will
continue to monitor (b)(6)-2 91WM6 SPC 2200 Zantac
50mg in 50ml NS IVPB started. NGT flushed c̄ 30cc
water. SaO2 95% c̄ 2L NC. Pt is currently sleeping no
signs of distress noted. Will continue to monitor (b)(6)-2 (b)(6)-2 91WM
2230 Zantac infusion complete. USS. will continue to
monitor (b)(6)-2 91WM6 SPC 0045 Pt is sleeping. SaO2
97% HR 104 pt denies pain and discomfort. will continue to
monitor (b)(6)-2 91WM6 SPC 0200. Unasyn started IVPB
USS. Swelling noted in pts Ⓡ arm. Arm elevated. IV site
patent. Will continue to monitor (b)(6)-2 91WM6 SPC
0230 Unasyn infusion complete. Pt denies any pain at this
time. SaO2 98% c̄ 4½L NC. NGT flushed c̄ 30cc
water. Will continue to monitor (b)(6)-2 91WM6 SPC
0400 Labs drawn A-line has ⊕ wave form. Pt USS
SaO2 97% 4½L NC no distress noted (b)(6)-2 91WM6 SPC

(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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6421

PROGRESS NOTES

DATE	
10Jul03	0445 Pt is currently sleeping. VSS. SaO2 97% 4 1/2 LNC
	labs done. Will give report to oncoming shift
	(b)(6)-2 91W M6
	SPC
10Jul03 @ 0500	Received report from off-going shift. Pt lying in bed
	c̄ eyes closed. Resp even, unlabored. ~~H~~ Error Arterial Pressure
	line into Ⓡ Radial artery zeroed & flushed. HL in Ⓡ AC
	infusing NS @ 150cc/hr. s̄ s/sx of infx. NGT to LIS draining
	dark green/brown drainage. Foley to gravity draining amber,
	clear urine. Surg incision dsg to mid abd CDI. Ⓛ
	arm splinted and ACE wrapped. Some drainage (blood)
	noted @ site. Pt receives IVPB abx. P1 143/67
	BP 155/65 P 107 R 32 SpO2 98% 4.5L NC. Will
	Try weaning pt from O2. ↓ to 4L @ this hour
	(b)(6)-2 91W20 M6
10Jul03 @ 0800	AM Labs Hct 24.1/Hgb 8.2 Dr. (b)(6)-2 ordered 20mg Lasix IVP
	NOW. Given. UOP at this time 375cc Clear/Yellow. Will cont
	to monitor. Bed bath given. received 4mg MSO4 IVP for
	discomfort and tenderness @ surg site. Tolerated well. Foley
	care done Ø s/sx of infection. SpO2 97% O2 ↓ to 3.5Lpm
	NC. IVF ~~LR~~ ↓ to 100cc/hr. (b)(6)-2 91W20 M6
10Jul03 @ 0915	Pt OOB to chair c̄ assist x2, able to support weight
	but unstable. 300cc Clear, yellow urine emptied @ 0900.
	~~Alter~~ Arterial line D/C'd per orders, pressure dsg applied over
	site. ~~HL~~ Δ'd to ~~AC Ⓡ D/T~~ noted edema to Ⓡ fa. LR
	infusing @ 100cc/hr. Pt. given 4mg MSO4 IVP for pain. O2
	↓ to 3LNC SpO2 96%. Will cont' to monitor (b)(6)-2 91W20 M6
10Jul03 @ 10:00	O2 ↑ to 4L D/T SpO2 of 94%. O2 sat p̄ Δ 96%. Pt encouraged
	to deep breath. Emptied 725cc clear/yellow urine. CBC due @ 15:00 (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE

10 July 03 Nutrition Note

O: 40 y/o ♂ S/P GSW; SB Resection

Diet: CL WT: estimated 75 kg

A: Pt c̄ increased nutritional needs 2° GSW and surgery. Portions of bowel resected should not pose a problem for digestion and absorption. Pt will benefit from nutrition supplementation p̄ diet progresses to regular.

P: 1) Will provide CIB as supplement TID p̄ diet progresses

2) Will monitor intake (b)(6)-2 MAJ, SP-RD/LD

10Jul03@ ~~10:30 O2 ↑ to~~ 1200 error SpO2 100% on 4LNC, O2 ↓ to 3.5L. Consumed 720cc of CL diet. ∅ c/o N/V. UOP ~~for p~~ since 10:00, 100cc amber/clear. Will cont' to monitor (b)(6)-2 91W21 M6

10Jul03@ 1500 CBC drawn taken to lab. Hct ↑ 25.3 from 24.1 and Hgb ↑ 8.3 from 8.2. Will notify Dr. (b)(6)-2 when he rounds. O2 @ 4LNC, SpO2 97%. Pt resting in bed. Resp even, unlabored. Infusing LR @ 100cc/hr. into Ⓡ AC s̄ s/sx of infx. Will cont' to monitor. (b)(6)-2 91W20M6

10Jul03@ 1700 UOP 50cc this hr. Report given to SPC (b)(6)-2 91WM6. (b)(6)-2 91W201

10Jul1730 Received pt this pm awake and responsive. Assessment done. see DA 4700. Pt had C/O pain. Given 2mg MS IVP as →

(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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE

10/21 ordered. Will continue to monitor pain level. Pt denied
dinner plate at this time. Pt USS. SaO2 96% c̄ 4L NC.
Pt has foley to gravity c̄ dark yellow urine. HR 104
RR 26 will continue to monitor (b)(6)-2 91WM6 SPC
1830 Pt currently sleeping. SaO2 dropped to 91% pt O2
turned from 4 1/2 L to 5L NC. SaO2 now 96%. HR 101
RR 26 will continue to monitor (b)(6)-2 91WM6 SPC 1915
Pt denies pain at this time. Pt is resting comfortably will
continue to monitor (b)(6)-2 91WM6 SPC 2000 Unasyn
infusion started pts USS SaO2 95% c̄ 5L NC will continue
to monitor 2030 Unasyn infusion complete. IV site patent
c̄ no s/s of infiltration. Pt is currently sleeping no distress
noted at this time will continue to monitor (b)(6)-2 91WM6 SPC
2230. Pt placed on NRB mask @ 15L. Pt SaO2 dropped to
84%. Pt given 4mg MS for pain. Zantac in 50ml NS
given IVPB. Pt SaO2 now 99%. Will continue to monitor
(b)(6)-2 91WM6 SPC 0100 Pt on 40% 12L VM. SaO2
97%. Pt denies pain at this time. HR 91 RR 23. Will
continue to monitor. (b)(6)-2 91WM6 SPC 0200
Unasyn started 100ml IVPB. Pt is currently sleeping no
distress noted SaO2 97% c̄ 40% 12L VM. will
continue to monitor (b)(6)-2 91WM6 SPC 0300 Unasyn
infusion complete. IV site patent c̄ no s/s of infiltration. Pt
SaO2 97% c̄ 40% 12L VM. HR 92 Pt is sleeping at this
time. No signs of distress noted will continue to monitor
(b)(6)-2 91WM6 SPC 0400 labs drawn on pt. Pt is
currently sleeping no signs of distress noted. (b)(6)-2 (b)(6)-2 91WM6
0445 Pt is resting comfortably will give report to oncoming shift
(b)(6)-2 91WM6 SPC

4mg MS sign
to oncomming

MEDICAL RECORD | PROGRESS NOTES

DATE

11Jul03@0500 Received report from off-going shift. Accepted partial carpuject c̄ 4mg MSO4 from SPC (b)(6)-2 91WM6. Pt lying in bed with eye closed, resp even unlabored. O2 @ 40% VM, SpO2 97%. Foley to gravity draining amber/clear urine, 80cc this hr. LR infusin @ 100cc/hr into Ⓡ AC, s̄ s/sx of infx. Ⓛ arm splinted & ACE wrapped c̄ small amt of dried blood noted around elbow. Inspiratory wheezes noted in lower right lobe. Ø cough Ø secretions. Encouraged to cough, deep breath. IS used while awake. Will cont' to monitor —— (b)(6)-2 91W20ML

11Jul03@0630 CXR done. IS used, pt able to maintain 900cc/sec for ≈ 1.5 sec. x 6 before pt became fatigued. O2 Sat ↓ to 90% during use. VM replaced @ 35% SpO2 returning to 94% @ this time. Will cont' to monitor. Ø S/sx of distress. —— (b)(6)-2 91W20ML

11Jul03@0700 Feed pt breakfast consumed 50% Reg diet c̄ 370cc fluid intake and CIB. SpO2 ↓ to 87% while off VM, placed O2 5LNC SpO2 ↑ 95%. Pt seen by Dr. (b)(6)-2 & Dr. (b)(6)-2, ordered 20mg Lasix IVP, given @ 0700 and ↓ LR to 50cc/hr, done. UOP @ this hour 60cc dark yellow/clear urine. Pt to be seen by surg today for removal of Ⓛ arm dsg then casted. Ø c/o discomfort @ this time. Will cont' to monito —— (b)(6)-2 91W20ML

11Jul03@0800 UOP 600cc light yellow/clear urine. Given 2mg MSO4 IVP for pain. P 104 R 29 SpO2 96% on 5LNC. Will cont' to monitor (b)(6)-2 91W

(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.

ICU

PROGRESS NOTES
Medical Record

(b)(6)-4

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PROGRESS NOTES

DATE

11July03@09:00 Dsg Δ'd to Ⓛ lateral abd. Small amt of serosanguinous fluid on
dsg. site s̄ s/sx of infx. Redressed c̄ 4x4's. 800cc UOP.
SpO2 @ 99% on 5LNC. ↓ flow to 4L. —— (b)(6)-2 91W20 MG

11Jul03@10:00 Pt ↑ OOB to chair c̄ assist of one. SpO2 ↓ 89% while
transferring, returned to 97% p̄ exertion. Pt encouraged to
cough, deep breath. IS used @ ~~400~~ (b)(6)-2 900cc/sec x4 600cc/sec
x6. UOP 325cc this hr. Will cont' to monitor (b)(6)-2 91W20 MG

11Jul03@11:00 Dr. (b)(6)-2 removed Ⓛ arm dsg. site appeared s̄ s/sx of
infection. Ortho tech rewrapped site and casted. ⊕ pulses
~~coll~~ cap refills <3 secs, pt can 'wiggle' fingers. Pt returned
to bed prior to procedure. SpO2 ↓ to 94% during
exertion returned to 98%, O2 4LNC. Will cont' to
monitor —— (b)(6)-2 91W20 MG

11Jul03@12:15 Pt consumed 30% of Reg diet and 300cc of fluids. Ø C/B
this meal. Given 2mg MSO4 IVP for pain. P 100bpm R 29
SpO2 95% on O2 4LNC. UOP 40cc this hr. Will cont' to monitor.
—— (b)(6)-2 91W20 MG

11Jul03@1500 Pt given IS, encouraged to cough, unable to bring up mucous.
Took in 120cc H2O @ this time. SpO2 ↓ to 93% during IS
use, has returned to 95%. —— (b)(6)-2 91W20 MG

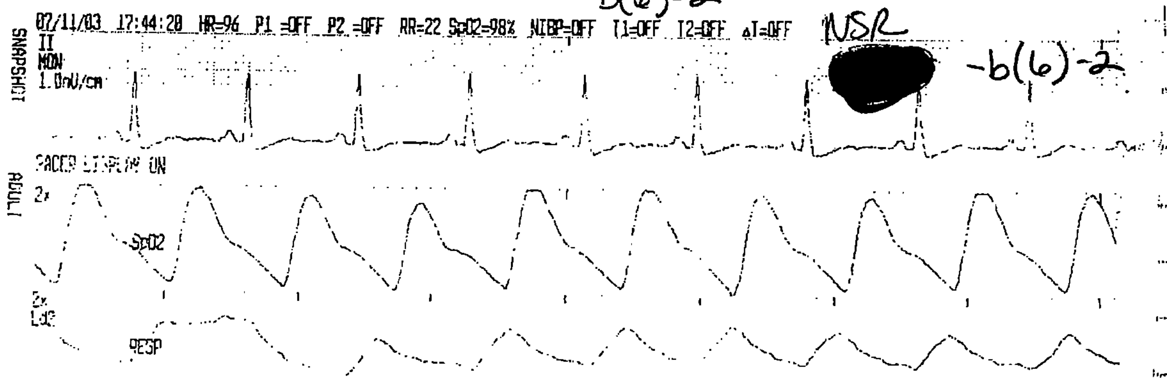
11Jul03@1550 Got pt ↑ OOB, amb approx 40ft. c̄ assist x2 unsteady, shuffle.
Returned to bedside noticed foul odor, brown (tan) discharge from
abd surg site. Dr. (b)(6)-2 notified pt returned to bed. MD
removed staples from around ~~s/e~~ drainage and removed approx
3-5cc of drainage. Packed c̄ 2x2 and covered. pt placed on
NPO. Given 4mg MSO4 IVP for pain. SpO2 ↓ 90% unable
to ↑ c̄ 40% VM, ↑ to 50% VM SpO2 @ 96% P 102 R 24 127/64.
Temp 101.1 T. UOP 100cc this hour. Will cont' to monitor (b)(6)-2 91WML

STANDARD FORM 50

MEDICAL RECORD	PROGRESS NOTES

DATE	
11Jul03@1735	Report given to on-coming shift. Handing all remain [redacted] (b)(6)-2
	MSO4 (4mg) to 1LT [redacted] (b)(6)-2 —— qcu m
1735	client in bed connected to cardiac monitor, on 50% VM
	O2 sat 98%, LR infusing via Ⓡ AC PIV, Foley patent and
	draining dark yellow urine, client c̄ eyes closed [redacted] b(6)-2
1800	Complete assessment done, see DA form 4700, client c̄ coarse
	crackles bilat lungs, good pulmonary toilet done, O2 sat ↓91%.
	on 50% VM, will monitor closely. Abdomen c̄ large midline
	dressing, also drsg to left lower abdomen, all dry + intact.
	Cast type drsg to left hand, unable to palpate left radial pulse
	due to cast, cap refill to fingers 2secs. able to wiggle fingers.
	—— [redacted] CT AN ——

b(6)-2


02/11/03 17:44:20 HR=96 P1 =OFF P2 =OFF RR=22 SpO2=98% NIBP=OFF T1=OFF T2=OFF ΔT=OFF

NSR [redacted] -b(6)-2

b(6)-2

1830	O2 sat 95% on 50% VM, client resting quietly [redacted] 1LT AN
1930	Dr [redacted] @ bedside, removed staples x3 from lower abdomen, small amt thick
	b(6)-2 tan drainage noted, medicated c̄ 4mg MS for pain, drsg change done by MD, notified
	of thick yellow sputum, orders obtained. ~~(Continue on reverse side)~~ [redacted] 1LT AN

66-2

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

REGISTER NO. b(6)-2

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PROGRESS NOTES
Medical Record

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#0034

PROGRESS NOTES

DATE
11 July 03
2000 pulmonary toilet done, good effort c̄ deep breathing and cough
moderate amt thick yellow sputum, lungs clear p̄ coughing — (b)(6)-2,
2100 O_2 sat 96% on 50% v/m, decreased O_2 to 40% at this time — (b)(6)-2
2115 O_2 sat 97% on 40% v/m — (b)(6)-2 CTA
2200 OOB c̄ one assist, ambulated, gait slightly unsteady and slow, up in
chair. — (b)(6)-2 1LT AN.
2330 Back to bed @ 2320, wet to dry dressing done to abdominal wound.
after premedicated c̄ 4mg MS IVP for pain. wound appears pink and
tan. Large amount of blood tinged tan drainage noted on old drsg.
client tolerated well. IS done c̄ good effort, productive strong
cough c̄ large amt thick yellow sputum, lungs cleared post
cough. — (b)(6)-2 1LT AN.
2400 No changes in previous assessment, lungs clear bilat
O_2 Sat 95% on 40% vm. — (b)(6)-2 1LT AN
12 July 03
0200 Client asleep at this time, VSS — (b)(6)-2 1LT AN
0400 Client awake, c/o pain to abdomen, medicated c̄ 4mg MS
IVP, IS x10 c̄ good effort, C&DB done, productive cough c̄
large amount thick yellow/greyish sputum. O_2 sat 99%.
on 40% vm. oxygen decreased to 35% on ventimask at
this time. — (b)(6)-2 1LT AN.
0415 O_2 sat ↓ 89% on 35% ventimask, increased FiO_2 to 40%
will monitor. — (b)(6)-2 1LT AN
0430 O_2 Sat ↑ 95% on 40% ventimask — (b)(6)-2 1LT AN
0450 blood drawn from right hand and sent to lab — (b)(6)-2 1LT AN
0500 Report given to oncoming shift, 2mg MS handed over to
SSG Irby, client in bed c̄ eyes closed connected to monitor
and oxygen. — (b)(6)-2 1LT AN

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES
DATE	
11 JULY 03	ORTHO
	S NO C/O
	O WOUND CLEAN
	NVI
	LAC PLACED
	A STABLE
	P CASTING FOR 3WK, THEN SPLINTING c̄ P.T. FOR ROM EXERCISES UNTIL UNION. WILL NEED STAPLES REMOVED BETWEEN 15 & 18 JULY.
	(b)(6)-2 [redacted]
	(b)(6)-2 [redacted]
	LTC, MC ORTHOPEDIC SERVICE
7/15/03	Op note
	Procedure Washout / Exp
	incidental appendectomy
	Surg [illegible]
	An GETA
	Fluids 2000 LR
	EBL 100
	Findings = ∅ abscess,
	∅ leak
	? hyperemic appy - taken out
	To PACU, stable
	(b)(6)-2 [redacted]

(Continue on reverse side)

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(b)(6)-4 [redacted]

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PROGRESS NOTES
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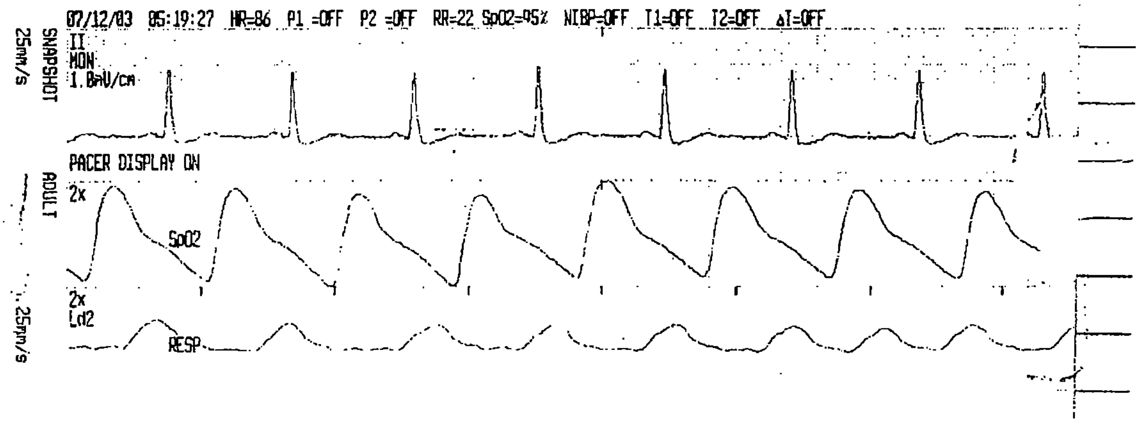
MEDICAL RECORD	PROGRESS NOTES

DATE

12 Jul 03



```
07/12/03 05:19:27 HR=86 P1 =OFF P2 =OFF RR=22 SpO2=95% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
```

0625 - Report recieved from 1LT (b)(6)-2 Pt sleeping in bed. VSS see above and DA-4700 for assessment (b)(6)-2

0700 - Pt OOB to chair, Pt denies any pain. AM care done. Incentive spirometer done. O_2 ↓ to 35% pt maintained SaO_2 @ 90%. O_2 ↑ to 40% SaO_2 92%. Pt now sitting in chair comfortably. (b)(6)-2 SSG/LPN

0730 Pt back into bed. Pt OOB for about 30 min. Pt tolerated well. Pt now resting comfortably. SaO_2 94% (b)(6)-2 SSG LPN

0900 - Pt resting in bed, denies pain. IS done - Pt had productive cough, thick yellow sputum. (b)(6)-2 LPN/

0910 - 20mg Lasix given per Dr. (b)(6)-2 order. (b)(6)-2 SGT/LPN

1000 - Dressing Δ performed - 2mg MSO_4 administered. When old dressing was removed, bloody green & brown thick exudate was noted. Pt tolerated dressing Δ well. (b)(6)-2 SGT/

1100 - Pt OOB to chair - Δd to NC @ 6lpm - did not maintain sats >90%, switched back to Venti mask @ 40%. (b)(6)-2 SG/LR

(Continue on reverse side)

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

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WARD NO. ICU

PROGRESS NOTES
Medical Record

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(b)(6)-4

(b)(6)-4
MEDCOM - 6430

PROGRESS NOTES

DATE	
12Jul03	Pt resting comfortably in bed. Ø c/o pain or discomfort
1300	at this time. ——— (b)(6)-2 SGT/LPN
1500	Pt awake - IS performed. O_2 ↑'d to 50%. 2° sats ↓ to
	90% on 40% O_2 ——— (b)(6)-2 LPN
1630	Type & cross drawn for transfusion of 2 units of
	blood. Taken to lab. ——— (b)(6)-2 SGT/LPN
1700.	Report given to oncoming shift. ~~Ø~~ ↓'d O_2 back to 40%,
	still sats > 96% ——— (b)(6)-2 SGT/LPN
1815	first bag PRBC hung. Y-tubing purged c̄ NS. IV site
W0016 03 002270 [Y]	patent no s/s of infiltration. Will monitor VS for 30min
	q5min. Lungs clear to auscultation. VS T 100.9 HR 160 BP $^{134}/68$
	SaO_2 96% c̄ 40% VM. Will continue to monitor (b)(6)-2 91WM6 SPL (b)(6)-2
	1820 - BP $^{123}/70$ HR-102 SaO_2 96% T 99^3 1825 BP $^{130}/64$
	HR 97 SaO_2 97% T 99^5 Maintenance Fluid Δ from LR to NS
	to infuse ~~over~~ duration of transfusion (b)(6)-2 (b)(6)-2 91WM6 SPL
	1915 Pt T is 99^2. New IV started 18g Ⓡ hand LR @ 50cc/hr
	infusing. IV sites are patent. VS 1830 BP 129/73 HR 101
	T 99^3 1845: BP $^{131}/74$ HR 97 T 99^5 1900 BP $^{131}/71$ HR 99 T 99^5
	1915 BP $^{132}/70$ HR 92 SaO_2 97% T 99^2 VS now q 30min
	will continue to monitor. (b)(6)-2 91WM6 SPL 1945 Pt
	resting in bed blood infusing. IV site patent. Pt has no s/s of
	reaction / distress SaO_2 96% c̄ 40% VM. Will continue to monitor
	(b)(6)-2 91WM6 SPL 2000 VS $^{127}/70$ HR 97 RR 30
	SaO_2 97% c̄ 40% VM pt in ~~no~~ no signs of distress at this
	time Will continue to monitor (b)(6)-2 91WM6 SPL 2030
	Unasyn infusion started. IV site patent no s/s of infiltration
	VS BP $^{124}/68$ HR 95 SaO_2 97% c̄ 40% VM T 99^5 →

MEDICAL RECORD	PROGRESS NOTES

DATE

12/2/03 will continue to monitor (b)(6)-2 91WM6 SPC 2100 VS BP
125/72 HR96 SaO_2 97% T $99^{2°}$ pt has no signs of discomfort
at this time will continue to monitor (b)(6)-2 91WM6 SPC 2130
Completed first PRBC c̄ no complications. pt given 40mg lasix
IVP as ordered. Will continue to monitor (b)(6)-2 (b)(6)-2 91WM6 SPC
2200 Second bag PRBC started VS 137/76 HR94 T 99^{5}
SaO_2 97%. Heparin 5000u given Zantac IVPB infusion started.
2453913 IV sites are patent c̄ no s/s of infiltration will continue to
monitor (b)(6)-2 91WM6 SPC 2215 VS 136/70 HR95
SaO_2 97% T 99^{6} no s/s of distress/reaction will continue
to monitor (b)(6)-2 91WM6 SPC. 2220. Pt urine output p̄
lasix 900 cc clear yellow urine. will continue to monitor (b)(6)-2 91WM6 SPC
2230 VS 130/70 HR96 T 99^{4} will continue to monitor
(b)(6)-2 91WM6 SPC 2245 VS 128/72 HR 91 T 99^{3}
Will continue to monitor (b)(6)-2 91WM6 SPC 2300 VS
131/73 HR95 SaO_2 96% c̄ 40% VM. Pt no s/s of distress
at this time. Urine output this hr 1400cc clear yellow urine.
Will continue to monitor (b)(6)-2 91WM6 SPC 2330 VS
126/71 HR93 SaO_2 97%. No s/s of distress at this time will
continue to monitor (b)(6)-2 91WM6 SPC 2400 VS 131/70
HR94 T 99^{3} no signs of distress noted. IV site patent
will continue to monitor (b)(6)-2 91WM6 SPC 2430
Dsg Δ done on midline incision site. Drainage noted from
top of incision white in color and malodorous. drainage also

(Continue on reverse side)

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

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(b)(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE

13Jul03 noted in mid drainage site. Site irrigated and packed c̄
moist dsg's and covered. Urine output this hour 700cc
clear yellow urine. Will continue to monitor. (b)(6)-2 91W
0130 VS $^{128}/_{72}$ HR 90 T 97.9 No signs of distress noted at
this time. SaO_2 97% c̄ 40% VM. Will continue to monitor
(b)(6)-2 91WM6 SPC 0145 2 unit PRBC complete.
Pt has no S/S of reaction, Afebrile HR 88 $^{127}/_{72}$ IV
site D/C after infusion 18g site in (L) hand remains patent
Lung sounds clear to auscultation. Will draw CBC pt
has no complaints at this time will continue to monitor
(b)(6)-2 91WM6 SPC 0200 Unasyn infusion started
IV site patent will continue to monitor (b)(6)-2 91WM6 SPC
0245 pt taken out of bed and sat in chair. SaO_2
95% c̄ 40% VM. CBC drawn and sent to lab pt
has no signs of distress at this time will continue to
monitor (b)(6)-2 91WM6 SPC 0315 Pt placed back in
bed. VSS SaO_2 95% c̄ 40% VM. no distress noted
will continue to monitor (b)(6)-2 91WM6 SPC
0445 Pt is currently sleeping VSS SaO_2 95% c̄ 40% VM
no signs of distress noted at this time. Will give report
to oncomming shift (b)(6)-2 91WM6 SPC
13Jul03 @ 0500 Received report from SPC (b)(6)-2 91WM6. Pt lying in bed
c̄ eyes closed, resp even, unlabored. VM @ 40% SpO_2 95%
Pt awakens easily. Ø A.M. labs drawn. Placed on VM @
35% SpO_2 @ 95% will cont' to ween from O_2. IVF ~~NS~~ LR
@ 50cc/hr. infusing into (R) wrist Ø s/sx of infx/
infiltration @ site. Foley to gravity draining amber/
clear urine UOP 100cc this hour. Will cont' to monitor (b)(6)-2

STANDARD FORM 50

MEDICAL RECORD	PROGRESS NOTES
DATE	
13Jul03@ 0	650 Pt given bed bath. Dsg Δ'd to surg sites. Dr. (b)(6)-2
	present removed x 10 staples from upper incision. Draining ± 2cc
	light tan drainage. Opening packed c̄ sterile 2x2's and covered.
	Pt given 4mg ~~for~~ MSO4 IVP for discomfort. SpO2 97% pt.
	placed on O2 4L NC. Will cont' to monitor (b)(6)-2 91W20 MG
13Jul03@	0715 Pt ↑ OOB to chair c̄ assist of x 1. Ⓛ arm in sling
	+ pulses to extremity. Given 2mg MSO4 IVP for discomfort
	Consumed 50% of Reg diet c̄ 240cc milk & CIB + 250cc
	H2O. SpO2 95% while up. (b)(6)-2 91W20 MG
13Jul03@ 08	45 Pt returned to bed c̄ assist x 1. SpO2 95%. O2 ↓ to 3.5LNC.
	Will cont' to monitor (b)(6)-2 91W20 MG
13Jul03@ 10	:00 Pt lying in bed c̄ eyes ~~co~~ closed. Resp even, unlabored.
	SpO2 @ 97% on ~~3.5 L NC~~. (b)(6)-2 91W20 MG
13Jul03@ 10:	10 Given 2mg MSO4 IVP for discomfort (b)(6)-2 91W20 MG
13Jul03@ 11:	20 SpO2 98% on 3.5LNC. O2 ↓ to 3LNC Will cont' to monitor (b)(6)-2 91W20 MG
13Jul03@ 12:	00 Consumed only ~~of~~ a few bites of Reg diet. Took in 240cc milk
	c̄ CIB. O2 Sat ↓ to 93% on 3.5LNC ~~while eating~~. O2 ↑ to
	~~4~~3 LNC. Will cont' to monitor (b)(6)-2 91W20 MG
13Jul03@ 12:15	SpO2 96% @ 3LNC. O2 ↓ to 2.5LNC (b)(6)-2 91W20 MG
13Jul03@ 13:	00 Pt ↑ OOB to chair c̄ assist x 1 SpO2 95% on 3LNC. Given 2mg
	MSO4 IVP for pain (b)(6)-2 91W20 MG
13Jul03@ 14:00	Pt @ BSC producing ~~fat~~ flatus Ø BM. Returned to bed O2 3LNC
	SpO2 95%. Took in 250cc H2O (b)(6)-2 91W20 MG

(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
Medical Record

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PROGRESS NOTES

DATE

13Jul03 @ 1530 O2 ↓ 2LNC, SpO2 95%. Pt lying in bed, quiet. Resp even, unlabored. Ø % discomfort @ this time — (b)(6)-2 91W20 ANC

13Jul03 1800 Received pt this Rm inbed resting. Assessment done See DA4700. Pt ate small amount of dinner and had 400ml PO water and c/B. Pt has no s/s of distress at this time will ~~continue to monitor~~ (b)(6)-2 91WM6 SPC 1900 Pt ambulated OOB to chair. VSS SaO2 95% IS done 10x. No distress noted at this time will continue to monitor (b)(6)-2 91WM6 SPC 2100 Unasyn infusion started IV site patent c̄ no s/s of infiltrat Pt is currently resting ~~SaO2 97% c̄ 3LNC~~ no signs of distress noted. Will continue to monitor (b)(6)-2 91WM6 SPC 2230 Dsg Δ preformd. Pt given 2mg ms as ordrd prior to Δ and 2mg @ 2230 p̄ Dsg Δ. Pt denies any pain at this time. Site clean mild drainage no odor noted. Dsg initialed and dated. Zantac started at 2200. IV site patent no s/s of infiltration will continue to monitor (b)(6)-2 91WM6 SPC 2430 pt is currently sleeping SaO2 98% c̄ 2LNC. VSS. No signs of distress ~~noted~~ will continue to monitor (b)(6)-2 91WM6 SPC 0200 Unasyn infusion started IV site patent. Pt is sleeping VSS SaO2 97% c̄ 2L NC. will continue to monitor (b)(6)-2 91WM6 SPC 0300 Unasyn infusion complete IV site patent ~~flushed. Pt stated~~ pain at incision site. 4mg ms given as ordrd for pain IVP. VSS. SaO2 96% 2LNC. Will assess pain levels (b)(6)-2 91WM6 SPC 0335 Pt currently sleeping VSS SaO2 97% c̄ 2LNC. No signs of distress noted will continue to monitor (b)(6)-2 91WM6 SPC 0430 labs drawn Pt is resting no signs of distress noted. Pt c/o pain at incision site given 2mg ms as ordrd used 10mg ms throughout

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD

PROGRESS NOTES

DATE	
14JUN	shift. Will continue to assess pain level (b)(6)-2 91WM6 (b)(6)-2 SPC
	0445 Pt is currently sleeping no distress noted. UBSS will give
	report to oncoming shift (b)(6)-2 91WM6 SPC
	0525 Pt being transferred to ICW report given to ICW staff
	(b)(6)-2 91WM6 SPC
15 July 03	Nsg shift assessment: Pt dressing was
@0100	changed last evening @ approx 2100.
	Midline (unsutured area) dressings
	had drained a moderate amt of
	serosanguinous fluid. Area appears
	reddish pink. Pt did not c/o pain
	during dressing change, but at approx
	1830, required 4mg PRN morphine.
	O2 Sats are above 98%, resps are
	even and unlabored. ~~Appears~~ to be
	asleep at this time, will continue to
	monitor (b)(6)-2 AN
0150	Nsg: Pt foley bag emptied of
	1200 cc of dark tea colored urine
	(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
Medical Record

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PROGRESS NOTES

DATE	NOTES
16 July 03	Report recieved from dayshift — Pt lying in bed awake
1800	follows commands - VSS 122/68 P-100 R-26 shallow P.O. 96%
	3L NC IVF LR @ 100cc/hr into Ⓡ 18G IV cath NGT to
	LIS (suction on) IS at bedside DSG to midline abd
	Ad taken by surgeon C, D and I - absent BS Pt NPO
	c̄ sips - Peripheral Pulses Palpable (+) pedal edema
	1600 Lasix given IV (1200cc out time now 1800) Lungs CTA
	coughing episode x1 (non productive)
1900	Pt. used IS c̄ good results Temp 100.7 Ⓣ
	Dayshift states surgeon aware Ø tylenol order written
	MSO4 for pain @ 1830 ——— (b)(6)-2
2000	Pt tolerating sips H_2O - Foley to Gravity draining clear dark
	yellow urine NGT LIS - Pt using IS while awake
	Pt OOB - moving slowly guarding stomach - DSG still
	intact Ø gross blood will continue to monitor (b)(6)-2
2100	Pt. enc. to cough and deep breath - Temp still 100.7 Ⓣ
	HOB ↑ 30° - Pt seems comfortable in this position
	Heparin SQ and IV unasyn started - Pt awake
	Vital Signs Stable 125/72 P-116 P.O 96% 3L NC - (b)(6)-2
2230	IS used - IV LR 100cc/hr infusing - NGT LIS
	apparatus on - Foley draining QS urine - (b)(6)-2

2245 - Cap refill to fingers on cast arm brisk - fingers
warm - not painful - Pt's complaints

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)*

F

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0030	Dsg to abd incision Δd - wound packed
17Jul03	by staff earlier in the day - 4x4 and tape
	to wound - NGT flushed c̄ 60cc sterile water
	tube patent ⊕ return ∅ blood noted
	Zantac 1IVPB infused into IV site s̄ difficulty
	Pt tolerating sips of water - ⊖BS noted
	IS enc - pt consistently raises the 900 per sec
	ball on IS - Pt positioned in bed for
	comfort (b)(6)-2
0200	Pt sleeping, VSS NGT LIS minimal output,
	Foley to gravity draining QS urine will
	continue to monitor ⇒ Temp 99.7 Ⓣ
4mg	~~MSO4 for pain~~ (b)(6)-2
0245	Pt positioned in bed - Temp 99.5 Ⓣ - Pt.
	used incentive Spirometer still 900cc per second
	2 balls - NGT LIS - Pt still tolerating sips of the (b)(6)-2
	-BS noted, Dsg to abd CDI
0300	Neuro checks to Ⓛ fingers cap refill brisk <2 sec.
	fingers pink, warm, ∅ pain - Pt. s̄
	complaints to Ⓛ arm (b)(6)-2 given
0400	Labs acquired sent to Laboratory
	CBC, Chem 8 - IS used at time of
	blood draw. weak effort, 600cc one ball raised
	NGT flushed 30cc sterile water (b)(6)-2
0500	Pt report given to dayshift - Pt. awake
	~~sleep~~ error Vital Signs stable 120/64 HR-94 Pulse ox 94%
	Lungs CTA - diminished bases shallow breaths

⊖BS - ∅ BM this shift ∅ [illegible] ie stated
Thru interp - - (b)(6)-2

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

MEDCOM - 6438

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 July 03 @ 0500.	Received report from off-going shift. Received Tmy MSO4 from SGT (b)(6)-2 91WMa Pt lying in bed c̄ eyes closed, resp even, unlabored. SpO2 96% on 3L NC. NGT c̄ green drainage @ LIS. Foley to gravity, draining clear, ~~yl~~ yellow urine. LR infusing into Ⓡ AC @ 100cc/hr. Pt uses IS s̄ difficulty unable to lift 3rd blue completely. Encourage to cough, expectorated sputum c̄ dark ~~flec~~ flecks. Dsg to midline abd site c̄ pink drainage visible in cover dsg; awaiting MD for dsg Δ. ⊕ pulse in all extremeties Ⓛ arm cast c̄ ⊕ pulses, ~~cdt~~ ↑ cap refills <3 sec. ⊖ bowel sounds. 0 flatus or BM per pt statement via 1 interepreter. Will cont' to monitor —— (b)(6)-2
17 July 03 @ 0730	Encouraged use of IS, unable to move 3rd blue. 0 c/o SOB or discomfort. Will cont' to monitor —— (b)(6)-2
17 July 03	Nutrition Note F/U
1000 A:	Pt currently NPO and has had marginal intake since admission. Given trauma and surgeries pt has undergone he is at high nutritional risk and a good candidate for nutritional support. We have a number of formulas available if feedings are needed

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

(b)(6)-4

REGISTER NO.
WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 July 03	Nutrition Note (cont)
1000 A:	to improve nutritional status.
P/R	Recommend Tube feedings to promote wound healing if intake doesn't improve p̄ feedings resume.
	(b)(6)-2 MAJ, SP RD/LD
17 Jul 03 @ 1030	Pt ↑ OOB → chair c̄ assist x1. Dsg Δ per Dr. (b)(6)-2 - Pt given 4mg MSO_4 IVP for discomfort. SpO_2 95% on 3LNC (b)(6)-2
17 Jul 03 @ 1300	Pt returned to bed: Ø c/o discomfort. SPO_2 95% on 3LNC. (b)(6)-2
17 Jul 03 @ 1615	Radiology for abd x-ray as ordered. (b)(6)-2 (b)(6)-2
1740	Received report from SGT (b)(6)-2 pt / resting in bed c̄ eyes open - Responds appropriately to verbal commands despite language barrier. Pupils 3mm + ⊕, O_2 @ 2LPM via NC, NG to LIS c̄ brown fluid coming out, pt is NPO c̄ sips of H_2O allowed. ↓ Resp. to bases of both lungs, wet-crackling sound can be heard. Pt. used incentive spirometer @ this time c̄ some encouragement. IV to ⊕ (b)(6)-2 Ⓡ AC, 18 G c̄ LR @ 100cc/HR. Ⓛ arm is in a cast up to the bicep, unable to feel for ~~pulse~~. Midline incision saturated serosanguinous fluid, changed by Dr. (b)(6)-2 this time ⊕ pulses x1 extremity + x2 ↓ext, cap. refill <3 sec x4 ext. DRSG to Ⓦ ABD CDI. Foley to gravity draining dark yellow urine. SPC (b)(6)-2

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

DATE	NOTES
17 July 03	
1740	⊖ BS, ⊖ BM, ⊖ flatus @ this time also. USS. ——— SPC (b)(6)-2
2000	Pt's. O2 ↑ to 4LPM due to SaO2 dropping to 78, SaO2 increased to 98%. Pt. spitting up large amounts of phlegm of a dark brown, thick nature. Dr. (b)(6)-2 notified due to Dr. (b)(6)-2 not being found. VO taken from Dr. (b)(6)-2 @ this time. USS. Will notify Dr. (b)(6)-2 L when he is found. Pt. encouraged to use IS @ this time, which he did. SPC K
2110	Dr. (b)(6)-2 informed of pts. phlegm being thicker brown ~ of Dr. (b)(6)-2 VO for Lasix. SPC (b)(6)-2
17 July 03 2200	Patient c/o pain to midline incision. Medicated c̄ 2mg morphine IVP. Encouraged use of incentive spirometer, elevated & walks c̄ effort. Lungs CTA to anterior fields post [illegible]. Response with urine output of 500cc this hour. O2 sats remain 95% and greater on 4L N/C. Remains in NSR s̄ ectopy. Will continue pulmonary toilet and medicate for pain as needed. ——— (b)(6)-2 [illegible]
0030	Patient repositioned in bed. Coughing up brown tinged sputum. Given Yankauer suction for use. Dressing reinforced c̄ 8x4 gauze due to excessive serous, sanguinous drainage. Medicated c̄ 2mg MSO4 (b)(6)-2 [illegible]

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID NUMBER *(SSN or Other)*

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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)*

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(b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4

MEDCOM - 6441

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18/1	Pt. resting quietly in bed, easily awoken, USS.
0200	⊖% pain, ⊖% coughing ———— SPC (b)(6)-2
0440 ~~0340~~2	pt. resting quietly in bed, ⊖% pain, ⊖% coughing,
	incentive spirometer use encouraged @ this
	time. USS. ———— SPC (b)(6)-2
0500	4mg MSO4 + report given to CPT (b)(6)-2 — SPC (b)(6)-2
18 July 03	NN: assumed care of patient. Neuro: patient
0600	awake, follows basic commands. pupils 3-4mm
	brisk reaction to light, pain control c̄ MSO4
	Q 2-3°. Resp: lung sounds coarse esp on expiration.
	Improve slighty c̄ TCDB. Using IS Q2° c̄
	encouragement. Productive cough c̄ thick brownish
	secretions. Resp rate slightly increased, at
	times mildly labored, sats 95-97% on 4L NC.
	CV: Skin warm + dry, afebrile. HR 80-90's, pulses
	palpable, B/P stable. GI: Abd firm, slightly
	distended, tender to touch esp. @ incision.
	BS hypoactive, Ø stool. NGT to LIS with
	moderate to large amounts thin green/brown
	drainage. Flushing Q4° c̄ 30cc NS. GU:
	foley c̄ clear dark yellow urine approx
	.5-1 cc/kg/hr. Lines: 18g to Ⓡ FA c̄ LR @100cc/°.
	Skin: Midline abd dsg, saturated c̄ foul
	smelling brownish drainage, outer dsg Δed.
	Cast to Ⓛ UE over ORIF, CMSV's to distal
	ext WNL. Meds: Zantac, cefotetan IVPB, Fluconazole
	PO, Heparin SQ. Plan: continue to monitor (b)(6)-2 CPT/

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 July 03	NN: Patient O2 Sats worsening. Now needs NRB
0800	@ 10L to maintain sats >90%. Lung sounds
	clear on Ⓛ, absent on Ⓡ. RT here, gave neb,
	performing chest PT. ——— (b)(6)-2
18 July 03	NN: Sats improved, now 98% on 6L NC, productive
0810	cough c̄ thick clear sputum. Will recommend
	CPT c̄ nebs Q 4°, next due 1200. ——— (b)(6)-2
18 July 0800	HHN Tx given c̄ 0.5 Albuterol and 2.5 NSS. BBS for ↓d to
Resp Therapy	Ⓡ Lobes and clear on Left. HR 104-109, O2 SAT on 12 L/min
	NRB mask 91%. P̄ Tx BBS for improved to Ⓡ but decreased.
	CPT done to Ⓡ lung segments. Pt c̄ weak effective cough for
	small amount thin clear secretions. Pt instructed on deep cough
	with splint to abdomen. Pt effort weak. Returned to NRB @ 12L/m.
	HR 106 O2 SAT 92-93% RR 20-24. Pt in no obvious Resp distress. — (b)(6)-2
18 July 03	4mg MSO4 given for incisional pain post
0830	CPT, patient up to chair ——— (b)(6)-2 CPT/
18 July 03	Sats still in Low 90's c̄ 12L O2 via NC, gave
0910	40mg Lasix IVP. ——— (b)(6)-2 CPT/AN
18 July 03	Good UOP from lasix. Given diflucan per NGT
1010	clamped x 30min ——— (b)(6)-2 CPT/AN
18 July 03	Am care done ——— (b)(6)-2 CPT/AN
1630	

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	ER

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(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 July 03	Small liquid brown stool, NGT D/C
1100	per Dr (b)(6)-2 Will continue to
	monitor —— (b)(6)-2
18 July 03	IVF to 30cc/°, started on clear liquid
1200	diet. CPT + neb done per RT —— (b)(6)-2
18 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS via aeromask. HR 109-112
1200	RR 30 & stable. BBS for ↓↓ to R lobes and clear on Ⓛ.
Resp Therapy	CPT given x 5 mins to Ⓡ lung segments. Pt c̄ strong productive
	cough for small amount thick brown secretions. p̄ Tx BBS for bilat
	breath sounds coarse throughout, HR 112 RR 34 O_2 SAT 96% on 6 L/min NC
	NAR —— (b)(6)-2 CRT
18 July 03	Resting quietly. Sats 98% on 6L. Tolerated
1500	PO fluids, will advance slowly. Plan to
	switch to PO pain meds. Using IS (b)(6)-2 CPT/AN
18 July 03	CPT done, foley D/C will give tylox
1600	prn pain per order —— (b)(6)-2 CPT/AN
	DTV NLT 2200 —— (b)(6)-2 CPT/AN
18 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS via Aeromask. BBS for
1600	Coarse to Ⓡ lung segments. HR 112 O_2 SAT 97% on 5 L/min NC
Resp Therapy	CPT done to Ⓡ lung segments x 5 mins c̄ Postural drainage
	Pt c̄ Productive wet cough. Pt performed IS x 15 c̄ 1200cc/rec
	continuously. p̄ Tx BBS for coarse. O_2 SAT 96% on 4 L/min NC HR 120.
	NAR —— (b)(6)-2 CRT
	(b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES

DATE	
18 Jul 03 1730	Pt. A+O x3, was able to speak to pt. through translator. O_2 @ 4LPM via NC, pt. has cast to Ⓛ arm from bicep to wrist, unable to palpate Ⓛ pulse due to cast. 18G IV to Ⓡ AC c̄ LR @ 30cc/HR. Coarse crackles heard on expiration to Ⓡ side ~~of lungs~~, Ⓛ side CTA. IS use encouraged and observed. DRSG to midline ABD CDI, DRSG to Ⓛ ABD CDI. Foley d/c'd @ 1600, pt. due to void c 2200, BS ⊕x4, hypo-active. Pt. consumed c̄ Carnation instant breakfast mix c̄ ⊖ N/V. ⊕ pulses x3, cap refill <3sec. Color normal for race, skin warm + dry. Pt has a pillow to splint ABD when coughing ⊖ cough or ⊖ sputum observed @ this time. SPC (b)(6)-2
2000	Pt. given ii tabs of tylox in preparation for getting up to chair and for c/o pain. Neb-treatment also given @ this time. VSS. Will continue to ~~monitor~~ SPC (b)(6)-2
2030	Pt. had a small, ~~tarry~~ bowel movement c̄ 300 cc's clear, yellow urine. Remained seated @ bedside chair. O_2 was taken off @ this time ~~and~~ percussion therapy performed. SaO_2 @ 94%, pt had a thick cough c̄ white, stringy phlegm. — SPC (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)*

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(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE 19July03	Skin: Abd incision dressed by MD. Large
0800	amount of brownish drainage on old
cont	dsg. Cast to Ⓛ UE for ORIF intact. Lines:
	new 20g IV Ⓡ wrist started this am
	c̄ LR @ 50cc/° infusing. Plan: ~~contin~~
	continue ABX, chest PT, will continue to
	monitor ——— (b)(6)-2 CPT/AN
19July03	Up to chair x 2° Bath done, linen changed.
0900	IS done ——— (b)(6)-2 CPT/AN
1200	4mg MSO4 IV given for c/o Ab pain. (b)(6)-2
1210	Pt gesturing he needs to have BM. Assisted (b)(6)-2
	to bedside commode c̄ minimal assist. — (b)(6)-2
1230	Ø BM at this time, gesturing to have pillow put behind
	back, Asked if pt wants to get into bed & he shook
	head no ——— (b)(6)-2
1410	Incentive spirometer given to pt & was able to do the
	900cc/sec chamber. Encouraged to deep breath but declined.
	——— (b)(6)-2
19July03	Chest PT done per RT, Ø change in
1600	condition. Will cont. to monitor — (b)(6)-2
19July03	HHN Tx given c̄ 0.5 Alb/2.5 NS via Aeromask. BBS for ↓'d tol
1600	RLL c̄ Rhonchi HR 88 RR 20 O2SAT 97% on 2l/min NC. CPT done
Resp Therapy	to RLL x 5 mins c̄ drainage. PTx BBS for unchanged. HR 89 O2SAT
	96% on 2l/min NC RR 20, NAR ——— (b)(6)-2 CRT

(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
Medical Record

STANDARD FORM 509 (REV. 7-91)
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USAPPC V1.00

(b)(6)-4

MEDCOM - 6446

PROGRESS NOTES

DATE

1700 Recieved report from dayshift 1700 Pt awake recieving
nebulizer tx from RT - alert and coperative
Perrl <3mm brisk c̄ light - Pt coughing/deep
breathing c̄ pain 4mg IV MSO4 to enc. cough/deep
breath - IS at bedside - Dsg to abd clean
Ø gross blood or discharge ⊕ radial pulses Ⓡ hand
Lungs: see RT note - Pt afebrile 98.7 ⓞ
+ cap refill Ⓛ hand - ext pink Ø swelling noted
Pt does c/o itching inside cast - slightly
edematous feet bilat ⊕1 pedal edema
improved c̄ OOB activity - will continue to
monitor ——— (b)(6)-2

1900 Pt ate small amt of dinner - Ø appetite
200 cc H_2O LR infusing 30 cc/hr into
20 g Ⓡ hand IV cath - IS use x 3 minutes
good effort - CPT done by RT (b)(6)-2
Pt medicated c̄ Lortab per Dr (b)(6)-2
(Ø Tylox) for dressing Δ by Dr (b)(6)-2
Pt s̄ complaints at this time (b)(6)-2

1930 Dsg Δ done by MD - Pt tolerated
procedure well O_2 sat > 97% on 2L NC
Vital Signs Stable 126/70 P-85 R-12
Temp 98.7 ⓞ hypoactive BS x 2 quadrants
Lungs expiratory wheezes Ⓡ LL Ø BM
This shift Ø urine output This shift

2200 200 cc urine output dark yellow urine
Pt s̄ complaints ——— (b)(6)-2
(b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6447

MEDICAL RECORD	PROGRESS NOTES
DATE	
2110	Pt. ambulated up and down ward x2. c̄
	assistance. Returned to bedside chair. —SPC (b)(6)-2
19 July 03	Pt. resting quietly in bed. 2L NC O2 was
0005	put back on pt for S.O2 dropping down
	to 92-94%, returned to 98-100 ——SPC (b)(6)-2
0300	Pt. resting quietly in bed. VSS ——SPC (b)(6)-2
19 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NC. BBS ~~for~~ clear
0800	slightly decreases to RLL, HR 92 O2 SAT 96% on 2 L/min NC
Resp Therapy	RR 24 stable. CPT performed while Pt was sitting up in
	chair. Pt c̄ ⊖ cough during Tx. P̄ Tx BBS clear ↓'d to RLL
	RR 20 O2 SAT 97% on 2 L/min NC HR 86 NAR — (b)(6)-2
19 July 03	NN: assumed care of patient @ 0500. Neuro:
0800	awake, alert, pupils 3mm brisk reaction
	to ~~pan~~ light. Minimal pain, moves all
	extremities well, 5/5 strength in all x̄ Ⓛ UE.
	Resp: lungs clear diminished LLL. Occasional
	productive cough c̄ thick clear sputum.
	Sats 97-99% on 2L NC. CPT c̄ albuterol
	nebs Q 4° per RT. CV: HR 70-90's, BP
	stable. Pulses palpable, afebrile. GI:
	BS⊕, ØN/V/D, tolerated 240cc ensure,
	1/2 box ~~[illegible]~~ cereal. GU: voiding in
	urinal. No bladder distention noted

(Continue on reverse side)

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

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PROGRESS NOTES
Medical Record

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(b)(6)-4

MEDCOM - 6448

MEDICAL RECORD PROGRESS NOTES

DATE

20Jul03 Nebulizer Tx by RT - pt tolerated treatment
0100 well - CPT performed by Spc (b)(6)-2
Pulse ox 97% on RA - Cefotan antibx -
infused - LR still infusing 30 cc/hr.
200 cc water intake PO (b)(6)-2
0200 Pt sleeping s̄ complaints - (b)(6)-2
0330 Pt requesting pain medication. 4mg MSO4 IV
Pt also c/o Ⓛ arm itching inside of
cast enc not to scratch - will consult
c̄ Dr about PO Benadryl for itching
(b)(6)-2
0500 Pt sleeping s̄ complaints Vital Signs
Stable 118/61 P-80 R-17 Pulse ox 100%
2LNC (b)(6)-2
0515 8mg MSO4 signed over from SGT (b)(6)-2 - pt resting
comfortable - arousable to voice. Pupils 3mm & PERLA, on
2 L O2 via NC sats 99-100%, lungs CTA except Ⓡ ↓ diminished
breath sounds, PIV to Ⓡ wrist @ KVO c̄ LR, NSR all pulses
palpable, dressing to midline abd CDI, BS hypoactive
x 4 quads, reg. diet, urinal @ BS, ∅ urine yet this shift.
Will monitor for ∆s. (b)(6)-2 SGT/LDN
0730 Pt bathed & Δd, Ate 70% of breakfast. ∅ complaints
at this time. (b)(6)-2 SGT/LDN

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or w... entries give: Name - last, first, middle; grade; rank; ra... ...spital or medical facility)

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(b)(6)-4

PROGRESS NOTES
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MEDCOM - 6449

MEDICAL RECORD

PROGRESS NOTES

DATE

~~0830~~

20 July 03 HHN Tx given c̄ 0.5 Alb/2.5 NS via mask. BBS for ↓'d in
0800 lower lobes but fairly clear. HR 90 RR 24 O2 SAT 97% on 2L/min NC
Resp Therapy CPT done to Ⓡ lung segments x 5 mins. Pt c̄ weak non-productive cough. p̄ Tx BBS unchanged HR 94 O2 SAT 98%. IS done. Good Pt effort 1000cc x 1 sec x 10. NAR (b)(6)-2

1015 Pt OOB to chair, linens Δd, satting >95% s̄ O2. NC still on @ 2 lpm. (b)(6)-2 SGT/CPN

1030 Pt had large formed BM x 1 (b)(6)-2 SGT/CN

20 Jul 03 ORTHO POD 11
1240 S NO ELBOW C/O INLAC
O WND CLEAN, STAPLES OUT LAC REAPPLIED
A DOING WELL
P CUT DOWN CAST TO LAS & BEGIN ROM OOA 24hr
XR A BEGINNING ROM

(b)(6)-2

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

20 July 03 HHN Tx given c̄ 0.5 Alb/2.5 NS, BBS for ↓'d bases
1200 but fairly clear. HR 90 RR 24 O2 SAT 100% 2L/min NC
Resp Therapy p̄ Tx BBS unchanged. NAR (b)(6)-2 CRT

(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

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(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	
20Jul03	Dr. (b)(6)-2 performed dressing Δ, Montgomery straps
1400	applied, pt urinated 575cc dark yellow urine, ate about 10%
	of meal + one carnation - logged onto calorie count
	being kept for MAJ (b)(6)-2. Pt lying in bed s̄ complaints
	of pain at this time. —— (b)(6)-2 SGT/
20 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS. BBS for ↓'d bases bilat
1600	but clear. HR 100 RR 24 O_2 SAT on 2 l/min NC 98%.
Resp therapy	Pt refused CPT c̄ c/o pain in abdomen. P̄ Tx BBS for unchanged
	HR 97 RR 24 O_2 SAT on 2 l/min NC 99%. NAR —— (b)(6)-2
1700	Pt resting in bed - Ø c/o pain at this time. (b)(6)-2 SGT/
	1800 Received pt this pm in bed resting. Awake appropriate, able
	to move ext x4. Pt has patent airway c̄ no difficulty breathing. Pt on
	2L NC SaO_2 100%. S1/S2 sounds present c̄ no extra sounds
	NSR @ 90BPM Pulses equal and palpable. No skin breakdown
	noted w/o to touch. Dsg to midline incision C/D/I. Cast on Ⓛ
	UE. BS ⊕ x4 quads abdomen soft tender non distended. Pt had
	BM this pm. Pt voids via urinal c̄ difficulty. Pt on regular
	diet c̄ CIB. Pt activity is OOB. Lung sounds clear c̄ diminished
	bases. Will continue to monitor (b)(6)-2 91WM SPC ——
	1900 Pt sat up in chair and washed face. pt had bm on bed
	side commode. VSS SaO_2 100% c̄ 2L NC. Will continue
	to monitor (b)(6)-2 91WMO SPC 1945 Pt placed back in bed
	no complaints noted at this time. Will continue to monitor ——

(Continue on reverse side)

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

REGISTER NO. (b)(6)-2

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 6451

PROGRESS NOTES

DATE

20Jul03 2200 Pt is resting comfortably no distress noted at this time. Pt
given heparin 5000u SQ and had 300ml urine output. Will
continue to monitor (b)(6)-2 91wm6 SPC 2400 Zantac
Infusion complete. IV site patent no s/s of infiltration.
SaO2 98% c̄ 2LNC. Albuterol given by RT. No distress
noted at this time. Will continue to monitor (b)(6)-2 91wm SPC
2430 Ceftazidime infusion started (b)(6)-2 91wm6 SPC
0100 pt given ii tabs percocet for pain as ordered. Pt c/o
pain at incision site. Will continue to monitor pain level
(b)(6)-2 91wm6 SPC 0130 Ceftazidime infusion complete
IV site remains patent No s/s of infiltration. VSS SaO2 98%
c̄ 2LNC. Pt is currently sleeping no signs of distress noted at this
time will continue to monitor (b)(6)-2 91wm6 SPC
0300 Pt is sleeping at this time no signs of distress noted VSS
SaO2 99% c̄ 2LNC Will continue to monitor (b)(6)-2 91wm SPC
0445 Pt is currently sleeping no distress noted at this time VSS
A-febrile SaO2 99% on 2LNC Will give report to oncoming
shift (b)(6)-2 91wm6 SPC

21Jul03 Report received from SPC (b)(6)-2 assessment performed.
0500 Pt asleep but easily arousable, pupils 3mm & briskly reactive,
on 2L O2 via NC satting 99-100%, resp unlabored, rate 15-20,
lungs CTA, ↓ bases, heart sounds audible, pulses palpable
x4, midline abd incision, dressed c̄ Montgomery straps in
place, cast to Ⓛ arm, circ √ good, BS hypoactive x 4quads,
reg. diet c̄ calorie count, BM x i last evening, no urine
out yet this shift. Pt denies pain at this time. Will
continue to monitor. (b)(6)-2 SGT/LPN

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS, BBS for b'd bases but
0800	clear. RR 20 O2 SAT on 2 l/min NC 97% HR 97. CPT refused by
Resp Therapy	Pt c̄ c/o pain in abdomen. p̄ Tx BBS unchanged. HR 96 O2 SAT 97 NAE — (b)(6)-2
0830	Pt ate 30% of breakfast + one Ensure, Dr (b)(6)-2
	performed dressing Δ. Pt placed NPO for debridement
	in OR today. IVF ↑'d to 100cc/hr, pt bathed, sitting
	up in bed. ——— (b)(6)-2 SGT/LPN
21 July 03	Nutrition Note F/U
0900	Performed calorie count for past 24°. Results as follows:
	1200 kcal — estimated needs 3000-3400 kcal 40-45 kcal/kg
	60-70 gm protein — estimated needs 110-150 gm 1.5-2.0 gm/kg
	pt meeting < 50% of nutritional needs. Pt is
	consuming all of Carnation Instant Breakfast. Will
	increase supplement of Carnation Instant Breakfast
	to 5-6 times/day. Will continue calorie count.
	(b)(6)-2 MAJ, SP RD/LDN
0915	Pts sats ↓ to 76%, after encouraging him to take deep
	breaths, only ↑'d to 89, ↑'d O2 to 4 lpm, sats went
	back up to 98%. Will monitor. ——— (b)(6)-2 SGT/LPN
0900	Pt pulled out IV catheter. Unknown exact time. only
	1/3 of Zantac went in. Will restart IV. (b)(6)-2 SGT/LPN
1000	Held Diflucan because pt is NPO — (b)(6)-2 SGT/LPN
0930	Started 20g IV to Ⓡ FA, Flushed c̄ patent. (b)(6)-2 SGT/LPN

(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 (b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
21 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS. BBS for ↓'d bilat bases
1200	but clear. HR 90 RR 20 O2 SAT on 2 l/min NC 99%. Pt
Resp Therapy.	refused CPT c̄ c/o pain. P̄ Tx BBS for unchanged. NAR —— (b)(6)-2 CRT
7/21	Operative Note
	Procedure: Exp Lap
	Wound debridement
	Anes: GETA
	Findings: - Necrotic edges of fascia
	- fluid collection pelvis
	- JP placed in pelvis
	- wound irrigated / approximated
	- skin open
	Fluids 1600, UOP 200 EBL 10
	To RR stable, extubated (b)(6)-2
	Matthews,

MEDICAL RECORD	PROGRESS NOTES

DATE	
21 Jul 03 1700	S/P Abdominal wound exploration c̄ JP drain. Titrated c̄ 20mg Morphine 150 EBL, 200cc U.O. 1100 Crystalloid, IVs: 20G to Ⓡ arm, 16G EJ to Ⓛ external jugular vein. N/G to Ⓡ nares. Patient transferred from litter to bed c̄ assessments as follows: Neuro: Sedated + Paralyzed with Vecuronium, One twitch noted using nerve stimulator, Versed + Morphine ordered to be infused, pending pharmacy orders. GI: N/G to Ⓡ Nares clamped. Jevity ordered to infuse @ 10cc/hr with residuals to be checked every four hours GU: Foley to gravity, clear yellow urine, CV: remains in Sinus Tachycardia, rate 100-104 beats per minute, Pulses 1+ to Ⓡ upper extremity 2+ to lower extremities, Ⓛ arm casted due to previous fracture to elbow, excellent cap refill. A line placed by anesthesia @ bedside, zeroed c̄ excellent waveform, Respiratory, lungs CTA c̄ copious amounts of white secretions noted, TV: 850 rate 9 peep 3, FiO2 50% ETT 8.0 at 23 cm at the lip, taped + secure. Dr (b)(6)-2 instructed all nursing ~~staff~~ to keep Train of 4 1 or less and to maintain paralytic ~~status~~ at all times. ~~Plan of Ca~~ Abdominal Dressing to exploratory lap covered c̄ 4x4's and Hypafix Dsg Dry and ~~intact~~ JP to bulb suction. Plan ① keep patient Train of four less than one twitch, ② Utilize aggressive pulmonary toilet to decrease copious amounts of secretions ③ Observe abdominal dressing for drainage and reinforce prn Call HO for excessive sanguinous outputs from JP. (b)(6)-2 RN

(Continue on reverse side)

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(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
27 July 03 1815	Patient waking up c̄ obvious movements. Given 5 mg Vecuronium bolus by Maj Moreum and Versed 5 mg IVP by Maj Moreum B/P before bolus 235/111, after bolus B/P 135/67, Remains in Sinus Tachycardia. Versed drip infusing @ 2 mg/hr, Vecuronium infusing @ 4 mg/hr, Morphine infusing @ 4 mg/hr, to titrate drips to effect. (b)(6)-2 MAJ
27 July 03 1850	Report given to CPT (b)(6)-2 by SGT (b)(6)-2. Cx Ray ordered and completed. Remains paralyzed as ordered. Will continue to monitor Train of Four. (b)(6)-2 MAJ
01 July 2003	1835: Received report on pt @ 1800. Assumed care. Pt sedated & paralyzed c̄ vecuronium @ 4cc/hr, MSO_4 @ 5cc/hr & versed @ 2cc/hr. LR infusing @ 50cc/hr via PA. LR infusing to (L) EJ @ 50cc/hr. Foley to gravity, clear yellow out. (+) JP to (R) LQ serosanguinous drainage, minimal amt. out. (+) dressing to midline incision. (+) serous drainage noted. (+) L arm casted. A-line to (R) wrist. (+) PIV 18g to (R) 7 ([illegible]) (+) NGT to (R) nare - secured, clamped. Bilateral eyes taped closed. Assessment as follows: Neuro: As per above, pt remains sedated c̄ versed, vecuronium as skel. muscle relaxant and MSO_4 as analgesic. (–) pupillary reaction to light c̄ pupil size of 1mm/1mm. (+) PNS use, 1 twitch @ this time. CV: NSR, (+) Tachycardia c̄ HR ~ 101-108 BPM. BP 115-120's/60's. Bilat dorsalis pedis pulses 1+, (R) Radial 1+, cap refill to (L) index ≤3 sec. (+) generalized (B) LE edema c 1+. A-line to (R) radial artery, secured, (+) ~~zeroed transduced~~ (overnight) transducer leveled & zeroed. Resp: (+) Vent - SIMV; VR 10 BPM, [illegible] TV: 800, FiO_2 @ 50%; Peep = 5. ETT tube @ 25 @ lip, #8.0, secured. (+) Suctioning per RT (b)(6)-2 q?hr. lung sounds clear throughout. GI: (+) abd dsg from distal sternum to pubic area dressing, C/I, (+) serous drainage, minimal amt. JP drain to (R) LQ. (+) serosanguinous drainage ~10-15 (–) abd distention, abd soft. ↓BS to BUQ. unable to assess lower quadrants d/t dressing. GU: (+) Foley to gravity - clear yellow urine out, app 75-100cc/hr. Foley secured to (R) thigh. Skin: Slight jaundiced, cool to touch, good turgor, (+) cast to (L) Arm. C/D/I. Cap refill to index ≤3sec. fingertip color normal for race, unable to assess radial pulse.

MEDICAL RECORD	PROGRESS NOTES

DATE	
21 July 03 1835	(NSG CONT) Ⓡ EJ NS infusing @ 50cc/hr. ⊖ evidence of infiltration. ⊕ 18g Ⓡ FA - infusing
	prescribed relaxant, analgesic, sedative ABx c̄ LR @ 50cc/hr. GI cont. ⓛ NGT, clamped,
	to Ⓛ Varic, ⊖ aspirate. Plan: Monitor cardiac/resp status closely. Monitor temperature
	drainage from wound, uop and JP drain. Maintain well sedated. —— (b)(6)-2
1850:	Pt thompson c̄ BS. ETT pulled back to 23 cm @ lip, tube secured —
	Vent settings unchanged. VS stable. —— (b)(6)-2 CPT/
PNS = 2twitch 1900:	PNS ⊕ 2 twitches – Vecuronium ↑ to total of 6mg/hr from 4mg/hr per
	recommendation of MAJOR Moran. BP 154/78 HR 103 RR 10 SaO2 100%. VERSED
	↑ from 2mg/hr - 4mg/hr. Pt remains sedated c̄ no response to external stimuli. (b)(6)-2
2030:	Ⓛ EJ dressing Δ'd, ⊕ flush, sluggish BR. to cont infusing @ 50cc/hr. Jevity
	tube feedings started @ 10cc hr. Residual V = Ø – next ✓ @ 0000 hrs.
PNS = 1twitch 2100	Δa (b)(6)-2 c̄ BS, pt stable. No new orders or actions —— (b)(6)-2
2200	Zantac ↑, Cipro pending receipt from pharmacy. —— (b)(6)-2
PNS: 1twitch 2230: ↑2300	Cipro infusing per orders, No Δ's in pt status. ⊕ T 100.1 will cont to monitor (b)(6)-2
0000:	Pt remains sedated. No Δ's from previous assessment —— (b)(6)-2
PNS: 1twitch 0100:	NGT residual = 5cc yellowish drainage. 5cc's replaced. Tube feedings cont. @ 10cc h.
0325 0200:	Pt VS stable. Tube feedings cont. —— (b)(6)-2
A line 77/44 112 0300:	VS NOTED ↓ via A-Line in systolic pressure <100 diastolic 40-50's,
NIBP 115/52 113	HR = 110's T = 101.6 RR remains 10 c̄ SAT @ 100%. A line transducer
10 100	zeroed, realigned c̄ BP ↓ to 70's systolically, 30-40's diastolically.
101.6	HR remains @ 110's. NIBP taken BP 115/52 HR 113. Pt remains
NIBP 102/52 70	sedated c̄ Vec @ 6mg/hr. MSO4 ↓ from 5mg/hr to 2mg/hr. Versed remains
90/51 113	@ 4mg/hr. Ice packs placed (Continue on reverse side) under armpits bilaterally

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

(b)(6)-4

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PROGRESS NOTES
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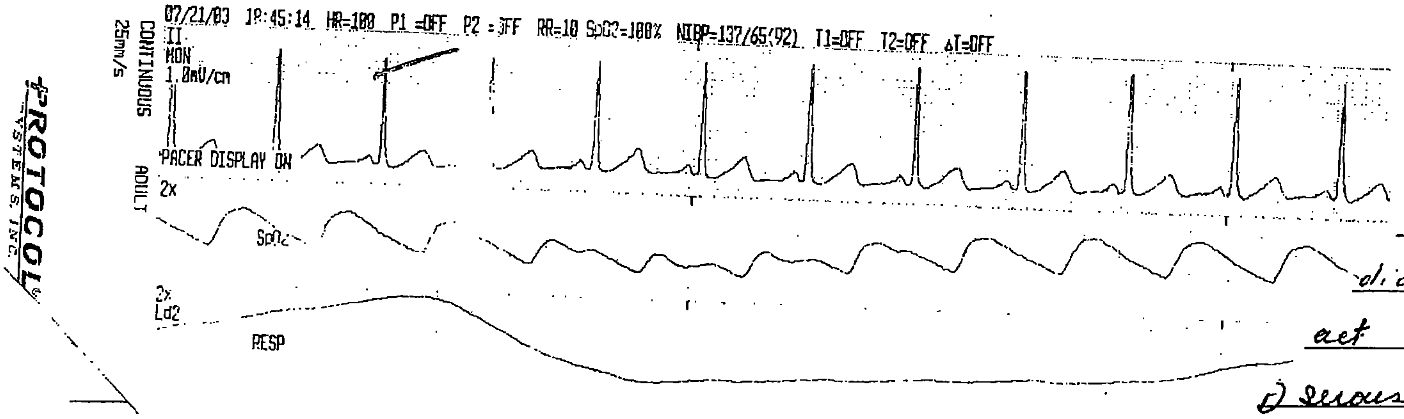


ed.

dically

act

② serous

drainage noted seeping from dressing, in between legs and scrotum. Pt washed, chucks placed under back and buttocks, app 100 cc's saturating sheet. Super sponge external dressings to abd removed and replaced c̄ co dressings. Residual ↓ @ 0400 = 120 cc⁺ output, bile color, Residual replaced. Tube feedings discontinued. Yellowish drainage noted under neck and shoulders. App 50 cc's out from oral cavity. HOB increased from 30° to ~40°, suction applied to ETT c̄ oral cavity c̄ Ø OP noted. NGT placed on LIS. Pt cleaned, chucks placed under body. VS stable. BS clear, ⊕ diminished bases, sats 100%, RR 10, T: ↓ 101.0. 0600 - Report given to SGT [redacted] b(6)-2

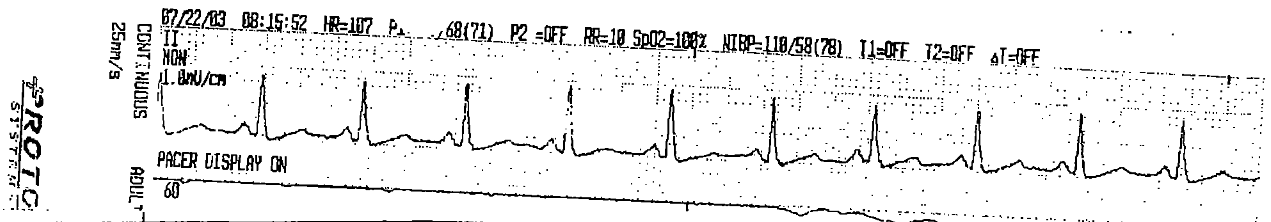
b(6)-2

MAJ [redacted] VS stable. Pt remains sedated c̄ paralyzed. T = 101.0. UOP TOTAL OF 830 cc clear yellow; JP total = 98. NGT Residual 125⁺; Intake totals: IV maintenance 1300 cc/12°; IVPB = 450 cc/12°.

(b)(6)-2

830
98
928 out
* drand drainage

1700: Intake


07/22/03 08:15:52 HR=107 P... 68(71) P2 =OFF RR=10 SpO2=100% NIBP=110/58(78) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm
CONTINUOUS
25mm/s
PROTOCOL SYSTEMS
PACER DISPLAY ON
ADULT
60

22Jul03 0620 Report received from CPT (b)(6)-2 Assessment performed. Upon use of electrical nerve stimulator, one twitch was obtained - Vecuronium @ 6cc/hr, Versed @ 6cc/hr, Morphine @ 2cc/hr, vented, SIMV, rate-10, TV-850, FiO2 50%, ETT -23cm @ lips, lungs CTA bilaterally, ↓ bases, sats 100%, Ⓛ EJ. PIV c̄ LR infusing @ 50cc/hr, Ⓡ FA PIV c̄ LR infusing @ 50cc/hr and all other drips infusing to that line, Ⓡ ulnar A-line reading pressures inconsistent c̄ NIBP, heart sounds audible, sinus tach, rate 110-120, ~~all~~ pulses palpable, unable to assess Ⓛ radial 2° cast (full arm) covering wrist, mild edema to both feet (worse in Ⓡ foot), color normal for race, Ø diaphoresis noted at this time, midline abd dressing, CDI, c̄ JP drain draining clear sanguinous fluid, BS hypoactive x 4 quads, NG to LIS (tube feeds held due to excessive residuals), Foley to gravity draining approx. 5cc (this hour) clear yellow urine. Will monitor UO due to significant ↓ in amount. Pupils 2mm and briskly reactive. Will continue to monitor for Δs. (b)(6)-2 SGT/LA

Plan of care: ① Assess neuro status/paralysis q1° to ensure train of four one or less, ② Suction prn to maintain sats >95%, ③ address nutrition care status this AM c̄ MD. (b)(6)-2 SGT/LA

(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

(b)(6)-4

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
0700	Dr. (b)(6)-2 performed dressing Δ, addressed tube feeds - will restart @ 1200. IVF ↑'d to 150cc/hr, 500cc NS bolus given —— (b)(6)-2 SGT/LPN
0930	(b)2 Dr [redacted] informed of low urine output of 7cc. An additional Bolus 500cc NSS infusing as ordered. Will recheck U.O and inform (b)2 Dr [redacted] of response. LR remains @ 150cc/hr, Vent Settings unchanged TV 850, Rate 10, FiO2 50%, Peep 5. N/G to LIS as ordered - (b)(6)-2
1100	Given complete AM care by SGT (b)(6)-2 O2 sats 98%, Vent Settings unchanged. Neuro: Pupils 2mm [illegible], 1 twitch as per Peripheral nerve Stimulator. Versed @ 4mg/hr, MSO4 @ 2mg/hr/ Vecuronium @ 6mg/hr. No movement of extremities present. Lungs CTA in all fields, diminished to bases. Suctioned by RT ē secretions present, O2 sats 98%. N/G to LIS with little drainage noted, Foley to gravity s̄ urine output, will inform Dr (b)(6)-2 of response. CV: remains in Sinus Tachycardia, pulses + to lower extremities 1+ edema noted to both feet. A-line ē respiratory variation, waveform adequate. Will continue to reassess and inform MD of changes, (b)(6)-2
1200	Tube feeds started - rate of 20cc/hr, still minimal urine output for shift. —— (b)(6)-2
1300	1000cc NS bolus given for minimal urine output, still no urine - MD notified. Pt VS remain unchanged, electronic nerve stimulator only producing one reaction, pupils 2mm & briskly reactive, ETT 23cm @ teeth ē holder in place, SIMV of 10, FiO2 50%, TV-850, PEEP 5, last ABG drawn this AM (0725), lungs CTA ē ↓ bases, all lines flushed & patent. IVF ↑'d to 150cc/hr, midline abd dressing CDI, JP draining small amts serous fluid, bowel sounds absent —— (b)(6)-2 SGT/LPN

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

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MEDICAL RECORD | PROGRESS NOTES

DATE

22JUL03 Another 500 cc NS bolus started per Dr. (b)(6)-2
1500 ss Still no increase in UO noted. IVF ↑'d to 200cc/hr
Residual ✓s performed for TFs, <5cc drawn out, TFs
continued @ 20cc/hr (b)(6)-2 SGT/LPN
1630 Ad BP cuff to Ⓡ arm - pressure now correlates to
A-line pressures. ~~One~~ ss 500cc Bolus complete, still ∅ UO after
one hour. Albumin infusion started, BP 92/49. Will
monitor (b)(6)-2 SGT/LPN
1800 Report given to CPT (b)(6)-2 Still minimal urine output after
Albumin transfusion, A-line pressures 90s/50s (unchanged),
JP drained 15cc serous fluid over shift. (b)(6)-2 SGT/LPN
22 July 2003 1810: Received report assumed care of pt. Pt remains sedated &
T: 101.1 paralyzed c̄ vecuronium @ 6mg/hr, MSO4 @ 2mg/hr and
BP: 102/53 94/51-NIBP versed @ 4mg/hr. LR PBig meds @ 100cc hr, LR to Ⓛ EJ @ 100 cc hr
HR: 106 ⊕ mechanical ventilation: SIMV; TV: 850; VR: 10; FiO2: 50% Resp S
RR: ~~16~~ 10 ~~[illegible]~~ SaO2 99%. ETT 8.0, 25cm @ lip, secured. ~~Rt~~ NGT to Ⓡ nare in place
SaO2: 98% Jevity infusing 20cc°, Residual ✓ q 2°. Ⓛ EJ c̄ LR @ 100cc/hr. ⊖ infiltrate
MAP: 62 placed 21 July ⊖ infection. Ⓡ 18g to FA c̄ vec/MSO4/versed/LR @ 100cc
vec: 6mg/hr ⊖ infiltration, - infection. A-line to Ⓡ radial artery, leveled & zeroed.
MSO4: 2mg/hr NIBP cuff to Ⓛ brachial. Leads in place, ⊕ cardiac cont. monitoring.
versed: 4mg/hr foley to gravity intact, secured Ⓡ thigh minimal uop, cloudy concentrated
LR @ 100 → Ⓛ EJ ⊕ Abd dressing from distal sternum to pubis, c/d/i ^ ⊕ JP drain Ⓡ LQ ⊕ cast to Ⓛ arm
LR @ 100 → Ⓡ FA CDI ⊕ cap refill ≤ 3 sec (continue on reverse side) unable to assess pulse, cool to touch

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

JP - 5cc serous
foley 20 cc concent

(b)(6)-4

(b)(6)-4

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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USAPPC V1.00

PROGRESS NOTES

DATE	
22 July 2003	Physical assessment. —— ✓ STANDARD form 511 for all VS/I-O's/Med mainten
1810	Neuro: Sedated, paralyzed, pupils 1mm/1mm PERRL. Peripheral nerve stimulator
NSG	0/4 vecuronium remains @ 6mg/h. ⊕ Tetanus. AQUA TEARS applied Bilat eyes
	eyes taped shut.
	Resp: ⊕ mechanical ventilation; SIMV, ⊕ ETT ⊕ chest movement = symmetrical
	Breath snds clear throughout, ⊕ diminished bases. ⊖ central/peripheral
	cyanosis.
430: Turned to	CV: NSR, BP monitoring via A-Line / NIBP Systolic avg 90's/diastolic
Ⓛ side	avg 45. MAP: >65 HR: Tachy ~ 103. ⊕ diaphoresis head, Back
	& legs. T: 100.3. ⊕ generalized edema, pitting 2+-1+ to Bilat L.E.
	1+ to knees. cap refill ≤ 3 sec fingertips, toes. Pedal pulses BILAT
	palpable, thready 1+. Ⓡ Radial palpable 2+. ⊖ JVD.
	GI: ⊕ Midline open incision ~ 45cm long heavily packed & dressed.
	⊖ drainage to superficial external dressings. Ø drainage noted from
	distal end between legs. JP drain to Ⓡ LQ serous drainage 2-3cc/h
	out. abd soft, unable to det. presence of BS R/T ENV. NOISE & VENT.
	GU: Foley draining to gravity concentrated, cloudy urine UOP <30cc. avg OP 15cc.
	Foley secured to Ⓡ thigh. (GI: ⊕ NGT Ⓡ nare gravity @ 20cc/h. Tube secured to nose.)
	Skin: Slightly jaundiced, warm to touch ⊕ fever >100°. Ice packs
	placed under armpits, woolen blankets removed from around body
	Disposable light weigh sheet placed. Skin turgor normal. Ø ulcers,
	lesions or other skin anomalies noted aside from those mentioned.
	Plan: Closely monitor VS to include BP/HR/O_2 Sats/T.
	Maintain strict I/O protocol. Maintain sedated & paralyzed.
	Continue tube feeding - monitor Residuals. Suction prn. Consider fluid
	resuscitation prn - per MD order —— (b)(6)-2
2000:	Pt resting. No Δ's from previous assessment. UOP ↑ to 50cc's/h. (b)(6)-2
	cont. concentrated, dark amber. ——

STANDARD FORM 509 (REV. 7-91) B
USAPPC V1.00

21-22 July (b)(6)-4 ICU, Tik

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1620	Pt head turned, suctioned small amt of thick white
	sputum from mouth. —— (b)(6)-2 SGT/Ch
1700	Pt turned onto right side. Bright red blood coming
	from NG tube in small amts - MD notified - flushed
	c̄ 60cc Saline x3 - appears to be clear now. Will
	continue to monitor. Temp still 101. (b)(6)-2 SGT/
1710	EJ PIV dc'd, dressing applied. —— (b)(6)-2 SGT/
1800	Pt temp ↓ to 100.4, a little more arousable - will give
	report to oncoming shift. —— (b)(6)-2 SGT/
1615	Received report assumed care of pt @ 1000. Pt supine, awake, alert
	oriented (error qaf ~~answering~~) following simple commands stated via translator
	Pt restless attempting to pull on ETT. Close monitoring provided. ⊕ bed bath, ic
	Pt remains ventilated SIMV c̄ TV @ 850, VR @ 6, FIO_2 @ 50%
	Peep 5, ETT = 8.0, 25cm @ lip - secured. ⊕ NGT to LIS c̄ bile color drainage
	mod amt out. NGT to Ⓡ Nare. ⊕ Ⓛ arm cast, ±01, cap refill ≤3 sec unable
	to palpate Radial pulse r/t cast position. ⊕ VIBRcuff to Ⓛ thigh. A Line
	to Ⓡ radial, leveled, zeroed good wave form. 18g placed 21 July to Ⓡ FA
	50cc LR infusing ∅ evidence infection or infiltration. ⊕ 18g proximal
	to 1st PIV on Ⓡ FA, placed 23 July ∅ evidence infiltration infection.
	Opsite to Bilat IV's. LR infusing IV # 2 @ 50 cc/hr. ⊕ foley to gravity
	clear yellow out, secured to Ⓡ thigh. ⊕ Midline abd incision dressing
	c/D/I ∅ evidence drainage to dressing ⊕ JP drain to Ⓡ LQ

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

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

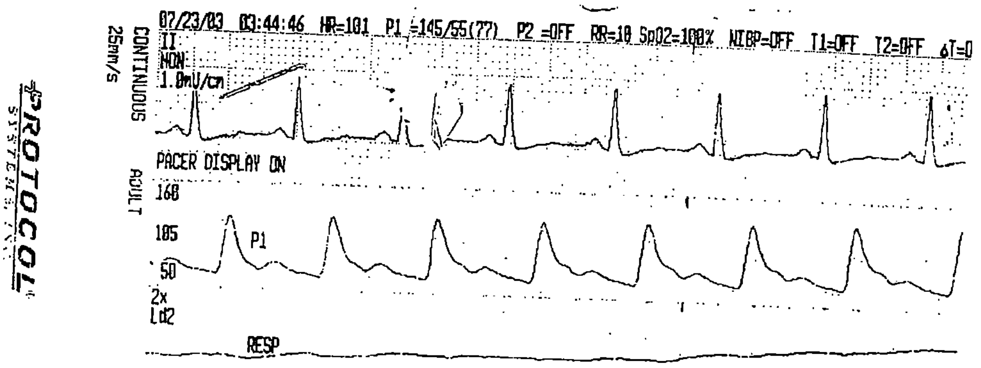
(b)(6)-4

REGISTER NO.

WARD NO. ICU

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 6463


PROTOCOL SYSTEMS
07/23/03 03:44:46 HR=101 P1 =145/55(77) P2 =OFF RR=10 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=0
25mm/s
CONTINUOUS
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
160
105
P1
50
2x
Ld2
RESP

√ (Sign each entry)

re yellow. JP drain
noted to dressing.
ess amt of dressing.
-99% VENT
Cipro, Zantac

administered per orders @ 2200. NGT feedings cont. Residuals < 3cc. T° ↓ from 100.9 @ 1800 to 100.1°F. Anasarca present c̄ ↑ edema centrally, peripheral. Monitoring to cont. (b)(6)-2 cry

22 July 0015 RT (b)(6)-2 @ BS providing suctioning, ⊝ op. confirms clear lungs and No Δ's to mech vent. settings. Pt repositioned from Ⓛ to Ⓡ side. (b)(6)-2 cry

22 July 0215 ⊕ Gurgling noted, BS coarse throughout. NIBP ↑ 138/85 HR 106 sats 100% A-line 151/58 HR 97 ~~SaO2~~ 100%. RT (b)(6)-2 notified Major (b)(6)-2 @ BS. Deep suctioning performed to ETT, yanker suctioning to oral cavity c̄ moderate amt of white secretions removed. Pt hyperventilated via ambu ~~c̄~~ O_2 @ 15L throughout suctioning procedure. Sats avg 100% RR between 14-22 BPM. Lung sounds clear s/p intervention. VS STABLE (b)(6)-2 cry

22 July 0300: No Δ's; Pt remains sedated, paralyzed; vent settings unchanged. (b)(6)-2

0415: Gentamicin infusing over 1 hr to Ⓛ EJ; maintenance

0450: LABS: CBC Chem 8 drawn from A-line, walked to lab results pending. CXR pending (b)(6)-2

0510: CXR - portable done. No other changes (b)(6)-2

0600: Report given to SGT (b)(6)-2; MAJ (b)(6)-2 Care of pt assumed by oncoming shift. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

21-22 July # 1 1011 Tik

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Jul03 0645	Report received from night shift - electronic nerve stimulator produced only one muscle twitch - Vecuronium infusing @ 6cc/hr, pupils 2mm & PERLA (brisk), ETT-25cm @ lips, vent SIMV @ rate of 10, TV-850, PEEP-5, FiO2 50%, lungs CTA c̄ diminished bases, ∅ secretions noted at this time, heart sounds audible, NSR (see rhythm strip), pulses palpable, good cap refill (<3sec) on Ⓡ hand where full arm cast covers, Ⓛ EJ PIV infusing LR @ 100cc/hr, Ⓡ FA PIV infusing LR @ 100cc/hr, Vec @ 6cc/hr, Morphine @ 2cc/hr, Versed @ 4cc/hr, Ⓡ ulnar A-line, pressure not correlating to NIBP, (approx 20 mmHg systolically higher), +2 pitting edema in lower extremities +1 pitting in upper, Jenty tube feeds infusing @ 20cc/hr, residual √s q2°, BS hypoactive x 4 quads, midline abd dressing CDI, JP draining serous fluid (minimal), Foley to gravity draining adequate amounts of clear, yellow urine. Will monitor for Δs —— (b)(6)-2 SGT/LPN
23 Jul 03 1730	Dr (b)(6)-2 at bedside. Dressing changed to abdominal wound. Incision clean, no evidence of odor or drainage. Dressing covered c̄ serous sanguineous fluid. Wound packed with kerlix soaked with NSS and covered with Dry kerlix. Abdominal wound covered with ABD pads and Hypafix. Lower Ⓛ abdominal wound with ~~gauze~~ small dime sized opening packed c̄ kerlix. Type + Cross for 2 units sent to the lab. —— (b)(6)-2

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

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

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 6465

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Jul03	(cont). 1240: 138/60, 105, 99^{3}
	(b)(6)-2 SGT/LPN
23 Jul 03	Nutrition Note F/u
1300	Pt currently receiving tube feeding of Jevity Plus
	at 30 cc/° Based on caloric needs of 3000-3400
	Goal rate should be 110 cc/° which will
	provide: 3200 calories
	148 gms protein
	Recommend increasing rate over 24-36° to final rate.
	(b)(6)-2 MAJ, SP RD/LD
1430	Residuals checked - still <5cc. 2nd transfusion
	complete. Preparing to draw labs. Pt turned onto
	left side, BP ↓d to 118/64. Breakdown noted to sacral area &
	mid back (between scapula), Plan to turn completely
	off of back everytime ~~Pt~~ is turned. Will continue to
	assess. (b)(6)-2 SGT/L
1440	Pt gurgling - suctioned by RT, approx 15cc thick white
	secretions suctioned. Pt moving slightly. (b)(6)-2 SGT/LPN
1500	Labs drawn, pt opened eyes when interpreter spoke his
	name. Appears to be waking up. All drips have been
	stopped. Will notify MD @ rounds. Pt still putting out ample
	amts clear urine. Temp rose to 101.4° - ice packs placed
	under arms, ~~to~~ neck & groin. Will monitor for Δs (b)(6)-2 SGT/L
1600	Tylenol suppository administered. Pt becoming more
	active - still not following commands. Dr. (b)(6)-2
	performed dressing Δ. Wound still appears clean s̄
	excessive drainage (JP emptied - 25cc/shift). Will
	monitor temp. (b)(6)-2 SGT/LPN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
Breakfast	eggs	240 Ensure
	1/2 Biscuit	
Lunch	1/2 Rice	240 Ensure
	1/4 Stew	180 water
1500		240 ENSURE
2000	Juice one cup	
2200	Carnation one packet	

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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(b)(6)-4 23 July 03

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	⊕ serosanguinous drainage app 1-2cc out. — Pt bathed, icepacks placed, heals elevated. Plan: Cont cardiac/resp cont. monitoring. Provide comfort measures to extubation c̄ support to weaning process for mech vent ex. Monitor temperature. Maintain body position off of sacral decub and to ↓ heal skin breakdown. Monitor UOP c̄ abd drainage ✓ NGT OP – Restart Tubefeedings ASAP c̄ MD order. — (b)(6)-2
1845:	Physical ASSESSMENT:
	Neuro: Awake, alert, oriented, obeys commands. Moves extremities spontaneously. Ø sedatives, analgesics or paralyzing agents in use @ this time. Pupils ⊕ PERRL 1mm-1mm
	Resp: lung snds c̄ medium expiratory crackles to bilat upper/middle Ⓡ Lobe, upper Ⓛ Lobe, ⓓ diminished bases bilaterally. ⊕ use accessory muscles. RR 30's c̄ VR set @ 6 SaO₂ @ 98%. ⊕ white secretion moderate amt c̄ suctioning.
	CV. NSR, ⊕ Tachycardia >100's BP per A-line; NIBP Systolic reading avg 120's diastolic 50-60's. Dorsalis pedis pulses bilaterally palpable, but weak and thready – 1+. Ⓡ radial pulse 2+. ⊕ generalized edema c̄ 2+ pitting to bilat lower extremities, 1+ to Ⓛ fingers, 1+ to Ⓡ UE. ⊖ JVD. Cap refill to finger; toes ≤ 3sec. —
	GI: ⊕ Midline incision from distal end of sternum to pubic area Wh clearly dressed c̄ gauze Ø drainage noted. JP drain to Ⓡ LQ, serosanguinous drainage <1cc/h. NGT intact to LIS.
	GU: Foley to gravity intact, in place draining clear yellow urine >30 cc/hr. VS c̄ 1/0's noted on Standard form 511.
	Skin: warm to touch. Abd incision noted per GI assessment. 1° decub to sacral area c̄ Ⓛ heal. Pt turned, propped off buttocks. Heal elevated off cot. ⊕ cast to Ⓛ arm. IV's as noted earlier — (b)(6)-2

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ICU

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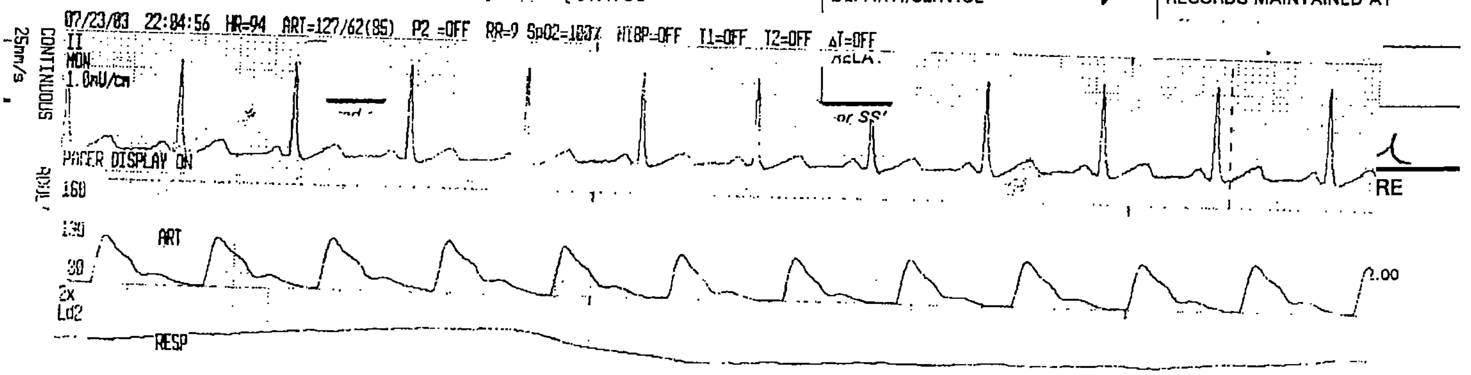
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Jly 2000° 1:	Pt disconnects extube. RR @ 16. VS Remain stable. RT (b)(6)-2
NSG	called to BS. ⊕ Suctioning per RT, reinflation of balloon
	ETT @ 25cm @ lip. Pt repositioned. SaO2 98%. (b)(6)-2
2100°:	Versed restarted @ 2cc/h for sedation overnight.
	Tube feeding restarted @ 30 cc/hr c residual ✓'s q2°
	VS monitored BP per A-L 122/62 HR 103 SaO2 @ 100%
	VR ↑ to 10 BPM. ⊕ ~~intermittent~~ spontaneous respirations.
	Close monitoring to continue (b)(6)-2
2300:	RT (b)(6)-2 @ BS, ⊕ suctioning small amt white secretions
	c/drawn. Resp status remains stable. Pt resting, Ø signs
	agitation. (b)(6)-2
0045:	No Δ's from previous ~~assessment~~. Pt sleeping quietly. (b)(6)-2
0230:	⊕ ~~hoarse~~ lung sounds on expiration, ⊕ quantity. Deep suctioning
	provided by RT (b)(6)-2. VS remains stable. LATE NOTE
	VERSED ↑ from 2mg to 3mg for improved sedation @ 2300
0300:	VERSED held. Tube feeding stopped. Residual ✓ pending.
	Pt repositioned off buttocks, heels elevated. No Δ's VS. 9AF
0400:	Pt moving arms, legs, opens eyes spontaneously. ⊕ attempt
	to pull at ETT. EBC/chem 7 drawn, taken to lab. CXR ordered;
	pending. Gent started to 18g Ⓡ PIV #2. LR cont @ 100cc/hr.
	foley draining clear amber urine > 75cc/hr og. Abd dressing
	~~CDI~~ error (b)(6)- intact w undeterminable amt of serous drainage

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


07/23/03 22:04:56 HR=94 ART=127/62(85) P2 =OFF RR=9 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
25mm/s
CONTINUOUS
II
MON
1.0mV/cm
PACER DISPLAY ON
160
130
ART
80
2x
Ld2
RESP
RE
2.00

MEDCOM - 6469

(b)(6)-4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 July 2003	1/4cc/serosanguinous drainage to VP drain. (b)(6)-2
0500	- 1cc Residual flow NGT. L19 restarted. VS 143/67 90 HR
	RR 12 SaO2 100%. FIO2 @ 50%; VR @ 10 TV 850
	LR @ 100cc - 50cc per PIV. A Line zeroed, leveled.
	Ø sedative, analgesic or paralytic administered @
	this time. (b)(6)-2
0630	Pt responsive, moving all extremities, sometimes follows
	commands, pupils 2mm & briskly reactive to light.
	still intubated, ETT 25 cm @ lips, SIMV rate 10, TV-850, FiO2
	50%, PEEP 5, at points of activity, pt breaths up to 18 over the
	vent. Lungs CTA bilat ↓ bases, sats 100%, heart sounds audible,
	NSR, rate 90-100, +2 pitting edema to both LE, all pulses
	palpable except Ⓛ hand 2° full arm cast, cap refill ≤ 3 secs on
	that hand, PIV in Ⓡ FA infusing LR @ 100cc/hr, Ⓡ ulnar
	~~radial~~ (b)(6)-2 A-line reading pressures correlating to non-invasive,
	Evidence of skin breakdown (approx 4cm) to mid-back,
	Sacral decubitus the ~~size of~~ 50 cent piece c̄ blistering
	to area and oozing. NG to LIS, BS hypoactive x 4 quads (cont.)
0500:	LATE NOTE RNG: Pt slightly restless, continues to attempt D/C'ing ET tube.
	Reassurance provided. Ⓡ PIV infiltrated. IV removed. sheets changed.
	No new IV placed c̄ this time. - Report given to SGT (b)(6)-2 @ 0600
	all questions answered. Care of pt. transferred to (b)(6)-2
0630	(cont.) Foley to gravity draining adequate amts clear,
	dark yellow urine. Will monitor for alertness, pain,
	discomfort (b)(6)-2 SGT/LR
0700	Lung sounds crackly on Ⓡ side, 40mg Lasix given prior to
	extubation trial (b)(6)-2 SGT/L

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0810	Transfusion vital signs: First unit 009176
	0810: 99^4, 152/75, 105
	0825: 99^6, 137/62, 103,
	0840: 99^4, 145/65, 101
	0855: 99^4, 134/61, 103 —— (b)(6)-2 [redacted] SGT/
29Jul03 0830	ABG @ 0830: TV: 850 FiO2 50% Peep 5 Rate: 10, ph. 7.481,
	pCO2 34.3, PaO2 138, HCO3 26, BE 2 Sat 99%. 1st unit
	Infusing s̄ complication. No signs of reaction noted ~ (b)(6)-2 [redacted] mgr
0930	30 min VS: 141/59, 99^5, 103 - Ø irritation noted @ site.
	Pt bathed and turned onto Ⓡ side. BP now correlating
	to NIBP since it was placed on leg. (b)(6)-2 [redacted] SGT/
1000	Residuals Vd - minimal. —— (b)(6)-2 [redacted] SGT/
1030	B/p 144/58 p= 102 Blood transfusion almost completed. No reaction
	noted. —— (b)(6)-2 [redacted] mgr
1050	Blood transfusion completed. Given Lasix 40mg IVP. Vital Signs
	Post transfusion VSS 98'- 96 -10 104/70. Will obtain second unit
	for transfusion. —— (b)(6)-2 [redacted] mgr
1140	Transfusion vitals - second unit: (b)(6)-4 [redacted]
	1140: 130/66, 103, 98^5
	1155: 145/67, 104, 99
	1210: 141/67, 103, 99^1
	1225: 147/64, 108, 99^2 ← (cont.)

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

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

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 July 03	2245 (Dsg cont)
	CV: NSR, BP 110s/60's HR 80's-90's ⊖ c/o chest pain
	⊖ edema, cap refill <3 secs all extremities (digit)
	Ⓛ radial, Bilat pedal pulses = 2+, 1+ to Ⓡ radial
	pulse.
Dsd	GI: ⊕ ABD dressing midline, C/D/I, Dr. (b)(6)-2
⊕ Pain -	provides dressing Δ's. PM Δ pending. ⊖ abd distention
2 percocets	⊕ abd tenderness on palpation. Percocet 2 tabs
	(ii PO) administered @ this time for pain,
	⊖ abd distention, ⊕ facial grimmacing, Eval pending —
⊕ VOP,	GU: Urinal @ BS - pts ambulates to ward comode.
475 clear	⊕ 475 cc VOP prior to assessment —
yellow	Skin: ⊕ decubit to coccyx, ⊖ necrotic tissue, drying
	healing. ⊖ evidence of drainage, ⊖ infection.
	Dressing Δ performed; washed w/NS, dried w/
	sterile gauze, zinc oxide applied topically,
	covered c̄ gauze and taped. Same pre-steps used
	for 2cm x 1cm to T6-T7 on back. —
	Plan: Cont to encourage quality and quantity nutrition
	c̄ main meal and snacks, breakfast drink, fruit, ect
	pudding. Encourage IS c̄ maximum inspiratory effort.

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

(b)(6)-4

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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	monitor 1/0 S.S. (b)(6)-2
2315	- Pt to bed and rest. He needs c̄ [illegible] (b)(6)-2
0200:	Pt resting quietly ø evidence discomfort.
	Will cont to monitor. (b)(6)-2
0420:	VS STABLE, Pt sleeping, Cardiac freq cont. [illegible]
	monitoring continuing (b)(6)-2
	LATE NOTE: Assessment 2200° - ⊕ Redness to
	adenoids ↑ over yesterdays assessment. ø thrush
	noted. Viscous lidocaine swish and spit 5cc [illegible]
30 Jul 03	administered. Pt slept after intervention (b)(6)-2
0630	Assumed care of pt, Rcvd report for outgoing
	Shift. Pt in bed c̄ eyes closed ø complaint
30 Jul 03	Voice at this time (b)(6)-2 SGT [illegible]
0700	Pt OOB → commode ø void. Pt ate a gd break
NRG note	fast. MD in to Δ Abd-drsg. Pt c/o pain to Abd
	ii percocet given PO. Am care performed.
	Intial assessment complete. Neuro: Pt alert
	awake c̄ oriented, pt appear sadden appearance
	Resp. LS CTA RR 20's SAO2 98% on RA. Pt maintain >95%
	when ambulates. Skin: MD Δ'd ABD drg. Stage II
	decubidi on coccyx c̄ drsg. intact, Stage I to
	upper back. drsg intact. Gastro. ⊕ BS x 4 quads
	Abd soft, non-distended. Incision site ø s/s redness
	or infection @ site. GU. Pt able to urinate
	s̄ difficulty urine clear yellow urine
	ø sedament noted, Cardiac: NSR HR 78
	⊕ peripheral pulses ⊕ color, sensation c̄ movement

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

BP 115/70 HR-81 SaO2 96% (RA) RR 12

3/21/03 1900 Received pt this pm in bed awake and responsive. Army Patient c̄ no difficulty breathing. SaO2 97% c̄ (RA) Chest expansion equal and full. Lung sounds clear to auscultation x4 lobes. S1/S2 sounds present c̄ no extra sounds. Skin is warm and dry to touch. Skin breakdown on upper buttocks Dsg CDI. No other breakdown. Pulses equal and palpable. Able to move ext x4. Dsg to midline incision CDI Δ'd by Doc. BS ⊕ x4 quads. Abdomen soft non-distended. Pt voids via urinal c̄ diff. (R) arm splinted. Pt preformed by pt tech —— (b)(6)-2 91WM6 SPC

1930 Pt consumed 50% of dinner no discomfort at this time (b)(6)-2 91WM6 SPC

2200 BP 115/69 HR-83 SaO2 96% c̄ (RA) RR-12 will continue to monitor (b)(6)-2 91WM6 SPC

2200 Heparin and Lantus given (b)(6)-2

0200 103/54 HR 82 SaO2 96% c̄ (RA) RR-14 Pt is resting comfortably no signs of distress noted at this time will continue to monitor (b)(6)-2 91WM6 SPC

0500 pt rested comfortably throughout shift No distress noted will give report to next shift (b)(6)-2 91WM6 SPC

0615 Assumed care of pt - recvd report from SPC Book Law. Pt in bed lying on side. HOB ↑ 30° angle NAD at this time (b)(6)-2 SGT USA 91WM6

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

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WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3Nov03 0900	0830 Pt OOB → Chair am care performed
	σ minimal assistance. Intial assessment.
	complete. Neuro: alert + oriented able
	to communicate via translater. Skin - warm
	ē dry to touch. drsg. to coccyx Δ'd clean
	σ NS, Zinc oxide applied c̄ guaze drsg.
	drg to Mid back Δ'd cleanie c̄ NC
	Zinc oxide σ guaze drsg applied. MD
	Δ drsg to Abd incision, drsg CDI ø
	S/s of infection ⓐ drsg. Resp RR 20
	non-labored SaO2 > 95% on RA LS: CTA
	ø SOB noted. Cardiac NSR HR 100
	⊕ peripheral pulses x 4 ⊕ color, sensation
	ē Movement to extremities, gd Cap refill < 3se
	Gastro: Abd soft, non-distended ⊕ BS x
	4 quad. ate gd breakfast, tolerated well
	ø BM this Am. ø nausea ø direhhea noted
	GU Pt able to urinate s̄ difficulty
	urine drk. yellow urine. Pt BTB
	Resting on Ⓡ side will monitor
	(b)(6)-2 SGT USA
1030	Pt OOB Ambulate → ~~commode~~ pt walking
	ⓐ ward. Am meds given, Pt BTB
	IS encouraged. 1200cc/sec x 10 Pt resting
	will monitor (b)(6)-2 SGT USA

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Jul 03	to all extremities. Skin: warm & dry ∅
NRS. Note	acute distress noted. Will continue to monitor
Cont'	——— (b)(6)-2 91W SGT USA
0745	Late Note: 0630 Pt c/o sore throat. Throat
	appears red Dr. (b)(6)-2 notified. Capacol
	suggested to relieve. Will monitor ———
	——— (b)(6)-2 91W MC SGT USA
0810	Pt splint removed of Ⓛ arm pt able to
	ROM on self. Pt ambulating @ ward 0830
	splint reapplied pt BTB ∅ complaint voiced [redacted]
	at this time ——— (b)(6)-2 SGT USA b(6)-2
30 Jul 03 1000	Nutrition Note F/U
	Results of 48 hour calorie count:
	Pt taking in approximately 1500 kcal and
	60 gms protein. Given his wounds pt needs
	closer to 3000 kcal and 150 gms protein. Pt is
	eating well given his current situation. In an
	effort to ↑ his intake I spoke c̄ him through
	translator and explained the importance of ↑
	intake especially protein. Pt will start drinking

continued

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 July 03 1000	Nutrition Note (cont)
	5 cans/day of ensure plus in addition to
	regular diet.
	(b)(6)-2 MAJ, SP RD/LDN
1015	Am med given. Cepacol given for
	sore throat. afebrile. Dietitian in to do
	F/U. Pt had 240 milk c̄ carnation tolerated
	well. Pt awake in ~~bed~~ will monitor
	(b)(6)-2
1200	Pt OOB → chair ate lunch seem to
	tolerate well. Pt → commode voided
	200cc drk yellow clear urine. Pt BTB
	Δ'd dsg to coccyx, clean c̄ NS Zinc oxide
	cream applied c̄ gauze ~~dsg~~ Ø complaint
	voiced at this time (b)(6)-2
1500	R/1400 Pt OOB → commode pt had a
	med loose formed stool Brown. Pt BTB
	1500 pt c/o pain to Abd. ii percocets given
	po. Pt appears to be resting at present time.
	will monitor (b)(6)-2
1800	Pt refused dinner wants to wait
	for pt c̄ Ⓛ arm. ii percocets PO given
	to premedicate for pain patient request.
	Will report given to oncoming shift
	(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31Jul03	Pt ~~OOB~~ in bed resting c/o sore throat Cepacol
1300	Lozenger pt appears comfortable will
	monitor (b)(6)-2 SGT USA
1500	Pt OOB Ambulated @ ward c/o sore throat
	T 99.6 po salt water gargle. Pt on commode
	c/o constipation will inform MD at 91WM6
	rounds (b)(6)-2 SGT USA
1505	VS: BP: 124/70 RR: 20 P: 89 T: 99.6
	(b)(6)-2 SPC 91WM6
1700	Pt request pain med for Physical Therapy
	at 1720. ii percocets given po. Pt in bed
	resting at present time will monitor
	(b)(6)-2 SGT USA 91WM6
1800	Physical therapy in to do PT to (L) arm
	report given to oncoming shift ~~with~~ (b)(6)-2 91WM6 SGT USA
1830	Received pt this pm in bed resting. Arousable and appropriate.
	Airway patent no difficulty breathing. Chest expansion equal
	and Full. Lung sounds clear to auscultation X4 lobes. S1/S2
	sounds present c̄ no extra sounds. Pulses equal and palpable Cap
	refill <3sec. Skin warm dry to touch. Skin breakdown
	on upper buttocks c̄ DSG CDI. BS ⊕ X4 quads pt on regular

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

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PROGRESS NOTES
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USAPA V1.00

(b)(6)-4

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31Jul03	diet and tolerates. Pt voids in urinal. (L) arm splinted able
	to move ext x4. pt ambulates c̄ steady gait s̄ assistance.
	Will continue to monitor (b)(6)-2 91WM6 SPC (b)(6)-2 ~~0400~~ 2100
	Pt is currently resting SaO2 95% c̄ (RA) No distress noted at this
	time. Will continue to monitor (b)(6)-2 91WM6 SPC 2200
	Heparin and Zantac given no distress noted will continue to
	monitor (b)(6)-2 91WM6 SPC 0200 Pt is sleeping VSS SaO2 97%
	c̄ (RA) no distress noted will continue to monitor (b)(6)-2 91WM6 SPC
	0515 Pt slept comfortably throughout shift No distress noted
	A-febrile SaO2 95% c̄ (RA) will give report to oncoming shift
	(b)(6)-2 91WM6 SPC
01 Aug 03	Pt sleeping - arousable to voice, follows commands, pupils
0630	3mm & briskly reactive to light, resp even & unlabored, lungs
	CTA bilaterally; sats >95%, heart sounds audible, NSR, all
	pulses palpable, skin intact except for sacral area decubitus
	dressed, BS ⊕ x 4 quads (hyperactive), regular diet + calorie
	count - Pt voids on own - no urine yet this shift. (b)(6)-2 SGT/L
0720	Dressing to sacral decubitus Δd. Zinc oxide applied & covered
	c̄ 2x2s. (b)(6)-2 SGT/LP
0730	Dr. (b)(6)-2 performed dressing Δ - wound pink c̄ Ø
	Signs infection, Ø drainage. (b)(6)-2 SGT/LP
0930	Pt had small, formed BM x I. (b)(6)-2 SGT/LPN
1130	Pt ate 50% of lunch + 1 Ensure. (b)(6)-2 SGT/LPN
1330	Pt sleeping. Had small, formed BM x I. (b)(6)-2 SGT/LPN
1530	Pt resting comfortable in bed. Ø % pain. (b)(6)-2 SGT/LP
1645	Pt drank Ensure (b)(6)-2 SGT/L

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES	
	(b)(6)-4	3 Jul 03
	Calorie Count	
-Breakfast	2 pancakes	240 ENSURE
		120 tea c̄ 4 sugar
		180 Juice
~~10 am~~		
10am		240 ENSURE
Lunch	1/2 spaghetti	240 Ensure
	3/4 apple	60 H_2O
Dinner	1 apple	250 H_2O
	100% peaches	
	100% green beans	
	25% mashed potatoes	
2200	250 ensure	

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1AUG 03	Breakfast
	1 1/2 pancakes
	100% eggs
	1 juice
	1 milk
	1 Ensure
1000	1 Ensure
	Lunch
	100% veggies
	1/2 potatoes
	3/4 chicken breast
	1 juice
1700	1 Ensure
1900	1/4 potatoes
	1/4 veggies
	1 Ensure
2100	1 Ensure
3 Aug	Breakfast
	100% fruit
	50% eggs
	1 milk
	1 Carnation c̄ milk
	Lunch
	100% corn
	1/2 stuffing
	1 Carnation c̄ milk

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

A: ① S/P GUNSHOT WOUND to Ⓛ ELBOW AND ABDOMEN –
② GRADE IV SACRAL DECUBITUS ULCER
P: TRANSFER FOR Flap coverage of Sacral Decubitus Ulcer – to (b)(3)-1
(b)(3)-1

(b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS
(b)(6)-2
(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)*
REGISTER NO.
WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

1 AUG 03

1900 Received pt this pm in bed c̄ Physical therapy working c̄ pt. Pt awake and alert. Pupils 3mm brisk reactive. Airway patent c̄ no difficulty breathing. Chest expansion full and equal. Lung sounds clear to auscultation x4 lobes. Ø cough. S1/S2 sounds present c̄ no extra sounds. Pulses equal and strong. Skin warm and dry to touch. Skin breakdown noted on upper buttocks dsg CDI. Dsg to midline incision CDI. No odor noted. BS ⊕ x4 quads. Abdomen soft nondistended s̄ tenderness. Pt voids via urinal c̄ difficulty. Pt ambulates c̄ a steady gait s̄ assistance. Able to move ext. x4. Will continue to monitor (b)(6)-2 91WMC SPC

2200 Pt ambulated and sat up in chair. Pt had 1 Ensure 250 ml. Heparin and Zantac given. VSS SaO2 98% c̄ (RA) Pt now back in bed and resting comfortably. No distress noted at this time. Will continue to monitor (b)(6)-2 91WMC SPC

0200 Pt ambulated to toilet and had small BM c̄ 500 cc urine output. Pt now back in bed resting comfortably. VSS SaO2 97% c̄ RA No signs of distress noted will continue to monitor (b)(6)-2 91WMC SPC

0515 Pt resting comfortably no distress noted throughout shift. Will give report to oncoming shift (b)(6)-2 91WMC SPC

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 6483

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 AUG 03	Assumed care of pt. Rcvd report from
0620	off going shift. Pt in bed resting on
	side. Intial assessment done.
	Neuro: easily arousable c̄ verbal stimuli
	alert, able to communicate needs via
	translator or gestures. Pupils 2mm Pearl.
	Resp RR 20 even; non-labored, SpO2 97% on RA
	LS: CTA ∅ SOB ————
	Cardiac. NSR HR 85 S_1 S_2 normal
	∅ murmur NAD ⊕ peripheral pulses
	x4 ⊕ color, sensation c̄ movement
	to all extremities, gd cap refill. Skin:
	warm c̄ dry. drsg to ABD Δ'd by MD CDI
	drsg to coccyx intact Gastro ⊕ BS Abd
	soft, flat, non-distended. GU: Pt able
	to urinate s̄ difficulty. Will monitor
	throughout shift —— (b)(6)-2 SGT USA 91WM6
0900	Pt OOB → chair am care performed
	Stage II decubiti drsg Δ'c area cleanse c̄
	NS decubiti pink @ edges c̄ white tissue
	drsg had yellow discharge. left open to
	air, Pt position on side. Will monitor
	———— (b)(6)-2 SGT USN CPTD
1030	Pt in bed on side Am meds
	administered will monitor ————
	———— (b)(6)-2 91WM6 SGT USA

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG03	Pt OOB ambulated @ ICU, pt ate
1230	fair breakfast c̄ lunch drank 240cc
	of ensure ī each meal - (b)(6)-2 [redacted] SGT USA
1600	Pt in bed resting on side ∅ SOB
	NAD will monitor — (b)(6)-2 [redacted] SGT USA
1620	II Percocets given PO for Physical therapy
	at 1700hr — (b)(6)-2 [redacted] SGT
1700	PT in to do Physical Therapy on (L) elbow
	pt. appear not to tolerate well. Will
	monitor — (b)(6)-2 [redacted] SGT USA
1800	Report give to on coming shift pt
	stable lying on side c̄ eyes closed
	∅ SOB, NAD — (b)(6)-2 [redacted] SGT USA
1900	Pt OOB to commode (+) BM hard, formed stool
	+ void 200 cc clear yellow urin.
2000	Wet to Dry Dsg to buttocks decubitus
	(Stage II resolving) aloe gel c̄ saline dsg
	and cloth tape - Back Decubitus
	1½ inch scab (resolving) ∅ dressing - [illegible]
2200	Carnation Instant Breakfast c̄ 8oz cup
	Juice — (b)(6)-2 [redacted] SGT
2300	OOB to commode 300 cc dark yellow urin

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

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

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9 202-1

MEDCOM - 6485

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2330	Pt seems depressed and/or lethargic
	compared to earlier in the week
	Pt c̄ no complaints of pain
	⊕ cap refill to Ⓡ hand brisk <2 second
	Vital Signs Stable See flow sheet
	——— (b)(6)-2 SGT
0130	Pt medicated c̄ 2 percocet for pain
	c/o Ⓛ elbow pain ——— (b)(6)-2 SGT
0300	Pt sleeping c̄ no complaints (b)(6)-2
0600	Received report from SGT (b)(6)-2 Pt asleep but arousable,
	obeys commands, moves all extremities. Pupils 3mm & briskly
	reactive to light. Resp even & unlabored. Sats 96% on RA,
	lungs CTA bilaterally. Heart sounds audible, NSR, all pulses
	palpable, skin warm dry, & intact except for 6mm decubitus
	to sacral area, dressing Δd, aloe applied & wet today. BS⊕
	x4 quads, regular diet, pt voids on own (no urine void this
	shift). Will monitor ——— (b)(6)-2 SGT/LPN
0900	Pt ate approx 10% of breakfast + one Carnation
	instant breakfast. Dr. (b)(6)-2 Δd dressing - wound
	pink & still healing. ——— (b)(6)-2 SGT
1100	Pt up walking to sink to clean up. Ø c/o pain.
	——— (b)(6)-2 SGT
1300	Pt sleeping. Ate very little of lunch. (b)(6)-2 SGT
1600	Dr. (b)(6)-2 Δd dressing to decubitus. Pt resting
	comfortably. ——— (b)(6)-2 SGT/RN
1630	Assumed care of pt. pt in bed. Physical
	therapy in to do therapy Ⓛ arm/elbow. pt
	pre-medicate ii percocet by SGT (b)(6)-2 at 1630 →

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 AUG 03	cont Pt appears to be tolerating well
1730	will report to oncoming shift ——
	—— (b)(6)-2 SGT USA 91W
1750	Pt awake. Refuses dinner – will give Carnation. Report
	will be given to oncoming shift. —— (b)(6)-2 SGT/LPN
1800	Report recieved from dayshift – Pt sleeping on side
	Ⓛ arm (↑) on stomach – Pt medicated for pain @
	1630 c̄ percocet – Dsg to coccyx intact – Respiratory rate
	shallow even & unlabored – Pulse ox of 97% on RA
	⊕ BS x 4 quadrants – Distal Digits to Ⓛ hand – warm,
	∅ numbness or tingling ⊕ cap refill brisk < 2 seconds
	—— (b)(6)-2
1850	Pt still refuses to eat – "not hungry" as stated to
	interpretor – will keep meal at bedside (b)(6)-2
1910	Sitting up @ bedside eating evening meal
	consumed one whole milk, 1/2 spaghetti, green beans,
	orea cookies and 200 cc water —— (b)(6)-2
1930	Dsg to buttocks Δ'd – wound looks improved
	resolving stage II – wet to dry dressing Δ c̄ duoderm
	gel —— (b)(6)-2
2030	Pt sleeping c̄ no complaints —— (b)(6)-2

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

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 6487

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2200	Dr. (b)(6)-2 Δ'd abd dressing – reinforced incision
112/60	c̄ 2 staples at the top – packed c̄ dry
P-88	gauze ∅ S/Sx of infx noted – ∅ discharge
R-12	or foul odor to old dressing —— (b)(6)-2
2230	Pt c̄ complaints ∅ pain – Pt stated thru
98⁷	interpreter appetite ↓ due to elbow pain
Temp	from physical therapy —— (b)(6)-2
0300	Pt sleeping c no complaints –
0600	Pt sleeping, Vital Signs Stable – Pt
	c̄ no complaints —— (b)(6)-2
0600	Report from last shift, client in bed asleep. – (b)(6)-2
0700	Assessment done, client oriented x3, sleepy but
	easily arousable. Lungs clear bilat. Apical pulse
	regular. Abdomen c̄ large midline dressing appears
	D+I. ⊕ BS x4 quad. Small gauze dressing to left
	lower abdomen D+I. client voids in bedside commode
	Cast to LUE intact, digits to left hand pink + warm
	good cap refill < 2 secs, mobile c̄ good strong grasp.
	—— (b)(6)-2 1LT An
0730	Medicated c̄ percocet x I for pain to abdomen.
	client ate < 25% of breakfast and drank an —
	ensure shake, denies Nausea. —— (b)(6)-2 CT:K
0830	Dr (b)(6)-2 at bedside, dressing change done.
	Old drsg removed c̄ moderate amt of tan and blood
	tinged drainage, Wound appears beefy red, wound
	packed c̄ gauze then 4x4's over gauze, secured c̄ tape.
	left hip drsg removed —— (b)(6)-2 1LT An

Continue on next pa-

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Aug 03 cont. 0830	small circular tan wound c̄ two staples intact, left
	Open to air per Dr (b)(6)-2 — (b)(6)-2
1000	Medicated per order... — (b)(6)-2
1115	Drank one ensure shake, tol well. — (b)(6)-2
1230	Client ate 60% of lunch, tolerated well. (b)(6)-2
1430	1 Ensure ~~shake~~ @1600. bath done c̄ assistance — (b)(6)-2
1600	Medicated c̄ ii tabs percocet for drsg change + pending ortho
	visit for left hand. Dr (b)(6)-2 changed drsg to
	abdomen, old drsg c̄ small amt tan drainage, wound
	beefy red, new dry gauze applied c̄ 4x4 then secure c̄ tape
1610	Drsg change done to decubitus on buttock, wound edges slightly
	dark c̄ yellow inside of wound. drsg cleaned c̄ saline, aloe
	vera ~~gell~~ gel applied to wound, 4x4 c̄ sterile H_2O over the
	then ABS pad applied on top and secured c̄ tape — (b)(6)-2
1715	Physical therapy to left hand done. old cast removed
	and new one applied. — (b)(6)-2
1800	Report recieved from LT (b)(6)-2 - Pt. lying in bed, HAD
	∅ complaints - ∅ IV access - will assess pt later
	p̄ meal — (b)(6)-2
1900	Pt ate 100% of meal - chicken, rice, 200 cc $H^{2}O$
	Pt a+o, Vital signs stable 110/66 P-80's
	Temp 98^7 Sats 98% RA Dressing to abd

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

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Report recieved from dayshift - Pt A+Ox3, VSS
5 AUG-03	Dsg to abd C,D & intact ĉ Dsg to buttocks
	C,D & intact Ⓛ elbow splinted and wrapped
	ĉ ace wrap ⊕ cap refill to Ⓛ hand pink
	< 2 seconds - c/o pain Ⓛ elbow and
	wrist - ⊕BS x 4 quadrants - Lungs CTA
	bilat ———— (b)(6)-2
2000	Splint to Ⓛ arm removed for comfort
	Pt may take splint off a short time while
	ambulating/standing per Dr (b)(6)-2 - must be
	kept on while arm is unprotected or
	sleeping - medicated ĉ percocet x ii for
	elbow pain - Dsg to buttocks wet to
	dry Δ'd - resolving stage II ulcer
	∅ S/Sx of infx pink ĉ white edges
2200	Fentanyl Patch ordered (Dr (b)(6)-2
	50 mcg q 3 days Δ @ 2200 3rd day
	Ⓛ chest area first patch) - Splint back on
	ĉ ace wrap ⊕ cap refill ——— (b)(6)-2
0000	Pt medicated percocet x ii for pain
	⊕ ambulation ⊕ void ⊕ fruit and carnation
	instant breakfast
0200	Pt. sleeping s̄ complaints, VSS. (b)(6)-2
0600	Pt sleeping s̄ complaints, VSS (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6490

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	C,D & intact ø gross discharge - cast and
	icewrap to Ⓛ elbow ⊕cap refill - fingers warm
	pink - Pt able to move all extremities
	Dsg to buttocks intact Δd @ 1610 - did
	not Δ at this time - Blister to Ⓛ lateral
	heel intact ø s/sx of infx - closed quarter
	sized blister resolving (b)(6)-2
2000	Pt medicated c̄ 2 percocets for Ⓛ elbow
	pain (b)(6)-2
2100	Pt OOB to commode 200cc void ⊖BM
	Pt, walking on ward and stretching
	(b)(6)-2
2300	Sleeping on side ø complaints (b)(6)-2
0100	Pt OOB - stretching left arm NAD
	walked to commode 300cc void ⊖BM
	(b)(6)-2
0200	Pt medicated c̄ 2 percocet for
	pain (b)(6)-2
5Aug03	Recieved report from offgoing
0600	shift. Pt in bed lying on side. 0630 Pt
	OOB → commode → BTB resting on
	side ~~will~~ monitor (b)(6)-2 SGT USA Guidne
1000	0730 Pt in Bed MD in to do DRSG Δ.
	Intial assessment Neuro: Pt alert + oriented x3
	3mm pearl brisk. able to move all extremities.
	denies pain at present time. Resp: RR 18
	non-labored even, LS CTA SAO2 98% on RA (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6491

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6Aug03 0615	Pt in bed sleeping, arousable to voice, responds appropriately, pupils 2mm & briskly reactive to light. Resp equal & unlabored, sats 98% on RA, lungs CTA bilaterally, heart sounds audible, NSR, all pulses palpable, Ø edema noted, skin intact except for midline abd dressing (CDI), dressing to sacral decubitus CDI, cast to Ⓛ arm, elbow fracture. Fentanyl patch to Ⓛ upperchest, due to be Δd on Friday. Will monitor pt for Δs —— (b)(6)-2 SGT/LPN
0715	Dr. (b)(6)-2 in to do dressing Δ. Wound pink-still healing well. Pt tolerated dressing Δ well. (b)(6)-2 SGT/LPN
0930	Pt resting comfortably. Ambulated to BSC to urinate. Ø c/o pain. —— (b)(6)-2 SGT/LPN
1200	Pt awake-eating lunch. Appears comfortable-denies pain. —— (b)(6)-2 SGT/LPN
1400	Pt resting comfortably —— (b)(6)-2 SGT/LPN
1630	Pt pre-medicated for PT c̄ 2 percocet. Δd dressing to sacrum. Pt tolerated well. —— (b)(6)-2 SGT/LPN
1800	Report given to oncoming shift. —— (b)(6)-2 SGT/LPN

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 6492

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1800	Report from day shift - Pt stable - Dsg Δ x2 done (Dr (b)(6)-2 & SPC (b)(6)-2) Pt lying in bed sleeping at Δ of shift - will assess later — (b)(6)-2
2000	Pt OOB to commode - ambulates c̄ steady gait - guards stomach - Pt ate corn, vegetables and water c̄ or milk - medicated for pain c̄ Percocet x ii - Lungs CTA bilat - ⊕ BS x 4 quadrants - Dsg to abd CDI - Dsg to buttocks left untouched done late in day during day shift - Pt s̄ concerns — (b)(6)-2
2200	Pt consumed one breakfast shake Heparin SQ administered to Ⓡ tricep region Vital Signs Stable — (b)(6)-2
0010	Pt asked for pain medication - Ⓛ elbow and wrist pain - ⊕ cap refill to left ~~tow~~ error distl hand - warm to touch pink - Dr (b)(6)-2 Δd abd dsg wound is beefy red ∅ s/sx of infx wound closing daily - 2 weeks estimate by Dr (b)(6)-2 closure time — (b)(6)-2
0400	Pt sleeping s̄ complaints. VSS — (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Calorie Count
	7Aug
6Aug	Breakfast Breakfast
	100% eggs
	100% hash browns
	1 chocolate milk
	1 Ensure
	1 Ensure
Dinner	Corn
	vegetables
	water
	1-milk
2200	Carnation Breakfast

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

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 6494

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Aug03 0615	Report received from SGT (b)(6)-2 Pt resting comfortably in
	bed, arousable to voice, pupils 3mm & briskly reactive
	to light. Respirations even & unlabored, rate 15, sats
	98% on RA, lungs CTA bilaterally, heart sounds audible,
	NSR, all pulses palpable, cap refill <3 seconds, ∅ edema
	noted, midline abd dressing CDI, dressing to sacrum
	CDI, half cast to (L) arm c̄ ACE wrap - will remove
	when pt wakes up. BS (+) x 4 quads, regular diet + 5
	Ensures/day, pt voids on own (no urine yet this
	shift). Will assist pt c̄ ambulation PRN. Will monitor
	for adequate pain control. ——— (b)(6)-2 SGT/LPN
0700	Pt refused breakfast, c/o nausea, tried to vomit but
	couldn't, 12.5 mg Phenergan administered I.M. Will
	monitor for effect. ——— (b)(6)-2 SGT/LPN
0845	MD in to Δ ABD drsg. wound beefy red
	c̄ ∅ s/s infection. ~~wound~~ packed c̄ guaze
	and cover c̄ guaze & tape pt tolerated well
	Pt resting at present the— (b)(6)-2 (b)(6)-2 SGT
1000	Pt in bed resting on side 1000 meds given
	NAD, ∅ SOB noted — (b)(6)-2 SGT USA
1200	Pt ate a fair lunch tolerated well ~~refused~~
	ensure resting on side NAD at this ti (b)(6)-2

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

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Report recieved from dayshift
7 Aug 03	Pt sleeping, VSS – 75% eaten tray
	② bedside P.O. intake ½ Gatorade
	——— (b)(6)-2
1900	Pt medicated $\bar{c}$ percocet x ii – Dr
	(b)(6)-2 $\bar{c}$ abd dsg Δ – discharge
	to abd dsg described as (1 in saturate) soapy – Serous disch
	minimal amt – Pt Vital Signs Stable
	——— (b)(6)-2
2000	Dsg Δ to buttock done – Wet to Dry
	resolving stage II & s/sx of infx – pink
	$\bar{c}$ white tissue edges – Pt ambulated to
	commode 300 cc dark yellow urine
8 Aug 03	——— (b)(6)-2
0200	Pt sleeping $\bar{s}$ complaints – slept
	Thru night 100.3 Ⓡ Temp
	Pt does not feel warm Ø diaphoresis
	——— (b)(6)-2
0400	Pt sleeping – will continue to monitor
	——— (b)(6)-2
0700	Pt resting comfortably, arousable, follows commands, pupils
	2mm & briskly reactive to light, resp even & unlabored, lungs CTA
	bilaterally, sats 98% on RA, heart sounds audible, NSR, all
	pulses palpable, cast removed, dressings to midline abd &
	sacrum Δd, BS(+) x 4 quads, ate 50% of regular diet. Pt
	bathed & shaved, will monitor. ——— (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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MEDCOM - 6496

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8Aug03 0900	Pt resting in bed, Ø c/o pain —— (b)(6)-2 SGT/LPN
1130	Pt's cast removed, pt up in bed ate nutri grain bar,
	some potato chips, 1 juice & 1 Ensure. (b)(6)-2 SGT/LPN
1330	Pts cast reapplied (pt c/o discomfort to elbow). pt still
	denies any pain —— (b)(6)-2 SGT/LPN
1600	Generator went down - pts taken outside off monitor,
	given cold packs then moved to EMT. Pt ate 80% of
	dinner
1830	Received pt this pm in bed resting. Arousable and responsive.
	Airway patent c̄ no difficulty breathing. Chest expansion
	equal and full. Pupils 3mm brisk. Lung sounds clear to
	auscultation x4 lobes. S1/S2 sounds present c̄ no extra
	sounds. Pulses equal and palpable. Skin warm and dry to
	touch. Skin breakdown on upper buttocks dsg CDI Ⓛ
	arm splint and wrapped. BS ⊕ x4 lobes. Abdomen soft non
	distended. Pt on regular diet and tolerates. Pt voids in
	urinal. Pt ambulates c̄ steady gait s̄ assistance. will
	continue to monitor (b)(6)-2 91WM6 SPC 2000
	Pt resting comfortably no signs of distress noted will
	continue to monitor (b)(6)-2 91WM6 SPC 2230
	Heparin and Zantac given fentanyl patch changed VSS no

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

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6497

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/1/03	of distress noted at this time will continue to monitor
	(b)(6)-2 91W SPC 0500 pt sleeping no signs
	of distress noted will continue to monitor (b)(6)-2 91W (b)(6)-2 SPC
	0545 VSS Pt is resting no signs of distress noted
	at this time will give report to oncoming shift
	(b)(6)-2 91W SPC
0630	Pt resting comfortably in bed, arousable to voice, follows
	commands, moves all extremities, pupils 3mm & PERLA,
	respirations even & unlabored, lungs CTA bilaterally, heart
	sounds audible, NSR, all pulses palpable, cap refill <2sec,
	skin intact other than midline abd dressing (CDI), & sacral
	decubitus dressed (CDI), BS (+) x4 quads. Will monitor pt for
	pain & discomfort. (b)(6)-2 SGT/LPN
0900	Pt up & bathed, linens Δd, dressing to sacral area Δd c̄
	wet to dry saline dressing. Dr. (b)(6)-2 in to Δ abd dressing,
	Pt tolerated well. (b)(6)-2 SGT/LPN
1100	Pt ate very little for lunch. ∅ % pain (b)(6)-2 SGT/LPN
1400	Pt resting, cool cloth to forehead, lost AC for
	30min, backup now will monitor pt for VS.
	(b)(6)-2 SGT/LPN
1745	Pt resting comfortably s̄ complaints. Will report to oncoming
	shift. (b)(6)-2 SGT/LPN
1800	Report from dayshift – Pt stable – Dsg
	to abd by Dr (b)(6)-2 – Packed c̄
	dry gauze – belly red ∅ s/sx of infx
	(b)(6)-2

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MEDCOM - 6498

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0500	Pt s̄ complaints, VSS ⊕ void QS urine
	no appetite This am — afebrile —
	Pt. slept Throughout The night
	Dsg Δ to buttocks wet to dry
	(b)(6)-2
0700	assumed care of pt. Rcvd report from
	offgoing shift. Pt OOB ambulate to commode
	breakfast at bedside Ø acute distress
	noted. Ø complaints voiced
	(b)(6)-2 SGT US-A
0800	PT OOB AM care perform, intial assessment
	Neuro: pt alert easily arouse c̄ verbal stimuli
	Ø complaint voiced: Resp: RR 14 SAO2 ↑ 90's on RA
	LS: clear, RR even, unlabored. Ø secretions.
	cardiac, S¹ S² normal, Ø murmur noted ⊕ peripheral
	pulses x4 ⊕ color sensation, c̄ movement. to
	extremities, splint to Ⓛ arm ⊕ pulse to
	distal pulse. Gastro Abd drsg CDI, abd soft
	non-distended ⊕ BS x4 quad. GU: pt walks to
	commode and urinates s̄ difficulty. Color drk
	yellow. Skin: stage II decubiti on coccyx drsg d/c'd at
	0600 by last shift drsg. CDI. Pt BTB resting on side

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REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6499

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 AUG 03 0800	Ø complaints voiced. will monitor —— (b)(6)-2 SGT USA
1100	pt in bed resting NAD at this time —— (b)(6)-2 SGT USA
1500	Pt in bed, ambulates on own & complaints voice. ate a gd. lunch NAD at this time —— (b)(6)-2 SGT USA
10 Aug 03 1930	Assessment done, client awake/alert oriented x3 denies pain, fentanyl patch intact to right upper chest. lungs clear bilat, respirations easy w/o labor, NAD, on room air, O2 sat 97%. heart regular s̄ ectopy. Pulses palpable to bilat pedal + radial pulse. Abdomen ⊕ BS x4 quads. large midline dsg intact and dry. ~~Cast~~ Sr dsg to left hand c̄ immobilized digit to left hand mobile/warm c̄ good cap refill. Dsg to decubitus on buttock changed, old dsg removed c̄ moderate amt of tan drainage, wound appears c̄ pink tissue around edge, inside yellow, no odor noted. (b)(6)-2 ~~dsg~~ wound cleaned c̄ sterile H_2O, aloe vera gel applied then wet sterile 4x4s c̄ H_2O then ABD pad and secured c̄ tape. VSS client tolerated procedure well— (b)(6)-2 1LT AN
	2200 Pt given Zantac and Heparin VSS no distress noted at this time will continue to monitor (b)(6)-2
2200	Medicated per order, in NAD —— (b)(6)-2 1LT
	0200 BP 93/57 HR 67 SaO_2 96% Pt is resting comfortably c̄ no signs of distress noted will continue to monitor (b)(6)-2 SGT

STANDARD FORM 600 (REV. 6-97) BACK

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MEDCOM - 6500

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MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
11AUG03 0630	Assumed care of pt. pt in bed resting intial assessment complete. Neuro: pt easily arouse c̄ verbal stimuli A×O×3 able to move all extremities. Resp. RR reg non labored, even bi-lat. LS CTA. Ø SOB Ø secretion noted. Cardiac NSR (+) peripheral pulses x 4 (+) color, sensation c̄ movement to all extremities. Gastro: ABD soft non-distended ABD drg C/D/I (+) BS x4 quad. GU. pt able to urinate in commode s̄ difficulty. Skin. STAGE III decubidi on coccyx, sacrum drsg Δ'd c̄ lge amount of drainage on drsg. area pink around edges hard center thick white skin. Brownish-yellow drainage when pressing edges. Area cleanse c̄ sterile H2O and wet → Dry sterile drsg applied. NAD. will inform MD ~~about~~ decubidi will monitor ——— (b)(6)-2 SGT US
1030	MD in to see coccyx, Pt NPO, will start LR @ 125cc hr. Ø complaints voiced at this time ——— (b)(6)-2 SGT USA
1200	20G IV ~~started~~ to Ⓡ AC c̄ excellent blood return LR infusing ⓒ 125 cc/hr. ——— (b)(6)-2

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REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6501

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11AUG03	Pt in bed, denies pain at this time
1400	IV 20g. to Ⓡ forearm infusing LR @ 125cc/hr
	s̄ difficulty / (b)(6)-2 91WM6 SGT USA
1430	Pt to OR for debridment. (b)(6)-2 SGT USA 91WM6
1545	Pt back from OR. PT BTB VSS. Bulk dsg
	to coccyx. ⊕ numbness to lower extremities
	⊕ pulses. Pt alert. Plan Reg Diet tonight, Clear
	liquids in AM back to surgery in AM. Pt
	on side understands needs to stay off
	wound to coccyx / (b)(6)-2
1730	Pt stable on side appears comfortable
	NAD Ø SOB ⊕ numbness to lower extremities
	will report to incoming shift / (b)(6)-2 SGT USA 91WM
1800	Pt stable 18g to Ⓡ forearm infusing LR
	@ 125cc/hr Ø s/s infiltration. Report given to
	SGT (b)(6)-2 / (b)(6)-2 SGT USA 91WM6
1830	Pt report recieved - a:0 x 3 - Vital Signs Stable
	Dsg to be Δd daily by surgery - Pt S/P wound
	debridement to coccyx - Dsg C,D, intact
	Pt s̄ complaints at this time — (b)(6)-2
2000	Pt on side - cast to Ⓛ FA intact + sensation
	to fingers ⊕ cap refill - Pt c̄ ⊕ BS x 4 quadrants
	Lungs CTA bilat. — ambulatory to commode
	earlier in the shift ⊕ void 300 cc
	dark yellow urine ⊖ BM — (b)(6)-2
2100	Pt c̄ LR infusing 125 cc/hr int
	Ⓡ FA IV site — (b)(6)-2

STANDARD FORM 600 (REV. 6-97) **BACK**

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2200	Dr. (b)(6)-2 Δd abd dsg – Ø gross
	discharge to packing – wound healing Ø s/sx
	of infx – IV to Ⓡ FA TKO LR @ 125cc/hr – Pt s̄
	complaints of pain —— (b)(6)-2
0100	Pt. sleeping s̄ complaints — (b)(6)-2
0300	Dsg Δ to buttocks on hold – Pt will
	go back to OR in am for debridement by
	surgeon – Pt s̄ complaints —— (b)(6)-2
0500	Pt has not eaten since 2100 – P.O. intake
	only – Diet clear liquid for procedure
	in am – Pt s̄ complaints Vital Signs
12 Aug 03	Stable —— (b)(6)-2
0600	Assumed care of pt. Report rcvd. Pt in
	bed. IV ~~#~~20g Ⓡ forearm infusing LR @ 125cc/hr
	pt appears comfortable./ —— (b)(6)-2 SET USA
0730.	Pt ~~vo~~gagging, vomitted sm. amount clear
	liquid into basin. Afebrile. Pt refused clear
	liquids. Intial assessment complete noted on
	DA form 4700. NAD at this time. Plan: Pt
	→ back to OR for additional debridment of
	decubiti wound./ —— (b)(6)-2

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Medical Record
STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1200	Pt resting in bed awaiting debridment. Pt urinate d/c yellow clear ~~urine~~. IV 20g to (R) forearm infiltrated d/c IV / (b)(6)-2 SGT USA 91WM6
1235	New IV started 20g IV to (R) hand infusing ~~LR~~ LR @ 125cc/hr / (b)(6)-2 SGT USA 91WM6
8/12	Op Note
	Procedure: Debridement sacral decubitus
	Surgeon: [illegible]
	Findings: Large S.D. Bilateral area of sacrum
	c̄ exudate, no purulence
	Well debrided sharply
	Will need grafting [illegible]
	(b)(6)-2
8/12	1300 Pt → OR for debridement ~~wd~~ and drsg
1350	Δ: Pt back to ICU via Litter @ 1350. Rcvd 5mg versed 250mcg fent. Transfer to bed monitors on VS 110/70 - 89 - 20 - 95% RA SaO2. ABD wound Δ'd in OR. NAD at this time. Pt resting on side Will monitor / (b)(6)-2 SGT USA 91WM6
1620	Pt on side saline Lock IV flush s̄ difficulty drsg on sacral area bulk drsg c̄ tape CDI II percocet given po for physical therapy of (L) arm at 1700hr. Pt ate grapes & drank juice tolerated well. Will monitor / (b)(6)-2 SGT USA 91WM6

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6504

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 AUG 03	Physical therapy here to do ROM to (L)
1730	arm, splint removed, ROM perform. Pt
	seem to be in pain, but tolerated
	well. Pt refuse dinner at present time
	left at bedside for later. Pt on side
	resting. Appears comfortable will report to
	oncoming shift. (b)(6)-2 SGT USA 91WM6
1930	Received pt this pm in bed awake and responsive.
	Assessment done see DA 4700. Dsg's CDI will continue
	to monitor (b)(6)-2 91WM6 SPC 2100 pt consumed 75%
	of dinner plate. No complaints noted at this time
	will continue to monitor (b)(6)-2 91WM6 SPC 0100
	pt sleeping VSS stable SaO2 96% c̄ (RA) no distress
	noted at this time will continue to monitor (b)(6)-2 91WM6 SPC
	0400 pt is sleeping. VSS no distress noted will
	continue to monitor (b)(6)-2 91WM6 SPC 0530 pt
	is resting in bed no distress noted SaO2 97% will
	give report to oncoming shift (b)(6)-2 91WM6 SPC
1815:	Assumed care of pt a/p receipt of report. Pt sleeping Ø/UFi. O2 per
VS: 105/66 71	RA. ⊕ Cont. cardiac monitoring in place. Physical assessment pending,
96% RA 14	to be recorded on DA Form 4700 (b)(6)-2

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REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 AUG 03	Assumed care of pt. Pt on clear liquid for
0830	breakfast drank 360cc of juice. ↑ ambulate
	to commode void 300cc yellow urine. 20g
	IV to (R) hand saline locked; Pt BTB resting
	on side. Initial Assessment done noted
	on DA 4700. Plan NPO 'til patient goes back
	to OR for drsg Δ will monitor /
	(b)(6)-2 SGT USA 91WM6
13 Aug 03	Assumed care of pt from SGT (b)(6)-2 Pt sleeping
1030	quietly c̄ out evidence Ø discomfort or pain.
	Pt awakens spontaneously to verbal/environmental
	stimuli. Up OOB to BR for washing/shave
	& oral care. Sheets Δ'd. Ø drainage noted
	to dressing on buttocks. dressing CDI. (+) splint
	to (L) arm CDI. cap refill ≤ 3 sec Ø edema noted
	good sensation, good movement.
1100	Pt returns to bed, ~~States~~ feeling weak, dizzy. Pt
	assisted to chair. BP Taken WNL RR 16 SaO$_2$
	96-97%. Pt returned to bed LR started @ 100 cc/h
	to 18 g PIV to (R) hand. (+) infiltrate. 22 g PIV
	placed to (R) hand c̄ LR infusing @ 100cc/h.
	Ø s. of infiltration, line secured will watch
	Pt remains NPO for I c̄ D @ 1800 in OR.
1230	VS: BP 109/67 (L) ~~HR~~ 96 sa$_2$ RR 71 96.7-T Tymp
	error (b)(6)-2
	Pt sleeping quietly (b)(6)-2
1300:	Pt transferred from bed to litter c̄ assist of OR staff x 2
	c̄/out problems. Pt escorted to OR per staff. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG03	1000 PT ↑ ambulating @ ward. Drsg to coccyx
1130	saturate re-enforce ē guaze c̄ combine drsg
	c̄ tape. pt. on side. 1000hr meds administer
	on time. Pt resting ē eyes close NAD
	at this time / (b)(6)-2 SGT
1400	Salinelock 20g to Ⓡ AC flushed s̄ difficulty
	pt denies pain at present time
	awaiting surgery / (b)(6)-2 SGT
1500	Pt to OR 1330 Pt back from OR
	VS 83/64-83-10 SpO2 99% RA T 98°. family member
	at bedside. Pt awake and speaking c̄
	family member. NAD at this time
	pt denies pain / (b)(6)-2 SGT
1730	Pt in bed awake visiting c̄ family relative
	pt HR ↑ 100's denies pain, NAD
	∅ Complaints voiced /
	(b)(6)-2 SGT
1800	Pt appears comfortable Report given
	to on coming shift / (b)(6)-2 SGT
1930	Received pt this pm in bed arousable. Pt is lethargic. Assessment
	done see DA 4700. Dsg CDI to Abd. and coccyx. Will
	continue to monitor (b)(6)-2 91W SPC

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(b)(6)-4

(b)(6)-2

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

MEDCOM - 6507

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
~~14Ab03 1930~~	~~Received pt this pm in bed awake. Responsive c̄ no difficulty breathing. (b)(6)-2 Assesment done see DA 4700 Pt is lathargic. Able to move all ext.~~
2200	Heparin, zantac, cipro and celexa given as ordred. VSS no distress noted will continue to monitor (b)(6)-2 0100 pt sleeping no distress noted will continue to monitor (b)(6)-2 91WM6 SPC 0400 Pt sleeping VSS no distress noted will continue to monitor— (b)(6)-2 91WM6 SPC 0530 Pt is sleeping no distress noted will give report to incomming shift (b)(6)-2 91WM6 SPC
0600	Assumed care of pt. Report given by Spc (b)(6)-2 pt in bed. IV 20g to Ⓡ AC. LR put on at KVO. Pt set up for breakfast, Ensure given. Pt tolerated well ate a fair breakfast. NAD noted, afebrile Intial assessment noted on DA 4700 will monitor/ (b)(6)-2 SGT USA 91WM6
0730	Labs drawn by Maj (b)(6)-2 AN and sent to Lab/ (b)(6)-2 SGT USA 91WM6
0930	Am care performed at sink pt ambulated @ ward. Ensure given pt tolerated well. pt ↑ chair. NAD Ø complaints voiced, denies pain at present time/ (b)(6)-2 SGT USA

STANDARD FORM 600 (REV. 6-97) **BACK**
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MEDCOM - 6508

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1550 13 Aug 03	Pt returns from OR accompanied by staff. Pt sedated minimally responsive to verbal stimuli. O2 per (b)(6)-2 @ 8L. RR 20-21 BPM, SaO2 @ 100%. VS taken & recorded q 5°, notation on VS Record sheet.
1515	145/96 96 - 21 - 100% O2 Δ'd to NC @ 5L RR 23 SaO2 100% pt arousable. obeys simple commands, wiggling fingers bilaterally, moved bilateral toes on command. Cont cardiac monitoring per Propaq continuous. NPS d/c'd PIV SL'd c̄ 7cc NS.
1530	Cousin @ BS, concerned about pt's present state. Interpreter requested for translation. Pt continues lethargic, is responsive VS 154/89 HR 98 · RR 13 SaO2 @ 100%. ↓ O2 to 2L.
1545.	Pt. c/o nausea, ~3cc mucous (clear) ~~discharge~~ Error. (b)(6)-2 expectorated. Phenergan 25mg SIVP administered per order Dr (b)(6)-2 No c/o N/V ⊖ emesis s/p administration. Pt sleepy, alert, oriented x3 @ this time. will cont to monitor — (b)(6)-2
1615	Cousin states desire to take pt home in 2wks. Pt's health status discussed c̄ cousin understanding need for cont tx — (b)(6)-2
1700	Pt remains sleeping on side s̄/out evidence of discomfort. VS stable (b)(6)-2

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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6509

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG	1930 Received pt this pm in bed asleep arousable. Assessmt
	done see DA 4700. Pt had procedure done to coccyx
	for skin breakdown and is scheduled for procedure again
	tommorow. Will continue to monitor (b)(6)-2 91WM SA
	2030 Pt is lethargic, arousable. Pt voices no complaints
	at this time. VSS SaO2 98% c̄ RA. Dsg's CDI. Will
	continue to monitor (b)(6)-2 91WMO SPC 2200
	Pt is sleeping. Pt easily arousable. Heparin and Zantac
	given. No distress noted will continue to monitor
	(b)(6)-2 91WMO SPC 0100 Pt sleeping arousable
	VSS SaO2 100% c̄ RA. Will continue to monitor —
	(b)(6)-2 91WMO SPC 0300 Pt sleeping No
	distress noted will continue to monitor —
	(b)(6)-2 91WO SPC 0500 Pt is sleeping VSS SaO2
	98% c̄ RA will continue to monitor (b)(6)-2 91WE SR
	0545 Pt is sleeping. No distress or discomfort noted
	throughout shift will give report to oncoming shift —
	(b)(6)-2 91WB SR —
0630	Assumed care of pt Recvd report from
	Spc (b)(6)-2 Pt OOB ambulate → commode
	wash up at sink. Pt BTB. Appears to
	be depressed ⊖ eye contact made c̄ staff.
	Intial assessment compete noted on DA 4700
	New IV started 20g saline lock to Ⓡ AC.
	Drsg to Sacral area soaked through c̄ drainage
	pt denies pain at present time Plan:
	Clear liquid for breakfast, NPO [illegible] 1300 [illegible]
	OR for debridment c̄ drsg Δ / (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/13	Op Note
	Procedure: Second Debridement
	Surgn: [illegible] (Kam
	Anes: Sedation + GA
	Findings - necrotic muscle extensive cavity
	debrided sharply. Fascia exposed, excellent
	tissue a fascia. Wound irrigated,
	packed.
	Tol, Stable
	(b)(6)-2

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

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

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

(b)(6)-4

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

MEDCOM - 6511

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 AUG 03	Pt in bed on side Ø complaints voiced
1130	NAD at this time. / (b)(6)-2 SGT USA [illegible]
1400	Pt ↑ ambulated to commode
	had a large brown formed stool
	Pt BTB, NAD, Denies pain will
	monitor / (b)(6)-2 SGT USA [illegible]
15 Aug 03	Nutrition Note F/U
1430 A/P	Pt referred again for worsening decubitis ulcer.
	Carnation Instant Breakfasts were d/c 2° to
	intolerance. Current Wt: 130# (taken today)
	In an effort to ↑ protein intake will provide
	pt c̄ double meat portions and 4-5 ensures per day
R:	Recommend Double meat portions and ensure 4-5/day
	(b)(6)-2 MAJ, SP RD/LDN
1730	Pt stable, in bed on side. Pt denies
	pain at present time. IV infusing LR @ KVO
	s̄ difficulty, VSS, afebrile, drsg to 4BD CDI, drsgs
	not Δ'd this shift, sacral Δ drsg CDI, plan: pt
	will return to OR 16 Aug 03 in am. NPO after
	MN will report to oncoming shift /
	(b)(6)-2 SGT DS [illegible]

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

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6512

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Pt sitting up in bed – A+O Vital Signs Stable
	20G IV to (R) wrist infusing LR @ 20cc/hr (KVO)
	Dsg to abd intact – Dsg to buttocks
	intact ∅ discharge – Pt instructed to
	stay NPO p̄ midnight for an procedure
	Pt c̄ no complaints — (b)(6)-2 SGT
1900	Pt. ate 2 pieces of chicken and vegetables
	on carnation shake 200 cc water
	(b)(6)-2 SGT 91WM
2000	Pt OOB to commode (+) void –
	dark yellow urine — (b)(6)-2 SGT
2200	Pt vital signs stable See Flow
	sheet afebrile 97° — (b)(6)-2
0200	Pt vital signs stable – sleeping – no c/o pain
	will monitor pain (b)(6)-2
0600	Pt NPO p̄ midnight – ∅ c/o pain
	(b)(6)-2
16 Aug 03 0715;	Assumed care of pt @ 0600 s/p receipt of report from SGT (b)(6)-2
00 15 ; 125/61H 72 HR	Pt in bed (R) side lying, sleeping quietly. O2 per RA
95% RA	IVF's infusing KVO to (R) AC. ∅ evidence infiltration or
95.6 TT	infection @ IV site. Pt remains NPO @ this time awaiting 1st case
16 RR	in OR this Am. Will monitor and ready for surgery — (b)(6)-2
	b(6)-2
0800;	VS taken and noted. (+) WNL. MASON [redacted], CPT [redacted] @ OS
	readying pt for OR. Pt awake, alert oriented x3 & assisted OOB
	to stretcher. IVF's @ KVO, Pt w/o complaints, ∅ evidence discomfort
	or problems (b)(6)-2

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*U.S. GPO: 2002 - 491-600/50818

MEDCOM - 6513

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1300	1 Brother-in-law and son @ Bedside ē tea c̄ food.
	[redacted] b(6)-4 appears content. (b)(6)-2
1800	Percocet ii tabs po administered as premed
	for PT. 1630 RE @ BS for PT to (L) arm.
WT TODAY:	LATE note: 1500 Blister to (L) lateral malleolus
	drains app 1cc blood, remains otherwise intact. Blister
134 lbs.	Washed rinsed c̄ wet to dry dressing applied.
1730	Family members gone. pt resting quietly in bed.
2000	BP 126/80 HR 81 SaO2 98% RR14 Received pt this
	pm awake in chair. Assessment done see DA 4700 Pt
	has no SOB SaO2 98% on (RA). Pt consumed food brought
	by family members. Will continue to monitor (b)(6)-2 (b)(6)-2
	2100 Pt given 4mg ms DUP for pain in (L) arm. Pt is
	resting in bed will continue to monitor (b)(6)-2
	2200 Zantac, Heparin, celexa and cipro given. VSS
	no distress noted will continue to monitor (b)(6)-2 (b)(6)-2
	2400 Pt sleeping no distress noted will continue
	to monitor (b)(6)-2 91WM6 SPC USA 0400 pt
	sleeping. No distress noted will continue to
	monitor (b)(6)-2 91WM6 SPC USA 0530 Pt is
	sleeping no distress noted will give report to oncoming
	shift (b)(6)-2 91WM6 SPC USA

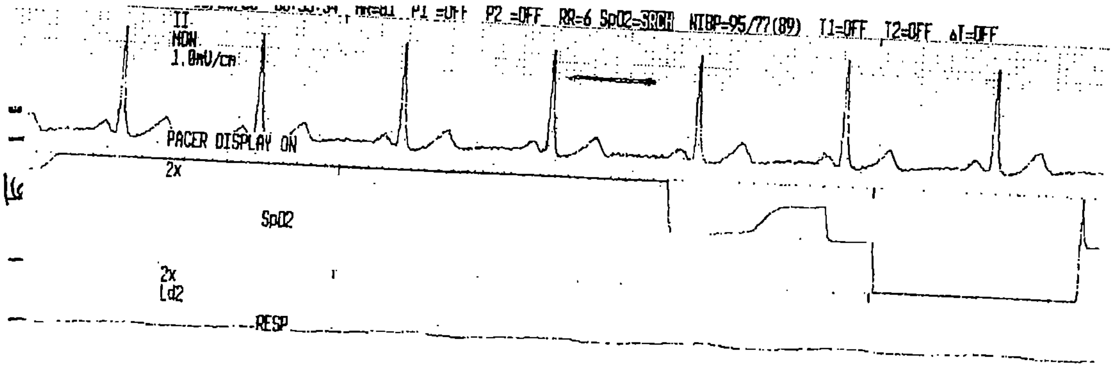
HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

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

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

(b)(6)-4

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


P1 =OFF P2 =OFF RR=6 SpO2=SRCH NIBP=95/77(89) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm
PACER DISPLAY ON
2x
SpO2
2x
Ld2
RESP

each entry)

	–'s (R B
	[illegible]
	commands.
	Moves all extremities, good sensation peripherally.
	lung sounds clear throughout – slightly diminished on (R) side
0845: 95/77	lower lobe. IV: NSR, VS WNP. ↓ BS x 4 (+) abd drsg c̄ 10¢ piece
HR: 67	size Reddish drainage noted to (R) Midline area, inferior to umbilicus.
SaO_2: 99%	Drainage is small, does not saturate through to (error (b)(6)-2 ~~superior~~ surface
RR: 6-8	dressing. Will cont. to monitor. Cap Refill ≤3 sec Bilat
T: 95.8	u/L Digits. (R) radial pulse 1+. All other pulses - dorsalis
	pedis/radial = 2+. (+) 1+ edema to (L) hand - good strength
0900: 101/69	good ROM, good sensation to hand/arm. Pt c̄ out foley
HR: 77	will notate void and BM activity. ~~Clean~~ (+) (L) arm splint CDI.
RR: 9	Large dressing to buttocks, over sacral area - CDI. Pt
SaO_2: 100%	placed on (R) side. presently sleeping. Will cont. ~~to~~
T: 96.1	monitor (b)(6)-2 CPT
	1000: Zantac, Heparin, Cipro administered per orders. Pt
0915 BP: 109/48	sleeping quietly. (b)(6)-2
HR: 69	1005: Pt drinks 6 oz Carnation Instant Breakfast. c̄/o c/o N/V
RR: 9	abd discomfort. (b)(6)-2
SaO_2: 100%	1100: Pt OOB for 'bird bath' and Δ of pj's. ~~Staff care managed~~ (b)(6)-2
T: 95.7	1200: Pt consumed app 95% of NOON meal w/o c/o N/V.
	Pt up and around ward back to chair. Pt presently
Chili x 2 portions	resting watching ward activities from cushioned chair
1 cucumber	1330: Pt in bed side lying (R) side. No complaint @ this
1/2 MRE crackers	time (b)(6)-2
8oz Instant Breakfast	1335: PIV restarted @ TKO to maintain patency

4oz tea c̄ sugar
1 can soda

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6515

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG03	Assumed care of pt. Rcvd report from Spc (b)(6)-2
0600	pt in bed on side resting. 20g IV to (R) AC infusing
	LR at KVO. NAD at this time (b)(6)-2
0730	Pt ate his breakfast c/o pain to
	(L) elbow ii percocet give PO for pain
	will monitor (b)(6)-2 SGT USA
1030	Pt ↑ ambulate @ ward AM care performed
	by pt c̄ ∅ assist. Reinforce drsg to sacral
	wound c̄ guaze c̄ tape. Pt denies pain
	at this time will monitor (b)(6)-2 SGT USA
1400	Pt resting - appears sad, dressing reinforced c̄ (b)(6)-2
	4x4s, no Δs in assessment — SGT/
1720	Pt lying in bed, no discomfort or c/o pain. pre-
	medicated c̄ ii Percocet for PT (b)(6)-2 SGT/

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

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6516

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
16 Aug 03 0835	OP NOTE PREOP Dx — SACRAL DECUBITI POST-OP Dx SAME PROCEDURE — DRESSING CHANGE SURGEON — Dr. (b)(6)-2 Anesth — Cpt (b)(6)-2 FINDINGS: Grade IV sacral decub Description — Conscious sedation — Removed dressing lateral aspects of wound granulating — tissue overlying sacrum appears nonviable. No evidence of infection. Cleansed w/ Hibiclens. Packed w/ saline soaked fluffs — Dressing. Pt tolerated procedure well. Transported to (b)(6)-2 stable condition. EBL Ø IV fluids in — 100 cc NS No Antibiotics. No Drains.
	(b)(6)-2
	(b)(6)-2, MD [redacted] MAJ, MC USA CHIEF, DOS

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REGISTER NO.

WARD NO.

(b)(6)-4

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

MEDCOM - 6517

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03	OP NOTE
0850	PRE-OP Dx - Sacral Decubitus / Open Abdom Wound
	POST-OP Dx - SAME
	PROCEDURE - I+D Sacral Decubitus / Dressing change
	Surgeon - Dr. Conway Anesth - CPT [redacted] b(6)-2
	Findings - Sacral Decubitus Eschar / Debris. Fibrin on Some
	Abdomen - Granulation bed -
	Description - General Sedation. Debridement of Sacral
	Decubitus of infection on [illegible], Irrigated w/ Hibiclens
	[illegible] packed w/ Saline Soaked Kerlix. Covered w/ Tegaderm.
	Abdomen - Removal dressing - Suprapubic CHIEF DOS [illegible] (b)(6)-2 [illegible]
	Granulation bed - No exposed [illegible]
	Packed w/ Saline Soaked Kerlix. Tol well +
	Transported to ICU in Stable cond.
	Comp 0 IV LR in - 200cc
	EBL 0 (b)(6)-2
	(b)(6)-2 MD MAJ, MC USA CHIEF, DOS

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6518

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
18 Aug 03	Pt returned from OR, arousable, lying on side in bed,
0900	debridement of abd wound & buttocks Δd dressing, pt
	appears sad. Resp even & unlabored, lungs CTA bilaterally,
	NSR, Post-op vital signs stable - see flowsheet. All pulses
	palpable, no edema noted, dressings to abd & buttocks CDI,
	Will monitor. (b)(6)-2 SGT/LPN
1000	Fentanyl patch not Δd last PM, Δd today will Δ time
	for next patch Δ (b)(6)-2 SGT/LPN
1230	Pt refused lunch - drank 1 Ensure (b)(6)-2 SGT/LPN
1450	Pt resting comfortably, ∅ c/o pain (b)(6)-2 SGT/LPN
1820	Received pt this pm. In bed awake. Airway patent
	SaO_2 97% (RA) ⊖ SOB. lung sounds CTA. x4 lobes
	S1/S2 sounds present. Pulses palpable. cap refill <3 sec
	Dsg to Abd. CDI Δ'd by MD. Dsg to coccyx CDI.
	No other breakdown noted. BS ⊕ x4 quad. Pt
	ambulates to ward commode. Pt on cardiac diet.
	Will continue to monitor (b)(6)-2 91WNO SG USA.
	1900 Pt consumed 2 pcs chicken and some vegetables
	for dinner. Pt now resting in bed will continue to
	monitor (b)(6)-2 91WNO SG USA 2200 VS 110/63
	HR-80 RR 12 SaO_2 96% T 96.3. Meds given pt
	had 6oz ensure c̄ meds. Pt sleeping easily aroused

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG	No distress noted at this time will continue
	to monitor. (b)(6)-2 91WM6 SPC USA 2400 Pt
	sleeping at this time. No distress noted will
	continue to monitor (b)(6)-2 91WM6 SPC USA 0200
	Pt sleeping easily arousable VS - 108/69 HR 71 - RR -
	12 SaO2 96% c̄ (RA). Dsg CDI. No distress noted
	at this time will continue to monitor (b)(6)-2 (b)(6)-2
	0400 Pt sleeping no distress noted at this time
	will continue to monitor (b)(6)-2 91WM6 SPC USA
	0600 VS 113/67 HR 66 RR 12 SaO2 95% Pt is resting
	in bed no distress noted will give report to oncoming
	shift (b)(6)-2 91WM6 SPC USA
18 Aug B- 0730	0600 assumed care of pt. Pt sleeping in bed on (L) set.
	Ø IVF's infusing, O2 per RA. Ø evidence of resp or other
	discomfort. Assessment and plan to follow —— (b)(6)-2
0830:	Pt up OOB to ward bathroom for complete bath, self accomplished
	Khalafa encouraged to walk around ward and throughout
	hospital for exercise and to ↓ amt of sleeptime q d. Plan
	↑ activity, ↑ nutritional intake c̄ concentration on proteins.
	↓ sleeptime and inactivity time, ↑ activities, promote
(b)(6)-2 0900	self-care. (b)(6)-2 0x liter outside, 1/2 liter plastic bottle filled
(b)(6)-2 1000	c̄ pebbles to be used for PT to (L) arm. (b)(6)-2 Pt resisted/
0900 Percocet	accompanied to Physical Therapy for PT to (R) Arm. —
1000 PT 1245:	Returns to ward tired and in pain. 0900 Percocet ii
1200 ward/sleep	tabs given for (L) arm pain. ——
MSO4	1230: Pt c/o pain to (L) arm, (+) facial grimacing (b)(6)-2
	(+) inability to raise, move arm c̄/out resist. —
	MSO4 2 mg IVP administered per 18 g (R) PIV c̄/o evidence

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*					
DATE:	Quantity (app.) c̄ Description					
	*Breakfast	Snack	*Lunch	Snack	*Dinner	Snack
16 Aug.	NPO	6 oz. Curnation	95% meal -	Ø	1 cucumber	
		Instant Breakfast	chili con carne		250 ml tea	
			1 MRE cracker		3 servings rice	
			1 cucumber		tomato soup 1 cup	
			8 oz Instant Breakfast			
17 Aug	240 milk	240 ensure				
	1/2 eggs					
	1/4 potatos					
	240 Ensure					
18 Aug	NPO		1 Ensure		1 ensure	
					2 pc chicken	
19 Aug	1/2 Double Portion of eggs	Breakfast	1 cup stew	1 instant	1/2 Noodles	
	1 milk (240)	Instant	Ø veggies	Breakfast	1/8 Stew	
wt 133 lbs	Potatoes	drink	3 cookie	1430°		
			1 Instant Breakfast			
			1			

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

(b)(6)-4

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

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20AUG03	Report recieved - Pt. sitting in bed - A+O x3
1830	Pt c̄ ∅ IV access - D/c'd during day shift - Pt
	c̄ multiple bouts of defecation ∅ diarrhea - soft
	formed stools - Δ in diet today - local food
	consumed from family - Pt c̄ no other complaints
	Dsg to abd C,D and intact - Dsg to buttocks
	Δ'd at 1600 - will monitor and change if saturated
	or unsecure - Lungs CTA bilat, ∅ cough
	⊕ BS hyperactive - Pt ambulating s̄
	problems —— (b)(6)-2
2000	one choc carnation instant breakfast c̄ water
	small amt beef c̄ rice H2O — (b)(6)-2
2100	Pt sitting in bed - 2200 meds given — 122/68 - 72
	—— (b)(6)-2
2200	Pt sleeping will monitor — (b)(6)-2
0200	Pt sleeping, VSS - ∅ c/o pain - ∅
	BM since 1800 — (b)(6)-2
0800	Pt resting comfortably - refused breakfast. Assessment.
	performed (see DA4700). Plan: Pt will ambulate to back for
	bath & daily weight - will give Ensure to supplement diet.
	—— (b)(6)-2 SGT/LPN
0900	Pt in back shaving & bathing - ambulated to BR & urinated
	approx 300cc clear yellow urine. (b)(6)-2 SGT/LPN
1000	Pt ate chicken c̄ bread, drank 1 Ensure (b)(6)-2 SGT/LPN
1300	Pt ate 1/2 lunch + watermelon & 1 Ensure (b)(6)-2 SGT/LPN

131/81, 75, 18, 98.?

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 Aug 03 1400	Pt resting comfortably in bed - sats 100% on RA. VS 106/58, 74, 17, 97.6 —— (b)(6)-2 SGT/LPN

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)*

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0730	Breakfast
	10% eggs
	10% hashbrowns
	250cc milk (full cream)
1000	Shake (carnation) c̄ 250cc milk (full cream)
1130	Lunch
	1/4 spaghetti
	ī can peaches
1320	Shake (carnation) c̄ 250cc milk (full cream)

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

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WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*			
20 Aug 03	Breakfast 0730	SNACK 1000	~~Lunch~~	Lunch 1400
WEIGHT:	1/4 chicken	1030: 1/2 MRE cracker	1300	2 meat patties
133 lbs	1/2 orange	2-4oz chicken	Breakfast drink	small piece
w/h BFD	8oz instant Breakfast	1 Instant Breakfast		chicken ~2-3oz
Carb: 5.7g/27		8oz		8oz Instant Break
Prot: 3.7g/5	SNACK - 1600	Dinner	Snack	
Fat: 1.6/0	1 Instant Breakfast	1/4 small portion meat		
Cal: 52/130		1/2 portion rice		
21 Aug 03	Ø Breakfast			
	Chicken c̄ pita (mod amt)			
	2 Ensure shakes			
	1/4 watermelon			
	1/2 double portion meat (lunch) c̄ rice			

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22AUG03	Nsg: Pt dressing was changed last
20245	night at approx 2200 to sacral
	region. 2 distinct decub ulcers seen.
	Both ulcers have marked tunneling,
	purulent drainage, grey areas to
	periphery of wounds, and granulation
	tissue towards the center. Pt
	is being turned away (position on
	bed) from lying on this wounded
	area. Encouraging fluid intake.
	VS are WNL, w/ Sats 95% or greater
	No labored breathing noted. Will
	cont to monitor (b)(6)-2
22AUG	PT AAOx3, PERRLA, VSS, DPP x4 extremities, bilat equal/strong, BBS CTA ē = EXPE
	SAO_2 95%, voiding via BSC, ø complaints, A dressing, will continue to monitor
	(b)(6)-2 SGT 91WM6
22AUG03	ASSESSMENT - 2230. AAOx3 PERRLA, LUNGS CTA BILAT, P.S = STRONG
	AND REG. ⊕ BS x4 ø % PAIN, A'd DRSG C/D/I, TOLERATING (b)(6)-2
	REG DIET. CARNATION INSTANT BREAKFAST x1. WILL CONTINUE TO MONITOR SPC
23Aug03	Nursing Shift Pt. bright + alert, ø signs of resp. distress,
1520	speaks clearly in native tongue. Lung CTA, ⊕ BS x4 Quads. (cont.)

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

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REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	**PROGRESS NOTES**

DATE	NOTES
	comfortable. BOD pt consumed meal, cont talking c̄ dad.
	(+) Instant Breakfast # 3, ~~[illegible]~~ today
	large well formed stools. Pt urinating c̄ out
	problems. (b)(6)-2
	1430: Brother, dad & Khalaf @ BS conversing. Brother
	shared chicken c̄ Khalaf. % intake unsure @ this time.
	1500: Dressing Δ to buttocks wet to dry. Large
	gaping decubitus stage IV, bilat buttocks. Deep,
	red. No necrotic tissue noted, ∅ foul smell (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)*

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Aug 03 1520	Nursing (cont.) BM x1, fentanyl patch changed this shift, no other pain relief needed. Drsg to small of back, change c̄ op-site. Sacral dressing changed W/D. Carnation x2 thus far today. Meals on calorie count for today. Ambulation with much encouragement. Favors (L) side. Continue to encourage AROM. (b)(6)-2 CPTA
23AUG03	- 2000 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG, (+)BS x4. Ø c/o PAIN. CARNATION x2, TOLERAT REG DIET. TURNING PT q 2°. DRSG TO ABDOMEN C,D,I. WILL CHANGE DRSG TO BUTTOCKS @ 2200. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT
23AUG03	- ASSESSMENT - 2200 - DRSG Δ'd. C,D,I. WOUND SHOWS NO SIGNS of INFECTION NO DRAINAGE. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT
25AUG03 @0200	NSg shift assessment: Dressing change was done last night at 2030. Bilat decubs to buttocks appear to have some damaged tissue (darkening) at the entrance. Significant tunnelling noted. Good granulation tissue seen. Pt denied any pain this shift. Ate majority of times, and appears to enjoy his carnation instant breakfast drinks. VS WNL. Resp are even and unlabored. Will cont to monitor (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03 -	KCAL COUNT - 1820 - PT ATE 100% DIET WHICH CONSISTED OF BAKED CHICKEN x2 PIECES, RICE, COLE SLAW, MIXED VEGETABLES, MILK. (b)(6)-2 SGT LPN
26AUG03 -	2230 ASSESSMENT - A&Ox3, PERRLA, LUNGS CTA [redacted] S1-S2 STRONG AND REG. ⊕BS x4. DRSG A/I. C,D,I. NO SIGNS OF INFECTION, Ø DRAINAGE. Ø c/o PAIN. OOB TO BR CARRYING x2. (b)(6)-2 WILL CONTINUE TO MONITOR SGT LPN
27 AUG03 2230	RN wound care note: Pt dressing changed: less tunnelling noted bilat, fresh granulation tissue is apparent (beefy-red). Diameter of wounds also appear smaller. Tolerated dressing change s̄ difficulty (b)(6)-2
27 Aug03	Nursing Notes: Pt Stable. Ate [illegible]. Ambulate without assistance slow steady gait. Pt Sat in Px for about 20 minutes. Ø c/o pain. Will continue to Monitor Status. (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03	Nsg shift assessment: Pt continues
@0410	on 3000 cal diet w/ Carnation instant
	breakfast supplements. Appears to
	be tolerating this diet s̄ difficulty.
	Voiding QS med colored yellow urine.
	Dressing change done to bilat decubs
	in sacral region. Tunneling does
	not appear to be progressing,
	and granulation tissue appears
	more abundant. Denied need for
	pain meds this shift. Sats are
	>96% on RA, VSWNL. — (b)(6)-2
26Aug 03	General Surgery SOL
1000	S: Pt [illegible] [illegible] c/o Telemetry Unit / Ambulate
	O: Afebrile VS WNL
	Sacral Decubitus - Grade IV - Still w/ substantial
	defect undergoing Wet to dry NS gauze dressing
	Afebrile and [illegible] [illegible]. Sup/inf granulation
	A: Sacral Decubitus
	P: ① Plastic Surgery consult to evaluate for
	Flap coverage. Will ask for [illegible] for [illegible]. [illegible] today
	② Continue Nutrition. (b)(6)-2 (b)(6)-2 MD

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPAR	CHIEF, DOS
SPONSOR'S NAME	SSN/ID NO.	RELAT	

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

(b)(6)-4

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

MEDCOM - 6530

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 03	Nutrition Note Results of kcal count: pt consuming approx 2100-2400 kcal/day 120-130 gm protein pt's needs based on wt of 135# is 2700 kcal/d Do not expect pt will be able to ↑ volume of food/supplements as he is currently at his maximum intake. If further supplementation is needed Night time tube feedings should be considered or ↑ carnation instant breakfasts to 6x/day. (b)(6)-2 MAJ, SP RD/LDN
28 Aug 03	PT A&Ox3, VSS, BBS CTA SaO2 96%, PPP bilat equal/strong, BS active last BM this AM voiding via latrine, sacral wound improving, ø complaints, will continue to monitor (b)(6)-2 9/WMG
29 AUG 03 @0330	Nsg shift assessment: pt had a hearty appetite this shift, continues to readily drink his carnation breakfast/milk supplements. Wound care done – bilat sacral wounds appear to be smaller in diameter w/ less drainage. Tunnelling still significant, granulation tissue is a beefy red color. Voiding and having BM's s̄ dif. — (b)(6)-2

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

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

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

(b)(6)-4

(b)(6)-4

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

MEDCOM - 6531

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Aug 03	1450: Dressing changed to sacral area with sterile Super Sponges moistened c̄ NSS covered with three 4x4's utilizing sterile technique. Decubitus to upper (L) gluteal margins with no drainage noted, yellow eschar present in the center of tissue. (R) decubitus packed c̄ sterile super sponge, beefy red tissue present s̄ signs of infection. Patient tolerated procedure without discomfort. CPT (b)(6)-2 informed of tissue appearance. (b)(6)-2
29 Aug 03 1505	Nursing Assessment: Pt awake, Ø c/o pain (alarm) A+O x4 + time. Lungs CTA, Ø SOB, O2 sats 96% on RA. HR 84, reg, Ø edema noted, Ø IV access. Abd soft, nontender, abd drsg CDI, will ask MD if drsg is to be Δ'd. Drsg to buttocks CDI. Pt ↑, amb self. Encouraging pt to drink shakes, pt mixing shakes himself. CPT (b)(6)-2
29 Aug 1905	Nursing notes: Assumed care of pt A+O. Pt ambulated to BR Ø complaint. Breathing intact Ø SOB or labored breathing. Abd soft and nontender dressing clean dry and intact. Voids spontaneously. Will continue to monitor status (b)(6)-2
2250	Dressing change completed. Wound looks OK Ø drainage or foul smell noted Ø significant change; will continue to monitor status (b)(6)-2 1LT/A

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Aug 03 1050	Nursing Assessment: Pt awake, ∅ c/o pain. Pt alert, Lungs CTA, O2 Sats 97% on RA. HR 82, reg, ∅ edema, ∅ IV access. Abd soft, nontender, hyperactive BS, ∅ BM so far today. Pt voiding well, ↑ OOB amb s̄ assist. Drsg to mid abd intact. Drsg to Bil. buttocks. Ⓛ Buttock beefy red c̄ tunneling ∅ active drainage noted. Ⓡ Buttock beefy red c̄ tunneling. Ⓛ side of area has small area yellow tissue. ∅ active drainage noted. Replace c̄ saline soaked gauze & covered c̄ 4x4. ——— 1LT (b)(6)-2 AN
30 AUG 03 @ 2300	Nsg shift assessment: Pt A+Ox3. Reports some pain to left wrist, given percocet. Dres Δ done, right decub area appears beefy red, some drainage noted, tunnelling still the same. Left decub appears to be healing better (less drainage, more granulation tissue). Poor appetite for dinner, did not appear to like the main entree (fish). No other skin integrity issues noted. Fluid intake appropriate, voiding (Q) amts. VS WNL and POX >98% on RA — (b)(6)-2

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

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

REGISTER NO.

WARD NO.

#31

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

MEDCOM - 6533

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31Aug 03 -	0838 - ASSESSMENT - A+Ox3, PERRLA, LUNGS CTA: S1-S2 STRONG AND REG. ⊕ BS x4. TOLERATED REG DIET, CARNATION x1. DRSG TO BE A/d @ 1000. ~~[illegible]~~ Ø C/O PAIN. DRSG TO ABD. C,D,I. WILL CONTINUE TO MONITOR (b)(6)-2
31Aug 03 -	1020 - NURSING - DRSG A/d. C,D,I. WOUND SHOWS NO SIGNS OF INFECTION, BEEFY RED COLOR. PT C/O Ø PAIN (b)(6)-2 WILL CONTINUE TO MONITOR SGT [illegible]
31Aug03	PT AAO, PERRLA, ~~[illegible]~~ BBS CTA 95% on RA, PPP bilat equal/strong, ~~PPP~~ BS active x4, voiding via latrine, dressing A, Ø complaints, will continue to monitor. (b)(6)-2 SGT 91WM6
Ø1 Sep 2003 1040	Nursing Assessment: Pt sleeping, easily aroused, Ø c/o pain @ present. Lungs CTA, O2 SAT 97% on RA. HR 82, reg, Ø edema noted. ⊕BS x4, abd soft, nontender. BM x 1 today. Pt voiding s̄ difficulty, ↑ OOB, amb s̄ assist. Drsg to abd, CDI. Drsg to bil. buttocks CDI 1Lt (b)(6)-2 AN
1SEP	PT AAO, PERRLA 3mm, BBS CTA 97% on RA, BS active in all 4 quadrants void via latrine, dressing A (improved), Ø complaints, will continue to monitor (b)(6)-2 91WM6
25Sep03 1100	Nursing Assessment: Pt awake, Ø c/o pain @ present. Lungs CTA, O2 SAT 97% on RA. HR 84, reg, +2 pulses x4, Ø edema noted. Abd soft, nontender ⊕BS x4. Pt reports Ø diarrhea (through interpreter) & voiding s̄ difficulty. ↑ OOB, amb s̄ assist. Drsg to buttocks c̄ sero-sang drainage. Wound is beefy red c̄ dime size area of yellow tissue to center of Ⓛ buttock wound & smaller area yellow tissue to Ⓡ edge of Ⓛ buttock wound. W→D drsg c̄ normal saline & supersponge gauze. Pt tolerated well. 1Lt (b)(6)-2

STANDARD FORM 600 (REV. 6-97) **BACK**

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	heavy. Voiding w/o diff., and pt VS WNL. will cont to monitor — (b)(6)-2
3SEP03 @2220	NSG Dressing Δ done. (R) decub continues to appear to be improving (less drainage more granulation tissue. (L) Decub appears the same as last night's dressing Δ. Pt tolerated the change s̄ difficulties (b)(6)-2
4Sep03 1800	Nursing: Shift Note Pt remains the same. Eating + hydrating well. Encouraged to ambulate more. VSS, Ø signs of resp. distress. Cont to mon (b)(6)-2 CP10
5Sep03 1045	Nursing: - Performed dressing change @ 1040. Ø drainage noted. Ø signs of infection. Wound has healthy beefy red color. Wound site appears to be healing. Site is smaller. Ensured pt was turned to his side to stay off of dressing. Dressing to buttocks CDI will continue to monitor throughout. [redacted] (b)(6)-2
5Sep03	Assessment - 1400 - A+Ox3, PERRLA, Ø c/o pain. Lungs CTA bilat, S1-S2 strong and reg, Abdomen BS, Turning [illegible] [illegible] [illegible] hours. Dsg [illegible] keeping on side. Will continue to monitor — (b)(6)-2
6SEP03 @0430	NSG shift assessment: Dressing changed to decubs on sacrum. Areas distal to wounds appear to be getting some more breakdown (where tape normally is). Taped area was made smaller to help alleviate this. No complaints at this time — (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3SEP03 @0745	NSg shift note: Pt decub dressing change. Diameter of Ⓡ sacral decub appears smaller, less drainage noted to Ⓛ decub. Pt had a good appetite at dinner. Ambulating of own volition, and gait remains steady. Continues to take in adequate PO and voiding QS urine (b)(6)-2
3Sep03 @1015	Nursing Assessment: Dressing change performed, dressing clean, dry and intact. Small amount of drainage. Pt tolerated dressing change with Ø pain. (b)(6)-2
3Sep03 1450	Nursing Shift note Pt. alert, bright, quiet c̄ pleasant facial gesture of content. Ambulating w/o difficulty. Encouraged to increase intake of shakes. Concur c̄ above note regarding dressing changes. Contin to monitor (b)(6)-2
3SEP03 @2100	NSg shift assessment: Pt continues to ambulate around ward + PLX area w/ a good gait and no apparent difficulties. Dressing to be changed at 2200. Pt appetite @ dinner was

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

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

MEDCOM - 6536

558-103 *See Instructions on Back of this Sheet)* NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)*

LOG NUMBER

ARRIVAL

DATE DAY	MONTH	YR.	TIME
8	7	03	0613

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☐ AMBULANCE
☑ OTHER *(Specify)* Air Evac

CURRENT MEDS. *(tetanus immunization and other data)* ⊖

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES NKDA.

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

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

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*

SEX M

AGE 50

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 0615.

VITAL SIGNS

TIME	0613		0625
BP	124/81	-8 (b)(6)-2	116/68
PULSE			90
~~RESP~~ O2	99%		98%
TEMP.			
WT. *(Child)*			

CATEGORY *(See reverse)*
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
CBC CHEM 12	(b)(6)-2	0620
Lytes ABG		0620
Type + Cross		0620
Chest Xray		0614
Elbow Xray		0614
Abd Xray		0614

ASSESSMENT/DIAGNOSIS
GSW LLQ
GSW Ⓛ olecranon.

DESCRIBE (1) Subjective data *(Pertinent History)*; (2) Objective data *(Examination - include results of tests and x-rays)*; (3) Assessment *(Diagnosis)*; (4) Plan *(Treatment/Procedures - include medication given and follow-up)*

TOI this AM Last meal 2300.
S: Pt is a 50 yo Iraqi ♂ EPW s/p GSW to LLQ and Ⓛ elbow

PMHx ⊖
PSHx
Leg.

⊖ Tob.

O: wdwn in mod dist A+O No resp dist.
HEENT: wnl.
Lungs: Ⓑ CTA
Cor: RRR
Abd: ⊖ BS. Tense, distended. ↑ tend globally
Ext: GSW x 3 to Ⓛ ASIS area + above.
open Ⓛ olecranon 2° to GSW.
⊕ pulses

Abd Xray.
mult frags
across entire Abd.

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)*
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0630.

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

(b)(6)-4

SIGNA (b)(6)-2

INSTR rdered, any limitations and follow-up plans)

TO OR.

MEDCOM - 6537 ATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24Jul03	1730		Pt OOB to chair, tolerated well other than elevated
			HR. ——— (b)(6)-2
24 July 2003		1845	Received report, assumed care of pt ē 1800. Pt up
O2 NC 4L	✓		in chair ē side of bed, awake, alert oriented, calm,
NGT			flat saddened affect. VS 81/59:BP/127:HR// RR:39/SaO2
Ⓡ FA PIV	✓		98%. Ø evidence of respiratory distress or discomfort.
LR ē 50			Pt denies pain. ⊕ NGT clamped, to Ⓡ nare. IVF's = LR
Foley to gravity	✓		ē 50cc/h to Ⓡ 18g PIV to FA. ⊖ evidence infection
JP drain	✓		infiltration, IV place 23 July. O2 per NC @ 4L.
Cast-Ⓛ arm			⊕ Foley to gravity, clear yellow urine out. ⊕ Dressing
Abd incision	✓		to abd incision - midline app 45cm extending
			from lower sternum to pubic region, CDI JP drain to
			Ⓡ LQ - Ø drainage noted @ this time. Ⓛ Arm cast
			CDI. Cap refill to index ≤3 sec. skin color to fingertips
			NFR. unable to palpate pulse related to
			casting material. ———
			Pt placed on BSC, BM x1, large soft dark
			brown. Pt cleaned, zinc oxide applied
			to decubitus on sacral area and on T6-T7
			of spinal process. Pt assisted to bed, placed on
			Ⓡ side, comfort measures provided, Pt resting.
			Physical Assessment:
			Neuro: Pupils 1-2mm/1-2mm PERRLA.
			A/A/Ox3 Moves all extremities purposely
			and spontaneously. Denies pain ē this time
			Resp: ⊕ O2 per NC @ 4L 98-100% SaO2 RR >30
			Dr (b)(6)-2 aware. ⊖ use of accessory muscles

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Jul 03	0800		Pt extubated s̄ difficulty. Suctioned a small amt thick white secretions - Pt satting 93-94% on NRB. RT at bedside monitoring. (b)(6)-2
	0845		Pt given neb treatment & CPT, coughed up more thick white sputum. Lungs still sound crackly on Ⓡ side.
	1000		Pt turned & bathed. Coughed up large amt thick white sputum - sats ↑'d to 100%, resp effort improving, pt in NAD c̄ a resp rate of 30-35, still on NRB @ 15 lpm, Zinc oxide applied to both sores on back & sacrum - Sacral wound appears to be tunneling now, pt turned onto Ⓛ side - continues to try to lay on back - appears much more comfortable on back. Will monitor resp status —— (b)(6)-2
	1200		Pt had episode of hiccups, turned NG suction down. MD notified. —— (b)(6)-2
	1500		25mg Thorazine given for continued hiccups - resolved immediately. Pt changed to NC @ 6 lpm, still satting > 98%. —— (b)(6)-2
	1600		A-line DC'd, tube feeds resumed, this hour 60cc given (30cc at a time). Pt sitting up in bed. IS done, pt still coughing up large amts thick white sputum. —— (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)*

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

CC

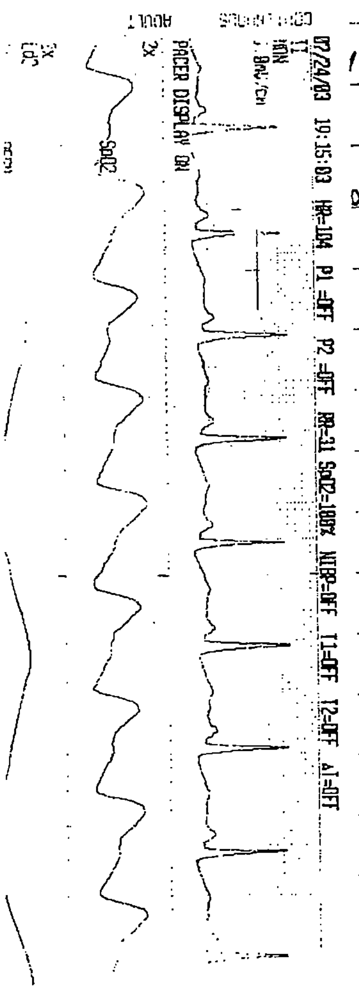
STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 6539

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 03	1845 —		zinc oxide applied. — Plan: Monitor Resp c̄ cardiac status continuously. Encourage REST. Monitor T and I/O's. Cont. IVF's encourage incentive spirometer deep breathing and coughing. Reposition pt. off ulcers AMAP. Cont tube feeds titrating from 30-60 cc/hr. Monitor residuals. Encourage PO H_2O intake. Provide comfort measures. WATCH stage I ulcers to bilateral heels, maintain elevated. — (b)(6)-2
	(Cont.)		Provide good pain control and emotional support c̄ much encouragement. — (b)(6)-2
		1900:	Pt c/o abd pain MSO_4 2mg IVP administered. Pt appears comfortable s/p administration. — [redacted]
		2030	Pt VS stable as noted on standard form 511. b(6)-2 Residual check for tube feedings @ 1900 = 75% feeds held. Dr (b)(6)-2 @ BS 2000 requests feeding to cont @ 30 cc/hr - slow titration to ↑ as tol. Feeds resumed @ this time. Residual ✓ @ 2200. Pt resting comfortably.
		2130:	Pt decubitus to coccyx tx'd c̄ wet gauze base, covered c̄ tegaderm. Back ulcer tx'd c̄ tegaderm; Pt turned on Ⓡ side c̄ coccyx off mattress. Heels elevated, donuts in place. MSO_4 2mg IVSP administered pre wnd intervention. — (b)(6)-2
		2200	Residual ✓ = 10cc, ⊕ 30cc H_2O flush. BS noted


07/24/03 19:15:03 HR=104 P1 =OFF P2 =OFF RR=31 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
PACER DISPLAY ON
II
SpO2
ADULT

-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6540

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 2003		1845	NSG Cont. Breathing shallow, nonlabored. Breath
			snds clear; diminished bases bilaterally. ⊖ JVD.
			⊕ white sputum, small amt, pt able to cough up
			c̄/out aid of suctioning. ~~cough~~ (error (b)(6)-2
			CV: NSR, Tachy c̄ HR > 100 BPM. BP WNP @ this
			time = 106/40 102 Ⓡ radial pulse 1+. Bilateral
			dorsalis pedis pulses 2+. ⊕ Edema bilat. lower
			extremities @ 1+. BP per NIBP Ⓡ brachial. ⊕ Cont
			Cardiac monitoring.
			GI: Abd dressing CDI, JP drain intact, minimal
			serosanguinous output. abd soft, tender on palpation
			⊕ ↓ BS Ⓡ U/LQ Ⓛ UQ - unable to assess Ⓛ LQ
			R/T dressing/position.
			GU: Foley to gravity clear yellow > 50 cc UOP
			Ø swelling noted to penis or scrotum, Ø discharge
			from meatus.
			MS: Pt stands w/assist, weak and hunched
			over. ⊕ ↓ strength to bilat U/L extremities; ⊕
			cast to Ⓛ ARM from proximal end of humerous
			to hand, ⊕ CDI
			Skin: ⊕ stage 2 decubitus ulcer to sacral
			area ~ 15cc diameter, ⊖ oozing. Zinc oxide
			applied, pt placed on side. ⊕ 3cm diam
			stage 1 ulcer to [illegible] area on back.

(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.

NURSING NOTES
Medical Record

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

MEDCOM - 6541

(b)(6)-4 25 July

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 2003		2200	(NSG Cont.) ⊖ abd distention. Pt tol. ~250cc
			PO H_2O intake c̄ 120cc @ this time. IVF's
			cont infusing. foley draining. VS stable —— (b)(6)-2
		2300	⊕ facial grimmacing ⊕ c/o abd pain MSO_4
			2mg IVP administered. Pt returns to sleep
			—— (b)(6)-2
25 July 2003		0415	Residual ✓ = 75cc feedings held. —— (b)(6)-2
			LATE NOTE: ⊕ use IS c̄ 20 breaths completing
			900 cc/sec. —— (b)(6)-2
		0200	Residual ✓ = 30cc out. Feedings cont. @ 30cc/hr. (b)(6)-2
		0300	Pt repositioned to Ⓛ side. Tegaderm to
			dorsal decubiti intact. MSO_4 2mg administered
			post repositioning. O_2 ↓ 3L SaO_2 remains @ 98%
			RR ↑ 30+ BPM. O_2 @ 4L - SaO_2 100% BPM = 20-22.
			O_2 ↑ to 4L via NC. Will attempt weaning
			later. ⊕ H_2O per oral rt. 60cc c̄/out c/o N/V
			—— (b)(6)-2
BP 107/58 —		0445	CBC, Chem 7 drawn, walked to lab - results pending. CXR -
HR /78			portable ordered - pending. Pt resting comfortably
RR 22			Gentamicin infusing. —— (b)(6)-2
SaO_2 100%		0515	CXR TECH @ BS Pt sleeping quietly VS STABLE (b)(6)-2
2L O_2		0545	Zantac ↑. Pt cont. sleeping quietly —— (b)(6)-2
NC		0600	Report given to SGT (b)(6)-2 Pt care assumed per
T 98.8°F -		Δx.	SGT (b)(6)-2

(Continue on reverse side) (b)(6)-2

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

RE (b)(3)-1

WARD NO. ICU

(b)(6)-4

NURSING NOTES

Medical Record

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

MEDCOM - 6542

(b)(6)-4

NURSING NOTES

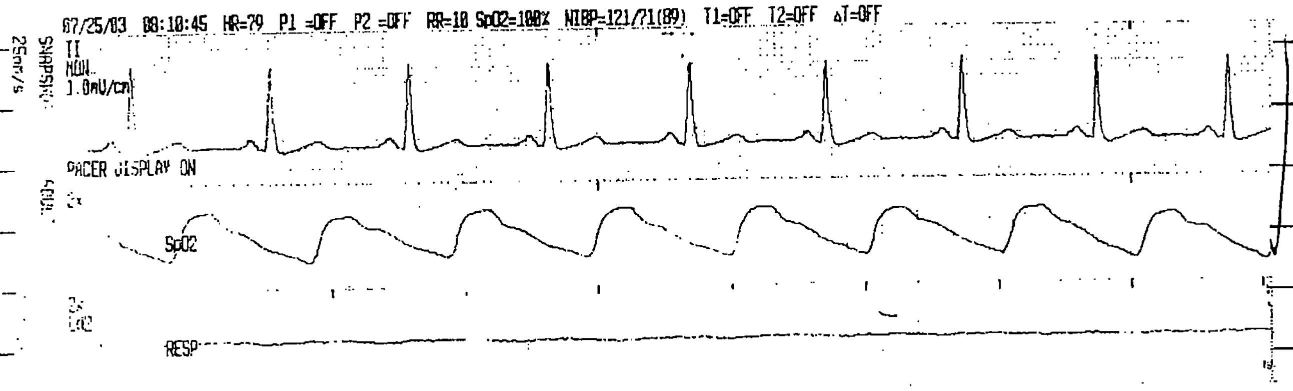
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July	0215		LATE NOTE: PT WEANED from 4L O2 to 3L @ 0300
			Pre weaning sats = 99-100% RR 20-21 BPM. Post
			weaning sats 98% RR 22 BPM. 0400 Pt weaned from
			3L to 2L NC ē sats remaining @ 98% RR @ 22.
			Will continue to monitor ~~and recommend weaning to day shift~~ (b)(6)-2 CPT
25 July	0630		assumed care of pt. Report given by CPT (b)(6)-2 AN
			Pt in bed ē HOB ↑ 30° angle. IV infusing @
			50cc/hr of LR. VS WNL will monitor ——
			—— (b)(6)-2 91W20M6
25 July03	0730		Dr. (b)(6)-2 at bedside Δ'd dressing to abd. remov
			JP drain. Intial assessment complete:
			Neuro: pt easily arousable; pupils 2mm Pearl
			Alert, able to move all extremities.
			Resp: RR 25 SAO2 99% on 2L O2 via NC. LS-Crackles
			heard throughout inspiratory/expiratory halations
			Pt coughs up thick yellow sputum —
			Skin: Warm ē dry color: Normal for Race. Abd drsg
			Δ'd by Dr. (b)(6)-2 this Am. JP drain removed
			Tegaderm on upper back intact. ~~W~~ (b)(6)-2 wet to dry
			drsg to coccyx intact will Δ ē Am care.
			Gastro: NGT ⊕ placement ē 50cc of residual
			flush s̄ difficulty, Jevity plus infusing @ 80cc hr
			at this time. Pt seems to tolerate feedings well
			⊕ BS x 4 quad. Abd soft non distended ——
			GU - Foley → gravity draining drk. yellow urine
			Cardiac: NSR HR 80's ⊕ peripheral pulse x 3
			unable to asses Ⓛ radial/brachial d/T cast. →

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July	0730		cont ~~pt~~ able to wiggle finger s̄ difficulty,
			gd. capillary ~~R~~efill. See rythm strip


07/25/03 08:10:45 HR=79 P1 =OFF P2 =OFF RR=10 SpO2=100% NIBP=121/71(89) T1=OFF T2=OFF ΔT=OFF
25mm/s
SNAPSHOT
II
NOM
1.0mV/cm
PACER DISPLAY ON
SpO2
RESP

			Plan: Pt OOB → Chair, Ambulate Pt, DBC
			and incentive spirometer (b)(6)-2 SGT USA
25 Jul 03	0900		Residual 10cc ↑'d Jevity feedings to
			60cc/hr. Am care done. Pt oob → chair
			Ineffective deep breath c̄ cough c̄ Incentive
			spirometer 600mL 2 1sec. Pt able to
			produce thick yellow sputum will
			continue to monitor (b)(6)-2 SGT USA 91WM
25 Jul 03	1030		Pt ambulated 50ft maintain SaO2 of
			98-100% on 2L O2 via NC. PT → BTB
			HOB ↑, Pt position on side will monitor
			(b)(6)-2 SGT USA 91W2
25 Jul 03	1100		50cc of residual, jevity @ 60cc/hr pt
			in bed resting appears comfortable will
			monitor (b)(6)-2 SGT USA 91WM
	1200		SaO2 ↓ 84% O2 ↑ 4L/m encourage to take
			deep breath SaO2 ↑ 98-100%. Pt position
			on back c̄ HOB ↑ 30% cye (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

91wme

MEDCOM - 6544

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July 03		1400	Dr (b)(6)-2 at bedside c̄ pt c̄ translator
			discussing PO intake. Diet advance to
			clear liquids. Drsg to coccyx Δ'd
			Cleanse c̄ NS c̄ stoma wafer applied
			pt on side ~~will~~ monitor ——
			—— (b)(6)-2 SGT USA 91W M6
		1442	Late note: 1300 MSO4 2mg given IVP for pain
			c̄ gd effect ~~pt resting~~ comfortable ——
			—— (b)(6)-2 SGT USA 91W M6
		1600	Dr (b)(6)-2 at bedside to do drsg Δ
			MSO4 2mg IVP given for pain. patient on
			Ⓛ side. Jevity ↑ to 90cc/hr @ 1500
			pt tolerates well. will continue to
			monitor—— (b)(6)-2 SGT USA 91W20M6
		1730	Report given to Cpt (b)(6)-2, AN ——
			—— (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)*

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 6545

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July	—	1800	Assumed care of pt from SGT (b)(6)-2. Pt in bed
			awake, alert oriented, ~~supine~~ error (b)(6)-2 lying on Ⓛ side
			O2 per NC @ 2.5L Sat 98% RR ~20 BPM
			Ø evidence resp distress. NGT to Ⓡ nare
			infusing Jevity @ 90 cc/hr w/out evidence
			of N/V or abd discomfort. Abd dressing
			to midline incision CDI. LR infusing @ 50
			cc/hr to Ⓡ AC 18g PIV placed 23 July 03
			Ø evidence infiltration ⊕ redness noted
			to insertion site. D/c of PIV and reestablish
			new one - pending. Ⓛ arm cast intact
			CD: (b)(6)-2
		1815	Pt care assumed by SGT (b)(6)-2, CPT (b)(6)-2 off ward
			for staff meeting. (b)(6)-2
		1900	Reassumed care of pt. Pt remains on
			Ⓛ side. Quiet, calm ⊖ evidence of discomfort
			Physical Assessment:
			Neuro: as above. Responds appropriately
			to simple commands, gestures needs appropriate.
		Pupils	3mm/3mm - PERLA. Moves all extremities
			purposefully. good muscle strength all
			ext. c̄ ↓ strength to Ⓛ arm. ⊕ sensation
		Resp:	Lungs clear; ↓ bilateral lower lobes. Sats 98-99.
			RR 20-22 BPM (Continue on reverse side) O2 @ 2.5 L via NC

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

(b)(6)-4

REG (b)(3)-1

WARD NO. ICU

NURSING NOTES
Medical Record

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

MEDCOM - 6546

NURSING NOTES

(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
25 July 2003	Cont	1800	NSG: (Resp) ⊕ productive cough, small amt
			of white thick sputum. (b)(6)-2 ———
		CV:	NSR, HR ~80-90 BPM, BP ~100-115/50-60's ~.
			Cap refill to all digits u/L ext. ≤3sec. pedal
			pulses strong @ 2+ Bilat, Ⓡ radial 1+ weak,
			unable to assess Ⓛ pulse r/t cast material.
			⊖ JVD. ⊕ 1+ edema to ankles ———
		GI	Dressing to abd incision intact, ø drainage
			noted. Abd soft, Tender on palpation, ⓒ guarding
			ē movement from sitting to lying ē vice
			versa. ⊕ BS x4 q. NGT ~~Ⓡ nare 90cc Jevity infusing~~.
		GU:	Foley to gravity light yellow urine
			out >150cc/h. ø discharge (purulent)
			from meatus. ⊖ swelling @ this time
		MS:	As stated in CV section. Pt pending OOB-chair
		Skin:	Warm to touch, pale, poor skin turgor.
		IV:	18g PIV to Ⓡ AC pending Δ this evening
			⊖ evidence infiltration ⊖ redness —
			⊖ warmth ⊖ tenderness, ⊖ purulent
			d/c. ———
		Plan:	Monitor Resp/cardiac status. Maintain ✓
			on I/O's ē O's, Abd. drainage. Encourage
			PO intake of H₂O, include jello, con't
			Jevity - ↑ Rate to target rate 110cc/h.
			✓ Residuals q 2°, Maintain IVF's LR
			@ 50cc/hr. Δ PIV site, D/C old site.
			Encourage ambulation, escort outdoors

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

510–112 NSN 7540–00–634–412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS
	A.M.	P.M.	Include medication and treatment when indicated
25 July (cont N56)			1900: Encourage IS, slow deep breathing
			and coughing. Maintain duoderm to coccyx
			keep off back and buttocks as much as
			possible. Provide emotional support, self care
			and comfort measures —— (b)(6)-2
		1940	: MSO4 2mg IV for c/o abd pain. ④ Incentive
			spirometer, 9 breaths @ 1200 cc/sec. Pt prepped
			for excursion outside. MSO4 2mg IV administered
			Pt assisted OOB to chair, pt stands c̄
			assist, encouraged to ambulate, ⊕ walking
			10 slow, calculated steps. Pt assisted
			to litter. IV HL'd, O2 per NC and portable
			tank. NGT clamped. Padding, sheets placed
			on litter. Pt secured HOB @ 45°. ∅ complaints
			of pain or discomfort. Pt assisted outdoors
			x 45 minutes, accompanied by 3 staff members
		2050	Pt returns to ward, placed in bed, O2 @ 2.5
			IVF's → 50cc/h - LR; NGT cont @ 90cc/hr
			Pt tol 250 cc H2O and 4 oz Jello prior to trip
			outside. Consumes 250cc H2O on arrival to ward.
			∅ c/o N/V. Pt posted on Ⓡ side off decub. — (b)(6)-2
		2130	. PIV placed 18g to Ⓡ wrist per zhT (b)(6)-2
			. Old PIV d/c'd - IVF's cont @ 50cc/h — (b)(6)-2
		2200	Heparin SQ 5000u administered per order

(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

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
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MEDCOM - 6548

(b)(6)-4

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
15 July 03		2200	Zantac infused over 15', Cipro follows for infusion to run over 30 min. PIV intact — (b)(6)-2
26 July		2400	Pt sleeping on (L) side. VS stable, breath sounds clear. Pt appears comfortable — (b)(6)-2
			LATE NOTE: Pt c/o sore throat — (+) redness to adenoids. Cepacol lozenge PO administered c̄ little Δ. — (b)(6)-2
		0140	Pt awake intermittently throughout shift. Repositioning onto (L) side and ↓ light on ward, ↑ pt's ability to sleep. Will cont. to monitor (b)(6)-2
		0420	Pt awake, denies pain; H_2O refuses; appear tired, saddened — (b)(6)-2
26 July 2003		1545	Report on pt given to oncoming shift. Pt resting w/o evidence of discomfort. Pt care responsibilities to be passed to oncoming shift @ 0600 AM — (b)(6)-2

510–112 NSN 7540–00–634–4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Jul 03	0600		Assumed care of pt. Reid report from Cpt (b)(6)-2 Pt in bed c̄ HOB ↑ 30° angle IV infusing LR @ 50cc/hr. Zantac infusing' Jevity infusing at 110cc/hr. Pt appears to be comfortable. —— (b)(6)-2 SGT USA 91WM
	0700		Pt on bedside commode am care given. Pt had a Med formed brown stool. IV site Heplocked per order, unable to flush, New site 18g Heplock to Ⓡ forearm flushes s̄ difficulty. Pt walk c̄ assistant outside about 200 ft maintain SAO2 @ 98% on 2L O2 via NC Pt BTB resting at this time —— (b)(6)-2 SGT USA 91Wm
	0800		Dr (b)(6)-2 at bedside to do drsg. Δ on Abd. MSO4 2mg IVP given for pain. Intial Assessment complete: Neuro: Pt alert, awake, able to follow commands. Pupil 2mm Pearl, Move all extremities. —— Resp. RR 22 SAO2 98% on 2L via NC. LS crackles heard. IS 600mL > 1sec x 4 Pt able to produce thick yellow Sputum. 0830 SAO2 95% on Room air. Ø SOB

(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.

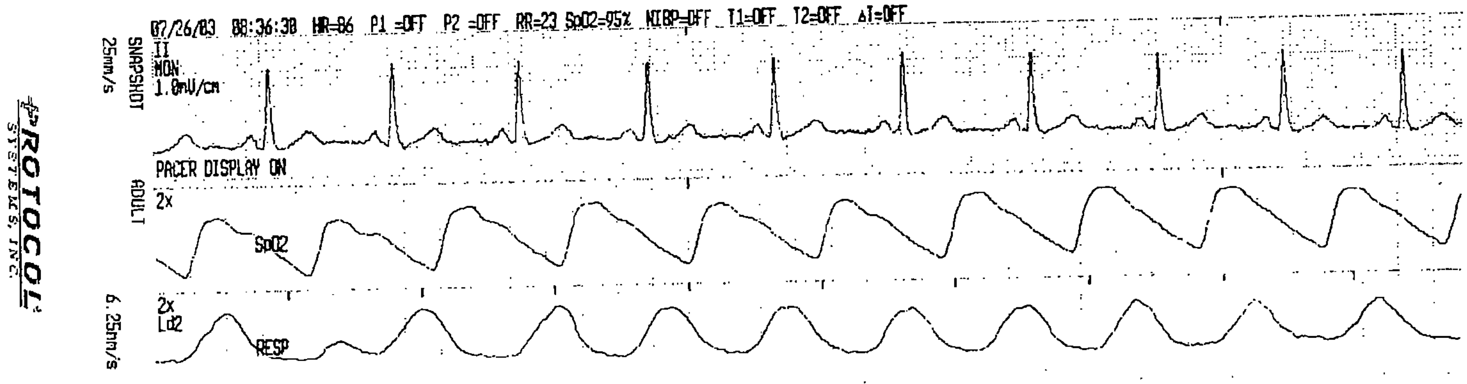
NURSING NOTES
Medical Record

MEDCOM - 6550

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0800		cont' skin: warm and dry to touch. Dr (b)(6)-2
			in to do Abd. drsg. drsg to upper back clean c̄
			intact. drsg on stage II decub. coccyx Δ'd
			IV: Heplock 18g to (R) forearm
			Gastro: NGT (+) placement c̄ 10cc residual
			flushes s̄ difficulty. Jevity infusing @ 110cc/hr
			Pt ate sm amt of breakfast this am
			tolerated well. BS x4 quads med brown
			formed stool this AM.
			GU: foley to gravity draining 300cc of
			urine. Foley d/c'd this AM, pt has
			not voide at this time.
			Cardiac NSR HR 80's + peripheral
			pulses able to move all extremities
			gd cap refill. slight edoma noted to lower
			extremitres. See rhythm strip.



			Will continue to monitor
			(b)(6)-2 SGT USA 91WM6

510–112 NSN 7540–00–634–4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26Jul03	1000		Pt in bed resting at present time
	NSG		SpO2 maintain 95% on RA. IS 800 1scc.
			Produces sputum, thick yellow. Will cont'
			to monitor —— (b)(6)-2
	1100		SGT (b)(6)-2 ortho tech in to remove
			cast. Pt OOB → chair. Pt walk 25Ft
			maintain SpO2 95%T on RA. X-Ray
			to Ⓛ elbow. ortho reapplied a splint
			to Ⓛ arm. Pt BTB position on Ⓡ
			side appears comfortable ——
			—— (b)(6)-2 SGT USA 91WM6
	1145		Rt in to do chest Pt c̄ pt
			—— (b)(6)-2 SGT USA 91WM6
26 July 03			HHN Tx given c̄ 0.5 Albuterol/2.5 NS. BBS for
1200			↓↓'d to RLL c̄ Rhonchi throughout. HR 102
Resp Therapy			RR 26 O_2SAT on R.A. 96%. p̄ Tx VS stable. CPT
			performed to RLL x 6 mins. Pt c̄ productive cough
			during CPT for moderate amount thick white secretions.
			p̄ Tx BBS for ↓↓ RLL c̄ Rhonchi to LLL, clear to apical
			regions. NAR —— (b)(6)-2
		1300	Pt c/o pain to abd. MSO4 2mg give IVP
			pt appears comfortable will monitor
			—— (b)(6)-2 SGT USA 91WM6

(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

NURSING NOTES
Medical Record

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

MEDCOM - 6552

NURSING NOTES

(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
		1600	Pt in bed, on side, able to produce thick white sputum. Ø complaints of pain at this time. Residual 10cc ⊕ placement verified by air bolus. will monitor — (b)(6)-2 SGT USA 91WM6
26 July 03 1600 Resp Therapy			CPT performed to RLL c̄ patient in lateral declined position. HR 96 O2SAT on R.A. 96% RR 26, BBS for ↓'d to bases but clear. Pt c̄ ⊖ cough during CPT. C/o Pain to abdomen NAR — (b)(6)-2 CRT
		1655	Pt in bed appears comfortable, able to reposition self c̄ minimal assistance IS 900mL for 1sec. Pt coughs & produces thick white sputum. Pt denies pain at this time — (b)(6)-2 SGT USA 91W20 M6
		1715	Pt nibbled at dinner tray ate ½ apple c̄ a few bites of main meal. Seem to tolerate well. Pt able to void × 3 p̄ foley been removed. will monitor — (b)(6)-2 SGT USA 91WM6
		1850	Pt in Bed c̄ HOB ↑ 45° angle pt appear comfortable will report to oncoming shift — (b)(6)-2 SGT USA 91WM6

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26JUL03		1815	Received report assumed care of pt ē 1800. Pt awake,
			alert oriented x3 lying on Ⓛ side in bed. NS infusing
			@ 20 cc/hr to 18 g to Ⓡ PIV placed 26 July 03.
			Ø evidence of infiltration. O2 per RA, Sat 98
			RR ~22, Ø evidence Resp distress. ⊕ NSR, HR ~
			BP WNL. NI cont cardiac monitoring in place. ⊕ splint
			to Ⓛ arm, moves all fingers, ⊕ sensation, normal
			skin color, cap refill ≤3 sec. ⊕ ↓ strength.
			⊕ Abd dressing CDI, Urinal @ BS. No evidence of dist
			@ this time (b)(6)-2
		1845+	Pt OOB to chair ē assist. ⊕ BM - mod, well
		2000	formed, voiding 250 clear yellow. error (b)(6)-2 ~~[illegible]~~
		(	NS held, PIV SL'd. TF held. Pt assisted outside
			ambulating 3/4 way around hospital. Returned to ward,
			sacral decubitus care provided-washed w/NS, dried,
			skin protective barrier from ostomy pouch placed over
			wound; Reinforced with tape. Upper back ulcer
			redressed ē tegaderm. See physical assessment for
			ulcer description. Pt returned to bed, placed
			on Ⓛ side, NS restarted @ 20cc/hr. TF restarted
			at 110cc target rate. Pt appears tired, allowed
			to rest (b)(6)-2
		Late	Note: Physical Assessment

(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.

NURSING NOTES
Medical Record

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

MEDCOM - 6554

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2d July 2003		1820	Physical Assessment:
2		—	Neuro: Alert, oriented x 3, flat affect, sad looking.
			Pupils: 3mm-3mm PEARLA; ⊕ redness to adenoids,
			pt c/o sore throat. Cepacol lozenges ē AS –
			pt given one @ time of assessment. ⊕ movement
			spontaneously of all extremities, good sensation
			Resp: O_2 per RA. SaO_2 ~98% RR 22-28 BPM. ⊕ crackles
			upper right/middle lobes; diminish Ⓡ base;
			⊕ crackles upper Ⓛ lobe c̄ fine exp. crackles to
			base. ⊕ intermittent cough w/ sm and thick
			clear-white sputum production.
			Cardiovascular: NSR HR: 90's – low 100's BP:
			140 systolically 50-60's diastolically; ⊖ JVD, ⊖ SOB c̄ rest
			∅ c/o chest pain, ⊖ palpitations. 1+ edema Bilat ankles.
			(dry skin color normal for race) Cap refill ≤3sec. c̄/4
			up-low ext.
			Intestinal: ⊕ ABD incision dressed heavily c̄ gauze
			dressing CDI, ⊕ BS x 4 q. ⊖ abd distention ⊕ tenderness
			on palpation. NGT Ⓛ N c̄ Jevity infusing @ 110cc/hr
			Residuals < 10cc/hr. (b)(6)-2
			to 1 solids c̄ liquids. (b)(6)-2
			GU: pt urinating via urinal good vol. clear yellow
			MS: Ambulates w/assist. ⊕ steady gait Ⓛ upper
			ext. c̄ ↓ strength.
			Skin slightly jaundiced; warm to touch. 2cm x 1cm
			2° decubitus to T2-T6 on back. ⊕ skin breakdown
			to sacral area – Ⓛ buttock ≤8cm x 3cm decub. –

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

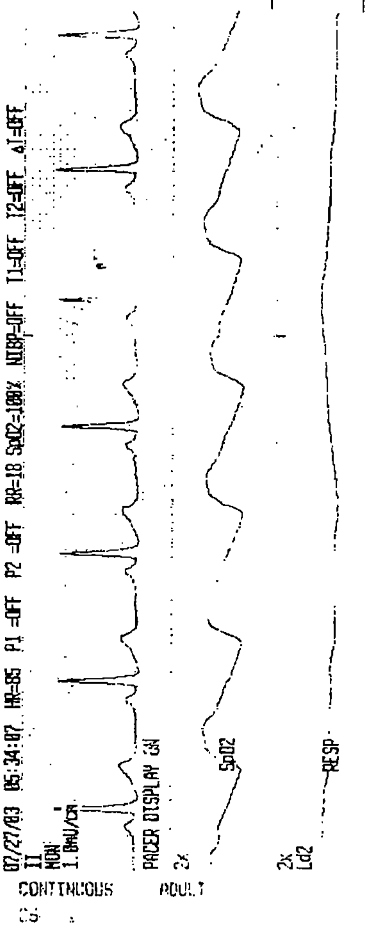
STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6555

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)


07/27/03 05:34:07 HR=85 P1 =OFF P2 =OFF RR=18 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/CM
PACER DISPLAY ON
2x
SpO2
2X
Ld2
RESP
CONTINUOUS
ADULT

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 July 2003	1820		Physical Assessment (Neg cont); ——
			necrotic inner aspect c̄ reddness c̄ periphery Ⓡ buttock
			3"x4" stage 2° decubitus. Wnd care performed as
			described earlier, STAGE 1 decub to heels Bilat Maintain c̄
		lines:	18g Ⓡ FA NS c̄ 20cc/h ⊖ evidence infiltration
			Plan: Monitor respiratory/cardiac status. Chest pt, IS
			deep slow Breathing, ambulation, coughing. Encourage
			PO solid & liquid intake, continue tube feeds c̄
			110 cc/h = target rate cont. residual V's.
			Encourage side-lying - off of decubitus; encourage
			self care; provide distraction/many resources - i.e.
			magazines, TV in PLX to promote emotional health.
			—— (b)(6)-2
		530:	PT (b)(6)-2 c̄ BS for CPT. ⊕ productive
			cough c̄ small amt of clear sputum production
			—— (b)(6)-2
		100	IS x 5 @ 900cc/sec. Pt appears tired. —— (b)(6)-2
		30:	Dr. (b)(6)-2 c̄ BS performing dressing Δ to
			abd. MSO4 IV 2mg administered pre dressing Δ (b)(6)-2
		300	PIV infiltrated. 22g placed to Ⓡ AC, NS
			TKO c̄ 20cc/h. —— (b)(6)-2
		0100:	Pt awake lying in bed, denies pain, Ref PO fluid
			intake ⊕ UOP clear yellow - 400cc's. O2 per NC @ 1L to ↓ RR 30
		0315:	Pt resting. VS STABLE, SaO2 98% RR 22-24 BPM

(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. ICU

NURSING NOTES
Medical Record

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

MEDCOM - 6556

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003	←	0535	Pt sleeping quietly. NS infusing TKO @ 20cc/h.
			TFeedings contin @ 110 cc/hr. HOB @ 35°. Pt appears comfortable
			Ø evidence of resp difficulties. —— (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6557

110 12/20 2 01 [illegible]

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27Jul03	0000		Assumed care of pt. Rcvd report from Cpt (b)(6)-2 AN. Pt in bed appear to be sleeping. ~~LR~~ NS D5 @ 20cc/hr, Zantac infusing NAD at this time —— (b)(6)-2 91WM
	0630		Pt in bed Intial assessment done: Neuro: easily arrousable, Alert moves all extremities. denies pain. Resp: RR 26 SaO2 100% on 2L O2 via NC LS: Ⓡ crackles. Productive cough, c̄ clear, thick white sputum. Skin: color normal for Race, skin warm and dry, Drsg to Abd CDI, Tegaderm to Mid back intact, drs to coccyx intact. AM care done at bedside, c̄ minimal assistance. IV - 22g IV patent flushes s̄ difficulty infusing NS @ KVO. Ø S/s infiltration present tin Gastro- Abd Soft Pt had large soft brown stool this am. ⊕ BS x4 quads. NGT ⊕ placement 140cc Residual Jevity stopped. Ate little at breakfast. 240cc PO Liquid. GU. Pt able to void → urinal s̄ difficulty urine clear yellow 400cc this Am

(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

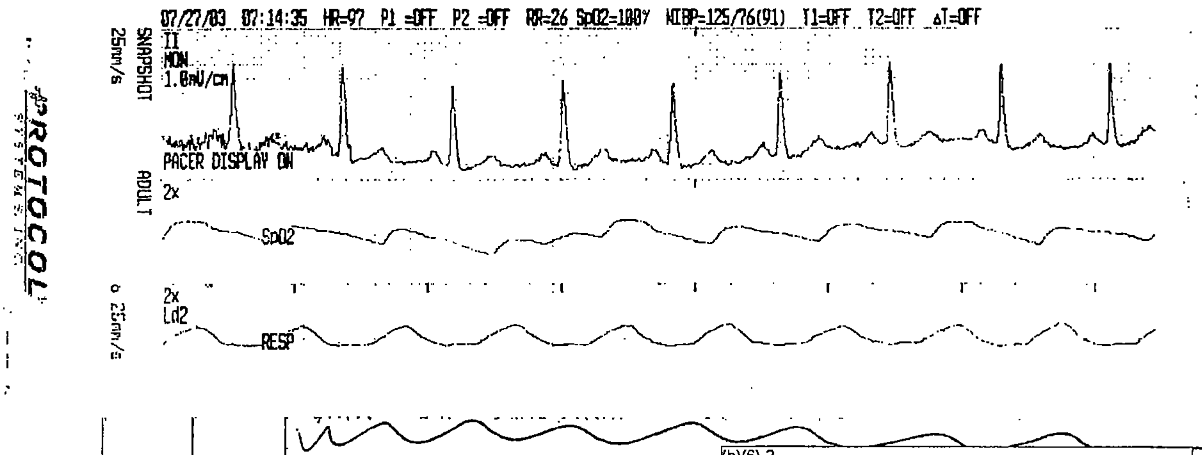
NURSING NOTES
Medical Record

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

MEDCOM - 6558

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 03	0630		cont Cardiac: NSR ⊕ peripheral pulse
			⊕ sensation to all extremities. HR 84
			See rythm strip ←


07/27/03 07:14:35 HR=97 P1 =OFF P2 =OFF RR=26 SpO2=100% NIBP=125/76(91) T1=OFF T2=OFF ΔT=OFF
SNAPSHOT
25mm/s
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
2x
SpO2
2x
Ld2
RESP
25mm/s
PROTOCOL SYSTEMS INC

			will monitor — (b)(6)-2 SGT
27 July 03			
0800			HHN Tx given c̄ 0.5 Albuterol/2.5 NS. BBS for
Resp Therapy			↓'d bases c̄ Rhonchi and Exp wheeze Ⓛ lung segments.
			HR 97 O2 SAT on 2L/Min NC 100% RR 22. CPT performed
			to RLL x 5 mins c̄ Pt in lateral recumbent. P̄Tx BBS for
			↓'d bases but clear. Pt c̄ ⊖ cough. Performed IS c̄
			Nurse for 1200 cc/sec x 10. HR 94 RR 24 O2 SAT on 2L/min NC
			@ 100%. NAR — (b)(6)-2 CRT
	0830		NGT ⊕ placement 20cc residual ē levity
			infusing @ 110cc/hr. Pt was OOB and
			ambulated: 50 ft s̄ difficulty maintain
			SAO2 ≥ 92% on RA. IS done in charge
			1200cc/sec x10 pt tolerated well, pt
			BTB - RT performed chest pt, appears
			Comfortable — (b)(6)-2 SGT

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 03	1010		0930 Dr. (b)(6)-2 at bedside to Δ abd drsg. Pt OOB → chair. Pt had a Lg Loose formed Brown BM. IV to Ⓡ forearm infiltrated: new IV site 20g Ⓡ underside of fore arm. unable to flush. New site to Ⓡ Hand ⊕ flash s̄ difficulty. Cipro infusing s̄ difficulty IV site ∅ s/s Infiltration Pt BTB appears comfortable will monitor —— (b)(6)-2
		1200	Cipro leaking @ IV site. IV site Heplocked. ~~New~~ Changed orders PO Cipro 500mg q 12°, Δ Fluconazole 100mg PO qd and Δ Zantac 150mg PO Per Dr. (b)(6)-2 Pt ↑ on commode Had a loose formed brown stool. Pt able to take PO med s̄ difficulty. Pt BTB, Pt refused Chest Pt V.S. 118/68 P 89 R 21 SaO_2 100% on RA LS clear Bilat ↓ in Bases. Pt refused lunch. 1230 Pt in bed at present time appears comfortable. ∅ complaints at this time —— (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)*

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 6560

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 04		1400	Pt c/o pain in abd unable to flush IV
			New order PO Percocet i - ii q 4-6 prn for pain
			Pt recieve ii PO Percocet for pain c gd
			effect. 1430 - Pt looks "sad" ask
			how he was feeling via translator
			State that he is sad. Pt OOB Ambulate
			to PLX corridor O2 sats remain > 95%
			on RA. PT BTB. 1500 Pt OOB sitting
			in chair drinking tea, looks sad. Tolerated
			Po fluid. NAD at this time
			(b)(6)-2 SGT USA 91WM6
		1600	family member in at bedside. Dr. (b)(6)-2
			in c translator to explain injuries
			New order D/C Gentamicin. Pt sitting
			in chair visiting family member NAD
			at this time (b)(6)-2 SGT USA 91WM6
		1630	Pt ↑ in chair c family member Chest PT
			Refused VS. 137/80, 94, 22, SAO2 100% on RA
			LS Clear on (L) side, slight Rhonci on (R)
			↑ base LS. IS 1200mL/sec x10 NAD at
			this time (b)(6)-2 SGT, USA 91WM6
		1730	Pt appetite ↑ ate chicken, potatoe c some
			corn. family member c pt. Pt tolerate meal
			well. SAO2 remains 100% on RA
			(b)(6)-2 SGT USA 91WM6
	CC		

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6561

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul03		1800	Pt on commode. Had sm loose formed stool. Pt BTB. ⊕ placement on NGT c̄ ∅ residual at this time. VS $^{135}/_{75}$ - 91 - 19 Sat O2 99% - 100% this shift. Jevity infusing @ 110cc/hr Report given to oncoming shift ——— (b)(6)-2 SGT

(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

NURSING NOTES

Medical Record

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

MEDCOM - 6562

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003			I/O's cont to monitor. ∅ edema to groin, scrotum. —
			MS: Pt strength good in all extremities ↓ to Ⓛ
UOP: 2000	375	clear yellow	arm. Pt requires assist on ambulation, ambulating
NIBP 123/78			outside pending.
98			Skin: Normal for race. Abd incision mentioned
100% SaO2			in Glasses. Skin turgor normal for pt. age.
24 RR			⊕ decubitus to sacral area, dressed c̄ ostomy skin
			protective barrier. ⊕ decub to T6-T7 back
			covered c̄ tegaderm.
			∅ PIV:
			- Plan: Cont cardiac resp monitoring
			- Encourage IS; cont CPT, deep ~~coughing~~ breathing (error (b)(6)-2
			coughing; ambulate amap
2000 - ambulate			- Promote good pain control c̄ Percocet and
s/p 47% SaO2			abd clutching on exertion.
107			- Encourage PO fluids to include milkshake.
28-30 RR			and PO solid intake. Cont Tube feedings
			✓ residuals. Monitor for BM, flatus, abd
			distention.
			- Monitor decubitus ulcer status - encouraging
			side lying while in bed, cont use of
			Alpha Fleece Bed pads, ↓ friction shear while
			in bed.
			- NHO of sorethroat, ↑ redness and complaint
			c̄ swallowing —— (b)(6)-2 CPT

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

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
17 July 2003		1815	Assume care of pt s/p receipt of report from Sgt (b)(6)-2 Pt supine
			in bed HOB @ 75°, awake, alert and oriented x3. Pt smiling, in
BP: 135/76 HR 95			good spirits. NGT to (L) nare intact, in place, Jevity
RR: 21 SaO2 100%			infusing @ 110 cc/h. Placement ✓ performed, (+) results.
			O2 per RA SaO2 100% RR 20-24 brm evidence
			resp discomfort. Abd drsg in place C D I. (L) arm
			cast-splint in place, intact. Complete physical assess-
1900:			ment to follow. Plan of care discussed via
			translator, pt questions answered.
			Physical Assessment:
1900 15 x 5	OOB	chair	Neuro: awake alert oriented x3, spontaneous movement
			(+) sensation to all extremities.
			Resp: lung sounds clear throughout, diminished bases
1915: Milkshake		240	bilaterally. RR/SaO2 WNP, as noted on form 511-119.
H2O	120		IS @ BS, CPT q4° - 2000: O2 per RA will supplement PRN
			CV: NSR; HR ~94. BP WNP. Bilat pedal pulses strong
			ē 2+ cap refill good @ ≤3 sec. (R) radial pulse
1934 Percocet i PO			1+, weak - (L) radial 2+, palpable. 1+ Edema to BLE.
			GI: (+) Midline abd. incision dressed ē [illegible] sponge - CDI
			(+) BS q4Q. (+) abd tenderness on palpation, Percocet i PO
			administered as per order. Eval pending. NGT in
			place ē Jevity cont. TF inf @ 110 cc/h. 1800 Residual
			V = 0 out, (-) abd distention
			GU: Urinal @ BS. good u/o on previous shift

(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.

NURSING NOTES

Medical Record

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003		2030	Pt c/c sore throat. Previous administration of cepacol
			lozenge @ 1830 ∅ work. Hurricane spray x 2 sprays
			administered c̄ relief indicated s/p administration
			——— (b)(6)-2
PLX -		2045	Pt assisted to PLX - ambulating, ⊕ Television
Milkshake	240cc		watching, 240 cc milkshake consumed, few peanuts
			and 2-3 tbsps pudding tolerated. Pt returns to ward
			in chair x ½ hr. No complaints needs. Oral care
			performed, pm hygiene complete. Pt assisted back
			to bed. ⊕ Ⓡ side lying. Pt presently resting — (b)(6)-2
		2200	Dr (b)(6)-2 c̄ BS performing ABD dressing
			A. ~~Heavy~~ Strong (b)(6)-2 coughing dislodged NGT, ~~partially~~ Replacement held per rec. (b)(6)-2
UOP - 250		2300	UOP - 250 cc clear yellow, Pt to chair. ⊕ 240cc
ORAL: Milkshake			intake Milkshake, 120cc H_2O and 2 oz. rice. ⊖ c/o
250			N/V. Pt returned to bed and rest ——— (b)(6)-2
H_2O: 120		0100	Pt sleeping. VS STABLE ——— will cont. to monitor (b)(6)-2
Rice: 2oz		0215	UOP 400 cc clear yellow urine to urinal.
			No Δ's in pt status ——— (b)(6)-2
		0315	Pt OOB to BSC. BM x1 - moderate amt of soft
			brown stool.
			LATE NOTE: BM x1 large dark brown, soft
			@ 0015. ——— (b)(6)-2
		0515.	Pt OOB to BSC. BM, UOP x1 moderate amt of brown,
			soft stool out - Attempt to place NGT failed

(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 (b)(6)-4		ICU

NURSING NOTES

Medical Record

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

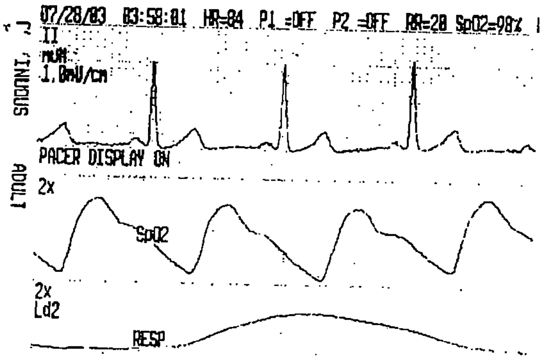
MEDCOM - 6565

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
28 July		0515	Dr (b)(6)-2 Ⓒ BS, aware of NGT status
			VO given to discontinue insertion. Calorie
			count strict to begin —— (b)(6)-2
Jevity 120cc c̄		0345	; Intake as noted Ⓞ side = 480cc. Pt aware
Milk 120cc			of need to ↑ PO intake —— (b)(6)-2
1 packet instant breakfast			0600 ; Report given and pt care
			assumed by SGT (b)(6)-2
Jevity 240cc		PO	
28 July		0600	Assumed care of Pt. Rcvd Report
NSG Note			from CPT (b)(6)-2 AW. Pt in bed on
			Ⓛ side appears to be sleeping
			VS, 105/51, 88, 22, 97.7 SaO2 95% on
			RA. Appears Comfortable. Plan:
			strict Calorie count, for PO intake
			—— (b)(6)-2
28 July03	0800		CPT Not performed. Pt up in chair bathing
Resp Therapy			BBS for ↓ bases but fairly clear. HR 92
			RR 22 O2SAT 96% on R.A. —— (b)(6)-2 CRT
28 July	0845		CPT performed to RLL x10 mins. BBS for
Resp Therapy			↓ bases c̄ scattered Rhonchi. HR 89 O2SAT R.A. 96
			RR 22, p̄ Tx BS for ↑'d in bases c̄ crackles,
			NAR —— (b)(6)-2 CRT
28 July		0900	~~Oo~~ Ⓞ late entry - 0730 Pt OOB → chair-
			ate breakfast, and perform am
			care c̄ minimal assistance. Pt
			had small loose formed Brown stool
			Initial assessment complete (b)(6)-2

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

afwmc


07/28/03 03:58:01 HR=84 P1 =OFF P2 =OFF RR=28 SpO2=98%
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
2x
SpO2
2x
Ld2
RESP

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
28 July	0950		Dr. (b)(6)-2 at bedside to Δ drsg to Abd. Abd. incision open tissue red c̄ sm. amout of white tissue noted. Wet → Dry drsg applied. Entry wound to Ⓛ lower abd. 2 staples put in at bedside total of three at entry wound. 3 staples removed from wounds @ entry wound. Ø s/s of infection or redness @ wounds Gauze drsg. applied. Pt denies pain at this time. will monitor (b)(6)-2 SGT USA 91WM6
	1030		Pt ↑ Ambulated to PIX corridor sat in chair for ½ hour Ambulate back to ICU O_2 sat maintain > 95% on RA BTB - AM meds taken s̄ difficulty will monitor — (b)(6)-2 SGT USA 91WM6
	1140		~~B~~ Pt OOB → chair eating lunch at present time. NAD at this time (b)(6)-2 SGT 91WM6
28 July 03 Resp Therapy	1200		CPT not performed. Pt sitting in chair in PIX. Pt Ambulated x 5 mins. HR 100 O_2 SAT on R.A. 98% RR 20. BBS for ↓'d to bases but clear — (b)(6)-2
	1220		~~Pt~~ c/o upset stomach New order 30cc Maalox given per oder. Pt ambulat to PIX corridor to watch TV. will monitor SaO_2 98% RA (b)(6)-2 SGT USA 91WM6

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

STANDARD FORM 510 (REV. 7-91) BACK

510–112 NSN 7540–00–634–41

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Jul03	1430		1330 Pt O_2 sat ↓ 92% on RA, RR ↑ 26
			O_2 2L via NC SAO2 ↑ 98%-100% ↓ RR 22
			Pt appear to be comfortable. in bed
			c̄ eyes closed — will monitor
			——— (b)(6)-2 SGT USA 91W
28July03	1600		CPT performed to RLL x 5 mins. BBS for ↓ to
Resp Therapy			bases but clear. HR 89 RR 24 O2 SAT on RA 97%
			P̄ tx BBS for ↑'d bs to lower lobe. O2 SAT on
			R.A. 97%. NAR ——— (b)(6)-2 CRT
28 Jul03	1655		Dr (b)(6)-2 in to do Rounds. Told
			Him about Pt upset stomach. Pt had
			Ø relief c̄ Maalox New orders: see DA
			Form 4256. -1730 Pt OOB on commode Pt
			BTB Drsg to coccyx removed. Wound
			has foul smell clean c̄ NS. Healthy
			red edge c̄ nacrotic tissue in center
			See by Dr (b)(6)-2 reccomended
			Dry sterile drsg and position Pt on
			side will monitor ———
			——— (b)(6)-2 SGT USA 91WM
	1730		SGT (b)(6)-2 Ortho Removed splint, ii Percocet
			for pain. Pt will back at 1800 to do
			physical therapy to Ⓛ arm. Will report

(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.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7–91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202

MEDCOM - 6569

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			to oncoming shift of status of
			Pt ——— (b)(6)-2 SGT US ammo
28 July 2003		1805	Received report on pt: Assumed care @ 1800 hrs. Pt
			supine in bed, awake alert oriented. PT @ BS performing
			physical therapy on Ⓛ arm. ⊕ Grimmacing, pt cooperative
1800 127/68 101			NIBP monitoring to Ⓡ Brachial. HR during therapy >120's
24 98%			BP 127/68 98% SaO2 39 RR. No evidence respiratory distress.
			Pt s/p percocet. SSG recommendation: cont. pronation &
			supination of wrist & elbow flexion ~~BID~~. 10-20x BID.
1900 ~~2000~~ 105/66 88			Physical Assessment:
30 RR 96%		-	Neuro: AAOx3, speaks in Arabic, knows few English words
			-speaks clearly & appropriately. Pupil Ⓡ 3mm / Ⓛ 3mm ⊕ PEARLA.
2000 100/54 87			Ø c/o pain; moves all extremities purposefully, spontaneously.
~~44~~ 96%		-	CV: NSR; VS q 4° WNL BP ~100's/60's HR 80-90's
			Ø chest pain, SOB, dyspnea. 2+ Radial/pedal pulses bilat.
2100			Cap refill <3 sec. R/L U/L Ext.; 1+ edema bilat ankles.
		-	Resp: Breath sounds clear throughout ē diminished Ⓛ base
2200 114/58 P: 92			bilaterally. O2 per NC RR ~20-25 sat 92%-98%
			⊖ accessory muscle use, good skin color — NFR.
			⊕ intermittent productive cough. dry/whitish, thick
			small amt of sputum product.
		-	GI: Abd dressing - midline intact, w/ glue
			Ø drainage. ⊕ BS x 4q. ⊖ abd distention, ⊖ abd
			discomfort on palpation.
		-	GU: VOC per urinal clear, yellow. I/O's being record
		-	MS: ⊕ Ⓛ Arm splint good movement, ROM ē PT
			earlier. ⊕ ~~sensation~~ movement all digits cap refill

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

STANDARD FORM 510 (REV. 7-91) BAC

MEDCOM - 6570

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 July 03			< 3 Sec.
		–	Skin – ⊕ decubitus to sacral area dressing in place
			⊕ small amt brownish drainage. Decubitus to T6-T7
			open to air 3cm in length 1.5cm width ⊖ drainage noted
		–	Plan: continue cardiac resp monitoring
		–	encourage ambulation / self care; keep off decubiti
		–	monitor intake solids and liquids –
		–	strict calorie ctn. encourage nutritious
		–	snacks – Breakfast drink c̄ milk, fresh/
			canned fruit and crackers. Request consult
			c̄ dietician.
		–	Monitor BM's and UOP. (b)(6)-2
28 July 2003		2100	Pt OOB to BR UOP = 350cc clear, yellow
			⊖ BM @ this time. Pt consuming PM meal
			c̄ 1 bite hamburger, 1/2 roll, ∅ potatoes,
			4 oz vanilla pudding, 95% MRE minestrone
			stew, 4 oz can mixed fruit; (error (b)(6)-2) ~~120~~ H_2O
			120cc – Breakfast drink c̄ milk c̄ 120cc [illegible]
			Pt returns to sleep (b)(6)-2
		2350	Pt sleeping on Ⓡ side, completely off decubitus, ∅ evidence
			discomfort or distress. VS stable (b)(6)-2
		2240	LATE NOTE: Dr (b)(6)-2 c̄ BS performing dressing Δ (b)(6)-2
			MAJOR (b)(6)-2 assisting
		0215	Pt OOB to BSC. ⊕ clear yellow UOP – 400 total

(Continued 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		

NURSING NOTES

Medical Record

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

MEDCOM - 6571

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			⊕ milkshake =1 Breakfast drink c̄ 240 cc milk.
			consumed 100%, 120 cc H_2O. PT c/o abd pain
			s/p milkshake. administered Percocet i̇ tab
			PO Eval Pending. Pt returns to sleep on Ⓡ sid
			off of sacral decubitus, ——— (b)(6)-2
			0530: Pt sleeping quietly VS STABLE BP 101/5
			79 HR RR 12 sat 95% ——— (b)(6)-2
29 July 03	0620		Rcv'd Report from CPT (b)(6)-2 AN, Assumed
			care of pt. Pt in bed appears to
			be sleep on Ⓡ side. VS 111/63-78-20
			SAO2 99% on RA T 96.7, NAD, appear
			comfortable at this time will
			monitor ——— (b)(6)-2 91W SGT USA
	0730		Pt OOB → commode had med ~~loose~~ formed
			stool. Pt in chair am care perform
			c̄ minimal assistance. Intial assessment
			complete. Neuro: alert, oriented
			able to move all extremities. denies
			pain at this time. Resp: RR 22
			SaO2 99% on RA. LS. Clear IS-
			1200cc/sec x10. Ø SOB, Resp. even, unlabored.
			Skin: Warm to touch. Stage II Decubidi on
			coccyx clean c̄ NS & drsg c̄ guaze
			stage I - on upper back clean c̄ NS
			Zinc oxide applied c̄ guaze drsg. Blister
			on heel drained c̄ sm. amt. of serousangious
			drainage clean c̄ NS guaze drsg applied →

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 July 03	0730		cont. Gastro: Abd. drsg clean, dry ē intact
intial assessment			/ abd. soft, non-distended (+) BS
			(x4) quad. Pt had med loose formed stool
			this AM, Pt Denies discomfort, nausea
			GU: Pt able to urinate s̄ difficulty
			urine clear yellow color. ——
			Cardiac. NSR HR 82 VS q 4° SaO2
			98% on RA. (+) peripheral pulse x4
			(+) color, sensation, ē movement
			to all extremities. DS NAD at
			this time. will monitor ——
			—— (b)(6)-2 SGT USA 91WM6
	1030		VSS, Pt resting on (L) side ē
			eyes closed. ∅ complaint voiced
			at this time — (b)(6)-2 SGT USA 91WM6
	1248		Pt OOB → chair ate a gd lunch
			tolerated well NAD at this time
			—— (b)(6)-2 SGT USA 91WM6
	1555		1530 Pt OOB - commode had lg
			form stool slight cramping but
			tolerable pt said. RTB on (R) side
			∅ complaints voiced. VS WNL ——
			—— (b)(6)-2 SGT USA 91WM6

(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

NURSING NOTES
Medical Record

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

MEDCOM - 6573

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 July 03		1730	Physical therapy in to do ROM
			to Ⓛ arm. Ortho removed c̄ reapply
			Splint. Pt. tolerate well.
			(b)(6)-2 SGT USA
		1745	Pt appear to be in pain c̄ physical
			therapy grimace c̄ moans but denies
			pain p̄ pt. MD d/c'd antibiotics will
			report to oncoming shift (b)(6)-2 SGT USA
29 July 2003		1845	Received report assumed care of pt @ 1800°. Pt in bed on Ⓛ
			side sleeping. O2 per RA, Ø IVF's, Ⓒ IV, Pt resting s̄
			evidence discomfort or distress. (b)(6)-2
BM x1 ⊕ UOP		1930	Pt OOB to Bathroom, ⊕ large ~~BM~~ error (b)(6)-2, brown soft stool c̄
			liq. app 200 cc's clear yellow. Pt ambulatory c̄/ou
Milkshake			assist in ward and to PX to watch television.
			Pt consumed 240cc milkshake (Breakfast - instant ch
⊕ JS-1 cc/sec			while watching television. Pt returned to ward
			and rest @ 2030°. No complaints, needs @ this time.
Dinner: consumed		2130	Pt oob to chair to consume evening meal.
½ cup chili c̄			⊖ c/o nausea, ⊖ vomiting. Pt remains oob x 4°. Pt
rice			watching ward activity. (b)(6)-2
½ cup "pasta		2245	Physical Assessment:
in Alfredo Sauce"			Neuro: A.A.O x3, ⊕ spontaneous movement, ⊕ sensation
½ roll			to all extremities. Pupils ⊕ PERRLA; 3mm/3mm.
4.5 oz canned fruit-			Speech appropriate. primary language arabic.
mixed			Resp: Lungs sounds clear throughout, chest movement
			Equal, symmetrical; RR 16-18 BPM SaO2 ~95%
⊕ Viscous lidocaine			on RA. ⊖ c/o dyspnea, SOB.

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE:

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Ex Lap Lt elbow ORIF

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition______
Tobacco____ppd X____yrs. Body Piercing______ Diabetes (Y) (N) ROM______ ASA/Motrin w/72 hrs (Y) (N)
ETOH______ Implants______ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures______ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

(b)(6)-4

VERIFICATIONS AT HOLDING AREA:

Emergency

! ID/Allergy Band
! H & P N/A
! NPO Since_____
~~! UHCG/LMP~~ N/A
! Consent/Blood Transfusion Signed/~~Witnessed~~/Dated N/A
~~! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon~~ N/A
~~! Contact Precautions~~ [✓ (Y)] (N)
~~! Family/Friend:~~ N/A

! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 6575

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 MAJ, AN 8 JUL 03 DATE

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

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

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

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

DATE: 8 JUL 03 TIME: 1245

REVERSE OF FORM 5179, JUN 91

MEDCOM - 6576

USAPA V1.0

MEDICAL RECORD

INTRAOPERA..VE .OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Stretcher BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2 AN (EMERGENCY)

3. DATE 8 JUL 03 TIME PATIENT ARRIVED IN SUITE 0638

4. PATIENT IN ROOM TIME 0638 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert. Speaks Iraqi-Arabic.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2, 91D (START-0640)	RELIEF SCRUB	SPEC (b)(6)-2 91D (0640-0720) SSG (b)(6)-2 91D (0720-END)
ASSIGNED CIRCULATOR	CPT (b)(6)-2 AN, 66E (START-0700)	RELIEF CIRCULATOR	MAJ (b)(6)-2 AN, 66E (0640-END) CPT (b)(6)-2 AN, 66E (0700-END)

7. POSITION AND POSITIONAL AIDS *(Specify)* Ⓡ arm abducted less than 90° on padded armboard. Ⓛ arm (broken) abducted less than 90° on padded armboard.

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

COMMENTS: AMSCO bed c̄ pads.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

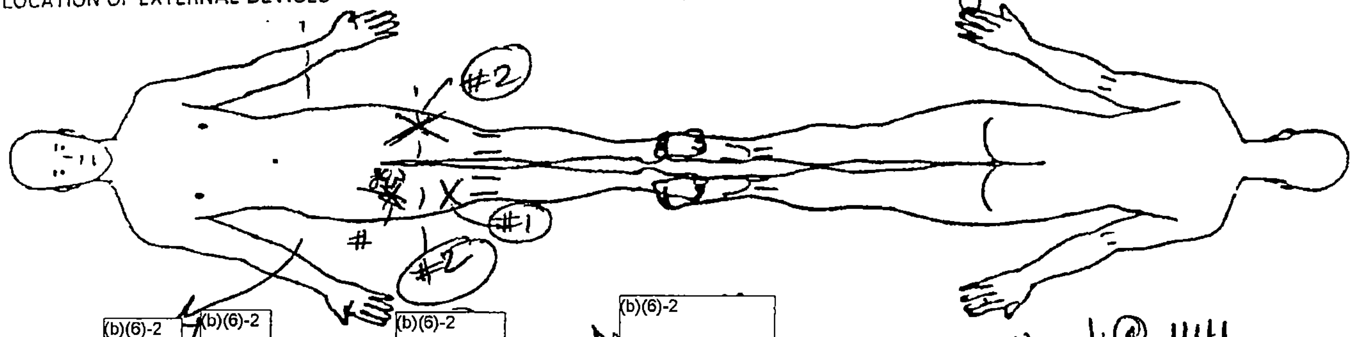
PREP SOLUTION *(Specify)* Beta 7.5% + NSS / Beta 10%

SITE: Chin → Ⓑ upper thighs BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap === Tourniquet Dr. ↑ at 0955 to 250 mmHg ↓ @ 1141 (b)(6)-2

Init by (b)(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

50/50 → 40/40

☒ ESU NO: 000442

GROUND PAD: BRAND Valleylab Polyhesive

LOT NO: EXP 05-92 H9462-4

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES E MEDCOM - 6577 ICH IS OBSOLETE. USAPA V1.01

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

K-wires
LOAD# 0413303 0.062 X 2ea
+ Surgical Steel Suture #2 Ethicon

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Foley 16FR	2.	3.
SITE	1. bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

①
4X8 dressings
2x2 dressings
4X4 dressings
Coverall

② Xeroform
Fluffs
Kerlix/Webril
Plaster Splints
Ace Wrap

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

① ExLap, Small Bowel Resection X2 ② Lt elbow ORIF

21. PATIENT TRANSFERRED TO ICU TIME 1245 METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 6578 USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

2. PATIENT IDEN (b)(6)-2 VERIFIED BY

3. DATE 15 July 03

TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0925 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2, 66E Lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

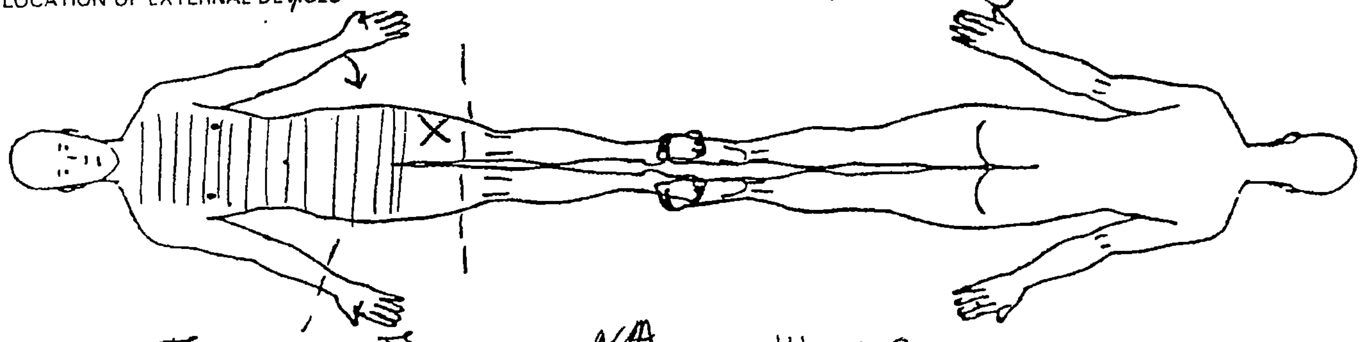
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR (b)(6)-2 ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR
☐ CLIP
COMMENTS: Ø nicks/cuts

PREP SOLUTION *(Specify)* Beta/Beta
SITE: ABD - Thorax to pubis BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad JS -- Safety Strap JS = = = Tourniquet N/A |||=prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley lab
LOT NO: 10527 2003-10

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6579 CH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 4x8s

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 fr Foley	2. Iodoform Gauze	3.
SITE	1. Bladder - arrived in place -	2. ABD incision	3.

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

Maj (b)(6)-2 CRNA / CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

1) Ex-lap

2) appendectomy, incidental

21. PATIENT TRANSFERRED TO ICU TIME 12³⁰ METHOD litter

(b)(6)-2 E Lt/An'

MEDICAL RECORD — **INTRAOPERAT... DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Ou

2. PATIENT IDEN (b)(6)-2 AND PROCEDURE VERIFIED BY

3. DATE: 2-Jly 03

TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: 1420 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	ILT (b)(6)-2 66E	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E SPC (b)(6)-2 91D	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

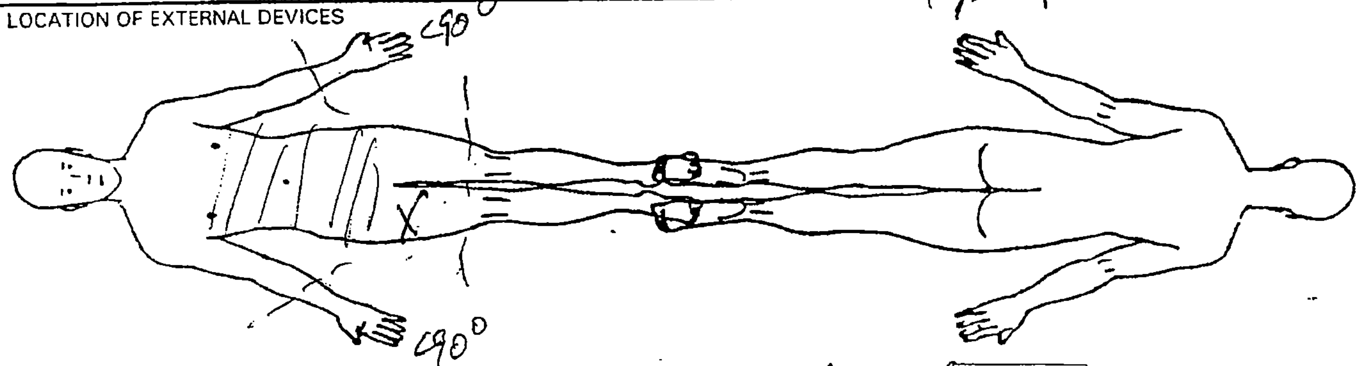
PREP SOLUTION *(Specify)* Beta / Beta

SITE: Abdomen nipple to groin BY WHOM: SPC (b)(6)-2 / (b)(6)-2

SITE: BY WHOM:

COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

(b)(6)-4

(b)(6)-4

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

☑ ESU NO: Pin C-1 30/30

GROUND PAD: BRAND Valley Lab LOT NO: 68671

☐ ESU NO:

GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

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MEDCOM - 6581

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr Foley Catheter c̄ clear yellow urine	Post Induc	Dr (b)(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	16 Fr Foley Cath	10 mm JP	
SITE	Bladder	Abd	

18. DRESSING/IMMOBILIZATION *(Specify)*
~~Belly Bag~~
4x8
Kerlix Tape

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
Exploratory laparotomy Wound debridement c̄ closure (primary)

21. PATIENT TRANSFERRED TO ICU TIME 1640 METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 6582 USAPA V1.01

MEDICAL RECORD | **INTRAOPERA... OCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2
3. DATE 11 Aug 03 — TIME PATIENT ARRIVED IN SUITE ____	4. PATIENT IN ROOM TIME 1420 — NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt accompanied by interpreter

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	2Lt (b)(6)-2 66E	RELIEF CIRCULATOR	CPT (b)(6)-2 (1520 - close)

7. POSITION AND POSITIONAL AIDS *(Specify)*

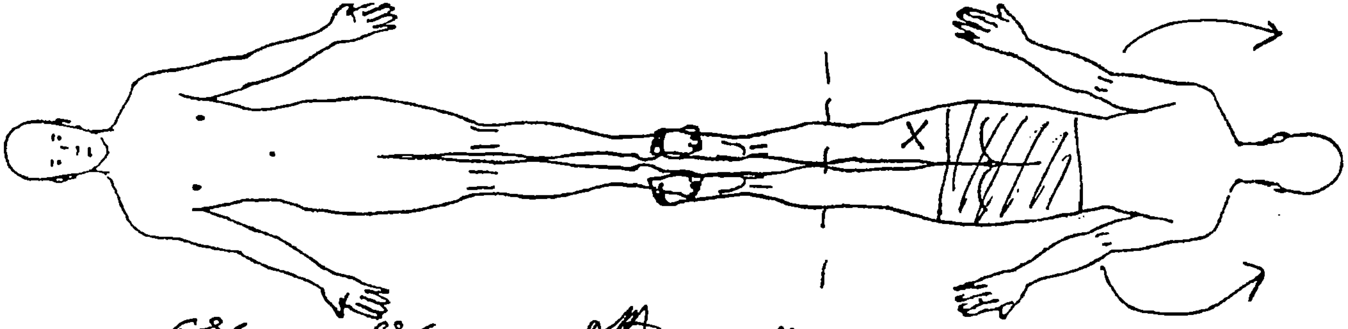
☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: pillows under legs + body; arm boards up towards head

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* Beta Sol SITE: lumbar to mid thigh BY WHOM: (b)(6)-2 SITE: BY WHOM: COMMENTS: ∅ pooling / irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ESC -- Safety Strap ESC = = = Tourniquet NA /// = prep

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

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)* (b)(6)-4 (b)(6)-4	12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO ☐ ESU NO: #1 cut/coag = 30/30 GROUND PAD: BRAND Valley lab LOT NO: 65786 exp 2004-11 ☐ ESU NO: GROUND PAD: BRAND (b)(6)-2 LOT NO: ☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA ... H IS OBSOLETE. MEDCOM - 6583 USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Iodoform gauze	2. x2 bottles 1/4" x 5yds	3.
SITE	1. buttocks	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs

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

Maj (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
I+D of Sacral decubiti

21. PATIENT TRANSFERRED TO IC TIME 1540 METHOD litter

22. REG (b)(6)-2

REVERSE

USAPA V1.01

MEDCOM - 6584

MEDICAL RECORD

INTRAOPERAT... ...OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY MAJ (b)(6)-2 AN66E

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 MAJ, AN

3. DATE 12 AUG 03 TIME PATIENT A... ...E 1255

4. PATIENT IN ROOM TIME 1255 NUMBER 141

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Iraqi Speaking. Helpful.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Ⓑ arms extended at side of head resting on padded armboards. Pillows under chest, hips, and lower legs.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

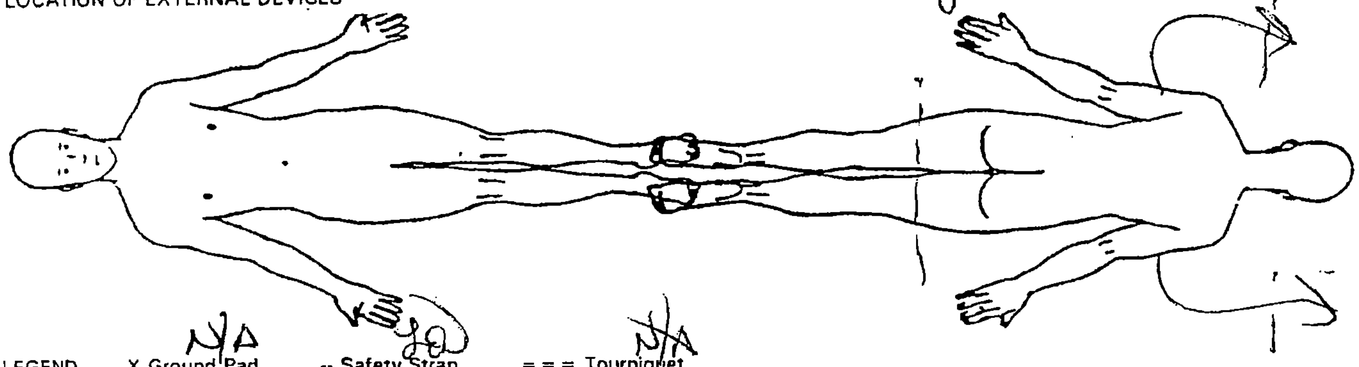
PREP SOLUTION *(Specify)* Betadyne 10% paint

SITE: Sacral region + Surround BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap JD = = = Tourniquet N/A

	C = Correct	I = Incorrect			
10. COUNTS	Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge ☐ Yes ☒ No					
Needle Sharp ☐ Yes ☒ No					
Instrument ☐ Yes ☒ No					
Other ☐ Yes ☒ No					

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

(b)(6)-4

(b)(6)-4

(b)(6)-4

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

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D... MEDCOM - 6585 ...H IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Iodoform Gauze	2.	3.
SITE	1. Sacral Decub	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 dressing sponges
Coverall

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2

MAJ (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

Sacral Decubitus D+I + Dressing Δ Abdominal Wound

21. PATIENT TRANSFERRED TO ICU

TIME 1335

METHOD litter

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

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

MEDCOM - 6586

MEDICAL RECORD — **INTRAOPER OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

2. PATIENT ID (b)(6)-2 [redacted] D PROCEDURE VERIFIED BY cut/AV

3. DATE 13 Aug 03

TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 13⁰⁰ NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: pillows under legs + torso; arms up towards head

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

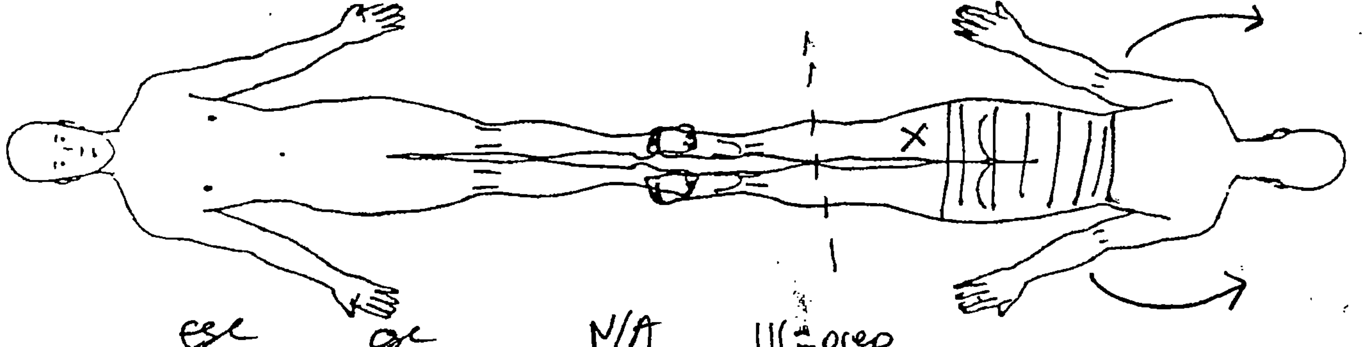
PREP SOLUTION *(Specify)* Beta/Beta

SITE: Buttocks - lumbar to upper thigh BY WHOM: (b)(6)-2 [redacted]

SITE: BY WHOM:

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ESC -- Safety Strap OC = = = Tourniquet N/A ||| = prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4 [redacted]

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

☐ ESU NO: #1 cut/coag = 40/40

GROUND PAD: BRAND Valley lab

LOT NO: 65706 exp2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 6587

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
(b)(6)-2		

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs

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

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED I+D Sacral decubitus

21. PATIENT TRANSFERRED TO ICU TIME 1450 METHOD litter

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

MEDICAL RECORD — **INTRAOPERA... DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: OR Staff
2. PATIENT I (b)(6)-2 VERIFIED BY
PROCEDURE: CMR
3. DATE: 14 AUG 03 TIME PATIENT ARRIVED IN SUITE:
4. PATIENT IN ROOM TIME: 1435 NUMBER: 1-1 #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

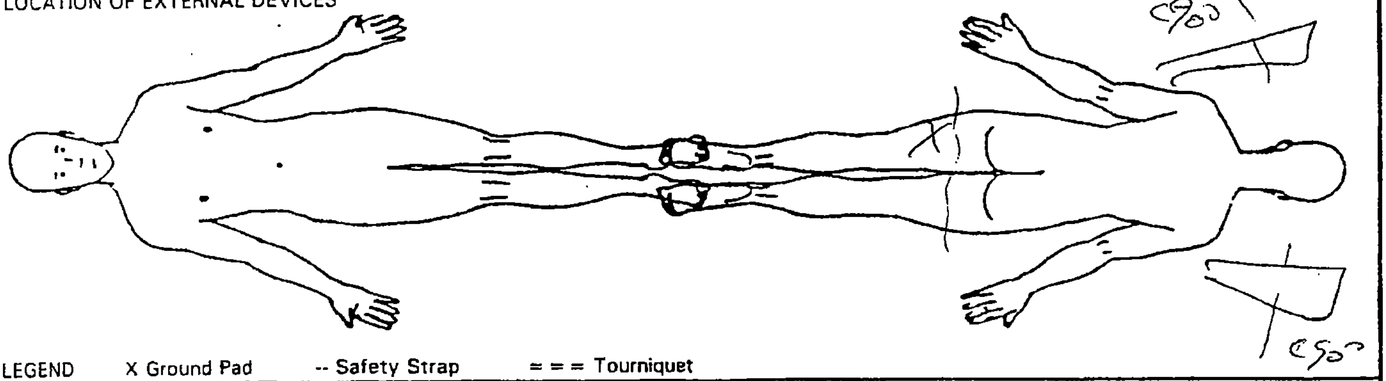
COMMENTS: Pillows x3

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Hibiclens
SITE: buttocks BY WHOM: (b)(6)-2 / (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

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

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

(b)(6)-4

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

☑ ESU NO: 1-1 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: Ø 65706 exp 2004-11
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:
Not in use

DA FORM 5179-1, OCT 87 REPLACES I... CH IS OBSOLETE. USAPA V1.01

MEDCOM - 6589

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATI IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. fluffs kerlex	2.	3.
SITE	1. Sacral decub.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs / Kerlex

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

Dr (b)(6)-2

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

I+D / Dressing Δ to Sacral decubitus

21. PATIENT TRANSFERRED TO ICU TIME 1515 METHOD litter

22. R(b)(6)-2 CPT, AN

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

MEDCOM - 6590

MEDICAL RECORD — **INTRAOPERA.. OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY anesthesia

2. PATIENT ID (b)(6)-2 VERIFIED BY

OCEDURE [illegible]

3. DATE 16 Aug 03

TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN TIME 0815

NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Lt (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: pillows under legs + torso ; arms towards head

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

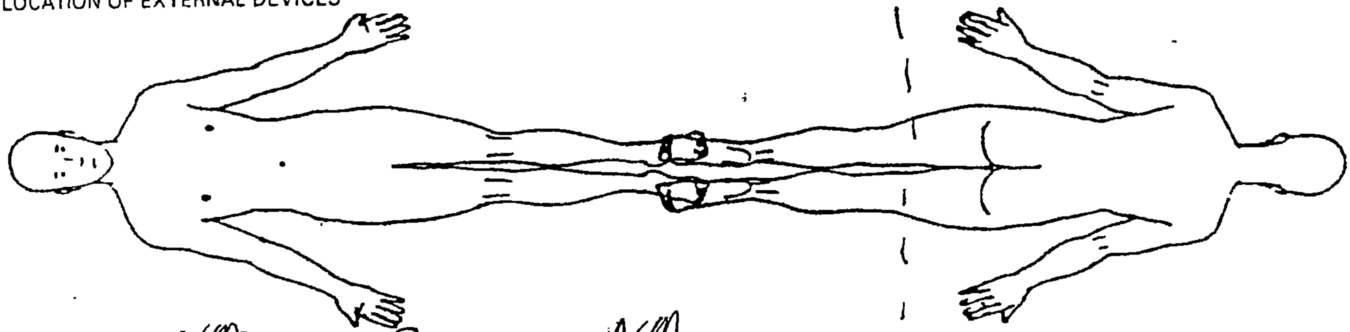
PREP SOLUTION *(Specify)* ∅

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap ESC = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6591 ICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S (b)(6)-2

15. X-RAY IN
YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Fluffs	2.	3.
SITE	1. Sacral Decub.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Wet to dry c̄ Kerlex
and Fluffs + ABD
Band Aid

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

CPT (b)(6)-2

20. OPERATION(S) PERFORMED
Dressing change

21. PATIENT TRANSFERRED TO ICU TIME 0840 METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDCOM - 6592

MEDICAL RECORD | **INTRAOPERA… …OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT (b)(6)-2

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

3. DATE 18 AUG 03 TIME PATIENT ARRIVED IN SUITE 0810

4. PATIEN TIME 0810 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p̄ MN. confirmed by nursing staff

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Ⓑ arms extended at head of bed on padded armboards. Pillows under chest, hips, and lower legs. Toes free

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

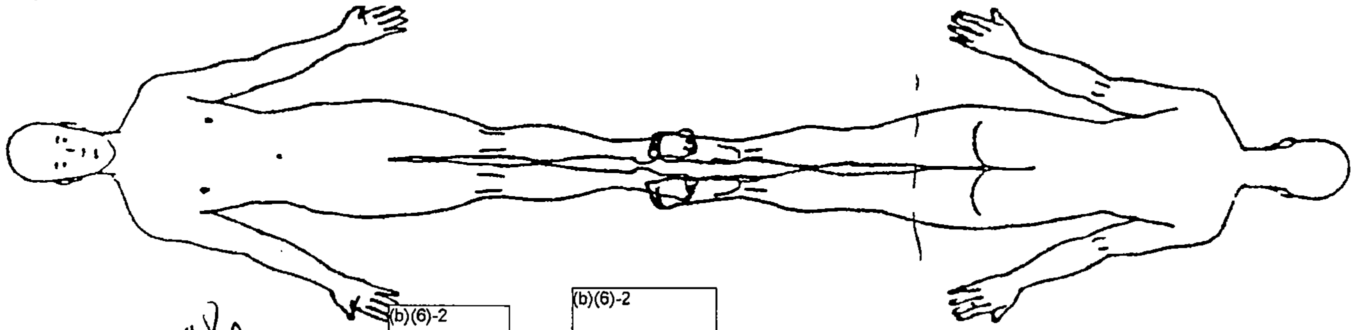
COMMENTS: from pressure.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Sacral decub. BY WHOM (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

(b)(6)-2

LEGEND X Ground Pad N/A -- Safety Strap = = =

10. COUNTS

C = Correct I = Incorrect N/A

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

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

(b)(6)-4

(b)(6)-4

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

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

DA FORM 5179-1, OCT 87 REPLACES D… …I IS OBSOLETE. MEDCOM - 6593 USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)

Buttocks Fluffs ABD Pad Coverall	Abd Fluffs Coverall

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

(b)(6)-2

20. OPERATION(S) PERFORMED

Sacral Decubiti Dressing Change

21. PATIENT TRANSFERRED TO ICU

TIME 0850

METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDCOM - 6594

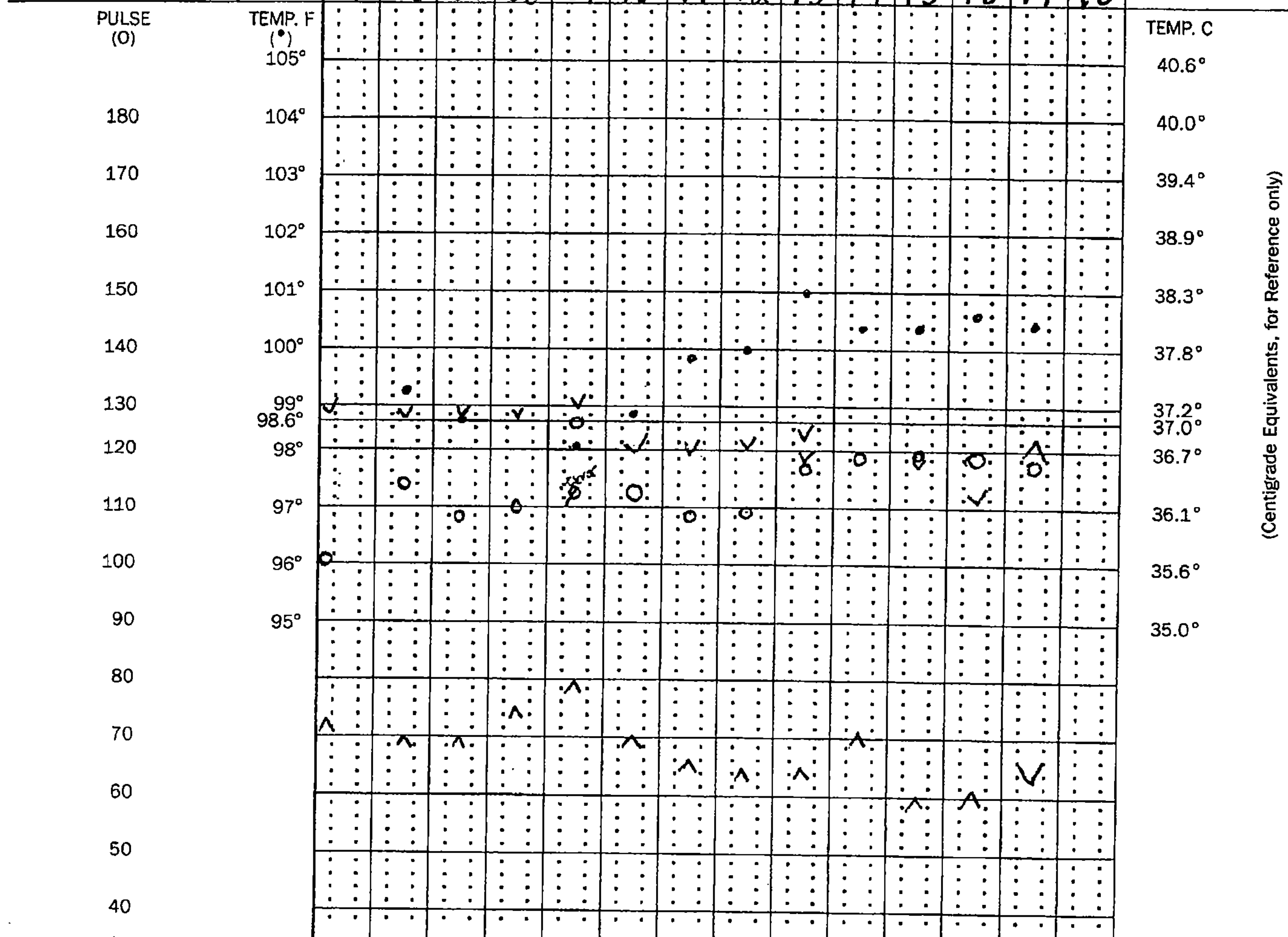
511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR 16 Jul 03 DAY															
19 HOUR	05	06	07	08	09	10	11	12	13	14	15	16	17	18	



Record special data only when so ordered

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	Totals	
RESPIRATION RECORD Resp →	32	30	33	34	32	33	37	37	40	42	42	37	38	35		
BLOOD PRESSURE →	126/73	127/70	128/70	127/75	129/79	119/69	119/66	120/65	118/65	123/71	117/60	117/61	121/68	121/67		
SpO2 →	94%	94%	96%	94%	95%	94%	95%	94%	93%	94%	94%	95%	95%	95%		
O2 →	2LNC	2LNC	2LNC	2LNC	2LNC	2LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC		
HEIGHT: WEIGHT →																
output NG		10	30	30	30	40	15	40	5	20	40	60	50	20	320	> 820
output Foley	2	70	30	40	50	30	30	50	80	40	50	30	800	400	500	
Intake IV	150	150	250	250	150	150	150	250	150	150	150	250	100	150	2200	> 2290
Intake Flush NGT				30				30				30			90	

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

REGISTER NO.

WARD NO. ICU

(b)(6)-4

Totals x 24 hr.

NGT 720

Foley 3550

IV 3600

Flush

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6595

MEDICAL RECORD

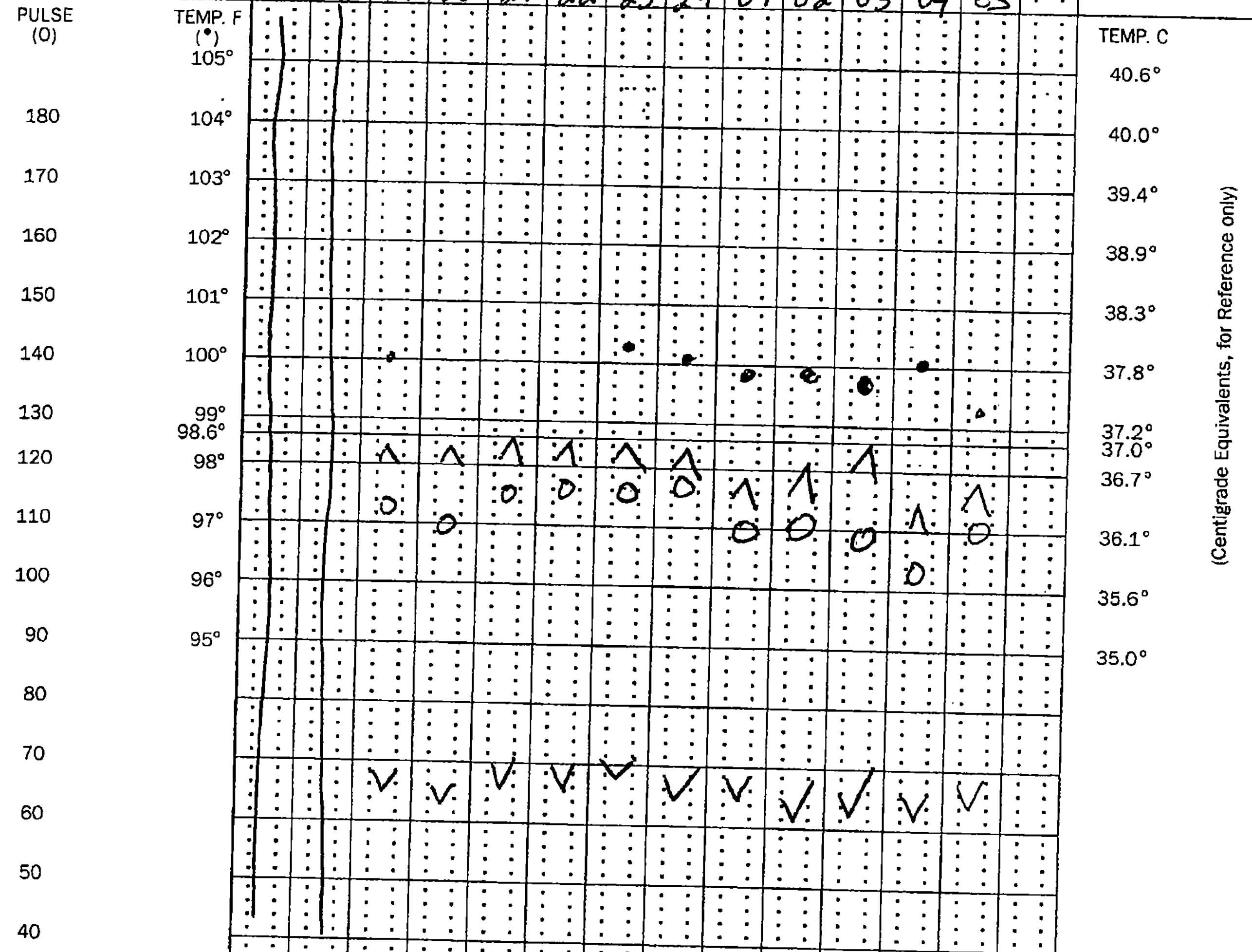
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 16 Jul 03 DAY

19 HOUR	17	18	19	20	21	22	23	24	01	02	03	04	05



Record special data only when so ordered

	17	18	19	20	21	22	23	24	01	02	03	04	05	
RESPIRATION RECORD Resp →	26		26	37	30	30	36	30	30	32	30	31	29	
BLOOD PRESSURE →	124/67		121/67	125/65	125/69	124/68	125/71	117/68	117/66	113/61	126/80	112/66	113/69	NGT 400
SpO2 →	96%		96%	96%	96%	96%	96%	96%	96	96	96	96	96	Foley 2550
O2 →	3L NC		3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	IV 1400
HEIGHT: WEIGHT →														Flush 120
output NG	20		20	10	20	50	20	100	20	30	20	20	20	
Foley	200		200	200	100	200	100	100	50	100	100	100	100	
Intake IV	100		100	100	100	100	100	150	100	100	100	100	100	
Flush NGT			30cc					60cc				30cc		

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

50cc hot tea @ 2200

60cc NGT Flush 0010

Totals x 24 hr

NGT 720 | IV 3600

[illegible] 2550 | Flush

MEDCOM - 6596

MEDICAL RECORD

VITAL SIGNS RECORD

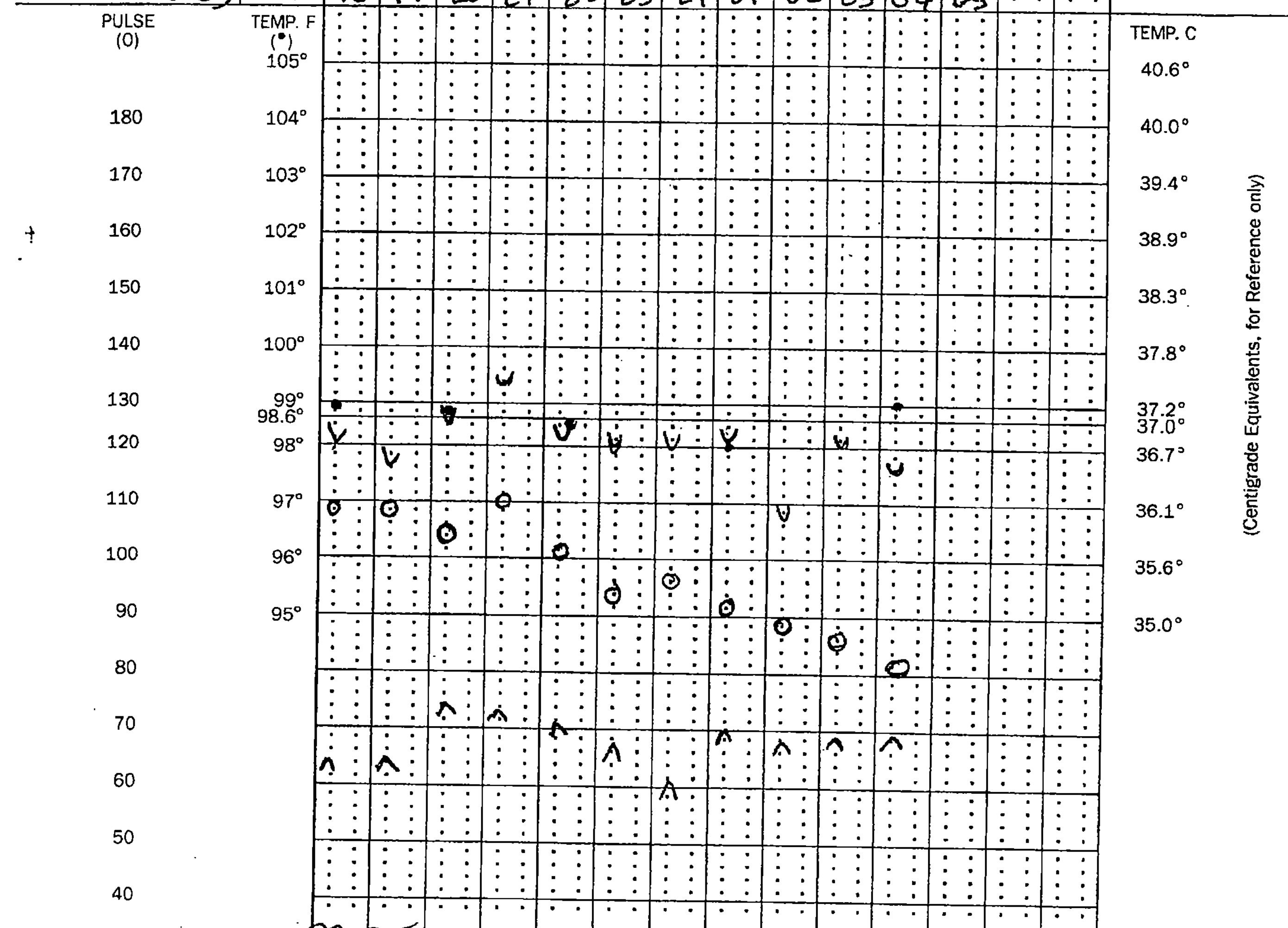
HOSPITAL DAY

POST- DAY

MONTH-YEAR 17 Jul DAY

19 2003 HOUR

(b)(6)-2



		18	19	20	21	22	23	24	01	02	03	04	05			
RESPIRATION RECORD	Resp →	29	35	36	32	27	30	28	20	24	20	21				
Record special data only when so ordered	BLOOD PRESSURE →	121/64	117/64	127/71	134/73	122/71	114/67	120/60	122/76	105/67	129/68	117/68				
	SpO2 →	100	100	98	99	99	98	98	100	100	99	100				
	O2 →	3LNC	3LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC				
	HEIGHT: WEIGHT →															Totals
output	NG	380	180	220	✓	600	280	260	100	80	50	30				3475
	Foley	120	40	60	1000	500	220	60	50	40	60	36				2680 > 6155
intake	IV	100	100	100	P.Lasix 100	100	100	300	100	100	100	100				2700 > 3[illegible]2C
	Flush NGT	30		30				30				30				270
	PO															150

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

REGISTER NO.

WARD NO. ICU

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6597

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

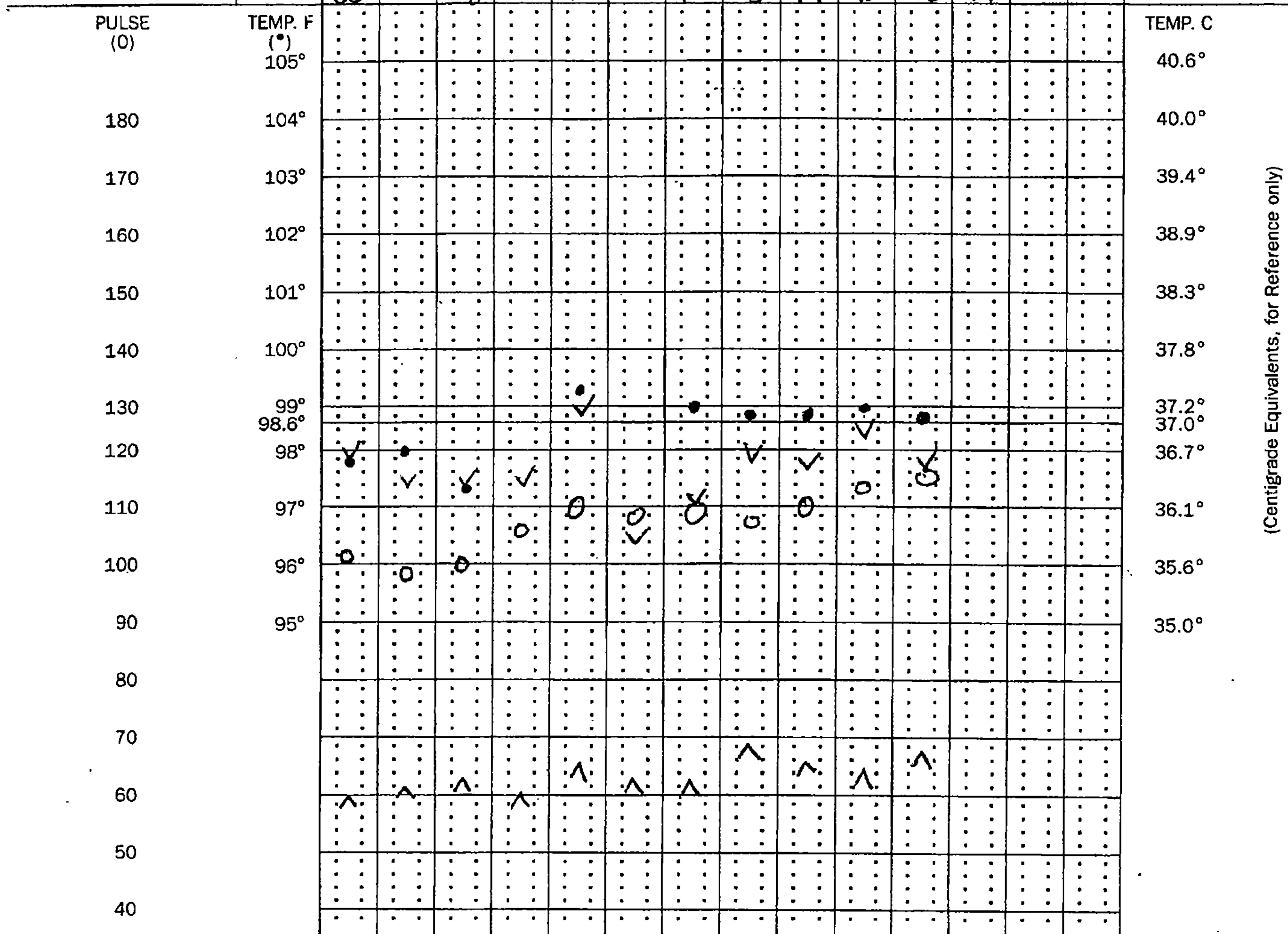
HOSPITAL DAY

POST- DAY

MONTH-YEAR 17 Jul DAY

19 2003 HOUR

HOUR	06	07	08	09	10	11	12	13	14	15	16	17	. .	. .



		06	07	08	09	10	11	12	13	14	15	16	17			
RESPIRATION RECORD	Resp →	26	27	26	29	30	17	30	31	29	30	33				
Record special data only when so ordered	BLOOD PRESSURE →	118/60	114/68	114/63	114/60	128/65	114/63	110/63	118/68	117/65	123/64	117/67				
	SpO2 →	96%	95%	95%	95%	93%	95%	96%	99%	100%	98%	99%				
	O2 →	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC				
	HEIGHT: WEIGHT →															Totals
Output	NG	40	120	110	130	175	0	90	200	80	~~350~~	350				>
	Foley	40	70	60	60	60	20	30	40	30	50	40				
Intake	IV	200	100	200	100	150	100	150	100	100	100	100				>
	Flush NGT			30				30				30				
	PO				60			30		60						

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

REGISTER NO.

WARD NO. ICU

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6598

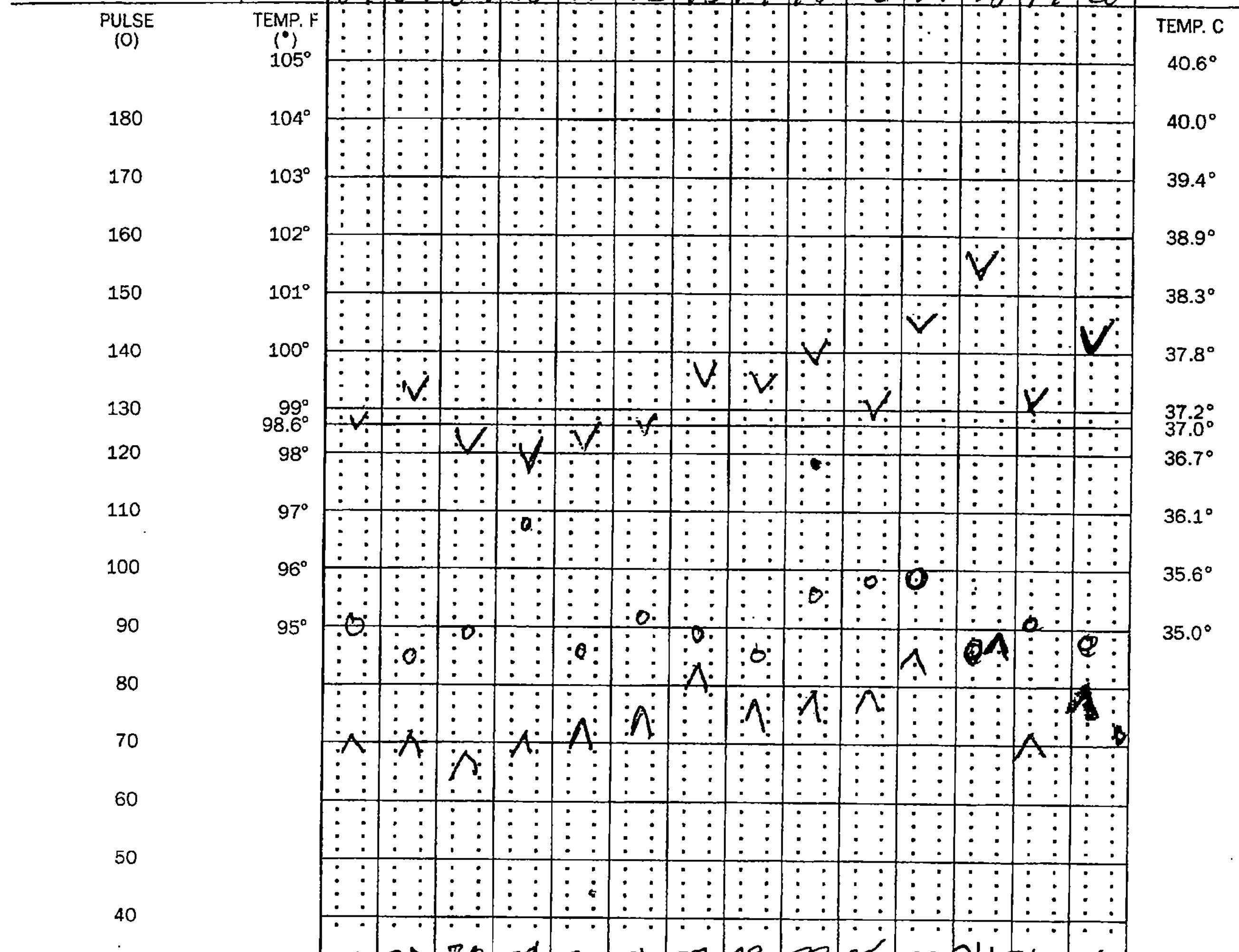
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	20Jul														
19	HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	



RESPIRATION RECORD		21	20	20	28	24	26	27	13	22	25	28	24	24	26	
Record special data only when so ordered	BLOOD PRESSURE	126/74	137/72	129/68	117/71	122/71	123/76	135/84		139/80	134/80					
	FiO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
	Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	HEIGHT: WEIGHT →					99	99	99	100	100	99	99	100	100	100	
	PO	140	0	0	0	50	0	0	0	0	150	0	500	0	0	
	IV	30	130	30	30	30	30	30	30	30	130	30	30	30	30	530 in
	Output	0	0	0	0	[illegible]	0	[illegible]	0	0	0	0	300	0	0	
						200										775 out

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

(b)(6)-4

(b)(6)-4

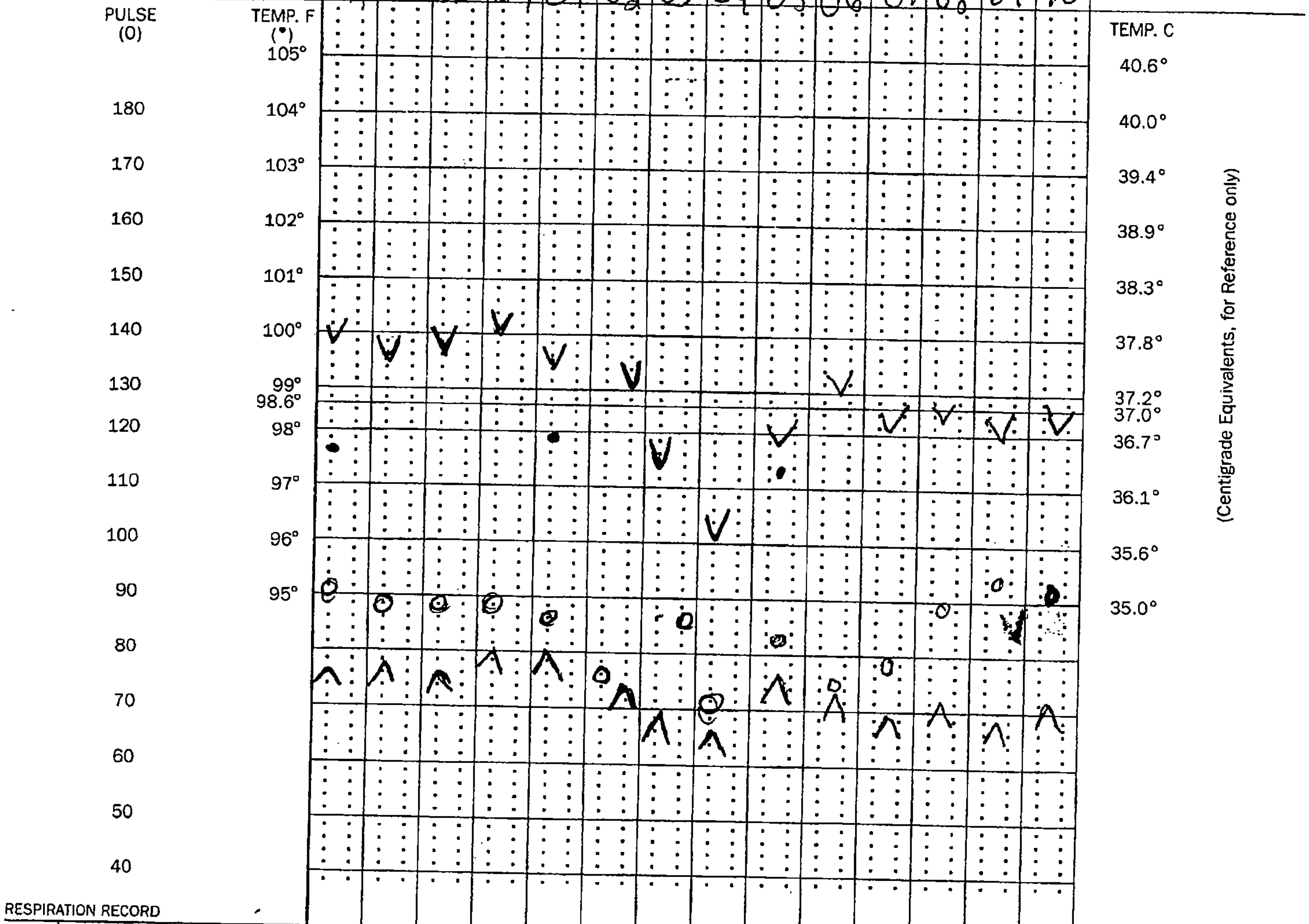
VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6599

MEDICAL RECORD		VITAL SIGNS RECORD													
HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	20Jul													
19	HOUR	21	22	23	24	01	02	03	04	05	06	07	08	09	10



RESPIRATION RECORD

Record special data only when so ordered

	21	22	23	24	01	02	03	04	05	06	07	08	09	10	
BLOOD PRESSURE R-	24	18	20	21	24	14	14	14	20	14	20	22	25	21	
O2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
HEIGHT: 5'6 WEIGHT →	98	98%	98%	100%	98%	99%	99%	99%	100	99	99	99	84	98	
PO	0	0	0	0	0	0	0	0	0						
IV	30	30	30	130	130	30	30	30	1030		530		in		1560
output	0	300	0	0	350	0	0	0	950		775		out		1725
								I	30	30	210	100	100	100	-165
								O	0	0	575	0	0	500	

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

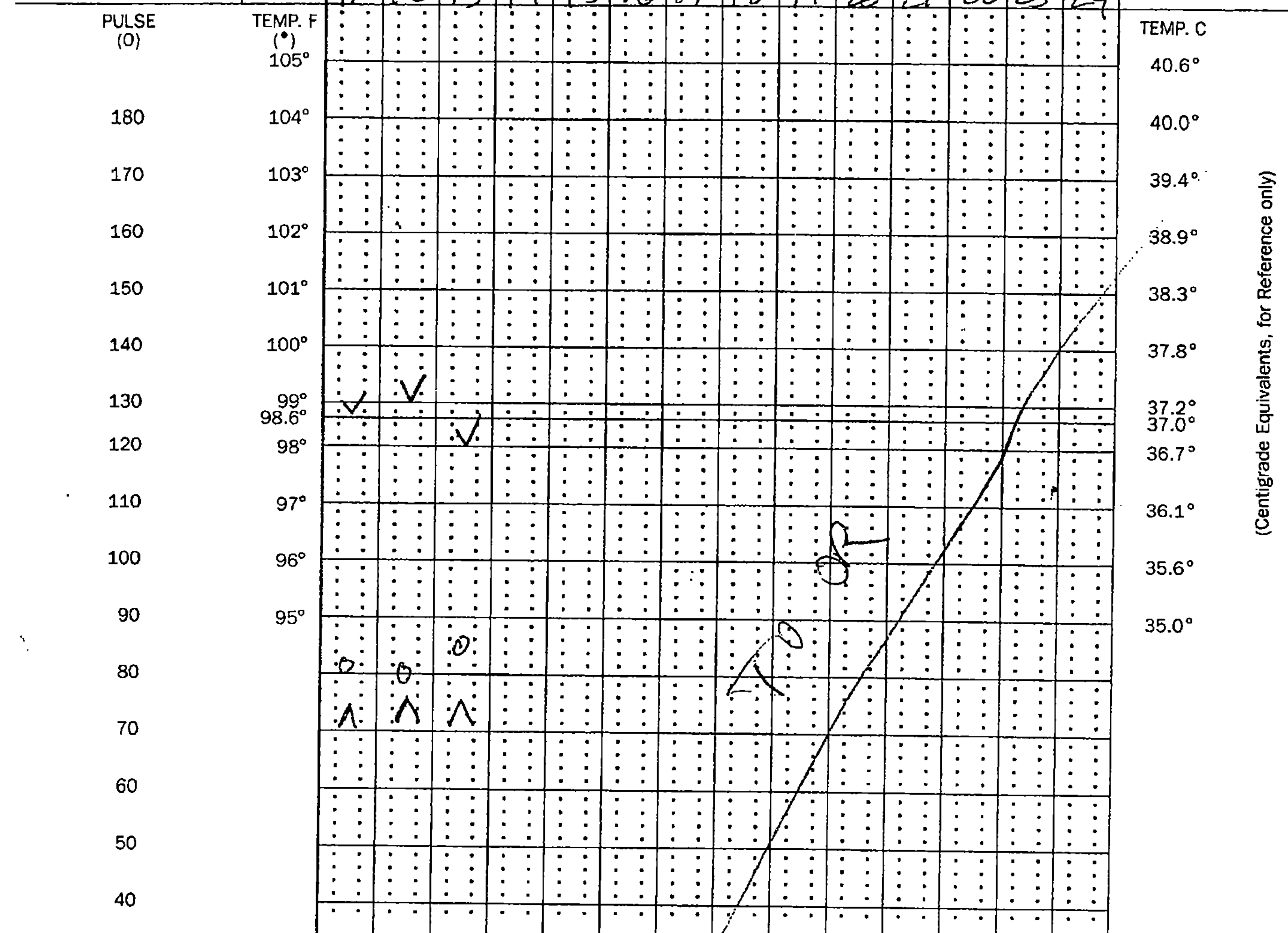
STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6600

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	21 Jul													
19	HOUR	11	12	13	14	15	16	17	18	19	20	21	22	23	24



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	20	18	24	
	22	22	22	
	NC	NC	NC	
HEIGHT: 5'4" WEIGHT →	100	99	99	
PO	0	0	0	
IV	100	100	100	
output	0	0	100	625

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

STANDARD FORM 511 (REV. 7–95) **BACK**

MEDCOM - 6601

Pt # [redacted] b(6)-4
ETT 8.0:
2~~4~~cm @ lip

VENT FLOW SHEET

	DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
	21July03	1640	SIMV	10	850	50%	+5	33	1:2.0	0	—	103	100%	129/58	8.0	MLT	[redacted]
ABG	21July	1720	PH 7.513		PCO2 36.9	PO2 158		HCO3 30		BE 7	SO2 100%		—	—	—	—	[redacted]
	21Jul	1934	SIMV	10	850	50	5	30	1:2	0	—	100	100	154/68	8	MLT	[redacted]
	21Jul	2200	SIMV	10	850	50	5	31	~~3~~1:2	—	—	102	100	140/60	8	MLT	[redacted]
	22Jul	0040	SIMV	10	850	50	5	30	1:2	0	—	114	100	133/61	8	MLT	[redacted]
	22Jul	0230	SIMV	16	850	50	5	29	1:2	0	—	107	100	125/58	8	MLT	[redacted]
	22Jul	0440	SIMV	10	850	50	5	29	1:2	0	—	106	100	96/49	8	MLT	[redacted]
	22July	0545	SIMV	10	850	50%	+5	28	1:2.0	0	—	116	100%	104/65	8.0	MLT	[redacted]
ABG	22July	0725	PH 7.513		PCO2 38.1		PO2 119	HCO3 30		BE 8	SO2 99%	110	—	—	—	—	[redacted]
	22July	0745	SIMV	10	850	50%	+5	26	1:2.0	0	—	109	100%	74/41	8.0	MLT	[redacted]
	22July	1010	SIMV	10	850	50%	+5	30	1:2.0	0	—	107	100%	89/52	8.0	MLT	[redacted]
	22July	1215	SIMV	10	850	50%	+5	28	1:2.0	0	—	109	98%	74/50	8.0	MLT	[redacted]
	22July	1350	SIMV	10	850	50%	+5	27	1:2.0	0	—	103	99%	97/54	8.0	MLT	[redacted]
	22July	1550	SIMV	10	850	50%	+5	28	1:2.0	0	—	105	98%	93/51	8.0	MLT	[redacted]
	22Jul	1800	SIMV	10	850	50	5	28	1:2	0	—	105	98	102/51	8	MLT	[redacted]
	22Jul	2040	SIMV	10	850	50	5	29	1:2	0	—	97	100	94/55	8	MLT	[redacted]
	22Jul	2150	SIMV	10	850	50	5	30	1:2	0	—	99	100	140/57	8	MLT	[redacted]
	23Jul	0130	SIMV	10	850	50	5	31	1:2	0	—	97	100	139/53	8	MLT	[redacted]
	23Jul	0220	SIMV	10	850	50	5	31	1:2	0	—	~~97~~ [illegible]	97	160/60	8	MLT	[redacted]
	23Jul	0515	SIMV	10	850	50%	+5	30	1:2.0	0	—	102	100%	138/56	8.0	MLT	[redacted]
	23Jul	0610	SIMV	10	850	50%	+5	31	1:2.0	0	—	101	100%	135/53	8.0	MLT	[redacted]
ABG	23Jul	0745	PH 7.481		PCO2 32.2		PO2 130		HCO3 26	BE 2	SO2 99%	—	—	—	—	—	[redacted]
	23Jul	0800	SIMV	10	850	50%	+5	30	1:2.0	0	—	101	100%	141/60	8.0	MLT	[redacted]
	23Jul03	1000	SIMV	10	850	50%	+5	30	1:2.0	0	—	102	100%	151/47	8.0	MLT	[redacted]
	23July	1150	SIMV	10	850	50%	+5	28	1:2.0	0	—	103	100%	141/67	8.0	MLT	[redacted]
	23July	1350	SIMV	10	850	50%	+5	31	1:2.0	0	—	112	100%	140/59	8.0	MLT	[redacted]

b(6)-2

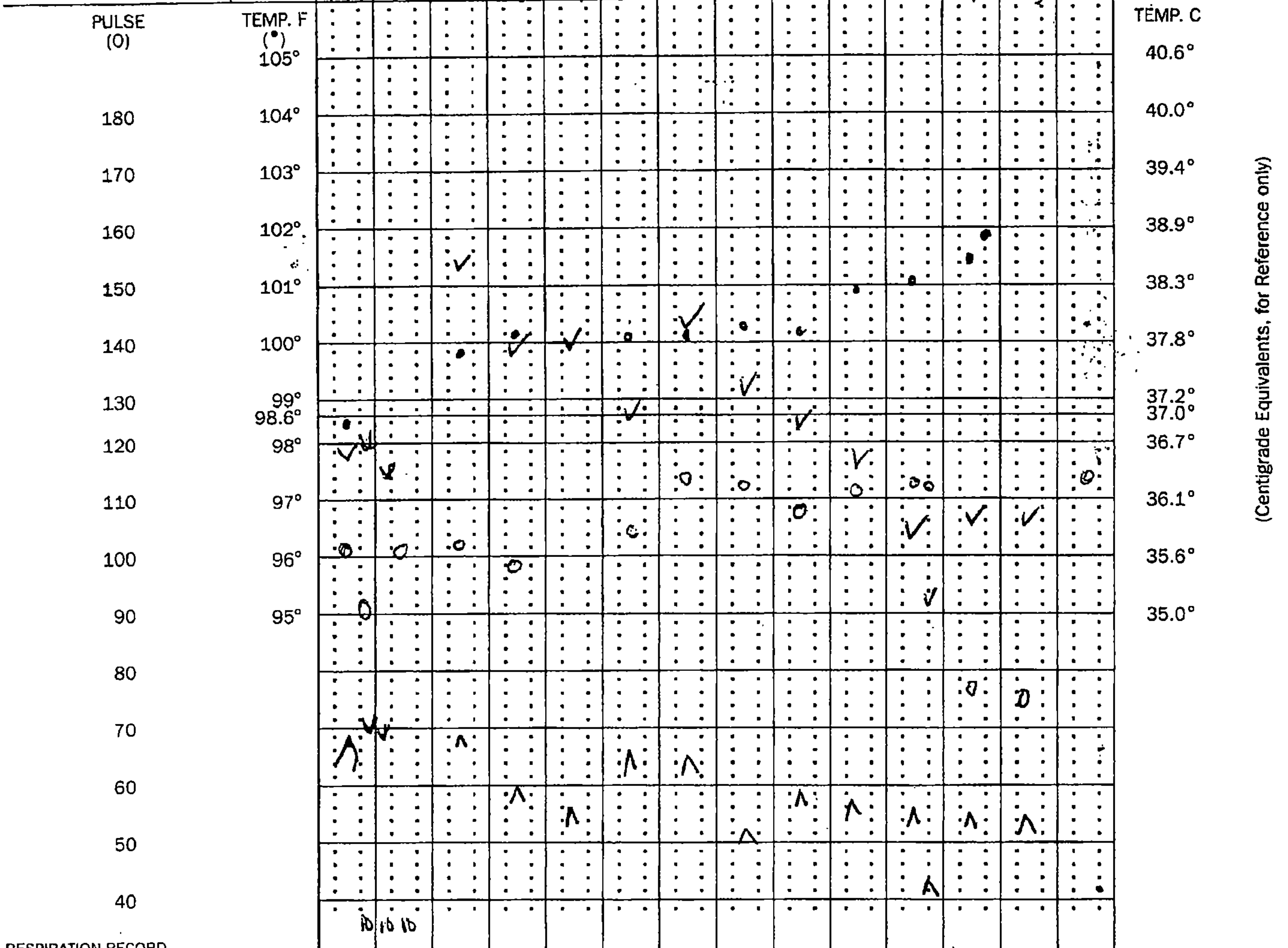
MEDCOM - 6602

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY	21 Jul								22 July					
19 / HOUR	17	18	19	20	21	22	23	24	01	02	03	04	05	06



	17	18	19	20	21	22	23	24	01	02	03	04	05	06	
RESPIRATION RECORD	10	10 10													
BLOOD PRESSURE	[illegible]											NIBP	NIBP		
A-line	115/61	124/68	154/68	139/59	140/56	120/64	144/64	137/52	127/54	1?/59	105/56	107/55	104/54	87/49	
HEIGHT: WEIGHT →															
SaO2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Foley		—	125	100	75	100	125	75	75	75	50	50	40		890 : OUT
JP ~~NG~~		—	10cc	35cc	15	10	10	5	5	5	0	3	5		98 : OUT
LR	100	100	100	100	100	100	100	100	100	100	100	100	100		1300 : IN
IVPB	0	0	0	0	0	100	250	0	0	0	0	100	0		450: IN ~~TOTAL~~

Record special data only when so ordered

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

REGISTER NO.

WARD NO.
ICU

	17	18	19	20	21	22	23	24	01	02	03	04	05
Vec	0	4	6	6	6	6	6	6	6	6	6	6	6
MSO4	0	5	5	5	5	5	5	5	5	5	5	2	2
Versed	0	2	4	4	4	4	4	4	4	4	4	4	4
NGT Residuals				Tube feeds				Resid. 5cc				Res 120+	

125: out

VITAL SIGNS RECORDS
Medical Record

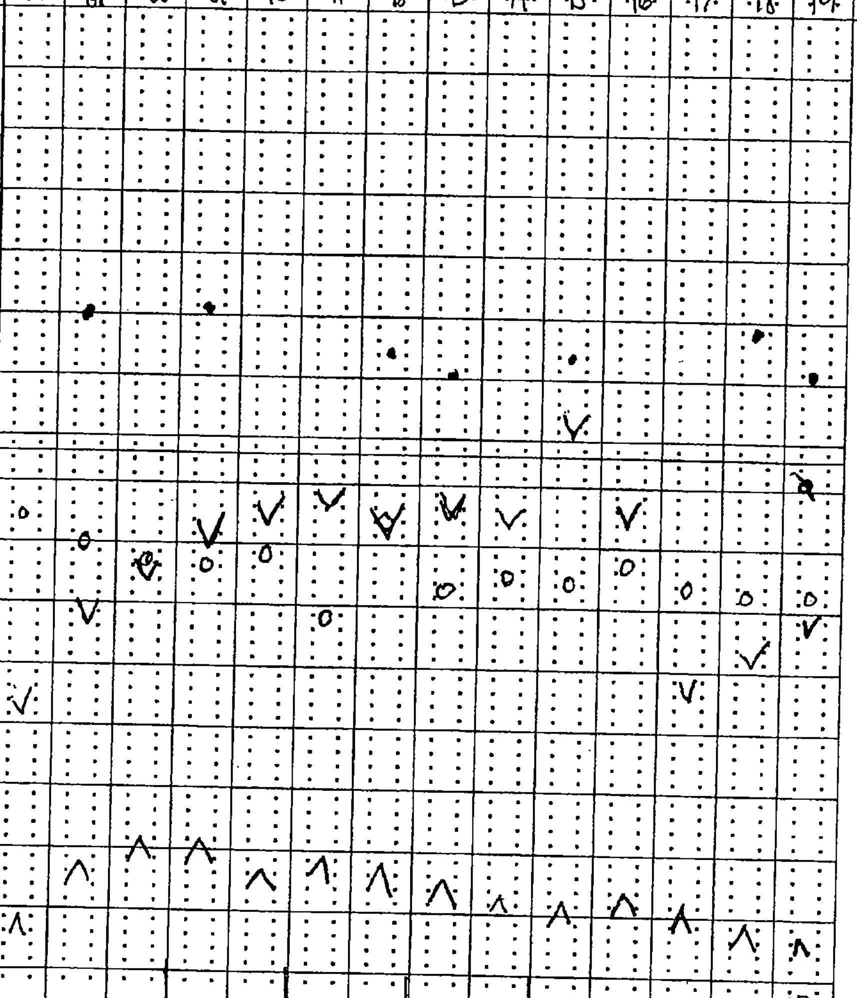
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6603

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY	22 Jul													
19 / HOUR	·06·	·07·	·08·	·09·	·10·	·11·	·12·	·13·	·14·	·15·	·16·	·17·	·18·	·19·



Output

Intake

Record special data only when so ordered

	·06·	·07·	·08·	·09·	·10·	·11·	·12·	·13·	·14·	·15·	·16·	·17·	·18·	·19·
RESPIRATION RECORD	10	10	10	10	10	10	10	10	10	10	10	10	10	10
BLOOD PRESSURE NIBP	108/69	117/69	117/58	114/63	116/58	114/58	113/58	103/65	114/64	134/52	115/54	86/52	91/49	92/58
SaO2	100%	100	100	100	100	100	99%	98	98	98	98	98	98	99%
Foley	40	0	0	10	7	0	10	0	15	20	15	5	10	15
HEIGHT: / WEIGHT T+F	1	1	1	1	1	1	1	1	1	1	1	1	1	
JP	—	3	—	—	—	—	—	—	—	—	—	—	15	3
Maint IV	100	100	600	150	150	150	150	575	575	575	160	200	200	200
Vec		6	6	6	6	6	6	6	6	6	6	6	6	6
Versed		6	4	4	4	4	4	4	4	4	4	4	4	4
MSO4		2	2	2	2	2	2	2	2	2	2	2	2	2
IVPB	100				100	250			100				100	0

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

Jevity

REGISTER NO

20 | 20 | 20 | 20 | 20 | 20 | 20 | 20

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

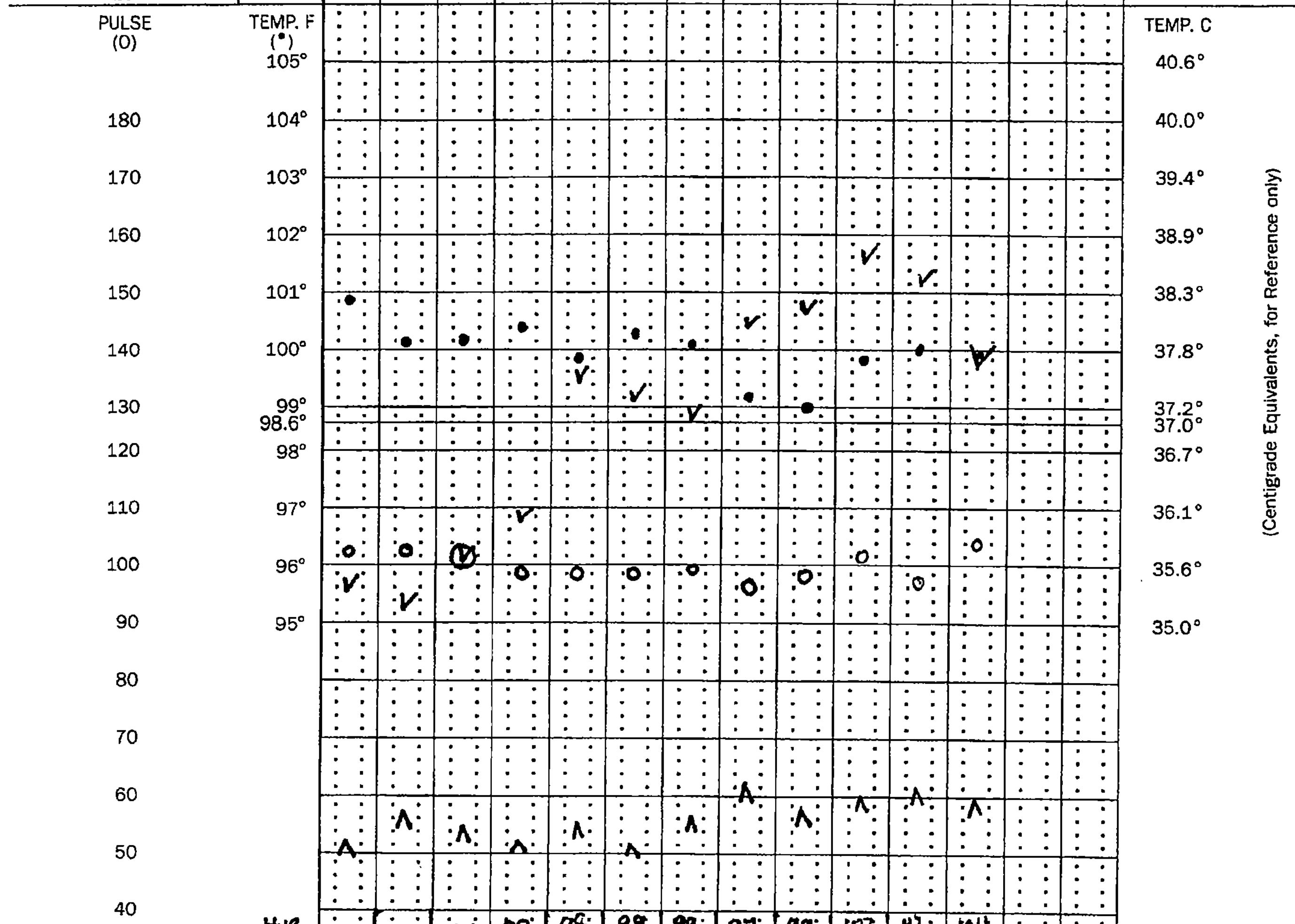
MEDCOM - 6604

(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD 22 July 2003 VITAL SIGNS RECORD

HOSPITAL DAY								23 July 2003						
POST- DAY														
MONTH-YEAR / DAY	18	19	20	21	22	23	24	01	02	03	04	05	06	—
19 / HOUR														



RESPIRATION RECORD

Record special data only when so ordered

	18	19	20	21	22	23	24	01	02	03	04	05
HR			101	98	98	99	99	97	99	102	97	104
MAP	67	66	66	69	82	86		81	82	85	84	88
BLOOD PRESSURE Aline	96/52	92/58	102/54	104/52	136/55	101/51	128/56	145/61	149/57	157/60	153/61	134/58
NIBP	94/51	98/47	95/49	100/47	105/56	111/58	105/54	107/59	114/64	113/63	110/62	115/61
SaO₂	96%	99%	99%	100%	100%	100%	100%	100%	100%	100%	1.00%	100%
HEIGHT: WEIGHT: VR ⟶	10	10	10	10	10	10	10	10	10	9	11	10
SimV-VENT: TV	850	848	850	850	660	850	850	850	850	850	850	850
FIO₂	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Peep	5	5	5	5	5	5	5	5	5	5	5	5
Lip 8.0 ETT	25	25	25	25	25	25	25	25	25	25	25	25
LR	200	200	200	200	200	200	200	200	200	200	200	200
Vec	6	6	6	6	6	6	6	6	6	6	6	6
MgSO₄	2	2	2	2	2	2	2	2	2	2	2	2
Versed	4	4	4	4	4	4	4	4	4	4	4	4

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

REGISTER NO

WARD NO.

	18	19	20	21	22	23	24	01	02	03	04	05
Levity	20	20	20	20	20	20	20	20	20	20	20	20
IVPB	0	0	0	0	0	350	0	0	0	0	0	100
Foley	10	15	50	32	70	90	125	250	125	140	105	155
JP	15	3	3	2	2	1	2	1	1	1	2	1
NGT Residual	—	—	3cc	—	2cc	—	—	4cc	—	—	10cc	—
Abd	0	0	0	0	0	0	0	0	0	min	0	0
OTHER	—	—	—	—	—	—	—	—	—	—	—	—
(TOF) PNS	1	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4

2400
72
24
48
2544
240
450
IN
3234
240
450
~~1152~~
~~162~~
FOLEY = 116
1191
out

VITAL SIGNS RECORDS 34 -JF

Medical Record 19 Residual

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

MEDCOM - 6605

⊕ Tet ⊕ Tet ⊕ Tet

b(6)-4
Pt #0034
ETT 8.0
23@ lip

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
23Jul03	1610	SIMV	10	850	50%	+5	26	1:2.0	13	/	119	100%	113/55	8.0	MLT	[redacted]
23Jul03	1740	SIMV	6	850	50	5	24	1:3.0	+13	–	115	97	110/52	8	MLT	[redacted]
23Jul	2030	SIMV	6	850	50	5	32	1:3	13		100	100	123/60	8	MLT	[redacted]
23Jul	2230	SIMV	10	850	50	5	31	1:3	13	–	103	100	127/52	8	MLT	[redacted]
23Jul	2300	SIMV	10	850	50	5	27	1:1.6	1	–	100	100	128/57	8	MLT	[redacted]
23Jul	0240	SIMV	10	850	50	5	27	1:1.6	0	–	96	100	137/62	8	MLT	[redacted]
23Jul	0430	SIMV	10	850	50	5	26	1:1.6	,	–	96	100	146/72	8	MLT	[redacted]
24Jul	0630	SIMV	10	850	50%	+5	29	1:1.6	0	/	88	100%	132/66	8.0	MLT	[redacted]
ABG 24July	0730	PH 7.512		PCO2 37.8	PO2 165		HCO3 31	BE 7		SO2 100%						[redacted]
24July	0805	PT Extubated placed on NRB Mask@ 12 L/min									102	97%				[redacted]

b(6)-2

MEDCOM - 6606

(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

23 July 2003 Lasix 20 IV

VITAL SIGNS RECORD

i-STAT G3+
Pt: 0034
Pt Name:__________

Vt 850
Rate 10
FiO2 50%
Peep +5

TCO2________27 mmol/L

At 37C
pH_______7.481
PCO2______34.3 mmHg
PO2________138 mmHg
HCO3________26 mmol/L
BEecf________2 mmol/L
sO2*________99 %
*calculated

At Patient Temp
pH_______7.502
PCO2______32.2 mmHg
PO2_______130 mmHg

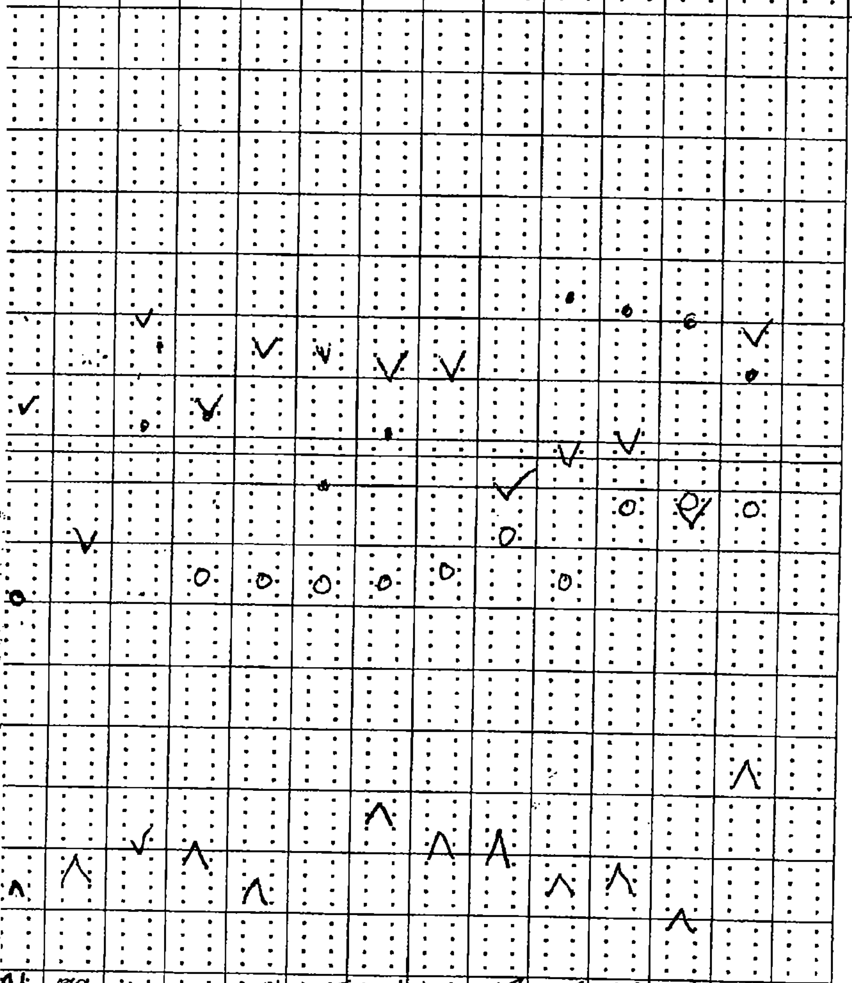
Patient Temp: 96.1F
FIO2________: 50
Sample Type_: ART

23JUL03 17:58

Oper: (b)(6)-2

hysician:__________

Ser# 4 90
Ver: JAMS045A
CLEW A91



	06	07	08	09	10	11	12	13	14	15	16	17	18	19
	01	99	108	105	104	105	104	106	112	115	118	120	117	
	~~77~~		87											
	[illegible]/55	137/60	149/60	142/56	154/64	159/70	140/68	144/65	118/51	120/53	124/51	138/78	151/[illegible]	
NIBP	[illegible]/57	109/59	137/60	134/62	144/51	144/58	144/69	140/64	119/61	126/57	128/58	115/52	147/70	
SaO2	100%	100	100	100	100	100	100	100	106	100	100	98	97	
HEIGHT: WEIGHT ~~VR~~ →	10	10	10	10	10	10	10	10	10	10	10	25	6	
Simv : VENT: TV	850	850	85	800	85	850	850	850	856	850	850	880	850	
FIO2	50%	50	50	50	50	50	50	50	50	50	50	50	50	
Peep	5	5	5	5	5	5	5	5	5	5	5	5	5	
~~Lip B.O eli~~ ETT	25	25	25	25	20	25	25	25	25	25	25	25	25	
LR	200	200	100	F00	100	100	100	100	100	100	100	100	100	
Vec	6	6	3	3	2	[illegible]	0	0	0	0	0	8	0	
MSO4	2	2	2	2	2	2	2	2	1	0	0	8	0	
Versed	4	4	4	4	4	4	2	1	2	8	0	0	8	
PO						350			250					
Jevity		20	20	20	30	20	30	30	20	30	Ø	Ø	Ø	
IVPB		100			50	250				100				
Foley	100	100	260	200	350	325	1600	775	500	300	200	150	75	
JP		Ø	Ø	–	–	–	–	–	–	–	25	0	3	
NGT Resids		Ø	–	–	10	–	–	Ø	–	– *	20	0	100	
Abd		Ø	–	–	0	–	–	–	–	–	–	–	–	
Other		Ø	–	–	0	–	–	–	–	–	–	–		
(TOF) PNS	1	1	1	1	Kaws 1	2	2	4	4	4	4	4	4	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS
~~Medical Record~~
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6607

* NG to LIS

Civ pt

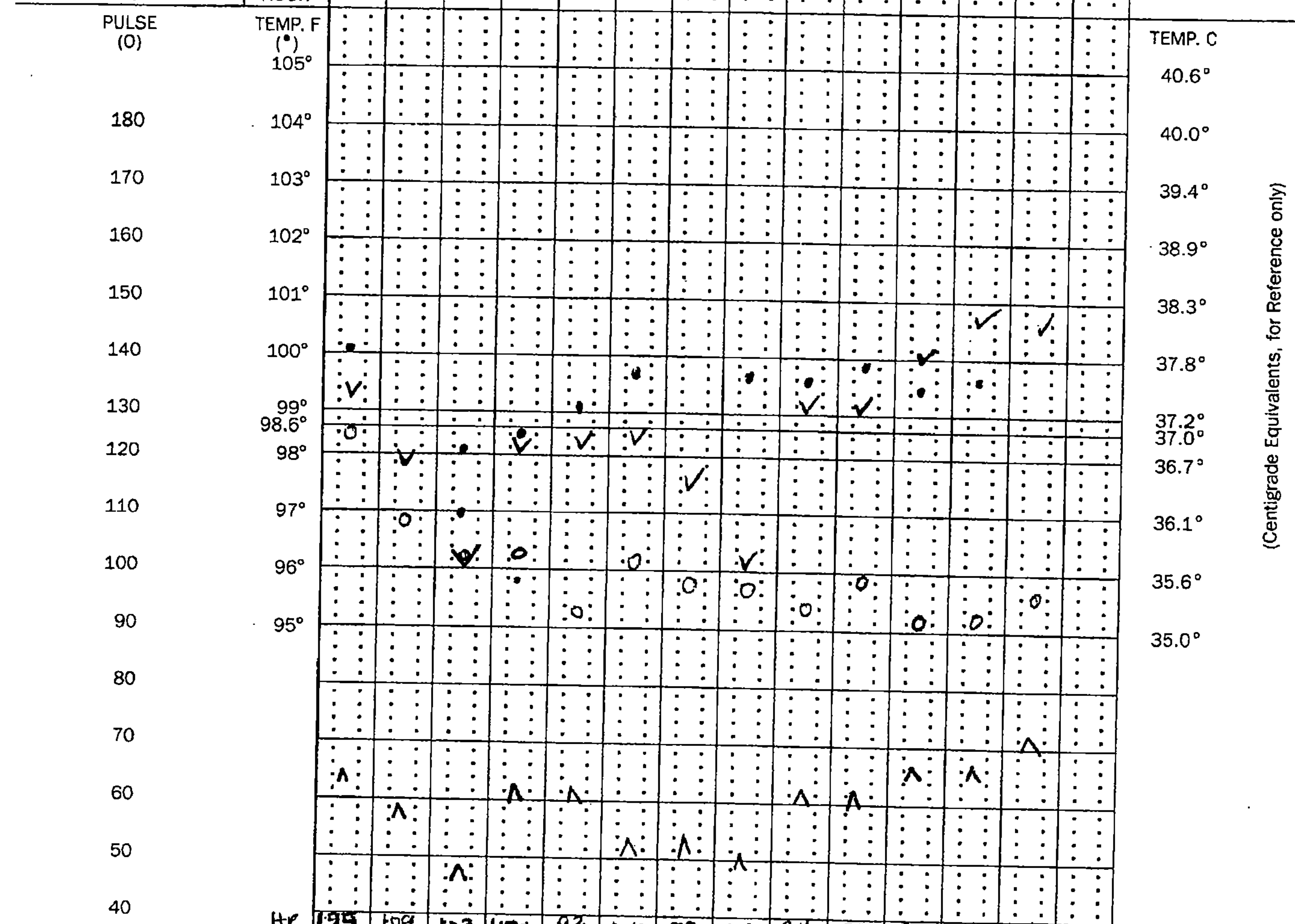
(b)(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

23 July 2003 | 24 July 2003

HOSPITAL DAY													
POST- DAY													
MONTH-YEAR 19 DAY HOUR	18	19	20	21	22	23	24	01	02	03	04	05	06



RESPIRATION RECORD

Record special data only when so ordered

HR	125	109	103	107	93	101	98	97	94	94	91	92	96	
MAP	99	78	67	83	83	73	~~78~~	66	84	85	86	91		
BLOOD PRESSURE A Line	133/65	119/58	102/48	128/62	122/62	124/53	125/56	104/50	130/62	131/60	140/68	147/68	146/71	
NIBP		124/53	106/48	122/54		134/56	115/54	102/45	121/47	124/44	145/61	157/61	—	
RR	36	23	26	~~10~~	~~0~~	0	0	0	0	0	0	0	0	
HEIGHT: WEIGHT ~~VR~~ →	6	6	6	10	10	10	10	10	10	10	10	10	10	-
SaO2	98%	98%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
FiO2	50%	50%	50%	50%	50%	50%	50%	50%	60%	50%	50%	50%	50%	
PEEP	5	5	5	5	5	5	5	5	5	5	5	5	5	
T:	100.1	—	98.1	98.9	99.1	94.8	—	99.8	99.7	99.9	99.5	99.6	—	
8.0 ETT	25	25	25	25	25	25	25	25	25	25	25	25	25	
OUTPUT FOLEY:	-	125	75 ~~7~~	75	105	120	70	110	90	100	125	165	100	1160 = 1170 out
JP:	-	—	—	—	7	—	—	—	2	—	—	—	10	10
OTHER:		—	—	—	—	—	—	—	—	—	—	—	—	
NGT: (Rec)		—	—	0	~~0~~	0	4cc	—	—	Changed 15	/	LIS	25	240

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

INPUT

MAINTENANCE LR 100/ 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | ~~1000~~ | 100 — 1200

Tube feedings Held | Held → | ~~30~~ 15 | 30 | 30 | 30 | 30 | 30 | 0 | 0 | 0 | 0 — 165

IVPB | 0 | 300 → | 0 | 0 | 0 | 0 | 100 | 0 | 0 — 400

versed | 4mg 3mg | 2mg | 3mg | 3mg | 3mg | 3mg | Held | 0 | 0 — 16

~~1224~~ ~~1200~~

TOTAL 1805 IN

1781

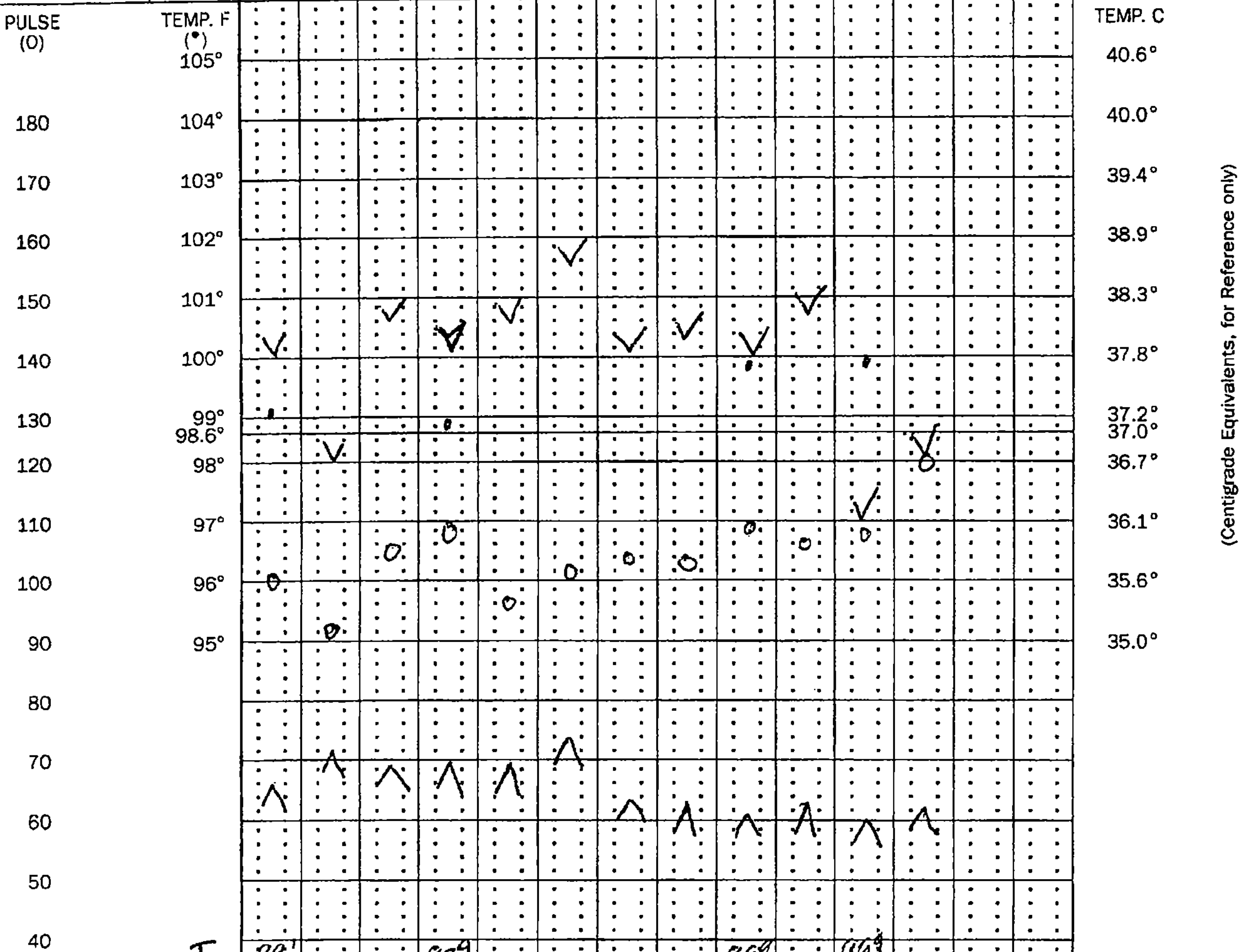
MEDCOM - 6608

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	24 July 2003													
POST- DAY														
MONTH-YEAR / DAY	07	08	09	10	11	12	13	14	15	16	17	18		
19 / HOUR														



	07	08	09	10	11	12	13	14	15	16	17	18		
T	99^{1}			98^{9}					99^{9}		99^{9}			
RESPIRATION RECORD RR	35	11	33	40	37	41	31	28	30	32	31	41		
BLOOD PRESSURE A-line	145/71	113/65	123/72	134/65	135/61	141/69	130/64	153/60	133/63	134/60				
NIBP	141/60	121/71	146/69	142/70	146/69	156/71	141/65	142/67	140/69	148/62	111/60	129/62		
HR	100	92	105	109	96	101	104	103	109	106	107	120		
HEIGHT: WEIGHT ~~MAP~~														
SaO2	100	100	~~100~~									96		
Vent SIMV: TV	850	850	~~850~~				NC	NC@6/3L	NC@6					
VR	10	10	~~10~~											
FIO2	50	50	~~50~~											
Peep	5	5	~~5~~											
Foley	100	1100	120	550	400	200	200	200	150	150	100			
JP	–	–	–	–	–	–	–	–	–	–				

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

IVF's	100	100	50	50	50	50	50	50	50	50	50	50
WPB's	100	0	0	50	250	0	0	100	0	0	0	
NGT	20	50	50	100	100	120	50	30	40*	120	60	

Meds :

VITAL SIGNS RECORDS

Medical Record

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

* NG tube INPUT

MEDCOM - 6609

MEDICAL RECORD	VITAL SIGNS RECORD													
HOSPITAL DAY														
POST- DAY														
MONTH-YEAR	DAY													
19	HOUR	19	20	21	22	23	24	01	02	03	04	05	06	07

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD R

Record special data only when so ordered

BLOOD PRESSURE	
#R	
HEIGHT: WEIGHT ~~Sat~~	
O2	6L
Method	NC
Foley	
JP	
IVF	
NG	

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

REGISTER NO.

WARD NO.

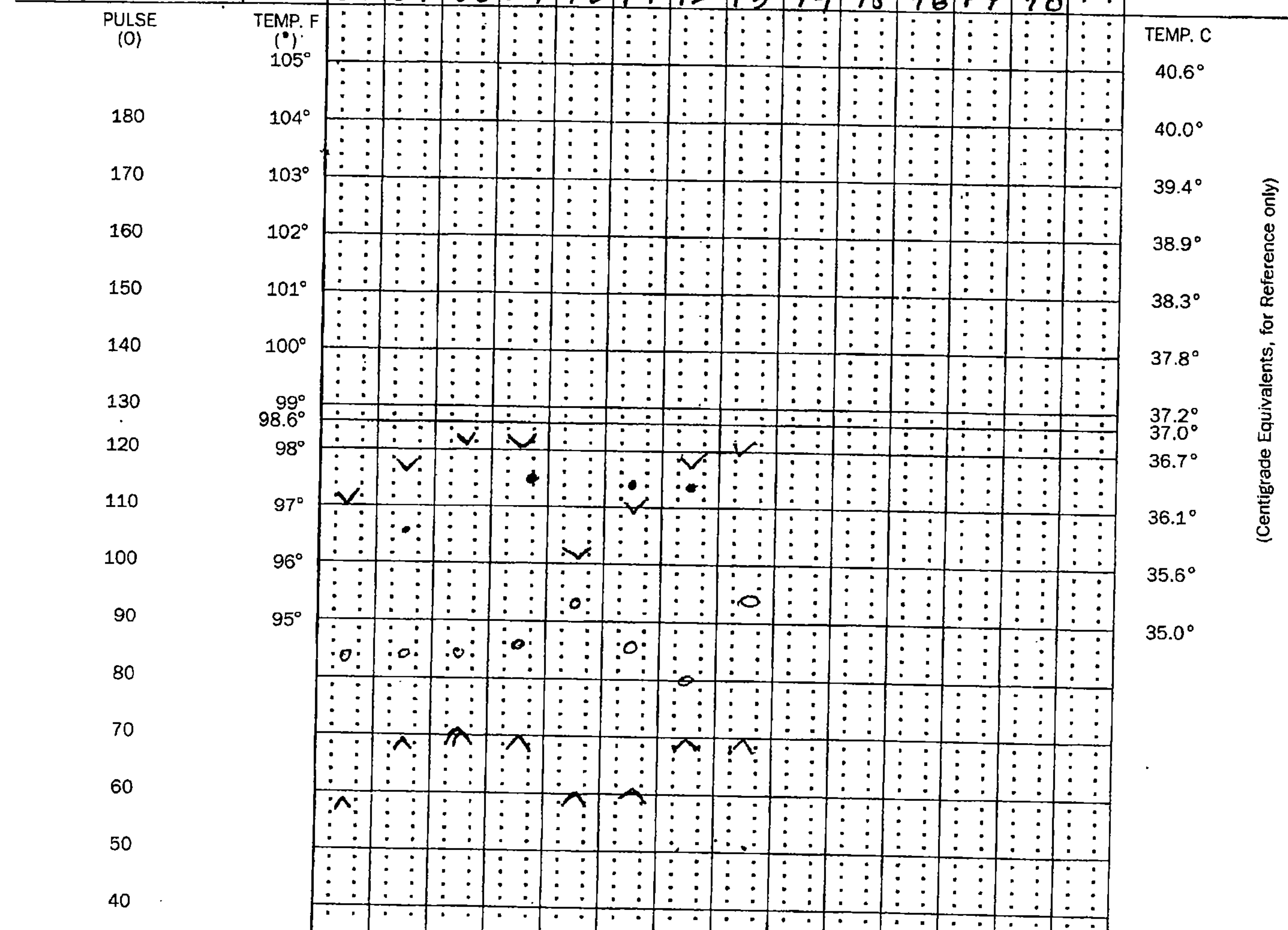
STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6610

(b)(6)-4

MEDICAL RECORD | 25 July | VITAL SIGNS RECORD

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



RESPIRATION RECORD

Record special data only when so ordered

HEIGHT: | WEIGHT

	06	07	08	09	10	11	12	13	14	15	16	17	18
BLOOD PRESSURE NIBP	110/59	114/69	124/71	129/69	101/58	109/61	118/70	128/[illegible]	129/70	129/68	111/58	114/57	
HR	84	85	85	86	92	86	81	89	87	88	91	90	
RR	22	24	23	22	24	12	20	18	20	22	22	23	
~~SaO2~~	98%	98%	98%	98%	100%	97%	100%	100%	100%	99%	99%	99%	
O2 MODE	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	N/C	NC	
L	2	2	2	2	2	2	3	3	3	3	3	3	
T:		96.7		97.7		97.4	97.4		97	97.1	97.7		
NGT	30	30	30	60	60	60	60	60	60	90	90	90	
Resid		50		10		50		12		5		35	
PO							240						
LR	50	50	50	50	50	50	50	50	50	50	50	50	

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

REGISTER NO

WARD NO. 400

STANDARD FORM 511 (REV. 7-95) BACK

	06	07	08	09	10	11	12	13	14	15	16	17	18
					Fucdizol		Cipro		[illegible]				
IVPB	50	50	50		50	50	50	50	50				
MSO4								2			2		
NGT Flushes	30			50		30		30		40		50	
Foley	100	100	100	100	75	75	50	175	100	75	150	150	
JP						D/C'd							
BM													
	06	07	08	09	10	11	12	13	14	15	16	17	18

Total intake 2470

Total 1250

1220

1020
240
600

230

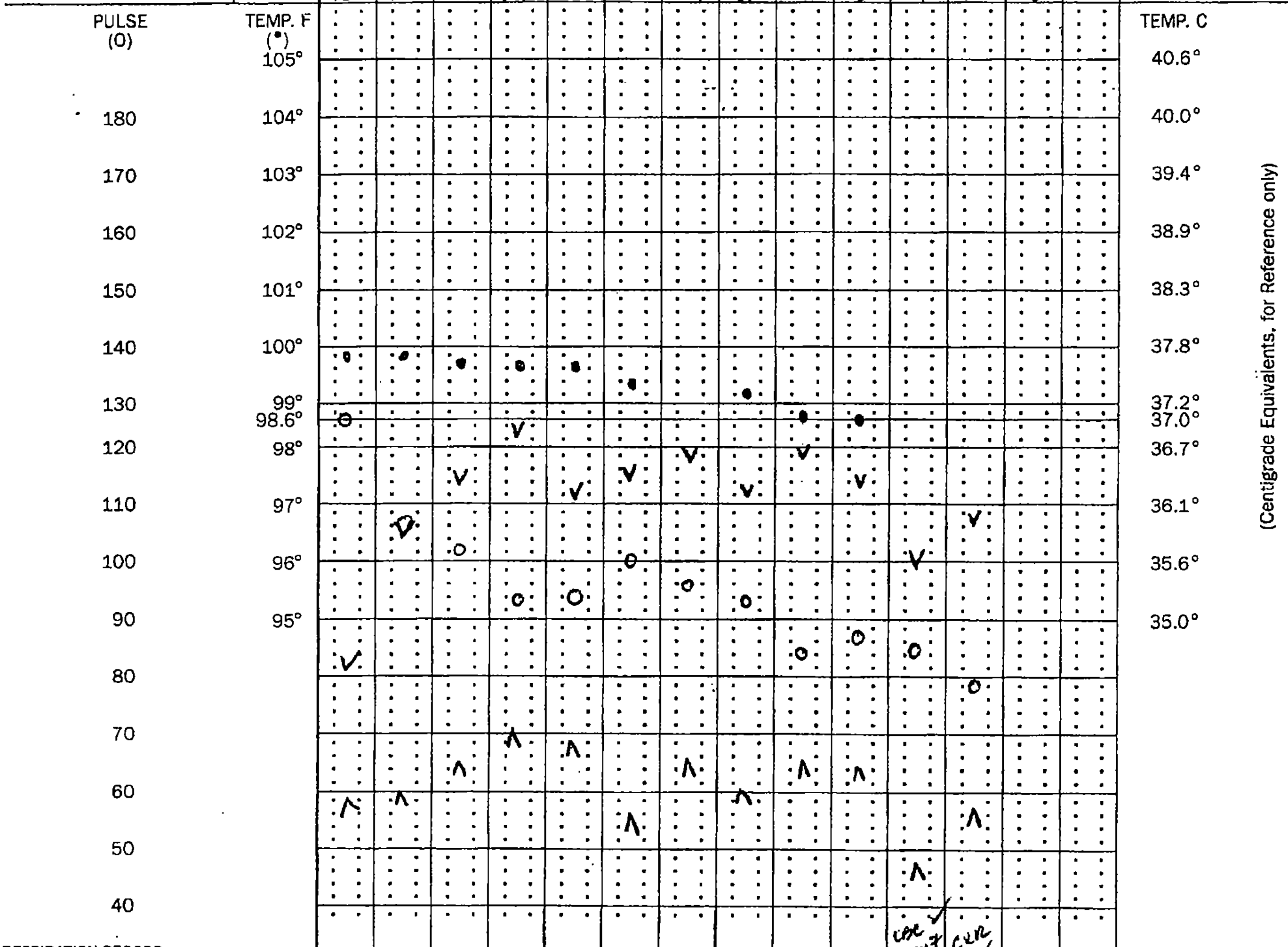
MEDCOM - 6611

(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD 24-25 July 2003 **VITAL SIGNS RECORD**

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY														
19 / HOUR	18	19	20	21	22	23	24	01	02	03	04	05	06	



RESPIRATION RECORD

Record special data only when so ordered

	18	19	20	21	22	23	24	01	02	03	04	05	06		
BLOOD PRESSURE NIBP	81/59	106/60	115/63	123/70	111/64	115/56	119/66	111/60	115/65	114/64	102/47	107/58	110/54		
HR	127	107	101	93	94	100	96	92	84	87	85	79	84		
SaO2	94%	99%	100%	99%	100%	100%	100%	100%	100%	100%	99%	99%	98%		
HEIGHT: / WEIGHT ~~RR~~	39	34	32	28	25	26	30	23	20	20	22	22	22		
T:	99.8	99.8	99.7	99.7	99.7	99.3	—	99.2	98.8	98.6	—	98.2	98.2		
O2 Mode	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC		
O2	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	3L	3L	2L		
IN Feeding NGT	0	0	30	30	30	30	HELD	HELD	30	30	15	60		~~255~~ 255	IN
OUT Residuals	—	75	—	—	10	—	75	0	30	—	45	—		Res 235	OUT
IN LR	50	50	50	50	0	0	50	50	50	50	Held	50		450	IN
IV IVPB	0	0	0	0	350	0	0	0	0	0	100	0		450	IN
IV MSO4	2mg	2mg	—	2mg	~~4mg~~	2mg	0	2mg	0	2mg	0	0		10	IV

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

	18	19	20	21	22	23	24	01	02	03	04	05		
oral				H2O 240	H2O 120	H2O 120	0	0	0	60	0	0	540	IN
Foley	100	50	50	100	90	70	85	70	100	125	125	75	Foley 1040	OUT
JP drain	0	0	5	0	0	0	2cc	0	0	0	2cc	0	JP 10	OUT
BM	x1L	0	0	0	0	0	0	0	0	0	0	0	x1	OUT

VITAL SIGNS RECORDS

Medical Record

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

Total: 1800-0500 → 1050
OUT = 1285 -235 Resi
In - 1165

MEDCOM - 6612

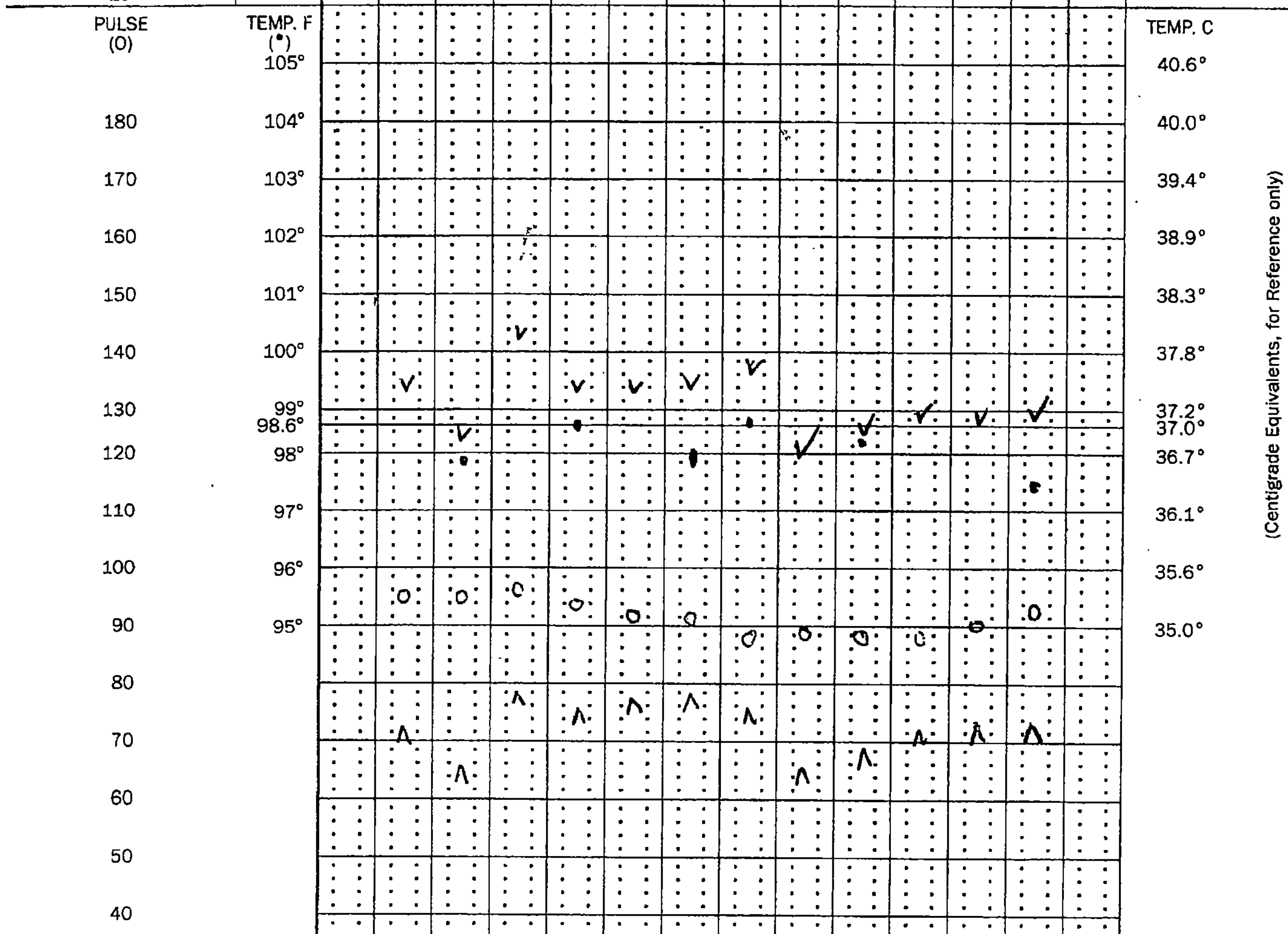
(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	25 July 2003								26 July 2003					
POST- DAY														
MONTH-YEAR / DAY	18	19	20	21	22	23	24	01	02	03	04	05	06	—
19 / HOUR														



RESPIRATION RECORD

Record special data only when so ordered

	18	19	20	21	22	23	24	01	02	03	04	05	06	—	
BLOOD PRESSURE NIBP		134/71	123/65	143/78	134/77	134/77	135/79	137/75	124/65	124/69	127/71	128/73	129/73		
HR		95	95	96	94	91	92	88	89	89	88	90	93		
RR		21	12	20	20	21	20	22	20	20	21	19	25		
HEIGHT: WEIGHT ~~SaO2~~		100%	98%	98%	99%	99%	98%	98%	99%	98%	98%	98%	98%		
T		—	97.9	—	98.6	—	97.9	98.7	—	98.3	—	—	97.5		
Mode / O2/L		2.5NC	2.5 NC	2.5 NC	2.5 NL	2.5 NC	2.5 NC	2.5/NC	2.5/NC	2.5NC	2.5NC	2.5NC	2.5NC		
IN Feeding NGT		90	0	40	90	90	90	100	100	110	110	110	110	1080	TF
Residuals →	—	8cc	—	—	14cc	—	—	8cc	10cc	—	5	—	—	+	
LR	50	50	50	50	50	50	50	50	50	50	50	50	50	600	LR
IVPB	0	0	0	0	350	0	0	0	0	0	0	0	50	400	IVPB
MSO4	0	4mg	0	0	0	0	0	2mg	0	0	0	0	0	6mg	MSO4

IN 2696

OUT 2625

+71

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

REGISTER NO

WARD NO. ICU

	18	19	20	21	22	23	24	01	02	03	04	05	06	—	
PO	0	0	240cc	240	120	0	0	0	0	0	0	0	4 Beg Juice	600	PO
Foley	200	175	175	150	225	250	250	200	175	200	225	200	200	2625	FOLEY
BM	0	0	0	0	0	0	0	0	0	0	0	0			
			OUTDOORS →	400	925			↑ feeding in GI 110	1000						

(b)(6)-4

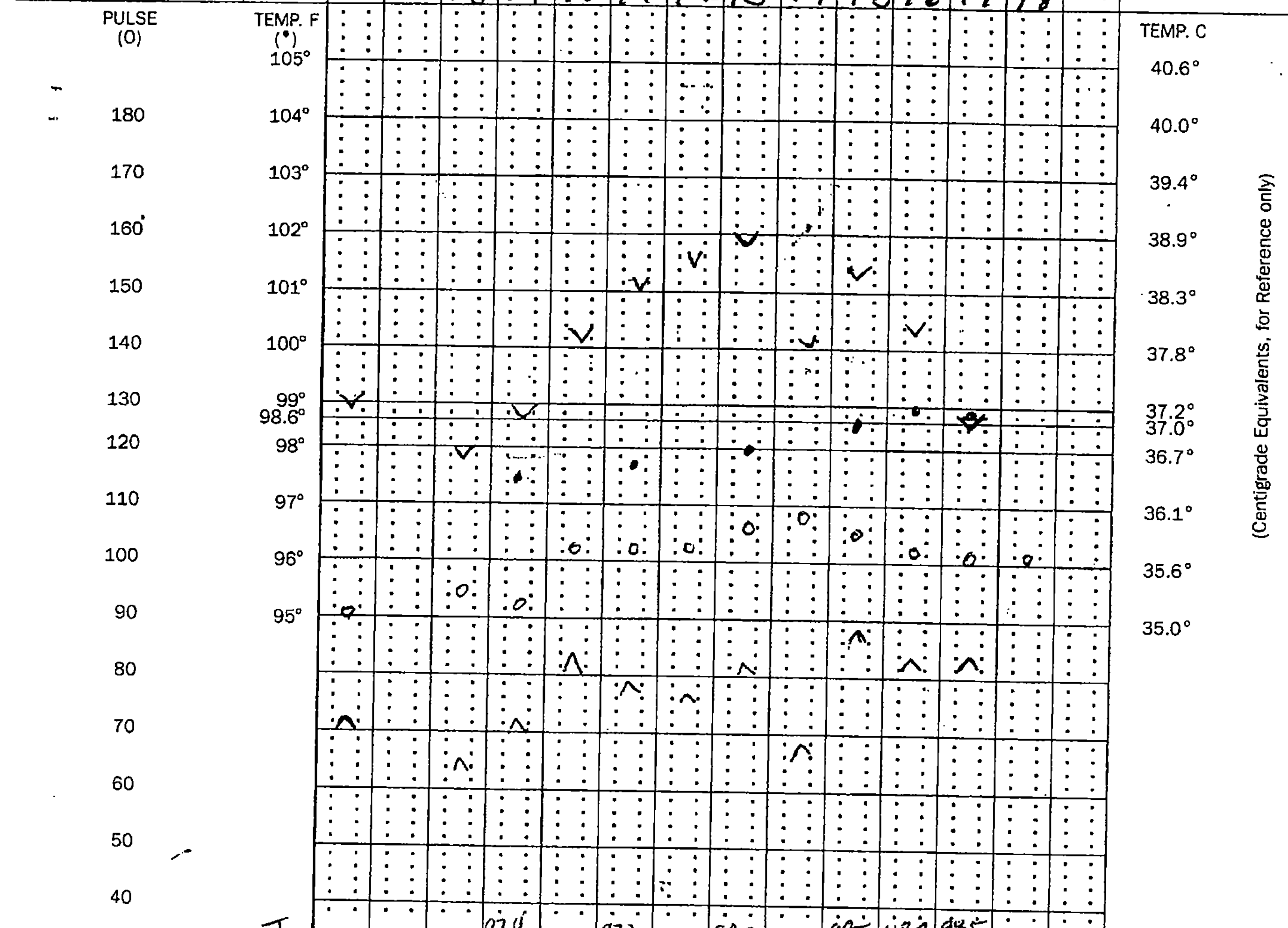
VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6613

MEDICAL RECORD	VITAL SIGNS RECORD
HOSPITAL DAY	
POST- DAY	
MONTH-YEAR DAY	26 July 03
19 HOUR	06 07 08 09 10 11 12 13 14 15 16 17 18



	06	07	08	09	10	11	12	13	14	15	16	17	18
I				97.4		927		99.0		~~98~~	98.7	98.5	
RESPIRATION RECORD	20		23	24	23		32	27	26	28	25	24	
BLOOD PRESSURE	129/73		117/65	129/73	147/84	154/71	150/96	154/81	141/64	153/88	142/81	125/82	
	91	102	94	99	102	102	103	96	96	103	102	101	101
	RL	aL	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
HEIGHT: WEIGHT →	99%	97%	94%	95%	94%	97%	96%	94%	96%	96%	96%	95%	96%
IV	50	50	D/C'd	→						20	20	20	20
PO fluids	0	120	120	0	60	0	0	0	0	60	0	120	0
IV Meds		50	50	50	50	50	50	0	50	0	0	0	0
Jevity	110	110	110	110	110	110	110	110	110	110	110	110	110
output				0	0	0	0	575	[illegible]	325	0	400	0
foley	100	100	100	D/c'd →									

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

Total intake : IV 180
PO 300
NGT 1320
Flush 200

2000 I
-1600 O
400
Bal 400

Outpute = Foley 300
900

Bal
+520

(b)(6)-4

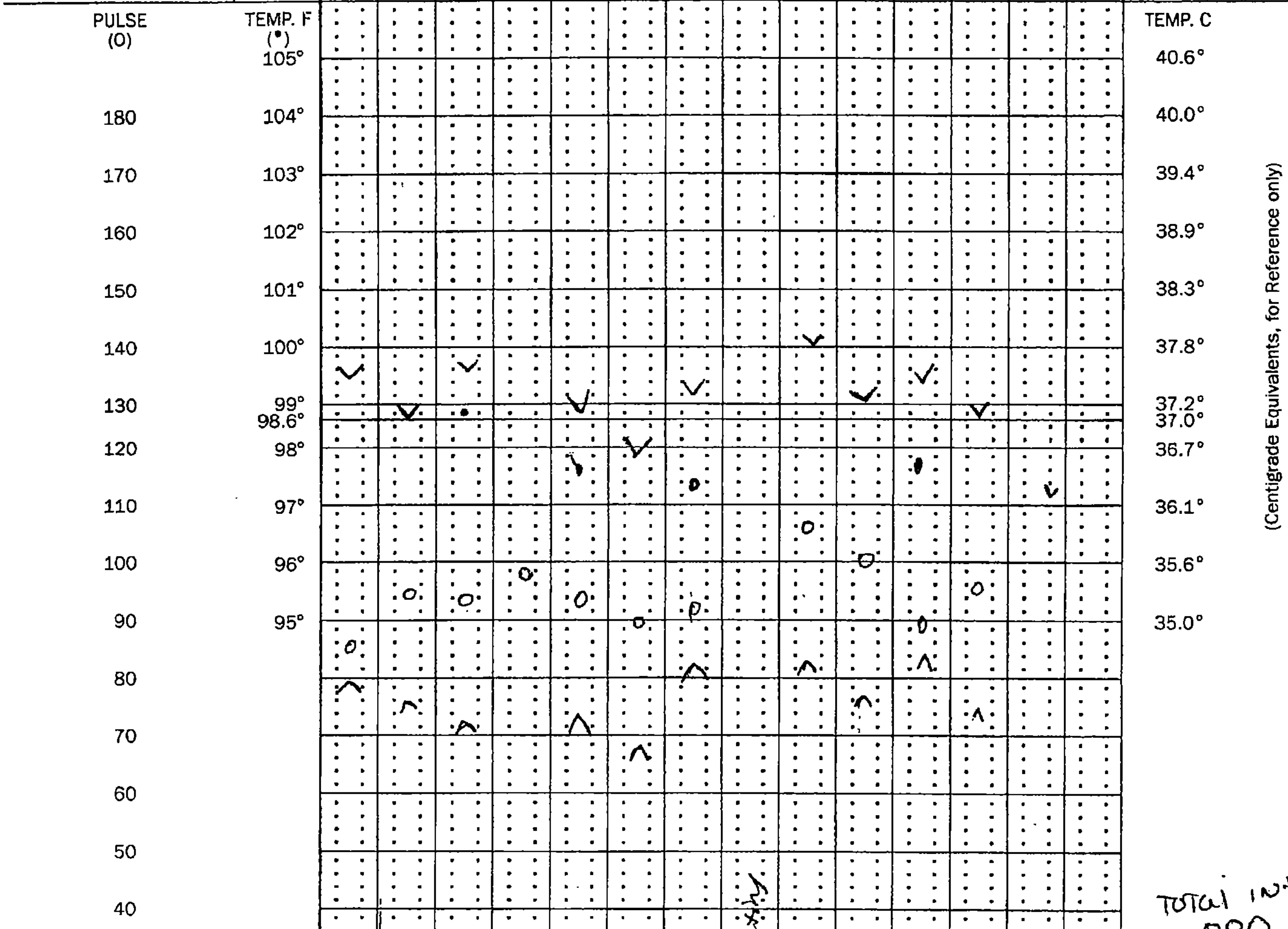
MEDCOM - 6614

ACLU-RDI 1407 p.204

511–119 NSN 7540–00–634–4124

MEDICAL RECORD 27 July 2003 VITAL SIGNS RECORD

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



TOTAL intake 2080

	06	07	08	09	10	11	12	13	14	15	16	17	18		
RESPIRATION RECORD T			98.8		97.1		97.4	Am. Anxiety			97.7				
BLOOD PRESSURE NIBP	135/79	125/76	138/71	off	120/72	118/60	132/82		141/83	132/78	134/81	126/74			Total output 700 t
HR	84	94	92	99	94	89	92		106	100	89	96			
RR	22	25	20	28	21	21	23		20	20	20	18			
HEIGHT: / WEIGHT SaO2	100%	100%	92%	100%	100%	100%	100%	X	100%	100%	100%	100%			
L / Source O2	NC	INC	RA	INC	INC	RA	RA	X	RA	RA	RA	RA			
Maintenance - IVF	20	20	20	20	0			0							80
PO	0	240	120	0	0	120	0	120	0	240	0	120			960
IVPB	50														150
MSO4	0	0	0	0	0	0	0	0	0	8	0	0			
UOP	0	0	400	0	0	-	0	300	-		0	0			700
BM		LG	c	r	MED	···	MED	"	0	0	0	6			

Record special data only when so ordered

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

TF	0	0	110	110	110	110	110	Held	~~110~~	~~110~~	110	110			990
Res.	140	/	10	/	50	/	/	/		/	20	/	/		

VITAL SIGNS RECORDS

Medical Record

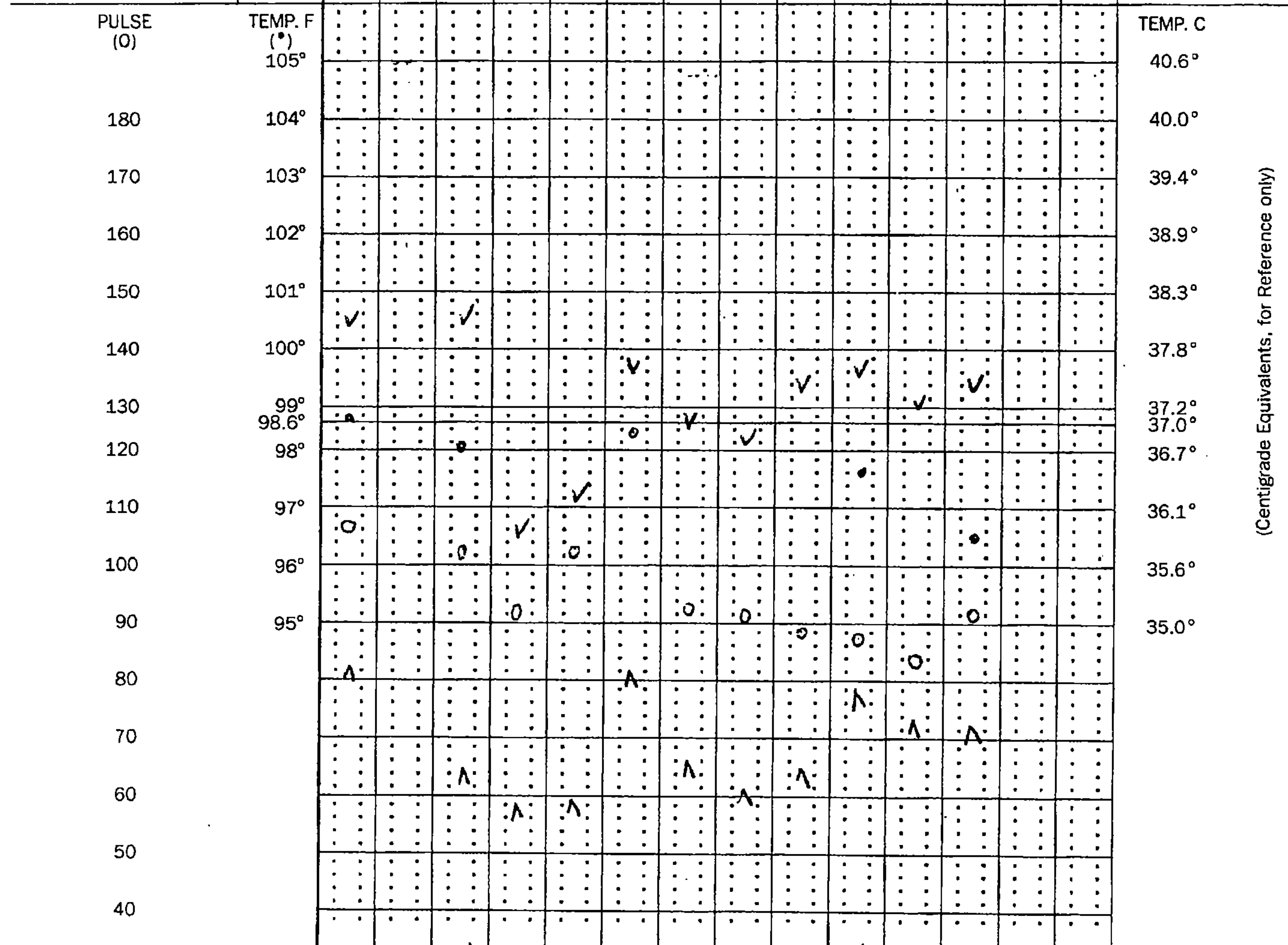
STANDARD FORM 511 (REV. 7–95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 6615

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	26 July	03							27 July	2003				
POST- DAY														
MONTH-YEAR / DAY	18	19	20	21	22	23	24	01	02	03	04	05	06	
19 / HOUR														



RESPIRATION RECORD

Record special data only when so ordered

	18	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
T:	98.7		98.1							97.4		96.5		
BLOOD PRESSURE NIBP	145/82		149/64	108/58	111/59	137/82	126/64	121/60	134/65	138/69	130/73	134/79	132/73	
HR	102		103	92	103	124	91	91	88	87	84	97	81	
RR	28		25	22	31	32	26	28	23	24	18	22	19	
HEIGHT: WEIGHT Sat	98%		98%	100%	100%	99%	99%	98%	100%	100%	100%	100%	100%	
✓/ Source O2	RA	RA	RA	RA	RA	RA	RA	NC1✓	NC1✓	NC1✓	NC1✓	NC1✓		
NS-IVF	20		20	20	20	20	20	20	20	20	20	20	20	240
PO	0	120	0	0	0	240	0	0	0	0	0	0	0	360
IVPB	0	0	0	0	300	0	0	0	0	0	100	0	50	450
MS	0	4mg		0	2mg	0	0	2mg	0	2mg	0	0	0	10mg
UOP	x1	0	0	0	300	0	250	0	0	0	400	0	0	950
BM	x1	0	0	0	0	0	0	0	0	0	0	0	0	x1
TF	110		110	110	110	110	110	110	110	110	110	110	110	1230
Res	–	–		55	–	–	–	55	–	–	–	65		

1230
1060
2290 — IW
950+ — out

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

REGISTER NO

WARD NO [redacted]

STANDARD FORM 511 (REV. 7-95) BACK

b(6)-2

OOKS

/15/Recid OSC Δ

Dsg Δ ABO

ate milk ice
t shake

ent

MEDCOM - 6616

MEDICAL RECORD		VITAL SIGNS RECORD													
HOSPITAL DAY		28 July 2003													
POST- DAY				0											
MONTH-YEAR	DAY	06	07	08	09	10	11	12	13	14	15	16	17	18	19
19	HOUR														

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

(Centigrade Equivalents, for Reference only)

OFF AM care performed

OFF OOB → chair

OFF Ambulated to PCU corridor

RESPIRATION RECORD

Record special data only when so ordered

		06	07	08	09	10	11	12	13	14	15	16	17	18	19
	T	97.7			98.5				98.5				98.7		
BLOOD PRESSURE	NIBP	105/51	109/52		110/55	129/70			124/69	124/71		127/66	113/62		105/66
	HR	83	89		89	94			97	93		98	93		83
	RR	25	21	20	22	24			26	28		20	20		23
HEIGHT: WEIGHT	SaO2	95%	96%	96%	97%	94%	98%	98%	97%	97%		96%	96		100%
O2-	mode	RA	RA	RA	RA	RA	RA	RA	3LNC	2NC	0	0	0		RA
	IS	0	x10	0	0	0	0	0	—	—	x10				x10
	CPT	0	RT	—	—	—	0	0	—	—					
	Amb	0	10ft	—	—	—	40ft	40ft	—	—	—	20ft	—		
PO {	Solids	0	eggs	—	—	—	1/8 meat	corn	—	—	—	—	—		
	Liquids	480	240	—	—	—	240 H2O		—	—		240			
NGT	Jevity	120	60	—	—	—	120	/	—	—	—	—	—		
	UOP	0	300	—	—	—	400	200	200	~~200~~		250			
	BM	0	sm	—	—	—	—	sm	sm						

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

REGISTER NO

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 6617

ACLU-RDI 1407 p.207

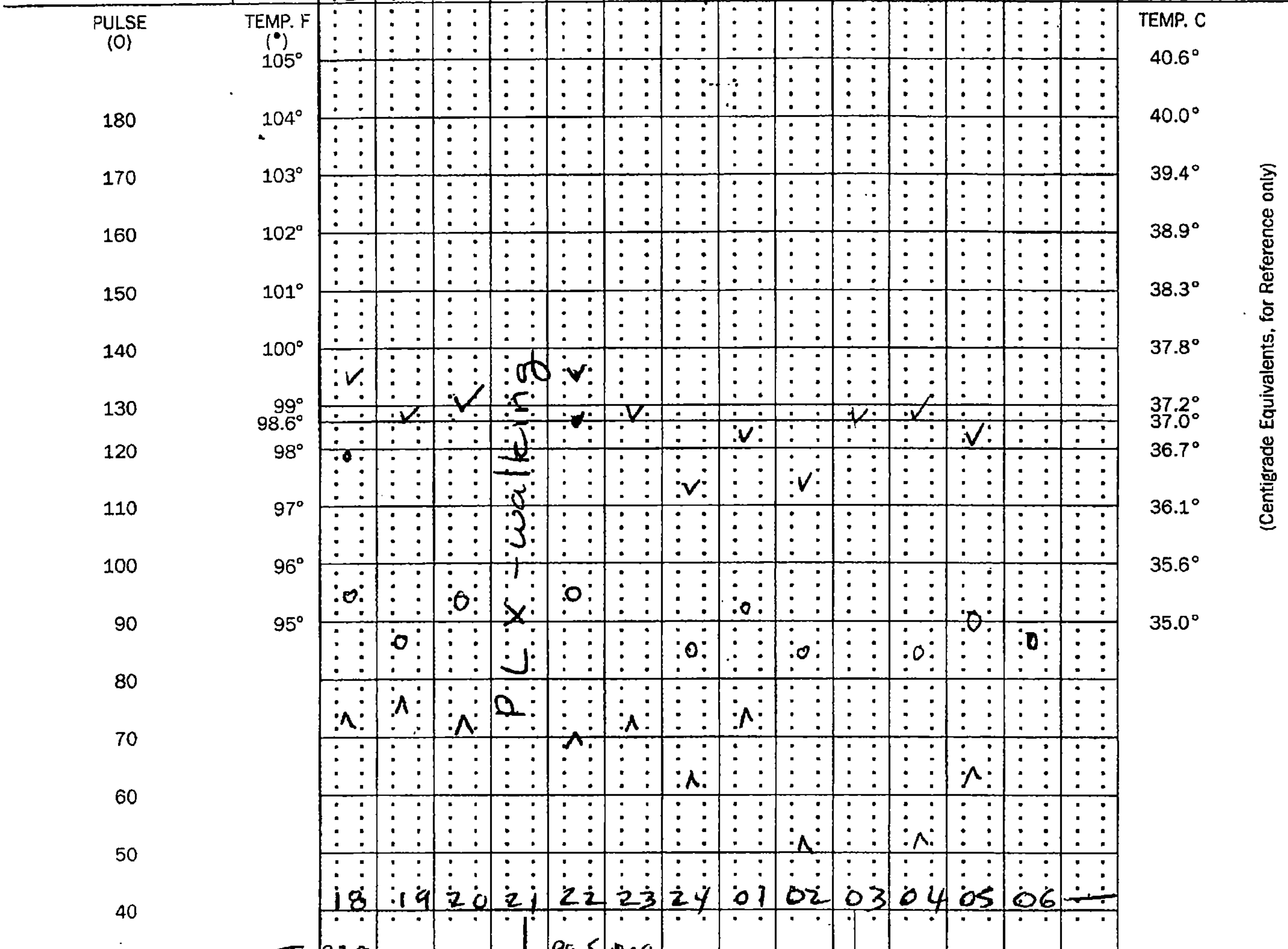
511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

27-28 July

HOSPITAL DAY															
POST- DAY	Sunday [illegible]								Monday						
MONTH-YEAR DAY	27														
19 HOUR	18	19	20	21	22	23	24	01	02	03	04	05	06	—	



	18	19	20	21	22	23	24	01	02	03	04	05	06	—	
RESPIRATION RECORD T	97.9				98.5	[illegible]									
BLOOD PRESSURE NIBP	135/76	128/77	130/72		135/70	~~[illegible]~~ 128/79	113/63	125/76	112/52	[illegible]/53	126/53	122/65	104/51		
HR	95	86	94		95	92	85	92	95		85	90	87		
RR	21	18	26		26	21	18	21	21		20	22	20		
HEIGHT: WEIGHT Sat O2	100%	100%	100%		100%	98%	99%	99%	100%		98%	99%	98%		
mode/L O2	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA		RA
IS	x5	0	x10	—	—	—	—	—	—	—	—	—	—		
PO solids	x1	—	—		—	x1	—	—	—		—	—	—		
PO liquids	300	120		240	—	240	—	—	240		—	—	480		1344 IN
Urinal UOP	0	375	0	0	0	250	0	400	x1		x1	x1	0		1025 + UOP
BM	~~0~~	0.	0	0	0	0	~~x1~~	0	x1		x1	x1	0		x3
Percocet	ε	T	0	0	0	0	0	0	0	0	0	0	0		+

Record special data only when so ordered

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

REGISTER NO

WARD NO.

milkshake 240 H2O 120

ambulated ~~[illegible]~~ c̄ PT

IS

PLX

Δ - BED - NGT D/C'd

[illegible] x1

Henry's NGT placement

VITAL SIGNS RECORDS

Medical Record

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

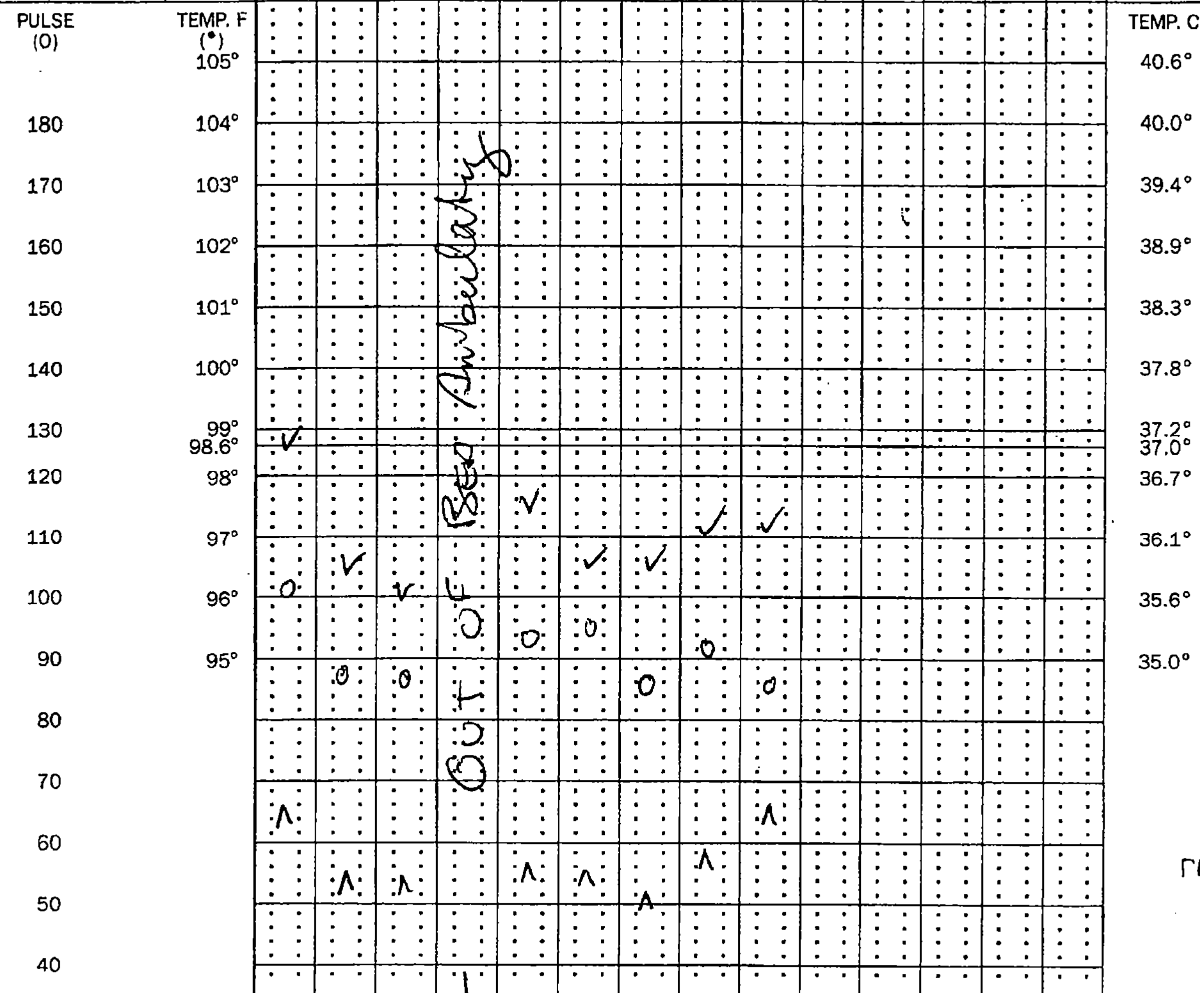
MEDCOM - 6618

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

28 July

HOSPITAL DAY							29 July 03						
POST- DAY													
MONTH-YEAR / DAY	1800	1900	2000	2100	2200	2300	0000	0100	0200	0245			
19 / HOUR													



RESPIRATION RECORD

Record special data only when so ordered

	1800	1900	2000	2100	2200	2300	0000	0100	0200	0245
BLOOD PRESSURE BP	127/68	105/56	102/54		119/59	106/56	105/51	111/59	111/67	
HR	101	88	87		92	95	89	91	87	
RR	24	30	41		26	25	20	21	21	
HEIGHT: WEIGHT: SAO2 →	98%	96%	96%		98%	98%	98%	99%	98%	
T:										
UOP	0	0	0	350	0	0	0	400	0	400
BM	0	0	0	0	0	0	0	0	0	0

output 1150

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

REGISTER NO.

WARD NO.

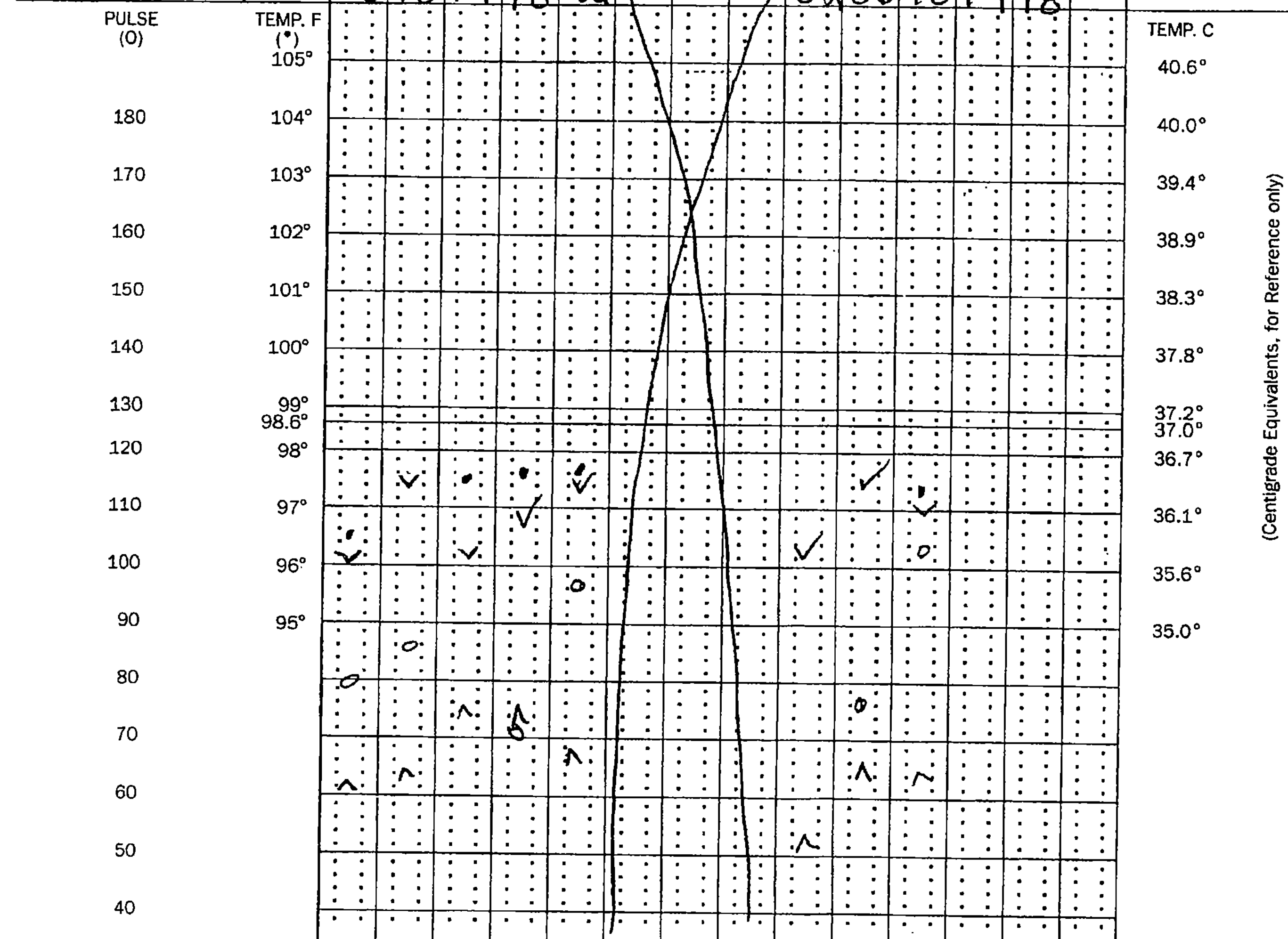
VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6619

MEDICAL RECORD	VITAL SIGNS RECORD													
HOSPITAL DAY														
POST- DAY	29 Jul 03								30 July					
MONTH-YEAR / DAY														
19 / HOUR	06	10	14	18	22				02	06	10	14	18	



RESPIRATION RECORD R)	22				28				28	14	20	20		
BLOOD PRESSURE BP	111/63	114/65	130/70	112/71	116/69				102/57	114/67	103/66	129/75		
P	80	86	94	71	97				79	76	103	93		
T	96.7	96.5		97.6	97.7				—		97.7	98.5		DAY
HEIGHT: WEIGHT SAO2 →	98%	99%	96%	98%	99%				97%	97%	98%	97%		
	RA	RA	RA	RA	RA				RA	RA	RA	RA		
intake	ø	720	360	0	ø				[illegible]	480	240	360		1080cc
output	/	250	200	200					ø	ø	100	300		650cc
BM	ø	ne X1	sn X1	Lg X1	BM Lg				ø	ø	0	X1		Evening/night

IN 480

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

REGISTER NO.

WARD NO.

OUT ~850 cc voo

(b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

240

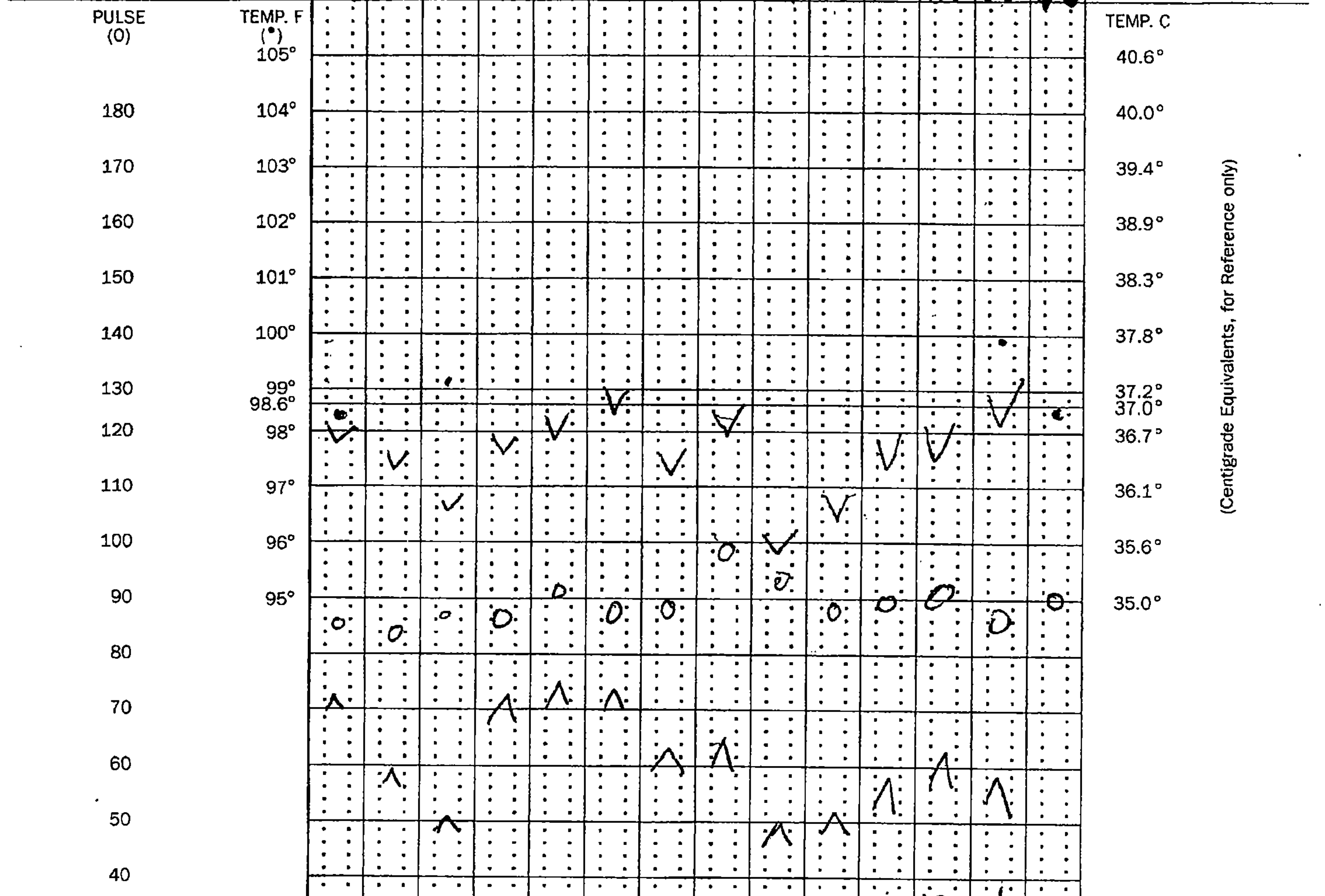
240

MEDCOM - 6620

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	2 Aug				3 Aug						4 Aug			
MONTH-YEAR Aug 03 DAY														
19 HOUR	06	10	14	18	22	02	06	10	14	18	22	02	06	10



RESPIRATION RECORD	98.3 18		99.2	140	14	16	18	20	16	18	14	12	14	20
Record special data only when so ordered — BLOOD PRESSURE	118/73	117/57	108/58				115/63	121/65	98/50	108/62	114/6	124/64	125/62	106/51
	85	84	87	85	90	91	88	99	93	88	88	90	90	
	20	20	18	16							12			
HEIGHT: WEIGHT O2Sat →	97%	98%	98%	98%	98%	98%	96%	96	97	97	97%	98%	95%	100%
intake	240		400				Ø	200		200				
output			300					600					VOIDED IN BEDSIDE COMMODE	

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

(b)(6)-4

MEDCOM - 6621

/

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

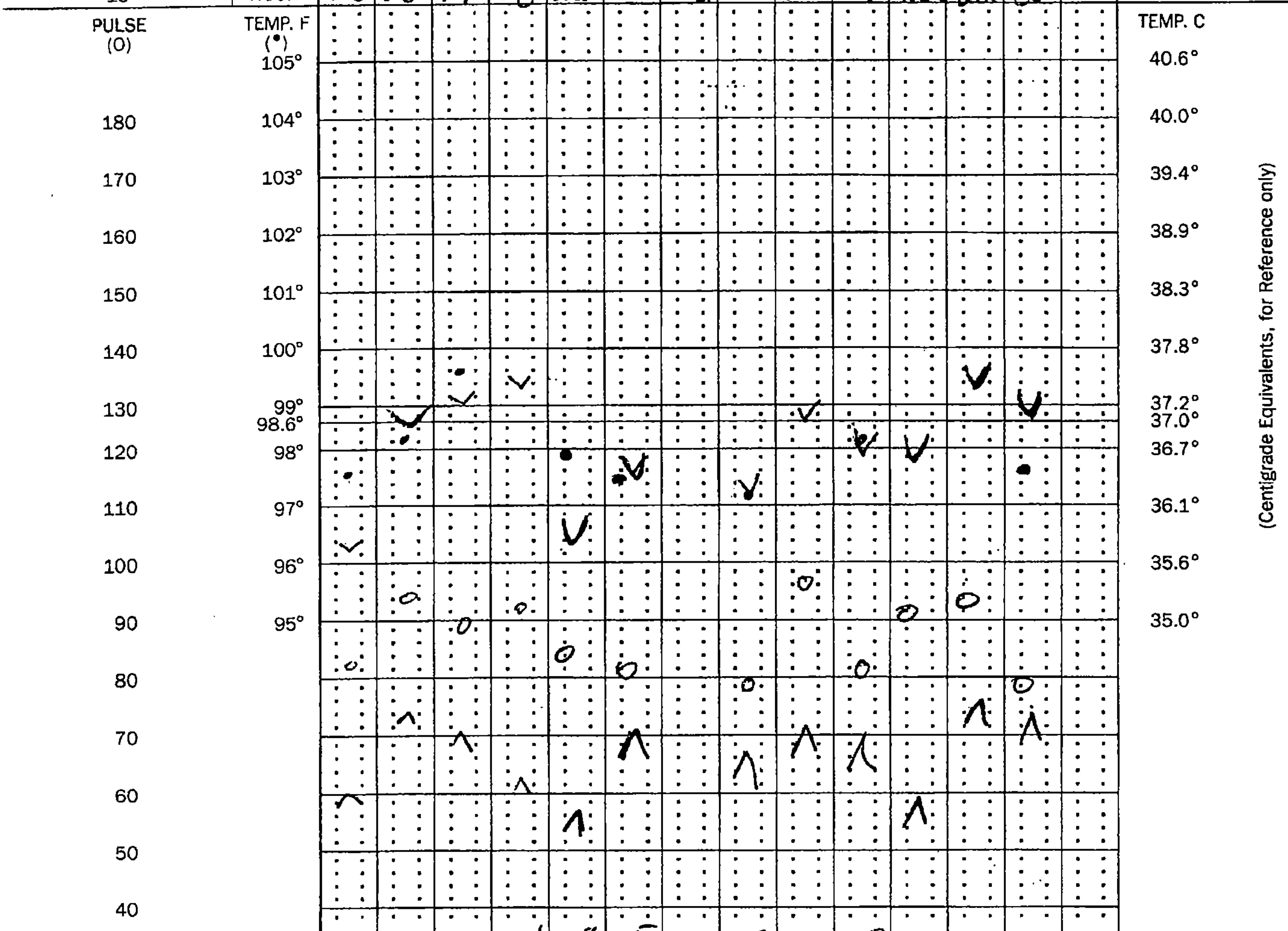
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19

DAY	31 July03						1 AUG03							
HOUR	06	10	14	18	22		02	06	10	14	18	22	02	



RESPIRATION RECORD	97.6	98.3	99.6	98.4	97^{8}	97^{5}		97^{2}		98^{2}		97^{9}	97^{5}	
BLOOD PRESSURE	103/59	125/74	131/70	132/63	104/54	114/70		117/62	127/71	119/70	119/57	134/70	89/73	
	83	93	89	91	82	83		78	96	82	42	43	61	
	20	20	20	98%ox	20	14		18	20	16	16	17	14	
HEIGHT: WEIGHT →	98%	97%		20	98%	97%		95%	97%	96	98%	97%	98%	
Intake	480				250						250	250		
Out								400	BMx1				BM	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6622

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	13 August				Post op.									
MONTH-YEAR / DAY														
19 / HOUR	1450	1455	1500	1505	1515	1530	1600							

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	135/85	131/88	142/85	137/84	145/96	153/84	
	105	105	102	97	96	95	
	22	22	21	18	21	16	
HEIGHT: / WEIGHT →	100%	100%	100%	100%	100%	100%	
	95.7	96.3		95.5	96.8	97.2	
				SL'd PL	Δ to NC @ 2L	O₂ ↓ 2L	

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

REGISTER NO.

WARD NO.

(b)(6)-4

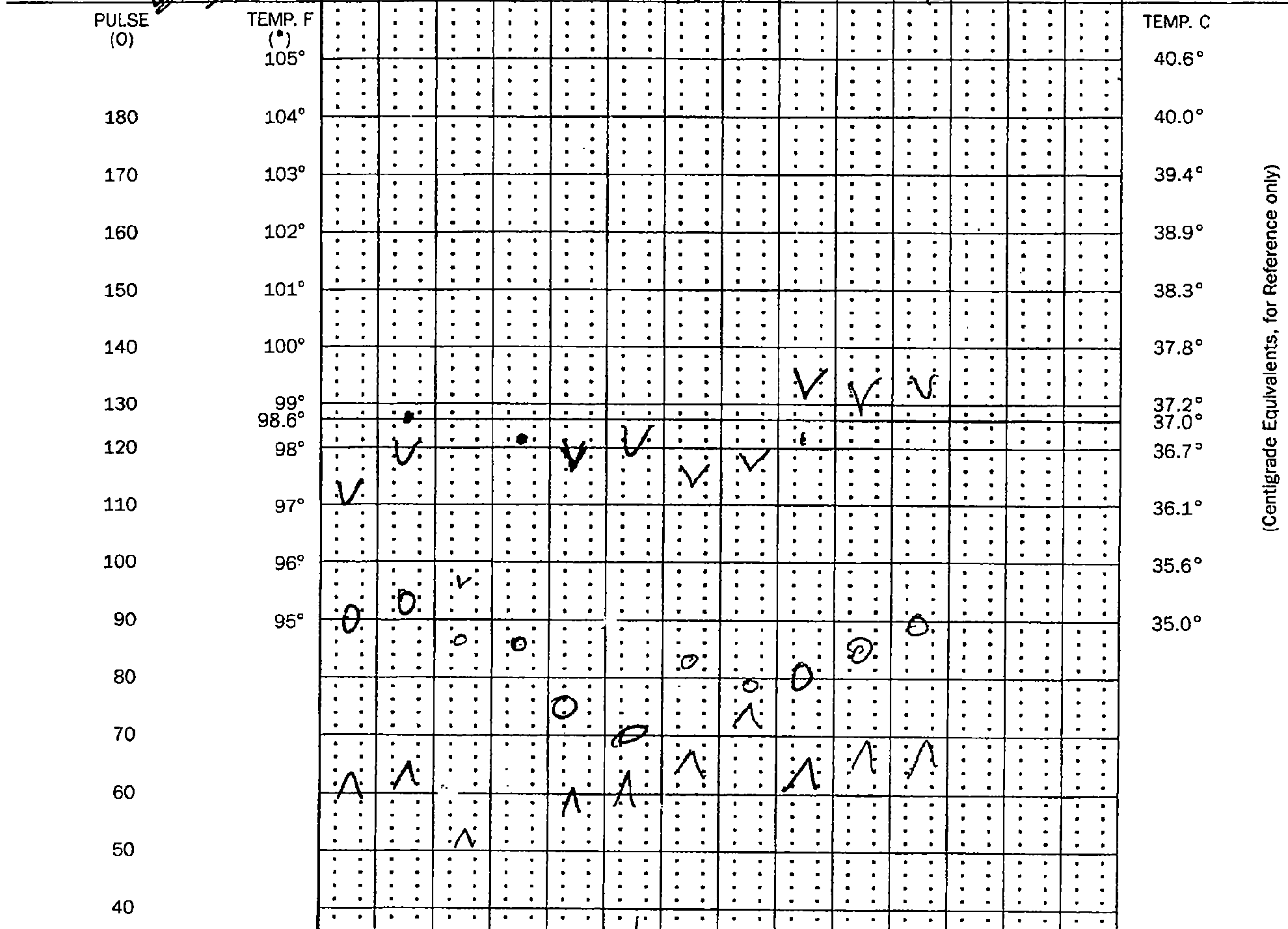
(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD	VITAL SIGNS RECORD										
HOSPITAL DAY											
POST- DAY	10	10									
MONTH-YEAR Aug DAY	02	04	14								
19 2003 HOUR				1700		06	16		22	02	06



RESPIRATION RECORD	14	14	14	16	14	14	19	18			
BLOOD PRESSURE	110/70	112/62	95/57	108/	114/	120/60	114/70	116/75	130/62	130/70	132/68
	90	92	83	59	/60	66	83	79	80	82	90
HEIGHT: WEIGHT →											
O2 sat				97%	98%	97%			97%		
Output									300		

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6624

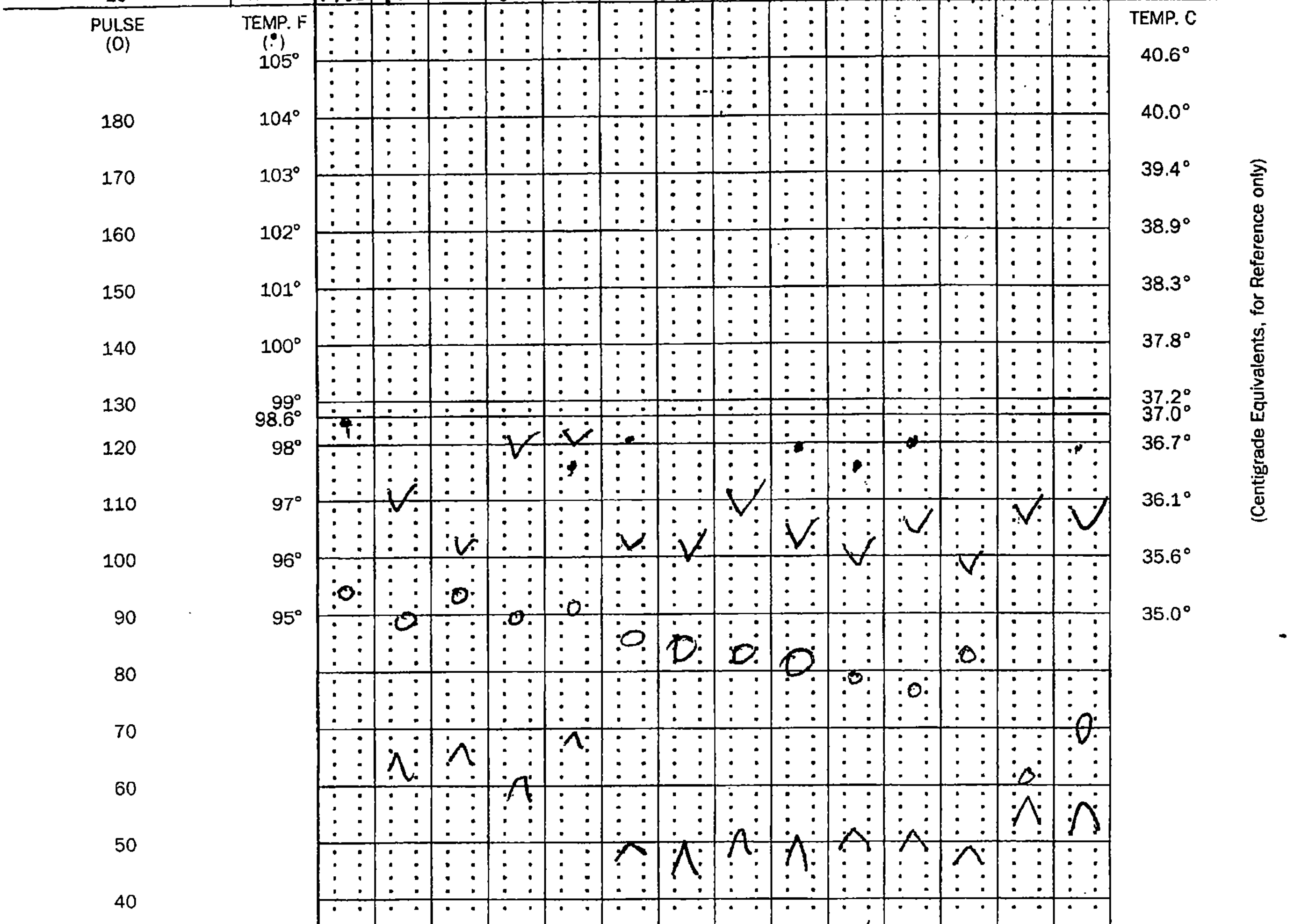
511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

9 Aug

HOSPITAL DAY														
POST- DAY	Monday													
MONTH-YEAR Aug. 03 / DAY	4 Aug				5AUG03				6 Aug					
19 / HOUR	1400	1800	2200	0200	0600	1400	1800	2200	0200	0600	10	14	18	22



RESPIRATION RECORD	24				26					97⁶				
BLOOD PRESSURE	104/57	110/66	114/66	120/60	112/70	104/49	110/49	110/50	106/60	99/53	104/58	97/49	106/51	110/60
					92.6	98.1				97.6	98.0			
		88	92	90	91	86	86	82	82	79	76	83	62	64
HEIGHT: / WEIGHT →														
O2 Sat	98%	98%	98%	99%	98%	97%	96%	97%	98	98	98	97	94	97%
Intake PO	120	100	100			200		200			500	250		I - 780
Output Urine	[illegible]	200				200					750			O - 400

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6625

19

EDICAL REC[illegible]

VITAL SIG[illegible] [illegible]ORD

NSN 7540-00-634-4124

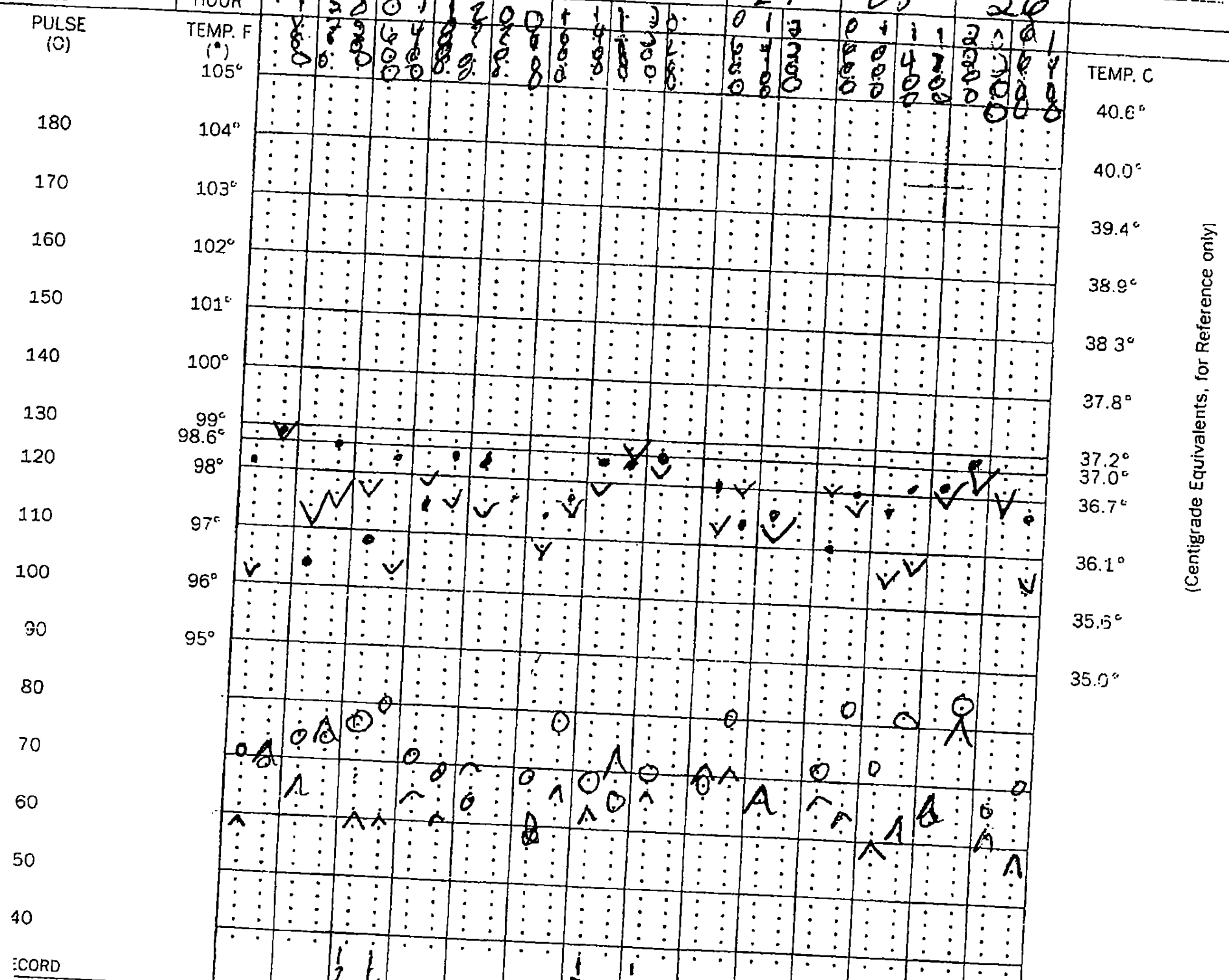
HOSPITAL DAY

DAY

H-YEAR 19

DAY: 22 23 24 25 26

HOUR



ECORD

BLOOD PRESSURE

102/59 111/67 116/61 114/65 112/70 114/68 110/64 102/64 113/72 111/62 119/67 104/60 115/62 119/63

127/72 114/66 103/64 115/61 127/73 119/72 116/65 137/86 [illegible] 137/87

95% 97% 97%

WEIGHT →

95% 95% 96% 95 97 98 98 95% 95% 97% 96% 98% 97% 96

95% 96% 98% 96% 97%

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

REGISTER NO.

WARD NO.

(b)(6)-4

02-1

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

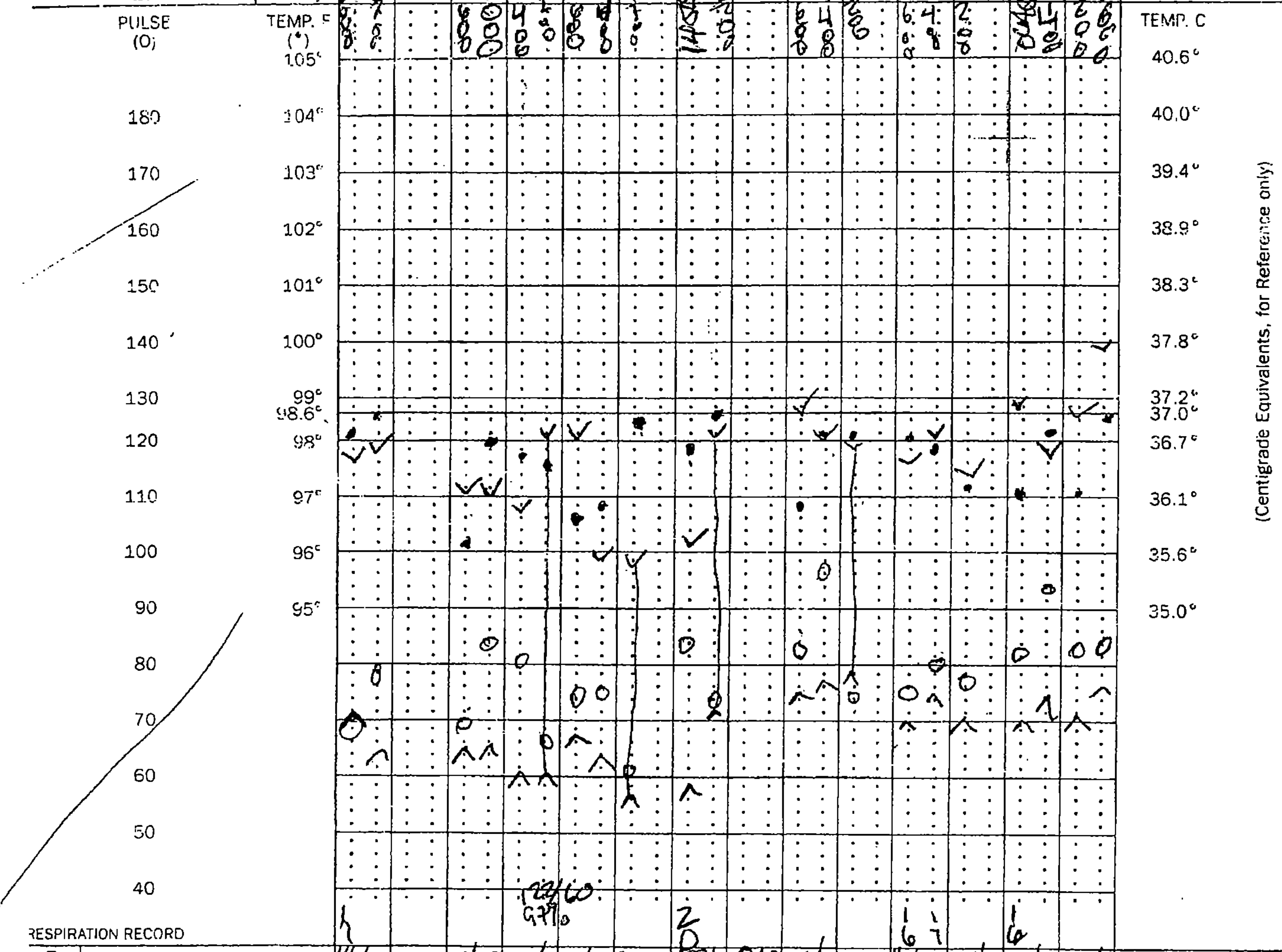
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6626

511-119 NSN 7540-00-634-4151

MEDICAL RECORD — VITAL SIGNS

HOSPITAL DAY	56
POST- DAY	
MONTH-YEAR AUG 03	DAY: 26, 27, 28, 29, 30, 31, 01 SEP
19	HOUR: 0800; 0800, 1000, 1400, 2000; 0800, 1800, 2000; 0300, 2000; 0600, 1400, 1800; 0600, 1400, 2200; 0800, 1400, 2000, 2000



122/60 97%

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE: 116/70, 118/69; 111/65, 110/65; 107/60; 121/67, 98/64; 99/64, 95/61; 102/68, 96%; 96/61, 72; 126/75, 120/77, 121/72; 98/3?; 114/70, 124/74; 114/70; 129/68, 118/74; 126/71, 135/71

HEIGHT: | WEIGHT → | 98%; 96%, 97%; 98%; 96%, 96%; 97%, 98%; 118/72; 98%; 98%, 96%; 95%; 100%, 97%; 97%, 98%

SpO2

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

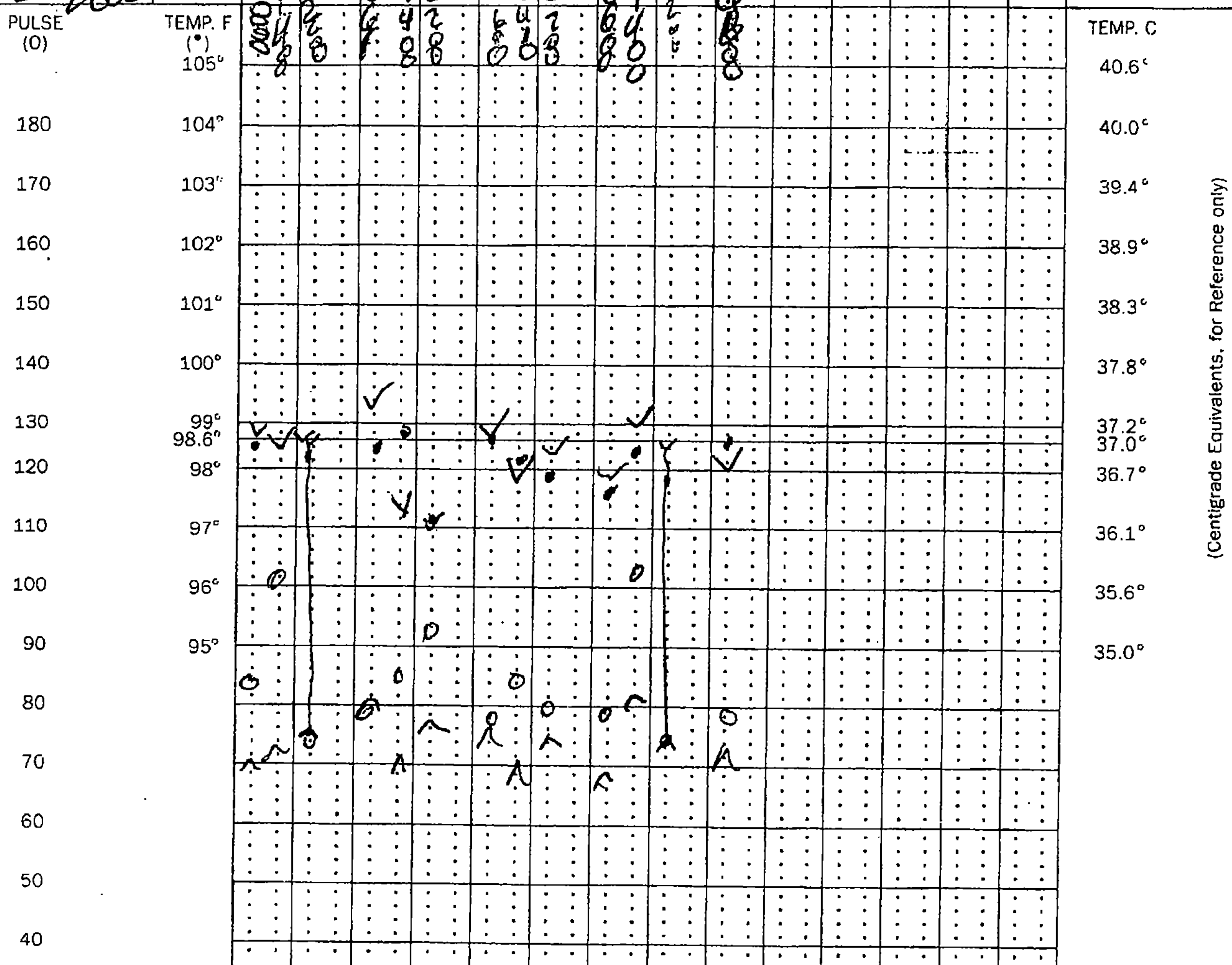
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-

MEDCOM - 6627

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	57							
POST- DAY								
MONTH-YEAR Sep	DAY	2	3	4 sep	5	6		
19 2003	HOUR		0 1 2	0 1 2	0 1 2	0		



ESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	126/71 124/73	90/51 74 124/76	134/86	119/77 98%	126/78 118/70 99%	107/65 97%	122/68 130/88 96	97.9 96% 75 128/73	120/78
HEIGHT: WEIGHT →									
Spo2			98/99		96%		98		98%

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

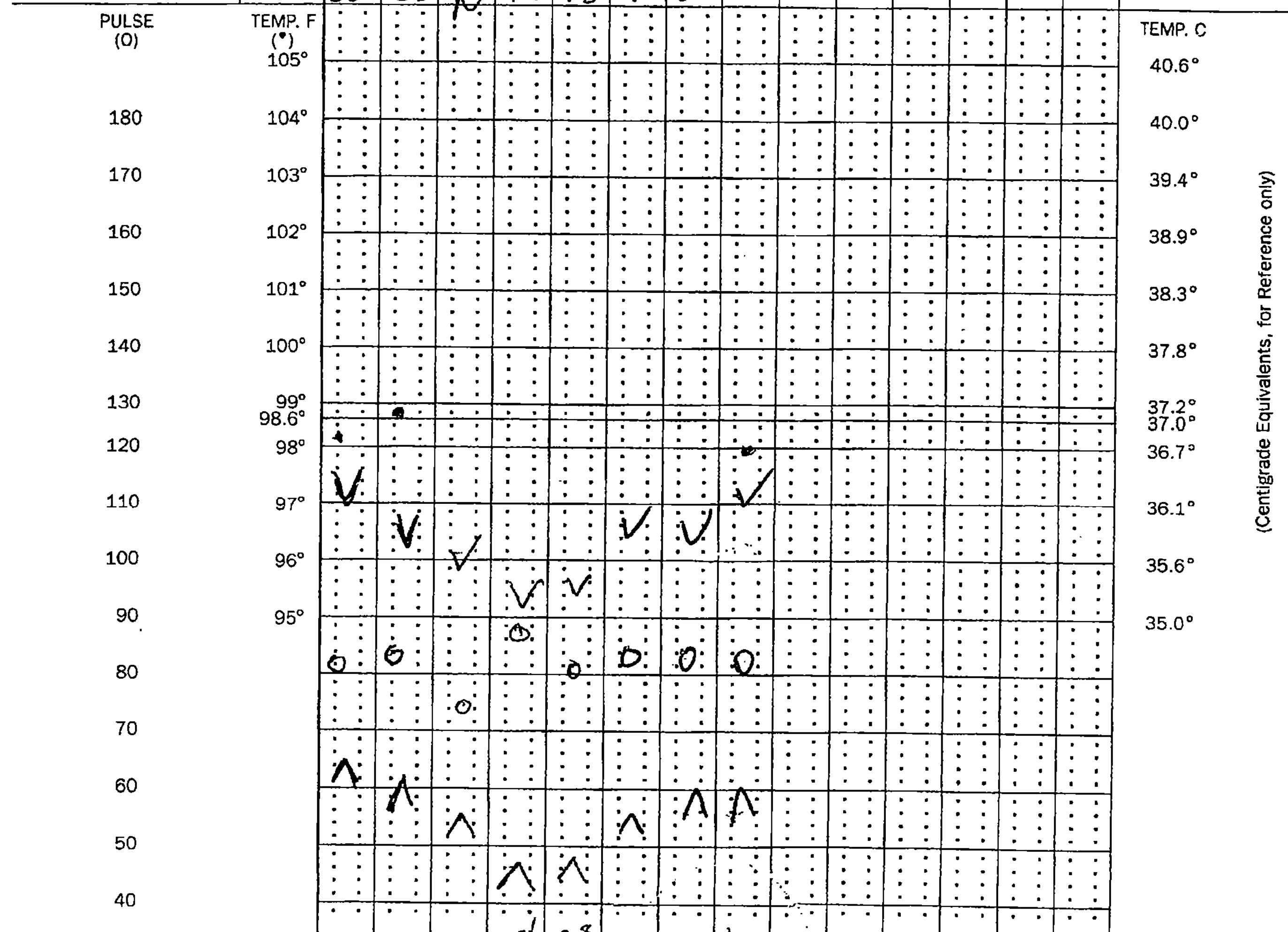
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6628

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY														
19 / HOUR	02	06	10	14	18	22	02	04						



Record special data only when so ordered

RESPIRATION RECORD				98.6	98.8							
BLOOD PRESSURE	110/66	104/60	98/56	93/47	94/48	[illegible]	104	100/60				
HR	61	84	74	87	81	90	92	90				
HEIGHT: / WEIGHT →	96%	95%	94%	96	96	97%	97%	97%				

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

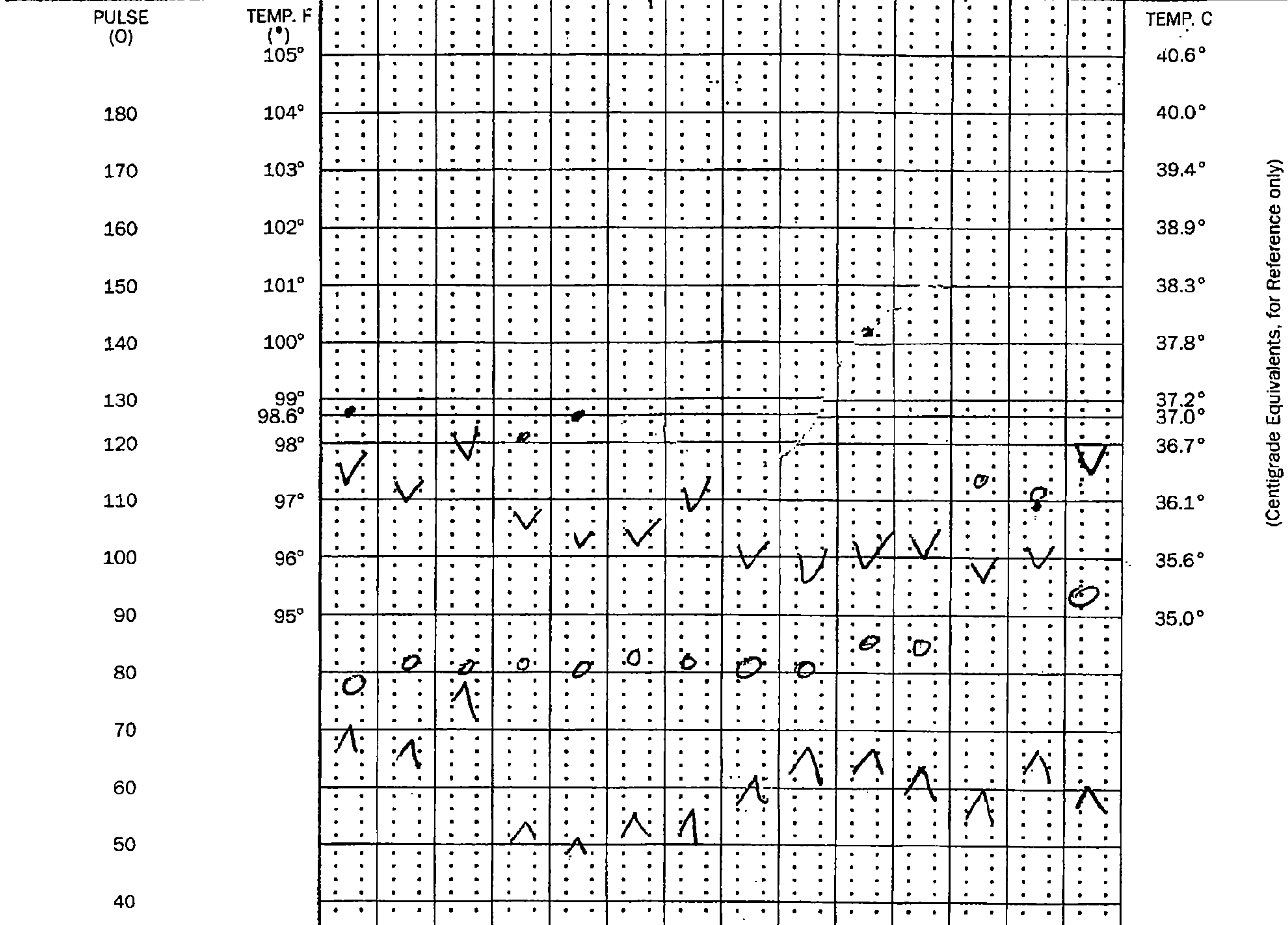
MEDCOM - 6629

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	06		07		07									
19	HOUR	18	22	02	06	10	14	18	22	02	06	10	14	18	22



Record special data only when so ordered

RESPIRATION RECORD	12	14	17	15	12	16	12				18	15	19	18
BLOOD PRESSURE	112/70	110/86	114/72	105/64	104/51	102/56		100/60	98/68	104/68	100/60	96/59	98/60	117/59
	78	82	80	82	80	85							111	90
Temp	98^6			98^2	986						85	114	109	98^2
HEIGHT: WEIGHT →				98%	97%	91%			97%	97%	95	94		97%
P.O.	97%	98%	96%	98		100		100			300			
intake	300	shake												
output		300				300								

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6630

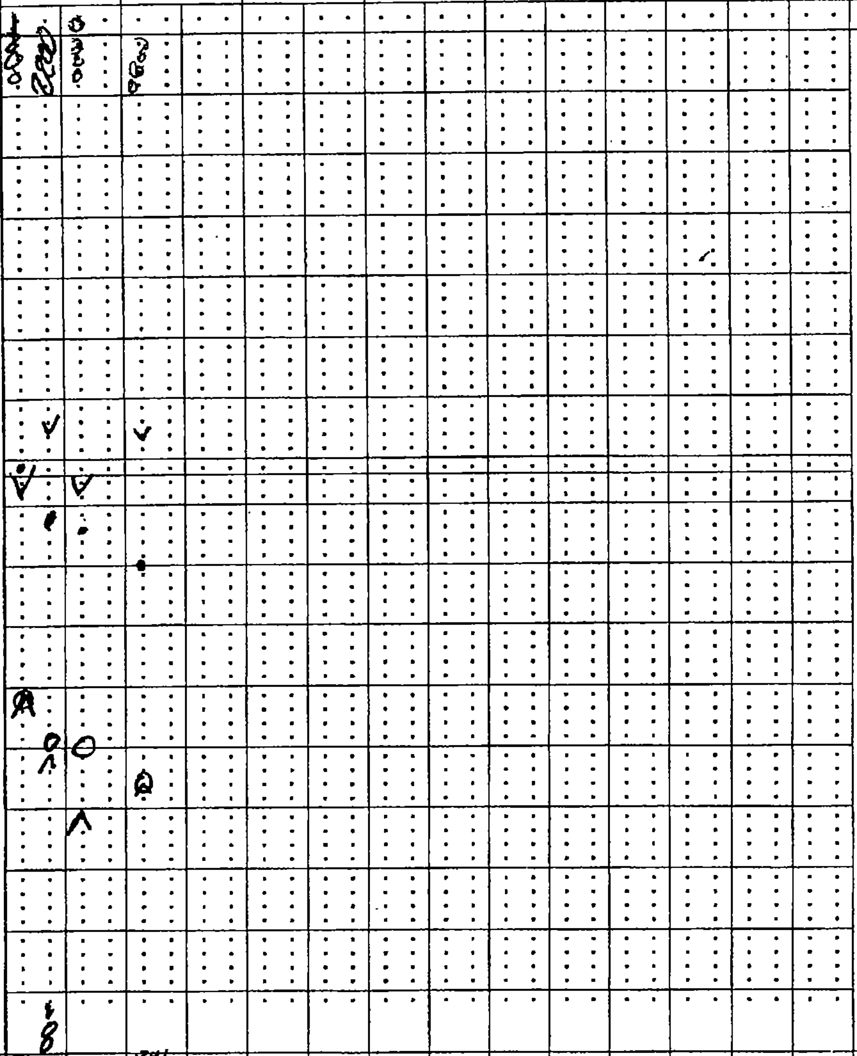
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY				
POST- DAY				
MONTH-YEAR	DAY		15	
19	HOUR	[illegible]	0320	[illegible]



RESPIRATION RECORD 18

Record special data only when so ordered

BLOOD PRESSURE	134/[illegible] 135/[illegible]	124/[illegible]	154/[illegible]	
HEIGHT:	WEIGHT → 98%			
	97	96%	97%	

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

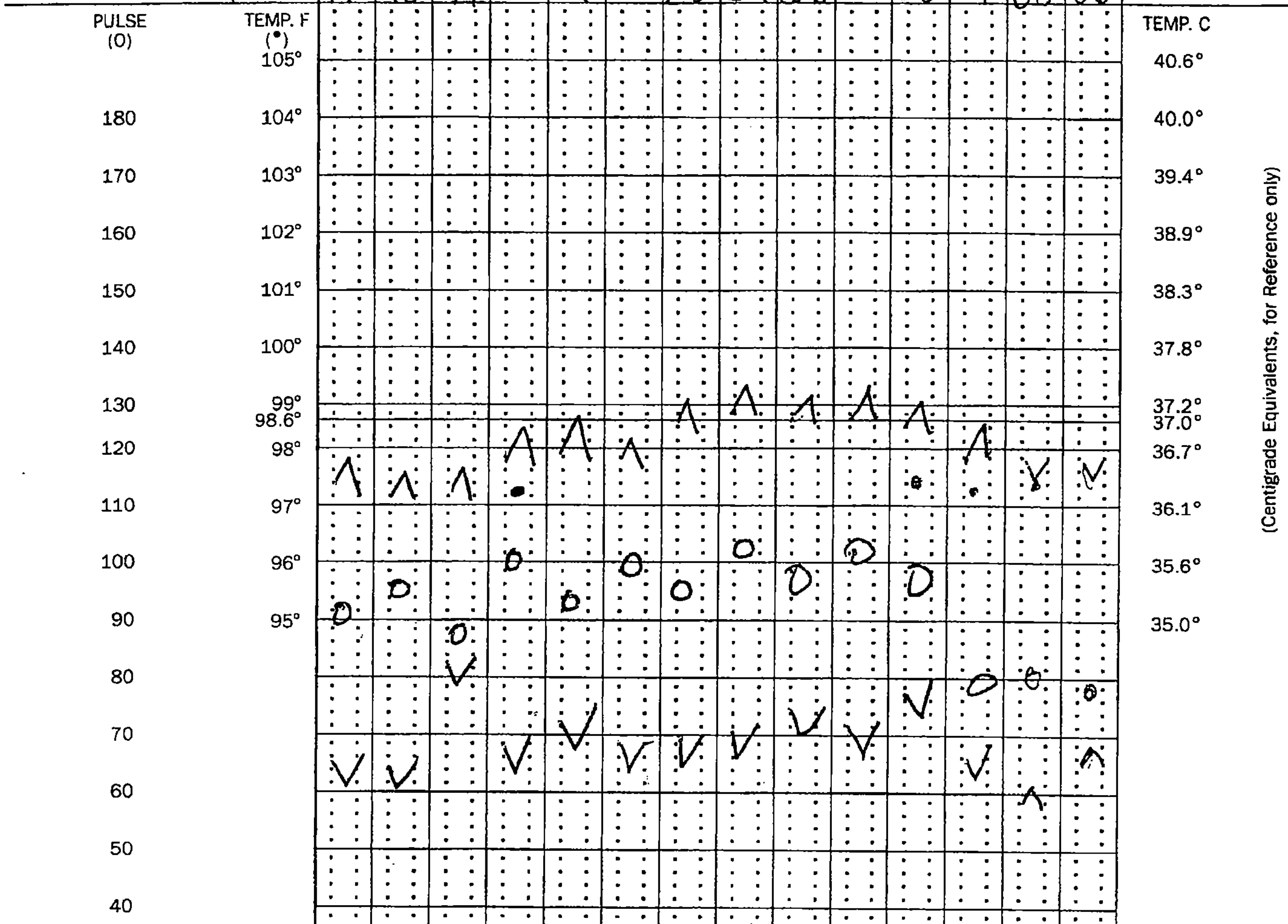
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6631

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY														
19 / HOUR	17	18	19	20	21	22	23	24	01	02	03	04	05	06



	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RESPIRATION RECORD	23	23	22	23	21	23	26	24	18	16	13	15	11	16
BLOOD PRESSURE	115/65	112/64	116/50	120/66	125/[illegible]	[illegible]	128/66	[illegible]/66	126/70	128/63	126/74	118/64	118/62	115/68
FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
Surce	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
~~HEIGHT:~~ PO, ~~WEIGHT~~ →	98%	98%	98	98	98	98	98	98	99	99	99	100%	99	100
PO	100				100		50			50				
IV	30	20	30	30	150	30	20	20	30	30	30	30	30	30
output						200					300			

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

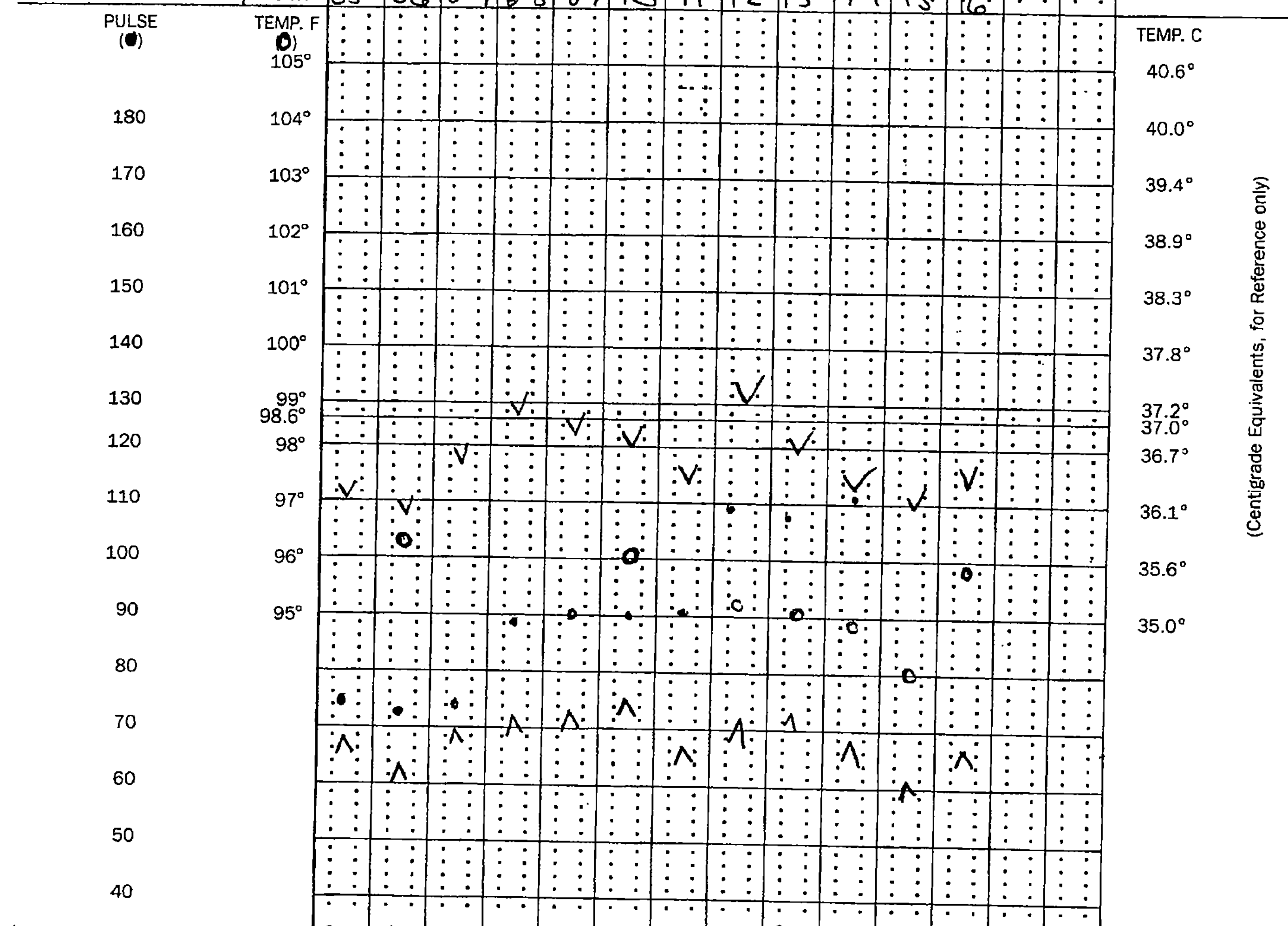
STANDARD FORM 611 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6632

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY														
19 / HOUR	05	06	07	08	09	10	11	12	13	14	15	16		



	05	06	07	08	09	10	11	12	13	14	15	16		
RESPIRATION RECORD	21	16	21	19	27	23	28	20	25	25	21	25		
~~BLOOD PRESSURE~~ FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2l	2L		
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC		
O2 sats	99%	99%	99%	97%	99%	99%	98%	99%	99	100	98	99		
HEIGHT: / WEIGHT →														
PO			60	240	120				240					
Input	30	30	30	130	30	30	30	30	30	30	30	130		
Output							300			200 x1 Stool				

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6633

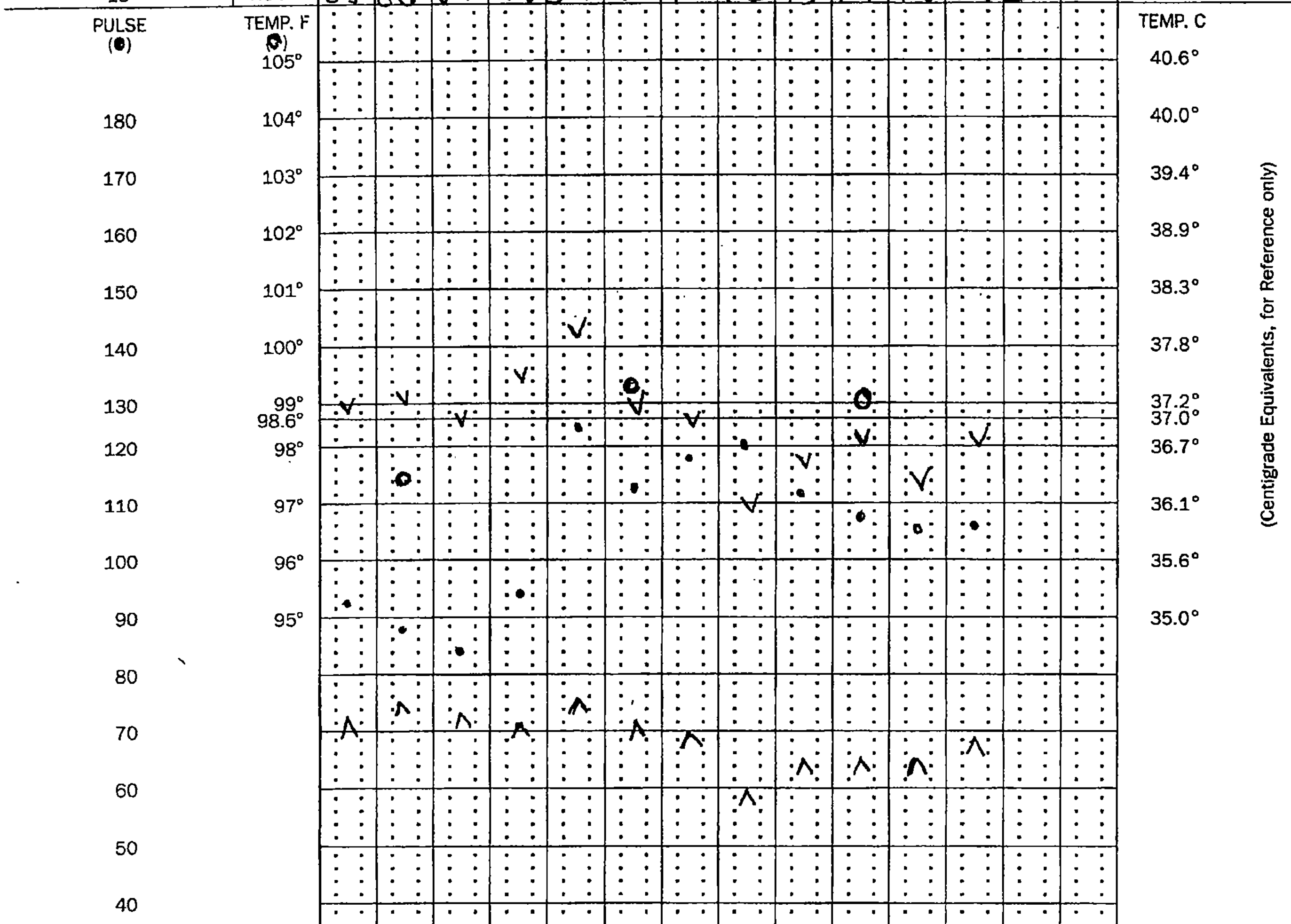
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY														
19 / HOUR	05	06	07	08	09	10	11	12	13	14	15	16	~~17~~	~~18~~



	05	06	07	08	09	10	11	12	13	14	15	16	17	18
RESPIRATION RECORD Resp -	23	26	27	36	30	30	30	30	30	30	32	32		
BLOOD PRESSURE														
SpO2	98%	97%	98%	93%	95%	99%	98%	98%	98%	98%	98%	97%		
O2	4L	4L	6L	10L	12L	10L	6L	6L	6L	6L	6L	4L		
HEIGHT: WEIGHT →														
Out NG	150	100	150	100	100	50	DC →							
Foley	50	50	45	50	50	560	420	120	50	50	50	50	D/C	
In IV	100	100	100	200	100	100	100	130	30	30	30	130		
Flush NG				30 →										
PO	30		30		30	....		60		60		60		

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

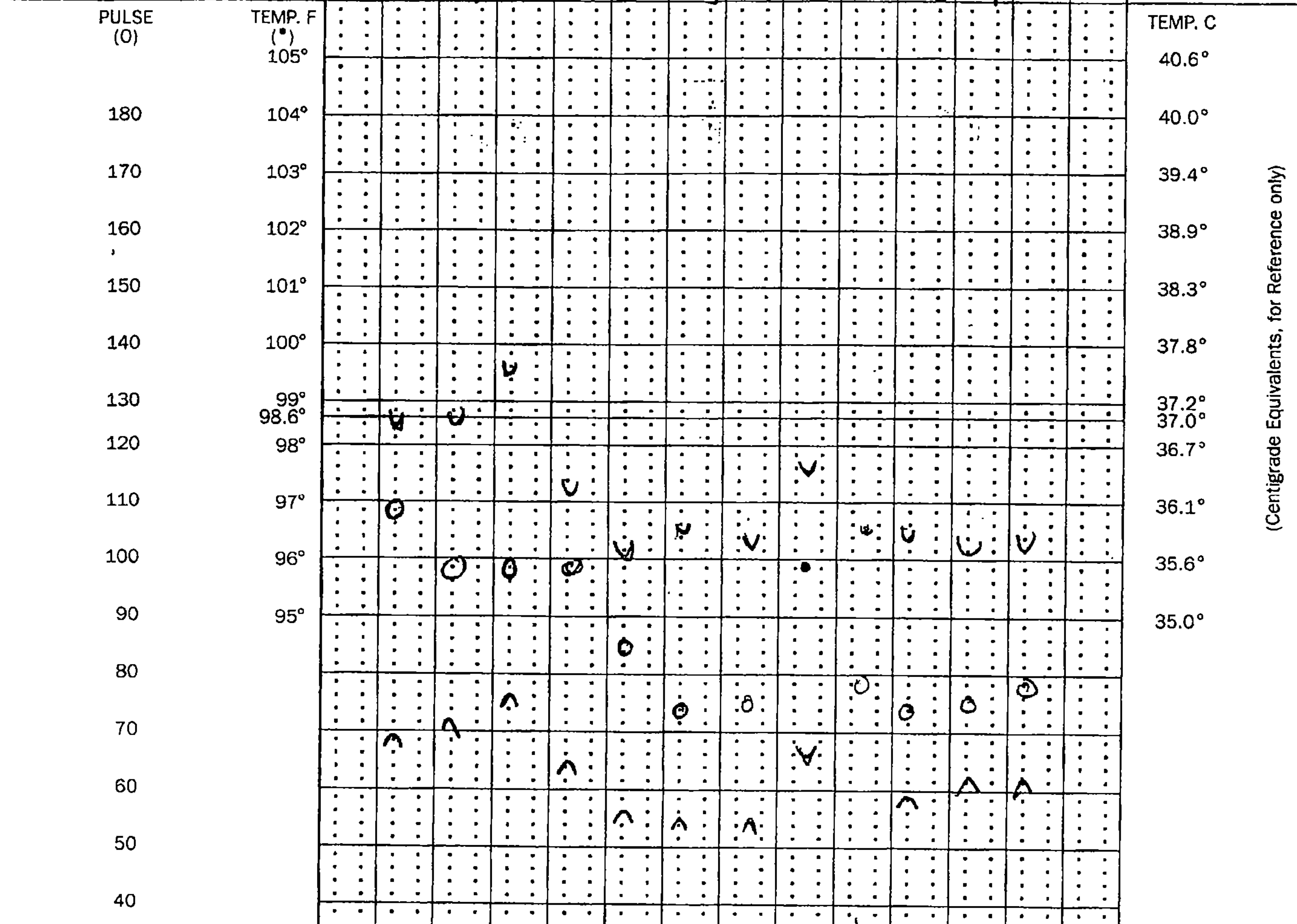
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6634

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY												
MONTH-YEAR / DAY												
19 / HOUR	17	18	19	20	21	22	23	24	01	02	03	04



RESPIRATION RECORD Resp-	30	31	29	30	12	12	19	18	5	14	16	18
BLOOD PRESSURE	123/69	123/72	135/76	117/64	101/56	105/53	104/56	114/67	105/63	100/54	142/62	105/62
SpO2	98	99	101	97	100	100		100%	100%	97	98	98
O2	4LNC	4LNC	4LNC	—	2LNC	2LNC		[illegible]	[illegible]	2LNC	2LNC	2LNC
HEIGHT: / WEIGHT →												
Output NG												
Foley-Urine			300									
Intake IV												
Flush NG												
PO												

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6635

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr. (b)(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.: (b)(6)-4	DATE: 8 Jul 03	TIME: 0623	SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

TEST	*RESULT*	*REF. RANGE*
WBC	21.1	4.8-10.8 x 10^3
RBC	4.24	4.7-6.1 x 10^9
Hgb	13.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.0	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fl (M) 81-99 fl (F)
Plt	397	130-500 x 10^3 verified
Lymph %	10.2	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	A POS

Coagulation Studies

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

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITH EVERY [illegible]
(REQUIRED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 6636

[redacted]

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

[redacted]

TEST	RESULT	REF. RANGE
roponin-I		
Drug of buse		

[redacted]

TEST	RESULT	REF. RANGE
ALB	3.2	3.5-5.5 g/dl
ALP	42	26-84 u/l
ALT	22	10-47 u/l
AMY	73	14-97 u/l
AST	29	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	16	7-22 mg/dl
CA^{++}	8.8	8.0-10.3mg/dl
CHOL	141	100-200 mg/dl
CRE	1.5	0.6-1.2 mg/dl
GLU	167	73-118 mg/dl
TP	6.5	6.4-8.1 g/dl

[redacted]

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

[redacted]

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

[redacted]

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

[redacted]

TEST	RESULT	REF. RANGE
NA^{+}	132	128-145 mmol/l
K^{+}	4.7	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	20	18-33 mmol/l

EMARKS: Type + Cross Lytes ABG CHEM 12 CBC

EPORTED BY:

DATE:

LAB ID NO.:

Ward/Section:	RE ... G PHYSICIAN:		RATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M (b)(6)-4	DATE 8JUL	TIME 1330	SSN/PSEUDO SSN:

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	11.2	4.8-10.8 x 10^3
RBC	3.74	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.1	42-52% (M) 37-47% (F)
MCV	93.7	80-94 fl (M) 81-99 fl (F)
Plt	235	130-500 x 10^3 verified
Lymph %	10.9	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 6638

(Subject to the Privacy Act of 1974)

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.9	3.5-5.5 g/dl
ALP	27	26-84 u/l
ALT	18	10-47 u/l
AMY	83	14-97 u/l
AST	31	11-38 u/l
TBIL	1.5	0.2-1.6 mg/dl
BUN	14	7-22 mg/dl
CA⁺⁺	7.4	8.0-10.3mg/dl
CHOL	90	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	158	73-118 mg/dl
TP	4.2	6.4-8.1 g/dl

(Piccolo) MetLyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6639

Ward/Section: ICU	REQU. (b)(6)-2 HYSICIAN:		L. .TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE 7/9/03	TIME 0530	SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	9.4	4.8-10.8 x 10^3
RBC	3.37	4.7-6.1 x 10^9
Hgb	10.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.3	42-52% (M) 37-47% (F)
MCV	92.8	80-94 fl (M) 81-99 fl (F)
Plt	228	130-500 x 10^3 verified
Lymph %	10.6	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:**	**LAB ID NO.:**

(b)(6)-4

MEDCOM - 6640

(b)(6)-4

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	7/9/03	0530	(b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	134	73-118 mg/dl
BUN	19	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	1266	39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	4.4	3.3-4.7 mmol/l
CL-	108	98-108 mmol/l
tCO_2	22	~~18-33 mmol~~/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2	09 Jul 03	

(b)(6)-4

(b)(6)-4

MEDCOM - 6641

ard/Section: ICU	REQUE	PHYSICIAN:	L. TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 10Jul	TIME 0400	SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	7.5	4.8-10.8 x 10³
RBC	2.62	4.7-6.1 x 10⁹
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	24.1	42-52% (M) 37-47% (F)
MCV	92.1	80-94 fl (M) 81-99 fl (F)
Plt	186	130-500 x 10³ verified
Lymph %	11.0	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:** 10 Jul 03	**LAB ID NO.:**

MEDCOM - 6642

LAST, FIRST, MI (b)(6)-4	DATE 10Jul	TIME 0400	SSN/PSEUDO SSN (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	136	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	2255	39-380 u/l (M) 30-190 u/l (F)
NA^+	132	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 10 Jul 03	LAB ID NO.:

MEDCOM - 6643

CBC

Ward/Section: ICU	REQ (b)(6)-2 YSICIAN:		**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 10 Jul 03	TIME 15:00	SSN/PSEUDO SSN:

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	7.8	4.8-10.8 x 10^3
RBC	2.71	4.7-6.1 x 10^9
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	25.3	42-52% (M) 37-47% (F)
MCV	93.3	80-94 fl (M) 81-99 fl (F)
Plt	211	130-500 x 10^3 verified
Lymph %	14.1	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:** 10 JUL 03	**LAB ID NO.:**

MEDCOM - 6644

C ISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section DCU

REQU PHYSICIAN:

LAST, FIRST, MI (b)(6)-4

DATE 11Jul

TIME 0400

SSN/PSEUDO SSN (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	94	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	1068	39-380 u/l (M) 30-190 u/l (F)
NA+	131	128-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
CL-	103	98-108 mmol/l
tCO2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 11 Jul 03	LAB ID NO.:

MEDCOM - 6645

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	DATE [illegible]	TIME 1150	SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.9	4.8-10.8 x 10³
RBC	2.50	4.7-6.1 x 10⁹
Hgb	7.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	23.4	42-52% (M) 37-47% (F)
MCV	93.5	80-94 fl (M) 81-99 fl (F)
Plt	240	130-500 x 10³ verified
Lymph %	15.1	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 11 Jul 03	LAB ID NO.:

MEDCOM - 6646

Ward/Section: ICU	REQUESTING PHYSICIAN: Ar (b)(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	DATE 12 Jul 03	TIME 0450	SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	7.8	4.8-10.8 x 10³
RBC	2.57	4.7-6.1 x 10⁹
Hgb	7.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	23.9	42-52% (M) 37-47% (F)
MCV	95.1	80-94 fl (M) 81-99 fl (F)
Plt	281	130-500 x 10³ verified
Lymph %	17.1	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:** 12 Jul 03	**LAB ID NO.:**

MEDCOM - 6647

LAST, FIRST MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	12Jul03	0450	(b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	85	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	613	39-380 u/l (M) 30-190 u/l (F)
NA⁺	131	128-145 mmol/l
K⁺	3.4	3.3-4.7 mmol/l
CL⁻	103	98-108 mmol/l
tCO₂	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2	12 Jul 03	

Met 8

Ward/Section ICU	REQU (b)(6)-2 HYSICIAN:	CL RY RESULT FORM (Subject to the Privacy Act of 1974)

LAST. FIRST. MI (b)(6)-4	DATE 12 Jul 03	TIME 0540	SSN/PSEUDO SSN

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	539	39-380 u/l (M) 30-190 u/l (F)
NA⁺	***	128-145 mmol/l
K⁺	3.3	3.3-4.7 mmol/l
CL⁻	105	98-108 mmol/l
tCO$_2$	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 13 Jul 03	LAB ID NO.:

MEDCOM - 6649

Ward/Section: ICU	REQU HYSICIAN:		L ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M (b)(6)-4	DATE 13Jul	TIME 0300	SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC			Urinalysis			Misc Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC	16.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.68	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	11.2	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct	33.6	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.2	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	324	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	8.5	20.5-51.1%	Bld		Negative	H. pylori		Negative

(Hematology) Manual Differential								
				pH		N/A	Micro Parasites	
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	Microscopic Urinalysis	
RBC Morph				HCG		Negative		

			CSF		Blood Bank	
Spun Hematocrit		42-52% (M) 37-47% (F)				
Sed Rate			Cell Count		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen	Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:** 13 Jul 03	**LAB ID NO.:**

MEDCOM - 6650

LABOR .Y RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, (b)(6)-4	STATUS 1330	DATE 8JUL	SSN

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na	145	138-146 mmol/L
K	46	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.21	7.31-7.45
PCO_2	41.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2	18	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3	17	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf	-11	(-2) - (+3) mmol/L
AGap	22	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	17	8-26 mg/dl
GLU	160	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	11	12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

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

Hematology

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph	
Other	

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

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

☺ "SHADOW" PJR

MEDCOM - 6651

Ward/Section: ICU	REQL	HYSICIAN:	L: ORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]	(b)(6)-4	DATE 14Jul	TIME 0400	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	10.7	4.8-10.8 x 10³
RBC	3.02	4.7-6.1 x 10⁹
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	92.0	80-94 fl (M) 81-99 fl (F)
Plt	277	130-500 x 10³ verified
Lymph %	17.2	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:** 14 Jul 03	**LAB ID NO.:**

MEDCOM - 6652

LAST FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	1424	0400	(b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	3.2	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH	7.437	7.31-7.45
PCO2	46.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	33	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	31	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	7	(-2) – (+3) mmol/L
AnGap	13	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	19	8-26 mg/dl
GLU	95	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	25	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.7	3.5-5.5 g/dl
ALP	50	26-84 u/l
ALT	35	10-47 u/l
AMY	176 *	14-97 u/l
AST	41	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	15	7-22 mg/dl
CA⁺⁺	7.8	8.0-10.3mg/dl
CHOL	99	100-200 mg/dl
CRE	0.7	0.6-1.2 mg/dl
GLU	100	73-118 mg/dl
TP	5.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6653

Ward/Section ICW	REQUESTING PHYSICIAN (b)(6)-2		**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE 15Jul03	TIME 0600	SSN/PSEUDO SSN (b)(6)-4

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na	139	138-146 mmol/L
K	3.2	3.5-4.9 mmol/L
Cl	101	98-109 mmol/L
pH	7.554	7.31-7.45
PCO2	30.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	5	(-2) – (+3) mmol/L
AnGap	14	10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	15	8-26 mg/dl
GLU	97	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	27	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB	1.8 *	3.5-5.5 g/dl
ALP	86	26-84 u/l
ALT	42	10-47 u/l
AMY	242 *	14-97 u/l
AST	77 *	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	13	7-22 mg/dl
CA++	7.8	8.0-10.3mg/dl
CHOL	85	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	99	73-118 mg/dl
TP	5.5	6.4-8.1 g/dl

(Piccolo) Melyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 15 Jul 03	**LAB ID NO.:**

MEDCOM - 6654

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

Hematology/CBC Profile

TEST	RESULT	REF. RANGE
WBC	10.4	4.8-10.8 x 10^3
RBC	3.13	4.7-6.1 x 10^9
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.9	42-52% (M) 37-47% (F)
MCV	92.2	80-94 fl (M) 81-99 fl (F)
Plt	325	130-500 x 10^3 verified
Lymph %	17.2	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2	15 Jul 03	

MEDCOM - 6655

16-29 9m

d/Section ICh	REQUESTIN (b)(6)-2 CIAN:		**LABOR / RESULT FORM** (Subject to the Privacy Act of 1974)
ST. FIRST MI (b)(6)-4	DATE 1621	TIME 0435	SSN/PSEUDO SSN (b)(6)-4

(Hematology) CBC			**Urinalysis**			**Misc Serology**		
EST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
3C	18.1	138-146 mmol/L	Color		N/A	RPR		Negative
C	3.45	3 5-4.9 mmol/L	App		N/A	**Microbiology**		
)	10.2	98-109 mmol/L	Glu		Negative	Source		
	32.2	7 31-7 45	Bili		Negative	Gram Stain		
	93.4	35-45 mmHg (art) 41-51 mmHg (ven)	Ket		Negative	O & P		
	523 ~~29.5~~	80-105 mmHg (art) N/A (ven)	SG		N/A	Occ Bld		Negative
nph %		23-27 mmol/L (art) 24-29 mmol/L (ven)	Bld		Negative	H. pylori		Negative

Hematology) Manual Differential								
			pH		N/A	Micro Parasites		
s	Mono		Prot		Negative	Malaria		
ids	Eos		Urob		0.2-1.0	Other		
nph	Baso		Nit		Negative	**Microscopic Urinalysis**		
p	Imm		Leuk		Negative			
C rph			HCG		Negative			

			CSF			**Blood Bank**	
n natocrit		42-52% (M) 37-47% (F)					
Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**	
ier			Directigen		Negative	ABO/Rh	

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
EST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
		9.8-13.6 secs			
TT		21-34 secs			
imer		<20 ug/ml			
P		<10 ug/ml			

MARKS:

PORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6656

(b)(6)-4

Ward/Section: ICU	REQUE	PHYSICIAN:	L TORY RESULT FORM (Sub (b)(6)-4 f 1974)
LAST, FIRST, MI. CBC	DATE 17Jul03	TIME	

Hematology CBC			Urinalysis			Misc Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC	26.0	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	2.45	4.7-6.1 x 10⁹	App		N/A	Mono		Negative
Hgb	7.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	23.3	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	95.3	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	572	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %	6.9	20.5-51.1%	Bld		Negative	H. pylori		Negative

17 July 0600

Hematology Manual Differential				Urinalysis (cont.)				
				pH		N/A	Micro Parasites	
Segs	90	Mono	3	Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph	7	Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph	Slight Hypochromasia slight Anisocytosis slight few Target Cells			HCG		Negative		

			CSF			Blood Bank	
Spun Hematocrit		42-52% (M) 37-47% (F)	Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Sed Rate							
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: (b)(6)-2	**DATE:**	**LAB ID NO.:**

(b)(6)-4

MEDCOM - 6657

(b)(6)-4

(b)(6)-4 DATE 17Jul03 TIME 0400 SSN/PSE (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Melyte 8

TEST	RESULT	REF. RANGE
GLU	109	73-118 mg/dl
BUN	16	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
~~CK~~		39-380 u/l (M) 30-190 u/l (F)
NA+	142	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	103	98-108 mmol/l
tCO2	29	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 17Jul03	LAB ID NO.:

17Jul03

(b)(6)-4

(b)(6)-4

MEDCOM - 6658

LABOR .Y RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	STATUS	DATE 0740 21 Jul 03	SSN (b)(6)-4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na	138	138-146 mmol/L
K	3.8	3.5-4.9 mmol/L
Cl	99	98-109 mmol/L
pH	7.395	7.31-7.45
PCO_2	49.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2	32	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	7	8-26 mg/dl
GLU	132	70-105 mg/dl
Creat	0.8	0.7-1.5 mg/dl
Hct	27	38-51% PCV
Hgb	10	12-17 g/dl

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Hematology

TEST	RESULT	REF. RANGE
WBC	126	4.8-10.8 x 10^3
RBC	3.06	4.7-6.1 x 10^9
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.4	42-52% (M) 37-47% (F)
MCV	92.4	80-94 fl (M) 81-99 fl (F)
Plt	926	130-500 x 10^3 verified
Lymph%	18.3	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microbiology

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

Microscopic Urinalysis

"SHADOW" PJR

MEDCOM - 6659

ACLU-RDI 1407 p.249

Ward/Section: ICU	REQUI	PHYSICIAN:	L… ATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE 22JU	TIME 0500	SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	27.0	4.8-10.8 x 10³
RBC	2.73	4.7-6.1 x 10⁹
Hgb	7.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.1	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	1069	130-500 x 10³ verified
Lymph %	15.5	20.5-51.1%

Hematology Manual Differentials

Segs	50	Mono	18
Bands	5	Eos	4
Lymph	14	Baso	
Atyp		Imm	8
RBC Morph	~~macrocytic~~/nor -microchromic/normal cytic -increased plt		
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

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

Chemistry

TEST	RESULT	REF. RANGE

C
A
G
Bi
K
S(
Bl
pH
Pr
U
N
L
H
C
C
D

VT 850
Rate 10
FIO2 50%
Peep +5

```
i-STAT EG7+

Pt: 0034
Pt Name:____________


Na_________137 mmol/L
K__________4.7 mmol/L
TCO2________31 mmol/L
iCa_______1.14 mmol/L
Hct_________24 %PCV
Hb*__________8 g/dL
  *via Hct

At 37C
pH_______7.534
PCO2______36.0 mmHg
PO2________110 mmHg
HCO3________30 mmol/L
BEecf________8 mmol/L
sO2*________99 %
   *calculated

At Patient Temp
pH_______7.513
PCO2______38.1 mmHg
PO2________119 mmHg

Patient Temp: 101.0F
FIO2________: 50
Sample Type_: ART

 22JUL03       07:27

Oper: 4132

Physician:_____________

Ser# 40709
Ver: JAMS0+5A
   CLEW A91
```

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY ~~UNIT REQUESTED~~

ABO/Rh

Crossmatch
EVERY UNI… BLOOD… STED)

E	CROSSMATCH

REMARKS:

(b)(6)-2

DATE: 07 22 03

LAB ID NO.: (b)(6)-4

MEDCOM - 6660

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	2701	0520	(b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.5 ↓	3.5-5.5 g/dl
ALP	100 ↑	26-84 u/l
ALT	66 ↑	10-47 u/l
AMY	69	14-97 u/l
AST	87	11-38 u/l
TBIL	0.5	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA⁺⁺	7.8 ↓	8.0-10.3mg/dl
CHOL	134	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	97	73-118 mg/dl
TP	5.3 ↓	6.4-8.1 g/dl

(Piccolo) Melyte 8

TEST	RESULT	REF. RANGE
GLU	96	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
		39-380 u/l (M) 30-190 u/l (F)
NA⁺	137	128-145 mmol/l
K⁺	4.5	3.3-4.7 mmol/l
CL⁻	101	98-108 mmol/l
tCO₂	31	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6661

* CBC / C 8 *

LABOR RY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	STATUS	DATE 22 July 2003	SSN (b)(6)-4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na	138	138-146 mmol/L
K	45	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	1.3	0.6-1.2 mg/dl
BUN	13	7-22 mg/dl
GLU	109	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Hematology

TEST	RESULT	REF. RANGE
WBC	21.8	4.8-10.8 x 10^3
RBC	2.11	4.7-6.1 x 10^9
Hgb	6.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	20.2	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	879	130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph	
Other	

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microbiology

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

Microscopic Urinalysis

☺ "SHADOW" PJR

MEDCOM - 6662

Ward/Section: ICU	REQU G PHYSICIAN: Dr (b)(6)-2	**L RATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	DATE 23 Jul	TIME 130	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	24.5	4.8-10.8 x 10^3
RBC	3.13	4.7-6.1 x 10^9
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.4	42-52% (M) 37-47% (F)
MCV	94.1	80-94 fl (M) 81-99 fl (F)
Plt	370	130-500 x 10^3 verified
Lymph %	10.1	20.5-51.1%

Hematology Manual Differential

Segs	55	Mono	19
Bands	22	Eos	1
Lymph	3	Baso	0
Atyp	0	Imm	0
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC + Chem 7

REPORTED BY: (b)(6)-2	**DATE:** 23 July 03	**LAB ID NO.:**

MEDCOM - 6663

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	27 Aug	1500	(b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8
Chem 7

TEST	RESULT	REF. RANGE
GLU	135	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
[redacted]		39-380 u/l (M) 30-190 u/l (F)
NA⁺	139	128-145 mmol/l
K⁺	3.7	3.3-4.7 mmol/l
CL⁻	101	98-108 mmol/l
tCO₂	30	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS: CBC, Chem 7

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6664

Ward Section: | R | IG PHYSICIAN:

ISTRY RESULT FORM
ct to the Privacy Act of 1974)

LAST, FIRST, MI | DATE | TIME | SSN/PSEUDO SSN:

I · STAT

TEST	RESULT	REF. RANGE
[illegible]		138-146 mmol/L
[illegible]		3.5-4.9 mmol/L
[illegible]		98-109 mmol/L
pH		7.31-7.45
[illegible]		35-45 mmHg (art) 41-51 mmHg (ven)
[illegible]		80-105 mmHg (art) N/A (ven)
CO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
[illegible]		95-98%
[illegible]		(-2) – (+3) mmol/L
[illegible]		10-20 mmol/L
[illegible]		1.12-1.32 mmol/L
[illegible]		8-26 mg/dl
[illegible]		70-105 mg/dl
[illegible]		0.7-1.5 mg/dl
[illegible]		38-51% PCV
Hgb		12-17 g/dl

CHEM - 12

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

METLYTE 8

TEST	RESULT	REF. RANGE
GLU	118	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	32	18-33 mmol/l

MISC.

TEST	RESULT	REF. RANGE
[illegible]		
[illegible]		

LIVER PANEL

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

ELECTROLYTE

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

REMARKS:

# (b)(6)-4

(b)(6)-2

DATE: 24 Jul

LAB ID NO.: (b)(6)-4

* CBC / Chem 7 / 24 July 2003 *

MEDCOM - 6665

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1-STAT G3+

Pt: (b)(6)-4
Pt Name:_____________

TCO2_________32 mmol/L

At 37C
PH_______7.490
PCO2______40.3 mmHg
PO2_________173 mmHg
HCO3_________31 mmol/L
BEecf_________7 mmol/L
sO2*________100 %
   *calculated

At Patient Temp
PH_______7.512
PCO2______37.8 mmHg
PO2_________165 mmHg

Patient Temp: 96.0F
FIO2_________: 50
Sample Type_: ART

 24JUL03      07:41

Oper: (b)(6)-2

Physician:______________

Ser# (b)(6)-4

Ver: JAM5045A
     CLEW A91
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P̄ Extubation

NRB@12L/min

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-------------------------
i-STAT G3+

Pt: (b)(6)-4
Pt Name:_____________

TCO2_________35 mmol/L

At 37C
PH_______7.520
PCO2______41.5 mmHg
PO2__________66 mmHg
HCO3_________34 mmol/L
BEecf________11 mmol/L
sO2*_________95 %
   *calculated

At Patient Temp
PH_______7.518
PCO2______41.7 mmHg
PO2__________67 mmHg

Patient Temp: 98.9F
FIO2_________: 90
Sample Type_: ART

 24JUL03      10:42

Oper: (b)(6)-2

Physician:______________

Ser# (b)(6)-4

Ver: JAM5045A
     CLEW A91
-------------------------
```

CBC / Cl " 7 (b)(6)-2 CPT/AN

Ward/Section: CU	REQUE… PHYSICIAN: DR (b)(6)-2		LA… ATORY RESU… …RM (Subject to the Privacy Act of 1974)
LAST, FIRST MI (b)(6)-4	DATE 25 July	TIME 0400	SSN/PSEUDO SSN:

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	10.6	4.8-10.8 x 10^3
RBC	2.86	4.7-6.1 x 10^9
Hgb	8.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.2	42-52% (M) 37-47% (F)
MCV	91.8	80-94 fl (M) 81-99 fl (F)
Plt	23	130-500 x 10^3 verified
Lymph %	21.2	20.5-51.1%

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

(b)(6)-2

DATE: 0400 25 July

LAB ID NO. (b)(6)-4

TCU

Pt # (b)(6)-4

MEDCOM - 6667

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Melyte 8

TEST	RESULT	REF. RANGE
GLU	145	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
[illegible]	160	39-380 u/l (M) 30-190 u/l (F)
NA⁺	139	128-145 mmol/l
K⁺	3.7	3.3-4.7 mmol/l
CL⁻	99	98-108 mmol/l
tCO₂	24	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6668

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

LAST, FIRST, MI (b)(6)-4	DATE 15 Aug 03	TIME 0730	SSN/PSEUDO SSN: (b)(6)-4

		E
WBC	6.6	4.8-10.8 x 10
RBC	3.87	4.7-6.1 x 10
Hgb	11.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	88.8	80-94 fl (M) 81-99 fl (F)
Plt	342	130-500 x 10 Verified
Lymph %	23.3	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

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

Urinalysis

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

MET 8

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

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB	2.6	3.5-5.5 g/dl
ALP	56	26-84 u/l
ALT	13	10-47 u/l
AMY	62	14-97 u/l
AST	15	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA**	9.0	8.0-10.3 mg/dl
CHOL	180	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	199	73-118 mg/dl
TP	7.2	6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 15 Aug 03	LAB ID NO: (b)(6)-4

MEDCOM - 6669

MEDICAL RECORD ANESTHESIA

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

DRUG	(Units)	Doses	TOTALS
midazolam	(mg)	1.5 1.5	3mg
fentanyl	(mcg)	50 50 50 50 50	250mcg
STP	(mg)	250	250mg
Succ/Vec	(mg)	100//6 4 3 2 2 2	100//17
	( )		
	( )		

VOLAT AGENT: Iso — % del: 0.3 1.2 0.7 0.8 1.0 1.4 1.0 1.0 1.0 1.5 1.5

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min: 8 2 2 2 2 2 2 2 2 2 2 2

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

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY

CRYSTALLOID–

COLLOID–

BLOOD–

FLUIDS

LINE site		
Hespan 14g RA	☐ Warmed	x —— 500
NS	☐ Warmed	—— 1000 —— 2000
LR RA 18g	☐ Warmed	—— 1000 X —— X —— 2000
PRBCs	☐ Warmed	1 —— 2 —— X

LOSSES

EST BLOOD LOSS: 400 500

URINE –: 225 225/450 200/650

PHYS STATUS: 1 2 [✓ 3] 4 5 [✓ E]

BODY WEIGHT: N 75 [✓ KG] LB

HEMATOCRIT: 21.1 > 13/40 < 397

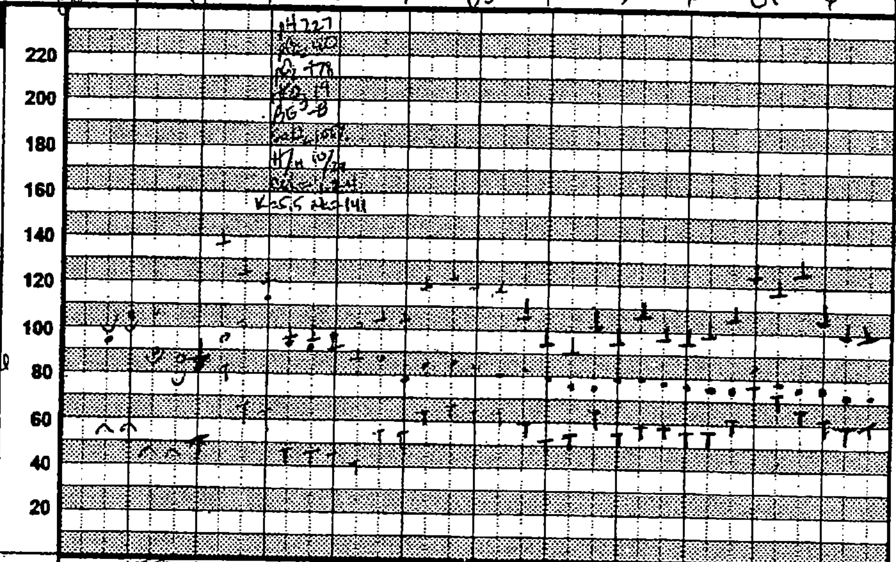
INITIAL DATA: BP – 98/57 HR – 95

EQUIP CHECK: OK? – [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? [initials] TIME – 0635

TIME → 0630 ø 0700 ø 30 ø 0800 ø 30 ø 0900 ø

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



1:6, 1:2 VT – ml		750	720	730	770	720	820	860	860	860	860	870
HME ⊕ f – breaths/min	18	10	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP		20	18	18	19	20	20	26	21	21	21	21
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C
✓ET CO2 (torr)	⊕	36	28	32	35	36	30	28	24	28	28	27
✓FIO2 (Frac or %)	.86	.85	.86	.84	.84	.84	.83	.83	.83	.83	.83	.83
✓SpO2 (%)	99	100	100	100	100	100	100	100	100	100	100	100
✓ECG	SR	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site												
✓N-M Block (T/4)	4/4	9/4	4/4	9/4	3/4	4/4		2/4	1/4	2/4	1/4	1/4

MONITORS / ACCESSORIES

✓ BP/Auto Cuff

BP / oth

✓ ART line

Steth- PC/ES

✓ CO2 Gas analyzer

Warming blkt

Conv warmer

Mark with letters & symbols, explain under REMARKS

EVENTS: Arms < 90° secured on padded armboards

Position → ↔ ——→ ——→

REMARKS– Code drugs with numbers, events with letters

0620 seen in EMT. Pre-op complete via interpreter. PE: GSW to abdomen. VSS.

0638 → to OR 1-1 via litter. Monitors on. Pre iV induction. Eyes taped shut. See Airway note below. OGT placed; stom decompressed. Soft-bite block placed. 16g IV start RH. Arrow cath A-line start (R) radial a

0733 (b)(6)-4 (#1

0750 (b)(6)-4

0800 Case Relief (b)(6)-2 MAJ/CRNA

0919 Kiebler CRAP brea

0930 Cont to Page #2

RECOVERY AT

PACU ICU ________ (Specify)

OTHER SEE

CONDITION: Page #2

RESP– SpO2–

BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0610	0638	1255

	Ready	Begin	End
PROC	0642	0705	1235

PROCEDURES and CPT Codes: Exploratory Laparotomy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA (O2/Iso)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: RSI c cricoid pressure. DL x 1 c Mac 3 grade II view c Anterior view to VC. 8.0 OETT placed & secured @ 23cm @ teeth. ⊕BBS ⊕sustained ETCO2. Stylet used.

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

(b)(6)-4

SURGEONS: (b)(6)-2 / (b)(6)-2

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

PROCEDURE LOCATION: OR 1-1

DATE: 8 JUL 03

PAGE 1 OF 3

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

MEDCOM - 6670

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

MEDICAL RECORD ANESTHESIA

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

DRUG (Units)												
( )												
( )												
( )												
( )												
MSO4 (mg)			3 2		2 3							
Ephedrine (mg)							X 5			5		
VOLAT. AGENT Isoflurane % del / % e.t.	0.7	.8	.8	1.1	1.1	1.1	-1.0	-0.6	-0.9	-0.9	-0.9	-0.4-
AIR L/Min												
N2O L/Min												
O2 L/Min	2	2	2	2	2	2	-2	-2	-2	-2	-2	-2-

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

FLUIDS

LINE site LR 2000 ☐ Warmed (3000)
NS (2000) ☐ Warmed
Hespan (500) ☐ Warmed
Blood (2U PRBC) ☐ Warmed

LOSSES

500 EST BLOOD LOSS 150/650
650 URINE – 150/300 100/400 100/1000

TOTALS

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY

CRYSTALLOID–

COLLOID–

BLOOD–

REMARKS– *Code drugs with numbers, events with letters*

0934-finish abd.
0955 start (L) elbow surg.

PHYS STATUS 1 2 [✓ 3] 4 5 [✓ E]

BODY WEIGHT ~ 75 [✓ KG] LB

HEMATOCRIT

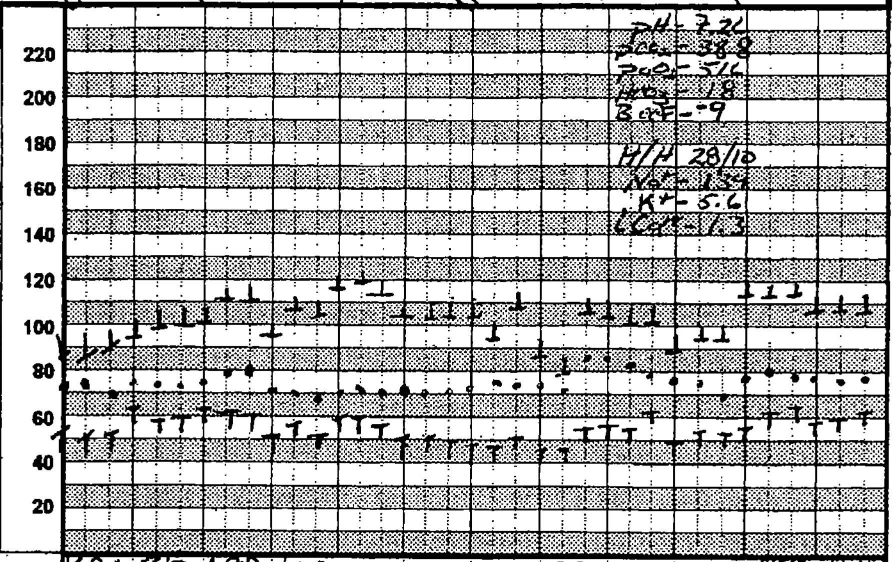
INITIAL DATA:
BP – 98/57
HR– 95

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME– 0635

TIME → 0930 · 1000 · 30 · 1100 · 30 · 1200

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



PH - 7.21
PCO2 - 38.8
PaO2 - 516
HCO3 - 18
BE - -9
H/H 28/10
Na+ - 134
K+ - 5.6
iCa - 1.3

VENTS

VT – ml	820	840	690	660				920	900	400	880	850
f – breaths/min	7	8	6	7	16	18	18	10	10	10	10	10
Peak inf pres / PEEP	20/2	21	20	19				21	21	21	21	21
MODE– S(pon), A(ssist), C(on)	C	C	C	C	A	A	A	C	C	C	C	C

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	27	31	33	33	52	56	68	38	31	28	28	27
BP / oth	FIO2 (Frac or %)	.84	.83	.84	.84	.83	.83	.83	.83	.83	.83	.83	.83
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site												
	N-M Block (T/4)	1/4		2/4	2/4	3/4							
Tourniquet @250 mmHg			↑							↓ total time 106 mins			
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS **EVENTS** *Position* ⟶ O–

RECOVERY AT

PACU ICU ________ (Specify)
OTHER ________
CONDITION: SEE Page #3
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0610	0638	1255
	Ready	Begin	End
PROC	0642	0705	1235

PROCEDURES and CPT Codes
Exp. Lap
ORIF (L) elbow

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
SEE Page #1

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

(b)(6)-4

SURGEONS: (b)(6)-2 (b)(6)-2 (b)(6)-2

ANESTHETISTS: (b)(6)-2 (b)(6)-2 MAJ CRNA

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION ISO 1-1

DATE 8 July 03

PAGE 2 OF 3

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6671

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

MEDICAL RECORD **ANESTHESIA**

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)	
	( )	
	( )	
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT ~~I50~~	% del	X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8

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

FLUIDS

LINE site		
¯R	☐ Warmed	3500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

650 EST BLOOD LOSS

1000 URINE –

TOTALS

TOTAL EBL 650

TOTAL URINE 1000

FLUIDS – SUMMARY

CRYSTALLOID– 5500

COLLOID– 500

BLOOD– 500

PHYS STATUS 1 2 [✓ 3] 4 5 [✓ E]

BODY WEIGHT ~75 [✓ KG] LB

HEMATOCRIT

INITIAL DATA:

BP – 98/57

HR– 95

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME– 0635

TIME → 45 1300

SYMBOLS:

BP by cuff V Λ

Heart rate ●

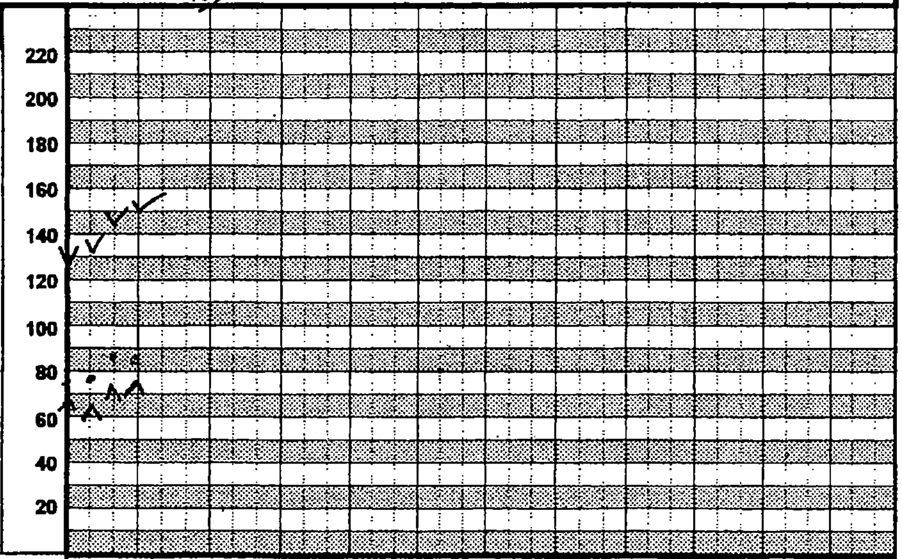
Resp rate

BP (transduced)

TOURNIQUET T – X

ANES– X-X

PROC ⊙ – Ø



REMARKS–

Code drugs with numbers, events with letters

1230 Cont From page #2

1243 pt SV ¯c good TV pt Extubated ¯c pos. pies ¯s suctioning

VENTILATION

VT – ml	
f – breaths/min	26
Peak inf pres / PEEP	
MODE– S(pon), A(ssist), C(on)	S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)
BP / oth	FIO2 (Frac or %)	.83
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	SR
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS **EVENTS**

Position → ¯c —

RECOVERY AT 1250

[✓ PACU] ICU ______ (Specify)

OTHER ______

CONDITION: Stable

RESP– 18 SpO2– 100

BP– 146/77 HR– 84

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0610	0638	1255
PROC	Ready	Begin	End
	0642	0700	1235

PROCEDURES and CPT Codes

Exp. Lap

ORIF (L) elbow

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

(b)(6)-4

(b)(6)-2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: intubation route, blade, technique, comments

SEE Page #1

SURGEONS: (b)(6)-2

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

AN, CRNA

Nurse Anesthetist

PROCEDURE LOCATION Iso 1-1

DATE 8 July 03

PAGE 3 **OF** 3

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6672

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

MEDICAL RECORD ANESTHESIA

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

DRUG	Units		TOTALS
Versed	(mg)	2 1 1 1	5mg
	( )		
Fent	(mg)	50, 50, 50, 50, 50,	250mcg
	( )		
	( )		
	( )		
VOLAT AGENT	% del		
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 - 8 - 8 - 8 - 8	

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

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS – SUMMARY
CRYSTALLOID– 700
COLLOID– 0
BLOOD– 0

FLUIDS
LINE site LR ☐ Warmed — (500)
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE –

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 50 [✓ KG] LB

HEMATOCRIT:

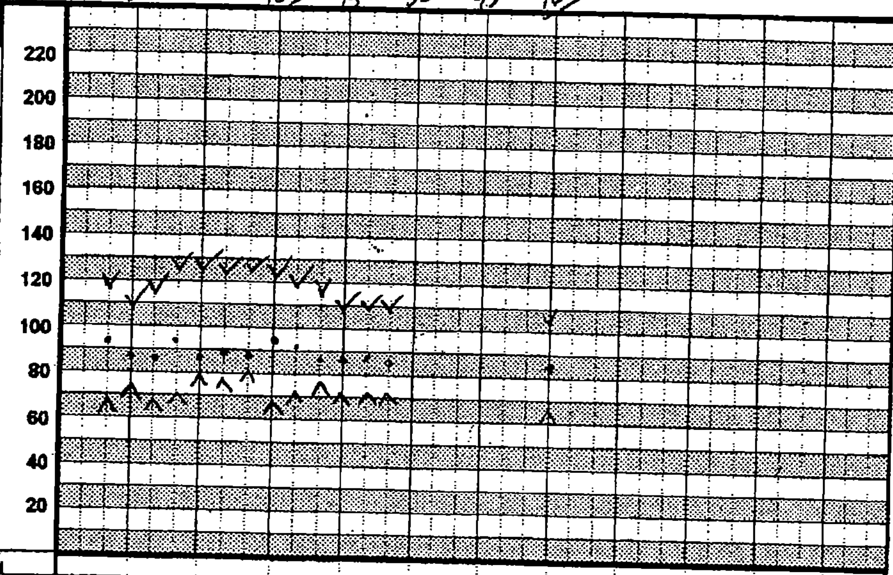
INITIAL DATA:
BP – 116/70
R-18
HR– 84

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME– 1420

TIME → 30 45 1500 15 30 45 1600

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ╪
TOURNIQUET T – X
ANES– X-X
PROC ⊙ – 0



REMARKS–
Code drugs with numbers, events with letters
1400 pt ID'd; plan of Care Reviewed
1420 In Room Mon. Ons
1425 SAB injected 12mg of 0.75% Marc
1430 pt turned prone & assist w/ pres. point padded & checked

VENTILATION

VT – ml					
f – breaths/min	20	19	18	18	
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS & ACCESSORIES

BP/Auto Cuff
BP / oth
ART line
Steth- PC/ES
Gas analyzer
Warming blkt
Conv warmer

ET CO2 (torr)					
FiO2 (Frac or %)	.21	>.21	>.21	>.21	>.21
SpO2 (%)	96	96	96	94	95
ECG	SR	SR	SR	SR	SR
TEMP- site					
N-M Block (T/4)					

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

RECOVERY AT 1525
PACU ICU ______ (Specify)
OTHER
CONDITION: Stable
RESP– SpO2– 100
BP– 116/77 HR– 77

ANESTHESIA / PROCEDURE TIME

ANES	Start	Room	End
	1400	1420	1530
PROC	Ready	Begin	End
	1430	1445	1520

PROCEDURES and CPT Codes
Sacral Decub Debred

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

(b)(6)-4

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks SAB; sitting L3-4; Betadyne prep X3; 1% Lidocaine skin wheal Midline X2; #20g Introducer Midline X2; #25g Whitacre via Introducer X2 (+)CSF (-)Para-Sthesia; Pt Tol. Well.

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

SURGEONS: (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 (b)(6)-2 AN, CRNA
Nurse Anesthetist

PROCEDURE LOCATION 1-1

DATE 10 Aug 03

PAGE 1 OF 1

MEDICAL RECORD ANESTHESIA
WAMC OP 376 REVISED
MEDCOM - 6673 1 Jan 99

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

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "( )"=CONSTANT INFUSION

DRUG			TOTALS
Versed	(mg)	2 1	4mg
Fent	(mcg)	50,50,50,50,50	250mg
	( )		0
	( )		
	( )		
	( )		
VOLAT AGENT	% del		
	% e.t.		
AIR	L/Min		
N2O	L/Min		
Blowby O2	L/Min	X– 8 –X	

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

FLUIDS

LINE site LR	☐ Warmed	600
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE –

TOTAL EBL: M/N

TOTAL URINE: 0

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– 0

BLOOD– 0

REMARKS–

Code drugs with numbers, events with letters

1245 pt ID'd ; plan of Care Reviewed c̄ pt

1255 In Rm Monitor on

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 60 KG LB

HEMATOCRIT:

INITIAL DATA:

BP – 130/64

R-20

HR– 88

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME– 1255

TIME → 1300 15 30 45 1400

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

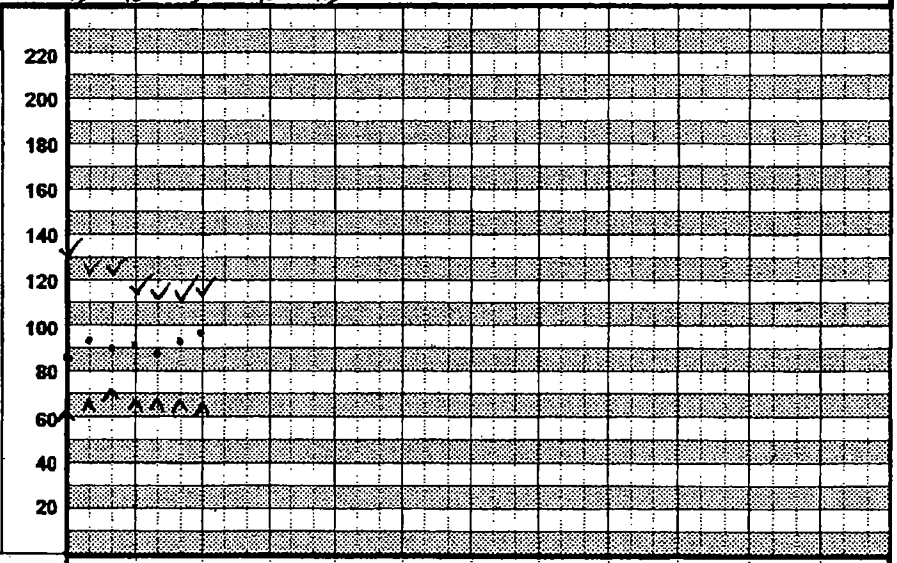
Resp rate

BP (transduced) ╧ ╤

TOURNIQUET T – X

ANES– X-X

PROC ⊙ – ∅



VENTIL

VT – ml		
f – breaths/min		
Peak inf pres / PEEP		
MODE– S(pon), A(ssist), C(on)	S	S

MONITORS / ACCESS LINES

BP/Auto Cuff	ET CO2 (torr)		
BP / oth	FIO2 (Frac or %)	.21	>.21
ART line	SpO2 (%)	95	97
Steth- PC/ES	ECG	SR	SR
Gas analyzer	TEMP- site		
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS EVENTS

Position → on

RECOVERY AT 1340

PACU [✓ ICU] (Specify)

OTHER

CONDITION:

RESP- 16 SpO2- 94

BP- 110/70 HR- 87

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	1245	1255	1345
PROC	Ready	Begin	End
	1300	1305	1335

PROCEDURES and CPT Codes

Dressing change : Sacral Debred

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

MAC

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

Natural

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

(b)(6)-4

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 AN, CRNA

(b)(6)-2

NURSE ANESTHESIA

PROCEDURE LOCATION 1–1

DATE 12 Aug 03

PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6674

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS – MG / MCG / ML. * I"=CONSTANT INFUSION

DRUG	Units		TOTALS
Versed	(mg)	1 1 1	3
Fentanyl	(mcg)	(100) 50 50	250
Ketamine	(mg)	50	
	( )	→ 20 / 30 / 50	100
Propofol	(mg)	(100)	
Sux / Vec	(mg)	(100) / 7 3 0 Reversed ĉ 4mg Neo 0.2mg Robinul	
VOLAT. AGENT	% del		
Isoflurane	% e.t.	1.3 1.0 0.2 X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 —— 10 1.5 1.5 1.5 8	

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

TOTAL EBL <50

TOTAL URINE 0

FLUIDS — SUMMARY
CRYSTALLOID– 700
COLLOID– 0
BLOOD– 0

FLUIDS
LINE site #22G (900T) ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE –

PHYS STATUS
1 [✓ 2] 3 4 5 E

BODY WEIGHT
50 [✓ KG] LB

HEMATOCRIT

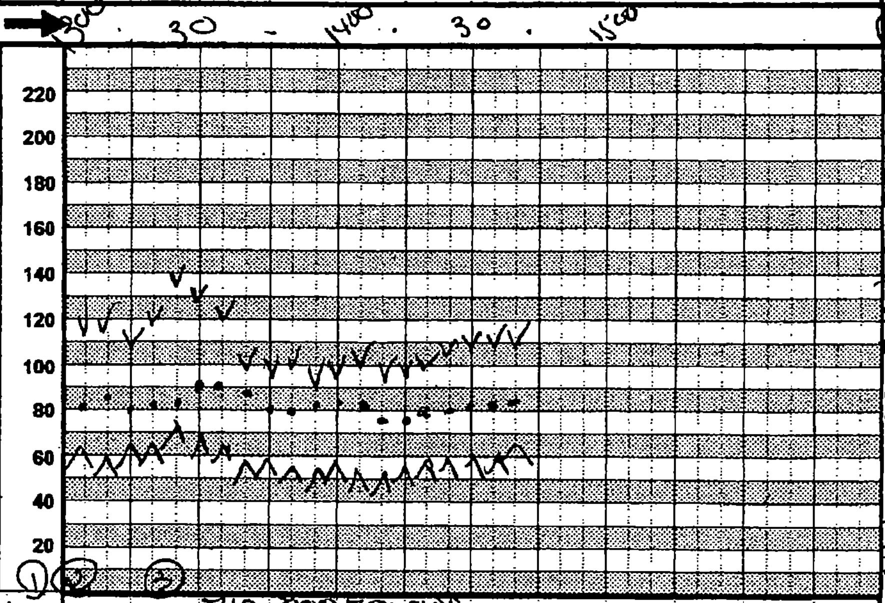
INITIAL DATA:
BP – 109/67
HR– 72

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? (b)(6)-2
TIME 1301

TIME → 1300 . 30 - 1400 . 30 . 1500

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – Ŧ
ANES– X-X
PROC-⊙-Ø



VT – ml			710	800	750	700		
f – breaths/min			9	9	7	6	12	
Peak inf pres / PEEP			23	22	22	22		
MODE– S(pon), A(ssist), C(on)	S	S	C	C	C	C	S	
ET CO2 (torr)	+ ——		+ 32	30	31	38	45	
FIO2 (Frac or %)	?	.21	.86	.85	.85	.85	.85	
SpO2 (%)	100	100	100	100	100	100	100	
ECG	SR	SR	SR	SR	SR	SR	SR	
TEMP- site axilla			eso	36.1	36.4	36.5		
N-M Block (T/4)			0/4 4/4 2/4		2/4		4/4 ĉ tet.	

MONITORS: ✓ BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; ✓ Gas analyzer; ✓ Hme; Warming blkt; Conv warmer
✓ ET CO2; ✓ FIO2; ✓ SpO2; ✓ ECG; ✓ TEMP; ✓ N-M Block

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → prone —— supine —— prone | sup.

REMARKS–
Code drugs with numbers, events with letters

① From ICU → OR via stretcher.
② Pt. positioned self prone. Pressure pts padded. Multiple pillows in use. BUE < 90°.
③ Surgeon anticipating more invasive surgery– requests GA. Flipped supine ĉ 4 personnel. Pre-O2 RSI ĉ cricoid. Flipped prone– pressure pts padded. BUE < 90°. Eyes/ears free of pressure.
Sxd / ext. intubated ĉ SV TV > 5cc/kg SaO2 ≥ 96. (ṗ pt turned supine.
→ ICU via stretcher IV patent. O2 in use. Report given.

RECOVERY AT 1443
PACU [✓ ICU] (Specify)
OTHER ī 95.7
CONDITION Sleeping
RESP– 24 SpO2– 100
BP 133/78 HR– 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1250	1300	1456
	Ready	**Begin**	**End**
PROC	1305	1306	1426

1353

PROCEDURES and CPT Codes
Sacral ~~decubitis~~ decubitus debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
IV sed — GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
natural ĉ O2 via FM | DLx1 MAC 4 #8.0 ETT @ 22cm ® lip Grade II view ⊕ ETCO2 ⊕ BBS Atraumatic cuff ↑

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

(b)(6)-4

SURGEONS (b)(6)-2

ANES (b)(6)-2 CRNA

(b)(6)-2
CPT, AN
CRNA

PROCEDURE LOCATION OR 1-1

DATE 13 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6675

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

Smoker
NKDA

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. • [ ]=CONSTANT INFUSION

DRUG	(Units)		TOTALS
midazolam	(mg)	11111	5mg
fentanyl	(mcg)	<250>	250mcg
Propofol	(mg)	30 20 20 20	90mg
	( )		
	( )		
	( )		

VOLAT AGENT		% del	
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	10 – 10 – RA.

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

TOTAL EBL: Min

TOTAL URINE: 0

FLUIDS – SUMMARY

CRYSTALLOID– 200cc LR

COLLOID– X

BLOOD– X

FLUIDS

LINE site (R) (cc) 20g RAC ☐ Warmed	200	
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES

EST BLOOD LOSS

URINE –

REMARKS–

Code drugs with numbers, events with letters

1430 Greeted pt in ICU
ⓟ ID. Preop unchan
as before. Labs/ch
review. Plan IV sed
for dressing Δ on
sacral decub, H
NPO since 10AM (clear

1515 To ICU via LTt
VSS. Pt stable.
Resp even / Reg
Report to SGT Win

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT —

INITIAL DATA:

BP – 123/71

HR – 91

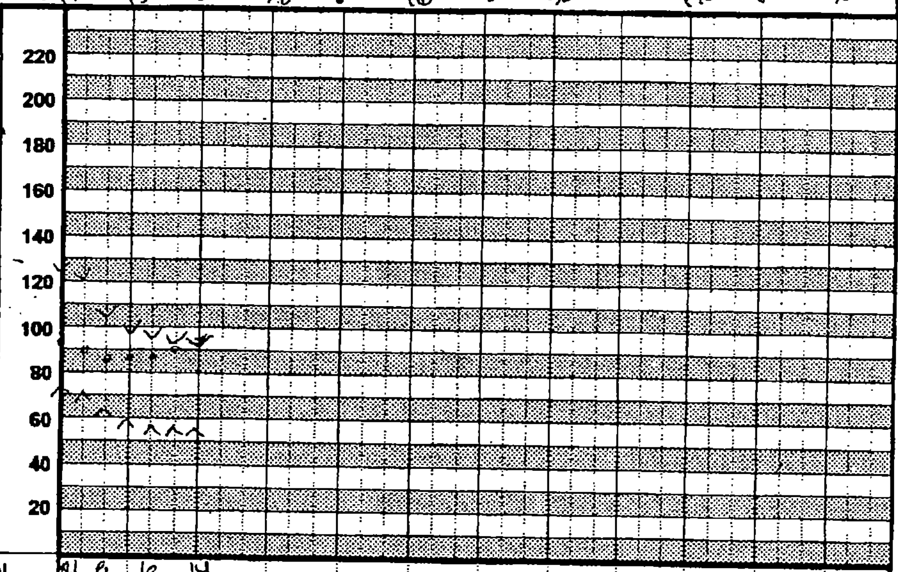
MACHINE CHECK OK?– [✓ Y] N

PATIENT READINESS OK for PROCEDURE yes

TIME– 1435

TIME ➡ 1445 1500 • 20 • 1600 • 20 • 1700 • 20

SYMBOLS:
Reg Adult
BP by cuff
V ⓟ
Λ art
Heart rate
●
Resp rate
BP (transduced)
TOURNIQUET
T – T
ANES– X-X
PROC–⊙–Ø



VT – ml	21	8	6	14
f – breaths/min				
Peak Inf pres / PEEP				
MODE– S(pon), A(ssist), C(ont)	S S	S	S	

✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕	⊕	⊕
BP / oth	✓ FIO2 (Frac or %)	>.21	>.21	RA
ART line	✓ SpO2 (%)	100	100	97
Steth- PC/ES	✓ ECG	SR	SR	SR
✓ ~~Gas~~ CO2 analyzer	✓ TEMP- site Axil			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS **EVENTS** All pressure points & genitals ✓d/padded.

Position ⟶ Prone → OR

RECOVERY AT 1515

PACU [✓ ICU] (Specify)

OTHER T= 96°

CONDITION: Stable

RESP– 14 SpO2– 97% RA

BP– 92/50 HR– 94

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1430	1435	1516
	Ready	Begin	End
PROC	1450	1455	1510

PROCEDURES and CPT Codes

Sacral Decubitus dressing change (debridement / Irrigation)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

IV sed

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Natural c̄ O2 FM.

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

(b)(6)-4

(b)(6)-4

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETISTS: (b)(6)-2 CPT CRNA

PROCEDURE LOCATION OR 1-1

DATE 14 AUG 03

PAGE 1 **OF** 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6676

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

MEDICAL RECORD ANESTHESIA

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

DRUG (Units)	30	45	1000	15	30	45	1100	15	30	45	1200	15
Versed (mg)	2											
Fent // MSO4 (mg)	250			//5		2			3			
STP (mg)	300										100	
Vec (mg)	10			2		2			1			
Neostig / glycop (mg)										5/0.8		
Ephedrine (mg)		5										
VOLAT AGENT Iso % del / % e.t.	X-0.6	1.5	1.5	1.0	1.0	1.0	1.0	1.5	1.5	1.0		
AIR L/Min												
N2O L/Min												
(O2) L/Min	X-8	2	2	2	2	2	2	2	2	2	2	

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

TOTALS	TOTAL EBL
2 mg	100
250 // 10mg	
	TOTAL URINE
	350

FLUIDS – SUMMARY

CRYSTALLOID– 2500

COLLOID– Ø

BLOOD– Ø

FLUIDS

LINE site LR ☐ Warmed — (1000) — (2000)

☐ Warmed

☐ Warmed

☐ Warmed (b)(6)-2

LOSSES

EST BLOOD LOSS ~~200~~

URINE – 200 150/350

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 27.8

INITIAL DATA:

BP – 134/70

T-97° R-16

Rm Air

SpO2-97%

HR– 74

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME– 0925

TIME → 30 45 1000 15 30 45 1100 15 30 45 1200 15

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

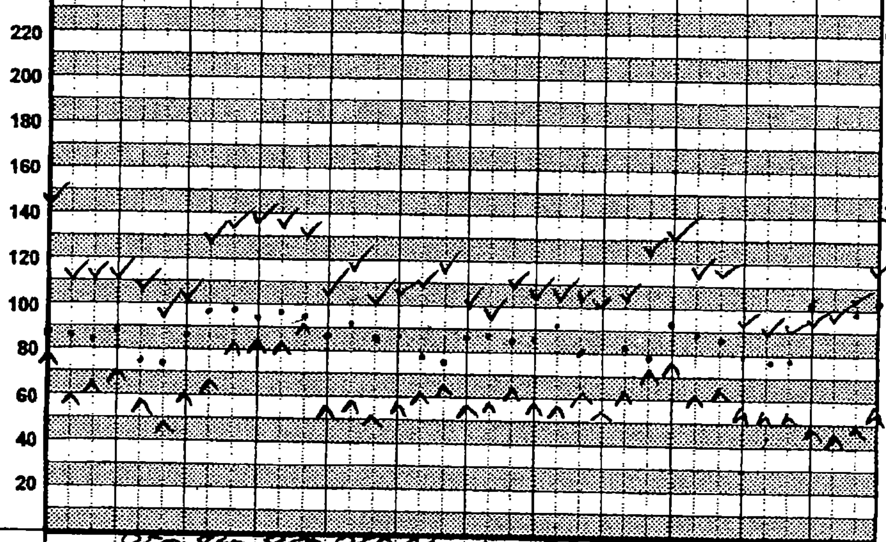
Resp rate

BP (transduced)

TOURNIQUET T — X

ANES– X-X

PROC– ⊙ – Ø



VENTILATION	VT – ml	850	860	850	880	900	900	870	1670		
	f – breaths/min	10	10	8	8	6	6	6	6	22	21
	Peak inf pres / PEEP	28	24	24	24	23	21	22	19		
	MODE– S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	S	S
BP/Auto Cuff	ET CO2 (torr)	30	33	31	28	31	34	33	52	47	46
BP / oth	FIO2 (Frac or %)	.83	.81	.77	.80	.82	.81	.82	.62	.81	.81
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site (Ax)	34.0	34.3	34.6	34.7	34.7	34.7	34.5	34.6	34.6	34.6
	N-M Block (T/4)	4/4	4/4	3/4	1/4	3/4	1/4		2/4		4/4 c̄ ST
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS **EVENTS**

Position —

REMARKS–

Code drugs with numbers, events with letters

0915 pt ID'd c̄ plan of Care Reviewed c̄ pt, chart Review

0925 In Rm Monitor

0930-0940 Induction ! Intubation

1010 NG Tube pl

1125 Relief [illegible]

1230 pt SV c̄ good TV pt Following Commands, pt Extubated c̄ pos. pres. p̄ Suction

RECOVERY AT 1235

PACU ICU________ (Specify)

OTHER________

CONDITION: Stable

T-96.1

RESP- 20 SpO2- 99

BP- 113/63 HR- 91

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0915	0925	1240
PROC	Ready	Begin	End
	0945	1000	1220

PROCEDURES and CPT Codes

EXP. Lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL X1 c̄ 2 Mil Grade II/III View, Intubated c̄ 8.0 ETT to 24cm @ lip Bil ↑BS ! ETCO2 x 5 waves Eyes taped

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

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 AN CRNA

(b)(6)-2

PROCEDURE LOCATION ISO 1-1

DATE 15 July 03

PAGE 1 **OF**

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6677

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

See previous pre op

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)		TOTALS
Versed	(mg)	2 1	3
Fentanyl	(ug)	(20)	250
Propofol	(mg)	40	40
	( )		
	( )		
	( )		
VOLAT AGENT	% del		
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10—10	

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

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS

LINE site		
LR #20 (R) AC ↑700	☐ Warmed	100
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

FLUIDS – SUMMARY

CRYSTALLOID– 100

COLLOID– 0

BLOOD– 0

LOSSES

EST BLOOD LOSS

URINE –

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 50 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA:

BP – 129/76

HR– 75

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? (Y)

TIME– 0816

TIME → 815 30 45

SYMBOLS:

BP by cuff V Λ

Heart rate ●

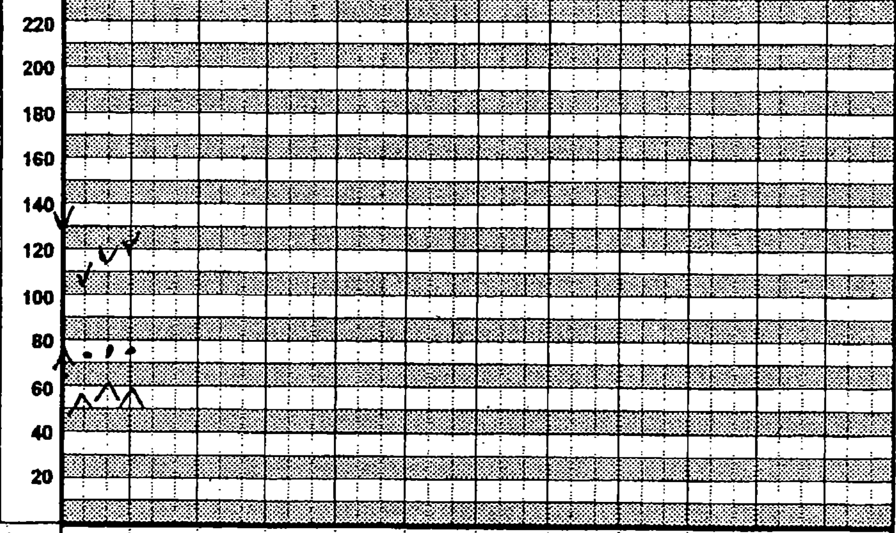
Resp rate

BP (transduced)

TOURNIQUET T – T

ANES– X-X

PROC-⊙-Ø



REMARKS–

Code drugs with numbers, events with letters

① From ICU → OR.

② Pt positioned self prone. O₂/monitors IV sed.

③ Moved to stretcher & personnel → ICU via stretcher with patient. Report to RN.

VENTIL

VT – ml	
f – breaths/min	18 16
Peak inf pres / PEEP	
MODE– S(pon), A(ssist), C(on)	S S

MONITORS / EQUIPMENT

X	BP/Auto Cuff	X	ET CO2 (torr)	+ +
	BP / oth	X	FIO2 (Frac or %)	> .21
	ART line	X	SpO2 (%)	99 98
	Steth- PC/ES	X	ECG	SR SR
	Gas analyzer	X	TEMP- site axil	
			N-M Block (T/4)	
	Warming blkt			
	Conv warmer			

RECOVERY AT 0837

PACU [✓ ICU] (Specify)

OTHER

CONDITION: 96.8

RESP– 10 SpO2– 96

BP– 111/61 HR– 72

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0815	0841
	Ready	**Begin**	**End**
PROC	0819	0820	0829

Mark with letters & symbols, explain under REMARKS **EVENTS** Pressure pts padded ABLE < 90° eyes/ears/genitals free of pressure

Position → prone

PROCEDURES and CPT Codes

Sacral decubitus dressing change

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

IV sed

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

natural c̄ O₂ via FM

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

C

(b)(6)-4

(b)(6)-4

SURGEONS (b)(6)-2

ANESTHETIST (b)(6)-2

(b)(6)-2

CPT, AN
CRNA

PROCEDURE LOCATION OR 1-1

DATE 16 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6678

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

ASA II
NKDA.

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Versed	(mg)	<5>	5 mg
Fentanyl	(mcg)	<250>	250 mcg
Propofol	(mg)	20 20	40 mg
	( )		X
	( )		
	( )		
VOLAT AGENT	% del		
	% e.t.		
AIR	L/Min		
N2O	L/Min		
NC O2	L/Min	4 4 4 RA	

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

TOTAL EBL Ø

TOTAL URINE Ø

FLUIDS

LINE site LR (L) 18g LH	☐ Warmed	200 cc
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES EST BLOOD LOSS
URINE –

FLUIDS – SUMMARY
CRYSTALLOID– LR = 200cc
COLLOID– X
BLOOD– X

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 50 [✓ KG] LB

HEMATOCRIT: —

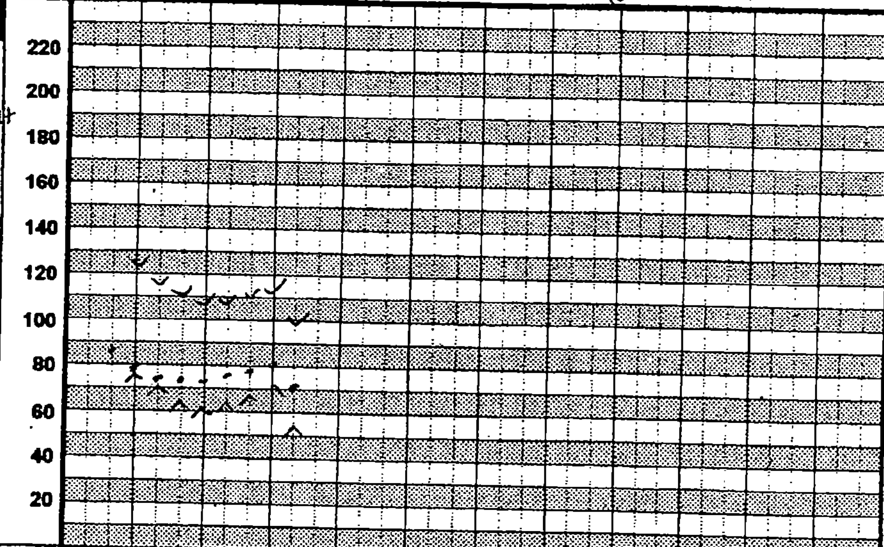
INITIAL DATA:
BP – 125/76
HR – 87

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Yes
TIME– 0745

TIME → 0800 15 30 45 0900 15 30 45 1000 15 30 45

SYMBOLS:
(R) arm BP by cuff
V Reg Adult Λ
Heart rate ●
Resp rate
BP (transduced) ⊥ T
TOURNIQUET T – ✗
ANES– X-X
PROC ⊙ – Ø



VENTIL.

VT – ml	Ø				
f – breaths/min	18	12	14	16	14
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS & EQUIPMENT

✓ BP/Auto Cuff	✓ ET CO2 (torr) Nasal				
BP / oth	✓ FIO2 (Frac or %)	>.21	>.21	>.21	>.21 [redacted] Bb-2
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
✓ O2 Gas analyzer	TEMP- site Axial				
	N-M Block (T/4)				
Warming blkt		✓			
Conv warmer					

Mark with letters & symbols, explain under REMARKS **EVENTS**
Position → Prone → X. Supine

REMARKS–
Code drugs with numbers, events with letters

0750 → Greeted pt in ICU ē ID. 18g IV start LH. Preop assessment unchanged from 8/13. VSS. Lungs CTA Ⓑ Heart S1S2 RRR.

0810 In OR 1-1 via litter. Positions self prone on OR bed. All pressure pts / genitals ✓'d + padded. O2 via NC.

0845 Sacral drsg Δ complete. Pt moves to litter → supine.

0849 Abdominal drsg Δ complete.

0850 To ICU via litter. VSS. Report to ICU staff. Pt stable

RECOVERY AT 0850
PACU [✓ ICU] (Specify)
OTHER T = 96²
CONDITION: Stable
RESP– 14 SpO2– 98
BP– 99/54 HR– 70

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0730	0810	0855
PROC	Ready	Begin	End
	0818	0825	0850

PROCEDURES and CPT Codes
Dressing change to Sacral decubiti ē I+D. Drsg Δ to abdomen.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
IV sedation

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
Natural ē O2 NC

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

SURGEONS: (b)(6)-2

ANES (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION OR 1-1
DATE 18 AUG 05
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan. 99
MEDCOM - 6679

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

NKDA
Cefotan 1200

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "( )"=CONSTANT INFUSION

DRUG	(Units)		TOTALS
Versed	(mg)	2 3	2/0
Fentanyl	(mcg)	(100) (100) 50	300/200
STP	(mg)	300	
(Sch) / Vec.	(mg)	(100) 10 3 3 4 5	
MSO4	(mg)	3 2 2 3 3 3 2 2	20/0
	( )		
VOLAT AGENT Forane	% del / % e.t.	0.6 1.4 1.4 1.4 1.4 1.1 0.7 0.7	
AIR	L/Min	1 1 1 1 1 1 1 1	
N2O	L/Min		
O2	L/Min	8 1 1 1 1 1 1 1 1 5	

TOTAL EBL 150

TOTAL URINE 200

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

FLUIDS

LINE site	Warmed	
#20 G LR (↑450)	☒ Warmed	(450) (1000) 1600
#16 G LR.	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

FLUIDS – SUMMARY
CRYSTALLOID– 1600
COLLOID– 0
BLOOD– 0

LOSSES
EST BLOOD LOSS 100 150
URINE – 180 200

PHYS STATUS 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT 75 [✓ KG] LB

HEMATOCRIT 28.4

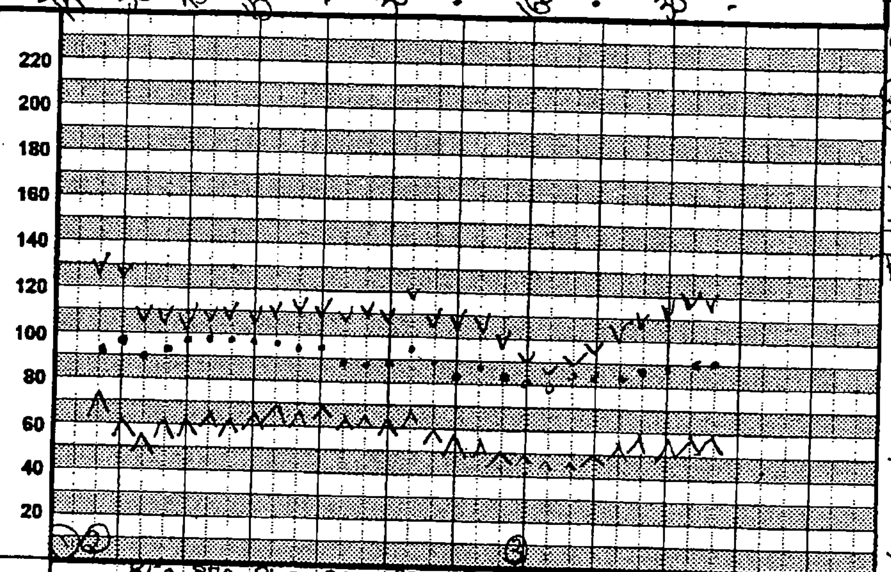
INITIAL DATA:
BP – 127/71
HR– 82

EQUIP CHECK OK? [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? [✓ Y]
TIME– 1421

TIME → 1415 30 45 1500 · 30 · 1600 · 30 ·

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T –
ANES– X-X
PROC-⊙-Ø



REMARKS– Code drugs with numbers, events with letters

① Trans ICU → OR via stretcher.
② → OR table & personnel. Pre-O2 / monitors RSI c̄ cricoid. NGT Ⓡ nares. Stomach ↓
③ #16 B IV started Ⓛ ...
④ Zofran 4mg IV
→ ICU via stretcher vent c̄ ambu bag. IV x 2 patent. Report given.

	1	2	3	4	5	6	7	8	9	10
VT – ml	850	870	860	820	830	800	800	760	760	
f – breaths/min	10	10	10	10	9	9	8	8	8	
Peak inf pres / PEEP	27/3	27/3	29/3	29/3	27/3	27/3	29/3	30/3	30/3	
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C
☒ ET CO2 (torr)	+	32	32	29	30	29	30	31	33	33
☒ FIO2 (Frac or %)	.9	.7	.69	.53	.52	.51	.51	.53	.52	.51
☒ SpO2 (%)	100	100	100	100	100	100	100	100	100	100
☒ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
☒ TEMP- site CSD		36.7	36.6	36.6	36.8	37.0	37.3	37.3	37.4	
☒ N-M Block (T/4)	0/4	4/4	0/4	1/4		1/4		2/4	1/4	

MONITORS / ACCESSORIES: ☒ BP/Auto Cuff, BP / oth, ART line, Steth- PC/ES, ☒ Gas analyzer, Warming blkt, Conv warmer

A-line inserted #20G Ⓡ radial by T. Schaaden CRNA 1 attempt c̄ sterile prep.

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → 0 — pressure pts padded BUE < 90° on taped c̄ intubation

RECOVERY AT ICU
PACU [✓ ICU] (Specify)
OTHER
CONDITION: intubated
RESP 8 / 9 / 10 SpO2– 100
BP– 99/50 HR– 103

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1405	1420	1650
	Ready	**Begin**	**End**
PROC	1432	1442	1632

PROCEDURES and CPT Codes
abdominal wound exploration

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments (previously noted airway) Light wand used attempt #2. #8.0 ETT secured @ 25 cm midline & tied in place. ⊕ BBS ⊕ ETCO2. Soft bite block placed. Cuff ↑

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

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

ANESTHETISTS: (b)(6)-2 [redacted] CPL

(b)(6)-2 [redacted]
CPT, AN
CRNA

PROCEDURE LOCATION OR-1
DATE 21 July 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED Jan 99
MEDCOM - 6680

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

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

Age 50 DAYS MOS [✓ YRS] **Sex** [✓ MALE] ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 [✓ E]
WT: ~75 [✓ KG]/LB **HT:** ____ **IN.**
ALLERGIES: NKDA

PROPOSED PROCEDURE: Ex Lap
SURGICAL SERVICE: GS – (b)(6)-2
NPO SINCE: 2300

HABITS:
TOBACCO: 0
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) 0
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:
7.33 pCO_2 38.7 pO_2 251
HCO_3 21 BE -5 SaO_2 100

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Denies medical problems per interpreter

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
prior leg fracture

PHYSICAL EXAMINATION 99%
BP 124/81 HR 91 R 18 T ___
Pain Scale 0-10 ______
HEENT - Teeth Poor dentition
Trachea Midline
3FB TMJ/Neck FROM
Oropharynyx MP II
Nares Patent
CHEST: CTA
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: (R) lower leg
Ulnar Filling:
BACK:
OTHER:

NPO Since 2300

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: (b)(6)-2 CPT/CRNA Date: 8 JUL 03 Time: 0020 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{✓} NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Signed (b)(6)-2 CPT/CRNA (b)(6)-2 Date: 9 JUL 03 Time: 1330 Hrs

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

Patient Identification: (Ward) ______
(b)(6)-4

* NOTE Anterior glottic opening Grade II view during laryngoscopy.
(b)(6)-2 CPT/CRNA

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DO:
MEDCOM - 6681
PATIENT RECORD COPY
Previous edition is obsolete
☆U.S. GPO: 2002-729-283

ANESTHESIA PLAN OF CARE PRE- ROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 50 DAYS MOS [✓ YRS] Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: sacral decub I/D
SURGICAL SERVICE: gen
NPO SINCE: this am

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 50 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: ~~___~~
DRUGS: ~~___~~

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Heparin
( ) Zantac
( ) Percocet prn
( ) Fentanyl patch
( )
( )

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

- ex lap
- sacral decubitus, debridement x2.
- (L) elbow

PHYSICAL EXAMINATION

BP 109/57 HR 22 R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth intact
Trachea _____
TMJ/Neck MP II
Oropharnyx 2 SFB MAL
Nares _____
CHEST: CTA (B) b/l bases
CARDIAC: S1S2
EXTREMITIES:
IV Access: #22G (R) wrist
Ulnar Filling:
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: { } LOCAL {X} MAC { } Regional (Specify): _____ {X} General: Mask Intubation
IV sed
B) 4

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the p (b)(6)-2

CPT AN
The patient/legal guardian (b)(6)-2 Questions answered.
Date: 8/13/03 Time: 1245 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{✓} NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
(b)(6)-2 VSS Pt o pn [illegible]
S (b)(6)-2 Date: 8/14 Time: 1130 Hrs

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

Patient Identification: (Ward) _____

(b)(6)-4

(b)(6)-4

WAMC Form 2300 (Revised) 15 Mar C. MCXC-DO

MEDCOM - 6682

Previous edition is ob
☆U.S. GPO: 200

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 50 DAYS MOS [✓ YRS] Sex (X) MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 75 KG/LB HT: 66 IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Wound EXP!
SURGICAL SERVICE: GEN
NPO SINCE: P MN

HABITS:
TOBACCO: Ø
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Zantac
( ) Unasyn
( ) Hep.
( ) MSO4 PRN
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ______ / ______
U/A:
OTHER:

10.7 > 27.8 / 9.0 < 277

~~5.2~~

~~277~~

141 / 100 / 19 < 95
3.2 / 33 / 0.7

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	[✓ N]	Y	
Pulmonary System:			
Asthma	[✓ N]	Y	
Bronchitis/URI	[✓ N]	Y	
COPD	[✓ N]	Y	
Other	[✓ N]	Y	
Renal System:			
Acuta/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	[✓ N]	Y	
Other Significant Hx:			
	N	Y	GSW to ALD
	N	Y	s/p Ⓛ elbow (8 July)
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

EXP lap i ORIF
Ⓛ elbow (8 July)

PHYSICAL EXAMINATION

BP 134/70 HR 74 R 16 T 97.0
Pain Scale 0-10
HEENT - Teeth Poor
Trachea Midline
TMJ/Neck FROM
Oropharynx MP II
Nares
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: GSW Ⓛ elbow
IV Access: #18g Ⓡ arm
Ulnar Filling:
BACK:
OTHER:

NPO Since P MN

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ______ Date: 15 July 03 Time: 0700 Hrs

MAJ (b)(6)-2 (b)(6)-2 AN, CRNA

[redacted]

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

Signed: ______ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ______

(b)(6)-4

SEDATION KEY:

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DC

MEDCOM - 6683
PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 50 DAYS MOS [✓ YRS] **Sex** [✓ M]MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 [✓ E]
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Wound Expl.
SURGICAL SERVICE: Gen - (b)(6)-2
NPO SINCE: 0700

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Heparin 5000U SQ BID
( ) Zantac 50mg IVPB q8h
( ) Fluconazole 100mg qd
( ) Cefotan 2g IV q12
( ) Albuterol Neb q4hr
( ) MSO4 PRN pain

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

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

21 JUL
12.6 > 9.3 / 28.4 < 926

138 | 99 | 7 < 132
3.8 | 32 | 0.8

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

GSW to (L) elbow/Abdomen 8 JUL

ASSESSMENT
PAST SURGICAL/ANESTHETIC
- Ex-lap ORIF (L) elbow 8 JUL
- Ex-lap 15 JUL 03

99-100% on.

PHYSICAL EXAMINATION
BP 128/[illegible] HR 92 R 20 T 97.9
Pain Scale 0-10 ______
HEENT - Teeth Intact - poor dent.
Trachea Midline
TMJ/Neck FROM
Oropharynx MP II
Nares patent
* TM dist 3 FM
CHEST: CTA - dim bases
CARDIAC: S1 S2 RRR
EXTREMITIES: GSW (L) elbow - cast
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since 0700

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ________ [✓ { }] General: Mask Intubation

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: (b)(6)-2 CPT/CRNA Date: 21 JUL 03 Time: 1215 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
[✓ { }] NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Pt. remains intubated, paralyzed, sedated. [illegible] - surgeon's care.
Signed: (b)(6)-2 Date: [illegible]/03 Time: 414 Hrs

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

Patient Identification: (Ward) ______

(b)(6)-4

(b)(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DC MEDCOM - 6684 PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

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)* ____________

VOLUME REQUESTED *(If applicable)* ____________ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
☐ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 8 JUL 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* ?

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to abdomen

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 (b)(6)-2 CPT/CRNA

DATE VERIFIED 8 JUL 03

TIME VERIFIED 0705

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR	RECIPIENT
ABO A	ABO A
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: Exp: 08 JUL 03

PREVIOUS RECORD CHECK: ☑ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DATE 08 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 0723 ON *(Date)* 08 JUL 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 CPT/CRNA

2nd VERIFIER *(Signature)* (b)(6)-2 MAJ/CRNA

TEMP. 97.0 PULSE 81 BP 88/49

DATE OF TRANSFUSION 8 JUL 03

TIME STARTED 0733

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME 0745 DATE 7/8/03 [✓ COMPLETED] 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 OF PERSON NOTING ABOVE (b)(6)-2 CPT/CRNA

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

Male

WARD OR

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

MEDCOM - 6685 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)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
Mult. trauma

DATE REQUESTED
8 July 03

DATE AND HOUR REQUIRED
ASAP

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)* ____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED
SEE Prior SF 518

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4
DONOR
ABO A
Rh POS

TRANSFUSION NO.
PATIENT NO.
(b)(6)-4
RECIPIENT
ABO A
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
☑ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 08 JUL 03

REMARKS:
Exp 08 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
(b)(6)-2

AT *(Hour)* 0733 | ON *(Date)* 08 JUL 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 CPT/CRNA

2nd VERIFIER *(Signature)*
(b)(6)-2 MAJ, AN

PRE-TRANSFUSION
TEMP. 97° PULSE 80 BP 113/62

DATE OF TRANSFUSION 8 JUL 03 | TIME STARTED 0780

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME DATE [✓ COMPLETED] INTERRUPTED
0900 8 July

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 OF PERSON NOTING ABOVE
(b)(6)-2 MAJ/CRNA

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

SEX M | WARD OR

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

MEDCOM - 6686 MEDICAL RECORD COPY

518-124

NSN 7540-00-634-4159

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) ______

VOLUME REQUESTED (If applicable) 2 u ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
☐ TYPE AND SCREEN
☑ CROSSMATCH

DATE REQUESTED 7/12

DATE AND HOUR REQUIRED 7/12 1600

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN (Print)
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE SB resectn

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.

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

DATE VERIFIED 12 Jul 03

TIME VERIFIED 1630

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4

TRANSFUSION NO.

PATIENT NO.
(b)(6)-4

DONOR		RECIPIENT	
ABO	A	ABO	A
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
☐ RECORD ☒ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

DATE 12 Jul 03

REMARKS:
Exp Date: 14 July 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA
(b)(6)-2

AT (Hour) 1750 ON (Date) 12 Jul 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

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

[redacted] TRANSFUSION
TEMP. 100.9 PULSE 100 BP 130/68

DATE OF TRANSFUSION 12 Jul 03

TIME STARTED 1805

POST-TRANSFUSION DATA

AMOUNT GIVEN 340 ML

TIME/DATE [✓ COMPLETED] INTERRUPTED 2130 12 Jul 03

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 99.2 PULSE 99 BLOOD PRESSURE 128/73

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
Spc (b)(6)-2 91wmb

[redacted]

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

SEX M

WARD ICU

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6687

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)* ____

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
☐ TYPE AND SCREEN
☑ CROSSMATCH

DATE REQUESTED 12Jul03

DATE AND HOUR REQUIRED 12Jul03 1600

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
SB resection

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
(b)(6)-2 LRN

DATE VERIFIED 12Jul03

TIME VERIFIED 1630

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4

TRANSFUSION NO.

PATIENT NO.
(b)(6)-4

DONOR
ABO A
Rh pos

RECIPIENT
ABO A
Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
☐ RECORD ☒ NO RECORD

SIGNATURE [redacted] FORMING TEST
(b)(6)-2

☐ CROSSMATCH NOT REQUIRED FOR THE [redacted] REQUESTED | DATE 12 Jly 2003

REMARKS: Exp: 14 July 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
(b)(6)-2

AT *(Hour)* 2135 ON *(Date)* 12 Jul 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 VERIFIER *(Signature)*
(b)(6)-2

TEMP. 99.2 PULSE 87 BP 128/93

DATE OF TRANSFUSION 12 Jul 03

TIME STARTED 2200

POST-TRANSFUSION DATA

AMOUNT GIVEN 390 ML

TIME DATE [✓ COMPLETED] INTERRUPTED
0145 13Jul03

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 OF PERSON NOTING ABOVE
(b)(6)-2

91W/M6

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

SPC (b)(6)-2

SEX M

WARD ICU

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

MEDCOM - 6688

MEDICAL RECORD COPY

518-124

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4159

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)* ____________

VOLUME REQUESTED *(If applicable)* ____________ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
☐ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 23 July 03

DATE AND HOUR REQUIRED on call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____________
HEMOLYTIC DISEASE OF NEWBORN? ____________

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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 (b)(6)-2

DATE VERIFIED 23 July 03

TIME VERIFIED 0730

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR
ABO A
Rh POS

RECIPIENT
ABO A
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
☒ RECORD ☐ NO RECORD

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

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 23 JUL 03

REMARKS: Exp: 23 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1109 ON *(Date)* 23 JUL 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 VERIFIER [redacted] (b)(6)-2 SGT/LPN

PRE-TRANSFUSION
TEMP. 97^{6} PULSE 101 BP 143/69

DATE OF TRANSFUSION 23 July 03 TIME STARTED 1130

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 23Jul03 1430

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 99 PULSE 112 BLOOD PRESSURE 118/64

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 PERSO (b)(6)-2 E SGT/LPN

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

(b)(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6689

Medical Record Copy

518-124 NSN 7540-00-634-4159

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

DIAGNOSIS OR OPERATIVE PROCEDURE

DATE REQUESTED 23 July 03

DATE AND HOUR REQUIRED on call

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)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED 23 July 03

TIME VERIFIED 0730

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

PREVIOUS RECORD CHECK:
☑ RECORD ☐ NO RECORD

(b)(6)-2

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 23 JUL 03

REMARKS: Exp: 23 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 1109 ON *(Date)* 23 JUL 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 VERIFIER *(Signature)* (b)(6)-2 SGT/LPN

PRE-TRANSFUSION TEMP. 97.6 | PULSE 101 | BP 143/69

DATE OF TRANSFUSION 23 July 03 | TIME STARTED 1130

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 23 JUL 03 1430

REACTION
☒ NONE ☐ SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99	112	118/64

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 SGT/LPN

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

(b)(6)-4

SEX M | WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6690

Medical Record Copy

518–124

NSN 7540–00–634–4159

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)* D (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

DATE REQUESTED 23 July 03

DATE AND HOUR REQUIRED On Call

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)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2

DATE 23 July 03

TIME VERIFIED 0700

REMARKS: Exp 29 July 03 23:59

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
☑ RECORD ☐ NO RECORD

(b)(6)-2

	DONOR	RECIPIENT
ABO	A ✓	A ✓
Rh	POS	POS

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 23 JUL 03

REMARKS: Exp 23 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 0801 ON *(Date)* 23 JUL 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 VERI (b)(6)-2

PRE-TRANSFUSION TEMP 96.9 PULSE 101 BP 143/59

DATE OF TRANSFUSION 23 July 03

TIME STARTED 0800

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 23 July 03 1100

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 98.1

PULSE 96

BLOOD PRESSURE 118/70

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

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

(b)(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 6691

Medical Record Copy

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED AP Lat (L) elbow	AGE	SEX M	SSN *(Sponsor)* 0034	WARD/CLINIC ICU	REGISTER NO.
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* (b)(6)-2 [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

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

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
01 Aug 03		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)* (b)(6)-4 [redacted]	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION
MEDCOM - 6692 ...T
...RD

STANDARD FORM 519-B
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED: Left elbow/arm X-RAy

AGE:

SEX:

SSN *(Sponsor)*: (b)(6)-4

WARD/CLINIC: Icu

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☐ NO

REQUESTED BY *(Print)*: Dr (b)(6)-2

TELEPHONE/PAGE NO.:

SIGNATURE OF REQUESTOR: (b)(6)-2 1CT Aw

DATE REQUESTED: 5 Aug 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*: broken / check pin placement

DATE OF EXAMINATION *(Month, day, year)*:

DATE OF REPORT *(Month, day, year)*:

DATE OF TRANSCRIPTION *(Month, day, year)*:

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

TATION IT

MEDCOM - 6693

1 — MEDICAL RECORD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 7/9
TIME OF ORDER 730 HOURS
LIST TIME ORDER NOTED AND SIGN

① ↓ IVF to 50/h ✓ — 730
② 20 mg iv push Lasix now ✓ — 730
③ CXR ✓
④ clears ✓
⑤ NC NG ✓ — 730

Noted 10 July 03 @ 0730 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10 July 03
TIME OF ORDER 0800 HOURS

D/C Abx
V.O. Dr (b)(6)-2 / (b)(6)-2 mngs (b)(6)-2 mgn

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10 July 03
TIME OF ORDER 1000 HOURS

Draw CBC @ 1500
V.O. Dr (b)(6)-2 ((b)(6)-2 mngs)

Noted 10 July 03 @ 10:00 (b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 (b)(6)-2 0330 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 11JUL03
TIME OF ORDER 0700 HOURS

① Lasix 20 mg IVP now.
2 ↓ IVF 50/hr

(b)(6)-2

Noted (b)(6)-2 11 Jul 03 @ 0700

NURSING UNIT | ROOM NO. | BED NO.

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

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

MEDCOM - 6694

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 11 July 03

TIME OF ORDER 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

Keep Patient NPO

1600

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

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/11

TIME OF ORDER 1930 HOURS

✓ (1) Wet → Dry dressing to wound bid with normal saline

✓ (2) Heparin 5000 u sq bid

✓ (3) OOB Ambulate [illegible]

noted 11 July 03 (b)(6)-2

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

(b)(6)-2 19 Am

2 IV 12 July 03 @ 0100

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 JUL 03

TIME OF ORDER 0900 HOURS

✓ (1) Lasix 20 mg IVP now

(b)(6)-2

12 Jul 03 0910

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/12

TIME OF ORDER 1620 HOURS

✓ (1) Transfuse 2u pRBC over 4hr each

✓ (2) 40 mg Lasix ivpsh in between each

12 Jul 03 1620

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2nd V done (b)(6)-2

UPT

IAW 0415 13 July 03

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

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

MEDCOM - 6695

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

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

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15July 03 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit to ICU ✓
② incentive spirometer ✓
③ I+O ✓
④ NG to LIS ✓
⑤ Flush with 30cc water Q 4° ✓
⑥ Foley to gravity ✓
⑦ NPO ✓
⑧ Heparin 5000u SQ bid ✓
⑨ Unasyn 3g IV Q6° ✓
⑩ MSO4 2-4mg IV Q 1° prn pain
⑪ Zantac 50mg IVPB Q 8° ✓
⑫ LR c̄ 150cc/hr
⑬ 0 labs needed

(b)(6)-2

NURSING UNIT Chart ✓ | ROOM NO. done | (b)(6)-2 | BED NO. RN

AM 16 July 0230

DATE OF ORDER 7/18 TIME OF ORDER 1530 HOURS

(b)(6)-2 16Jul03 1530

① Lasix 40 mg iv now ✓
② CBC, Chem 7 c̄ AM ✓
③ Sips OK ✓

(b)(6)-2

24° (b)(6)-2 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 198?-363-710

MEDCOM - 6696

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

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 7/16 TIME OF ORDER 1600 HOURS
LIST TIME ORDER NOTED AND SIGN

① ↓ IVF to 100 cc/hr — done 1600 (b)(6)-2

(b)(6)-2

Noted 16 Jul 03 1600 (b)(6)-2

NURSING UNIT | ROOM NO | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 17 JUL 03 TIME OF ORDER 0900 HOURS

Noted (b)(6)-2 17 Jul 03 1030

① D/C Unasyn.
② Fluconazole 200mg IV now + then 100 mg po qd.
③ Cefotetan 2gm IV q 12° 1st dose now.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/17 TIME OF ORDER 1600 HOURS

Noted (b)(6)-2 17 Jul 03 1630

① Abdomen X-Ray now

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 17 July 03 TIME OF ORDER 2000 HOURS

① Lasix 40mg IVP X1 now

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

(b)(6)-2

24° (b)(6)-2 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 July 03 TIME OF ORDER 0800 HOURS

LIST TIME ORDER NOTED AND SIGN

Chest PT c̄ albuterol nebs

Q4°

VO: Dr (b)(6)-2 / (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 July 03 TIME OF ORDER 0915 HOURS

noted (b)(6)-2 7/18/03 0920

lasix 40mg IVP x1 now

VO: Dr (b)(6)-2 / (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ______ HOURS

① IVF 30cc/hr (TKO)

② clear

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/18 TIME OF ORDER 1600 HOURS

① D/c Foley

② Tyl #3 1-2 tab q4 prn pain

24° (b)(6)-2 14Jul03

(b)(6)-2

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO | BED NO.

DATE OF ORDER 21 July 03 TIME OF ORDER 0050 HOURS

LIST TIME ORDER NOTED AND SIGN

① Percocet ii tab po prn for pain Q 4-6°
② D/C Tylox (pharmacy not here)
V/O Dr. (b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/21 TIME OF ORDER 0700 HOURS

1) NPO
② IVF e 100/hr
③ CBC, Chem 7 now
(b)(6)-2

21 Jul 03
1700
(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/21 TIME OF ORDER HOURS

① Admit ICU VS / I&O strict
② Foley gravity, JP to bulb suction
③ NG tube
④ IVF LR 100 cc/hr
⑤ Heparin sub q 5000 u bid
⑥ Vent : 850, .85, R 10 FiO2 50%
⑦ Vecuronium paralytic protocol Start at 4 mg iv/hr

180
(b)(6)-2
mgr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

⑧ Fluconazole 100 mg iv qd
⑨ Cefotetan 1g ivp bid
~~⑩ Zantac 50 mg ivp tid~~
⑪ Tube feeds Jevity @ 10 cc/hr ✓residuals q4
⑫ Versed ivd 2mg iv/hr titrate
⑬ Morphine ivd 5mg/hr

1800
(b)(6)-2
mgr

(b)(6)-2

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

⑭ Labs now; ABG
⑮ Labs in AM - CBC, Chem 12
⑯ CXR now, q AM

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MEDCOM - 6699

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

PATIENT IDENTIFICATION
(b)(6)-4

(wt: 70 Kg)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 JUL 03 TIME OF ORDER 1830 HOURS
LIST TIME ORDER NOTED AND SIGN

① D/C Cefotetan.
② Begin Cipro 400mg IV q12°.
Gentamicin 5mg/Kg IV q24°.
(b)(6)-2
(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 22 Jul 03 TIME OF ORDER 0530 HOURS

① Stop Jevity feed for now
② ~~ONG OG~~ NG to LIS
(b)(6)-2
V/O Dr. (b)(6)-2
(b)(6)-2 MAJ

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 22 JUL 03 TIME OF ORDER 1500 HOURS

① NS bolus x 2L - done.
② NS bolus x 500cc - now then
↑ LR 200 cc/hr. (b)(6)-2

22 JUL 03
1500.
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 6700

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

PATIENT IDENTIFICATION
#
(b)(6)-4

DATE OF ORDER 7/22
TIME OF ORDER 0700 HOURS
LIST TIME ORDER NOTED AND SIGN 22Jul03 0700 (b)(6)-2

① [illegible] to [illegible] now
② Start TF at 12N
✓ residual q2°
③ 500 NS bolus now
④ ↑ IVF to 150/hr (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 22July03
TIME OF ORDER 1000 Late entry HOURS
1000 (b)(6)-2

Bolus 500cc NSS x 1 now IV
V.O. Dr (b)(6)-2 / (b)(6)-2 mngr
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 2/22
TIME OF ORDER HOURS
(b)(6)-2 1200

1L NS bolus now
CBC, Chem 8 in AM
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 22July03
TIME OF ORDER 1700 HOURS
22Jul03 (b)(6)-2

Infuse Albumin 25% now for
U.O. less than 30cc/hr
V.O. Dr (b)(6)-2 (b)(6)-2 mngr
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 6701

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 7/22

TIME OF ORDER 0500 HOURS

LIST TIME ORDER NOTED AND SIGN

1) titrate Vecuronium off
2) ~~↓ IVF to 100cc/hr~~
3) Transfuse 2u pRBC
4) Lasix 40mg IVP between blood units
5) Labs 7/24 CBC, chem 7

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Transcribed

(b)(6)-2

DATE OF ORDER 23 July

TIME OF ORDER 0800 HOURS

NIO 1.) Turn pt q 2°

(b)(6)-2 cah

DR (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 23 Jul

TIME OF ORDER 0810 HOURS

VO DR (b)(6)-2

1.) Bacitracin to meatus, bid.
2.) Elevate scrotum.

Taken by (b)(6)-2 cah

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/23

TIME OF ORDER HOURS

1) CBC Chem 7
at 1500

(b)(6)-2

23Jul03
1240

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256

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

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MEDCOM - 6702

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

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

PATIENT IDENTIFICATION

DATE OF ORDER 23Jul03 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN 23Jul03 1708 (b)(6)-2

① Tylenol 650mg PR x1 for temp of 101.5
② Irrigate N/G with 60cc NSS for lavage of [illegible] old blood
V.O. Dr (b)(6)-2 ((b)(6)-2 [illegible])
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

① Stop N/G Feeds of Jevity
② Place N/G to LIS
V.O. Dr (b)(6)-2 ((b)(6)-2 [illegible])
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 23 July TIME OF ORDER 2100 HOURS

Transcribed (b)(6)-2 LPN 23 July 2200

VO Dr (b)(6)-2
1.) Versed 1-2cc/hr IV until 0300 24 July, Then Hold.
2.) Δ VR to 10.
Taken by (b)(6)-2 CRL
X (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 23 July 03 TIME OF ORDER 2210 HOURS

1.) Start Tube feeds @ 30cc/hr. Hold @ 0300 24 July 03.
Taken by (b)(6)-2 CRL

VO X: Dr (b)(6)-2
Date (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

IDENTIFICATION
(b)(6)-4

Transcribed (b)(6)-2

3 UNIT | R | NO.

DATE OF ORDER 24 July 03 TIME OF ORDER 0500 HOURS

LIST TIME ORDER NOTED AND SIGN

VO Dr (b)(6)-2

1) Resume LIS.

Taken by (b)(6)-2

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

T IDENTIFICATION

IG UNIT | ROOM NO. | BED NO.

DATE OF ORDER 24 JUL 03 TIME OF ORDER 0700 HOURS

① Lasix 40 mg IV X I now (b)(6)-2

24 Jul 03 (b)(6)-2

NT IDENTIFICATION

ING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/24 TIME OF ORDER 0230 HOURS

① ↓ IVF to 50/h

② [illegible] now

(b)(6)-2

MA [illegible]

24 Jul 03 (b)(6)-2

ENT IDENTIFICATION

ING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 24 July 03 TIME OF ORDER 1230 HOURS

Thorazine 25 mg IM

D/C Versed | Morphine drips

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

(b)(6)-2

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

[redacted]

4256

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

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MEDCOM - 6704

CLINICAL RECORD - DOCTOR'S ORDERS

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

L RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD
RITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

LIST TIME ORDER NOTED AND SIGN

CATION

DATE OF ORDER 7/25
TIME OF ORDER 0520 HOURS

① heplock IVF

② D/C qAM CXR

(b)(6)-2 [redacted]

ROOM NO.
BED NO.

DATE OF ORDER 25 July 03
TIME OF ORDER 0800 HOURS

TIFICATION

① D/C Foley

V.O. Dr (b)(6)-2 [redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

mgm

(b)(6)-2 [redacted]

mgm

(b)(6)-2 [redacted]

UNIT
ROOM NO.
BED NO.

DATE OF ORDER 26 July 03
TIME OF ORDER 1130 HOURS

IDENTIFICATION

Chest PT Q4°

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

Noted [illegible]

(b)(6)-2 [redacted]

ING UNIT
ROOM NO.
BED NO.

DATE OF ORDER 27 JUL 03
TIME OF ORDER 1130 HOURS

ENT IDENTIFICATION

① Δ Cipro → 500mg po q12° @ next dose.

② Δ fluconazole 100mg po qd @ next dose.

③ Δ Zantac 150mg po bid

(b)(6)-2 [redacted]

Noted 7/27/03

UNIT
ROOM NO.
BED NO.

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

/9 4256

MEDCOM - 6705

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

T IDENTIFICATION

(b)(6)-4

(b)(6)-4

S UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/24 TIME OF ORDER 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

24Jul03
1600
(b)(6)-2

① Incentive Spirometry
10x every 15 minutes

② OOB to chair / Ambulate OK

③ D/C Foley

④ Start TF @ 30/hr. Increase as tolerated

(b)(6)-2

T IDENTIFICATION

DATE OF ORDER 24 July TIME OF ORDER 1830 HOURS

VO Dr (b)(6)-2

1.) O2 titrate to maintain sats > 95%. ✓

2.) MSO4 2-4mg IV q2°' prn pain ✓

3.) Zinc oxide to decubiti TID TOP. ✓

4.) Chem 7, CBC in Am ✓

(b)(6)-2

TRANSCRIBED
CPT (b)(6)-2
24 July 03
2200

S UNIT | ROOM NO. | BED NO.

T IDENTIFICATION

DATE OF ORDER 25 July TIME OF ORDER 1230 HOURS

Advance diet to clear liquids

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

(b)(6)-2

(b)(6)-2

(b)(6)-2

S UNIT | ROOM NO. | BED NO.

IDENTIFICATION

DATE OF ORDER 25 July 03 TIME OF ORDER 2000 HOURS

VO DR (b)(6)-2

1.) Cepacol Lozenges for sore throat, PRN PO.

Taken by (b)(6)-2

(b)(6)-2

X

Dr (b)(6)-2

ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 6706

CLINICAL RECORD - DOCTOR'S ORDERS

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

L RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD
WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

DATE OF ORDER 27 JUL 03	TIME OF ORDER 1400 HOURS	LIST TIME ORDER NOTED AND SIGN
① Percocet I-II po q 4-6° prn pain		(b)(6)-2
② D/C Tr... (b)(6)-2 (b)(6)-2		
DATE OF ORDER 27 July 03	TIME OF ORDER 2000 HOURS	
VO, DR (b)(6)-2		
1, Lidocaine viscous, ℞ 15 cc swish and spit q 3 hr prn for sore throat		✓
2,) Hurricain spray, I-2 sprays to adenoids x 1 now.		✓
Scher by (b)(6)-2	(b)(6)-2	
DATE OF ORDER 28 July 03	TIME OF ORDER 0630 HOURS	
NIO		
1) STRICT CALORIE CTN.		
2) Consult c̄ dietician	(b)(6)-2	
DATE OF ORDER 28 JUL 03	TIME OF ORDER 1200 HOURS	
① Maalox or Mylanta 30cc po q 4° prn indigestion.	(b)(6)-2	

ICATION

(b)(6)-4

T	ROOM NO.	B

NTIFICATION

Transcribed (b)(6)-2 27 July 2003

UNIT	ROOM NO.	BED NO.

T IDENTIFICATION

(b)(6)-2

0630 28 Jul

ISING UNIT	ROOM NO.	BED NO.

TIENT IDENTIFICATION

Noted

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

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

MEDCOM - 6707

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 7/28 TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

① Lactobacilli tab x 1 dose po now

② ~~Kaopectate~~ 30cc now and q 12 150
x 2 doses (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 28 July 03 TIME OF ORDER: 1800 HOURS

① D/C above Orders

② Give Kaopectate 2 capsules repeat x 1 (b)(6)-2
V.O. Dr. (b)(6)-2 (b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

PATIENT IDENTIFICATION

Transcribed 2200 28 July 03

DATE OF ORDER: 28 July 2003 TIME OF ORDER: 2130 HOURS

VO Dr. (b)(6)-2

① VS q 4°

Johnny (b)(6)-2

(b)(6)-2

x

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

29 Jul 03 Noted (b)(6)-2

DATE OF ORDER: 7/29 TIME OF ORDER: 1600 HOURS

① D/C Cipro

② D/C [illegible] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 6708

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 7/31 TIME OF ORDER 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

(6) Ensure 5 cans/day

TRANSCRIBED 1 Aug 03 2300

(b)(6)-2

(b)(6)-2

3 July 03

JRSING UNIT 24 ✓ ROOM NO. (b)(6)-2

ATIENT IDENTIFICATION

DATE OF ORDER 1 AUG 03 TIME OF ORDER 1645 HOURS

AP LAT (L) ELBOW OUT OF SPLINT

1 Aug 03 done

(b)(6)-2

(b)(6)-2

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

JRSING UNIT ✓ ROOM NO. done 4 Aug 03 BED NO. (b)(6)-2

ATIENT IDENTIFICATION

Noted 5 Aug 03

DATE OF ORDER 5 Aug 03 TIME OF ORDER 1600 HOURS

X-Ray of (L) Arm

V.O. Dr (b)(6)-2 / (b)(6)-2 ~mg (b)(6)-2 1600 mg

(b)(6)-2

RSING UNIT ROOM NO. BED NO.

TIENT IDENTIFICATION

DATE OF ORDER 5 Aug 03 TIME OF ORDER 1630 HOURS

~~Morphine 3mg IM x I now~~ error

(b)(6)-2 1630

(b)(6)-2 mg

(b)(6)-4

JRSING UNIT ROOM NO. BED NO.

24 ✓ 9 Aug 03 2330 (b)(6)-2

ORM 4256
R 79

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

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MEDCOM - 6709

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

Noted 5Aug03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5Aug2003 TIME OF ORDER 1640 HOURS

LIST TIME ORDER NOTED AND SIGN

Morphine 5mg IM x 1 now

V.O. Dr. (b)(6)-2 (b)(6)-2 1645 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5AUG03 TIME OF ORDER 2130 HOURS

FENTANYL IM 50µg (b)(6)-2

Q30

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7Aug2003 TIME OF ORDER 0700 HOURS

Phenergan 12.5mg IM

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

24° 9 Aug 03 0233 (b)(6)-2 [illegible]

PATIENT IDENTIFICATION (b)(6)-2

Transcribed 1640 11Aug03

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

① NPO

② ~~[illegible]~~ C 125 cc/hr

③ Clear in am

④ Reg diet now (b)(6)-2

24° (b)(6)-2 [illegible] 14Aug03 @ 0300

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

MEDCOM - 6710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

noted 12Aug03

DATE OF ORDER 8/12 TIME OF ORDER 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ ① heplock IVF ✓

✓ ② Regular diet ✓

✓ ③ clears for am 8/13 breakfast ✓

✓ ④ NPO after 8/13 breakfast

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

noted -

done 1510-

(b)(6)-2

DATE OF ORDER 8/13 TIME OF ORDER 1430 HOURS

✓ ① Reg diet now ✓

✓ ② heplock IVF ✓

✓ ③ NPO p̄ ~~[illegible]~~ Am breakfast, clears for breakfast ✓

④ Surgery [illegible] 8/14 [illegible] ✓

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[illegible] 1530 13 Aug 03

(b)(6)-2

DATE OF ORDER 8/13 TIME OF ORDER 1500 HOURS

✓ ① Cipro 500 mg po bid

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 13 Aug 03 TIME OF ORDER 1555 HOURS

✓ ① Phenergan 25mg IVP now

(b)(6)-2 MD)

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

✓ (b)(6)-2 [illegible] 14Aug03 0800

FORM 4256 APR 79

REPLACES EDITION OF 1 (b)(6)-2 WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 August 2003 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

~~① [illegible] @ [illegible]~~ error

② LR @ KVO

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

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14AUG03 TIME OF ORDER 2000 HOURS

① Celexa 20 mg i po qd 1st dose now.

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

24° ✓ 15 Aug 03 0545 (b)(6)-2

PATIENT IDENTIFICATION

Done 15 Aug

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 AUG 03 TIME OF ORDER 0725 HOURS 0800

① CBC, Chem 12 this AM (b)(6)-2 (b)(6)-2

(b)(6)-2 (b)(6)-2 Y, MD

PATIENT IDENTIFICATION

15AUG03 noted

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 Aug 03 TIME OF ORDER 1730 HOURS

NPO MN

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

(b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

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

24° ✓ 17 Aug 03 @ 0145 (b)(6)-2

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

MEDCOM - 6712

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

↓

DATE OF ORDER 16 AUG 03 TIME OF ORDER 0835 HOURS

LIST TIME ORDER NOTED AND SIGN: Noted (b)(6)-2 1412

① Resume previous order

(b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS

(b)(6)-2

17 Aug 03 @ 0145 (b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER Chart Val 17 Aug 03 2345 (b)(6)-2 (b)(6)-2 HOURS

17 Aug 03 0855 (b)(6)-2

① [illegible] 12 h - Dr

② Resume Prior orders

③ S/P Drug change

④ [illegible] IV

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

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

PATIENT IDENTIFICATION
(b)(6)-4

Noted 19 Aug 03 @ 1826 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 August 03 TIME OF ORDER 1800 HOURS

Wet to dry to sacral wound - BID

VO Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 MD
(b)(6)-2
MAJ, MC USA
CHIEF, DOS

(b)(6)-2 (b)(6)-2 20 Aug 03

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 6713

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 1 Sep03 TIME OF ORDER 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

Noted (b)(6)-2 [illegible]

D/C Fentanyl patch

(b)(6)-2

24º chart check 2 Sep03 @ [illegible] (b)(6)-2 10/a

PATIENT IDENTIFICATION

noted 1005 2Sep03 1.14 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2 Sep03 TIME OF ORDER 1000 HOURS

① D/C Heparin

VO: Dr (b)(6)-2 /14 (b)(6)-2

3 Sep03 24º chart check (b)(6)-2

4 Sept 24º chart check (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ______ HOURS

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

MEDCOM - 6714

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)**

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Jul Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	8	9	10	11	12	13	14	15
8Jul03	(b)(6)-2	N/G to L/S	05	/	(b)(6)-2			D/C'd 10Jul03			
			17	(b)(6)-2					(b)(6)-2		
8Jul03		Flush N/G c̄ 30cc Water Q4°	04	/	(b)(6)-2						
	v		08	/							
			12	/							
			16	(b)(6)-2				D/C'd 10Jul03			
		20	~~28~~	(b)(6)-2					(b)(6)-2		
			24								
8Jul03	(b)(6)-2	Foley to Gravity	05	/	(b)(6)-2						
			17	(b)(6)-2							
8July03		Incentive Spirometer	05	/							
			17	(b)(6)-2							
8July03		Labs @ am: CBC, Chem 8	06	/							
				/	/	/	/	/	/	/	/
10July03		ACT: OOB	05	—	/	(b)(6)-2			Δ'd 11Jul03		
			17	—	/	(b)(6)-2				(b)(6)-2	
10Jul03		Diet: Clears advance as tolerated (Reg)	07	/	/	/	(b)(6)-2				
			12	/	/	(b)(6)-2		NPO			
		c̄ CIB	17	/	/	(b)(6)-2					
10July03		Cough and Deep Breathing (DB)	05	—	—	/	(b)(6)-2				
			17	—	—	/	(b)(6)-2				
11July03		~~Keep Patient NPO~~	05	/	/	/	(b)(6)-2		Δ'd 13Jul03		
			17	/	/	/			(b)(6)-2		
11July03		wet→dry dressing to	10	/	/	/	/	(b)(6)-2			
		wound bid c̄ normalsaline	22	/	/	/	(b)(6)-2				
13Jul03		Diet: Regular	05	—	—	—	—	/	(b)(6)-2		
		c̄ CIB	17	—	—	—	—	/	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
DX= Small Bowel Resection
Exp Lap, ORIF Ⓛ elbow

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

USAPA V1.00

MEDCOM - 6715

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 07 Yr 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8Jul03	(b)(6)-2	Labs: CBC, Chem 8	8Jul03	1300	Done	
8 July 03		Admit to ICU	8 July 03		done	
10 Jul03		/ D/C A-line	10 Jul	0800	0900	(b)(6)-2
10 Jul03		1500 CBC	10 Jul	1500	1500	
12Jul		Transfuse 2u PRBC over 4hr each	12Jul	1600	1800	
12Jul		40mg Lasix IVPush in between units	12Jul	2000	2145	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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USAPA V1.00

MEDCOM - 6716

DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15
11 July 03	(b)(6)-2	OOB Ambulation TID	06	✓	(b)(6)-2			
			14	✓	(b)(6)-2			
			22	(b)(6)-2				
	(b)(6)-2	VS Q4 x 8hrs (on order)	06	✓			(b)(6)-2	
			10	✓	✓	✓	✓	
			14	✓				
			18	(b)(6)-2	✓	✓		
			22	(b)(6)-2				
			02					
			06					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Small bowel resection
Exp lap, orif Delbow

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	15	16	17	18	19	20	21	22
15Jul03	(b)(6)-2	Incentive spirometry	05	(b)(6)-2							
		Q 2-3° while	17	(b)(6)-2							
		awake									
15JUL03	(b)(6)-2	I&O	05	(b)(6)-2							
			17								
15 Jul	(b)(6)-2	NG to LIS	05	(b)(6)-2							
			17	(b)(6)-2					7/18/03		(b)(6)-2
15 Jul	(b)(6)-2	Flush NG c̄ 30cc	04	/	(b)(6)-2						
		H2O Q 4°	08	/	(b)(6)-2						
			12	/							
			16	(b)(6)-2					7/18/03		(b)(6)-2
			20								
			24								
15 Jul	(b)(6)-2	Foley to gravity	05	(b)(6)-2					DC 7/18/03		(b)(6)-2
			17	(b)(6)-2							
15 Jul	(b)(6)-2	~~NG~~ (b)(6)-2 NPO	05	(b)(6)-2							
		Sips O.K.	17	(b)(6)-2					7/18/03		(b)(6)-2
18 July	(b)(6)-2	start clears as	05	/	/	/	(b)(6)-2				
		tolerated (may adv)	17	/	/	/	(b)(6)-2				
		NPO									

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P exploratory lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6718

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* Jul 0 *Yr* 3 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15 Jul	(b)(6)-2	admit to ICU	15 Jul 03	now	1245	done
15 Jul		No labs needed	15 Jul	—	—	done
16 Jul		CBC, Chem 7 in a.m.	17 Jul	0600	Done	(b)(6)-2
17 Jul		Abdomen XRay NOW	17 Jul	NOW	1645	
18 Jul		DTV @2200	18 Jul	2200	—	
21 Jul		CBC, Chem7 now	21 Jul	now	—	
21 Jul		NPO	21 Jul	AM	AM	

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

MEDCOM - 6719

CLINICAL RECORD

ERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Aug Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	01	02	03	04	05
16 Aug	(b)(6)-2	brand or Carnation instant breakfast 1 packet 4-5 times/day	#1 #2 #3 #4 #5	(b)(6)-2						
14 Aug	(b)(6)-2	W→D drsg to sacral wound BID	10 22	(b)(6)-2						
30 Aug	(b)(6)-2	Abd drsg Δ q3 days (Dry drsg)	10	(b)(6)-2	/	/	/	(b)(6)-2	/	/

Medical Record

Wound and ~~nt~~

Progress Notes

Date and Time

Stage I-IV Surgical or Non-Su (b)(6)-2 (b)(6)-2

Location

Shape Measurements

Tissue Color

s and Type

Drainage (amt and color)

Dressing Type

Dressing Change Frequency Wound Cleansing

onal Info (turning, elevation of extremeties, etc.)

Date and Time Wound number

Stage I-IV ~~Surgical or Non-Surgical~~

Location

Shape Measurements

Tissue Color

Drains and Type

Drainage (amt and color)

Dressing Type

Dressing Change Frequency Wound Cleansing

Additional Info (turning, elevation of extremeties, etc.)

Date and Time Wound number

Stage I-IV Surgical or Non-Surgical

Location

Shape Measurements

Tissue Color

Drains and Type

Drainage (amt and color)

Dressing Type

Dressing Change Frequency Wound Cleansing

Additional Info (turning, elevation of extremeties, etc.)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW abd / [illegible] buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Patient ID:

(b)(6)-4

(b)(6)-4

Unit No.

Standard Form 509

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 6720

CLINICAL RECORD

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

Mo. Aug Yr.

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 19	20	21	22	23	24	25	26	27	28	29	30
14 Aug 03	(b)(6)-2	Wet/Dry to R Sacral Wound	10	/	(b)(6)-2										
		BID	22	(b)(6)-2									(b)(6)-2		
26 Aug 03	(b)(6)-2	VS Q 8°	6	/	/	/	/	/	/	/	/	(b)(6)-2		(b)(6)-2	
			14	/	/	/	/	/	/	(b)(6)-2					
			22	/	/	/	/	/	/	(b)(6)-2					
	(b)(6)-2	Record patient intake/meals for Kcal count	6	(b)(6)-2											
			18	(b)(6)-2											

Braden Scale Evaluation

Date:

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	~~Very Limited~~	2		Very Limited	2
	~~Completely Impaired~~	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	~~Constantly Moist~~	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	~~No Apparent Problem~~	3
	Walks Occasionally	3		Potential Problem	2
	~~Chairfast~~	2		Problems	1
	~~Bedfast~~	1			

Total Score: ______

Above 20	Low Risk
~~16-19~~	~~Med Risk~~
~~11-15~~	~~High Risk~~
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Date:

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	~~Very Limited~~	2		Very Limited	2
	~~Completely Impaired~~	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		~~Very Poor~~	1
Activity	Walks Frequently	4	Friction and Shear	~~No Apparent Problem~~	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: ______

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Patient (b)(6)-4

Unit No. ______

Standard Form 509

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Abd Wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6721

CLINICAL RECORD

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

Mo. July *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	21	22	23	24	25	26	27	28	29	30	31	1	2	3
21 Jul 03	(b)(6)-2 [redacted]	VS	05 17	/	(b)(6)-2 [redacted]										(b)(6)-2 [redacted]		
21 Jul 03		I&O / Shift	05 17	/	(b)(6)-2 [redacted]										(b)(6)-2 [redacted]		
21 Jul 03		Foley to Gravity	05 17	(b)(6)-2 [redacted]													
21 Jul 03		JP to Bulb Suction	05 17	(b)(6)-2 [redacted]					DC 25 Jul 03								
21 Jul 03		NG Tube [illegible]	05 17	(b)(6)-2 [redacted]					D/C 25 July 03								
21 Jul 03		Vent [illegible] 850 Peep 5 [illegible]	05 17	(b)(6)-2 [redacted]				DC'd 0800 24 July 03									
21 Jul 03		Dressing change [illegible]	05 17	/	(b)(6)-2 [redacted]												
21 Jul 03		[illegible] √ Residues q 4°	04 08 12 16 20 24	/	(b)(6)-2 [redacted]												
21 Jul	(b)(6)-2 [redacted]	Foley Δ am	06	(b)(6)-2 [redacted]			D/C'd										
22 Jul		Start TF @ 20 ✓ Residual q 2	06 18		(b)(6)-2 [redacted]	22 Jul 03 0220 D/C'd 23 Jul 03											
23 July	(b)(6)-2 [redacted]	Turn pt q 2°; N/10	05 17	/	/	(b)(6)-2 [redacted]	D/C'd 24 July 03										
23 July		Elevate scrotum while edematous	05 17	/	/		DC'd										

REQUESTING PHYSICIAN
LAS
Privacy Act of
...O SSN: (b)(6)-2 [redacted]
STAT) (Piccolo) Ch
Metabolic Pa
TEST | RESULT | REF. RANGE
Na 136-146 mmol/L | ALB
K 3.5-4.9 mmol/L | ALP
Cl 98-109 mmol/L | ALT
pH 7.31-7.45 | AMY
PCO2 35-45 mmHg (art) 41-51 mmHg (ven) | AST
PO2 80-105 mmHg (art) N/A (ven) | TBIL
TCO2 23-27 mmol/L (art) 24-29 mmol/L (ven) | BUN
HCO3 22-26 mmol/L (art) 23-28 mmol/L (ven) | CHOL
BEecf mmol/L | CRE
AnGap 10-20 mmol/L | GLU
Ca 1.12-1.32 mmol/L | TP
BUN 8-26 mg/dl
GLU 70-105 mg/dl
Crea 0.7-1.5 mg/dl
Hct 38-51% PCV
Hgb 12-17 g/dl
Misc. Chemistry
TEST | RESULT | REF. RANGE
Troponi
Drug Abuse
(Piccolo) MultiLyte 8
TEST | RESULT | REF. RANGE
GLU 73-118 mg/dl
BUN 7-32 mg/dl
CRE 0.6-[illegible] mg/dl
CK 39 [redacted] (M) /30 (F)
NA 128-145
K 3.3-4.7 mmol/l
CL 98-108 mmol/l
tCO2 18-33 mmol/l
(Piccolo) Liver Panel Plus
TEST | RESULT | REF. RANGE
ALB 3.3-5.5 g/dl
ALP 20-85 u/l
ALT
AMY 14-97 u/l
AST 11-38 u/l
TBIL 0.2-1.6 mg/dl
GGT 5-65 u/l
TP [redacted] g/dl
(Piccolo) Electrolyte
TEST | RESULT | REF. RANGE
NA 128-145 mmol/l
K 3.3-4.7 mmol/l
CL 98-108 mmol/l
tCO2 18-33 mmol/l

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx: S/P Abdominal wound exp
Cond: stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

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

REPORTED BY: | DATE: | LAB ID NO.:

ACTION TIMES
~~USE PENCIL. CIRCLE ACTION TIMES~~

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

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

MEDCOM - 6722

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(b)(6)-2	Admit ICU S/P Abdmal Wnd exp	/	/	Done	
21 July		CXRay Now	21 July	1800	Done	
21 July		LAB ASB	21 July	ASAP	1820	(b)(6)-2
21 July		Labs in Am: CBC, Chem 12	22 July	0600	0500	
22 Jul		NG to LIS now	23 Jul	0700	0700	
23 July		CBC, Chem 8 in Am	23 July	0400	0430	
24 July		Labs: 7/24 CBC, Chem 7 (b)(6)-2 24 July (b)(6)-2	24 July	0400	0400	
23 Jul		CBC Chem 7 @ 1500	23 Jul	1500		
23 Jul		Irrigate N/G with 60cc NS for drainage of bright red blood	23 Jul	1700	1700	(b)(6)-2
23 July		Jevity Tube feeds 50cc/hr from 2100 23 July to 0300 24 July then (b)(6)-2	23 July	23 July	2100-0300	
23 July		Resume LIS @ 0500 24 July	24 July	0500	0500	
24 Jul		Extubate now	24 Jul	now	0800	
24 Jul		D/C Ativan				
24 July		Chem 7, CBC in Am	25 July	0400	0400	
26 Jul		D/C Foley		0800	800	

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	23	24	25	26	27	28	29	30	31	1	2	3	4	5
23 July	(b)(6)-2	NGT to LIS	05	(b)(6)-2		>	D/c'd 24 July 2002										
			17	(b)(6)-2		/											
24 Jul		Incentive Spirometer	06	/	/	(b)(6)-2											See new sheet
		10x every 15 minutes	18	/	(b)(6)-2									(b)(6)-2			
24 Jul		OOB to chair/ambulate OK	06	/	/	(b)(6)-2											
			18	/	(b)(6)-2									(b)(6)-2			
24 Jul		Start TF @ 30/hr, Increase	06	/	(b)(6)-2					D/C							
		as tolerated	18	/	(b)(6)-2												
24 July		Zinc oxide to decubiti	06	/	/	/	/		D/C'd								
		TID TOPICAL	14	/	/												
			22	(b)(6)-2			[redacted]										
25 July		NIO: WET TO Dry dressing	05	/	/	/	D/C'd 28 July 03										
		to sacral decubitus	17	/	(b)(6)-2												
		cover w/tegaderm —		[redacted]													
25 July	(b)(6)-2	Tegaderm to stage I ulcer	05	/	[redacted]												
		Thoracic Region.	17	/	(b)(6)-2												
25 July		Maintain heels elevated	05	/	/	(b)(6)-2											
		to allow air circulation.	17	/	(b)(6)-2												
25 July		Place pt on side off	05	/	/	(b)(6)-2											
		ulcers while in bed	17	/	(b)(6)-2												
25 July		Advance diet to clear	05	(b)(6)-2								D/c'd					
		liquids	17	/	/	(b)(6)-2											
25 July		NIO Duoderm to	05	/	/							28 July					
		coccyx	17	/	/												
26 Jul 03		Chest PT q 4°	(b)(6)-2		(b)(6)-2												
					(b)(6)-2												
								(b)(6)-2									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx: S/p ABD WND EXP.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6724

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July Yr 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Aug	(b)(6)-2	AP Lat Ⓛ elbow out of splint	1 Aug	1645	1700	(b)(6)-2

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

MEDCOM - 6725

USAPA V1.00

CLINICAL RECORD

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

Mo. July *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	28	29	30	31	1	2	3	4	5	
28 July	(b)(6)-2	D/O: STRICT	06	/	(b)(6)-2								
		CALORIE CNT	16	(b)(6)-2				(b)(6)-2					
28/July		VS: q 4°	06	/	(b)(6)-2								
			18	(b)(6)-2				(b)(6)-2					
2 July		Ensure 1 can x5	#1	/		/	(b)(6)-2				(b)(6)-2		See new sheet
		q day	#2	/		/		(b)(6)-2					
			#3	/		/		(b)(6)-2					
			#4	/		/							
			#5	/		/					2000		
4 Aug 03	(b)(6)-2	Drsg Δ to buttock BID	04	/	/	/	/	/	/	/	/		
		Aloe vera gel, then 4x4 c̄	16	/	/	/	/	/	/	/	(b)(6)-2		
		sterile H2O, covered c̄ ABD											
		Pad ~~+~~ tape.											

ALLERGIES: ☐ YES ☐ NO
N

PRIMARY DIAGNOSIS:
Dx: S/P abd. wound exp.
Cond: Stable

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

PATIENT IDENTIFICATION:
(b)(6)-4
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDICAL RECORD | VITAL SIGNS RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July Yr 2003

Order Date	Clerk/Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20 Jul	(b)(6)-2	Consult c̄ dietician Major (b)(6)-2 Regarding pts caloric etc SOP	28 Jul	ASAP		

Verifying Initialing

HOSPITAL DAY

POST DAY

MONTH-YEAR 19 DAY HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 6727

USAPA V1.00

ICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

INITIALING R	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
ment pt	(b)(6)-2 [redacted]	Vital Signs q4°	06	(b)(6)-2 [redacted]											D/C see below		
			18														
3	(b)(6)-2 [redacted]	NIO: STRICT CALORIE CNT	06			(b)(6)-2 [redacted]				D/C							
			18	(b)(6)-2 [redacted]				(b)(6)-2 [redacted]									
			18	(b)(6)-2 [redacted]													
	(b)(6)-2 [redacted]	Ensure bean or Carnation	#1	(b)(6)-2 [redacted]										(b)(6)-2 [redacted]			
		instant Breakfast 1 packet 4-5	#2	(b)(6)-2 [redacted]			(b)(6)-2 [redacted]		(b)(6)-2 [redacted]								
		times a day	#3		(b)(6)-2 [redacted]								(b)(6)-2 [redacted]	(b)(6)-2 [redacted]		(b)(6)-2 [redacted]	
			#4						(b)(6)-2 [redacted]								
			#5					(b)(6)-2 [redacted]									
r	(b)(6)-2 [redacted]	I/O's	08		(b)(6)-2 [redacted]									D/C			
			18	(b)(6)-2 [redacted]			(b)(6)-2 [redacted]										
y	(b)(6)-2 [redacted]	Incentive Spirometer	06			(b)(6)-2 [redacted]						D/C					
			18	(b)(6)-2 [redacted]													
g	(b)(6)-2 [redacted]	ACTIVITY: AD LIB / Ambulate TID	06		(b)(6)-2 [redacted]				DC 18 Aug 03								
			18	(b)(6)-2 [redacted]													
		Saline Lock PIV	06			(b)(6)-2 [redacted]			D/C'd								
			18	(b)(6)-2 [redacted]													
g03	(b)(6)-2 [redacted]	S/P dressing change	06				(b)(6)-2 [redacted]		D/C								
			18														
	(b)(6)-2 [redacted]	NIO: Ambulate 4x q d for	08					(b)(6)-2 [redacted]	D/C								
		>20min c time.	12														
			04					(b)(6)-2 [redacted]									
			20						D/C								
	(b)(6)-2 [redacted]	NIO: DAILY WEIGHT	10														

ES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ABD WND /

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ________

NT IDENTIFICATION:

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

USAPA V1.00

ORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

CLINICAL RECORD

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

Mo. Aug *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				5	6	7	8	9	10	11	12	13	14	15	16	17	18
28 July	(b)(6)-2	VS q4°	06	(b)(6)-2													
			18	(b)(6)-2										(b)(6)-2			
29 July		N10: Strict Calorie Cnt	06	(b)(6)-2													
			18											(b)(6)-2			
31 July		Ensure 1 can x5 q d	#1						(b)(6)-2	HOLD					(b)(6)-2		
			#2	(b)(6)-2													
			#3														
			#4	(b)(6)-2													
			#5														
1 Aug 03	(b)(6)-2	Drsg Δ to Buttocks BID	08	(b)(6)-2								D/C'C					
		Aloe vera gel, then 4x4	10									10 AUG 03					
		gauze c̄ sterile H_2O, covered															
		c̄ abd pad & tape															
2 July 03	(b)(6)-2	I/O's – STRICT	06		(b)(6)-2					(b)(6)-2					(b)(6)-2		
			18	(b)(6)-2										(b)(6)-2			
04 July		Insentive Spirometer	06										(b)(6)-2		(b)(6)-2		
		10x q 15 min	18	(b)(6)-2										(b)(6)-2			
4 July		ACTIVITY: OOB to Chair –	06								(b)(6)-2				(b)(6)-2		
		Ambulate	18	(b)(6)-2										(b)(6)-2			
11 Aug		NPO	08	/	/	/	/	/	DS	>	D/C'd			11 Aug 03			
~~11 Aug~~		~~Clear diet~~ error (b)(6)-2															
11 Aug		Reg DIET	06							/	(b)(6)-2				(b)(6)-2		
		Start 12 Aug.	11							/							
			17							/				(b)(6)-2			
13 Aug	(b)(6)-2	Saline Lock PIV	06									D/C'd					
			18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ABD WND EXP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ________

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[illegible]	(b)(6)-2	X-Ray to (L) Arm	1700	1700		(b)(6)-2
10AUG		Clear Diet PM 11 Aug 03.				
12AUG		Clear liquid for Breakfast 8/13	13AUG	0600	0600	(b)(6)-2
12AUG		NPO after Breakfast	13AUG	0800	0900	
13 Aug		NPO after AM breakfast / Clear Breakfast	14Aug	0600	0900	
		Surgery 8/14 @ 1300	14Aug	1300	1400	
15Aug		NPO after MN	15-16 ~~[illegible]~~ Aug	2400	2400	
16Aug		Resume previous orders	16Aug	[illegible]	[illegible]	
15Aug03		CBC, Chem 12 this am	15Aug03		done	(b)(6)-2
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
- - - -	- - - - -		
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MEDCOM - 6730

USAPA V1.00

CLINIC.

THERAPEUTIC DOCUMENTATION CAR LAN *(MEDICATIONS)*

For use of this form, see AR 4   7; the proponent agency is the Office of The   geon General.

Mo. July *Yr.* 03

VERIFY BY INIT

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11	12	13	14	15
8 July 03	(b)(6)-2	IVF: LR @ 150 cc/hr	05	/	(b)(6)-2		Δ'd 10 Jul 03				
			17	(b)(6)-2				(b)(6)-2			
8 July 03		Zosyn 3.375 gm	02	/	(b)(6)-2						
		IV Q6°	08	/							
			14	(b)(6)-2			D/C 7/9/03				(b)(6)-2
			20	(b)(6)-2							
8 July 03	(b)(6)-2	Zantac 50mg IVP q8°	06	/	(b)(6)-2						
			14	(b)(6)-2							
			22								
9 July 03	(b)(6)-2	Unasyn 3gm Q6°	02	/	/	(b)(6)-2					
		IV	08	/	/						
			14	/	(b)(6)-2						
			20	/							
10 Jul 03	(b)(6)-2	IVF: LR @ 100 cc/hr	05	—	/	(b)(6)-2			Δ'd 11 Jul 03 1130 (b)(6)-2		
			17	—	/						
11 Jul 03		IVF: LR @ 50 cc/hr	05	—	—	/	(b)(6)-2				
			17	—	—	/	(b)(6)-2				
11 July 03		Heparin 5000 u sq bid	10	/	/	/					
			22	/	/	/					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx: S/P X-Lap, Small bowel resection (L) elbow ORIF

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8 July 03	(b)(6)-2	IV: bolus NS 500cc	8 July 03	/	2235	(b)(6)-2
10 July 03		20mg IVP Lasix NOW	10 Jul 03	NOW	0730	
11 Jul 03		20mg Lasix IVP NOW	11 Jul 03	NOW	0700	
12 Jul 03		Lasix 20mg IVP now	12 Jul	0900 now	0910	
12 Jul		Transfuse 2u PRBC (b)(6)-4 Y	12 Jul	1600	1800	
		over 4° each (b)(6)-4				
12 Jul		40mg lasix IVP inbetween units	12 Jul	2100	2200	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
8 Jul 03	(b)(6)-2	Morphine 2-4mg Q°	D	8 Jul	8 Jul	8 Jul	8 Jul	~~[illegible]~~	~~[illegible]~~ 2330	7/9/03 1200	7/9 1300	7/9 1600	10 Jul 0800	10 Jul 0915	10 Jul 1100	10 Jul 1730
		prn pain: Max 16mg	T	1315 c/h6	1415 2hC	1515 c/h6	1615 c/h3	1815 4	2 (b)(6)-2	2mg IVP	4mg IVP	4mg IVP	4mg IVP	4mg IVP	2mg IVP	2mg IVP
		in 4hrs	I	(b)(6)-2						(b)(6)-2 ⊕	⊕	⊕	(b)(6)-2 ⊕	⊕	⊕	
			E	⊕	⊕	⊕	⊕	⊕	⊕							⊕
8 July 03	Recopied (b)(6)-2	Morphine 2-4mg Q° PRN	D	11 Jul	11 Jul 0800	11 Jul 0945	11 Jul 1215	11 Jul 1600	11 Jul 03 1920	11 Jul 03 2325	12 Jul 03 0400	12 Jul 03 0450	13 Jul 0645	13 Jul 0730	13 Jul 1010	13 Jul 1300
		pain: Max 16mg in	T	2245 4mg	2mg IVP (b)(6)-2	2mg IVP	2mg IVP	4mg IVP	4mg IVP (b)(6)-2	4mg IVP	4mg IVP	2mg IVP	4mg IVP (b)(6)-2	2mg IVP	2mg IVP	2mg IVP
		4 hrs.	I	(b)(6)-2	⊕	⊕	⊕	⊕	⊕	⊕		⊕	⊕	⊕	⊕	⊕
			E													
8 Jul 03	Rewritten (b)(6)-2	MSO4 2-4mg q̄ prn	D	13 Jul 2200	13 Jul 2030	14 Jul 0300	14 Jul 0430	14 Jul 1830								
		pain = Max 16mg in	T	2mg IVP	2mg IVP	4mg IVP	2mg IVP	4mg prn								
		4°	I	(b)(6)-2												
			E	⊕	⊕	⊕	⊕									

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22
15Jul	(b)(6)-2	Heparin 5,000U	10	/	(b)(6)-2						
		SQ BID	22	(b)(6)-2							
15 Jul	(b)(6)-2	Unasyn 3gm	06	/	(b)(6)-2		D/C'd 17Jul03				
		IVPB Q6°	12	/	(b)(6)-2						
			18	(b)(6)-2							
			24								
15Jul	(b)(6)-2	LR @ 150cc/hr	06			Δ'd 16Jul03			(b)(6)-2		
			17	(b)(6)-2							
15Jul	(b)(6)-2	Zantac 50mg IVPB	08	/	(b)(6)-2						
		Q8°	16	(b)(6)-2							
			24	(b)(6)-2							
16Jul03	(b)(6)-2	LR @ 100cc/hr	05	/	(b)(6)-2		D/C 7/18/03				
			17	/	(b)(6)-2						
17Jul03		Fluconazole ~~200mg IV~~	10	—	—	/	(b)(6)-2				
		100mg po qd.									
17Jul03		Cefotetan 2gm IV q 12°	12	—	—	/	(b)(6)-2				
			24	—	/	(b)(6)-2					
18July03		Albuterol nebs Q4°	04	/	—	/	/	/			
		c̄ CPT	08	/	/	(b)(6)-2					
			12	/	/	/	(b)(6)-2				
			16	/	/	/					
			20	/	/	/					
			24	/	/	/					
18July	(b)(6)-2	LR @ 30cc/° (KVO)	05	/	/	/					
			17	/	/	/					

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

S/p Exploratory Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6733

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. July Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
16 Jul	(b)(6)-2	Lasix 40mg IVP NOW	16 Jul	Now	1625	(b)(6)-2
~~17 Jul 03~~		~~Fluconazole 200mg IV NOW~~ (b)(6)-2				
17 Jul 03		Fluconazole 200 mg IV Now	17 Jul 03	NOW	1030	(b)(6)-2
17 Jul		Cefotetan 2 gm IV 1st dose Now	17 Jul	Now	1200	
17 July		Lasix 40mg IVP now	17 July	2000	done	
18 July		Lasix 40 mg IVP now	18 July	0910	done	
21 Jul		IVF @ 100/hr	21 Jul	—		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED				not given									
15 Jul	(b)(6)-2	MSO4 2-4mg IV Q1° PRN pain	4mg	2mg	4mg	4mg 15 Jul	4mg 15 Jul	4mg 15 Jul	4mg 16 Jul	4mg 16 Jul	SL 16	SL 16	SC 16	17 Jul	17 July	18 July
-----			1504 15 Jul	1600 15 Jul	1700 15 Jul	1910 (b)(6)-2	2010	2235	0200	0430	4mg 1800	4mg 1930	4mg 2300	0200 4mg	0220 2mg	0030
-----			(b)(6)-2			⊕	⊕	⊕	⊕		⊖	⊕	⊕	(b)(6)-2 +	(b)(6)-2 ⊕	(b)(6)-2 ⊕
-----			⊕	⊖ still pain												
18 July	(b)(6)-2	MSO4 2-4mg IV	D	7/18 0830	7/19 1700	19 1700	19 2330	20 July 0330		20 Jul 1020		20 Jul 1200				
-----		Q1° prn pain	T	4mg IVP	4mg IV	4mg (b)(6)-2	4mg	4mg		4mg		4mg				
-----			I	(b)(6)-2												
-----			E		--											
18 July	(b)(6)-2	Tylox 1-2tabs PO	1821 ii tabs	19 written												
-----		Q4-6° prn	2001 (b)(6)-2	1830												
21 Jul	(b)(6)-2	Percocet 1-2 tabs PO	2121 ii tabs													
-----		Q4-6° prn	2445 (b)(6)-2													

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	16	17	18	19	20	21	22	23	24	25	26	27	28	29
16 Aug	(b)(6)-2	O2 : maintain sats >95%	08	(b)(6)-2													
			18														
16 Aug		Zantac 150 mg PO	10	(b)(6)-2												/	(b)(6)-2
		BID	22													(b)(6)-2	
16 Aug		Heparin 5000 u SQ	10	(b)(6)-2													
		Bid	22	(b)(6)-2													
16 Aug		Fentanyl Patch Δ Q3	10	/	(b)(6)-2							/	/		/	/	
		days. 50 mcg Topical															
16 Aug		Cipro 500 mg PO Bid	10	(b)(6)-2													
			22														
16 Aug		LR c̄ TKO	06		(b)(6)-2		>	D/c'd									
			18	(b)(6)-2													
16 Aug		Celexa i tab PO 20 mg	22	(b)(6)-2													
		QD													(b)(6)-2		
12 Aug		Heplock IV	06	/	/	/	(b)(6)-2	/	D/c'd								
			18	/	/	/	●	/									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6735

Verify by Initialing	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	*Mo.*______ *Yr.* ______

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
13 Aug	(b)(6)-2	Phenergan 25mg kSP	25 mg 31 P 1600 13 Aug	(b)(6) -2 (b)(6)-2												

MEDCOM - 6736 USAPA V1.00

CLINICAL RECORD

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

Mo Aug Yr 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 31 01 02 03 04 5
16 Aug	(b)(6)-2	O2: Maintain sats >95%	06	(b)(6)-2 D/CD per dime
			18	(b)(6)-2
16 Aug		Zantac 150mg PO BID	16 22	(b)(6)-2
16 Aug		Heparin 5000U SQ BID	10 22	(b)(6)-2
16 Aug		Fentanyl patch Δ Q3 days 50 mcg topical	22	/ / / / / / / / / / DC
16 Aug		Cipro 500mg PO BID	10 22	(b)(6)-2
16 Aug		Celexa ī tab po 20mg QD	22	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW abd / Decub (B) buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. Aug		Yr. 2003	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 Sep	(b)(6)-2	DIC Heparin	2 Sep	Now	1005	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
27 Jul		Percocet i – ii po Q	30 Aug 2 tabs
		4-6° prn pain	@ 2245 (b)(6)-2
20 Jul		Cepacol Lozenges sore	
		throat prn	
21 Jul		Lidocaine Viscous	
		15cc po swish & spit Q3° prn sore throat	
22 Jul		Maalox or Mylanta	
		30 cc po Q4° prn indigestion	
22 Jul		MSO4 2-4mg IVq 2°-4°	
		prn pain	

MEDCOM - 6738

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8 9 10 11 12 13 14 15 16
24 July 03	(b)(6)-2	O2: Maintain Sats >95%	08	(b)(6)-2 (b)(6)-2
			18	
27 July 03		Zantac 150 mg PO Bid	10	(b)(6)-2
			22	
21 July 03		Heparin 5000 u SQ Bid	10	(b)(6)-2
			22	
5 AUG 03		Fentanyl Patch	22	(b)(6)-2 / / (b)(6)-2 / / (b)(6)-2 / / (b)(6)-2 / / /
		Δ Q3 days 50 mcg		
11 AUG		IVF – LR @ 125cc/hr	06	/ / / / / / (b)(6)-2 / DC'd
			18	/ / / / / / (b)(6)-2 / 12 AUG 03
3 Aug		Cipro 500mg PO	10	/ / / / / / / / / (b)(6)-2
		BID	22	/ / / / / / / / (b)(6)-2
13 Aug 03		Heplock IV	06	/ / / / / / / / / (b)(6)-2 / DC'd 14 Aug 03
			18	/ / / / / / / / / /
14 AUG		LR @ KVO	06	/ / / / / / / / / / (b)(6)-2
			18	/ / / / / / / / / / (b)(6)-2
14 Aug		Celexa i tab 20mg		
	- - - - - -	PO QD 1st dose now	22	(b)(6)-2 / / / / / / / / / (b)(6)-2 / / /
	- - - - - -			
	- - - - - -			
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	- - - - - -			
	- - - - - -			

above orders rewritten 16 Aug 03

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

?

PRIMARY DIAGNOSIS: ABD WND EXP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6739

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Aug Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5Aug03	(b)(6)-2	Morphine 5mg IM x i now	5 Aug03 1645	1645	1645	(b)(6)-2
7Aug03		Phenergan 12.5mg IM x i now	7 Aug03	0700	0700	
13Aug		Cipro 500 mg PO x 1 after awaken	13 Aug	1830	1830	
		from sedation / surgery				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
			TIME/DATE DISPENSED													
27 July	(b)(6)-2	Percocet i-ii PO q 4-6 PRN	D 5Aug	6 Aug	6 Aug	7 Aug 2000	10 Aug 0100	12 Aug 1620	16 Aug		16 Aug	17 Aug	17 Aug	17 Aug	18 Aug 03 0900	2: Aug 2230
		pain	T 1400	1650	2000	ii	ii	ii	1600 ii PO		2000 ii	0930 ii	1720 ii	2200 ii	ii (b)(6)-2	(b)(6)-2
			(b)(6)-2 F c̄ D	⊕	(b)(6)-2 SL ③	⊕	②	⊕	(b)(6)-2		(b)(6)-2					
25 July	(b)(6)-2	CEPACOL lozenges sore throat PRN	7													
27 July	(b)(6)-2	Lidocaine Viscous														
		15 cc PO swish c̄ spit														
		q 3° PRN sore throat														
28 July	(b)(6)-2	Maalox or Mylanta	D													
		30cc PO q 4° PRN	T													
		INDIGESTION	I													
			E	16 Aug 2100	18 Aug 03 1230		18 Aug 1930									
25 July	(b)(6)-2	MSO4 2-4mg IV q 2°-4°	D T	4mg	2mg IV	03	2mg IV									
		PRN pain	I E	(b)(6)-2												

USAPA V1.00

MEDCOM - 6740

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	31	1	2	3
21July03	(b)(6)-2	IVF: LR@100cc/hr	05	/	(b)(6)-2	>	DC'd	22JUL03 0700									
			17	(b)(6)-2					(b)(6)-2								
21July03		Heparin 5000u SQ BID	10	/	(b)(6)-2												
			20	(b)(6)-2													
21July03		Vecuronium paralytic Protocol Start at 4mg IV/hr	05	/	(b)(6)-2			>	DC'd		22Jul03						
			17	(b)(6)-2	(b)(6)-2							(b)(6)-2					
21July03		Fluconazole 100mg IV qday	10	/	(b)(6)-2					Δ'd 27July							
21July03		Cefotetan 1gm IV BID	10	/	D/C'd 21July03												
			22														
21July03		Zantac 50mg IV	06	/	(b)(6)-2					Δ'd 27 July							
			14	/													
			22	(b)(6)-2													
21July03		Versed IV 2mg IV/hr Titrate	05	/	(b)(6)-2		>	DC'd		24Jul03							
			17	(b)(6)-2							(b)(6)-2						
21July03		Morphine 5mg/hr IV	05	/													
			17	(b)(6)-2													
21July03		Begin Cipro 400mg IV q12°	10	/	(b)(6)-2					Δ'd 27 Jul							
			22	(b)(6)-2													
21July03		Gentamicin 5mg/kg IV q24°	04							D/C 27 July03							
22Jul03		↑ IVF to 150cc/hr	06	/	(b)(6)-2	>	DC'd	22Jul03									
			18	/						(b)(6)-2							
22Jul03		↑ LR 200cc/hr	06	/	(b)(6)-2	>	DC'd	23Jul03									
			18	/	(b)(6)-2						(b)(6)-2						
23July03		Titrate Vecuronium off	05	/	/	(b)(6)-2	>	Off		23Jul03		(b)(6)-2					
	- - - - -		17	/	/	Hold											
	- - - - - -																

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
Dx: S/P Abdominal wound exp
Cond - Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6741

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. July	Yr. 03		
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
22 Jul	(b)(6)-2	~~NG FOLIS now~~ (b)(6)-2	~~22 Jul~~	~~0700~~	~~0700~~	(b)(6)-2
22 Jul		500 NS bolus now	22 Jul	now	0700	
23 July		500cc NSS Bolus Now	23 July	now	1400	
23 July		1 Liter NSS Bolus Now	23 July	Now		
22 Jul		NS bolus x 500cc	22 Jul	now	now	(b)(6)-2
22 Jul		Infuse Albumin 25% now per U.O. less than 30cc/hr	22 Jul	—	1700	
23 July		Transfuse 2 Units PRBC's # 1009176	23 July	0820	0820	
		#3463309	23 July	1130	1130	
23 July		Lasix 40mg IVP Between Units	23 July	1040	1040	
23 Jul		Tylenol 650mg PR x1 for temp of 101.5	23 Jul	now	1600	
23 July		Versed 1-2mg/hr, titrate to effect				
		to start 2100 23 July - 0300 24 July then held	23 24 July		2100- 0300	(b)(6)-2
24 July		Thorazine 25mg IM x i for hiccups	24 July			

Order/ Expir Date		PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED							
25 Jul		MSO4 2-4mg IV q 2-4° PRN Pain	24 July 1900 (b)(6)-2 IV 2mg	24 July 2100 (b)(6)-2 IV 2mg	24 July 2300 (b)(6)-2	25 July 0100 23 IV	25 July 0300 (b)(6)-2 2mg IV	25 July 0130 2mg (b)(6)-2	25 July 1530 2mg (b)(6)-2	
25 Jul		MSO4 2-4mg IV q 2-4° PRN Pain	1930 25 July 2mg (b)(6)-2	1945 25 July 2mg IV (b)(6)-2	26 July 0800 2mg (b)(6)-2	26 July 1230 2mg (b)(6)-2	27 July 1430 4mg (b)(6)-2	27 July 2200 2mg (b)(6)-2	28 July 0100 2mg (b)(6)-2	28 July 0300 2mg (b)(6)-2
25 July		Cepacol lozenges for sore throat PRN	2100 25 July (b)(6)-2	26 July 1830 (b)(6)-2						
		Kaopectate 30cc q 12° x 2 doses	D I I E	28 July						
28 Jul	(b)(6)-2	Kaopectate 2 tabs x 1	DI	0230 29 July 03 (b)(6)-2						

Rewritten (b)(6)-2 04 Aug

US

MEDCOM - 6742

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26 27 28 29 30 31 1 2 3 4 5
23Jul03	(b)(6)-2	↓ IVF to 100cc/hr	05	(b)(6)-2 D/C'd 24Jul03
			17	(b)(6)-2 (b)(6)-2
23 July 03		Bacitracin to	05	(b)(6)-2
		meatus	17	(b)(6)-2
24Jul		↓ IVF to 50/hr	06	/ (b)(6)-2 D/C'd
			18	/ (b)(6)-2
24 July 03		O2 - MAINTAIN SATS	05	/ (b)(6)-2
		>95%	17	/
			/	/ / / / / / / / / / / / / /
27Jul03		Fluconazole 100mg	10	(b)(6)-2 D/C'd
		PO qd	/	/ / / / / / / / / / / / /
				29Jul03
27Jul03		Zantac 150mg PO BID	10	(b)(6)-2 / / (b)(6)-2
		BID	22	/ / / (b)(6)-2
			/	/ / / / / / / / / / / / / /
27Jul03		Cipro 500mg PO	10	(b)(6)-2 / / (b)(6)-2 D/C'd
		q12°	22	/ / / (b)(6)-2
				29 Jul 03
27 July 03		Heparin 5000u SQ	10	/ / / / / / / / / / / / (b)(6)-2
	- - - - - -	BID	22	/ / / / / / / / / / / /
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Rewrite See new sheet

Rewrite See new sheet

Rewrite See new sheet

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6743

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. Jul Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
24 Jul	(b)(6)-2	Lasix 40mg IV x I now	24 Jul	now	0200	(b)(6)-2
24 Jul		D/C Versed / Morphine Drips	24 Jul			
27 July		Hurricaine Spray to adenoids	27 July	2000	2000	
		2 sprays x 1 now				
28 July		Lactobacili tab x I dose now	28Jul03	now	Not give	
28/July	-----	Kaopectate ~~30cc NOW~~ error (b)(6)-2 II tabs now	28 Jul	Now	1800	
	-----	repeat x 1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED						
27Jul03	(b)(6)-2	Percocet I-II PO q 4°-6° prn pain D	27 July 1400 (b)(6)-2	27 July	28 July	30 July	31 July	1 Aug	2 Aug
		T	1400	2030 I PO	II 0700	II 1500	I 1800	II 1700	II 1630
		I	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
		E	(b)(6)-2				(+)		
27 Jul	(b)(6)-2	Lidocaine Viscous							
		15cc PO -swish c spit							
		q 3° PRN sore throat							
28 Jul	(b)(6)-2	Maalox or Mylanta D	28Jul						
		30cc PO q 4° prn T	1220						
		indigestion I	(b)(6)-2						
		E	(−)						

Rewritten
See new sheet
04 Aug (b)(6)-2

USAPA V1.00

MEDCOM - 6744

Verify by Initialing	THERAPE IC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo.	Yr.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
27Jul04	(b)(6)-2	Percocet 1-2	3AUG 0130	3Aug 1630	4Aug 0030 0730	4 Aug 03	4 AUG ..	5AUG ..		Rewritten						
- - - - -	- - - - -	tabs Q4-6° prn pain	(b)(6)-2 ..	(b)(6)-2	T (b)(6)-2	II	2000	0100		Please refer to new sheet						
- - - - -	- - - - -															
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USAPA V1.00

MEDCOM - 6745

5 KG
3 [illegible]
Hpth

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

28
10

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

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

ate: 8 JUL
me In: 1300
lergies: NK
re-op V/S: 98/57 95
rocedures: Ex lap Sm Bowel Resec
(L) elbow [illegible] debridement

OR Intake: Crystalloid 3500 LR / [illegible] NSS Colloid 2u
EBL
OR Output: UOP
Meds/Times: [illegible] [illegible] 8 ve
1000 out
EBL 650

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

History

Pre Op Meds

Time	1300	1305
SaO2	100	
FIO2	1R	
Methods	m	
240		
220		
200		
180		
160		160
140		
120		
100		104
80		85
60		
40		
20		
RR		13
T		95 98
Time		1300
Pain (0-10)		
LOS		

Pacu Intake

Time	Solution	Amount	Site	By	Infused

Labs:

X-rays:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

(b)(6)-4

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

Previous edition is obsolete USAPPC V2.00

DA FORM 4700, MAY 78

WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)

MEDCOM - 6746

PAGI

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS	1715	IN (b)(6)-2 [redacted]		INITIALS
NEURO	PUPILS	Refer to nurses' note 8 July 03 1300		3 mm PERL			
	SENSORIUM			Drowsy, alert to			
				verbal stimuli			
RESPIRATORY	RESPIRATORY PATTERN			RRR			
	BREATH SOUNDS			↓ to bases			
	SECRETIONS			⊖ cough ⊖			
				secretions			
				4L O2 to NC			
SKIN	COLOR			Normal for race			
	INTEGRITY			midline ABD incision			
				② ABD incision			
IV SITE	LOCATION			Ⓛ AC 18 G Ⓡ			
	CONDITION			Ⓛ Ⓡ A-line			
				Ⓡ AC line LR @			
				150 cc/HR			
				⊖ s/s infiltration			
GASTRO	ABDOMEN			soft - nondistended			
	BOWEL SOUNDS			⊕ BS x4			
				NG to LIS			
GU	URINE:			Foley to gravity			
	COLOR/CLARITY			dark yellow			
CARDIOVASCULAR	CARDIAC RHYTHM			SR - tachy @ 110			

[redacted]

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired (b)(6)-2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC
ICU 2 east

DATE
8 JUL

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ... facility)*
[redacted]

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL
☐ FLOW CHAR
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Spec*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 6747

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700 INITIAL (b)(6)-2	INITIALS 1730 INITIALS (b)(6)-2
NEURO	PUPILS	2mm brisk reaction to	PERRLA 2mm brisk
	SENSORIUM	light, opens eyes to	opens eyes to touch
		touch/voice, moves	moves ext x4
		all ext on command	
		Ø apparent pain c̄ this time	
RESPIRATORY	RESPIRATORY PATTERN	Lungs clear, mildly	lungs clear to
	BREATH SOUNDS	diminished in bases	auscultation diminished
	SECRETIONS	will encourage IS this am	bases pt has IS
		Resp rate even + unlabored	Resp. even unlabored
		sats 92-95% on RA →96% 2L	SaO2 96% c̄ 2LNC
		Ø cough	Ø cough
SKIN	COLOR	Skin warm + dry	Skin warm + dry
	INTEGRITY	midline incision CDI, LLQ	to touch midline
		c̄ moderate old drainage	incision C/D/I LLQ c̄
IV SITE	LOCATION	ACE/Splint to LUE intact	drainage
	CONDITION	18g Ⓛ AC c̄ LR @ 150cc/°	Splint to LUE intact
		Aline Ⓛ radial c̄ good	18g Ⓛ AC c̄ LR @ 150/hr
		wave form	A line Ⓛ radial c̄
	meds/gtts	Zantac IVPB TID	good wave form
		Zosyn IVPB Q6°	
GASTRO	ABDOMEN	Abd soft mildly tender	Abd soft tender
	BOWEL SOUNDS	esp over incision, BS	BS ⊕ hypoactive
		hypoactive. NGT to LIS	NGT LIS c̄ minimal
		c̄ minimal output, NPO, Ø stool	output pt NPO
GU	URINE:	Foley draining dark yellow	Foley to gravity c̄
	COLOR/CLARITY	urine 30-60cc/° no bladder	dark yellow urine
		distention	30-60cc/hr
CARDIOVASCULAR	CARDIAC RHYTHM	NSR mildly tachy 90-100	NSR tachy 90-110
		pulses palpable x4 ext	pulses palpable
		good cap refill to Ⓛ UE	cap refill <3 sec
		B/P stable 120-150/70's	
		Labs done H/H 10.4/31.3	

LEGEND
Cr - Creatinine
F$_I$O$_2$ - Fraction of Inspired O$_2$
HCO$_3$ - Bicarbonate
ICP - Intracranial Pressure
PCO$_2$ - Pressure of Arterial CO$_2$
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2 re & Title)
CPT/AN

DEPARTMENT/SERVICE/CLINIC
ICU 2 east

DATE
9 July 03

or typed or written entries give: Name—last, first, pital or medical facility)

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

(b)(6)-4

DA FORM 1 MAY 78 4700 MEDCOM - 6748 IAMC OP 375 (Redesignated)

DATE	DX									HOSPITAL DAY								
VITAL SIGNS TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	158/72	142/70	151/76	151/74	127/75	152/73	146/71	134/64		139/68	135/67	136/66	134/64	130/64	132/64	133/65	135/70	
BP Cuff	138/75	127/72	127/73	136/76	125/62	121/71	120/67	122/62		122/64	110/61	113/58	117/57	115/56	120/56	111/54	115/54	
Temperature	973				973					992				993				
Pulse	102	101	99	97	98	103	105	109		111	111	109	110	111	110	111	110	
Respiratory Rate	12	22	19	23	24	28	26	25		29	25	26	23	25	25	25	24	
O2 sats	95%	96%	97%	97%	97%	96%	95%	95%		96%	96%	96%	96%	96%	96%	95%	95%	
source	RA	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
INTAKE TIME	05	06	07	08	09	10	11	12	8°	13	14	15	16	17	18	19	20	8°
IVF	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	
IVPB		50		50						100	50						100	
NG Flush		30				30					30			~~3~~	30			
TOTALS	150	230	150	200	150	180	150	150		250	230	150	150	150				
OUTPUT URINE HOUR / TOTAL	60 / 60	40 / 100	60 / 160	40 / 200	40 / 240	100 / 340	60 / 400	40 / 440		40 / 480	80 / 560	60 / 620	60 / 680		25	100	100	
URINE sp gr																		
URINE S/A																		
NG OUTPUT	0				100					50				50				
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS	60	40	60	40	14	[illegible]	[illegible]	40		40	80	60	60					

MEDCOM - 6749

POST-OP DAY

PAGE 3 OF 4

V I T A L S I G N S

24	22	23	24	01	02	03	04	
152/68	144/66	142/67	154/71	137/60	133/61	139/64	143/61	
129/64	123/67	121/64	122/66	116/57	137/62	159/68	154/66	
98.7				99.1		99.5		
110	111	109	112	109	113	110	110	
26	26	27	28	29	28	30	26	
95%	93%	95%	94%	97%	97%	96%	97%	
2L	2L	2L	3L	4L	4L	4L	4L	

21	22	23	24	01	02	03	04	~~8°~~
150	180	150	150	150	150	150	150	3670
	50				100			
	30							

50	30	35	100	50	50	100	100	1400
								1720
50							50	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY THERAPY			
		TIME	0053
		MODE	
		F_iO_2	
		TV	
		RATE	
		PEEP	
ABG		pH	
		PCO_2	
		pO_2	
		HCO_3	
		SAT	
		BASE	

LABORATORY DATA	
TIME	0530
GLUCOSE	134
Na/K	136 / 4.4
Cl/CO_2	108 / 22
BUN/Cr	19 / 1.2
WBC/PLATELET	9.4 / 228
Hct/Hgb	10.4 / 31.3

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

TIME

TURN

SUCTION

24° I&O TOTALS

wt Yesterday ____

wt Today ____

INTAKE

IV ____

po ____

TOTAL 3670

OUTPUT

Urine: ____

TOTAL 1720

BALANCE 1950 +

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDCOM - 6750

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS	1745 (b)(6)-2 [redacted]	INITIALS
NEURO	PUPILS	Refer to Nurses note 8 July 03 1300	3mm PERL	
	SENSORIUM		Drowsy, alert to verbal stimuli	
RESPIRATORY	RESPIRATORY PATTERN		RRR	
	BREATH SOUNDS		dim to bases	
	SECRETIONS		⊖ cough, ⊖ secretion 4L O2 to NC	
SKIN	COLOR		Normal for race	
	INTEGRITY		midline ABD incision Ⓛ ABD incision	
IV SITE	LOCATION		Ⓛ AC 18G Ⓡ	
	CONDITION		Ⓛ Ⓡ A-line Ⓡ AC to LR @ 150 cc/HR ⊖ s/s infiltration	
GASTRO	ABDOMEN		soft-non-distended	
	BOWEL SOUNDS		⊖ BS x4 NG to LIS	
GU	URINE:		Foley to gravity	
	COLOR/CLARITY		dark yellow	
CARDIOVASCULAR	CARDIAC RHYTHM		SR - tachy @ 110	

[redacted]

LEGEND
Cr - Creatinine
FiO2 - Fraction of Inspired (b)(6)-2 [redacted]
HCO3 - Bicarbonate
- Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 8 JUL 03

PATIE[redacted]n entries give: Name—last, first, midd[redacted]acility)

(b)(6)-4 [redacted]

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

MEDCOM - 6751

POST-OP DAY

VITAL SIGNS	~~21/76~~	~~22/77~~	~~23/78~~	~~24/79~~	~~[illegible]~~	~~[illegible]~~	~~[illegible]~~	~~[illegible]~~	
	122/72	121/71	127/7	129/69	138/79	142/74	147/74	149/73	
		125/69		125/72	131/76	130/75			
		974							
	108	110	109	105	100	101	102	101	
	14	15	20	17	17	18	18	19	
	99	96	97	96	96	95	96	96	
	hc	RA	RA	RA	RA	RA	RA	RA	
INTAKE	~~21/76~~	~~22/77~~	~~23/78~~	~~24/79~~	~~01/20~~	~~02/21~~	~~03/22~~	~~04/23~~	8° T
	150	150	650	150	150	150	150	154	2250
		50				50			200
		30		30					90
OUTPUT	60	140/440	40	40/520	50	40	35	35	630
									100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA			
	TIME		1370
	MODE		
	F_IO_2		
	TV		
	RATE		
	PEEP		
A	pH		7.211
	PCO_2		414
	pO_2		
B	HCO_3		17
	SAT		100
G	BASE		

LABORATORY DATA	
TIME	1330
GLUCOSE	160
Na/K	145/4.8
Cl/CO_2	
BUN/Cr	17
WBC/PLATELET	11.2/255
Hct/Hgb	11.4/35.1
Ph	7.211

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

```
i-STAT G3+

Pt: (b)(6)-4
Pt Name:________

TCO2________21 mmo.

At 37C
PH_______7.302
PCO2______40.3 mmHg
PO2________147 mmHg
HCO3________20 mmol/L
BEecf_______-6 mmol/L
sO2*________99 %
 *calculated

At Pat         mp
PH______      05
PCO2____     .9 mmHg
PO2________146 mmHg

Patient Temp: 98.2F
FIO2________: 30
Sample Type_: ART

03JUL03        17:05

Oper: (b)(6)-2

Physician:

Ser# (b)(6)-4
      0MS0450
      CLEW A91
```

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
TOTAL

OUTPUT
Urine: ______
TOTAL ______

NURSE'S SIGNATURE | **INITIALS**

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

MEDCOM - 6752

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800 INITIALS (b)(6)-2	1730 INITIALS (b)(6)-2	INITIALS
NEURO	PUPILS	PERL 3mm brisk	PERRLA 3mm brisk	
	SENSORIUM	Lethargic easily awakens to verbal stimuli	pt awakens to verbal stimuli	
RESPIRATORY	RESPIRATORY PATTERN	Resp even unlabored	even unlabored	
	BREATH SOUNDS	CTA bilat	lung sounds clear to auscultation	
	SECRETIONS	Ø	Ø cough	
SKIN	COLOR	pink w/o	pink warm and dry	
	INTEGRITY	intact	to touch, dsg on midline incision [illegible]	splint c̄ dsg, CDI
IV SITE	LOCATION	Ⓡ AC	Ⓡ AC site is patent	
	CONDITION	noted swelling @ site. LR infusing @ 150cc/hr. s̄ difficulty will cont' to monitor	c̄ LR@ 100cc/hr	
GASTRO	ABDOMEN	flat soft Ø distention	non-distended tenderness	
	BOWEL SOUNDS	⊕ BS all quads slow	⊕ BS hypoactive x4 quads	
GU	URINE: COLOR/CLARITY	Amber/clear foley to gravity	foley to gravity c̄ dark yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR @ 98 bpm cap refills <3 sec	SR 106 BPm cap refill <3 sec	

LEGEND

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

(Continue on reverse)

PREPA (b)(6)-2 [illegible]	DEPARTMENT/SERVICE/CLINIC ICU 2 [illegible]	DATE 10 Jul 03

PATIEN *(… written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent Dept of Nurs

MEDCOM - 6753

AMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

PAGE 2 OF 4

DATE 10 Jul 03

DX

HOSPITAL DAY

VITAL SIGNS																		
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	143/67	145/67	149/66	95/64	D/c'd													
BP Cuff	155/65	158/68	149/67	110/56	113/59	92/52		112/64		105/55	105/55	113/57	104/57	106/55	113/56	111/53	123/61	
Temperature			100.7					99.0 T						98.9				
Pulse	107	103	103	101	101	98		104		105	99	108	106	103	107	105	101	
Respiratory Rate	32	32	28	32	31	28		30		30	26	29	26	25	27	23	26	
SpO2	98%	97%	97%	97%	97%	96%		100%		94%	100%	96%	96%	97%	95%	95%	95%	
O2	4.5LNC		4.5LNC	4LNC	3.5LNC	3LNC		4LNC		4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	5LM	
pain																		
intervention																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS	150	150	150	100	100	100	100	100		100	100	100	100	100	100	100	100	
Zantac		50		~~50~~							50							
Unasyn				100							100						100	
Flushes						10												
PO	~~85~~							620		~~700~~								
TOTALS	150	200	150	200	100	110	100	720		100	250	100	100	100 / 2329	100	100	200	

OUTPUT																		
URINE HOUR / TOTAL			100	375	300	725	0	100		?	?	?	~~300~~	50	80	60	60	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS			100	375	3c								300	/1900				

MEDCOM - 6754

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
114/62	120/64	122/62	106/55	109/61	108/61	105/60	120/60	
		99.2						
102	104	101	95	90	90	94	94	
29	31	29	24	24	23	25	26	
95%	94%	99%	97%	96%	96%	97%	95%	
5L NC		10L NRB		40% VM	40% VM	40% VM	40% MV	

INTAKE

16	17	18	19	20	21	22	23	8°T
100	100	100	100	100	100	100	100	
	50				100			
100	150	100	100	100	200	100	100	3880

OUTPUT

100	100	50	60	50	50	40	120	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME	0400	1500							
GLUCOSE	136								
Na/K	132/3.8								
Cl/CO_2	106/24								
BUN/Cr	14/0.8								
WBC/PLATELET	7.5/186	7.8/211							
Hct/Hgb	24.1/8.2	25.3/8.3							

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME					
TURN						
SUCTION						

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
TOTAL 3880

OUTPUT
Urine: ________
TOTAL 2470

BALANCE 1410+

NURSE'S SIGNATURE	INITIALS
(b)(6)-2 91W20 M6	(b)(6)-2
(b)(6)-2	(b)(6)-2

MEDCOM - 6755

PAGE 2 OF 4

DATE 10 Jul 03	DX													HOSPITAL DAY				
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	143/67	145/67	140/66	95/64	D/c'd													
BP Cuff	155/65	158/68	149/67	110/56	113/59	92/52		112/64		105/55	105/55	113/57	104/57	106/55	113/56	111/53	123/61	
Temperature			100.3					99.0 T						99.8				
Pulse	107	103	103	101	101	98		104		105	99	108	106	103	107	105	101	
Respiratory Rate	32	32	28	32	31	28		30		30	26	29	26	25	27	23	26	
SpO2	98%	97%	97%	97%	97%	96%		100%		94%	100%	96%	96%	97%	95%	95%	95%	
O2	4.5L NC		4.5LNC	4LNC	3.5LNC	3LNC		4LNC		4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	5LM	
pain																		
intervention																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
NS	150	150	150	100	100	100	100	100		100	100	100	100	100	100	100	100	
Zantac		50		~~50~~							50							
Unasyn				100							100						100	
Flushes						10												
PO	[illegible]							620		~~700~~								
TOTALS	150	200	150	200	100	110	100	720		100	250	100	100	100 2389	100	100	200	
URINE HOUR / TOTAL			100	375	300	725	0	100		?	?	?	300	50	80	60	60	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
DRAINS																		
DRAINS																		
TOTALS			100	375	300	725	0	100					300	1900				

MEDCOM - 6756

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0545	INITIALS (b)(6)-2 [redacted]	1800	INITIALS (b)(6)-2 [redacted]		INITIALS
NEURO	PUPILS	PERL 3mm, brisk		PERRLA			
	SENSORIUM	Lethargic, easily		opens eyes to tactile			
		awakened c̄ verbal		stimulus, follows commands			
		stimuli.		MAE x4			
RESPIRATORY	RESPIRATORY PATTERN	Even, unlabored		tachypneic RR ↑30's.			
	BREATH SOUNDS	Inspiratory wheezing		coarse crackles bilat, (b)(6)-2 [redacted]			
	SECRETIONS	in RLL.		thick yellow, large amt			
		Ø secretions, cough &		IS c̄ good effort, cough/deep			
		deep breath encouraged		breathing, lungs cleared c̄			
		IS while awake.		C&DB. 50% vm O2 Sat 91%.			
SKIN	COLOR	pink		WNL			
	INTEGRITY	W/D intact		see notes.			
IV SITE	LOCATION	Ⓡ AC		Ⓡ AC 1			
	CONDITION	Ø s/sx of infx/infiltrate		Ø s/s of infection or			
				infiltration, flushed c̄			
				5cc NS ⊕ blood return			
				LR infusing @ 50cc/h			
				dsg & site intact.			
GASTRO	ABDOMEN	Soft, flat		soft, round			
	BOWEL SOUNDS	⊕ BS, slow in upper		⊕ BS x4 quads.			
		and lower right quads		Dsg to abd D+I.			
		⊖ BS in lower left quad					
GU	URINE:	foley to gravity.		foley → gravity.			
	COLOR/CLARITY	dark yellow / clear		dark yellow /clear			
CARDIOVASCULAR	CARDIAC RHYTHM	SR @ 96 bpm		SR → ST HR 90s → 100s			
		Cap refills < 3 secs.		cap refill ≥ 2 secs.			
				bilat pedal + ⊕ radial			
				pulses palpable. Cap			
				refill to LUE 2secs.			

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [redacted] 91W20M6

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 11 Jul 03

PATIENT'S I[redacted]ritten entries give: Name—last, first, middle; g[redacted]cal facility)

(b)(6)-4 [redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 6757

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PAGE 2 OF 4

DATE 11 July 2003 | DX | HOSPITAL DAY

VITAL SIGNS TIME	05	6	07	8	9	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	112/58	119/60	115/61	123/67	113/61	100/59	113/62	112/67		97/62	114/61	116/66	127/64	111/63	120/65	112/62	110/62	
Temperature	99.1 T	98.7 T	99.1 T	98.7 T	98.3 T	98.5 T	98.7 T	98.7 T	~~98.7~~ T	99.7 T	99.9 T	100.3	101.1	98^{5}	99^{4}			
Pulse	89	90	107	104	97	97	97	100		100	101	100	103	98	103	92	91	
Respiratory Rate	18	24	32	29	24	25	24	27		27	27	28	24	19	32	23	14	
SpO2	96%	95%	95%	96%	98%	97%	98%	95%		95%	95%	96%	97%	98%	91%	97%	97%	
O2	40% V/M	35% V/M	5LNC	5LNC	5LNC	4LNC	4LNC	4LNC	~~4LNC~~	4LNC	4LNC	4LNC	50% V/M	50% V/M	50% V/M	50% V/M	50% V/M	
INTAKE TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	8° T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	8° T
LR	100	100	100	50	50	50	50	50		50	50	50	50	50	50	50	50	
Zantac		50									100							
Unasyn				100							100						100	
p.o.			370		120			300 500				120						
TOTALS	100	150	470/720	150	170	50/1090	50	350		50/1540	250	170	50/2010	50/2060	50/2110	50/2160	150/2310	
OUTPUT URINE HOUR/TOTAL	80	50	60/190	600	800	325/1915	75	40		30/2060	60	60	100/2280	70/2350	30/2380	55/2435	60/2495	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 6758

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
113/64	114/65	104/56	109/58	106/64	106/63	104/60	105/58	
99¹			98⁸				98²	
95	91	92	86	83	85	85	85	
19	21	28	20	19	20	23	20	
96%	97%	96	95	97	96	97%	97%	
↓ 90% Vm	90% Vm	90% Vm	40% Vm	40% Vm	40% Vm	40% Vm	↓ 40% Vm	

INTAKE

~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	8° T
50	50	50	50	50	50	50	50	
	50							
					100			
50/2360	100/2460	50/2510	50/2560	50/2610	150/2760	50/2810	50/2860	2860

OUTPUT

60/2555	60/2615	45/2660	50/2710	40/2750	50/2800	70/2870	60/2930	2930

2930

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
ABG PCO_2									
ABG pO_2									
ABG HCO_3									
ABG SAT									
ABG BASE									

LABORATORY DATA

TIME	0400								
GLUCOSE	94								
Na/K	131/3.6								
Cl/CO_2	103/24								
BUN/Cr	13/1.1								
WBC/PLATELET	7.9/240								
Hct/Hgb	23.4/7.8								

ACTIVITIES OF DAILY LIVING

TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

TURN — TIME: Self

SUCTION: N/A

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

TOTAL 2860

OUTPUT

Urine: ________

TOTAL 2930

BALANCE ⊖70

NURSE'S SIGNATURE		INITIALS
(b)(6)-2	q1w20 M6	(b)(6)-2
(b)(6)-2	4TAW	(b)(6)-2

MEDCOM - 6759

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0625 INITIAL (b)(6)-2	1500 INITIA (b)(6)-2	INITIALS
	PUPILS	Perrla	PERRLA 3mm brisk	
	SENSORIUM	Awakens to touch.	Awakens to touch	
			responsive	
RESPIRATORY	RESPIRATORY PATTERN	Even unlabored R-20	even unlabored	
	BREATH SOUNDS	Clear ↑ lungs ; coarse	lung sounds clear	
	SECRETIONS	↓ lungs.	to auscultation	
SKIN	COLOR	Pink	pink warm dry	
	INTEGRITY	Warm	to touch Ⓛ arm splint	
		All Dsg CDI.	midline drsg CDI Δ BID.	
IV SITE	LOCATION	Ⓡ AC	Ⓡ AC Ⓛ hand infusing	
	CONDITION	Patent ō NS s/s infiltrate	LR@ 50cc/hr site patent	
		LR @ 50cc/hr	no s/s of infiltration	
GASTRO	ABDOMEN	soft nondistended	soft tender nondistended	
	BOWEL SOUNDS	BS hypoactive in ↑ quads	BS⊕ hypoactive	
	pt NPO	BS in ↓ Quad hypo + faint	pt NPO	
		to auscultation		
GU	URINE:	Foley to gravity / intact	foley to gravity	
	COLOR/CLARITY	yellow / clear	yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR @ 86 BPM	SR @ 95 bpm	
	extremities	Pulses palpable x3.	pulses equal and palpable	
		Cap Refill < 3sec x 4.	x3 ext cap refill	
			< 3sec x4	

LEGEND

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 SSG/LPN

DEPARTMENT/SERVICE/CLINIC: ICU ~~2nd~~

DATE: 12 July 03

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

(b)(6)-4

(b)(6)-4

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

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

MEDCOM - 6760

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE 12 July03

DX

HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	105/61	106/59	107/59	108/56	111/62	118/62	102/53	108/61		113/63	120/66	126/67	133/73	126/70	130/68	131/71	127/70	
	Temperature					98³					99³					99³			
	Pulse	92	82	84	83	91	80	81	89		86	94	96	102	106	100	101	97	
	Respiratory Rate	19	18	24	20	27	19	18	14		26	30	27	28	32	30	30	30	
	O2 Sat	95%	98%	92	96	97	97	99	94%		95	95	97	97	98	96%	95%	96%	
	Oxygen	40%	40%	40%	40%	40%	40%	40%	40%		40%	40	50	50	50	40	40	40	
	Method	VM	VM	VM	VM	VM	VM	VM	VM		VM	VM	VM	VM	VM	VM	VM	VM	
	[illegible]																		
	[illegible]																		
INTAKE	TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	8°T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	8°T
	LR	50	50	50	50	50	50	50	50		50	50	80	60	50	50	50	50	
	Zantac		100		~~100~~50						100								
	Unasyn				100													100	
	IVP						5												
	NS													955			15	15	
	PRBC 2U																		
	PO																		
	TOTALS					450				605							65	165	
OUTPUT	URINE HOUR / TOTAL	40/40	85/125	60/185	40/225	40/265	1100/1365	500/1865	100/1965		40/2005	30/2035	150/2185	40/2225	30/2255	40	50	60	
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH												4255						
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	DRAINS																		
	DRAINS																		
	TOTALS																		

MEDCOM - 6761

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

21	22	23	24	01	02	03	04	
129/72	137/76	131/73	129/69	128/72	129/73	103/63	118/73	
99.2				97.5				
99	99	94	88	97	88	88	86	
28	27	27	26	22	27	30	27	
97%	96%	96%	97%	97%	97%	95%	96%	
40	40	40	40	40	40	40	40	
VM	VM	VM	VM	VM	VM	VM	VM	

INTAKE

~~[illegible]~~								
50	50	50	50	50	50	50	50	
	100			~~100~~	100			
15	15	15	15	15				
							905	
	360				360		320	
							1625	
65	65	65	65	65	130	90	50	

OUTPUT

100	900	1400	700	150	50	100	40	
					3590			

RESPIRATORY

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME	0500								
GLUCOSE	85								
Na/K	131/3.4								
Cl/CO_2	103/26								
BUN/Cr	14/0.8								
WBC/PLATELET	7.8/231								
Hct/Hgb	23.3/7.7								

ACTIVITIES OF DAILY LIVING

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

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

TOTAL 2580

OUTPUT

Urine: ________

TOTAL 5845

BALANCE 3265 –

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2

MEDCOM - 6762

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	IN(b)(6)-2	1730	INITIAL(b)(6)-2		INITIALS
NEURO	PUPILS	PERL 3mm brisk		PERRLA 3mm brisk			
	SENSORIUM	Alert. lang barrier		Alert responsive			
		able to voice basic					
		needs					
RESPIRATORY	RESPIRATORY PATTERN	Even, unlabored		even lung sounds			
	BREATH SOUNDS	CTA		clear to auscultation			
	SECRETIONS	0		X4 lobes pt on 2L			
				NC SaO2 97%			
SKIN	COLOR	pink		pink w/d to touch			
	INTEGRITY	w/D intact c̄ midline		midline dsg CDI Ⓛ			
		abd incision + Ⓛ flank		UE splint			
IV SITE	LOCATION	Ⓡ wrist		IV Ⓡ hand patent c̄			
	CONDITION	CDI 0 s/sx of infx		no s/s of infiltration			
				LR @ 50cc/hr			
GASTRO	ABDOMEN	tender around surg site		Tender around dsg ⊕			
	BOWEL SOUNDS	+ BS slow		BS hypoactive			
				Reg diet c̄ CIB			
GU	URINE:	Amber / clear		Amber / clear Foley			
	COLOR/CLARITY	foley to gravity		to gravity site clean			
CARDIOVASCULAR	CARDIAC RHYTHM	SR @ 87 bpm		SR 87 bpm pulses			
		Cap refills <3 sec.		equal palpable cap			
				refill <3sec			

LEGEND

- Cr - Creatinine
- F_iO_2 - Fraction of Inspired O_2
- HCO_3 - Bicarbonate
- ICP - Intracranial Pressure
- PCO_2 - Pressure of Arterial CO_2
- PEEP - Positive End Expiratory Pressure
- SIA - Fractional
- SAT - Saturation
- TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 niwze M6

DEPARTMENT/SERVICE/CLINIC: ICU 2 East

DATE: 13 Jul 03

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

(b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 6763

AMC OP 375 (Redesignated)
1 Apr 90 (USXC NU)

DATE 13Jul03 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
BP Arterial Line	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Cuff	128/74	129/73	125/71	121/67	116/65	114/66	110/66	124/73	~~126/73~~	126/73	109/63	119/67	124/63	114/67	123/69	124/70	116/64	
Temperature	97.4 T	97.1 T	96.9 T	96.8 T	96.4 T	96.8 T	97.4 T	97.5 T	~~98.7 T~~	98.8 T	98.8 T	98.3 T	99.1 T		98.1			
Pulse	83	81	83	91	85	80	75	87	~~92~~	92	94	[illegible]	87	89	94	92	86	
Respiratory Rate	27	22	22	24	21	20	17	22	~~24~~	24	27	24	25	26	27	25	27	
SpO2	95%	97%	98%	95%	97%	97%	98%	97%	~~98%~~	95%	95%	96%	95%	96%	96%	96%	96%	
O2	35% VM	4LNC	4LNC	4LNC	4LNC	3.5L NC	3.5L NC	3.5L NC	~~3LNC~~	3LNC	3LNC	3LNC	2LNC	2LNC	2LNC	4LNC	4LNC	
pain																		
intervention																		

INTAKE																		
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	~~8°T~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~8°T~~
LR	50	50	50	50	50	50	50	50	~~50~~	50	50	50	50	50	50	50	50	
Zantac		100									100						100	
Unasyn				100							100							
po.			500		120			240			250	240		220	400		300	
Flush					10													
																	450	
TOTALS	50	150/200	550	150/900	180/1080	50	50/1180	240		50/2520	500/3020	240/3310	50/3360	270	450	50	~~100~~	

OUTPUT																			
URINE	HOUR/TOTAL	100	40/140	60	60/260	40/300	40	30/370	60		40/470	60/530	60/590	50/640	40	50	100	50	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	
21	22	23	24	01	02	03	04	
121/73	106/68	119/65	114/62	116/57	114/65	113/64	129/64	
98.3				98.1				
61	77	75	78	76	76	78	80	
24	18	18	24	21	18	19	18	
97%	98%	98%	97%	97%	97%	96%	96%	
3Lnc	3Lnc	3Lnc	2Lnc	2Lnc	2Lnc	2Lnc	2Lnc	

INTAKE

~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	8°T
50	50	50	50	50	50	50	50	
	100				100			
								5180
50	150	50	50	50	150	50	50	

OUTPUT

50/	100/	40/	50/	50/	50/	40/	50/	1310

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
A		pH									
	A	PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY DATA

TIME	0300	0540							
GLUCOSE		101							
Na/K	/	/3.3	/	/	/	/	/	/	/
Cl/CO$_2$	/	105/25	/	/	/	/	/	/	/
BUN/Cr	/	18/0.7	/	/	/	/	/	/	/
WBC/PLATELET	16.1/324	/	/	/	/	/	/	/	/
Hct/Hgb	33.6/11.2	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	5180	TOTAL	1310

BALANCE 3870+

NURSE'S SIGNATURE	INITIALS
(b)(6)-2 91WZ0 MG	(b)(6)-2
(b)(6)-2	(b)(6)-2

MEDCOM - 6765

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1300 INITIALS (b)(6)-2 [redacted]	1730 INITIALS (b)(6)-2 [redacted]	1800 INITIAL (b)(6)-2 [redacted]
NEURO	PUPILS	PERRLA	3mm (=)	Perrl 3mm
	SENSORIUM	Pt able to follow	Able to follow	able to follow
		commands, move	simple commands	commands – cooperative
		extrem x 4.		
RESPIRATORY	RESPIRATORY PATTERN	Normal R 18	RRR @ 20-30	even – unlabored
	BREATH SOUNDS	clear bilat	CTA	Shallow 2° pain
	SECRETIONS	Pt sneezes	⊕ cough, ⊖ secretions	NC 3L sats >95%
		No secretions	NC @ 2LPM O_2	
		noted		
SKIN	COLOR	Normal	normal, cool + dry	normal
	INTEGRITY	Cool, Dry	Midline ABD incision	Dsg to midline c̄
		[illegible]	CDI, Ⓛ ↑E to cast	cast ↑LE shoulder to
I.V. SITE	LOCATION	Ⓡ AC	Ⓛ AC c̄ 18 ga	hand – cap refill – pk
	CONDITION	patent c̄ no s/s	patent LR @ 150cc/HR	in color
		of infiltration	⊖ s/s infiltration	
		LR @ 150cc/hr		
GASTRO	ABDOMEN	Firm/nondistended	soft / non-distended	
	BOWEL SOUNDS	No bowel sounds noted	⊖ BS x4	
	N/G (LIS)	Dsg to midline Abd + to	NG to LIS	NGT LIS
		Ⓛ Abd. CDI ~~no s/s~~	infection	
GU	URINE:	Foley to gravity	foley to gravity	Lasix x 40mg x1 1600
	COLOR/CLARITY	Clear yellow	clear yellow	⊕ 1900 1400cc output
			urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR HR 82	SR @ 101	SR PR-113
		Pulses present x 4 ext.	pulses x3 extremities	Distal Pulses Present
		Cap refill < 3 sec	cap refill <3 sec x	
		↑ elbow cast on Ⓛ arm	ext. ↑ L arm [illegible]	
			cast	

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] SSG / LPN

DEPARTMENT/SERVICE/CLINIC ICU ~~[illegible]~~

DATE 15 July 03

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

(b)(6)-4 [redacted]

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 6766

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

Admit 10

DATE	DX S/P Exp Lap	HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff								113/63		111/62	114/67	106/54	106/59	118/63	105/53	111/58	109/63	
Temperature								96^{1}				99^{4}		99^{3}			99^{0}	
Pulse								91		77	88	94	97	101	102	103	106	
Respiratory Rate								22		15	17	22	25	29	27	27	29	
SaO2								99		100	100	97	98	98	98	98		
								(b)(6)-2										
															2L	2L	2L	

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR						00 → 2500cc				150	150	150/450	150/600	150/750	150	150	150	
NG flsh													30				30	
IVP													100					
TOTALS																		

OUTPUT

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
URINE	HOUR / TOTAL								01 350		50/50	50/100	40/140	30/170	20/190	60/250	40/290	40/330	
	Sp gr																		
	SA																		
NG	OUTPUT										Scant	N 30cc	N 45/75cc	30/100	50/150				
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 6767

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
114/69	123/70	99/59	124/74	132/50	124/72	127/71	130/77	
		98^{9}				99^{0}		
104	104	106	106	103	109	107	112	
30	32	32	35	29	30	29	31	
97	97	96	96	95	94	96	96	
Nc	nc	nc	nc	nc	nc	nc	nc	
2L	2L	2L	2L	2L	2L	2L	2L	

INTAKE

21	22	23	24	01	02	03	04	8° T
150	150	150	150	150	150	150	150	2400
		~~3~~	30				30	120
			200					300

OUTPUT

20/350	40/390	30/420	50/470	42/510	50/560	40/600	80/	680
		90					300	~~372~~
								540

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA: TIME, MODE, F_iO_2, TV, RATE, PEEP

A B G: pH, PCO_2, pO_2, HCO_3, SAT, BASE

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

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

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

PO ______

TOTAL ______

OUTPUT

Urine: ______

TOTAL ______

BALANCE ______

NURSE'S SIGNATURE

(b)(6)-2

(b)(6)-2

MEDCOM - 6768

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line																	112/[illegible]	
BP Cuff		69/57		~~[illegible]~~		9	99/46			110/70		108/57	113/53					
Temperature		96.7					97.7			97.6							97.8	
Pulse		69					78			78		83	86				86	
Respiratory Rate		20					18			20		20	16				14	
										95%		97%	95%				97%	
										RA		RA	RA				RA	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	125 125	125 250	125 375	125 500	125 625	125 750	125 875	125 1000	1000									
TOTALS																		

OUTPUT

URINE	HOUR TOTAL				500 500													
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS

22	23	24	01	02	03	04	05	
		106/64				94/50		
						98¹		
		69				71		
		12				12		
		98%				96%		
		RA				RA		

INTAKE

22	23	24	01	02	03	04	05	8° T

OUTPUT

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
	PCO_2								
B	pO_2								
	HCO_3								
	SAT								
G	BASE								

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE — OUTPUT

IV ________ Urine: ________

po ________ ________

________ ________

TOTAL ________ TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

MEDCOM - 6770

PAGE 1 OF

MEDI ~L RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	630	INITIALS (b)(6)-2	INITIALS	1930 INITIALS (b)(6)-2
NEURO	PUPILS	Seems depressed			
	SENSORIUM	Alert ̄c mented x3			Pt asleep arousable
		responds appropriately			lethargic A&Ox3
		moves all			responds to commands
		extremities			moves ext x4
RESPIRATORY	RESPIRATORY PATTERN	Reg; non labored			
	BREATH SOUNDS	even ↑↓ chest			unlabored full equal
	SECRETIONS	Ø SOB Ø secretions			chest expansion SaO2 97%
		RR 18 SAO2 97% RA			RA Ø SOB
SKIN	COLOR	Normal for race			
	INTEGRITY	ABD Drg CDI Δ by MD			warm dry to touch
		Sacral Drg ̄c good-lg amount of drainage			Abd Dsg CDI Δ by
IV SITE	LOCATION	Ⓡ 20g saline lock			MD. Sacral Dsg CDI
	CONDITION	— Flush appear			IV Ⓡ hand [illegible]
		to have infiltration			no s/s of infiltration
GASTRO	ABDOMEN	Soft non distended			
	BOWEL SOUNDS	↓ active BS x4			Soft non distended
		Ø BM			BS⊕ x4 quads
					Ø BM
GU	URINE:	ark yellow clear			
	COLOR/CLARITY	Pt ambulates			voids via urinal
		to commode			clear yellow urine
CARDIOVASCULAR	CARDIAC RHYTHM	NSR HR 88			Pt ambulates to commode
		⊕ peripheral pulse x4			
		⊕ color sensation ̄c			NSR HR 81 S1/S2
		movement			̄c no extra sounds
		Skin warm ̄c Dry			capillary < 3 sec

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

(Continue on reverse)

(b)(6)-2 SGT 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 12AUG03

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

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

MEDCOM - 6771

OP 375 (Redesignated)

PAGI

DATE		DX												HOSPITAL DAY				
VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
	BP Arterial Line																	
	BP Cuff	104/44				134/81						83/54	109/51	118/73				110/71
	Temperature	96°										98.0°						98.7
	Pulse	88				82						83	99	101				89
	Respiratory Rate	14				14						10	16	22				24
		97%				99%						99%						98%
		RA				RA						RA		RA				RA

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

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

MEDCOM - 6772

ST-OP DAY

22	23	24	01	02	03	04	05	
			W					
			103/64				114/66	
			98.7				98.4	
			88				84	
			94%				97%	
			RA				RA	

22	23	24	01	02	03	04	05	8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
A	PCO_2									
B	pO_2									
B	HCO_3									
G	SAT									
G	BASE									

LABORATORY DATA								
TIME								
GLUCOSE								
Na/K								
Cl/CO₂								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

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

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
____
TOTAL ________

OUTPUT
Urine: ________
____
____
TOTAL ________

BALANCE ________

NURSE'S SIGNATURE | INITI

PAGE 1 OF

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0830	INITIAL (b)(6)-2 [redacted]	INITIALS	1930 INITIAL (b)(6)-2 [redacted]
NEURO	PUPILS				
	SENSORIUM	a+o x3 Moves			pt asleep arousable
		all extremities			lethargic
		repsonds appropriately			moves ext x4
					responds to commands
RESPIRATORY	RESPIRATORY PATTERN	Reg non labored			full cx expansion
	BREATH SOUNDS	even ↑↓ chest			unlabored LS CTAX
	SECRETIONS	LS: CTA SaO2 97% RA			4 lobes SaO2 98% RA
		∅ secrection			
		∅ SOB			
SKIN	COLOR	Normal for Race			Warm dry to touch
	INTEGRITY	ABD Drsg CDI			Abd Dsg CDI
		sacral drsg CDI			Coccyx Dsg CDI
IV SITE	LOCATION	20g Saline lock			20g hep lock Ⓡ hand
	CONDITION	to Ⓡ Hand			no redness/swelling
		(−) flushes pt c/o			
		pain when flush			
GASTRO	ABDOMEN	soft, nondistended			soft nondistended
	BOWEL SOUNDS	active BS x4			tender at Dsg site
		ABD drsg Δ'd by			BS + x4 quads
		MD			
GU	URINE:	via urinal, commode			Via urinal s̄
	COLOR/CLARITY	yellow clear			difficulty
		∅ complaint of burning			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 normal ∅			S1/S2 c̄ no dysrh
		murmur noted			sounds HR 75 bpm
		HR 60			Pulses equal and
		⊕ peripheral pulses			palpable [redacted]
		to extremities			

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
(b)(6)-2 [redacted] al
uration
- Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] SGT/E5

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 13 Aug 03

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

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

DA FORM 4700, 1 MAY 78 MEDCOM - 6774 IAMC OP 375 (Redesignated)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line																		
BP Cuff			113/61		91/51								127/76	115/68	115/70	98/50	114/56	
Temperature			96.4										98.9	98.6				
Pulse			92		74								88	85	76	75	79	
Respiratory Rate			18		16								15	11	12	13	14	
			98%		98%								98%	96%	100%	98%	98%	
			RA		RA								RA	RA	RA	RA	RA	

INTAKE

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

OUTPUT

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

PAGE 3 OF

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

22	23	24	01	02	03	04	05	
		104/54			112/74		104/65	
		98^{9}			98^{2}			
		82			80		81	
		17			14		16	
		96%			97%		98%	
		AA			DA		DA	

INTAKE

22	23	24	01	02	03	04	05	8° T

OUTPUT

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

______

TOTAL ______

OUTPUT

Urine: ______

______

______

TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

MEDCOM - 6776

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	0700 TIME	15AUG03 INITI (b)(6)-2 [redacted]	15 AUG INITIA (b)(6)-2 [redacted]	INITIALS
NEURO	PUPILS	Seems depress	AEO - Perrl -	
	SENSORIUM	Alert oriented	Follows commands	
		able to move	Sitting up in bed	→
		all extremities		
		Responds appropreatley		
RESPIRATORY	RESPIRATORY PATTERN	Reg RR 14 SaO2 96% RA	RRR - 16 BPM	
	BREATH SOUNDS	LS CTA	97% RA SaO2	
	SECRETIONS	⊘ secretions	Lungs CTA	
		even ↑↓ chest	no c/o SOB	→
		⊘ SOB	∅ cough	
SKIN	COLOR	Normal for Race	NFR	
	INTEGRITY	drsg ABD CDI Δ by MD	Dsg to abd	
		Sacral drsg CDI Δ by MD	Dsg to buttocks	
IV SITE	LOCATION	20g IV Ⓡ wrist	IV patent Ⓡ wrist	
	CONDITION	infusing LR@KVO	infusing LR 20 cc/hr	
		⊘ S/S infiltration	KVO	
			∅ s/sx of infx	
			infiltration	→
GASTRO	ABDOMEN	firm, nondistend	⊕ BS - tolerated	
	BOWEL SOUNDS	flat abd, ABD Drsg CDI	meal -	
		BS ⊕ x 4 quads		→
		Hypoactive		
GU	URINE. COLOR/CLARITY	dk yellow	ambulates to commode	
		urine,		
		⊘ sedement noted		
CARDIOVASCULAR	CARDIAC RHYTHM	HR 51 NSR	NSR Pulse - 88	
		BP 117/68	⊕ peripheral pulses	
		⊕ peripheral		
		pulses x4		→
		gd cap refill <3 sec		

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

(b)(6)-2 [redacted] SGT/E5

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [redacted] SGT/E5 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 15AUG03

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

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

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

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

MEDCOM - 6777

OP 375 (Redesignated)

PAGI

DATE		DX												HOSPITAL DAY				

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
	BP Arterial Line																	
	BP Cuff			117/62			111/68				124/74			115/60				
	Temperature			97.0							97.8			97.5				
	Pulse			82			84				79			74				
	Respiratory Rate			14			18				18			18				
				96%			95%				95%			98%				
				RA			RA				RA			RA				

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
	LR	20	20 90	20 60	20 80	20 100	20 120	20 140	20 160	160	20 180	20 200	20 280	20 240	20 260	20	20	20
	PO	480	X	X	60 540	240 780		300 1080		1080						30		
	TOTALS																	

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

MEDCOM - 6778

ST-OP DAY

22	23	24	01	02	03	04	05	
118/60				112/62				
118/60				120/62				
97⁶				97⁴				
81				80				
16				14				
97%				97%				
RA				RA				

22	23	24	01	02	03	04	05	24° 8° T
20	20	20	20	20	20	20	20	480
200								1480
200								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

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

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

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	1480	Urine:	multiple voids
PO	480		
TOTAL	1960	TOTAL	

BALANCE ______

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

INIT. (b)(6)-2

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	~~0400~~/1000	INITIALS (b)(6)-2 [redacted]	INITIALS	1400 · INITIALS (b)(6)-2 [redacted]
NEURO	PUPILS	3 mm Brsk Pearla			3mm Brisk pt
	SENSORIUM	good movement, good sensation to all extremities Pt AAO x3. Converses fluently in arabic.			awake alert. able to move ext x4.
RESPIRATORY	RESPIRATORY PATTERN	Chest movement symmetrical, expansion equal			full equal CX expansion
	BREATH SOUNDS	Clear throughout			Ø SOB SaO2 95%
	SECRETIONS	slightly diminished (R) LL, RR - 15-16 BPM SaO2 - 96% Ø cough, Ø secretions, Ø R distress			(R) lung sounds CTA x4 lobes
SKIN	COLOR	NFR			Warm dry to touch
	INTEGRITY	(+) midline abd incision dressing intact ē drainage drains to inferior aspect of abd. (+) dressing for decubitus ulcer to sacral area / accepted by [illegible] as (10-11 cm - deep 5 cm deep) dressing CDI. (+) (R) arm splint CDI.			Dsg to abdomen D/I'd by MD CDI no S/S of infection or drainage.
IV SITE	LOCATION CONDITION	(+) scar 3cm lgth - 1cm wide to T6-T7 spinal process dry. Ø evidence infection. 18g PIV to (L) AC placed 14 Aug. Dressing CDI. Ø evidence infection infiltration. (+) Flush ē BR. LR ē TKO.			Dsg to coccyx D/I'd by MD CDI Ø drainage Ø odor. IV to (L) A/C infusing without [illegible] Blister on (L) heel noted
GASTRO	ABDOMEN BOWEL SOUNDS	(+) BS x4 q. soft nondistended. (+) abd incision covered w/ dressing. Ø N/V c/o pain. Ø gas Ø flatus. (per eve RN)			BS (+) x4 quads abd tender at dsg side nondistended pt on regular diet
GU	URINE: COLOR/CLARITY	Clear yellow per ward commode-			Pt voids [illegible] yellow urine pt ambulates to commode
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, HR/BP WNL. Cap refill brisk all 4 ext. Big toes and index fingers (+)(L) [illegible] pulses Radial/pedal bilat			NSR ē extra sounds S1/S2 present pulses palpable and equal

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU

DATE 16 Aug 03

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

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

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

DA FORM 1 MAY 78 4700 MEDCOM - 6780 OP 3/5 (Redesignated)
Proponent: Dept of Nurs

PAG

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line															~~124/78~~		
BP Cuff			125/61	109/78						124/70					124/78		
Temperature			95^{6} TT	95.8						96.8					97^{9}		
Pulse			72	69						78					81		
Respiratory Rate			16	9						13					14		
			RA	RA						RA					98%		
SaO2			98%	100%						97%					RA		
Intake: kcal/g	N	P O	—														
											WT:	134	lbs.				
			OR	Recovery													

INTAKE

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

OUTPUT

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

MEDCOM - 6781

OST-OP DAY

2315

22	23	24	01	02	03	04	05	
124/100		—	124/74			117/71		
[illegible]	94.7		97.1					
71			74			71		
98%			98%			98%		
12			12			14		

22	23	24	01	02	03	04	05	8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
	ABG	pH								
		PCO_2								
		pO_2								
		HCO_3								
		SAT								
		BASE								

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

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

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

____

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE | INITL

MEDCOM - 6782

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	~~A~~ 0700 INITIALS (b)(6)-2	17 AUG 03 INITIAL (b)(6)-2	INITIALS
NEURO	PUPILS		WNL	
	SENSORIUM	alert oriented	Pt Q+ - cooperative	
		pleasant ♂	sittg ↑ in chair	
		WGT: 135 lbs		
RESPIRATORY	RESPIRATORY PATTERN	RR Reg	RRR	
	BREATH SOUNDS	LS CTA	Lungs CTA bilat	
	SECRETIONS	even ↑↓ chest		
		⊘ SOB ⊘ secretions		
SKIN	COLOR	normal for Race	normal for race	
	INTEGRITY	ABD DRSG CDI	abd dsg CDI	
		sacral DRSG seeping	reinforce ē gauze	
IV SITE	LOCATION	20g IV to Ⓡ AC	20G IV HL	
	CONDITION	⊘ S/S infiltration	flushed	
		infusing LR @		
		KVO		
GASTRO	ABDOMEN	soft, nondistended	soft - nondistended	
	BOWEL SOUNDS	⊕ BS x4 quad	⊕ BS - ⊘ urge	
		last BM 16 AUG 03	⊘ BM	
GU	URINE	Pt amb → commode	Pt QS urine	
	COLOR/CLARITY	Clear yellow urine	clear yellow	
			urine	
CARDIOVASCULAR	CARDIAC RHYTHM	HR Reg HR 68	HR - 60 - 70s	
		S1 S2 normal		
		⊘ murmur noted		
		⊕ perpheral pulses x4		

LEGEND	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_1O_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
	HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

SGT USA 9AUM6

DEPARTMENT/SERVICE/CLINIC
ICU

DATE
17 AUG 03

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

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

DA FORM 1 MAY 78 4700 MEDCOM - 6783 OP 375 (Redesignated)
Proponent: Dept of Nurs

PAGI

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line						113/68											
BP Cuff						113/68						128/77					
Temperature						97.7						98.2					
Pulse						70						79					
Respiratory Rate						20						20					
						98%						99%					
						RA						RA					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
ER	70	20	20		20	20											
TOTALS																	

OUTPUT

URINE	HOUR / TOTAL																	200
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 6784

)ST-OP DAY

22	23	24	01	02	03	04	05
120/70							
98							
80							
18							
100%							
RA							

22	23	24	01	02	03	04	05	8° T
HL	HL	HL	HL	HL	HL	HL	HL	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		
	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
A	pH	
A	PCO_2	
B	pO_2	
B	HCO_3	
G	SAT	
G	BASE	

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

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

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

TOTAL ______

OUTPUT

Urine: ______

TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INIT.

(b)(6)-2

(b)(6)-2

MEDCOM - 6785

18 Aug 03

PAGE 1 OF

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800	INITIALS (b)(6)-2 [redacted]		INITIALS	1900	INI (b)(6)-2 [redacted]
NEURO	PUPILS	3mm/3mm PEARLA				3mm Bl PERRLA	
	SENSORIUM	Moves all extrem purposefully				Follow Commands, MAE	
		good sensation throughout					
RESPIRATORY	RESPIRATORY PATTERN	RR-12-14 Bpm SaO2 100% RA.				RR 16 ~~[illegible]~~ Unlabored	
	BREATH SOUNDS	Clear throughout				CTA	
	SECRETIONS	Ø				Ø	
		c̄ cough					
		chest movement symmetrical					
		lung expansion equal.					
SKIN	COLOR	ONFR				NFR	
	INTEGRITY	(+) Decubitus to coccyx, Dressing CDI, Dressing Δ's per Dr.				(+) Decub to sacrum	
		Lowry (+) midline incision. Dressing CDI, Dr Lowry redress				Midline Abd - CDI	
IV SITE	LOCATION	dressing D2. 3cm & 1cm lesion to T5-T6 area - Stat removed				PIV (L) hand	
	CONDITION	by SGT Smith, Duoderm placed over. Ø drainage.					
		(+) 3cm x 3cm blood filled blister to (R) lateral					
		malleolus. Shift change. Will clean & dress.					
		(+) PIV 18G to (R) hand - SL'd (+) flush Ø BR					
		Reevaluate c̄ [illegible] into area.					
GASTRO	ABDOMEN	(+) BS x 4 q - ~~Abd~~ soft				BSX4, Abd Soft, NonT	
	BOWEL SOUNDS	non distended Ø pain on					
		palpation. Last BM					
		17-Aug 03.					
GU	URINE:	Clear yellow to [illegible]				Clear Yellow	
	COLOR/CLARITY	commode.					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR. VS normal.				NSR	
		(+) 1+ edema to (L) hand					
		cap refill <3sec X1					
		digit all extremities.					

LEGEND
Cr - Creatinine
FiO2 - Fraction of inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

0800 - Assessment (b)(6)-2 [redacted] CPT

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE

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

(b)(6)-4 [redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 6786

OP 375 (Redesignated)

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

PAGE

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff	113/67		101/44							113/66				102/50			
Temperature			97.0							97.7				97.8			
Pulse	66		74							88				82			
Respiratory Rate	18		14							14				16			
Sat	98		100%							98%				97			

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21
po		240 240			480 240			600 120	600								
TOTALS																	

OUTPUT

		06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21
URINE	HOUR / TOTAL		400 400														XI	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																	Lg	
DRAINS																		
TOTALS																		

MEDCOM - 6787

(b)(6)-4 [redacted]

18 Aug 03

OST-OP DAY

ACUITY LEVEL CLASSIFICATION

22	23	24	01	02	03	04	05	
186/					105/			
91					60			
74					78			
70					80			
					98			
99								

22	23	24	01	02	03	04	05	8° T

RESPIRATORY DATA

		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
A		pH								
		PCO_2								
B		pO_2								
		HCO_3								
		SAT								
G		BASE								

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ________

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800	(b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	3mm Pearla		3mm Perrl - A+O×3	
	SENSORIUM	moves all extremities		moves all ext - ambulates ̄c	
		⊕ sensation throughout		difficulty → self sufficient	
		AAOx3			
RESPIRATORY	RESPIRATORY PATTERN	chest movement equal		RRR - Lungs CTA	
	BREATH SOUNDS	symmetrical		SaO_2 - 99% on RA	
	SECRETIONS	BS clear throughout posteriorly		∅ cough - ∅ secretions	
		∅ secretion			
		∅ cough RR - 14-16 bpm			
		SaO_2-RA 98-100%			
SKIN	COLOR	WFR.		normal for race	
	INTEGRITY	⊕ ABD incision. midline dressing CDI		⊕ Dsg to Abd CDI	
		⊕ decubitus ulcer [illegible]			
IV SITE	LOCATION	18G PIV to Ⓛ hand.		∅ IV access	
	CONDITION	Painful on flushing. ~~∅ evidence of~~			
		infiltration, & ∅ evidence			
		infection			
GASTRO	ABDOMEN	BS x4 q. Abd soft, non-distended		⊕ BS - x 4 ∅	
	BOWEL SOUNDS	non tender to palpation		diarrhea multiple times	
		tol. Reg diet. Strict		drinking fluids	
		tol. LTW 3000 cal/day diet.		Δ in foods today	
GU	URINE COLOR/CLARITY	Clear yellow			
		to WARD commode			
		v/o problems			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, VS Stable.		NSR, ⊕ cap refill ≤	
		⊖ cap refill ≤3sec		all extremities	
		index bilat. and big toes Bilat.			
		∅ edema BLE 1+ to Ⓛ hand ⊖			
		dependent edema.			

LEGEND

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU

DATE

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

(b)(6)-4

(b)(6)-4

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

DA FORM 1 MAY 78 4700 MEDCOM - 6789 OP 375 (Redesignated)
Proponent Dept of Nurs

(b)(6)-4

20 Aug

PAG

DATE	DX	HOSPITAL DAY

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff		131/68						131/60					137/76				
Temperature		96.3	0800					97.0					96.8				
Pulse		76						72					78				
Respiratory Rate		14						15					16				
		100%						97%					97%				
		RA						RA					RA				

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

URINE	HOUR / TOTAL	600 600				x1					x1					x1		
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL						x1 mod					x1 mod				x1 small	x1		
DRAINS																		
TOTALS																		

MEDCOM - 6790

OST-OP DAY

22	23	24	01	02	03	04	05	
122/65				118/62				
122/64				118/62				
97°				96				
16				14				
99%				99%				
RA				RA				

22	23	24	01	02	03	04	05	8° T
300								
x1								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		
	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	
ABG	PCO_2	
ABG	pO_2	
ABG	HCO_3	
ABG	SAT	
ABG	BASE	

LABORATORY DATA	
TIME	
GLUCOSE	
Na/K	
~~Cl/CO$_2$~~	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING	
TIME	0800
MOUTH CARE	
BATH	-Self
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

______

TOTAL ______

OUTPUT

Urine: ______

______

______

TOTAL ______

BALANCE ______

NURSE'S SIGNATURE

(b)(6)-2

INITL

(b)(6)-2

PAGE 1 OF

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

B6-2

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	3mm Ø PERLA					
	SENSORIUM	alert, oriented, follows commands, moves all extremities					
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored					
	BREATH SOUNDS	CTA bilaterally					
	SECRETIONS	Ø noted					
SKIN	COLOR	normal for race					
	INTEGRITY	dressing to mid abd & sacrum CDE					
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN	soft, non distended					
	BOWEL SOUNDS	⊕ x4 quads, pt refused breakfast					
GU	URINE:	BSC					
	COLOR/CLARITY	clear, yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, all pulses palpable, Ø edema noted					

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

(Continue on reverse)

PREPARED BY (b)(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 21 Aug 05

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

(b)(6)-4

(b)(6)-4

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

DA FORM 4700 1 MAY 78
Proponent Dept of Nurs

MEDCOM - 6792

OP 375 (Redesignated)

PAG

DATE	DX	HOSPITAL DAY

VITAL SIGNS

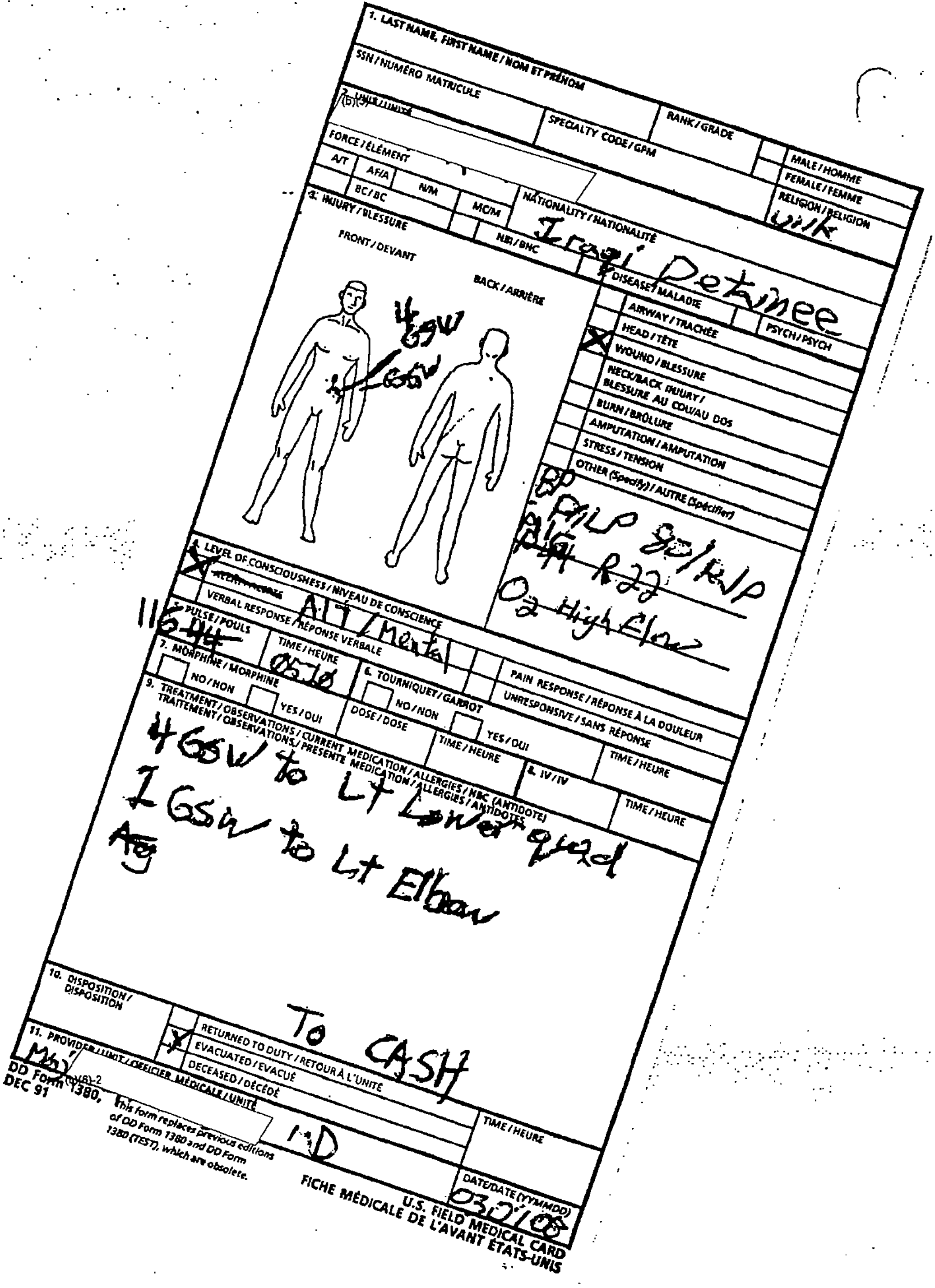
TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line										106/58							
BP Cuff	131/81				124/77												
Temperature	97.8									97.6							
Pulse	75				69					74							
Respiratory Rate	18				20					17							

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
PO	0				1200					500							
TOTALS																	

OUTPUT

URINE	HOUR / TOTAL					600					0							
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		



1. LAST NAME, FIRST NAME / NOM ET PRÉNOM

SSN / NUMÉRO MATRICULE

2. UNIT / UNITÉ (b)(3)

SPECIALTY CODE / GPM

RANK / GRADE

☐ MALE / HOMME

☐ FEMALE / FEMME

RELIGION / RELIGION unk

FORCE / ÉLÉMENT

A/T AF/A N/M MC/M BC/BC

NATIONALITY / NATIONALITÉ Iraqi Detainee

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE

NBI / BNC

☐ DISEASE / MALADIE

☐ PSYCH / PSYCH

☐ AIRWAY / TRACHÉE

☒ HEAD / TÊTE

☐ WOUND / BLESSURE

☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS

☐ BURN / BRÛLURE

☐ AMPUTATION / AMPUTATION

☐ STRESS / TENSION

OTHER (Specify) / AUTRE (Spécifier)

BP Palp 90/palp

~~P 44~~ R 22

O2 High Flow

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☒ ~~ALERT / ALERTE~~ ALT / Mental

☐ VERBAL RESPONSE / RÉPONSE VERBALE

☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR

☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS 116 ~~44~~ TIME / HEURE 0510

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☐ YES / OUI DOSE / DOSE TIME / HEURE

8. IV / IV TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

4 GSW to Lt Lower quad Abd

1 GSW to Lt Elbow

10. DISPOSITION / DISPOSITION

☐ RETURNED TO DUTY / RETOUR À L'UNITÉ

☒ EVACUATED / EVACUÉ To CASH

☐ DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ (b)(6)-2 MD

DATE / DATE (YYMMDD) 03/7/08

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)

TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE				
BP / PS	80/Pulp			
PULSE / POULS	108			
RESP / RESP	40			

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS *(Specify)* / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES *(Spécifier)* / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE

DATE/DATE (YYMMDD)

TIME / HEURE

16. DISPOSITION / DISPOSITION
- ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
- ☐ EVACUATED / EVACUÉ
- ☐ DECEASED / DÉCÉDÉ

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- ☐ BAPTISM / BAPTISÉ
- ☐ ANOINTING / ONCTION
- ☐ CONFESSION / CONFESSION
- ☐ PRAYER / PRIÈRE
- ☐ COMMUNION / COMMUNION
- ☐ OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

MEDCOM - 6795

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM

RANK / GRADE

☐ MALE / HOMME

☐ FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION unk

2. (b)(3)-1

FORCE / ÉLÉMENT

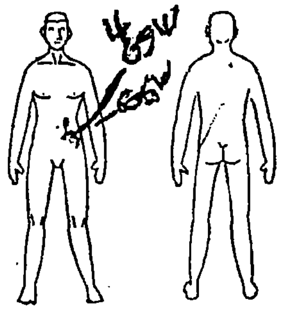
☐ A/T ☐ AF/A ☐ N/M ☐ MC/M ☐ BC/BC

NATIONALITY / NATIONALITÉ Iraqi Detainee

☐ NBI / BNC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



☐ AIRWAY / TRACHÉE

☐ HEAD / TÊTE

☒ WOUND / BLESSURE

☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS

☐ BURN / BRÛLURE

☐ AMPUTATION / AMPUTATION

☐ STRESS / TENSION

☐ OTHER (Specify) / AUTRE (Spécifier)

BP PALP 80/RJP

R/R R22

O2 High Flow

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☒ ~~ALERT / ALERTE~~ Alt / Mental

☐ VERBAL RESPONSE / RÉPONSE VERBALE

☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR

☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS 116 ~~44~~

TIME / HEURE 0510

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI

TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☐ YES / OUI

DOSE / DOSE

TIME / HEURE

8. IV / IV

TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

4 GSW to Lt Lower quad

1 GSW to Lt Elbow

Aeg

To CASH

10. DISPOSITION / DISPOSITION

☐ RETURNED TO DUTY / RETOUR À L'UNITÉ

☒ EVACUATED / EVACUÉ

☐ DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ Maj (b)(6)-2 MD

DATE / DATE (YYMMDD) 030708

DD Form 1380, DEC 91 … of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 6796

ADMISSION A... CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. MT... ...TION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME *(Last, First, Middle Initial)*
(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
4	0	Y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION
UNK

10. LENGTH OF SERVICE

32	33	34

ETS
N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(6)-4

ORGANIZATION *(Active Duty Only)*
N/A

13. MARITAL STATUS

46
U

HOUR OF ADMISSION
0615

BRANCH / CORPS
N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63
[redacted]	[redacted]

(b)(3)-1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
0

PREV. ADMISSION
YEAR
☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD
ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
(b)(3)-1

21. TYPE OF DISPOSITION

73	74
2	6

22. MTF TRANSFERRED TO

75	76	77	78	79	80

(b)(3)-1

23. DATE OF DISPOSITION *(YYYYMMDD)*

81	82	83	84	85	86	87	88
2	0	0	3	0	9	0	6

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(YYYYMMDD)*

99	100	101	102	103	104	105	106
2	0	0	3	0	7	0	8

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

(b)(3)-1

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(YYYYMMDD)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
959.1 ~~903.3~~

Dx 86330
86359
81314
7070
99831 E9912

Pr: 7932
8345
4562
9904(6)

Inj Trauma
450 1

ADMITTING O... (b)(6)-2
(b)(6)-2 COL, MC

SIGNATURE OF ADMITTING CL... (b)(6)-2
(b)(6)-2 SSG, 91G

FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

MEDCOM - 6797

1900 — Recieved e-mail from OPS - about major concerns by M.E., current OPS - ~~explained~~ told at differ
C/A faced.

2100 - learned from C/A body still in morgue - o-dered
C/A to keep it there. Cmd Col [redacted] b7C-3,4
made arrangements to get body up to
Bagram b7C-3, b6-3 b7C-3, b6-3

2115 - LTC [redacted] / Col [redacted] - CID requested For Autopsy,
8A ICF

2130 - Body

Nov 02 e-mailed OPS/ ~~--~~ request autopsy from M.E.
~~1000~~

1200 - Contacted Col [redacted] b7C-3, b6-3 TF 44 ~~0~~ requested Travel of Forensic team.

9 Nov - Team contacted, order out pending autopsy.

F

[redacted]

1530 b7C-3,b6-3

~~E~~ b7C-3,b6-3 Ingwersen

[redacted] ME A Landstuhl.

OSN - [redacted] b7C-3,b6-3

-8106 →

Information Desk b7C-3,b6-3

49 [redacted]

b7C-1, b6-1 b7C-4, b6-4

0335, 07 Nov 03 [redacted]
I: 90 T: 0
b7C-1, b6-1

OTHER INVESTIGATIVE ACTIVITY: About 0335, 7 Nov 03, SA [redacted] interviewed SSG [redacted] [redacted], A Co, 3rd Bn, 3rd SFG, FOB Gereshk, AF. SSG [redacted] was identified as the Special Forces medic who conducted the initial physical examination of Mr WAHID. SSG [redacted] related WAHID was lucid, in complete control of all his motor functions and he appeared to understand directions. SSG [redacted] further related in spite of the extensive pre-existing injuries, WAHID did not appear to be suffering any life threatening condition. (See Sworn Statement of SSG [redacted] for details)

b7C-4, b6-4 b7C-4, b6-4 b7C-4, b6-4 b7C-4, b6-4

0840, 07 Nov 03 [redacted]
I: 0 T: 40 b7C-1, b6-1

OTHER INVESTIGATIVE ACTIVITY: RETURNED TO KAF VIA AIRCRAFT.

b7C-1, b6-1 b7C-1, b6-1

0930, 07 Nov 03 [redacted]
I: 20 T: 0

OTHER INVESTIGATIVE ACTIVITY: BRIEFED SAC [redacted], BAF, ON THE STATUS OF THIS INVESTIGATION.

0935, 7 Nov 03 – SA [redacted] briefed on investigative aspects. SO. AF. No signs foul play. – SF had documented injuries to PAC ~~AF~~ before he was ad- to FOB

b7C-3, b6-3

1200, 07 Nov 03 [redacted]
I: 120 T: 10
b7C-1, b6-1

OTHER INVESTIGATIVE ACTIVITY: About 1200, 7 Nov 03, LTC (Dr) [redacted], [redacted], General Surgeon, 911th Forward Surgical Team (FST), Task Force (TF) Warrior, KAF, conducted a physical examination of WAHID in a effort to ascertain the cause and manner of death. LTC [redacted] limited his examination to opening the chest cavity, obtaining tissue samples of the liver and heart and samples of blood for toxicology. X-rays of the body were exposed. Photographs were exposed prior to and during the examination. (See DA Form 4137 and photographic packet for details)

b7C-3, b6-3 b7C-1, b6-1

AGENT'S COMMENT: SA [redacted] obtained the Standard Form 509, Progress notes, pertaining to the examination.

~~There was a rush to do autopsy~~ Autopsy pend.

b7C-1, b6-1

1430, 08 Nov 03 [redacted]
I: 30 T: 20
b7C-1, b6-1

OTHER INVESTIGATIVE ACTIVITY: COORDINATED WITH MORTUARY AFFAIRS TO OBTAIN FLIGHT INFORMATION TO BAF AND CONFIRM THE REMAINS WERE PROPERLY STORED IN ANTICIPATION OF AN AUTOPSY AT BAF.

1530, 08 Nov 03 [redacted]
I: 20 T: 0
b7C-1, b6-1

OTHER INVESTIGATIVE ACTIVITY: BRIEFED SAC [redacted] ON THE SITUATION CONCERNING THE REMAINS AND PROVIDED TRANSPORT INFORMATION.

b7C-1, b6-1 later in day, maybe nite

b7C-1, b6-1 b7C-3, b6-3

1700, 08 Nov 03 [redacted]
I: 30 T: 0

OTHER INVESTIGATIVE ACTIVITY: About 1700, 8 Nov 03, SA [redacted] Briefed CPT [redacted] [redacted], Office of the Staff Judge Advocate, TF Warrior, KAF, all aspects of this investigation.

Inv: 310 (9.50) Trv: 70 (1.50)

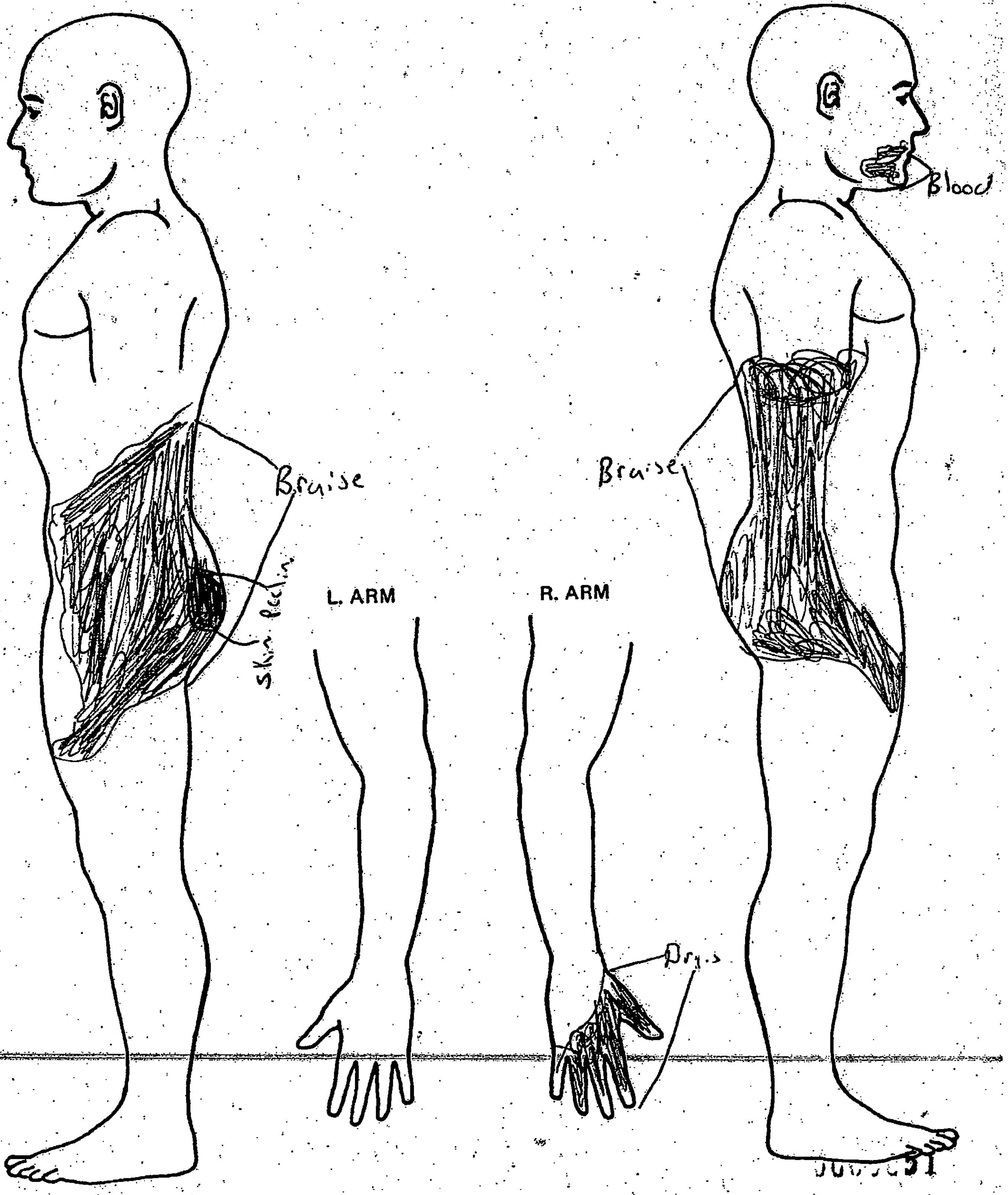
b7C-1, b6-1

1210, 7 Nov 03 – SA [redacted] – Autopsy done – General Surgeon – No C/M [illegible] – told how –
1330, 7 Nov 03 – Contacted by Reg [illegible]
1356 7 Nov updated OK

Full body, male, lateral view.

Name ______________________ Autopsy No. ______________

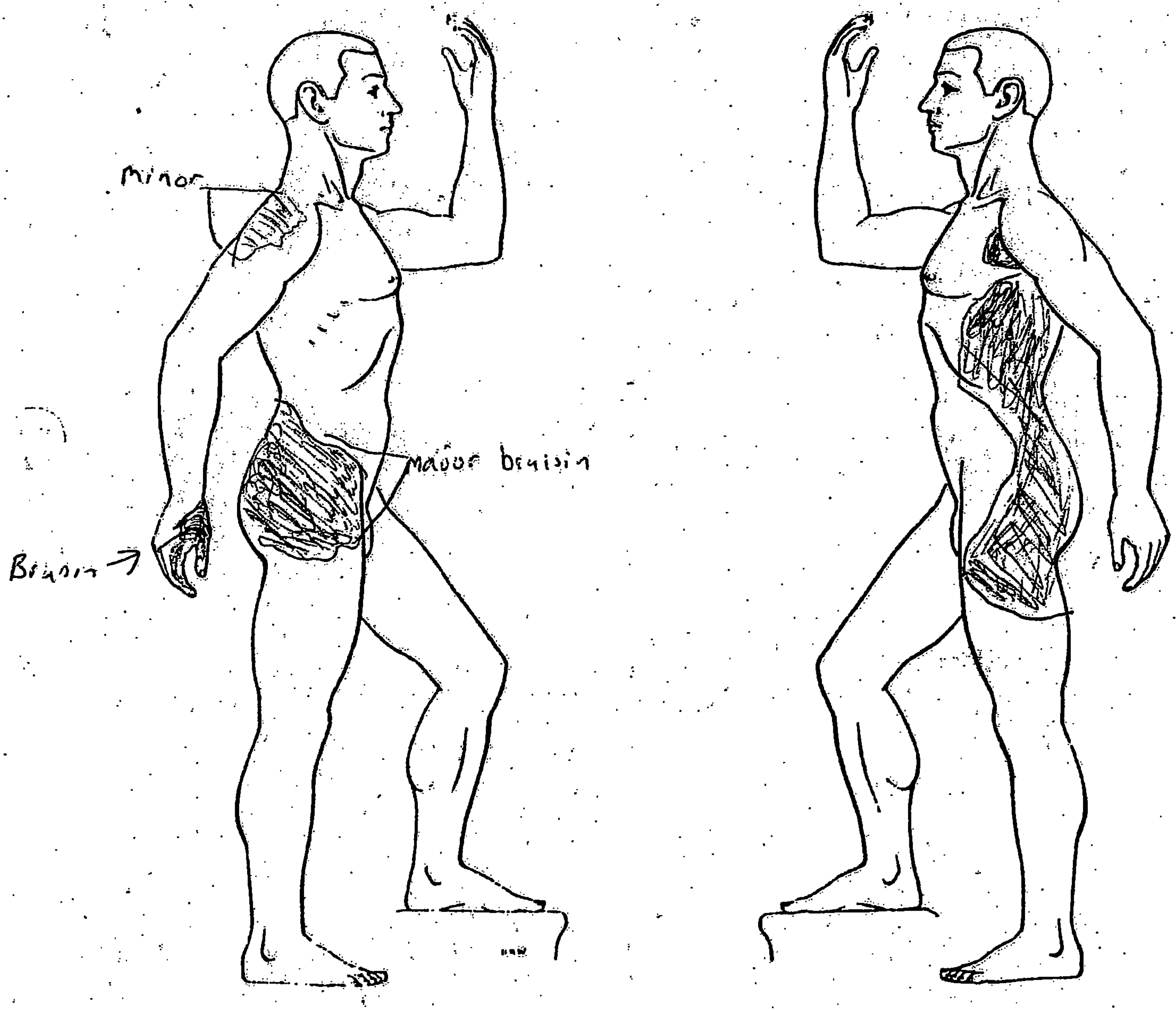
Age ________ Race ________ Sex ________ Date / /



000051

Cat. No. 44-1-005-00

CASE NO. 0174-03-C70369 **NAME** ____________________



FORM B

b7C-4, b6-4

[redacted] - Medic 6NOV03 2305Z SSG

4-6 Z initial insect

noted excessive bruising

but PUC was "in no danger of

imminent death from prior injuries"

All PUC's had these injuries

FB Geresh?

[redacted] b7C-4, b6-4

b7C-4, b6-4

6Nov03 (2130Z) SFC [redacted], A Co 3/3 SFG
7 Nov03 ~~0100~~
(6Nov ⇒ 1515) found person
walked "into" holding facility
A - lying in the middle of floor wrapped
in a blanket

Found PUC dead

b7C-4, b6-4

SFC [redacted] 6 Nov 03 (2144Z)
Received PUC - 4 Nov 03 745 Z
subject standing on his own
understood directions b7C-4, b6-4
evaluated by → SFC [redacted] 180
Normal Health needed no special consideration
Checked with all the other Detainees
6 Nov 03 1030 Z
what's an ODA
what are the "basic complaints
they all express" —

b7C-3, b6-3

CPT [redacted]

b7C-3, b6-3

CPT [redacted] - 3rd Bn 3SG -

b7C-3, b6-3

Maj [redacted] - 3rd SFG

coordination with his higher HQ - Kandahar

- Wazid . . (24 hours) outside the customs

SF - Body been released to family - they ~~had~~ Body is back (2 hours body in posse.

50 yds

14 SF guys

3 of Hesco barriers

IED's

1 SF casualty ←

last week local CE - contract hit

b7C-3, b6-3

open building - holding facility - took it to [redacted]

0~~[illegible]~~ 1200 -

JU C48

b7C-4, b6-4

[redacted] 1300

LTC Clinic TF 41 SJA →

b7C-4, b6-4

[redacted]

3rd Group SJA CPT [redacted]

b7C-3, b6-3

014035

(1053) Dead PUC

Afghan MI — turned over 2 days ago

medic Physical assessment upon arrival

(→ Extensive bruising to butt (common way of punishing in Arab world)

(wax burns - to [redacted] 6K-3, 6b-3

Received AMF — guy was alert/responsive

~~[illegible]~~ Medic —

180 medic — ~~By~~ pre-existent condition

Preliminary Exam — No head/

Abdul - Wahid - Afghani (25-27yrs old)

→

Doctor to do autopsy

Surgean

Page(s)

45____________________.

________________________.

Referred to:

U.S. CENTRAL COMMAND
7115 SOUTH BOUNDARY BLVD
ATTN: CCJ6-DM
MACDILL AIR FORCE BASE
FLORIDA 33621-5101

Master Sergeant Pamela Andrews
andrewsp@centcom.smil.mil
(813) 827-5341/2830

Investigative Plan: 0174-03-CID369-49232

1 - Coordinate for transportation to FOB Gereshk, AF to conduct additional interviews. ( )

2 - Establish 24/48/72 time line of period leading up to WAHID's death. ( )

3 - Brief CDR, TF 33, 3rd Bn, 3rd SFG, KAF. ( )

4 - Interview AMF guard on duty at the time of WAHID's death. ( )

5 - Attempt to identify AMF and local national police force responsible for the interogation of WAHID prior to his being turned over to USSF, FOB Gereshk. ( )

6 - Obtain death certifcate of WAHID. ( )

7 - Obtain final autopsy report. ( )

b7C-1, b6-1
0335, 07 Nov 03
[redacted]
I: 90 T: 0

OTHER INVESTIGATIVE ACTIVITY: b7C-1, b6-1
About 0335, 7 Nov 03, SA [redacted] interviewed SSG [redacted] b7C-4, b6-4
[redacted], A Co, 3rd Bn, 3rd SFG, FOB Gereshk,
AF. SSG [redacted] was identified as the Special Forces medic who b7C-4, b6-4
conducted the initial physical examination of Mr WAHID. SSG
[redacted] related WAHID was lucid, in complete control of all his b7C-4, b6-4
motor functions and he appeared to understand directions.
SSG [redacted] further related in spite of the extensive b7C-4, b6-4
pre-existing injuries, WAHID did not appear to be suffering
any life threatening condition. (See Sworn Statement of SSG
[redacted] for details) b7C-4, b6-4

b7C-1, b6-1
0840, 07 Nov 03
[redacted]
I: 0 T: 40

OTHER INVESTIGATIVE ACTIVITY:
RETURNED TO KAF VIA AIRCRAFT.

b7C-1, b6-1
0930, 07 Nov 03
[redacted]
I: 20 T: 0

OTHER INVESTIGATIVE ACTIVITY:
BRIEFED SAC [redacted], BAF, ON THE STATUS OF THIS b7C-1, b6-1
INVESTIGATION.

b7C-1, b6-1
1200, 07 Nov 03
[redacted]
I: 120 T: 10

OTHER INVESTIGATIVE ACTIVITY:
About 1200, 7 Nov 03, LTC (Dr) [redacted] b7C-3, b6-3
[redacted], General Surgeon, 911th Forward Surgical Team
(FST), Task Force (TF) Warrior, KAF, conducted a physical
examination of WAHID in a effort to ascertain the cause and
manner of death. LTC [redacted] limited his examination to b7C-3, b6-3
opening the chest cavity, obtaining tissue samples of the
liver and heart and samples of blood for toxicology. X-rays
of the body were exposed. Photographs were exposed prior to
and during the examination. (See DA Form 4137 and
photographic packet for details)

AGENT'S COMMENT: SA [redacted] obtained the Standard Form b7C-1, b6-1
509, Progress notes, pertaining to the examination.

b7C-1, b6-1
1430, 08 Nov 03
[redacted]
I: 30 T: 20

OTHER INVESTIGATIVE ACTIVITY:
COORDINATED WITH MORTUARY AFFAIRS TO OBTAIN FLIGHT
INFORMATION TO BAF AND CONFIRM THE REMAINS WERE PROPERLY
STORED IN ANTICIPATION OF AN AUTOPSY AT BAF.

b7C-1, b6-1
1530, 08 Nov 03
[redacted]
I: 20 T: 0

OTHER INVESTIGATIVE ACTIVITY:
BRIEFED SAC [redacted] ON THE SITUATION CONCERNING THE b7C-1, b6-1
REMAINS AND PROVIDED TRANSPORT INFORMATION.

b7C-1, b6-1
1700, 08 Nov 03
[redacted]
I: 30 T: 0

OTHER INVESTIGATIVE ACTIVITY: b7C-4, b6-1
About 1700, 8 Nov 03, SA [redacted] Briefed CPT [redacted] b7C-3, b6-3
[redacted], Office of the Staff Judge Advocate, TF Warrior, KAF,
all aspects of this investigation.

Inv: 310 (9.50) Trv: 70 (1.50)

b7C-1,b6-1

1700, 09 Nov 03 CONTACTED M.E. VIA E-MAIL REGARDING SECOND AUTOPSY. ALSO
[redacted]. FORWARDED HER PHOTOGRAPHS OF WAHID WHEN HE ENTERED FOB,
I: 35 T: 0 AND PHOTOGRAPH TAKEN BEFORE AUTOPSY.

1130, 20 Nov 03 OTHER INVESTIGATIVE ACTIVITY: b7C-1,b6-1 b7C-3,b6-3
[redacted]. About 1130, 20 Nov 03, SA [redacted] briefed LTC [redacted]
I: 60 T: 0 [redacted] Commander, Task Force (TF) 33, 3rd
b7C-1,b6-1 Battalion (Bn), 3rd Special Forces Group (SFG), Kandahar Air Field, APO AE 09355 (KAF), on all aspects of this investigation. SA [redacted] further initiated transportation arrangements to Gereshk, AF. b7C-1,b6-1

1054, 22 Jan 04 PREPARED AND FORWARDED AIR TRANSPORTATION REQUEST FOR
[redacted]. TRAVEL TO FOB GERESHK.
I: 20 T: 0 b7C-1,b6-1

0900, 23 Jan 04 RECEIVED NOTIFICATION FROM THE AVIATION LNO THE SPECIAL
[redacted]. AIR REQUEST TO FOB GERSHK WAS DENIED. WILL SUBMIT
I: 15 T: 0 b7C-1,b6-1 REQUEST FOR RE-SUPPLY RING.

1145, 30 Jan 04
[redacted]. FOLLOWING AAS ENTRY TRANSFERED FROM 0181-03-CID369-49237
I: 10 T: 0 b7C-1,b6-1 THIS AGENT WAS ON EMERGENCY LEAVE IN THE STATES FROM 30
DEC 03 - 15 JAN 04.

1810, 30 Jan 04 PREPARED AND FORWADED AN AIR MISSION REQUEST TO FOB
[redacted]. GERESHK FOR 4 FEB 04.
I: 10 T: 0 b7C-1,b6-1

1000, 02 Feb 04 PREPARED AND FORWARDED VIA E-MAIL RFA TO FT BRAGG RA
[redacted] (CID) RETURNED UNDELIVERABLE.
I: 20 T: 0 b7C-1,b6-1

1800, 04 Feb 04 RESENT RFA VIA E-MAIL TO FT BRAGG RA (CID).
[redacted]
I: 10 T: 0 b7C-1,b6-1

b7C-4,b6-4

0900, 06 Feb 04 RECEIVED CONFIRMATION OF RECEIPT FROM FT BRAGG RA (CID)
[redacted] FOR RFA TO INTERVIEW [redacted] AND [redacted]. THEIR b7C-4,b6-4
I: 15 T: 0 b7C-1,b6-1 SEQUENCE NUMBER 0065-04-CID023, SA [redacted]. b7C-1,b6-1

1400, 11 Feb 04 COORDINATED WITH TF 3/1, SPECIAL FORCES, FOR
[redacted] TRANSPORTATION TO FOB GERESHK. TENTATIVELY SCHEDULED FOR 15
I: 15 T: 0 b7C-1,b6-1 FEB 04 ITH ONE HOUR GROUND TIME.

0800, 12 Feb 04 TRANSPORTATION TO FOB GERESHK WAS SCRATCHED. TRAVEL AND
[redacted] TIME ON GROUND WAS MODIFIED WITHOUT PRIOR NOTIFICATION.
I: 30 T: 0 b7C-1,b6-1 WILL CONTINUE EFFORTS.

Inv: 240 (4.00) Trv: 0 (0.00)

0900, 25 Feb 04 RECEIVED NOTIFICATION FROM FT BRAGG (CID) THAT THE INTERVIEWS REQUESTED VIA RFA HAVE BEEN SCHEDULED.
[redacted]
I: 10 T: 0 b7C-1, b6-1

1925, 24 Mar 04 FORWARDED A REQUEST TO THE FT BRAGG (CID) CHECKING ON THE STATUS OF THE RFA TO INTERVIEW THE 3 SF SOLDIERS.
[redacted]
I: 10 T: 0 b7C-1, b6-1

b7C-4, b6-4

0900, 20 Apr 04 Received/Reviewed case file. Discussed case file with SA [redacted], who related he was awaiting an RFA from Ft. BRAGG pertaining to the interview of SSG [redacted]. SA [redacted] b7C-1, b6-1 related due to ACIRS being down at the Kandahar Field Office, the case file had not been updated.
[redacted]
I: 30 T: 0 b7C-1, b6-1

1617, 20 Apr 04 TC Review:
[redacted] b7C-1, b6-1
I: 120 T: 0

1. Need to determine status of RFA to Ft. BRAGG.

~~2.~~ Need to coordinate with Dr. [redacted], Armed Forces b7C-3, b6-3 Regional Medical Examiner, for cause and manner of death.

~~3.~~ Need to obtain Death Certificate.

4. Need to have BRAGG get a detailed interview from SFC [redacted], SSG [redacted], and SFC [redacted] refernce description of the state the PUC was in once he had been found. The Death Report indicates that SSG [redacted] believed the PUC was in a b7C-4, b6-4 state of Rigor Mortis which is inconsistant with the supposed 10-15 minutes which the gaurd had been out fo the room.

b7C-4, b6-4

5. Need to make sure that the exact state of the PUC is fully described in the statements or another RFA will be going out to BRAGG to re-interview him.

6. There were no canvas interviews conducted at the Detainment facility. We need to go back and see if anyone remembers anything if the unit has not conducted Reliefe In Place (RIP).

7. There are no Death Scene Photographs. Need togo back and obtain photographs of the scene.

b7C-1, b6-1 b7C-4, b6-1

8. In the After Action Report of SA [redacted], CITF-180, SA [redacted] related he obtained numerous photographs, however photographs are not in the case file. Need either the photographs or a Memorandum For Record.

9. Need to make sure that Policy has been established reference Medico-legal advice pertaining to a qualified

Forensic Patholgist be provided in a timely manner, to prevednt confusion on who conducts autopsies on Prisoners Under Control which have expired.

b7C-3,b6-3

10. Need to coordinate with Dr. [redacted] for a preliminary report on findings during the autopsy.

11. Need to obtain copies of the X-ray photographs which had been taken on WAHID during the initial examination by Dr. LTC [redacted] b7C-3,b6-3

b7C-3,b6-3

12. Need to interview Maj [redacted] reference the Medical Record Progress Notes.

13. Need to re-coordinate with OSJA reference legal perspective on the death of a PUC. Added coordination to AIR.

14. Add all infromation to an AIR and update case file.

15. Need to determine what PUCs were in the facility and obtian a translator and conduct canvass interviews of the PUCs.

16. Need to fill out Fingerprint cards. b7C-3,b6-3

17. Need to determine who LTC [redacted] is and either interview or eliminate from the case file.

18. Need to obtian original signed After Action Report from SA [redacted] and add to case file. b7C-1,b6-1

19. Need to determine for what reason the PUC was left unattended, and obtain a copy of the SOP for leaving PUCs unattended.

20. Need to mark all documents with FOUO, case number and Exhibit stamps as needed.

21. Need to correct sketch's to reflect appropriate spelling of Mr. WAHID's name. and correct further discrepencies.

22. Need major activity in case file ASAP as this case is out of CIDR195-1 standards.

23. Need to place case file in appropriate order.

24. Need to update IP and get this case file in order.

25. Case to SAC for review.

Inv: 0 (6.50) Trv: 0 (0.00)

b7C-1,b6-1

1815, 23 Apr 04 CASE TO SAC FOR REVIEW
[redacted]
I: 20 T: 0

24 Apr 04
[redacted]
b7C-1,b6-1

SAC Review:

① Reviewed file. For some unknown reason there are two files for this case. Take the info from the other file and consolidate into this one.

② Very good TC Review agree with all.

③ MAJ [redacted] b7C-3,b6-3 is a significant interview and needs to be completed ASAP! Get verbal over the phone to determine need for written stmt.

④ Someone needs to verify the sketches!

⑤ NOTE! SA [redacted] b7C-1,b6-1 asked an incriminating question of SFC [redacted] b7C-4,b6-4 in his statement w/o advising.

⑥ Update IP.

⑦ There was absolutely no oversight by the previous SAC. Ensure you document ALL discrepanci

AGENTS ACTIVITY SUMMARY (CID Regulation 195-1)	Control Number 0174-03-CID369-49232
TIME, DATE, AND AGENT	SUMMARY OF INVESTIGATIVE ACTIVITY
24 Apr 04 [redacted] I: 20 b7c-1, b6-1	Received case file. Per SAC Guidance: 1. Noted. 2. Noted. 3. Noted. 4. Noted. 5. Unbelievable. Noted. 6. Noted. 7. When Current Case Agent Received case file, on 20 Apr 04, it was noted that there were no AIR's. SA [redacted] related he did not have the ability to create and prints AIR entries. Later it was discovered that there was another case file with pertinent information at Bagram Air Field (BAF), which SA [redacted] did not inform current agent. No Investigative Activity had been conducted on this case since 20 Nov 03. No Follow up with the AFIP Medical Examiner had been conducted. No attempts to Identify or Interview MAJ [redacted] were ever made. As of 24 Apr 04, there is no one remaining at Kandahar Air Field or FOB GERESHK which had any involvement in this investigation.
b7c-1, b6-1 b7c-1, b6-1 b7c-3, b6-3	
b7c-4, b6-4	DELAYED ENTRY: About 0412, 7 Nov 03, the undersigned interviewed SSG [redacted], A CO 3rd BN, 3rd SFG, who related he had conducted the interrogation of Mr. WAHID while in SFG control. (See Statement)
b7c-1, b6-1	DELAYED ENTRY: About 0900, 8 Nov 03, the undersigned was provided a After Action Report (AAR), from Resident Agent-in-Charge [redacted] CITIF, which indicated all actions taken by SA [redacted]. (See AAR)
	DELAYED ENTRY: About 0900, 13 Nov 03, the undersigned received Mr. WAHID's Certificate of Death and a preliminary Autopsy Report A03-144 which indicated Mr. WAHID's manner of death was Homocide and cause of death was Blunt Force Trauma complicated by Rhabdomyolysis.
28 Apr 04	No Investigative Activity 23-27 Apr 04, Case Agent

CID FORM 28
1 Oct 80

PREVIOUS EDITIONS OF THIS FORM WILL BE USED UNTIL EXHAUSTED

AGENTS ACTIVITY SUMMARY **(CID Regulation 195-1)**	**CONTROL NUMBER**
TIME, DATE, AND AGENT	**SUMMARY OF INVESTIGATIVE ACITIVITY**
[redacted] b7C-1,b6-1 I: 20	Awaiting Transportation to KAF.
24 Apr 04 [redacted] b7C-1,b6-1 I: 20	Left a message for the Ft. BRAGG office to contact Case Agent Reference RFA (0065-04-CID023).
1300, 29 Apr 04 [redacted] b7C-1,b6-1 I: 40	About 1300, 29 Apr 04, SA [redacted] b7C-1,b6-1 coordinated with the 125th Finance Bn, KAF, who was unable to locate or identify MAJ [redacted]. b7C-3,b6-3
1500, 29 Apr 04 [redacted] b7C-1,b6-1 I: 20	About 1500, 29 Apr 04, SA [redacted] b7C-1,b6-1 conducted an Outlook Search as well as an Army Knowledge Online search for MAJ [redacted] which met with negative results. b7C-3,b6-3
6 May 04 [redacted] b7C-1,b6-1 I: 20	No Investigative Activity 30 Apr 04-5 May 04, as case agent was working priority Death Investigation 0044-04-CID369-69272.
1200, 6 May 04 [redacted] b7C-1,b6-1 I: 20	Attempted to Email SA [redacted] b7C-1,b6-1 reference the RFA forwarded to Ft. BRAGG. The email was returned stating that the email address was no longer active.
11 May 04 [redacted] b7C-1,b6-1 I: 20	SAC COMMENT: On 10 May 04, this office merged from the ACIRS database to the ACI2 database. This office will use MS Word CIDF28 to document all activity, because of the length of time it takes to make one entry in ACI2. All man hours will be documented in the ACI2 application. AIRs will be generated in MS Word, and their information will be copy and pasted in ACI2 once approved by the SAC. All ACI2 errors will be documented in an AAS entry and other reports, as appropriate.
0930, 12 May 04 [redacted] b7C-1,b6-1 I: 20	About 1200, 7 May 04, SA [redacted] b7C-1,b6-1 briefed CPT [redacted] b7C-3,b6-3 Office of Staff Judge Advocate (SJA), Kandahar Air Field (KAF), Afghanistan, on the status of this b7C-3,b6 investigation. CPT [redacted] opined Mr. WAHID's death was a result of injuries he received in the custody of the Afghanistan Militia Force (AMF), and there had been no wrong doing by the American Forces.
0930, 12 May 04 [redacted] b7C-1,b6-1 I: 20	About 0930, 12 May 04, SA [redacted] b7C-1,b6-1 received an electronic generated Final Autopsy Report, substitute for SF 503, A03-144, which indicated that the cause of Mr. WAHID's death was Multiple Blunt Force Injuries complicated by Rhabdomyolysis, and the manner of death was Homocide. (See AIR)

CID FORM 28
1 Oct 80

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AGENTS ACTIVITY SUMMARY (CID Regulation 195-1) b7c-3, b6-3	CONTROL NUMBER b7c-1, b6-1
TIME, DATE, AND AGENT	**SUMMARY OF INVESTIGATIVE ACITIVITY**
1700, 13 May 04 [redacted] b7c-1, b6-1 I: 30	About 1700, 13 May 04, SA [redacted] coordinated with LTC [redacted] in an attempt to prepare a timeline in which the injuries would have occurred and amount of injuries to the time of death.
17 May 04 [redacted] b7c-1, b6-1 I: 30	Prepared STATUS Report. STATUS to SAC For approval.
2100, 17 May 04 [redacted] b7c-1, b6-1 I: 20	Attempted to contact Ft. BRAGG. No Answer.
18 May 04 [redacted] b7c-1, b6-1 I: 20	Case to SAC for review.
20 May 04 / [redacted] b7c-1, b6-1	Received descrepancy notice from HQUSACIDC which noted that the Initiated year should read 2003, Opened the case in ACI2 and noted in was 1903, which is contributed to the transfer of data from ACIRS to ACI2.

CID FORM 28
1 Oct 80

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014078

AGENTS ACTIVITY SUMMARY (CID Regulation 195-1)	Control Number 0174-03-CID369-49232
TIME, DATE, AND AGENT	**SUMMARY OF INVESTIGATIVE ACTIVITY**
19 May 04 b7C-1,b6-1 [redacted] I: 40	Prepared an Update RFA and forwarded to the Ft. BRAGG Office requesting further Investigative activity.
19 May 04 b7C-1,b6-1 [redacted] I: 40	Prepared an RFA and forwarded to the Kaiserslautern, GE, CID Office, requesting medical coordination's.
20 May 04 b7C-1,b6-1 [redacted] I: 20	Received case file. Per SAC Guidance: 1. Noted.
20-25 May 04 [redacted] b7C-1,b6-1 I: 20	No Investigative Activity. Pending Return to Kandahar Air Field, Afghanistan.
26 May 04 [redacted] b7C-1,b6-1 I: 25	b7C-1,b6-1 Coordinated with SA [redacted], Ft. BRAGG, and requested an update on the RFA.
27 May-10 Jun 04 [redacted] I: 20 b7C-1,b6-1	No major Investigative Activity Between 27 May 04 to 10 Jun 04. Worked priority Category I investigations 0064-04-CID369-69280.
3 Jun [redacted] I: 25 b7C-1,b6-1	Notified RFA to K-Town would be completed ASAP, as LTC [redacted] was currently TDY. b7C-3,b6-3
3 Jun [redacted] I: 25 b7C-1,b6-1	b7C-1,b6-1 Received an update on the RFA from SA [redacted], Ft. BRAGG.
1200, 12 Jun 04 [redacted] I: 20 b7C-1,b6-1	b7C-3,b6-3 Received notification from Dr. [redacted], Landstuhl, GE, who related that she believed the injuries occurred while in AMF custody and the rhabdomyolysis was consistent with the timeline from which Mr. WAHID expired due to his injuries.
1000, 13 Jun 04 [redacted] I: 20 b7C-1,b6-1	b7C-1,b6-1 About 1000, 13 Jun 04, SA [redacted] coordinated with LTC [redacted], Armed Forces Regional Medical Examiner, Landstuhl Regional Medical Center, GE, who related in her medical opinion Mr. WAHID's injuries would have caused rhabdomyolysis, which would have set in about 24 to 48 hours causing Mr. WAHID to expire. Which is consistent with the time frame from which Mr. WAHID was handed over from AMF custody to USSF personnel. LTC [redacted] further related during the autopsy no other injuries were discovered after the documented injuries had occurred. (See AIR) b7C-3,b6-3 b7C-3,b6-3

CID FORM 28
1 Oct 80

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AGENTS ACTIVITY SUMMARY **(CID Regulation 195-1)**	**CONTROL NUMBER**
TIME, DATE, AND AGENT	**SUMMARY OF INVESTIGATIVE ACTIVITY** b7C-3,b6-3
13 Jun 04 [redacted] b7C-1,b6-1 I: 20	Briefed SAC on receipt of LTC [redacted], Medical Opinion.
14 Jun 04 [redacted] b7C-1,b6-1 I: 20	b7C-1,b6-1 b7C-2,b6-2 On 14 Jun 04, SA [redacted] coordinated with CW5 [redacted] Operations Officer, 3d MP Grp (CID), who agreed that based on the facts of this case there was no U.S. personnel involved or assisted in the death of Mr. WAHID. Therefore, this investigation will be closed.
14 Jun 04 [redacted] b7C-1,b6-1 I: 20	Coordinated with Ft. BRAGG and requested the RFA be closed and the results be forwarded to the Bagram Airfield, CID Office.
23 Jun 04 [redacted] b7C-1,b6-1 I: 145	Prepared case file for closure. Case to SAC.
b7C-1,b6-1 23 Jun 04/[redacted]	SAC Review: Make minor corrections to Final(C).
b7C-1,b6-1 23 JUN 04/[redacted]	Corrections completed Awaiting receipt of RFA from Ft. Bragg.

CID FORM 28
1 Oct 80

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AGENTS ACTIVITY SUMMARY
(CID Regulation 195-1)

Control Number
0174-03-CID369-49232

b7C-1,b6-1

TIME, DATE, AND AGENT	SUMMARY OF INVESTIGATIVE ACITIVITY
0830/27 Jul 04 b7C-1,b6-1 [redacted]	Received email information report from CW4 [redacted] Ft Bragg district. Provided the information to SA [redacted] for input into the Final Report. The hard copy Information Report with enclosures is en route. b7C-1,b6-1
13 Aug04 b7C-1,b6-1 [redacted] I: 20	Received hard copy Info Report. Missing Last/2nd Page of SFC [redacted] statement. Added to Final Report. b7C-4,b6-4

:2

000044

014081

Page(s)

29-32.

__________.

Withheld due to:

____ Foreign Language

____ Photos depicting Americans

____ Photos depicting foreign nationals

X Civilian Agency Records

DEPARTMENT OF THE ARMY
AFGHANISTAN MP DET (CID)
3D MILITARY POLICE GROUP (CID)
BAGRAM AIR FIELD
APO AE 09354

REPLY TO
ATTENTION OF

CICR-EF 18 May 04

MEMORANDUM FOR RECORD

SUBJECT: Operational Review of 0174-03-CID369-49232

1. On 10 May 04, this office received a Request for Investigation (0212-04-CID001) from Headquarters, USACIDC, requesting this office to conduct an operational review of all detainee deaths and other crimes against detainees by U.S. Military personnel.

2. On 18 May 04, the undersigned conducted an operational review of the above referenced Report of Investigation (ROI) and determined that it was operationally insufficient. This ROI was initiated on 6 Nov 03, and the undersigned assumed operational responsibility of the ROI on 20 Apr 04. Even though this is an open investigation, some of the investigative leads should have been accomplish prior to 20 Apr 04. There were no operational reviews conducted on this ROI prior to 20 Apr 04. During the operational review, the following investigative leads were identified as being outstanding:

b7c-3, b6-3

a. Locate, fully identify, and interview Dr. (MAJ) [redacted] (conducted the examination of Mr. WAHID after his death).

b. Pending an RFA which was forwarded to Ft Bragg Resident Agency on 4 Feb 04, to re-interview three Special Forces personnel who had direct contact with the decedent. A 2nd RFA is forthcoming to Ft Bragg RA, in order to ensure they ask specific questions of the interviewees, which was not originally detailed in the original RFA.

c. No canvass interviews were conducted during the preliminary investigation.

d. No documentation showing that death scene photographs were exposed.

e. Coordination with the pathologist, Landstuhl Regional Medical Center, to inquire if the pathologist could determine if the injuries which eventually caused the demise of Mr. WAHID, could corroborate the interviews of U.S. military personnel in that the injuries were caused by Afghan Military Forces (AMF).

f. This investigation was also administratively insufficient, and is currently being adjusted to meet the standards of CIDR 195-1 and FM 19-20.

3. All indications and facts are leaning toward the AMF causing the injuries, which eventually led to the demise of Mr. WAHID. After the above leads are accomplished, and there is no other indication of U.S. military personnel involvement in the death or abuse of Mr. WAHID, this a Status Report will be generated changing the unknown subject to an unknown Afghan Military Forces subject, and then a Final Report will be dispatched.

4. POC for this action is the undersigned at DSN: [redacted] or email: NIPR [redacted]@baf.afgn.army.mil, SIPR [redacted]@baf.cjtf76.army.smil.mil.

b7c-1, b6-1

b7c-1, b6-1

b7c-1, b6-1

[redacted]
CW3, MP
Special Agent-in-Charge

No Encl

0000028

014068

[redacted] b7c-3, b6-3

b7c-1, b6-1

From: [redacted] CW3
Sent: Tuesday, November 18, 2003 4:25 PM
To: [redacted] b7c-3, b6-3
Subject: FW: Undetermined death

b7c-1, b6-1

-----Original Message-----
From: [redacted] - OEF
Sent: Thursday, November 06, 2003 12:43 PM
To: [redacted] (E-mail) b7c-1, b6-1
Subject: Undetermined death

Chief,

I'm in the office, 1715Z, 6 Nov 03, and I just got notified a few minutes ago of an undetermined death. The Special Forces SJA came by and said he just got notified that earlier this evening, a Person Under Control (PUC), located at the Geresh Forward Operating Base (FOB), that had been turned over by the Afghanistan Military Forces (AMF), was alive. Later in the day they went back to feed and water him and we was discovered dead. Tomorrow morning at about first light I will be heading out with a convoy that includes, probably, the Commander of the SF Group that's hear, a medical doctor, myself, SF SJA, and a few other strap hangers to get the details. As it stands right now that is about all we have. We were told that the PUC may have been a High Value Target (HVT) as it is believed he confessed to involvement in a number of actions against coalition forces. SA [redacted] says he's going too and of course I didn't discourage him as he has more experience with the PUC side of the house. I've tried to call but you number is busy. I am going to continue trying but if you get this message before I get a hold of you I should be here for a little while longer.

b7c, b6

[redacted]

SA [redacted] b7c-1, b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355
DSN: [redacted] b7c-1, b6-1
DNVT: [redacted] b7c-1, b6-1
"Do what has to be done"

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b7C-3, b6-3

[redacted] b7C-1, b6-1

From: [redacted] CW3
Sent: Tuesday, November 18, 2003 4:26 PM
To: [redacted] b7C-3, b6-3
Subject: FW: Call SAC - getting hammered by Command about Autopsy

ABDUL WAHID BACK 041103.JPG
ABDUL WAHID FRONT 041103.JPG

-----Original Message-----
From: [redacted] - OEF
Sent: Friday, November 07, 2003 9:43 AM
To: [redacted] CW3
Subject: RE: Call SAC - getting hammered by Command about Autopsy

b7C-3, b6-3 b7C-3, b6-3

Chief,
I just finished talking to CPT [redacted], SF's SJA, and he explained the decision to conduct the autopsy was coordinated, beginning with LTC [redacted], Commander, 3rd Battalion, 3rd Special Forces Group, then to CJTF180, CJSOTIF, and all the way back to Ft Bragg, NC. He also explained because that SF Team does a lot of humanitarian work out there at the fire base they have had a few local nationals, excuse the term, expire on them. He, the SF Team Commander, a CPT, didn't think anything of it to release the body. b7C-3, b6-3 It was after the report went up that he was told that's not the way it's done so he b7C-3, b6-3 requested the family return the remains. It was MAJ (Dr) [redacted], Battalion Surgeon, 3rd Battalion, 3rd Special Forces Group, KAF, that went out to the fire base with us and conducted the preliminary physical examination on the remains. The decision to use LTC (Dr) [redacted] 10th Mtn Div, was made as he was the most qualified person in b7C-3, b6-3 theatre. The remains are currently located on KAF, at mortuary affairs, and I can certainly stop any movement of them if a ME is required. Again in my own defense I had people, much more qualified than I, render professional medical opinions that there were no outward signs of anything criminal. This PUC, Mr Abdul WAHID, until he was discovered had been responsive, moving under his own power, and did not exhibit any signs of distress. I know it may appear that I left a lot out of this but again I had three Special Forces Medics and two physicians tell me that there were no external signs of foul play. Based on the extent of the beating this guy received before he even arrived at the fire base I'm surprise he lasted as long as he did. I will attach some photographs so you can get an idea of the extent of the injuries.

The two images I have attached to this e-mail are of the injuries he presented to the fire base with. I will send a second e-mail with images of how we found him this morning.

SA [redacted] b7C-1, b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355
DSN: [redacted] b7C-1, b6-1
DNVT: [redacted] b7C-1, b6-1
"Do what has to be done"

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-----Original Message-----
From: [redacted] CW3 [mailto:[redacted]@baf.cjtf180.army.mil] b7C-1, b6-1
Sent: Friday, November 07, 2003 8:50 AM
To: [redacted] - OEF b7C-1, b6-1
Subject: Call SAC - getting hammered by Command about Autopsy

b7C-3, b6-3 b7C-3, b6-3

[redacted]: Give me a call right away. I've got [redacted] on my ass, as well as several medical examiners as to how the decision was made to autopsy the PUC.

[redacted] b7c-3,b6-3

From: [redacted] CW3 b7c-1,b6-1
Sent: Tuesday, November 18, 2003 4:27 PM
To: [redacted] b7c-3,b6-3
Subject: FW: Pre-autopsy photo

-----Original Message----- b7c-1,b6-1
From: [redacted] -OEF
Sent: Friday, November 07, 2003 9:53 AM
To: [redacted] (E-mail) b7c-1,b6-1
Subject: Pre-autopsy photo

Chief,
I am only attaching one image to this e-mail. Heads up as it is quite graphic. You will see the extent of the bruising around the pelvic region, it is not liver mortis, it is bruising. You'll also see the extent of the burns to his chest area. Remember all of this was done to him prior to his being turned over to the Special Forces Team down there.

DSCN0034.JPG

SA [redacted] b7c-1,b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355
DSN: [redacted] b7c-1,b6-1
DNVT: [redacted] b7c-1,b6-1
"Do what has to be done"

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b7c-3,b6-7

[redacted]

b7c-4,b6-4

From: [redacted] CW3
Sent: Tuesday, November 18, 2003 4:26 PM
To: [redacted] b7c-3,b6-3
Subject: FW: In my defense

b7c-1,b6-1

-----Original Message-----
From: [redacted] - OEF
Sent: Friday, November 07, 2003 10:23 AM
To: [redacted] (E-mail) b7c-1,b6-1
Subject: In my defense

Chief,
We received notification about 2130, 6 Nov 03, by 2400, 6 Nov 03, we were on a Black Hawk helicopter to a fire base about 30 minutes flight time northeast of Kandahar. We did a hot landing, basically they pushed us and our equipment out of the aircraft and took off. We were met by two HUMVEE's with 50 Cal machineguns mounted on them. We went to this God forsaken fire base where we were told until a few hours ago this guy was alive and apparently doing okay. Nobody saw this guy in any kind of distress. If necessary I will go back out there and talk to everyone that was in the compound at the time of his untimely demise. To date there sure hasn't happened too much for you to have any confidence in me but I did everything I thought we were suppose to do. There wasn't any indication of foul play, as related by three SF medics, a SF Intel guy, and two physicians. I don't know if this whole autopsy thing was just done so that this wouldn't happen and it happened anyway. I haven't seen an SOP that tells me that PUC's in our facilities get autopsied by a Medical Examiner. I did coordinate with Mortuary Affairs and explained to them they are not to release the remains until they've talked to me. ~~Am I to understand the CJTF180~~ Surgeon is making arrangements to have a ME brought in? Anyway I know sorry doesn't fix but I certainly know enough of what needs to be done to believe I was doing it before this blew up in our face. I'm still in my office and will be until you call.

SA [redacted] b7c-1,b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355 b7c-1,b6-1
DSN: [redacted]
DNVT: [redacted] b7c-1,b6-1
"Do what has to be done"

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b7c-3,b6-3

[redacted]

b7c-1,b6-1

From: [redacted] CW3
Sent: Tuesday, November 18, 2003 4:27 PM
To: [redacted]
Subject: FW: Air Mission

-----Original Message----- b7c-1,b6-1
From: [redacted] - OEF
Sent: Saturday, November 08, 2003 4:25 AM
To: [redacted] (E-mail) b7c-1,b6-1
Subject: Air Mission

Chief,
This is the information we discussed.

Mission #: [redacted] b7E
Flash #: [redacted] b7E
Wheels down (here): 0645Z, 9 Nov 03 (figure about 3 hours turn around and 1 1/2 hour flight time)
TCN: [redacted] b7E

b7c-3,b6-3

As I explained I spoke with SGT [redacted] NCOIC, Mortuary Affair, KAF who explained the remains is currently in the freezer and will be iced approximately 30 minutes prior to shipping.

Mortuary Affairs Bagram: SGT [redacted], NCOIC, [redacted] b7c-3,b6-3

Hope this helps and I'm working on the initial right now.

SA [redacted] b7c-1,b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355
DSN: [redacted] b7c-1,b6-1
DNVT: [redacted] b7c-1,b6-1
"Do what has to be done"

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[redacted] b7C-3, b6-3

b7C-1, b6-1

From: [redacted] CW3
Sent: Tuesday, November 18, 2003 4:28 PM
To: [redacted] b7C-3, b6-3
Subject: FW: Tasker out from TF 44, Bagram

-----Original Message----- b7C-1, b6-1
From: [redacted], CW3
Sent: Sunday, November 09, 2003 7:28 AM
To: [redacted] SrA LND b7C-3, b6-3
Subject: Tasker out from TF 44, Bagram

b7C-3, b6-3

Ma'am: I coordinated face-to-face with COL [redacted], TF 44, Bagram, AF, and relayed what you requested. He called in the information for the tasker - four pax (yourself, assist M.E., forensic dentist, and mortuary affairs specialist). He reqeusted priority on the flight. In order to put the tasker in they had to go through CENTCOM, then to EUCOM to USAREUR. Once I hear more information as to specifics, I will pass that on by e-mail.

He relayed to mortuary affairs, your concerns regarding temperature control.

WAHID's remains arrived, two of our SA's went there to make sure all is in order. They just made it back. They exposed photographs (35mm) of the remains. They also coordinated with morturary folks, per your request. Nothing outstanding was noted.

b7C-3, b6-3

LTC [redacted], the general surgeon who performed the autopsy at Kandahar, will be ordered up here to Bagram until you are completed with your work. COL [redacted] will replace him with another surgeon for the time he is up here.

I will also try to send the photos I had told you back in additional messages.

b7C-1, b6-1

CW3 [redacted]
Special Agent in Charge
87th MP Det (CID) (Fwd)

[redacted] b7c-3, b6-3

From: [redacted] CW5 CJTF7-Field Ops. Officer b7c-3, b6-3
Sent: Monday, November 17, 2003 8:10 PM
To: [redacted] b7c-3; b6-3
Subject: RE: Status ROI on death case

[redacted] b7c-1, b6-1

Remain the offense as "Undetermined Death" until you get the final autopsy report. Her findings are preliminary. [redacted]

(b)7c-3, b6-3

-----Original Message-----
From: [redacted]
Sent: Monday, November 17, 2003 10:36 AM
To: [redacted] CW5 CJTF7-Field Ops. Officer b7c-3, b6-3
Subject: Status ROI on death case

Chief: I am about to do a Status ROI on the death case involving the Afghani who died at the Special Forces forward operating base. The Regional M.E. and her team performed their forensic autopsy on Thursday; which we attended. On Saturday, 15 Nov 03, she provided us with her Preliminary Autopsy Report, which states the Manner of Death is Homicide, with Cause of Death listed as "Multiple Blunt Force Injuries Complicated by Probable Rhabdomyolysis." She also provided us with an overseas Certificate of Death, which has the same Manner and Cause.

She related to us that the victim died because his system, primarily kidneys and liver, were not able to filter the higher than normal level of toxins produced when his body tried to heal the massive muscle damage inflicted on him before he was transported to the SF FOB.

Besides giving you a heads-up, I also just double checking with you. I have had some instances where we (CID) would prefer to wait until we receive the Final Autopsy Report before we go with the status changing from Undetermined; however, I don't feel this is a problem in this case because the M.E. already provided a Certificate of Death.

[redacted] b7c-1, b6-1

From: [redacted] CW3 b7c-1, b6-1
Sent: Friday, November 21, 2003 3:31 PM
To: [redacted] b7c-1, b6-1
Subject: FW: 0177-03, Missing NVG's, C Co, 10th Sig Bn

-----Original Message----- b7c-1, b6-1
From: [redacted] - OEF
Sent: Tuesday, November 18, 2003 2:10 AM
To: [redacted] CW3 b7c-1, b6-1
Subject: RE: 0177-03, Missing NVG's, C Co, 10th Sig Bn

[redacted] b7c-1, b6-1

b7c-1, b6-1

Hey it's [redacted]. I can provide some limited detail about the interviews/interrogations (understanding that this if off the record, due to classification of Intel reports). WAHID was a Taliban operative (working in assassination and coalition force disruption). I can't say much more than that without compromising the reports. Now something to remember is that he confessed to this to the AMF (under duress and an ass whopping), and reiterated this to USSF at the FOB. He would have been sent forward to KAF or BAF detention, for future interrogation had he lived. There is currently no Afghani law against AMF beating there people down (although, we frown against it) during interrogations - we see it a lot.

b7c-3, b6-3

Reason no callalous' to his hands and feet is due to the nature of his business and local society. Think about this? A US Soldier climbs up and down hills and gets blisters, and [redacted] climbs the same hills and never breaks a sweat, why? He/she is used to it. These people are hard core when it comes to this climate and living conditions. Question I have for you to consider is how do you charge [redacted] AMF for murder if they committed this crime (only illegal in the states and other civilized countries ha, ha)? Which more than likely occurred. I understand why we are conducting the investigation to clear US Forces of wrong doing, but, how do we unfound/found this case in the event that more than likely the AMF did it? I ask because this is one of those cases when you know it's going to happen again, and I was surprised that it hadn't happened before this case. b7c-3, b6

b7c-1, b6-1

Also, [redacted] asked me (before the initial went out) if I could find additional Bio info. What you have is what USSF obtained from the kid before death. DOB is hard to relate to here as there calendar is totally different than ours. Address is normally just a vill. name, and there is no real tracking by numbers (i.e. our SSN #'s in the states). What you have is actually all we (USSF/ CITF and MI) obtain, sorry!

b7c-1, b6-1

[redacted] asked me to see if we (probably you there) can obtain how long it would have taken for the Acid to build up and cause a caustic reaction to the body, and then ultimately cause death? Curious enough this may be a good point to make determining how long before death would have occurred, eliminating some of the USSF of wrong doing. One more thing from [redacted], he is going to send the Statements he took from the USSF personnel that interacted with the Detainee prior to his death (I'm [redacted] secretary now! ha, ha) for your review to see if all questions were answered (?). b7c-1, b6-1 b7c-1, b6-1

One last thing, would you like for me to check and see if we can have the reports declassified for adding to the report (which probably will not happen), or you can increase the level of the classification of your report, which I would think isn't necessary in this case (my opinion only). [redacted] involvement in Taliban/ AQ isn't really necessary to prove no wrong doing on part of USSF. b7C-1, b6-1

Hopefully, I've helped you a little, and offered good points for consideration.

Thanks,

[redacted] b7c-1, b6-1

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-----Original Message-----
From: [redacted] CW3 [mailto:[redacted]@baf.cjtf180.army.mil] b7C-1, b6-1
Sent: Monday, November 17, 2003 8:15 AM b7C-1, b6-1
To: [redacted] - OEF
Subject: RE: 0177-03, Missing NVG's, C Co, 10th Sig Bn

b7C-1, b6-1

[redacted] Take a look at the synopsis in ACIRS, and make sure it is factually correct. I tweaked it a little. Also update your AAS's. Go ahead and index him, and build the report if it s factually correct. Make sure you do a spell check, too. E-mail me when it is ready. Sorry, it took me a day or so to look at this - I just love these lost equipment cases.

Also, the M.E. finished her autopsy before the weekend. She ruled Manner of Death "Homicide." I will try to update my AAS entries in that file. Get your IP ready in ACIRS, so I can take a look at what you have planned. I will print out an IP up here, and put it in the case file. You can work off another copy. You will need to go back out to the FOB, or call those guys in, whichever you can work out. We need specific questions about this guys condition, behavior. One of the big questions, of course, is make sure nothing further was done to this guy after he arrived in the FOB. Since he is dead, I don't think it will comprimise anything if you ask them who this guy was. He obviously wasn't a foot soldier in Taliban/Al Quada because his feet and hands did not appear to be callused. We need to find out why they didn't just turn him back to the Afghani's. It appears that the medic or somebody missed it in the evaluaion that this guy was in serious condition. The doc's Cause of Death was Blunt Force Trauma /Complicated by Probable Rhabdomyolysis. I haven't done any research on it, but according to the guys, who attended the autopsy, this means that the kidneys/liver were not able to filter out all of the toxins created in the blood as his body reacted to all the destroyed muscle tissue. In the healing process, there is apperently a lot of acid released, and there was so much acid released, that his kidneys/liver were not able to filter it out sufficiently, and he died as a result.

b7C-3, b6-3

I was getting ready to do a Status ROI changing manner from Undeterminede to Homicide, based on the Death Certificate and Preliminary Autopsy Report. I gave Mr [redacted] a heads up I was about to do this. He said hold the presses; let's wait for the Final Autopsy Report. But, consider it a Homicide case. You need to resort to the old 72/48/24 hour time line on this guy. You will probably have trouble with the 72 to 48 hours, but give it a good shot. Balls back in your court.

b7C-1,b6-

[redacted] - OEF

From: [redacted] SA [redacted]@bragg.army.mil] b7C-1,b6-1
Sent: Tuesday, February 24, 2004 8:03 AM
To: [redacted] - OEF b7C-1,b6-1
Subject: RE: Request for Assistance, ROI: 0174-03-CID369-49232

Sir,
I am just now getting to the interviews, we were finally able to get to one of the three SF guys yesterday. I will interview him at 0930, today, and then I will go directly to the unit and track down the other two. I will try to close this out before the end of the week, if there is anything else that you need, please let me know.

V/R,
SA [redacted] b7C-1,b6-1
87th MP DET (CID) (ABN) DSE
Fort Bragg, NC 28310
[redacted] b7C-1,b6-1
Fax: (910)396-[redacted]

-----Original Message-----
From: [redacted] - OEF b7C-1,b6-1
Sent: Thursday, February 05, 2004 1:16 AM
To: [redacted] SA b7C-1,b6-1
Cc: [redacted] SA b7C-1,b6-1
Subject: Request for Assistance, ROI: 0174-03-CID369-49232

SA [redacted] b7C-1,b6-1
Part III b7C-4,b6-4

<< File: 0174-03, Statement (SSG [redacted]).pdf >>

SA [redacted] b7C-1,b6-1
Special Agent-in-Charge
Afghanistan MP Detachment (CID)
Kandahar Air Field Branch Office (CID)
Afghanistan, APO AE 09355
DSN: [redacted] b7C-1,b6-1
DNVT: [redacted] b7C-1,b6-1
"Do what has to be done"

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[redacted] **SAC, CICR-EF - OEF** b7C-1,b6-1

From: [redacted] SA [redacted]@bragg.army.mil] b7C-1,b6-1
Sent: Wednesday, April 14, 2004 10:04 AM
To: [redacted] SAC, CICR-EF - OEF b7C-1,b6-1
Subject: RE: RFA, ROI: 0174-03-CID369-49232

b7C-4,b6-4

Sir, I have interviewed SSG [redacted], the other two were not at the unit, I will call over there this morning and see if they are back. I will get those interviews done ASAP and get them out to you.

-----Original Message-----
From: [redacted] SAC, CICR-EF - OEF b7C-1,b6-1
Sent: Tuesday, April 13, 2004 2:25 PM
To: [redacted] SA b7C-1,b6-1
Subject: RFA, ROI: 0174-03-CID369-49232

SA [redacted]

I'm writing to inquire as to the status of this RFA and the interviews of the three service members. My last correspondence with you was on 24 Feb 04, and I have yet to hear whether or not the interviews have been completed. Could you please provide me with an update on this action? Thank you in advance.

[redacted] b7C-1,b6-1
Special Agent-in-Charge
87th Military Police Detachment (ABN)(CID)(FWD)
Kandahar Branch Office (CID)
Kandahar Airfield
Kandahar Afghanistan
APO AE 09355
DSN: [redacted] b7C-1,b6-1
DSN (fax): 841 [redacted]
"Do What Has to be Done"

DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
3D MILITARY POLICE GROUP (CID)
AFGHANISTAN MILITARY POLICE DETACHMENT (CID)
KANDANAR AIR FIELD, AFGHANISTAN
APO AE 09355

REPLY TO
ATTENTION OF

CICR-EF (195-1) 2 February 2004

MEMORANDUM FOR Special Agent-in-Charge, 87th Military Police Detachment (ABN)(CID)(DSE), 3D Military Police Group (CID), USACIDC, Building 8 1221 Randolph Street, Fort Bragg, NC 28310

SUBJECT: Request for Assistance (RFA) (0174-03-CID369-49232)

1. This office is conducting an investigation pertaining to the Undetermined Death of a local national Person under custody (PUC).

2. This investigation was initiated upon notification by CPT [redacted], Office of the Staff Judge Advocate, 3rd Battalion, 3rd Special Forces Group, Kandahar Air Field, APO AE 09355 (KAF), who reported a local national, being detained by US Special Forces (USSF), and guarded by the Afghanistan Militia Forces (AMF), at the Forward Operating Base (FOB) Gereshk, Helmand Province, Afghanistan (AF), WAHID was discovered by an AMF guard crumpled on the floor of a holding area deceased. b7c-3, b6-3

3. Efforts to conduct follow-on interviews of three individuals assigned to FOB Gereshk, AF who had direct contact with WAHID have met with negative results.

b7c-3, b6-3

4. Request your office conduct follow-up interviews of the following individuals: SFC [redacted], SFC [redacted], and SSG [redacted], all of A Company, 3/3rd Special Forces Group, Ft Bragg, NC 28310. Specifically request the questioning to focus on the specifics of their personal interaction with WAHID, specifically any complaints and the nature of them, the depth of the physical assessment upon receipt of WAHID at FOB Gereshk, AF and if there is a Standard Operating Procedure pertaining the receipt and processing of PUC's upon their arrival at the FOB b7c-4, b6-4 b7c-4, b6-4

5. The point of contact regarding this is the undersigned at DSN: [redacted] or email [redacted]@kaf.cjtf180.army.mil b7c-1, b6-1

[redacted] b7C-4,b6-4
WO1, MP
Special Agent-in-Charge

Encl:
1. Initial Report
2. CIDF 44 and statement of, SFC [redacted] b7C-4,b6-4
3. CIDF 44 and statement of SFC [redacted] b7C-4,b6-4
4. CIDF 44 and statement of SSG [redacted] b7C-4,b6-4

[redacted] b7C-1, b6-1

From: [redacted] SA [redacted]@us.army.mil] b7C-1, b6-1
Sent: Thursday, May 20, 2004 3:15 AM
To: [redacted] b7C-1, b6-1
Cc: [redacted] SA b7C-1, b6-1
Subject: RE: RFA b7C-3, b6-3
Sensitivity: ~~Confidential~~ UNCLASSIFIED

[redacted] SECURITY MANAGER, USACIDC

SA[redacted] b7C-1, b6-1

b7C-1, b6-1

It was sent to SA[redacted] so we will get you one. I cc'd the case agent on this so you can go direct with him.

Keep your head down.

SA[redacted] b7C-1, b6-1

[redacted] b7C-1, b6-1
SPECIAL AGENT IN CHARGE
87TH MP DETACHMENT (CID)(ABN)(DSE)
FORT BRAGG, NC 28310-5000
[redacted]DSN: 236 FAX 8595 b7C-1, b6-1
CELL[redacted] b7C-1, b6-1
"STRENGTH AND HONOR"

-----Original Message-----
From: [redacted] [mailto[redacted]@baf.afgn.army.mil] b7C-1, b6-1
Sent: Thursday, May 20, 2004 4:27 AM
To: [redacted] SA b7C-1, b6-1
Subject: RFA
Importance: High
Sensitivity: ~~Confidential~~ UNCLASSIFIED

SA[redacted] b7C-1, b6-1

I am re-sending an RFA which had been sent to your office and opened under 0065-04-CID023. I have not received any info reports or updates on the case file, so I am resending the RFA with further specific points which I would like to get addressed. Also I was wondering if the current Case Agent could get in touch with me and update me on the status, as this type investigation has become a higher priority. Please notify me upon receipt of this RFA. Thanks, for the support.

<<RFA.doc>>

014051
14051
011

V/R

[redacted] b7C-1, b6-1

Kandahar Branch Office
Special Agent-in-Charge
DSN [redacted] b7C-1, b6-1

5/20/2004

[redacted]SAC WC37AA b7C-1, b6-1

From: [redacted] L CW5 [redacted]@belvoir.army.mil] b7C-3, b6-3
Sent: Wednesday, May 26, 2004 2:12 AM
Subject: FW: CG's Update

> -----Original Message-----
> From: Ryder, Donald J. MG
> Sent: Tuesday, May 25, 2004 5:27 PM
> To: COL [redacted]; [redacted] (E-mail); [redacted] b7C-3, b6-3
> (E-mail); [redacted]
> Cc: LTC [redacted]; LTC [redacted]; LTC [redacted]; LTC [redacted] LTC [redacted]; LTC b7C-3, b6-3
> [redacted]; LTC [redacted]; LTC [redacted] LTC [redacted] LTC [redacted]; Major b7C-3, b6-3
> [redacted]; Mr. [redacted]
> Subject: Commander's Update
>
> Troops,
>
> I know that all of you are aware that detainee abuse issues are at the forefront right now and that our associated criminal investigations are very, very important pieces to resolving the overall issues. Let there be no doubt that: 1) our Army is still at war, 2) it is not business as usual , 3) CID's top priority is detainee abuse investigations. The challenges are greater than they've ever been, but this Command is going to meet those challenges head-on just as we have for the past 33 years.
>
> To put the matter into some context, I have already briefed the Secretary of Defense and Congress on our detainee abuse cases and met with the national media. Reviews are being conducted by the Schlesinger Commission, DoDIG, and DAIG, while MG Fay conducts a review of military intelligence operations. Completed products include MG Taguba's 15-6 and various ICRC reports as well as my PMG assessment of detention operations last Fall. The common thread that runs through most of these processes is our criminal investigation product, so data sharing and collection is quite extensive.
>
> I have made some recent decisions that will facilitate timely, thorough investigations while simultaneously satisfying increasing demands for information from our senior leadership, Congress, the media, our Sister Services, and the multiple reviewing and investigating entities.
>
> -- I have suspended CID IG inspections for at least 120 days in order to use the IG Team as the nucleus of an investigative task force to oversee macro-level issues associated primarily with Abu Ghraib and to conduct "sufficiency" reviews on our closed detainee death cases.
>
> -- I have designated all detainee abuse cases as "Cat I Monitorships," which is what we do for our highest priority cases.
>
> -- I have asked my Task Force commander, LTC [redacted], to tell me what resources she needs, which means that I will likely have to pull a few personnel from CID Headquarters and the field with special skills. b7C-3, b6-3
>
> The G-3 will publish an OPORD that lays all of this out, and I also owe you what the IG inspection schedule will look like for the future.
>
> I want to make perfectly clear that these decisions are NOT based on a lack of confidence in our agents or someone not doing their job. Quite

> the contrary -- everyone, and especially our folks deployed in theater,
> are busting their butts to make it all happen. It is simply the unique
> circumstances that drives us to do business a bit differently.
>
> Every facet of this Command needs to work together as a team to get the
> job done. This is clearly a time in which leadership will make a
> difference. I have confidence in all of you and know that I have your
> full support in doing what has to be done.
>
> DJR
>
>

DEPARTMENT OF THE ARMY
U. S. ARMY CRIMINAL INVESTIGATION COMMAND
6010 6TH STREET
FORT BELVOIR, VIRGINIA 22060-5506

REPLY TO
ATTENTION OF

CIOP-ZA

25 May 2004

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Designation of Category I Monitorship ROI

1. References:

a. AR 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October 1997

b. CIDR 195-1, paragraph 4-6b(1), CID Operations, 15 January 2004.

2. As of 21 May 04, this Command has initiated 74 Reports of Investigation (ROI) in Afghanistan and Iraq concerning the abuse of detained persons by U.S. military and civilian contracted personnel. These investigations have generated significant Department of Defense, Congressional, and international attention. Several Congressional and Department of Defense task forces and commissions have been created to review divergent aspects of detainee operations as well as investigations conducted by the USACIDC. It is expected this scrutiny and oversight will continue for the foreseeable future.

3. Effective 25 May 04, the Commanding General, USACIDC, has designated all detainee abuse ROIs as category I monitorship. All field elements are directed to reference 1b for timeliness and timely reporting requirements. In addition, all ROIs dispatched effective this date will be SSI reportable and will reflect the following statement as the first paragraph of the investigative summary, "This is a detainee abuse investigation."

4. For the purposes of this requirement a "detainee" is defined as any person captured or otherwise detained by an armed force. The detention need not occur at a MP controlled detention facility and may include checkpoints and cordon and search operations. "Abuse" includes, but is not limited to, punitive articles of the Uniform Code of Military Justice and/or similar provisions of Title 18, US Code.

5. Weekly updates to this headquarters as described in reference 1b will be forwarded via e-mail to Mr. [redacted] [redacted]@belvoir.army.mil and CW5 [redacted] b7c-3, b6-3
[redacted]@belvoir.army.mil b7c-3, b6-3

6. The termination date of this memorandum cannot be determined.

Printed on Recycled Paper

b7C-3, b6-3

7. Point of contact is CW5 [redacted] ([redacted]) or [redacted]@belvoir.army.mil

FOR THE COMMANDER:

b7C-3, b6-3

//Original signed//
[redacted]
Colonel, GS
Deputy Chief of Staff, G-3

DISTRIBUTION: A

b7c-1,b6-1

[redacted] SAC WC37AA

From: [redacted] SA [redacted]@us.army.mil] b7c-1,b6-1
Sent: Thursday, June 03, 2004 2:51 AM
To: [redacted] SAC WC37AA b7c-1,b6-1
Cc: [redacted] SA; [redacted] SA b7c-1,b6-1
Subject: RE: Request For Information (0065-04-CID023)

Sensitivity: ~~Confidential~~ UNCLASSIFIED [redacted] b7c-3,b6-3
Security Manager, USACIDC

b7c-1,b6-1

SA [redacted] b7c-1,b6-1

b7c-4,b6-4 b7c-4,b6-4

SA [redacted] conducted the interview of SSG [redacted] last night (2 Jun 04) and obtained a sworn statement. SFC [redacted] is TDY here and is in a school. He was instructed to call SA [redacted] today to schedule and interview. SFC [redacted] was contacted is just got back 1 Jun 04, from leave. b7c-1,b6-1 b7c-4,b6-4

The doctors identity is still unclear, as he was not in the same unit.

These interviews will be conducted as soon as humanly possible. Please direct any future questions towards me. Thank you for your patience.

SA [redacted] b7c-1,b6-1

---

b7c-1,b6-1

From: [redacted] SAC WC37AA b7c-1,b6-1
Sent: Thursday, June 03, 2004 6:05 AM
To: [redacted] SA; [redacted] SAC WC37AA b7c-1,b6-1
Cc: [redacted] CW2; [redacted] SA; [redacted] SA b7c-1,b6-1
Subject: RE: Request For Information (0065-04-CID023)
Importance: High
Sensitivity: ~~Confidential~~ UNCLASSIFIED

SA [redacted] b7c-1,b6-1

I still have not received anything, can you please intervene and get me an update?

Thanks,

b7c-1,b6-1

-----Original Message-----
From: [redacted] SA [mailto:[redacted]@us.army.mil]
Sent: Tuesday, June 01, 2004 2:47 AM
To: [redacted] SAC WC37AA b7c-1,b6-1
Cc: [redacted] CW2; [redacted] SA; [redacted] SA b7c-1,b6-1
Subject: RE: Request For Information (0065-04-CID023)
Sensitivity: ~~Confidential~~ UNCLASSIFIED

SA [redacted] b7c-1,b6-1

I will have the case agent get back to you today.

SA [redacted] b7c-1,b6-1

b7c-1,b6-1

Please send an information report to SA [redacted] some time today.

SA [redacted] b7c-1,b6-1

-----Original Message-----
From: [redacted] SAC WC37AA b7c-1,b6-1
Sent: Monday, May 31, 2004 9:21 PM

To: [redacted] SA 67C-1, 66-1
Subject: Request For Information (0065-04-CID023)
Importance: High
Sensitivity: ~~Confidential~~ UNCLASSIFIED

SA [redacted] 67C-1, 66-1

I never received an information report pertaining to the RFA 0065-04-CID023. I coordinated with you a couple of weeks ago, reference an information report, but due to the OPSTEMPO of your office, I never received an update. As of 25 May 04, case 0174-04-CID369-49232, RFA 0065-04-CID023 has become a Category 1 Investigation. I would like to request that I receive an update on the status of the case file, what leads still remain and an approximate timeline for completion. I appreciate the assistance in this matter. If you need anything from me to facilitate the completion of the RFA please let me know.

V/R

[redacted] 67C-1, 66-1

Special Agent-in-Charge
Kandahar, Afghanistan MP Det (CID)
APO AE 09355
DSN [redacted] 67C-1, 66-1
Fax [redacted]

[redacted] SAC WC37AA b7C-1, b6-1

From: [redacted] SA [redacted]@bragg.army.mil] b7C-1, b6-1
Sent: Thursday, June 03, 2004 1:31 PM
To: [redacted] SAC WC37AA b7C-1, b6-1
Cc: [redacted] SA b7C-1, b6-1
Subject: Info report (0065-04-CID023)

b7C-4, b6-4 b7C-3, b6-3

Sir,
I interviewed SFC [redacted] today and SFC [redacted] is on leave. I will interview him upon his return, he was supposed to come back off of leave today, but I can't reach him. I will notify you as soon as I reach him.

[redacted]

V/R,
SA [redacted] b7C-1, b6-1

DEPARTMENT OF DEFENSE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY
AFGHANISTAN MP DET (CID)
3D MILITARY POLICE GROUP (CID)
BAGRAM AIR FIELD
APO AE 09354

REPLY TO
ATTENTION OF

CICR-EF (195-1) 19 May 2004

MEMORANDUM FOR Special Agent-in-Charge, 87th Military Police Detachment (ABN) (CID)(DSE), 3D Military Police Group (CID), USACIDC, Building 8, 1221 Randolph Street, Fort Bragg, NC 28310

SUBJECT: 2nd Request for Assistance (RFA) (0174-03-CID369-49232) 87th Military Police Detachment RFA 0065-04-CID023

1. This office is conducting an investigation pertaining to the Undetermined Death of a local national Person Under Control (PUC).

2. This investigation was initiated upon notification by CPT [redacted] Office of the Staff Judge Advocate, 3rd Battalion, 3rd Special Forces Group, Kandahar Air Field, APO AE 09355 (KAF), who reported a local national, being detained by US Special Forces (USSF), and guarded by the Afghanistan Militia Forces (AMF), at the Forward Operating Base (FOB), Gereshk, Helmond Province, Afghanistan (AF), WAHID was discovered by an AMF Guard crumpled on the floor of a holding area deceased. b7C-3, b6-3

3. Efforts to conduct follow-on interviews of three individuals assigned to FOB GERESHK, AF, who had direct contact with WAHID have met with negative results.

b7C-3, b6-3

4. Request your office conduct follow-up/interviews of the following individuals: SFC [redacted], SFC [redacted] and SSG [redacted], all of A Company, 3/3rd Special Forces Group, Ft Bragg, NC 28310. Specifically request the questioning to focus on the specifics of their personal interactions with WAHID, specifically any complaints and the nature of them, the depth of the physical assessment upon receipt of WAHID at FOB Gereshk, AF, and if there is a Standard Operating Procedure (SOP), pertaining to the receipt and processing of PUC's upon their arrival at the FOB. Further, obtain a detailed description of the state which Mr. WAHID was found in, as SSG [redacted] indicated Mr. WAHID was in a state of Rigor, determine how SSG [redacted] is qualified to make that determination. Attempt to ascertain if any of the above listed individuals can identify MAJ [redacted], who conducted an examination of the deceased. Also attempt to determine if any reports about the length of time the AMF had Mr. WAHID in custody prior to being turned over to U.S. Forces, were provided to any of the above listed individuals.

b7C-4, b6-4
b7C-4, b6-4
b7C-4, b6-4
b7C-4, b6-4
b7C-3, b6-3

5. The point of contact for this is the undersigned at DSN: [redacted] or email [redacted]@Kaf.afgn.army.mil. b7C-1, b6-1

///S/// [redacted] b7C-1, b6-1
SSG, MP
Special Agent-in-Charge

Encl:
1. Initial Report b7C-3, b6-3
2. Statement of SFC [redacted]
3. Statement of SFC [redacted] b7C-4, b6-4
4. Statement of SSG [redacted] b7C-4, b6-4

DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
87TH MILITARY POLICE DETACHMENT (CID) (ABN)
3RD MILITARY POLICE GROUP (CID)
FORT BRAGG, NC 28310

CIRC-ABB 23 Jul 04

MEMORANDUM FOR Special Agent in Charge, Afghanistan MP DET(CID), 3D Military Police Group (CID), Bagram Air Field, APO AE 09354

SUBJECT: Final Information Report (0065-04-CID023)

1. Reference your Request for Assistance (0174-03-CID369-49232).

2. Requested activity has been completed as reflected in the attached enclosures.

3. No CID funds were used, nor were any privacy act disclosures generated. Manhours were expended as follows:

Investigative	- 8
Administrative	- 1
Travel	- 2

4. Point of Contact is SA [redacted], commercial [redacted], fax (910) 396-8595, or email [redacted]@bragg.army.mil. b7C-1, b6-1 b7C-1, b6-1

[redacted] b7C-1, b6-1
CW3, MP
Special Agent in Charge

4 Encls: b7C-1, b6-1
1 - AIR of SA [redacted]
25 Jun 04
2 - Sworn Statement of
SSG [redacted], 24 Feb 04 b7C-4, b6-4
3 - Sworn Statement of
SSG [redacted] 2 Jun 04 b7C-4, b6-4
4 - Sworn Statement of
SFC [redacted], 3 Jun 04 b7C-4, b6-4

014041
0000001

DATE: 08 NOV 2003 12:37
FROM: AFGHANISTAN CID OFFICE //CICR-BGR//
TO: DIRUSACRC USACIDC FT BELVOIR VA //CICR-ZA//
ENDURING FREEDOM BRANCH OFFICE //CICR-EF// b7C-3,b6-3
CHIEF OF STAFF, CJTF-180, BAGRAM AIR FIELD
PROVOST MARSHAL OFFICE, CJTF 180 (MAJ [redacted]) //CJTF180-PMO-DPM//
COMMANDER, TF DRAGON, BAGRAM AIR FIELD (COL [redacted]) b7C-3,b6-3
CDR, KANDAHAR AIR FIELD BASE OPERATIONS (LTC [redacted]) b7C-3,b6-3
PROVOST MARSHAL OFFICE, KANDAHAR AIR FIELD (CPT [redacted]) b7C-3,b6-3
CDR, TF WARRIOR, KANDAHAR AIR FIELD (COL [redacted]) b7C-3,b6-3
SPECIAL OPERATIONS COMMAND LIAISON (SA [redacted]) b7C-1,b6-1
SAC, KANDAHAR BRANCH OFFICE, 87TH MP DET (CID)
3RD MILITARY POLICE GROUP FWD (OPNS OFFICER)
CDR 5TH MP BN CID KAISERSLAUTERN GE //CIRB-KA//
DIR AFIP WASH DC b7C-3,b6-3
CDR, TF 44TH MED (COL [redacted])
BAGRAM BLOTTER CLERK
PROVOST MARSHAL OFFICE, BAGRAM AIRFIELD (CPT [redacted])
STAFF JUDGE ADVOCATE, CJTF180 (LTC [redacted])
SJA, FOB 33, KAF (CPT [redacted])
CDR 3D MP GRP CID FT GILLEM GA //CIRC-ZA//
CDR USACIDC FT BELVOIR VA //CIOP-ZA//
CRIM INVES TASK FORCE, USACIDC, FT BELVOIR, VA //CITF-ZA//
SUBJECT: CID REPORT - INITIAL / SSI - 0174-03-CID369 - 49232 - 5H93
DRAFTER : [redacted] b7C-1,b6-1
RELEASER: [redacted] b7C-1,b6-1

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1. DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 06 NOV 2003/1415 - 06 NOV 2003/1500; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. DATE/TIME REPORTED: 06 NOV 1903, 2150 b7C-1,b6-1,b2 [illegible]

3. INVESTIGATED BY: SA [redacted]; SA [redacted] b7C-1,b6-1,b2

4. SUBJECT: (NONE); [UNDETERMINED DEATH].

5. VICTIM: 1. WAHID, ABDUL [DECEASED]; CIV; AFGHANISTAN, AFGHANISTAN; M; OTHER; CT; [NFI]; [UNDETERMINED DEATH].

6. INVESTIGATIVE SUMMARY: THE INFORMATION IN THIS REPORT IS BASED UPON AN ALLEGATION OR PRELIMINARY INVESTIGATION AND MAY CHANGE PRIOR TO THE COMPLETION OF THE INVESTIGATION.

"THIS IS AN OPERATION ENDURING FREEDOM INVESTIGATION."

THIS INVESTIGATION WAS INITIATED UPON NOTIFICATION BY CPT [redacted], OFFICE OF THE STAFF JUDGE ADVOCATE, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KANDAHAR AIR FIELD, APO AE 09355 (KAF), WHO REPORTED A LOCAL NATIONAL, BEING DETAINED BY US SPECIAL FORCES (USSF), AND GUARDED BY THE AFGHANISTAN MILITIA FORCES (AMF), AT THE FORWARD OPERATING BASE (FOB) GERESHK, HELMAND PROVINCE, AFGHANISTAN (AF). WAHID WAS DISCOVERED BY AN b7C-3,b6-3

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AMF GUARD (NFI) CRUMPLED ON THE FLOOR OF A HOLDING AREA.

PRELIMINARY INVESTIGATION DETERMINED WAHID, A LOCAL NATIONAL, DIED WHILE IN CUSTODY AT FOB GERESHK, AF. HE HAD BEEN IN CUSTODY AT THE FOB FOR APPROXIMATELY 48 HOURS PRIOR TO HIS DEATH. AMF HAD INTERROGATED WAHID FOR AN UNKNOWN PERIOD BEFORE HE WAS BROUGHT TO FOB GERESHK. WHEN HE WAS BROUGHT TO THE FOB, USSF MEDICS DOCUMENTED WAHID'S INJURIES. WAHID SUFFERED FROM EXTENSIVE BRUISING TO THE GROIN AREA, BUTTOCKS AND HIPS. HE ALSO HAD WHAT APPEARED TO BE BURN TYPE INJURIES TO THE CHEST AREA. AT THE TIME OF WAHID'S ARRIVAL, HE WAS DESCRIBED AS LUCID, IN COMPLETE CONTROL OF ALL MOTOR FUNCTIONS, AND HE APPEARED TO UNDERSTAND DIRECTIONS. WAHID WAS PLACED IN A HOLDING AREA, AND THEN GUARDED BY AMF PERSONNEL, WITH GUARD TOWER OVER-WATCH BY USSF PERSONNEL. AT APPROXIMATELY 1415, 6 NOV 03, THE AMF GUARD RESPONSIBLE FOR OBSERVATION OF WAHID, LEFT DIRECT OBSERVATION FOR APPROXIMATELY 15 MINUTES. WHEN HE RETURNED THE AMF GUARD NOTED THAT WAHID WAS CRUMPLED ON THE FLOOR. HE NOTIFIED SFC [redacted], A CO, 3RD BN, b7C-3, b6-3 3RD SFG, FOB GERESHK, AF, WHO CONDUCTED A PRELIMINARY EXAMINATION OF WAHID, AND DETERMINED THAT WAHID WAS DECEASED.

USSF PERSONNEL THEN NOTIFIED THEIR CHAIN OF COMMAND AT KAF, WHO NOTIFIED USACIDC. EXAMINATION OF THE SCENE BY USACIDC REVEALED NO APPARENT SIGNS OF FOUL PLAY. USSF PERSONNEL INTERVIEWED BY USACIDC, SAID WAHID HAD CONFESSED TO AMF OF BEING INVOLVED IN SEVERAL HIGH PROFILE CRIMES. THEY FURTHER RELATED WAHID WAS BEING HELD AT THE FOB FOR EVALUATION TO DETERMINE IF HE WOULD BE INTERNED AS A PERSON UNDER CONTROL (PUC) AT ONE OF THE PUC FACILITIES AT KAF OR BAGRAM AIR FIELD (BAF), BOTH IN AFGHANISTAN. WAHID HAD NOT BEEN ASSIGNED A PUC NUMBER YET.

UPON USACIDC NOTIFICATION, TWO USACIDC SPECIAL AGENTS, SA [redacted] AND SA [redacted], CRIMINAL INVESTIGATIONS TASK FORCE (CITF), CPT [redacted], AND MAJ (DR) [redacted], [redacted], BATTALION SURGEON, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KAF, TRAVELED VIA HELICOPTER TO FOB GERESHK. PRIOR TO TAKEOFF IT WAS LEARNED THE REMAINS OF WAHID WERE RELEASED TO RELATIVES FOR BURIAL. THIS IS A NORMAL PRACTICE FOR THE USSF TO RELEASE THE REMAINS OF DECEASED PERSONS FOR BURIAL, DUE TO CULTURAL AND RELIGIOUS REASONS. UPON NOTIFICATION THAT THE REMAINS WERE NEEDED FOR EXTERNAL AND POTENTIAL INTERNAL EXAMINATIONS, USSF PERSONNEL RECOVERED THE REMAINS FROM THE FAMILY OF WAHID.

b7C-1, b6-1
b2

b(7)C-4, b(6)-4
b7C-3, b6-3
b(7)C-4 b(6)-4
b7C-3, b6-3

AN AUTOPSY WAS CONDUCTED ON 7 NOV 03 BY LTC (DR) [redacted] [redacted], GENERAL SURGEON, [redacted], 911TH FORWARD SURGICAL TEAM (FST), TASK FORCE (TF) WARRIOR, KAF. LTC [redacted] WAS UNABLE TO DETERMINE THE CAUSE OR MANNER OF DEATH AT THE TIME OF HIS EXAMINATION. X-RAY PHOTOGRAPHS WERE EXPOSED OF THE REMAINS IN AN EFFORT TO ASSIST WITH THE DETERMINATION OF THE CAUSE AND MANNER OF DEATH.

FURTHER COORDINATIONS BY USACIDC DETERMINED THE NEED FOR A FORENSIC AUTOPSY OF WAHID'S REMAINS. COORDINATIONS CONTINUE TO SCHEDULE A FORENSIC AUTOPSY BY AN ARMED SERVICES MEDICAL EXAMINER. WAHID'S REMAINS ARE SCHEDULED FOR TRANSFER TO BAF ON

9 NOV 03, PENDING A FORENSIC AUTOPSY.

INVESTIGATION CONTINUES BY USACIDC.

7. CID REPORTS ARE EXEMPT FROM AUTOMATIC TERMINATION OF PROTECTIVE MARKINGS IN ACCORDANCE WITH CHAPTER 3, AR 25-55.

DATE 17 MAY 2004

FROM AFGHANISTAN CID OFFICE, BAGRAM AIRFIELD //CICR-BGR//

TO: DIR USACRC FT BELVOIR VA //CICR-ZA//

SUBJECT: CID REPORT OF INVESTIGATION - 2D STATUS/SSI - 0174-2003-CID369-49232 - 5H1D

DRAFTER: [redacted] b7C-1, b6-1

RELEASER: [redacted] b7C-1, b6-1

1. DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. DATE/TIME REPORTED: 06 NOV 1903, 2120

3. INVESTIGATED BY:

SA [redacted] b7C-1, b6-1, b2
SA [redacted]
SA [redacted] b7C-1, b6-1, b2
b7C-1, b6-1

4. SUBJECT:
1. CHANGED (UNKNOWN), ; MURDER (NFI)

5. VICTIM:
1. WAHID, ABDUL (DECEASED) ; CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT ; MURDER (NFI)

6. INVESTIGATIVE SUMMARY:

THE INFORMATION IN THIS REPORT IS BASED UPON AN ALLEGATION OR PRELIMINARY INVESTIGATION AND MAY BE CHANGED PRIOR TO THE COMPLETION OF THE INVESTIGATION.

"THIS IS AN OPERATION ENDURING FREEDOM INVESTIGATION."

2ND STATUS:

THIS STATUS REPORT IS BEING GENERATED TO CHANGE THE MANNER OF DEATH AS IT PERTAINS TO MR. WAHID FROM UNDETERMINED TO A HOMICIDE AND TO DOCUMENT TO THE RECEIPT OF THE FINAL AUTOPSY REPORT. THIS REPORT WAS LATE WAS BECAUSE OF ACI2 COMPLICATIONS AND CONNECTION ISSUES.

~~ON 12 MAY 04, THIS USACIDC OFFICE RECEIVED FINAL AUTOPSY REPORT~~

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A03-144, WHICH INDICATED MR. WAHID'S MANNER OF DEATH WAS HOMICIDE AND THE CAUSE OF DEATH WAS MULTIPLE BLUNT FORCE INJURIES COMPLICATED BY RHABDOMYOLYSIS.

INITIAL:

THIS INVESTIGATION WAS INITIATED UPON NOTIFICATION BY CPT [redacted], OFFICE OF THE STAFF JUDGE ADVOCATE, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KANDAHAR AIR FIELD, APO AE 09355 (KAF), WHO REPORTED A LOCAL NATIONAL, BEING DETAINED BY US SPECIAL FORCES (USSF), AND GUARDED BY THE AFGHANISTAN MILITIA FORCES (AMF), AT FORWARD OPERATING BASE (FOB) GERESHK, HELMOND PROVINCE, AFGHANISTAN (AF). WAHID WAS DISCOVERED BY AN AMF GUARD (NFI) CRUMPLED ON THE FLOOR OF A HOLDING AREA. b7C-3, b6-3

PRELIMINARY INVESTIGATION DETERMINED WAHID, A LOCAL NATIONAL, DIED WHILE IN CUSTODY AT FOB GERESHK, AF. HE HAD BEEN IN CUSTODY AT THE FOB FOR APPROXIMATELY 48 HOURS PRIOR TO HIS DEATH. AMF HAD INTERROGATED WAHID FOR AN UNKNOWN PERIOD BEFORE HE WAS BROUGHT TO FOB GERESHK. WHEN HE WAS BROUGHT TO THE FOB, USSF MEDICS DOCUMENTED WAHID'S INJURIES. WAHID SUFFERED FROM EXTENSIVE BRUISING TO THE GROIN AREA, BUTTOCKS AND HIPS. HE ALSO HAD WHAT APPEARED TO BE BURN TYPE INJURIES TO THE CHEST AREA. AT THE TIME OF WAHID'S ARRIVAL, HE WAS DESCRIBED AS LUCID, IN COMPLETE CONTROL OF ALL MOTOR FUNCTIONS, AND HE APPEARED TO UNDERSTAND DIRECTIONS. WAHID WAS PLACED IN A HOLDING AREA, AND THEN GUARDED BY AMF PERSONNEL, WITH GUARD TOWER OVER-WATCH BY USSF PERSONNEL. AT APPROXIMATELY 1415, 6 NOV 03, THE AMF GUARD RESPONSIBLE FOR OBSERVATION OF WAHID, LEFT DIRECT OBSERVATION FOR APPROXIMATELY 15 MINUTES. WHEN HE RETURNED THE AMF GUARD NOTED THAT WAHID WAS CRUMPLED ON THE FLOOR. HE NOTIFIED SFC [redacted], A CO, 3RD BN, 3RD SFG, FOB GERESHK, AF, WHO CONDUCTED A PRELIMINARY EXAMINATION OF WAHID, AND DETERMINED THAT WAHID WAS DECEASED. b7C-3, b6-3 b7C-3, b6-3

USSF PERSONNEL THEN NOTIFIED THEIR CHAIN OF COMMAND AT KAF, WHO NOTIFIED USACIDC. EXAMINATION OF THE SCENE BY USACIDC REVEALED NO APPARENT SIGNS OF FOUL PLAY. USSF PERSONNEL INTERVIEWED BY USACIDC SAID, WAHID CONFESSED TO AMF OF BEING INVOLVED IN SEVERAL HIGH PROFILE CRIMES. THEY FURTHER RELATED WAHID WAS BEING HELD AT THE FOB FOR EVALUATION TO DETERMINE IF HE WOULD BE INTERNED AS A PERSON UNDER CONTROL (PUC) AT ONE OF THE PUC FACILITIES AT KAF OR BAGRAM AIR FIELD (BAF), BOTH IN AFGHANISTAN. WAHID HAD NOT BEEN ASSIGNED A PUC NUMBER YET.

b7c-4, b6-1

UPON USACIDC NOTIFICATION, TWO USACIDC SPECIAL AGENTS, SA [redacted] AND SA [redacted], CRIMINAL INVESTIGATIONS TASK FORCE (CITF), CPT [redacted] AND MAJ (DR) [redacted], BATTALION SURGEON, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KAF, TRAVELED VIA HELICOPTER TO FOB GERESHK. PRIOR TO TAKE OFF IT WAS LEARNED THE REMAINS OF WAHID WERE RELEASED TO RELATIVES FOR BURIAL. THIS IS A NORMAL PRACTICE FOR THE USSF TO RELEASE THE REMAINS OF DECEASED PERSONS FOR BURIAL DUE TO CULTURAL AND RELIGIOUS REASONS. UPON NOTIFICATION THAT THE REMAINS WERE NEEDED FOR EXTERNAL AND POTENTIAL INTERNAL EXAMINATIONS, USSF PERSONNEL RECOVERED THE REMAINS FROM THE FAMILY OF WAHID. b7c-4, b6-1 b7c-3, b6-3

AN AUTOPSY WAS CONDUCTED ON 7 NOV 03, BY LTC (DR) [redacted] GENERAL SURGEON, [redacted], 911TH FORWARD SURGICAL TEAM (FST), TASK FORCE (TF) WARRIOR, KAF. LTC [redacted] WAS UNABLE TO DETERMINE THE CAUSE OR MANNER OF DEATH AT THE TIME OF HIS EXAMINATION. X-RAY PHOTOGRAPHS WERE EXPOSED OF THE REMAINS IN AN EFFORT TO ASSIST WITH THE DETERMINATION OF THE CAUSE AND MANNER OF DEATH. b7c-3, b6-3 b7c-3, b6-3

FURTHER COORDINATION'S BY USACIDC DETERMINED THE NEED FOR A FORENSIC AUTOPSY OF WAHID'S REMAINS. COORDINATION'S CONTINUE TO SCHEDULE A FORENSIC AUTOPSY BY AN ARMED SERVICES MEDICAL EXAMINER. WAHID'S REMAINS ARE SCHEDULE FOR TRANSFER TO BAF ON 9 NOV 03, PENDING A FORENSIC AUTOPSY.

INVESTIGATION CONTINUES BY USACIDC.

7. COMMANDERS ARE REMINDED OF THE PROVISIONS OF AR 600-8-2 PERTAINING TO SUSPENSION OF FAVORABLE PERSONNEL ACTIONS AND AR 380-67 FOR THE SUSPENSION OF SECURITY CLEARANCES OF PERSONS UNDER INVESTIGATION.

8. USACIDC REPORTS ARE EXEMPT FROM AUTOMATIC TERMINATION OF PROTECTIVE MARKINGS IN ACCORDANCE WITH CHAPTER 3, AR 25-55.

DATE 17 MAY 2004

FROM AFGHANISTAN CID OFFICE, BAGRAM AIRFIELD //CICR-BGR//

TO: DIR USACRC FT BELVOIR VA //CICR-ZA//
CG USACIDC FT BELVOIR VA //CIOP-ZA//
CDR USACIDC 3D MP GRP FT GILLEM GA
CHIEF OF STAFF, CJTF-180, BAGRAM AIR FIELD
PROVOST MARSHAL OFFICE, CJTF 180 (LTC [redacted] b7C-3, b6-3
SAC, KANDAHAR BRANCH OFFICE
STAFF JUDGE ADVOCATE, CJTF180 (MAJ [redacted] b7C-3, b6-3
DIR AFIP AFME WASH, DC//AFIP-CPLF

SUBJECT: CID REPORT OF INVESTIGATION - 3D STATUS/SSI - 0174-2003-CID369-49232 - 5H1D b6-1

DRAFTER: [redacted] b7C-1, b6-1

RELEASER: [redacted] b7C-1, b6-1

1. DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. DATE/TIME REPORTED: 06 NOV 1903, 2120

3. INVESTIGATED BY:
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1

4. SUBJECT:
1. (UNKNOWN), ; MURDER (NFI)

5. VICTIM:
1. WAHID, ABDUL (DECEASED) ; CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT ; MURDER (NFI)

6. INVESTIGATIVE SUMMARY:

THE INFORMATION IN THIS REPORT IS BASED UPON AN ALLEGATION OR PRELIMINARY INVESTIGATION AND MAY BE CHANGED PRIOR TO THE COMPLETION OF THE INVESTIGATION.

"THIS IS AN OPERATION ENDURING FREEDOM INVESTIGATION."

3RD STATUS:

THIS STATUS REPORT IS BEING GENERATED TO UPDATE THE DISTRIBUTION INFORMATION FROM THE PREVIOUSLY SUBMITTED STATUS REPORT DUE TO AN ACI2 ERROR.

2ND STATUS:

THIS STATUS REPORT IS BEING GENERATED TO CHANGE THE MANNER OF DEATH AS IT PERTAINS TO MR. WAHID FROM UNDETERMINED TO A HOMICIDE AND TO DOCUMENT TO THE RECEIPT OF THE FINAL AUTOPSY REPORT. THIS REPORT WAS LATE WAS BECAUSE OF ACI2 COMPLICATIONS AND CONNECTION ISSUES.

ON 12 MAY 04, THIS USACIDC OFFICE RECEIVED FINAL AUTOPSY REPORT A03-144, WHICH INDICATED MR. WAHID'S MANNER OF DEATH WAS HOMICIDE AND THE CAUSE OF DEATH WAS MULTIPLE BLUNT FORCE INJURIES COMPLICATED BY RHABDOMYOLYSIS.

INITIAL:

THIS INVESTIGATION WAS INITIATED UPON NOTIFICATION BY CPT [redacted], OFFICE OF THE STAFF JUDGE ADVOCATE, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KANDAHAR AIR FIELD, APO AE 09355 (KAF), WHO REPORTED A LOCAL NATIONAL, BEING DETAINED BY US SPECIAL FORCES (USSF), AND GUARDED BY THE AFGHANISTAN MILITIA FORCES (AMF), AT FORWARD OPERATING BASE (FOB) GERESHK, HELMOND PROVINCE, AFGHANISTAN (AF). WAHID WAS DISCOVERED BY AN AMF GUARD (NFI) CRUMPLED ON THE FLOOR OF A HOLDING AREA.

b7c-3, b6-3

PRELIMINARY INVESTIGATION DETERMINED WAHID, A LOCAL NATIONAL, DIED WHILE IN CUSTODY AT FOB GERESHK, AF. HE HAD BEEN IN CUSTODY AT THE FOB FOR APPROXIMATELY 48 HOURS PRIOR TO HIS DEATH. AMF HAD INTERROGATED WAHID FOR AN UNKNOWN PERIOD BEFORE HE WAS BROUGHT TO FOB GERESHK. WHEN HE WAS BROUGHT TO THE FOB, USSF MEDICS DOCUMENTED WAHID'S INJURIES. WAHID SUFFERED FROM EXTENSIVE BRUISING TO THE GROIN AREA, BUTTOCKS AND HIPS. HE ALSO HAD WHAT APPEARED TO BE BURN TYPE INJURIES TO THE CHEST AREA. AT THE TIME OF WAHID'S ARRIVAL, HE WAS DESCRIBED AS LUCID, IN COMPLETE CONTROL OF ALL MOTOR FUNCTIONS, AND HE APPEARED TO UNDERSTAND DIRECTIONS. WAHID WAS PLACED IN A HOLDING AREA, AND THEN GUARDED BY AMF PERSONNEL, WITH GUARD TOWER OVER-WATCH BY USSF PERSONNEL. AT APPROXIMATELY 1415, 6 NOV 03, THE AMF GUARD RESPONSIBLE FOR OBSERVATION OF WAHID, LEFT DIRECT OBSERVATION FOR APPROXIMATELY 15 MINUTES. WHEN HE RETURNED THE AMF GUARD NOTED THAT WAHID WAS CRUMPLED ON THE FLOOR. HE NOTIFIED SFC [redacted]

b7c-3, b6-3

b7C-3, b6-3

[redacted] A CO, 3RD BN, 3RD SFG, FOB GERESHK, AF, WHO CONDUCTED A PRELIMINARY EXAMINATION OF WAHID, AND DETERMINED THAT WAHID WAS DECEASED.

USSF PERSONNEL THEN NOTIFIED THEIR CHAIN OF COMMAND AT KAF, WHO NOTIFIED USACIDC. EXAMINATION OF THE SCENE BY USACIDC REVEALED NO APPARENT SIGNS OF FOUL PLAY. USSF PERSONNEL INTERVIEWED BY USACIDC SAID, WAHID CONFESSED TO AMF OF BEING INVOLVED IN SEVERAL HIGH PROFILE CRIMES. THEY FURTHER RELATED WAHID WAS BEING HELD AT THE FOB FOR EVALUATION TO DETERMINE IF HE WOULD BE INTERNED AS A PERSON UNDER CONTROL (PUC) AT ONE OF THE PUC FACILITIES AT KAF OR BAGRAM AIR FIELD (BAF), BOTH IN AFGHANISTAN. WAHID HAD NOT BEEN ASSIGNED A PUC NUMBER YET.

b7C-1, b6-1

UPON USACIDC NOTIFICATION, TWO USACIDC SPECIAL AGENTS, SA [redacted] AND SA [redacted], CRIMINAL INVESTIGATIONS TASK FORCE (CITF), CPT [redacted], AND MAJ (DR) [redacted] BATTALION SURGEON, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KAF, TRAVELED VIA HELICOPTER TO FOB GERESHK. PRIOR TO TAKE OFF IT WAS LEARNED THE REMAINS OF WAHID WERE RELEASED TO RELATIVES FOR BURIAL. THIS IS A NORMAL PRACTICE FOR THE USSF TO RELEASE THE REMAINS OF DECEASED PERSONS FOR BURIAL DUE TO CULTURAL AND RELIGIOUS REASONS. UPON NOTIFICATION THAT THE REMAINS WERE NEEDED FOR EXTERNAL AND POTENTIAL INTERNAL EXAMINATIONS, USSF PERSONNEL RECOVERED THE REMAINS FROM THE FAMILY OF WAHID.

b7C-1, b6-1, b2
b7C-3, b6-3

AN AUTOPSY WAS CONDUCTED ON 7 NOV 03, BY LTC (DR) [redacted], GENERAL SURGEON, [redacted], 911TH FORWARD SURGICAL TEAM (FST), TASK FORCE (TF) WARRIOR, KAF. LTC [redacted] WAS UNABLE TO DETERMINE THE CAUSE OR MANNER OF DEATH AT THE TIME OF HIS EXAMINATION. X-RAY PHOTOGRAPHS WERE EXPOSED OF THE REMAINS IN AN EFFORT TO ASSIST WITH THE DETERMINATION OF THE CAUSE AND MANNER OF DEATH.

b7C-3, b6-3
b7C-3, b6-3
b7C-3, b6-3

FURTHER COORDINATION'S BY USACIDC DETERMINED THE NEED FOR A FORENSIC AUTOPSY OF WAHID'S REMAINS. COORDINATION'S CONTINUE TO SCHEDULE A FORENSIC AUTOPSY BY AN ARMED SERVICES MEDICAL EXAMINER. WAHID'S REMAINS ARE SCHEDULE FOR TRANSFER TO BAF ON 9 NOV 03, PENDING A FORENSIC AUTOPSY.

INVESTIGATION CONTINUES BY USACIDC.

7. COMMANDERS ARE REMINDED OF THE PROVISIONS OF AR 600-8-2 PERTAINING TO SUSPENSION OF FAVORABLE PERSONNEL ACTIONS AND AR 380-67 FOR THE SUSPENSION OF SECURITY CLEARANCES OF PERSONS UNDER

INVESTIGATION.

8. USACIDC REPORTS ARE EXEMPT FROM AUTOMATIC TERMINATION OF PROTECTIVE MARKINGS IN ACCORDANCE WITH CHAPTER 3, AR 25-55.

VAULT
OPEN

27-8

DATE 28 MAY 2004

FROM

TO: DIR USACRC FT BELVOIR VA //CICR-ZA//
CDR USACIDC 3D MP GRP FT GILLEM GA
CHIEF OF STAFF, CJTF-180, BAGRAM AIR FIELD
PROVOST MARSHAL OFFICE, CJTF 180 (LTC [redacted]) b7C-3, b6-3
SAC, KANDAHAR BRANCH OFFICE
STAFF JUDGE ADVOCATE, CJTF180 (MAJ [redacted]) b7C-3, b6-3
DIR AFIP AFME WASH, DC//AFIP-CPLF
CG USACIDC FT BELVOIR VA //CIOP-ZA//
AFGHANISTAN CID OFFICE, BAGRAM AIRFIELD //CICR-BGR//

SUBJECT: CID REPORT OF INVESTIGATION - 4TH STATUS/SSI - 0174-2003-CID369-49232 - 5H1D

DRAFTER: [redacted] b7C-1, b6-1

RELEASER: [redacted] b7C-1, b6-1

1. DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. DATE/TIME REPORTED: 06 NOV 2003, 2120

3. INVESTIGATED BY:
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1

4. SUBJECT:
1. (UNKNOWN), ; MURDER (NFI)

5. VICTIM:
1. WAHID, ABDUL (DECEASED) ; CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT ; MURDER (NFI)

6. INVESTIGATIVE SUMMARY:

THE INFORMATION IN THIS REPORT IS BASED UPON AN ALLEGATION OR PRELIMINARY INVESTIGATION AND MAY BE CHANGED PRIOR TO THE COMPLETION OF THE INVESTIGATION.

"THIS IS A DETAINEE ABUSE INVESTIGATION."

~~"THIS IS AN OPERATION ENDURING FREEDOM INVESTIGATION."~~

UNCLASSIFIED - FOR OFFICIAL USE ONLY

4TH STATUS:

THE PURPOSE OF THIS STATUS REPORT IS TO DESIGNATE THIS INVESTIGATION AS A CATEGORY I MONITORSHIP INVESTIGATION AS DIRECTED BY HQUSACIDC ON 25 MAY 04.

3RD STATUS:

THIS STATUS REPORT IS BEING GENERATED TO UPDATE THE DISTRIBUTION INFORMATION FROM THE PREVIOUSLY SUBMITTED STATUS REPORT DUE TO AN ACI2 ERROR.

2ND STATUS:

THIS STATUS REPORT IS BEING GENERATED TO CHANGE THE MANNER OF DEATH AS IT PERTAINS TO MR. WAHID FROM UNDETERMINED TO A HOMICIDE AND TO DOCUMENT TO THE RECEIPT OF THE FINAL AUTOPSY REPORT. THIS REPORT WAS LATE WAS BECAUSE OF ACI2 COMPLICATIONS AND CONNECTION ISSUES.

ON 12 MAY 04, THIS USACIDC OFFICE RECEIVED FINAL AUTOPSY REPORT A03-144, WHICH INDICATED MR. WAHID'S MANNER OF DEATH WAS HOMICIDE AND THE CAUSE OF DEATH WAS MULTIPLE BLUNT FORCE INJURIES COMPLICATED BY RHABDOMYOLYSIS.

INITIAL:

THIS INVESTIGATION WAS INITIATED UPON NOTIFICATION BY CPT [redacted] OFFICE OF THE STAFF JUDGE ADVOCATE, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KANDAHAR AIR FIELD, APO AE 09355 (KAF), WHO REPORTED A LOCAL NATIONAL, BEING DETAINED BY US SPECIAL FORCES (USSF), AND GUARDED BY THE AFGHANISTAN MILITIA FORCES (AMF), AT FORWARD OPERATING BASE (FOB) GERESHK, HELMOND PROVINCE, AFGHANISTAN (AF). WAHID WAS DISCOVERED BY AN AMF GUARD (NFI) CRUMPLED ON THE FLOOR OF A HOLDING AREA.

b7C-3, b6-3

PRELIMINARY INVESTIGATION DETERMINED WAHID, A LOCAL NATIONAL, DIED WHILE IN CUSTODY AT FOB GERESHK, AF. HE HAD BEEN IN CUSTODY AT THE FOB FOR APPROXIMATELY 48 HOURS PRIOR TO HIS DEATH. AMF HAD INTERROGATED WAHID FOR AN UNKNOWN PERIOD BEFORE HE WAS BROUGHT TO FOB GERESHK. WHEN HE WAS BROUGHT TO THE FOB, USSF MEDICS DOCUMENTED WAHID'S INJURIES. WAHID SUFFERED FROM EXTENSIVE ~~BRUISING TO THE GROIN AREA, BUTTOCKS AND HIPS. HE ALSO HAD WHAT~~

APPEARED TO BE BURN TYPE INJURIES TO THE CHEST AREA. AT THE TIME OF WAHID'S ARRIVAL, HE WAS DESCRIBED AS LUCID, IN COMPLETE CONTROL OF ALL MOTOR FUNCTIONS, AND HE APPEARED TO UNDERSTAND DIRECTIONS. WAHID WAS PLACED IN A HOLDING AREA, AND THEN GUARDED BY AMF PERSONNEL, WITH GUARD TOWER OVER-WATCH BY USSF PERSONNEL. AT APPROXIMATELY 1415, 6 NOV 03, THE AMF GUARD RESPONSIBLE FOR OBSERVATION OF WAHID, LEFT DIRECT OBSERVATION FOR APPROXIMATELY 15 MINUTES. WHEN HE RETURNED THE AMF GUARD NOTED THAT WAHID WAS CRUMPLED ON THE FLOOR. HE NOTIFIED SFC [redacted] b7C-3, b6-3 [redacted], A CO, 3RD BN, 3RD SFG, FOB GERESHK, AF, WHO CONDUCTED A PRELIMINARY EXAMINATION OF WAHID, AND DETERMINED THAT WAHID WAS DECEASED.

USSF PERSONNEL THEN NOTIFIED THEIR CHAIN OF COMMAND AT KAF, WHO NOTIFIED USACIDC. EXAMINATION OF THE SCENE BY USACIDC REVEALED NO APPARENT SIGNS OF FOUL PLAY. USSF PERSONNEL INTERVIEWED BY USACIDC SAID, WAHID CONFESSED TO AMF OF BEING INVOLVED IN SEVERAL HIGH PROFILE CRIMES. THEY FURTHER RELATED WAHID WAS BEING HELD AT THE FOB FOR EVALUATION TO DETERMINE IF HE WOULD BE INTERNED AS A PERSON UNDER CONTROL (PUC) AT ONE OF THE PUC FACILITIES AT KAF OR BAGRAM AIR FIELD (BAF), BOTH IN AFGHANISTAN. WAHID HAD NOT BEEN ASSIGNED A PUC NUMBER YET.

b7C-4, b6-4
UPON USACIDC NOTIFICATION, TWO USACIDC SPECIAL AGENTS, SA [redacted] AND SA [redacted], CRIMINAL INVESTIGATIONS TASK FORCE (CITF), b7C-1, b6-1, b2 CPT [redacted], AND MAJ (DR) [redacted], BATTALION b7C-3, b6-3 SURGEON, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KAF, TRAVELED VIA HELICOPTER TO FOB GERESHK. PRIOR TO TAKE OFF IT WAS LEARNED THE REMAINS OF WAHID WERE RELEASED TO RELATIVES FOR BURIAL. THIS IS A NORMAL PRACTICE FOR THE USSF TO RELEASE THE REMAINS OF DECEASED PERSONS FOR BURIAL DUE TO CULTURAL AND RELIGIOUS REASONS. UPON NOTIFICATION THAT THE REMAINS WERE NEEDED FOR EXTERNAL AND POTENTIAL INTERNAL EXAMINATIONS, USSF PERSONNEL RECOVERED THE REMAINS FROM THE FAMILY OF WAHID.

b7C-3, b6-3
AN AUTOPSY WAS CONDUCTED ON 7 NOV 03, BY LTC (DR) [redacted] GENERAL SURGEON, [redacted], 911TH FORWARD SURGICAL TEAM (FST), TASK FORCE (TF) WARRIOR, KAF. LTC [redacted] WAS UNABLE TO DETERMINE THE b7C-3, b6-3 CAUSE OR MANNER OF DEATH AT THE TIME OF HIS EXAMINATION. X-RAY PHOTOGRAPHS WERE EXPOSED OF THE REMAINS IN AN EFFORT TO ASSIST WITH THE DETERMINATION OF THE CAUSE AND MANNER OF DEATH.

FURTHER COORDINATION'S BY USACIDC DETERMINED THE NEED FOR A FORENSIC AUTOPSY OF WAHID'S REMAINS. COORDINATION'S CONTINUE TO

SCHEDULE A FORENSIC AUTOPSY BY AN ARMED SERVICES MEDICAL EXAMINER. WAHID'S REMAINS ARE SCHEDULE FOR TRANSFER TO BAF ON 9 NOV 03, PENDING A FORENSIC AUTOPSY.

INVESTIGATION CONTINUES BY USACIDC.

7. COMMANDERS ARE REMINDED OF THE PROVISIONS OF AR 600-8-2 PERTAINING TO SUSPENSION OF FAVORABLE PERSONNEL ACTIONS AND AR 380-67 FOR THE SUSPENSION OF SECURITY CLEARANCES OF PERSONS UNDER INVESTIGATION.

8. USACIDC REPORTS ARE EXEMPT FROM AUTOMATIC TERMINATION OF PROTECTIVE MARKINGS IN ACCORDANCE WITH CHAPTER 3, AR 25-55.

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1*	ROI NUMBER -04-CID369
	PAGE 1 OF 1 PAGES

DETAILS

About 1030, 2 Mar 05, this office received a Request for Correction (0128-05-CID001) from the Detainee Abuse Task Force (DATF), Headquarters, USACIDC, Fort Belvoir, VA 22060, requesting this office reopen the investigation to correct some deficiencies noted during their review of the investigation.

b7c-1, b6-1 b7c-3, b6-3

About 0930, 3 Mar 05, SA [redacted], this office, coordinated with CPT [redacted] Trial Counsel, Office of the Staff Judge Advocate, KAF, who concurred with the findings of the DATF in that probable cause exists to believe the unknown AMF personnel committed the offenses of Aggravated Assault, Torture and Voluntary Manslaughter, when the unknown AMF personnel assaulted and tortured WAHID, which contributed to his death.

//LAST ENTRY//

b7c-1, b6-1, b2

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-1, b6-1	ORGANIZATION Afghanistan MP Det (CID) 3rd MP Gp (CID), USACIDC, APO AE 09354	
SIGNATURE [redacted] b7c-1, b6-1	DATE 3 Mar 05	EXHIBIT 18

CID FORM 94
1 FEB 77

Page(s)

54-192

Referred to:

U.S. ARMY MEDICAL COMMAND
FREEDOM OF INFORMATION/
PRIVACY ACT OFFICE
ATTENTION: MCFP
2050 WORTH ROAD, SUITE 13
FORT SAM HOUSTON, TEXAS
78234-6013

MR. JOHN PETERSON
John.Peterson1@cen.amedd.army.mil
(210) 221-7826

DEPARTMENT OF THE ARMY
87th MILITARY POLICE DETACHMENT (ABN)(CID)
3d Military Police Group (CID)
Building 8-1221 Randolph Street
Fort Bragg, North Carolina 28310

REPLY TO
ATTENTION OF

CIRC-ABB

27 Jan 05

MEMORANDUM FOR RECORD

SUBJECT: Missing Document for CID ROI 0174-03-CID369-49232

1. In Jun 04, this office mailed a Final Information Report (0065-04-CID023) regarding the aforementioned investigation from the Bagram CID Office, APO AE 09354. When the information report was mailed to the office, the back side of a statement made by SFC [redacted] was inadvertently not mailed with the report. Sometime later, the case agent pulled the case and mailed the back page of the statement himself, but never made copies of the statement prior to mailing it. The back page of the aforementioned statement was lost in the mail and never received by the Bagram CID Office. Since SFC [redacted] and the agent who took the statement from him are currently unavailable, the back page of the statement could not be reconstructed.

b7c-4, b6-4

b7c-4, b6-4

2. Point of contact for this office is the undersigned at DSN: [redacted]

b7c-1, b6-1

for [redacted]

b7c-1, b6-1

CW3, MP
Special Agent in Charge

DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Afghanistan MP Det (CID)
Building 591, Bagram Airfield, APO, Armed Forces Africa, Canada, Europe &
Middle East 09354-9354

21 Oct 2004

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0174-2003-CID369-49232 - 5H1D

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

DATE/TIME REPORTED: 06 NOV 2003, 2120

INVESTIGATED BY:
SA [redacted] b7c-1, b6-1, b2
SA [redacted] b7c-1, b6-1, b2
SA [redacted] b7c-1, b6-1

SUBJECT:
1. (UNKNOWN), ; AFGHANISTAN MILITIA FORCES, FORWARD OPERATING BASE GERESHK, AF; MURDER (NFI)

VICTIM:
1. WAHID, ABDUL (DECEASED); CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT; MURDER (NFI)

INVESTIGATIVE SUMMARY:

"This is a Detainee Abuse Investigation"

This investigation was initiated subsequent notification by the Office of the Staff Judge Advocate, 3rd Battalion, 3rd Special Forces Group, Kandahar Airfield, APO AE 09355 (KAF), who reported a local national being detained by US Special Forces (USSF), and guarded by the Afghanistan Militia Forces (AMF), at Forward Operating Base (FOB) Gereshk, Helmond Province, Afghanistan (AF), was discovered by an AMF guard deceased on the floor of the holding area.

Investigation disclosed that on 6 Nov 03, WAHID had been discovered by an AMF guard unresponsive in a crumpled position in the detainment facility, FOB, Gereshk, AF. USSF personnel conducted an initial medical examination of WAHID and determined that WAHID had expired. WAHID had been in the custody of the AMF for an undetermined period of time prior to being turned over to USSF Personnel. Upon receipt of WAHID by USSF personnel at FOB Gereshk, AF, the USSF Medics documented numerous bruises to WAHID's groin area, buttocks, hips and injuries which appeared to be burn type injuries to his chest. Approximately 48 hours after being turned over to USSF personnel WAHID expired. On 13 Nov 03, an autopsy was conducted on the remains of WAHID which disclosed the cause of WAHIDs death as Multiple Blunt Force Injuries complicated by Rhabdomyolysis, and the manner of death was Homicide.

Further investigation revealed that from the onset of Rhabdomyolysis to the time of WAHID's death, Rhabdomyolysis was consistent with the type of injuries WAHID had received prior to USSF custody which caused his death within the 48 hours.

STATUTES:

Unknown Afghanistan Law

EXHIBITS/SUBSTANTIATION:

Attached:

b7c:1, b6-1

1. Agent's Investigation Report (AIR) of SA [redacted] 13 Nov 03, pertaining to initial notification, unit coordinations, witness interviews, After Action Reports and Pathologist coordination.

b7c-4, b6-4

2. Sworn Statement of SFC [redacted] 7 Nov 03, detailing his knowledge of Mr. WAHID expiring.

b7c-4, b6-4

3. Sworn Statement of SFC [redacted], 7 Nov 03, detailing his knowledge of Mr. WAHID expiring.

4. Photographs of Mr. WAHID, 7 Nov 03.

5. Medical Record of Mr. WAHID, 7 Nov 03.

b7C-4, b6-4

6. Sworn Statement of SSG [redacted] 7 Nov 03, detailing his knowledge of Mr. WAHID expiring.

7. AIR of SA [redacted] 7 Nov 03, pertaining to Death Scene Examination. b7C-1, b6-1

8. Crime Scene Sketches prepared by SA [redacted], 7 Nov 03. b7C-1, b6-1

9. After Action Report of SA [redacted], 8 Nov 03. b7C-1, b6-1

10. Certificate of Death and Preliminary Autopsy Report of Mr. WAHID, 13 Nov 03.

11. AIR of SA [redacted] 13 Jun 04, pertaining to SJA and medical coordinations. b7C-1, b6-1

12. Autopsy Report A03-144, conducted on the remains of Mr. WAHID, 12 May 04.

13. AIR of SA [redacted] 25 Jun 04, pertaining to the interviews of USSF Personnel. b7C-1, b6-1

14. Sworn Statement of SSG [redacted] 24 Feb 04, detailing his medical examination of Mr. WAHID. b7C-4, b6-4

15. Sworn Statement of SSG [redacted] 2 Jun 04, detailing his medical examination of Mr. WAHID. b7C-4, b6-4

16. Sworn Statement of SFC [redacted] 3 Jun 04, detailing the Standard Operating Procedures for handling detainees. b7C-4, b6-4

17. Compact Disc (CD) containing the photographic images of the preliminary autopsy. (USACRC and File copies only)

Not Attached:

None.

The originals of Exhibits 1 through 8, 11 and 13-17 were forwarded to USACRC with the original of this report. The original of Exhibit 9 is retained in the files of the Criminal Investigative Task Force (CITF), Bagram Airfield, Afghanistan APO AE 09354. The originals of Exhibits 10 and 12 are retained in the files of the Office of the Armed Forces Regional Examiner, Landstuhl Regional Medical Center, Landstuhl, Germany APO AE 09180.

STATUS: This is a Final (C) Report. This investigation was terminated IAW CIDR 195-1, para

4-17a(6) in that the Special Agent-in-Charge (SAC) of this USACIDC unit determined that furtherance of the investigation would be of little or no value or leads remaining to be developed are not significant. SUMMARY OF REMAINING LEADS: Obtain X-Ray photographs of the initial autopsy conducted by LTC [redacted] b7C-3, b6-3

REPORT PREPARED BY

[redacted] b7C-1, b6-1, b2

SA [redacted]
Special Agent, [redacted]

REPORT APPROVED BY

[redacted] b7C-1, b6-1

Special Agent-in-Charge

DISTRIBUTION:
1-Dir, USACRC, Ft Belvoir, VA
1-Commander, USACIDC, ATTN: DSCOPS, 6010 6th Street, Ft Belvoir, VA 22060
1-Commander, 3rd MP Group, USACIDC (Operations), Fort Gillem, GA
1-Dir, Armed Forces Institute of Pathology, Bldg 102, 1413 Research Blvd, Rockville, MD
1-SAC, KANDAHAR BRANCH OFFICE (email only)
1-STAFF JUDGE ADVOCATE, CJTF 76 (MAJ [redacted])(email only) b7C-3, b6-3
1-PROVOST MARSHAL OFFICE, BAGRAM AIRFIELD (SFC [redacted])(email only) b7C-3, b6-3
1-PROVOST MARSHAL, CJTF 76 (LTC [redacted])(email only) b7C-3, b6-3
1-FILE

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0174-03-CID369-49232

PAGE 1 OF 2 PAGES

DETAILS

About 2150, 6 Nov 03, This investigation was initiated upon notification by CPT [redacted], Office of the Staff Judge Advocate, 3rd Battalion, 3rd Special Forces Group (SFG), Kandahar Air Field, APO AE 09355 (KAF), who reported a local national, being detained by US Special Forces (AMF), at Forward Operating Base (FOB) Gereshk, Helmond Province, Afghanistan (AF), WAHID was discovered by an AMF guard crumpled on the floor of a holding area, believed to be dead. b7c-3, b6-3

b7c-1, b6-1 b7c-1, b6-1

About 0005, 7 Nov 03, SA [redacted] and SA [redacted], Criminal Investigative Task Force (CITF), CPT [redacted], and MAJ (DR) [redacted] [redacted], Battalion Surgeon, 3rd Battalion, 3rd SFG, traveled via rotary wing aircraft to FOB Gereshk. Prior to departing it was learned the remains of Mr. WAHID had been released to the family for burial. b7c-3, b6-3

b7c-1, b6-1 b7c-4, b6-4

About 0100, 7 Nov 03, SA [redacted] interviewed SFC [redacted], [redacted], A Company (CO), 3rd BN, 3rd SFG, FOB Gereshk. SFC [redacted] was identified as the Special Forces medic who had been notified upon the discovery of Mr. WAHID. SFC [redacted] related he conducted a preliminary assessment and based on the onset of rigor mortis no lifesaving measures were initiated. (See Statement) b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4

About 0215, 7 Nov 03, SA [redacted] interviewed SFC [redacted] [redacted], A CO, 3rd BN, 3rd SFG, FOB Gereshk. SFC [redacted] was identified as the individual who had initially received Mr. WAHID upon his arrival at the FOB at which time WAHID was photographed and medically examined and the presence of the existing injuries were identified. SFC [redacted] was further identified as the last U.S. Service Member (SM), who had seen Mr. WAHID alive. (See Statement/Photographs and Medical Record for further details) b7c-4, b6-4 b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4

About 0412, 7 Nov 03, SA [redacted] interviewed SSG [redacted] [redacted], A CO 3rd BN, 3rd SFG, who related he had conducted the interrogation of Mr. WAHID while in SFG control. (See Statement)

b7c-1, b6-1

About 0900, 8 Nov 03, SA [redacted] was provided a After Action Report (AAR), from Resident Agent-in-Charge [redacted], CITIF, which indicated all actions taken by SA [redacted]. (See AAR) b7c-1, b6-1 b7c-1, b6-1

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-1, b6-1, b2	ORGANIZATION Kandahar Branch Office Kandahar Airfield Afghanistan, APO AEN 09355

SIGNATURE [redacted] b7c-1, b6-1	DATE 13 NOV 03	EXHIBIT 1

CID FORM 94
1 FEB 77

FOR OFFICIAL USE ONLY

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0174-03-CID369-49232

PAGE 2 OF 2 PAGES

DETAILS

b7c-1, b6-1

About 0900, 13 Nov 03, SA [redacted] received Mr. WAHID's Certificate of Death and a preliminary Autopsy Report A03-144 which indicated Mr. WAHID's manner of death was Homicide and cause of death was Blunt Force Trauma complicated by Rhabdomyolysis. (See Certificate of Death and Preliminary Autopsy Report) ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-1, b6-1, b2	ORGANIZATION Kandahar Branch Office Kandahar Airfield Afghanistan, APO AEN 09355
SIGNATURE [redacted] b7c-1, b6-1	DATE 13 NOV 03
	EXHIBIT

0174-03-CID369-49232

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).

PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately

ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.

DISCLOSURE: Disclosure of your social security number is voluntary.

b7C-4, b6-4

1. LOCATION Gersk	2. DATE (YYYYMMDD) 20031106	3. TIME [redacted] 2130Z	4. FILE NUMBER 0174-03-CID369-49232
5. LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7C-4, b6-4	6. SSN [redacted] b7C-4, b6-4		7. GRADE/STATUS E-7
8. ORGANIZATION OR ADDRESS A co 3/3 SFG b7C-4, b6-4			

9. I, [redacted] [redacted] b7C-4, b6-4 , WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

I was the 1st person to discover the PUC was deseased. Appox 1045Z I was coming back in the gate after moving another Team here and the 2IC of the AMF called me over. He told me the PUC was dying. I immedatly walked into the holding facility and noticed the "PUC" lying in the middle of the floor wrapped in a blanket. I removed the blanket and checked for a carotid [redacted] ~~ptose~~ b7C-4, b6-4 pulse. Upon checking for breathing/circulation and moving his head to try and check carotid on opposite side, I noticed his head/neck were stiff. I then checked for eye reflex, Rigor mortis, pooling. ⊖ eye reflex when ~~Ey~~ Elashes brushed. slight rigor ⊖ pooling. I ran (on 4wheeler) and got my stethascope and came back (Appox 1-2 min) and listened for 1-2 minutes b7C-4, b6-4 ⊖ heart tones. At that time another 18D showed up on ~~scene~~ [redacted] scene and I had him check pt. with same results. At that time I question the guards and notified Higher.

Question: SA [redacted] b7C-1, b6-1

Answer: SFC [redacted] b7C-4, b6-4

b7C-4, b6-4

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4, b6-4	[redacted] PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ TAKEN AT ____ DATED ____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

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LAW ENFORCEMENT SENSITIVE

01399 Exhibit 2

000013

b7C-4,66-4 b7C-4,66

STATEMENT OF [redacted] TAKEN AT [redacted]30 Z DATED 20031106

9. STATEMENT *(Continued)*

b7C-4,66-4

[redacted] Q: Did you perform any life saving measures?

A: No, after I discovered rigor & such I didn't

Q: Did the PUC appear to have been dead for awhile?

A: No, it was quite a warm day, for the most part he appeared flacid except for his neck area.

Q: Is there anything you want to add to this statement?

A: Nothing to add \\\\ end of statement \\\ [redacted] b7C-4,66-4

b7C-4,66-4

AFFIDAVIT

I, [redacted] b7C-4,66-4, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2 [redacted]. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

[redacted] b7C-4,66-4
(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 6 day of ~~August~~ November [redacted], 2003
at [redacted] b7C-1,66-1
(Signature of Person Administering Oath)

SA [redacted] b7C-1,66-1
(Typed Name of Person Administering Oath)

Article 136, UCMJ
(Authority To Administer Oaths)

b7C-1,66-1

INITIALS OF PERSON MAKING STATEMENT

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PAGE 2 OF 2 [redacted] PAGES

PAGE 3, DA FORM 2823, DEC 1998

USAPA V1.00

LAW ENFORCEMENT SENSITIVE

Exhibit 2

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary. b7C-4, b6-4 b7C-4, b6-4

1. LOCATION FB GERESHK b7C-4, b6-4	2. DATE *(YYYYMMDD)* 2003 [redacted] 06	3. TIME 2144 Z [redacted]	4. FILE NUMBER 0174-03-CID369-49232
5. LAST NAME, FIRST NAME, MIDDLE NAME [redacted]	6. SSN [redacted] b7C-4, b6-4		7. GRADE/STATUS SFC/E-7
8. ORGANIZATION OR ADDRESS A Co 3/3 SFG (A)			

9. [redacted] [redacted] b7C-4, b6-4, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

I RELIEVED ABDUL WAHID ON OR ABOUT 040745ZNOV03. WHEN HE ARRIVED I WAITED APROX. 15 MINUTES BEFORE PROCESSING & INTERROGATING IN ORDER TO PREPARE MY QUESTIONS AND GET A TERP AND [redacted] b7C-4, b6-4 18D. ~~to~~ WHEN INTERROGATION STARTED SUBJECT WAS STANDING ON HIS OWN AND WAS ALERT AND ANSWERING QUESTIONS INDICATING COMPLETE MENTAL AWARENESS. AFTER INTEROGATION SUBJECT WAS PLACED INTO HOLDING FACILITY. SUBJECT WAS ASSESSED MEDICALLY BY 18D (SFC [redacted]) b7C-4, b6-4 DURING INTEROGATION. MEDIC INFORMED ME SUBJECT WAS OF NORMAL HEALTH AND NEEDED NO SPECIAL CONSIDERATION. DURING THE NEXT 48 HRS UNTIL TIME OF DEATH SUBJECT WAS PERIODICALLY CHECKED W/ ALL OTHER DETAINEES FOR ANY DEVELOPMENT OF HEALTH ISSUES AND TO BE FED AND GIVEN WATER. AT NO TIME DID SUBJECT HAVE ANY INDICATORS OF FAILING HEALTH. AT ABOUT 061030ZNOV03 WAS THE LAST TIME I INSPECTED b7C-4, b6 [redacted] b7C-4, b6-4 PUC. I CARRIED A CASE OF WATER TO DETAINMENT FACILITY [redacted] b7C-4, b6-4

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4, b6-4	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ TAKEN AT ____ DATED ____

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THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

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LAW ENFORCEMENT SENSITIVE

Exhibit 3

USE THIS PAGE IF NEEDED. If THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

67C-4,66-4 67C-4,66-4

21,442 [redacted]

STATEMENT OF [redacted] TAKEN AT FB GERESHK DATED 06 11 03

9. STATEMENT (Continued) 67C-4,66-4

[redacted] AND INSTRUCTED GUARD TO ISSUE WATER. ALL DETAINEES DRANK 1 BOTTLE OF WATER. I TOLD GUARD TO WAIT 10-15 MINUTES AND GIVE MORE WATER. AT THIS TIME SUBJECT GAVE NO INDICATORS OF ILL OR FAILING HEALTH. I LEFT SUBJECT. THE SINGLE GUARD LEFT SHORTLY [redacted] 67C-4,66-4 BEHIND ME (TO OPERATE GATE FOR ARRIVING ODA) FOR APPROX. 10 MINUTES. AFTER THE ODA WAS RECIEVED I WAS NOTIFIED BY SFC [redacted] 67C-4,66-4 (18D) SUBJ. WAS DECEASED.

Questions: SA [redacted] 67C-4,66-4

ANSWERS: SFC [redacted] 67C-4,66-4

Q: Were you present during the physical assessment?

A: During the first one.

Q: At that time did the PUC appear to have any life threatening injuries?

A: No

Q: At any time, while you were with the PUC, did he appear to be in any distress, physically?

A: No

Q: During the times you questioned the PUC were you ever physical with him? [redacted] 67C-4,66-4

67C-4,66-4 67C-4,66-4

INITIALS OF PERSON MAKING STATEMENT [redacted] ficial Use Only PAGE 2 OF 3 [redacted] PAGES

PAGE 2, DA FORM 2823, DEC 1998 USAPA V1.00

LAW ENFORCEMENT SENSITIVE

Exhibit 3

014002 000016

b7C-4,66-4

STATEMENT OF [redacted] TAKEN AT 2144Z DATED 061103

9. STATEMENT *(Continued)*

[redacted] b7C-4,66-4

A: No

Q: Did the PUC every complain to you about any physical ailment or discomfort he may have been experiencing?

A: Nothing unusual, no more than the basic complaints they all express.

Q: Is there anything else you want to add to this statement?

A: NO /// END OF STATEMENT /// [redacted] b7C-4,66-4

b7C-4,66-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR R[redacted]HOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEM

b7C-4,66-4

[redacted] *erson Making Statement)*

b7C-4,66-4

WITNESSES:

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 6th day of ~~August~~ NOV [redacted], 2003

at

[redacted] b7C-1,66-1

(Signature of Person Administering Oath)

ORGANIZATION OR ADDRESS

SA [redacted] b7C-1,66-1

(Typed Name of Person Administering Oath)

Article 136, UCMJ

(Authority To Administer Oaths)

ORGANIZATION OR ADDRESS

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b7C-4,66-4

INITIALS OF PERSON MAKING STATEMENT

PAGE 3 OF 3 [redacted] PAGES

LAW ENFORCEMENT SENSITIVE

Exhibit 3

Page(s)

18 - 22

Referred to:

U.S. CENTRAL COMMAND
7115 SOUTH BOUNDARY BLVD
ATTN: CCJ6-DM
MACDILL AIR FORCE BASE
FLORIDA 33621-5101

Master Sergeant Pamela Andrews
andrewsp@centcom.smil.mil
(813) 827-5341/2830

014004

Page(s)

23 .

.

Referred to:

U.S. ARMY MEDICAL COMMAND
FREEDOM OF INFORMATION/
PRIVACY ACT OFFICE
ATTENTION: MCFP
2050 WORTH ROAD, SUITE 13
FORT SAM HOUSTON, TEXAS
78234-6013

MR. JOHN PETERSON
John.Peterson1@cen.amedd.army.mil
(210) 221-7826

014005

0174-04-CID368-4823

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.

PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately

ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.

DISCLOSURE: Disclosure of your social security number is voluntary. [redacted] b7C-4,b6-4

1. LOCATION Gereshk, Afghanistan	2. DATE *(YYYYMMDD)* 2003/11/06	3. TIME 23:05Z	4. FILE NUMBER 0174-03-CID369-49232
5. LAST NAME, FIRST NAME, MIDDLE NAME [redacted]	6. SSN [redacted]		7. GRADE/STATUS E-6 b7C-4,b6-4

8. ORGANIZATION OR ADDRESS
A Co 3/3 SFG, Ft. Bragg, NC 28310

[redacted] , WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH: b7C-4,b6-4

On or about 0400-0600Z of 04NOV03 the initial visual inspection of Abdul Wahid yield no concern about his physical condition. The interrogation was in progress upon my approach to the individual. He was standing without aid, exhibiting balance, and normal stature. The actual visual inspection was done over about 1 hr. and 30 min. During that time wounds were noted to his anterior thorax appearing as burns, and obvious bruising (excessive) to his entire buttock region. The individual was answering questions appropriately and in a timely manner, evidence of intact mental status. There was no evidence of trauma or deformity to any appendages. In addition, no outer obvious signs of gross bleeding or even a decrease in mental status which would suggest loss of b7C-4,b6-4 [redacted]

b7C-4,b6-4 [redacted] b7C-4,b6-4

10. EXHIBIT	11. INITIALS OF [redacted] MAKING STATEMENT	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ___ TAKEN AT ___ DATED ___

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

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LAW ENFORCEMENT SENSITIVE

014006
000024

Exhibit 6

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

b7c-4b6-4 [redacted] b7c-4b6-4

STATEMENT OF [redacted] TAKEN AT 23:052 DATED 2003/11/06

b7c-4,b6-4

9. STATEMENT (Continued)

[redacted] blood. Considering the individuals stature and mental acuteness, at the time of inspection there was no evident factors to warrant further hands on evaluation. In my medical opinion, he was in no danger of imminent death from his prior injuries.

Questions: SA [redacted] b7c-1,b6-1

ANSWERS: SSG [redacted] b7c-4,b6-4

Q: Did WAHID ever exhibit any signs of distress during your assessment?

A: No, he never motioned for anything or said he was hurting anywhere.

Q: Were the visible injuries found of WAHID unusual?

A: No, not considering other PUCs we had gotten in before. They all had injuries to the buttocks. The only injury unique to WAHID was the burns to his chest.

Q: Were the burns to WAHID's chest life threatening?

A: No.

Q: Is there anything you want to add to this statement?

A: No /// End of statement. /// [redacted] b7c-4,b6-4

b7c-4,b6-4 b7c-4,b6-4

INITIALS OF PERSON MAKING STATEMENT [redacted] For Official Use Only

PAGE 2 OF 3 [redacted] PAGES

PAGE 2, DA FORM 2823, DEC 1998 USAPA V1.00

LAW ENFORCEMENT SENSITIVE

014007 Exhibit 6

000025

b7C-4,b6-4 b7C-4,b6-4

STATEMENT OF [redacted] TAKEN AT 23:05Z [redacted] DATED 2003/11/06

9. STATEMENT *(Continued)*

NOT USED [redacted] b7C-4,b6-4

b7C-4,b6-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT. [redacted] b7C-4,b6-4

[redacted] *(Signature of Person Making Statement)* b7C-4,b6-4

WITNESSES:

Subscribed and sworn to before me, a person [redacted] by law to administer oaths, this 6 day of ~~August~~ Nov [redacted], 2003 at

ORGANIZATION OR ADDRESS

[redacted] b7C-1,b6-1

(Signature of Person Administering Oath)

SA [redacted] b7C-1,b6-1

(Typed Name of Person Administering Oath)

ORGANIZATION OR ADDRESS

Article 136, UCMJ

(Authority To Administer Oaths)

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INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4,b6-4 [redacted] b7C-4,b6-4

PAGE 3 OF 3 PAGES

PAGE 3, DA FORM 2823, DEC 1998

LAW ENFORCEMENT SENSITIVE

USAPA V1.00

Exhibit 6

AGENT'S INVESTIGATION REPORT 0174-03-CID369-49232

CID Regulation 195-1 PAGE 1 OF 2 PAGES

b7C-1,b6-1,b2

About 0230, 7 Nov 03, SA [redacted], Criminal Investigations Task Force (CITF), Kandahar Airfield, Kandahar, Afghanistan, APO AE 09355 (KAF) conducted a crime scene examination of the detainee area, located three feet from the main entrance into Forward Operating Base (FOB) Gereshk, Helmand Province, AF.

Characteristics of the Scene: The area identified, as the detainee area was a plywood structure shaped octagonally, with approximately four foot high cubicles. The cubicle areas had a ceiling (about 3' x 4'), and was open in the center of the structure. The area was free of debris and appeared clean. There was a folding metal chair, resting upright on the floor, and centered on the west wall, and a box, which contained bottled drinking water. The structure was unpainted and was constructed of treated plywood. There was an entrance and exit (E/E), which was merely a 2" x 4" piece of wood, which made a forced a person to bend at the waist to enter the structure. There was no door, nor were there any locks to keep a person from leaving. However, the structure was surrounded by concertina wire, and two Afghanistan Militia Forces (AMF) soldiers, who were stationed inside the detainee area, guarded the area. The guard area merely consisted of a holding area with the structure, and the folding metal chair. The over-watch of the detainee facility was being performed the U.S. Special Forces (USSF) unit assigned to the FOB positioned in a guard tower approximately 100 meters inside the base which was approximately 50 meters in height.

Condition of the Scene: The scene was clean of dirt, and there were several empty bottles of water laid on the floor of the detainee areas at the time of the examination, there was only one detainee sleeping in a cell of the structure. The detainee area was structurally sound, and appeared unsecured, besides the guards positioned inside the structure guarding the detainee. There was also a heat source in another of the cells, which was not operating at the time of the examination.

b7C-1,b6-1,b2

SA [redacted] b7C-1,b6-1,b2

Criminal Investigations Task Force
Kandahar Airfield, Kandahar, AF
APO AE 09355

Signature: for [redacted] b7C-1,b6-1

Date: 7Nov03

EXHIBIT: 7

CID Form 94

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Environmental Conditions: At the time of the outdoor scene examination the outside temperature was about 35 degrees Fahrenheit, and there was a slight wind. No unusual odors were noted. There had not been any precipitation within the last twenty-four hours.

Scene Documentation: A Rough Crime Scene Sketch was completed by SA [redacted] and verified by SA [redacted], Afghanistan MP Det (CID), Kandahar Branch Office (CID), KAF. SA [redacted] also exposed photographs of the scene using a Nikon Coolpix, Model 995. (See photographic packet and sketch for details) b7C-1, b6-1 b7C-1, b6-1

////////////////////////////Last Entry////////////////////////

b7C-1, b6-1, b2

SA [redacted]

Criminal Investigations Task Force
Kandahar Airfield, Kandahar, AF
APO AE 09355

b7C-1, b6-1

Signature: [redacted] b7C-1, b6

per [redacted]

Date: 7 Nov 03

EXHIBIT: 7

CID Form 94

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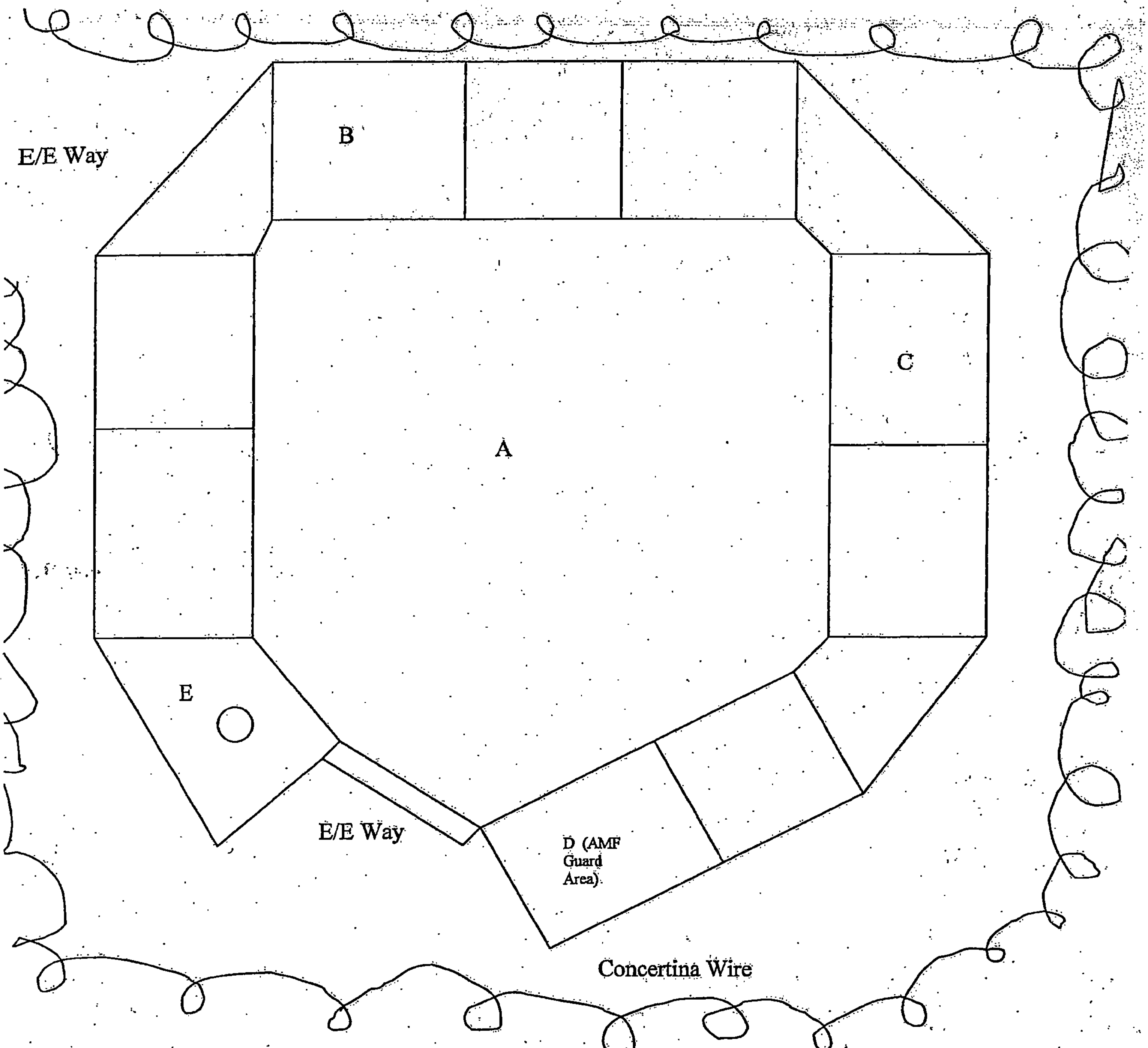
014010

0114-03-CID369-49252

Rough Crime Scene Sketch of Detainee Area at Geresch Forward Operating Base, Helmand Province, Afghanistan



Legend

A. Location of Discovered deceased

B. Location of other Prisoner

C. Location of Deceased holding area

D. AMF Guard Position

E. Heat Source area

3' to Main gate of FOB

150 meters to Guard Tower

For Official Use Only

LAW ENFORCEMENT

NOT TO SCALE

Title Block

Offense: Undetermined Death
Victim: Abdul Wahlid
Subject: Unknown
Location of Scene: Detainee Area, Geresch Foward Operating Base, Helmand Province, Afghanistan
Time/Date of Sketch: 2145Z, 7 Nov 03
Sketch Prepared By: SA [redacted]

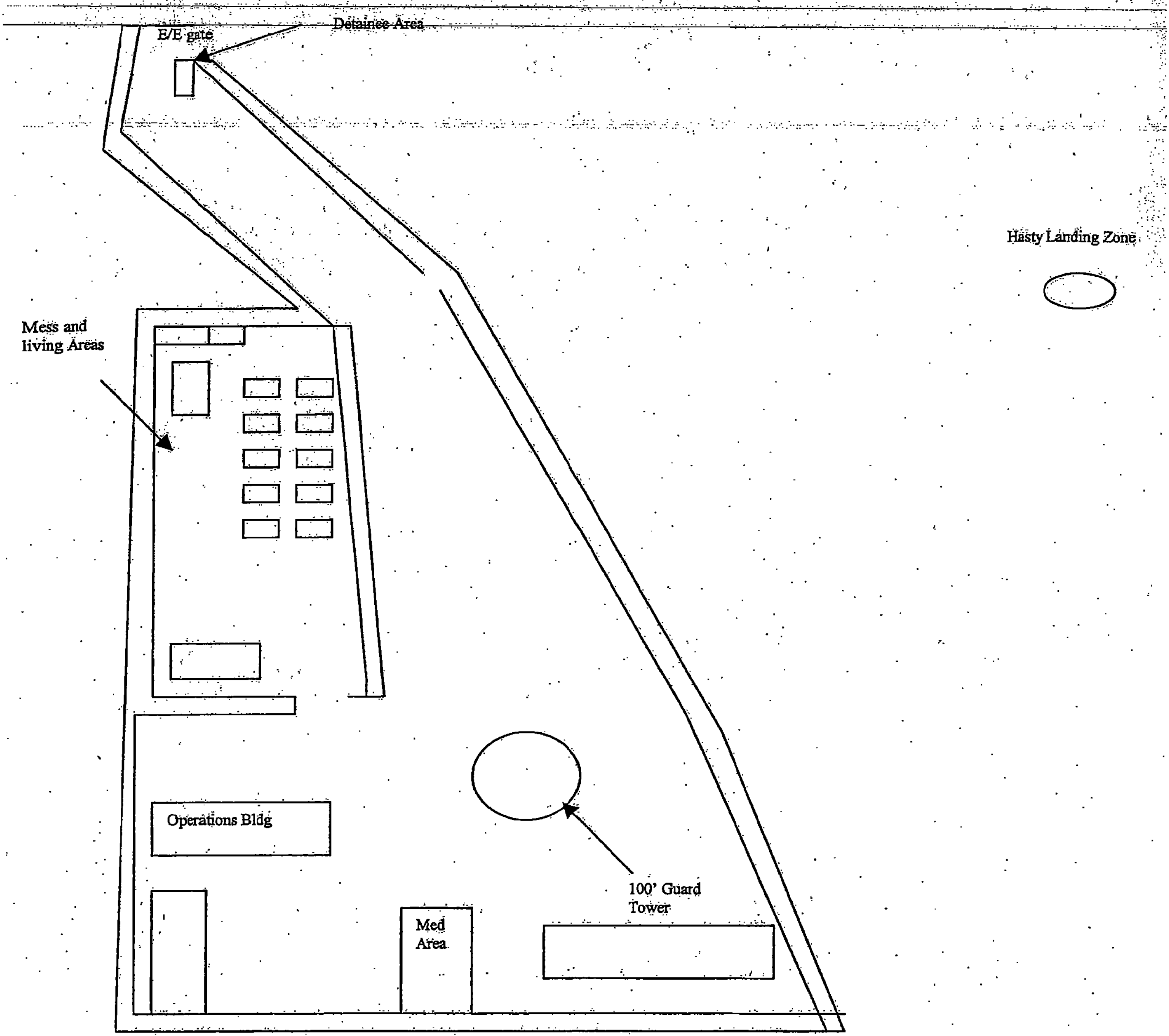
6R-1, 66-1

014011

Exhibit 8

000029

Rough Sketch eresch Forward Operating Base, Hel d Province, Afghanistan



Legend

N ↘
Not To Scale

Title Block
Offense: Undetermined Death
Location: Geresch FOB, Helmand Province, Afghanistan
Subject: Unknown
Victim: Abdul Wahlid
Time/Date of Sketch: 2145Z, 7 Nov 03
Prepared By: SA [redacted]

014012

b7c-4,b6-1

For Official Use Only

LAW ENFORCEMENT SENSITIVE

Exhibit 8

000030

Page(s)

31- 34

Referred to:

DEPARTMENT OF DEFENSE
CRIMINAL INVESTIGATION
TASK FORCE
9900 DALRYMPLE ROAD
BUILDING 714 –2674
FORT BELVOIR, VIRGINIA
22060-5506

Major Louis P. Yob
Louis.P.Yob@beml101.belvoir.army.mil
(703) 805-2074

014013

Page(s)

35-37.

.

Referred to:

U.S. ARMY MEDICAL COMMAND
FREEDOM OF INFORMATION/
PRIVACY ACT OFFICE
ATTENTION: MCFP
2050 WORTH ROAD, SUITE 13
FORT SAM HOUSTON, TEXAS
78234-6013

MR. JOHN PETERSON
John.Peterson1@cen.amedd.army.mil
(210) 221-7826

014014

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1*	ROI NUMBER 0174-03-CID369-49232
	PAGE 1 OF 1 PAGE

b7C-3, b6-3

DETAILS

About 1200, 7 May 04, the undersigned, briefed CPT [redacted] Office of Staff Judge Advocate (SJA), Kandahar Air Field (KAF), Afghanistan, on the status of this investigation. CPT [redacted] opined Mr. WAHID's death was a result of injuries he received in the custody of the Afghanistan Militia Force (AMF), and there had been no wrong doing by the American Forces. b7C-3, b6-3

About 0930, 12 May 04, the undersigned, received an electronic generated Final Autopsy Report, substitute for SF 503, A03-144, which indicated that the cause of Mr. WAHID's death was Multiple Blunt Force Injuries complicated by Rhabdomyolysis, and the manner of death was Homicide. (See Final Autopsy Report for further details)

b7C-3, b6-3

About 1000, 13 Jun 04, the undersigned coordinated with LTC [redacted], Armed Forces Regional Medical Examiner, Landstuhl Regional Medical Center, GE, who related in her medical opinion Mr. WAHID's injuries would have caused rhabdomyolysis, which would have set in about 24 to 48 hours causing Mr. WAHID to expire. Which is consistent with the time frame from which Mr. WAHID was handed over from AMF custody to USSF personnel. LTC [redacted] further related during the autopsy no other injuries were discovered after the documented injuries had occurred. b7C-4, b6-4 b7C-3, b6-3 b7C-4, b6-4
///Last Entry///

b6-1, b7

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7C-1	ORGANIZATION Kandahar Branch Office Kandahar Air Field Afghanistan, APO AE 09355	
SIGNATURE [redacted] b7C-1, b6-1	DATE 13 June 2004	EXHIBIT 014045

CID FORM 94
1 FEB 77

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Page(s)

39-45

Referred to:

U.S. ARMY MEDICAL COMMAND
FREEDOM OF INFORMATION/
PRIVACY ACT OFFICE
ATTENTION: MCFP
2050 WORTH ROAD, SUITE 13
FORT SAM HOUSTON, TEXAS
78234-6013

MR. JOHN PETERSON
John.Peterson1@cen.amedd.army.mil
(210) 221-7826

0174-03-CID369-49282

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0065-04-CID023

Page 1 of 1

BASIS FOR INVESTIGATION:

This investigation was initiated when this office received a Request for Assistance (RFA) from the Afghanistan Military Police Detachment (CID), 3D Military Police Group (CID), Bagram Air Field, APO AE 09354, to locate and fully identify and conduct follow up interviews of SFC [redacted], SFC [redacted] SSG [redacted] all A Company, 3rd Battalion, 3rd Special Forces Group (A/3/3 SF GRP), Fort Bragg, NC (FBNC), regarding the death of Mr. WAHID (NFI), a local national Person Under Custody (PUC).

b7C-4, b6-4 b7C-4, b6-4 b7C-4, b6-4

At 1053, 24 Feb 04, SA [redacted] interviewed SSG [redacted], A/3/3 SFG, FBNC, who rendered a Sworn Statement, wherein he detailed his medical examination of Mr. WAHID (NFI). SSG [redacted] stated he had not seen anyone inflict any injuries upon Mr. WAHID. (SEE STATEMENT)

b7C-1, b6-1 b7C-4, b6-4 b7C-4, b6-4

About 1430, 2 Jun 04, SA [redacted] coordinated with MAJ [redacted], A/3/3 SFG, FBNC, who related SSG [redacted] was available for interview and would contact this agent ASAP. MAJ [redacted] stated SFC [redacted] was on leave and did not know when he was returning. He additionally stated SFC [redacted] was at an Intelligence Course until approximately 1 Jul 04, but he would have him contact this agent ASAP.

b7C-1, b6-1 b7C-3, b6-3 b7C-4, b6-4 b7C-3, b6-3 b7C-4, b6-4

About 2103, 2 Jun 04, SA [redacted] interviewed SSG [redacted] who provided a Sworn Statement, wherein he further detailed his medical examination of WAHID. (SEE STATEMENT)

b7C-1, b6-1 b7C-4, b6-4

About 1826, 3 Jun 04, SA [redacted] interviewed SFC [redacted], who provided a Sworn Statement, wherein he detailed his contact with WAHID and standard operating procedures for handling detainees at his camp. (SEE STATEMENT)

b7C-1, b6-1 b7C-4, b6-4

About 1527, 25 Jun 04, SA [redacted] coordinated with SFC [redacted], A/3/3 SFG, FBNC, who stated the unit had just deployed to Afghanistan and SFC [redacted] would be at the same firebase as the last rotation. SFC [redacted] was the Rear Detachment NCO and was not sure which day SFC [redacted] had deployed. b7C-3, b6-3

b7C-1, b6-1 b7C-3, b6-3 b7C-3, b6-3

This case is closed in the files of this office, no other investigative activity is anticipated. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7C-1, b6-1, b2	ORGANIZATION ~~87th Military Police Detachment (CID) (DSE)~~ 3d MP Group, Fort Bragg, NC 28310-5000

SIGNATURE [redacted] b7C-1, b6-1	DATE 25 Jun 04	EXHIBIT 13

CID FORM 94
1 FEB 77

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

SWORN STATEMENT

[redacted] b7C-4, b6-4

0174-04-CID369-49232

File Number: ~~0075~~ 0065-04-CID023 Time: 10:53 [redacted] b7C-4, b6-4
Location: CID office, Fort Bragg, NC 28310
Date: 24 Feb 04 b7C-4, b6-4
Statement of: SSG [redacted] b7C-4, b6-4
SSN [redacted]
Grade/Status: ~~E-7/AD~~ E-6/AD [redacted]
Org/Address: A Co., 3rd Battalion, 3rd Special Forces Group (ABN), Fort Bragg, NC 28310

I, [redacted] WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH: b7C-4, b6-4

Q. SA [redacted] b7C-1, b6-1
A. SSG [redacted] b7C-4, b6-4
Q. Is there anything that you did not mention in your statement taken by SA [redacted] that may be of importance to our investigation? b7C-1, b6-1
A. No, I don't think so.
Q. What was your personal interaction with WAHID?
A. I just medically reviewed him, consisting of only a visual inspection, when he was brought into the camp, only for about 5 minutes, and then I checked him when he deceased.
Q. Did you note any injuries when evaluating WAHID?
A. His buttocks and lower back were extremely bruised, he had 10 to 15 assorted sized burns on his chest to his navel area.
Q. Who inflicted the injuries on WAHID?
A. The Afghan Militia Force.
Q. Did WAHID have voice any complaints?
A. No, not while I was there.
Q. How in depth are the medical assessments for detainees?
A. We photograph them, and any injuries that they have, take their vitals, and ask them if they have any medical problems or concerns.
Q. What is the SOP for processing detainees when they arrive at your camp?
A. There is an initial questioning involving background history, a medical assessment, which involves a full body medical assessment, and then they are taken to their cells, to await interrogation.
Q. Who conducted the medical assessment of WAHID?
A. SFC [redacted] b7C-3, b6-3
Q. How were you notified of WAHID's death?
A. Someone, who I can't remember came in and told me that a detainee had died and then I went and observed him, he was outside the PUC hooch, on the ground, covered by a blanket, lying on his back, supine position, he looked like he had been sleeping, so I checked his heartbeat and found none, then I inspected his mouth, to make sure that he didn't choke on anything.
Q. Do you have anything else to add to this statement?
A. No.///END OF STATEMENT///[redacted] b7C-4, b6-4

LAW ENFORCEMENT
SENSITIVE

b7C-4, b6-4

Exhibit: ______ INITIALS [redacted] Page 1 of 2

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014018 Exhibit 14

STATEMENT CONTINUATION
TAKEN AT CID Office, Fort Bragg, NC 28310
Dated 2/24/2004

CONTINUED

[redacted]

AFFIDAVIT

b7C-4,b6-4

[redacted] I, [redacted] HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT. [redacted] b7C-4,b6-4 2

b7C-4,b6-4

[redacted]
(Signature of Person Making Statement)

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 23rd day of Feb 04 at the Fort Bragg CID office, Fort Bragg, NC.

[redacted] b7C-1,b6-1
(Signature of Person Administering Oath)

SA [redacted] b7C-1,b6-1,b2
(Typed Name of Person Administering Oath)

ARTICLE 136 (b)(4) UCMJ
10 USC 936 (b)(4)

(Authority To Administer Oaths)

LAW ENFORCEMENT SENSITIVE

Exhibit: ______

INITIALS [redacted] b7C-4,b6-4

0174-04-CID369-49232

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

b7C-4, b6-4

1. LOCATION CID Office, Fort Bragg, NC 28310	2. DATE *(YYYYMMDD)* 2004/06/02	3. TIME 21:03 [redacted]	4. FILE NUMBER 0065-04-CID023
5. LAST NAME, FIRST NAME, MIDDLE NAME [redacted]	6. SSN [redacted]	7. GRADE/STATUS E-6/AD	

b6-4 b7C b7C-4, b6-4

8. ORGANIZATION OR ADDRESS
A Company, 3rd Battalion, 3rd Special Forces Group, Fort Bragg, NC 28310

9. [redacted] [redacted] b7C-4, b6-4 , WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

b7C-4, b6-4

Q. SA [redacted]
A. SSG [redacted] b7C-4, b6-4
Q. When did you first see WAHID?
A. During his inprocessing.
Q. What was your contact with WAHID?
A. I just visually examined, I did not touch him or talk to him.
Q. Can you describe in detail the initial examination process?
A. We would check their vital signs, listen to their lungs, ask them through an interpreter if they had any medical problems or if they were on any medication or if they were allergic to anything.
Q. Can you descibe how you examined WAHID? b7C-4, b6-4
A. I did his initial exam while SFC [redacted] was inprocessing him. I visually inspected him and noted his injuries.
Q. Can you describe WAHID's injuries?
A. He had real bad bruising on his lower back and buttocks, he had one large scorch mark on his abdomen and a bunch of smaller ones surrounding it.
Q. How big of an area was bruised on WAHID's buttocks?
A. His entire buttock region and about the bottom 3" of his lower back were covered.
Q. How big was the scorch mark on his abdomen? b7C-4, b6-4
A. The large one was about 1" X 1", the smaller ones varied in size.
Q. When were these injuries inflicted upon WAHID?
A. I was told SFC [redacted] that the injuries were inflicted by Afghan Militia Forces.
Q. Did he tell you how the injuries were inflicted?
A. He told me that the scorch marks had been caused by the AMF dripping hot wax on WAHID, I didn't ask about the bruising because almost all detainees had similar bruising when they were transferred into our custody.
Q. Do you know how long WAHID had been in the custody of the AMF before being turned over to US forces?
A. No idea.
Q. Do you know why WAHID had been taken into custody?
A. He was suspected as having killed 2 UN worker's with an IED, I believe.
Q. How long were detainees kept at your camp once it was identified that they may be of intelligence value?
A. I don't know.
Q. Can you detail the process of receiving detainees into US custody?
A. They would be received by whichever team was back in the camp, taken to the medical tent and stripped of all clothing. Team personnel would then photgraph their face for identification purposes and then their body without clothing to document any injuries, or lack there of.
Q. During your previous statement you stated when you found WAHID deceased he was in a state of rigor, can you describe this in further detail?
A. The rigor mortis was in his jaw and the rest of his body was flaccid. I went and researched rigor mortis on the internet and it stated that rigor mortis sets in the jaw first, so I figured he must have died within about 30 minutes of my examining him.
Q. What qualifies you to conduct medical examinations?
A. I went through the 18D course.
Q. Do you know the doctor who examined WAHID at the time of his death?
A. Dr [redacted] who was our Battalion Doctor, there was one other doctor with him, but I don't know his name? b7C-3, b6-3
Q. Can you describe the other doctor?
A. He was about 5'9", short brown hair, a long face, clean shaven, he was probably in his late 30's early 40's.

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4, b6-4	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ *TAKEN AT* ____ *DATED* ____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE USAPA V1.00

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Exhibit 15

0174-04-CID369-49232

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

67C-4,66-4

STATEMENT OF SSG [redacted] TAKEN AT Fort Bragg, NC DATED 2 JUN 04

9. STATEMENT *(Continued)*

Q. Was there an SOP at your camp that detailed the handling of detainees?

A. There may be something somewhere, but I did not read anything. 67C-4,66-4

Q. Do you know MAJ [redacted]?

A. I don't remember the name.

Q. Do you have anything else to add to this statement at this time?

A. No. ///END OF STATEMENT/[redacted] 67C-4,66-4

014021

INITIALS OF PERSON MAKING STATEMENT [redacted] 67C-4,66-4

PAGE 2 OF 3 PAGES

PAGE 2, DA FORM 2823, DEC 1998

USAPA V1.00

LAW ENFORCEMENT SENSITIVE

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Exhibit 15

b7C-4,b6-4 0174-04-CID369-49232

STATEMENT OF SSG [redacted] TAKEN AT Fort Bragg, NC DATED ______

9. STATEMENT *(Continued)*

Not Used [redacted] b7C-4,b6-4

b7C-4,b6-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

b7C-4,b6-4

[redacted]
(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 2nd day of June, 2004 at CID Office, Fort Bragg, NC 28310

[redacted] b7C-1,b6-1
(Signature of Person Administering Oath)

SA [redacted] b7C-1,b6-1
(Typed Name of Person Administering Oath)

UCMJ: Art. 136(b)(4)
(Authority To Administer Oaths)

01402

INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4,b6-4

PAGE 3 OF 3 PAGES

PAGE 3, DA FORM 2823, DEC 1998

LAW ENFORCEMENT SENSITIVE

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USAPA V1.00

Exhibit 15

0124-04-CID369-49232

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL	To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES:	Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE:	Disclosure of your social security number is voluntary.

b7C-4, b6-4

1. LOCATION CID Office, Fort Bragg, NC 28310	2. DATE *(YYYYMMDD)* 2004/06/03	3. TIME 182[redacted]	4. FILE NUMBER 0065-04-CID023
5. LAST NAME, FIRST NAME, MIDDLE NAME b7C-4, b6-4 [redacted]	6. SSN [redacted] b7C-4, b6-4		7. GRADE/STATUS E-7/AD

8. ORGANIZATION OR ADDRESS
A Company, 3rd Battalion, 3rd Special Forces Group, Fort Bragg, NC 28310

9. [redacted] b7C-4, b6-4 , WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

b7C-4, b6-1
Q. SA [redacted]
A. SFC [redacted] b7C-4, b6-4
Q. When did you first see WAHID?
A. About 36 to 48 hours before he died.
Q. What was your contact with WAHID?
A. He was a detainee being held for questioning about the killing of two OGA members and a 7th SF Group guys, he was known to be targeting Americans.
Q. Did WAHID have any injuries when he inprocessed at your camp?
A. Severe bruising to his lower back, buttocks, and hamstrings, he also had burn marks on his stomach.
Q. Can you describe these injuries?
A. He had one continuous, massive black bruise from his lower back to just above his knees. He had third degree burn marks on his abdomen approximately 1 inch in diameter in size from the Afghan Militia Force dripping burning plastic on him. Both his hands and feet were bruised and had abrasions.
Q. Do you know how long WAHID had been in the custody of the AMF?
A. No.
Q. How did you find out how these injuries were inflicted?
A. I can't remember, but I didn't find out until a sometime later. after he had died what had happened.
Q. Can you detail the process of receiving detainees into your camp?
A. They would come into the camp, go through an initial medical assessment, go through an initial interrogation to obtain biographical data, get issued their uniform and blankets and go to the holding area.
Q. During your interrogation of WAHID, did he give you any reason to believe that he would die?
A. No indication of serious injuries other than the ones noted during the medical exam.
Q. Was there an SOP for handling detainees in use at your camp?
A. Yes, we had an unwritten SOP, that was not deviated from except for operational necessity
Q. Do you know the doctor who examined WAHID at the time of his death?
A. I think it was Dr. [redacted], our Battalion PA. b7C-3, b6-3
Q. Can you describe the other doctor?
A. No.
Q. Do you know MAJ [redacted]? b7C-3, b6-3
A. No.
Q. Do you have anything else to add to [redacted] statement at this time?
A. No. ///END OF STATEMENT/// [redacted] b7C-4, b6-4

b7C-4, b6-4

10. EXHIBIT	11. INITIALS OF [redacted] MAKING STATEMENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT [redacted] TAKEN AT ____ DATED ____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

014023

DA FORM 2823, DEC 1998

DA FORM 2823, JUL 72, IS OBSOLETE

USAPA V1.00

LAW ENFORCEMENT SENSITIVE

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000052

Exhibit 16

DATE 03 MAR 2005
FROM AFGHANISTAN CID OFFICE, BAGRAM AIRFIELD //CICR-BGR//
TO: DIR USACRC FT BELVOIR VA //CICR-ZA//
CG USACIDC FT BELVOIR VA //CIOP-ZA//
DIR AFIP AFME WASH, DC//AFIP-CPLF
SPECIAL OPERATIONS COMMAND LIAISON (SA [redacted]) b7c-1, b6-1
STAFF JUDGE ADVOCATE, CJTF 76 (MAJ [redacted]) b7c-3, b6-3
SJA, CFC (COL [redacted]) b7c-3, b6-3
PROVOST MARSHAL OFFICE, CJTF 76 (COL [redacted]) b7c-3, b6-3
SAC, KANDAHAR BRANCH OFFICE

SUBJECT: CID REPORT OF INVESTIGATION - 1ST SUPPLEMENTAL /SSI - 0174-2003-CID369-49232 - 5H1D / 5H2D / 5C1N / 5Y2E

DRAFTER: [redacted] b7c-1, b6-1
RELEASER: [redacted] b7c-1, b6-1

1. DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. 01 OCT 2003, 0001 - 04 NOV 2003, 1214; UNKNOWN LOCATION, AFGHANISTAN

2. DATE/TIME REPORTED: 06 NOV 2003, 2120

3. INVESTIGATED BY: b7c-1, b6-1, b2
SA [redacted] b7c-1, b6-1, b2
SA [redacted] b7c-1
SA [redacted] b7c-1, b6-1

4. SUBJECT:
1. (UNKNOWN), ; AFGHANISTAN MILITIA FORCES, UNKNOWN LOCATION, AF; MURDER (UNFOUNDED), VOLUNTARY MANSLAUGHTER, AGGRAVATED ASSAULT, TORTURE (NFI)

5. VICTIM:
1. WAHID, ABDUL (DECEASED) ; CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT ; MURDER (UNFOUNDED), VOLUNTARY MANSLAUGHTER, AGGRAVATED ASSAULT, TORTURE (NFI)

6. INVESTIGATIVE SUMMARY:

THE INFORMATION IN THIS REPORT IS BASED UPON AN ALLEGATION OR PRELIMINARY INVESTIGATION AND MAY BE CHANGED PRIOR TO THE COMPLETION OF THE INVESTIGATION.

"THIS IS A DETAINEE ABUSE INVESTIGATION."

1ST SUPPLEMENTAL:

THE PURPOSE OF THIS SUPPLEMENTAL REPORT IS TO DOCUMENT THE REOPENING OF THIS INVESTIGATION TO ADD ADDITIONAL OFFENSES AND TO UNFOUND THE OFFENSE OF MURDER PERTAINING TO THE UNKNOWN AMF PERSONNEL.

ON 2 MAR 05, THIS OFFICE RECEIVED A REQUEST FOR CORRECTION (0128-05-CID001) FROM HQUSACIDC IN WHICH THE DETAINEE ABUSE TASK FORCE (DATF), USACIDC, DOCUMENTED THEIR FINDINGS DURING THEIR REVIEW OF THIS INVESTIGATION. DURING THEIR REVIEW, IT WAS NOTED THERE WAS NO EVIDENCE IN THE INVESTIGATION TO SUPPORT THE OFFENSE OF MURDER IN THAT SPECIFIC INTENT COULD NOT BE ESTABLISHED. FURTHERMORE, IT WAS NOTED THAT A SECOND INCIDENT BE ADDED TO ENCOMPASS THE PERIOD BEFORE WAHID'S RELEASE TO THE USSF, AND TO LIST THE OFFENSES OF AGGRAVATED ASSAULT AND TORTURE AS IT PERTAINS TO THE UNKNOWN AMF PERSONNEL. THEREFORE, THIS REPORT REFLECTS THE RECOMMENDATIONS AND REQUEST FOR CORRECTIONS BY THE DATF.

ON 3 MAR 05, COORDINATION WAS EFFECTED WITH THE OFFICE OF THE STAFF JUDGE ADVOCATE, KAF, WHO CONCURRED WITH THE FINDINGS OF THE DATF IN THAT PROBABLE CAUSE EXISTS TO BELIEVE THE UNKNOWN AMF PERSONNEL COMMITTED THE OFFENSES OF AGGRAVATED ASSAULT, TORTURE AND VOLUNTARY MANSLAUGHTER, WHEN THE UNKNOWN AMF PERSONNEL ASSAULTED AND TORTURED WAHID WHICH CONTRIBUTED TO HIS DEATH.

INVESTIGATION PENDING CLOSURE.

FINAL REPORT:

THIS INVESTIGATION WAS INITIATED SUBSEQUENT NOTIFICATION BY THE OFFICE OF THE STAFF JUDGE ADVOCATE, 3RD BATTALION, 3RD SPECIAL FORCES GROUP, KANDAHAR AIRFIELD, APO AE 09355 (KAF), WHO REPORTED A LOCAL NATIONAL BEING DETAINED BY U.S. SPECIAL FORCES (USSF), AND GUARDED BY

THE AFGHANISTAN MILITIA FORCES (AMF), AT FORWARD OPERATING BASE (FOB) GERESHK, HELMOND PROVINCE, AFGHANISTAN (AF), WAS DISCOVERED BY AN AMF GUARD DECEASED ON THE FLOOR OF THE HOLDING AREA.

INVESTIGATION DISCLOSED THAT ON 6 NOV 03, WAHID HAD BEEN DISCOVERED BY AN AMF GUARD UNRESPONSIVE IN A CRUMPLED POSITION IN THE DETAINMENT FACILITY, FOB GERESHK, AF. USSF PERSONNEL CONDUCTED AN INITIAL MEDICAL EXAMINATION OF WAHID AND DETERMINED THAT WAHID HAD EXPIRED. WAHID HAD BEEN IN CUSTODY OF THE AMF FOR AN UNDETERMINED PERIOD OF TIME PRIOR TO BEING TURNED OVER TO USSF PERSONNEL. UPON RECEIPT OF WAHID BY USSF PERSONNEL AT FOB GERESHK, AF, THE USSF MEDICS DOCUMENTED NUMEROUS BRUISES TO WAHID'S GROIN AREA, BUTTOCKS, HIPS AND INJURIES WHICH APPEARED TO BE BURN TYPE INJURIES TO HIS CHEST. ON 13 NOV 03, AN AUTOPSY WAS CONDUCTED ON THE REMAINS OF WAHID WHICH DISCLOSED THE CAUSE OF WAHID'S DEATH AS MULTIPLE BLUNT FORCE INJURIES COMPLICATED BY RHABDOMYOLYSIS, AND THE MANNER OF DEATH WAS HOMICIDE.

FURTHER INVESTIGATION REVEALED THAT FROM THE ONSET OF RHABDOMYOLYSIS TO THE TIME OF WAHID'S DEATH, RHABDOMYOLYSIS WAS CONSISTENT WITH THE TYPE OF INJURIES WAHID HAD RECEIVED PRIOR TO USSF CUSTODY WHICH CAUSED HIS DEATH WITHIN THE 48 HOURS.

7. COMMANDERS ARE REMINDED OF THE PROVISIONS OF AR 600-8-2 PERTAINING TO SUSPENSION OF FAVORABLE PERSONNEL ACTIONS AND AR 380-67 FOR THE SUSPENSION OF SECURITY CLEARANCES OF PERSONS UNDER INVESTIGATION.

8. USACIDC REPORTS ARE EXEMPT FROM AUTOMATIC TERMINATION OF PROTECTIVE MARKINGS IN ACCORDANCE WITH CHAPTER 3, AR 25-55.

DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Afghanistan MP Det (CID)
Building 591, Bagram Airfield, APO, Armed Forces Africa, Canada, Europe &
Middle East 09354-9354

03 Mar 2005

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL SUPPLEMENTAL/SSI - 0174-2003-CID369-49232 - 5H1D / 5H2D / 5C1N / 5Y2E

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2003, 1345 - 06 NOV 2003, 1430; FORWARD OPERATING BASE (FOB) GERESHK, GERESHK, APO AE 09355, AFGHANISTAN

2. 01 OCT 2003, 0001 - 04 NOV 2003, 1214; UNKNOWN LOCATION, AFGHANISTAN

DATE/TIME REPORTED: 06 NOV 2003, 2120 b2

INVESTIGATED BY:
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1, b2
SA [redacted] b7C-1, b6-1

SUBJECT:

1. (UNKNOWN), ; AFGHANISTAN MILITIA FORCES, UNKNOWN LOCATION, AF; MURDER (UNFOUNDED), VOLUNTARY MANSLAUGHTER, AGGRAVATED ASSAULT, TORTURE (NFI)

VICTIM:

1. WAHID, ABDUL (DECEASED) ; CIV; AFGHANISTAN; AFGHANISTAN; MALE; OTHER; CT ; MURDER (UNFOUNDED), VOLUNTARY MANSLAUGHTER, AGGRAVATED ASSAULT, TORTURE (NFI)

INVESTIGATIVE SUMMARY:

"This is a Detainee Abuse Investigation."

This investigation was initiated subsequent notification by the Office of the Staff Judge Advocate, 3rd Battalion, 3rd Special Forces Group, Kandahar Airfield, APO AE 09355 (KAF), who reported a local national being detained by U.S. Special Forces (USSF), and guarded by the Afghanistan Militia Forces (AMF), at Forward Operating Base (FOB) Gereshk, Helmond Province, Afghanistan (AF), was discovered by an AMF guard deceased on the floor of the holding area.

Investigation disclosed that on 6 Nov 03, WAHID had been discovered by an AMF guard unresponsive in a crumpled position in the detainment facility, FOB Gereshk, AF. USSF personnel conducted an initial medical examination of WAHID and determined that WAHID had expired. WAHID had been in custody of the AMF for an undetermined period of time prior to being turned over to USSF personnel. Upon receipt of WAHID by USSF personnel at FOB Gereshk, AF, the USSF medics documented numerous bruises to WAHID's groin area, buttocks, hips and injuries which appeared to be burn type injuries to his chest. Approximately 48 hours after being turned over to USSF personnel, WAHID expired. On 13 Nov 03, an autopsy was conducted on the remains of WAHID which disclosed the cause of WAHID's death as Multiple Blunt Force injuries complicated by Rhabdomyolysis, and the manner of death was homicide.

Further investigation revealed that from the onset of Rhabdomyolysis to the time of WAHID's death, Rhabdomyolysis was consistent with the type of injuries WAHID had received prior to USSF custody which caused his death within the 48 hours.

Further investigation disclosed that the facts of the investigation did not support the offense of Murder, which was subsequently unfounded. However, investigation did support the offenses of Aggravated Assault and Torture as committed by the unknown AMF personnel, which ultimately led to the death of WAHID.

STATUTES:

Unknown Afghanistan Law: Aggravated Assault
Unknown Afghanistan Law: Torture
Unknown Afghanistan Law: Manslaughter
Unknown Afghanistan Law: Murder (Unfounded)

EXHIBITS/SUBSTANTIATION:

Added Attached:

18. Agent's Investigation Report (AIR) of SA [redacted], 3 Mar 05, detailing the reopening of this investigation and coordination with the Office of the Staff Judge Advocate. b7c-1, b6-1

Added Not Attached:

None.

The original of Exhibit 18 is forward to USACRC with the original of this report.

STATUS: This is a Final Supplemental Report.

REPORT PREPARED BY b7c-1, b6-1, b2

[redacted]
SA
Special Agent, [redacted]

REPORT APPROVED BY b7c-1, b6-1

[redacted]
Special Agent-in-Charge

DISTRIBUTION:
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1 - CDR 3D MP GRP USACIDC FT GILLEM GA (email only)
1 - Dir, Armed Forces Institute of Pathology, Bldg 102, 1413 Research Blvd, Rockville, MD (email only)
1 - PROVOST MARSHAL OFFICE, CJTF 76 (COL [redacted]) (email only) b7c-3, b6-3
1 - STAFF JUDGE ADVOCATE, CJTF 76 (MAJ [redacted]) (email only) b7c-3, b6-3
1 - SPECIAL OPERATIONS COMMAND LIAISON (SA [redacted]) (email only) b7c-1, b6-1
1 - FILE

0071-04-CID342

SWORN STATEMENT

0128-04-CID259-80194

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).

PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.

ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.

DISCLOSURE: Disclosure of your social security number is voluntary.

b7C-4,66-4

1. LOCATION: RR2 Box 455, McAlisterville, PA 17049
2. DATE (YYYYMMDD): 2004/07/15
3. TIME: 1510 [redacted]
4. FILE NUMBER: 0071-04-CID342
5. LAST NAME, FIRST NAME, MIDDLE NAME: [redacted]
6. SSN: [redacted]
7. GRADE/STATUS: E-6/AR b7C-4,66-4
8. ORGANIZATION OR ADDRESS: 320th Military Police Battalion DET 1, Sugar Notch USARC, Ashley, PA 18706

9. I, SSG [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH: b7C-4,66-4

I was in Iraq from March 2003 until February 2004: March 2003 until July 2003 Camp Bucca, Umm Qasar, July 2003 until February 2004 Baghdad Correctional Facility, Abu Ghraib. During that time my duty position was as an NCO in the 320th MP BN S-3 section where I worked primarily in the battalion TOC. My duties included supervising the communication center, drafting reports to be reviewed by my superiors and updating status boards in the TOC. My contact with detainees was minimal because of workstation being located in the BN TOC. My recollection of specific air MEDEVACs or a detainee death is vague due to the volume of incidents and the operational pace. My involvement in these situations was limited to monitoring the submission of the 9 line MEDEVAC request by the TOC RTO, and drafting the Serious Incident Report to be reviewed by my superiors, which would in turn submit it to higher headquarters.

Regarding [redacted] I have no recollection of neither his situation, nor those who would have escorted him or performed any medical treatment.

Q: SA [redacted] b7C-4,66-4

A: SSG [redacted] b7C-4,66-4

Q: Did you ever witness a detainee being physically abused, while in Iraq?

A: No.

Q: Did you ever witness the death of a detainee at the hands of a U.S service member?

A: No.

Q: Did you ever witness the death of a detainee, while deployed to Iraq?

A: No.

Q: Did you ever witness or participate in life saving measures on a detainee?

A: No.

Q: Were you at any time responsible for guarding and or escorting detainee's?

A: Not at Baghdad, but while I was at Bucca, Iraq, I escorted detainee's on occasion.

Q: Do you have any recollection of a detainee being air evacuated and subsequently dying at Baghdad Central Correctional Facility (BCCF), Abu Gharib, on 03 Nov 03?

A: No.

Q: Is it possible you had some involvement in this incident?

A: I might have filled out the Serious Incident Report for the air evacuation, however I have no recollection of this.

Q: Approximately how many such air evacuations of detainees were you involved in, while at BCCF?

A: I was probably involved in around 70 air evacuations while I was at BCCF.

Q: Do you have anything you wish to add to this statement?

A: No.///End of Statement/// [redacted] b7C-4,66-4

10. EXHIBIT: 19
11. INITIALS OF PERSON MAKING STATEMENT: [redacted] b7C-4,66-4

PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

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

Admission Remarks

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

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

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

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

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

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

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

31. Selected Administrative Data

Marital Status: Z
DoB:
In/Out Patient: Inpatient
MOS:

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

34. Diagnosis / Operations and Special Procedures:

GSW to neck

S/P neck exploration gor zowell GSW

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of A (b)(6)-2 MAJ,MC

Signature of PAD or Medical Records (b)(6)-2

Automat acsimile - DA FORM 3647, May 79 MEDCOM - 7102

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION

Unknown age young male Iraqi shot by US Forces today in North. Reportedly shot at US Forces when approached.

All- NKDA   MEDS / ∅   PMH / ∅   PSH / ∅

TOB ?

ETOH-?

PHYSICAL EXAMINATION (b)(3)-1

Gen Thin male in NAD. Awake, alert + responsive
HEAD-∅ EYES-PERRLA, EOMI. EARS-∅ NOSE ∅ Throat ∅
NECK Single penetrating wound through platysma ZONE II (L)
CHEST-∅ LUNGS∅ ABDOMEN∅ GU-∅ MS - No deformity
Neuro intact.

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

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

(b)(6)-2 , MD

(b)(6)-2

09 Sept 03

IDENTIFICATION NO.	ORGANIZATION

REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: ... grade; date; hospital ...)*

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 7103

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL REC[illegible] MEDICAL CARE**

DATE	[illegible]MS, DIAGNOSIS, TREATMENT, TREAT[illegible] ORGANIZATION *(Sign each entry)*
9 SEP 03	Pt presents c̄ GSW to neck. 1416 IV
1413	bag Changed. 1416 pulse 73 bpm. 1417 trachal
	deviation. 116/90 BP. 1420 R 18. 1420 fem
All: NKDA	stick performed. Pox 100% – (b)(6)-2 [redacted]
SHx: None	

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

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

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

REGISTER NO.

WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09Sept03	PRE-OP DX - ZONE II Neck injury
1623	POST-OP DX - ZONE II neck wound -
	PROCEDURE - LEFT NECK EXPLORATION
	SURGEON - Dr. (b)(6)-2 / (b)(6)-2 GETA (b)(6)-2
	FINDINGS - Bullet fragments at (L) side C5 Body, and portion in
	Soft tissue.
	Description: GETA. Incision made slightly parallel to
	Left SCM - Dissection made inferior the carotid sheath.
	Tract posterior to carotid sheath ending at (L) side of C5
	Vertebral Body. Carotid sheath opened - Vagus Nerve + Carotid
	artery examined - No evidence of injury. Trachea + esophagus
	distant from injury. Portion bullet entry 3 cm inf to mastoid
	tract traveled posteriorly and transversely in soft tissue.
	wounds explored & irrigated w/ NS. ~~Then~~ wound closed, SCM
	approx. w/ using 3-0 Vicryl followed by closure of Platysma w/
	using 3-0 Vicryl. Skin edges approx w/ Running subcut w/ 4-0
	Vicryl / Benzoin / Steri-Strips. 2 entrance wounds packed w/
	1/4 inch gauze. Pt tol procedure / anesthesia / Extubated and
	transported to ICU in stable condition COND - STABLE Comp - ∅
900 550	IVF: Crystalloid 900cc LR UO - 550cc
100	Antibiotic Ancef 1 gm EBL - 100cc

(b)(6)-2 (b)(6)-2 , MD
MAJ MC USA
(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST		NUMBER

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. 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

MEDCOM - 7105

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9. Sept 2003	EPW S/P Ⓛ neck exploration c̄ debridement c̄ removal of foreign
	body + bullets. Discovered around ammo dump firing upon
	US Soldiers. Ⓛ tracheal deviation upon arrival to ER
	Gen anesthesia 2mg Versed, 200mg Fentanyl, received 900 cc
	LR, U.O. 550cc, 100 cc EBL. 18G to Ⓛ A/C, 16G to
	Ⓡ Hand, Ⓡ Radial A line placed by SGT [redacted] in the OR. (b)(6)-2
	Returned to ICU @ 1630, transferred to bed c̄ assist of four.
	A line zeroed c̄ excellent waveform. 16G to Ⓛ Wrist placed c̄ LR at
	100 cc/hr. 18G heplocked, flushed + patent. Oxygenated 55%
	Ventimask, will wean patient as tolerated to maintain Sats of
	93%. Assessment as follows: Neuro, Pupils 3mm brisk, able to
	move all extremities, resting comfortably c̄ complaints of pain. Resp: Even
	+ unlabored. Lungs CTA in upper fields, diminished in the bases, O2 sats 100%
	on 55% Ventimask. GI: Abdomen flat s̄ distention, BS hypoactive + 4
	Quads. GU: Foley to gravity, clear yellow urine. CV: Pulses 2+ to
	all extremities, skin cool to touch temp 95.6, covered c̄ blankets.
	SR s̄ ectopy 60's-70's. Cap refill brisk. Skin: Noted bulky dressing to
	Ⓛ neck side, dry + intact, will reinforce prn, medicate for
	pain, call HO for difficulty c̄ airway, deviated trach or
	increased swelling due to hematoma ——— (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.

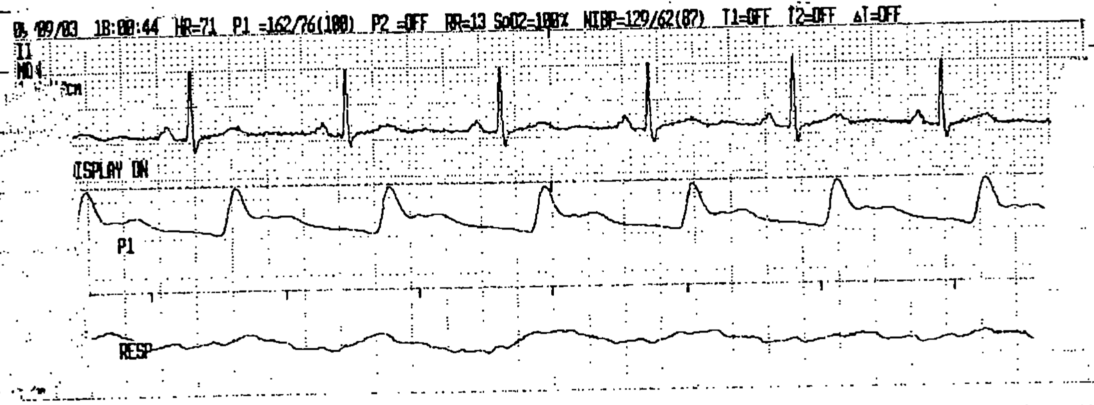
WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

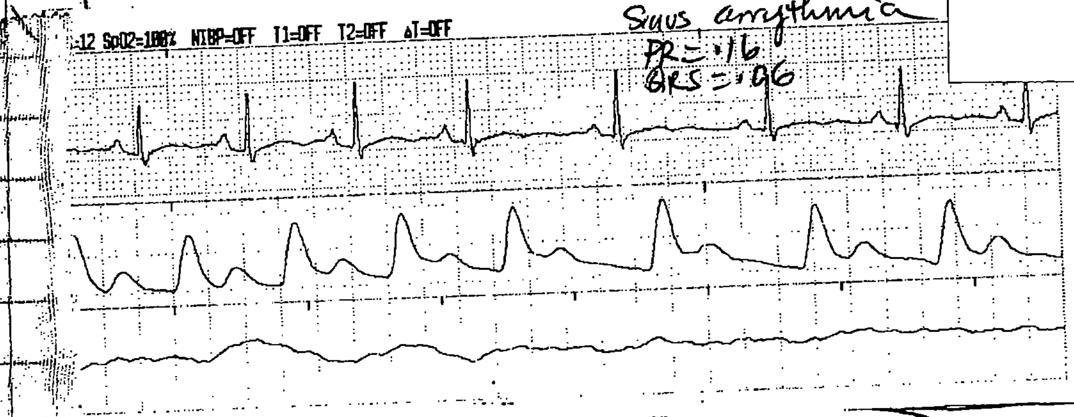

09/09/03 18:00:44 HR=71 P1 =162/76(100) P2 =OFF RR=13 SpO2=100% NIBP=129/62(87) T1=OFF T2=OFF ΔT=OFF
II
MON
1CM
DISPLAY ON
P1
RESP

9 Sept 2003 PR. 16 QRS .08. Patient remains in NSR. O2 Sat on room AR 100%. Dsg to Neck Dry + Intact. Report given to 1LT (b)(6)-2 Patient requesting pain medication. Will notify Dr. (b)(6)-2 —— (b)(6)-2 mg/

9 Sep 03 1800 Report received from day shift. Client in bed connected to cardiac monitor. IVF infusing via Ⓡ hand PIV, foley patent and draining, drsg to Ⓛ neck D+I. —— (b)(6)-2 (b)(6)-2 1LT

1815 Client c/o pain to Ⓛ neck, medicated c̄ 5mg Morphine via IVP. (b)(6)-2 1LT

1900 complete assessment done, see DA form 4700. —— (b)(6)-2 1LT



Sinus arrythmia
PR = .16
QRS = .06
(b)(6)-2

2000 client asleep at this time. (b)(6)-2 1LT

2200 client asleep in NAD, Drsg D+I (b)(6)-2 1LT

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

MEDCOM - 7107

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Sept 03	OP NOTE
1900	PRE-OP DX – ORW GSW w (L) Neck
	POST-OP DX – Same
	PROCEDURE – I&D wound (L) neck
	SURGEON – Dr (b)(6)-2 GETA – Anesth – Cpt (b)(6)-2
	FINDINGS – No evidence of infection but dirty Purulent.
	Description – GETA – Removed Iodoform sponge – Purulent [illegible] –
	No cellulitis or abscess – Cleansed w/ HIBICLENS – Irrigated
	w/ 2L NS then packed wound p̄ debridement (8mg)
	of the two entry wounds. Dressing applied
	Pt tol. procedure well → Anesthesia & extubated
	then transferred to ICU in stable condition.
Ancef 1gm	Drain – Foley [illegible] (b)(6)-2 MD
Unasyn 3gm	(b)(6)-2 (b)(6)-2 MAJ, MC USA
600cc LR	CHIEF, DOS (b)(6)-2
500 UO	

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0900	Pt ~~bathed~~ & Δd. 2 pt ~~restraints~~ on Ⓡ hand & Ⓡ leg – MP guard @ bedside. VSS, pt denies pain. (b)(6)-2 SGT/LPN
1100	Pt c/o dizziness, HOB ↑d to 45°, pt now resting comfortably. (b)(6)-2 SGT/LPN
1300	Pt still c/o dizziness, will notify MD. (b)(6)-2 SGT/LPN
1330	Pt c/o pain - 3mg MSO4 given. Will monitor. (b)(6)-2 SGT/LPN
1600	Pt c/o pain to neck - 3mg MSO4 given. Dressing beginning to ~~drain through~~. Dressing Δd, pt now resting (b)(6)-2 SGT/LPN
10Sept03	S: Pt [illegible] no complaint
	O: Afebrile, VS ~~[illegible]~~
2248	$16.1 \rangle \frac{11.6}{35.4} \langle 302$ $\quad \frac{129}{4.3} \Big| \frac{100}{26} \Big\langle \overset{5}{0.5}$ 122
	Neck - No active bleeding. No trachea deviation or hematoma.
	A: POD# 1 Neck exploration
	P: will take back to OR tomorrow for washout and DPC
	(b)(6)-2 MD
	(b)(6)-2
	MAJ, MC USA
	CHIEF, DOS
	(b)(6)-2

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

MEDCOM - 7109

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

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

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4 [redacted]

MEDCOM - 7110

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Sep 03 0100	Client in bed, asleep, connected to monitor in NAD — (b)(6)-2 [redacted] 1LT
0300	No changes in assessment. — (b)(6)-2 [redacted] 1LT
0330	Medicated with 3mg morphine IVP for pain — (b)(6)-2 [redacted] 1LT
0500	client in bed asleep, in NAD — (b)(6)-2 [redacted] 1LT
0530	client c/o pain to Ⓛ neck area, medicated c̄ 3mg MSO4 IV for pain — (b)(6)-2 [redacted] 1LT
0610	Received report on pt from 1LT [redacted] b(6)-2 Assumed care. Pt a a supine in bed. O2 per RA SaO2 @98% RR 11. Ø evidence distress or resp. discomfort. LR infusing to Ⓡ hand @ 125cc/h Ø evidence infection or infiltration. ⊕ PIV to Ⓛ AC SL'd, ⊕ dried blood around catheter tip, insertion site cleaned & redressed. ⊕ flush, ⊕ BR, ⊕ AL to Ⓡ radial Art. transduced, level, good waveform. ⊕ NIBP cuff to Ⓡ brachial. Cont. A-line monitoring, NIBP x1 q hrs ⊕ correlation. ⊕ foley to gravity clear yellow urine. Pt resting s̄/out evidence pain or discomfort. ⊕ 2pt leather ~~1st to~~ (error Sg) restraints, 1st to Ⓛ wrist, 2nd to Ⓡ ankle. Guard @ BS. Pt speaks arabic, understands some English as reported by 1LT (b)(6)-2 [redacted] Monitoring to cont. Plan: Cont. Cardio Resp monitoring via A-Line, NIBP. c̄ PO. Monitor for airway disturbances, and drainage from wound site. Prep for OR I&D & wound closure for later this am.

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 [redacted]

PROGRESS NOTES
Medical Record

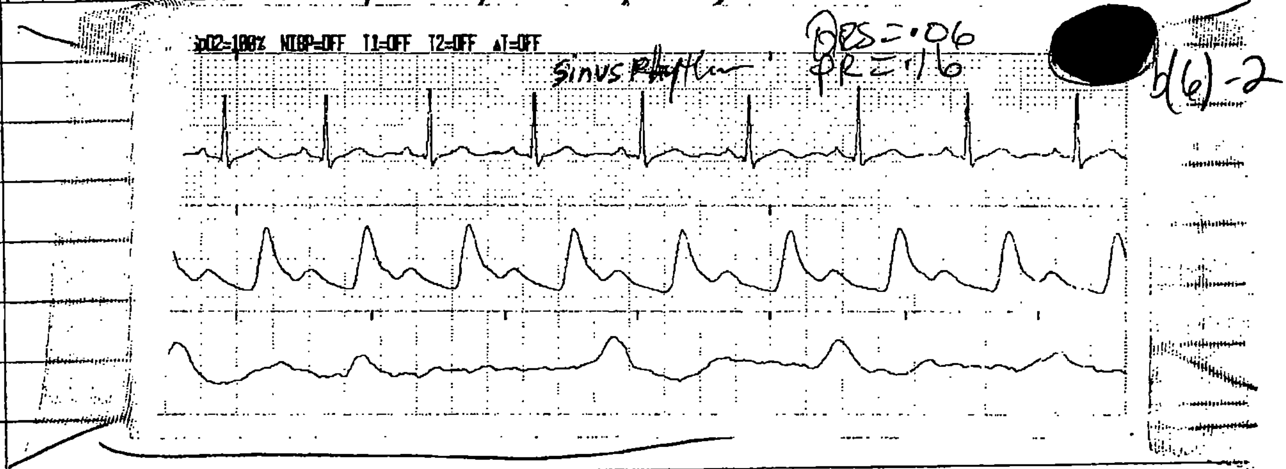
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 7111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

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



Sinus Rhythm
QRS=.06
PR=.16
[redacted] b(6)-2

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

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Nursing cont. 11 Sept 03 0700.

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

0750 Pt prepped for OR. Report on pt status provided to CPT [redacted] b6-2 Pt transferred to OR on litter c̄ LR infusing, foley draining to gravity, O2 per RA. Pt accompanied to OR per staff x2 - no problems on transfer (b)(6)-2

0910 Pt returns from OR on stretcher accompanied by staff x2. O2 per RA. SaO2 98% RR 10 ∅ evidence resp difficulties. Pt A&O, c̄ oriented. moves all extremities, good sensation throughout ⊕ NSR BP 158/96 via A-line, 134/77 via NIBP - HR 71. T= 97.1. A-line zeroed, leveled, ⊕ good waveform. Dressing to neck c/d/i, ∅ drainage. Monitoring to cont. (b)(6)-2

Aline NIBP
915: 152/75 73 98% RR12 133/75 74
920 152/73 73 99% RR13 134/77 72
925 156/76 74 98% RR12 137/78 74

0930
VOPi = 75cc out. 0930: BS = Rhonchi throughout. Will encourage IS. SaO2 = 97-98% RR 13-14 BPM (b)(6)-2

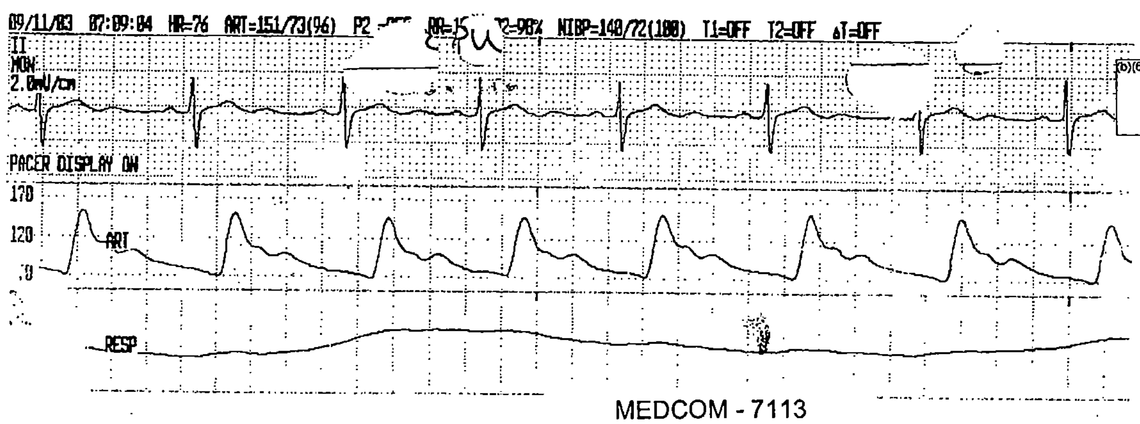
0940: LATE NOTE - 0915: 2PT RESTRAINTS placed - One to Ⓛ wrist, 2nd Ⓛ ankle. Guard c̄ BS. (b)(6)-2

0945 IVF's ↓ 100cc/hr per MD order. IVF to Ⓑ wrist neg ∅ evidence infection infiltration. 87)

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

SPONSOR'S NAME

SPONSOR'S ID NUMBER (SSN or Other)


09/11/03 07:09:04 HR=76 ART=151/73(96) P2 RR=15 2=98% NIBP=148/72(100) T1=OFF T2=OFF ΔT=OFF
CONTINUOUS
II
MON
2.0mV/cm
PACER DISPLAY ON
ADULT
170
120
70
ART
RESP

(b)(6)-4

WARD NO. ICU

ESS NOTES
cal Record

STANDARD FORM 509 (REV. 5/199
ed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

MEDCOM - 7113

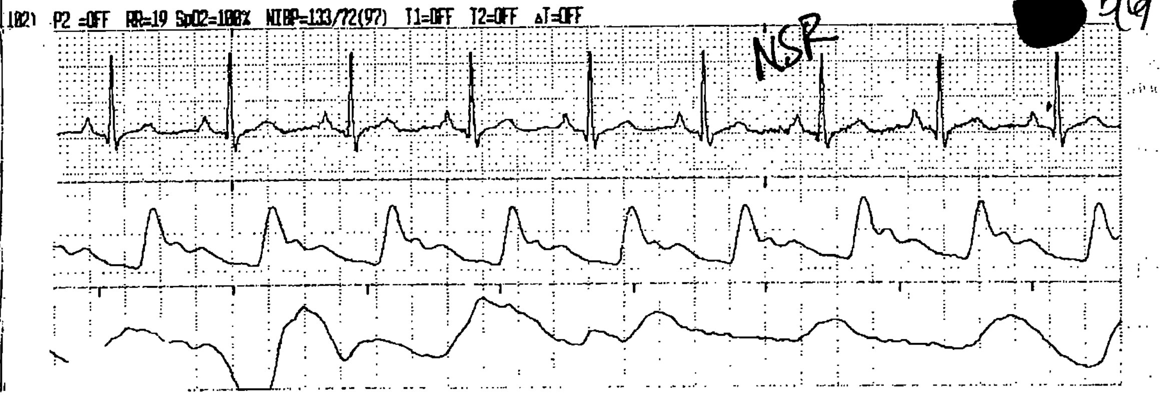
ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Sept 3 1230-	HR - 120's-130's BP - 150-160 systolically - 80's 90's diastolically. Pt c/o headache - Percocet ii PO administered. Pt offered PO intake - H_2O & food - declined solids - consumed 120cc H_2O & soda. (b)(6)-2
~1300	134/74 134HR MAP 91. Pt cont. to complain of headache to (L) side - temporal region, rated 6/10 on pain scale. MSO_4 3mg SIVP administered. Eval pending (b)(6)-2
1320:	MSO_4 2mg IVP administered c/o pt c/o headache VS unΔ'd c̄ HR ↑ 120. Dr. Lowry notified MSO_4 administered. Eval. pending (b)(6)-2
(1320) 128/70 112 HR RR17 SaO_2 98%	1400-: Pt denies pain, States feeling comfortable. Ref. lunch - solids c̄ purees, tolerated 240cc's Instant breakfast. Pt continues to cooperate c̄ IS attaining 1200cc/sec x 4 breaths. & 900cc/sec 8-10 breaths. Dressing to neck saturated c̄ serous drainage. Dressing Δ'd. Will cont to monitor. (b)(6)-2
-	1500-1630 Complete head-to-toe bath, shampoo, shave, ADLS - encouraged and completed. VS remain unchanged c̄ HR @ 120's 130's - BP 130's systolically 70-80's diastolically. Pt denies pain. Dr (b)(6)-2 notified of VS. No new action taken. (b)(6)-2
	1630: Foley d/c'd. Pt up ambulating around ward. Continued practicing w/ incentive spirometer.
(PO) intake this shift = 700 total (UOP) = 1195	1705: Pt Back to bed (R) PIV 16g infiltrated - D/c'd. IVF-LR @100cc/hr started in (L) AC 18g. A-line zeroed, good wave form - leveled. Pt encouraged PO intake & tolerated - 240cc's of fluids. 2 pt restraints placed 1 to (R) UE, 1 to (L) LE skin color good pulses 2+, Pt resting quietly in bed VS taken noted on DA Form 4700 - Physical assessment noted on same DA Form. Report given to oncoming shift 1st (b)(6)-2 (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Sep 03 1800	b(6)-2 Report received from CPT [redacted] client in bed awake + alert. follows commands, connected to cardiac/resp monitor, Ⓡ radial art line c̄ drsg + site intact, good waveform on monitor. LR infusing @ 100cc/hr via Ⓛ AC PIV. —— (b)(6)-2 [redacted] 1LT AN
1900	Assessment done, see DA form 4700. —— (b)(6)-2 [redacted] 1LT
2000	Medicated per order c̄ Unasyn IV, explained to client via interpreter that it is important for him to void soon due to foley being dc'd on previous shift. —— (b)(6)-2 [redacted] 1LT
2030	client up OOB, ambulated well to bathroom with escort, unable to void at this time. Drank 500 ml H_2O, tolerated well and back to bed. —— (b)(6)-2 [redacted] 1LT
2100	Art line zeroed and calibrated, good waveform on monitor VSS. —— (b)(6)-2 [redacted] 1LT AN



1021 P2 =OFF RR=19 SpO2=100% NIBP=133/72(97) T1=OFF T2=OFF ΔT=OFF

NSR

[redacted] b(6)-2

RELATIONSHIP TO SPONSOR

LAST	FIRST	MI:	(SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 7115

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2230	375 cc of dark yellow urine ̄p ambulating to bedside commode —— (b)(6)-2 —
2250	Medicated ̄c 5mg MSO4 for pain to Ⓡ neck + head. — (b)(6)-2 1LT AN
2355	client c/o HA, Pupils round, reactive, medicated ̄c ꜟꜟ percocet PO for HA. —— (b)(6)-2 1LT AN
2400	Dr [redacted] (b)(6)-2 notified of client c/o HA. Ordered toradol IV now. MD aware of client getting percocet for pain. — (b)(6)-2 1LT AN
2400	client on NPO status for surgery in Am. — (b)(6)-2 1LT AN
12 Sep 03 0050	Medicated ̄c 25mg phenergan for nausea — (b)(6)-2 1LT AN
0300	Client asleep in NAD. —— (b)(6)-2 1LT AN
0500	blood drawn from Ⓡ radial art line and sent to lab for analysis. —— (b)(6)-2 1LT AN
0600	Client up to commode, voided 400 cc clear yellow urine ambulated well. Report given to SGT (b)(6)-2 client back to bed on cardiac monitor A-line intact LR @ 100 cc/hr, Drsg to neck D+I. —— (b)(6)-2 1LT AN
0625	Assumed care of pt Rec'd report from 1LT (b)(6)-2 Pt in bed ̄c HOB ↑ 45° angle LR infusing @ 100cc/hr to 18g IV Ⓛ AC. A-Line to Ⓡ wrist zeroed does not correlate ̄c NIBP, restraints on / —— (b)(6)-2 SGT USA

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-4

MEDCOM - 7116

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12Sept03 0930	OP NOTE
	PRE-OP Dx - Open Neck wnds
	POST-OP Dx - Same
	PROCEDURE - I+D, DPC
	SURGEON - Dr. (b)(6)-2 Anesth - CPT (b)(6)-2
	FINDINGS - Clean wnds.
	DESCRIPTION - GETA. Wnds clean s̄ DC - Removed packing, irrigation w/ 2L NS + Undermined wound edges undermined. Muscle fascia approx. w/ 3-0 Vicryl. Skin on 2 ends ~~sites~~ then closed w/ interrupted vertical mattress sutures of 3-0 Nylon. Now plan Steri-strips applied on incisions. Dsg applied. Pt tol procedure well → Ambulated Extubated + Xported to PACU in stable cond.
	IV fluids in - 250cc LR Antibio - UNASYN 3 gm
	UO = ~~MIN~~ → No Drains (b)(6)-2 **MD**
	MAJ, MC USA CHIEF, DOS
	(b)(6)-2 (b)(6)-2 (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1

MEDCOM - 7117

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12Sept03 0630	Pt in bed. Initial assessment complete Neuro/ alert & oriented, easily arousable c̄ verbal stimuli. ⊕ movement to all extremities. Resp./ RR 10 SAO2 98% non labored even ↑↓ Chest LS: CTA & SOB ~~noted~~ Cardiac/ ~~HR~~ HR 71 NSR S^1 S^2 normal & extra sounds & murmur noted. ⊕ peripheral pulses x4. A-Line → Ⓡ wrist zeroed poor wave form does not correlate c̄ NIBP Gastro/ Abd. flat, soft, non-distended. ⊕ BS x4 good ⊖ BM noted. GU/ pt able to urinate → urinal & urine this shift. W/ 18g IV Ⓛ AC infusing LR @ 100cc/hr Ø s/s infiltration, redness. Plan = Pt back to surgery this Am. Will monitor pt. (b)(6)-2 SGT USA
	(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.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

MEDCOM - 7118

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12SEP03 -	1130 - ADMISSION - 25 y/o ♂ RECEIVED FROM ICU VIA LITTER - Dx: HD/DPC NECK WOUND. COND: STABLE. PT AAOx3, PERRLA, LUNGS CTA BILAT c̄ SYMMETRICAL RISE AND FALL IN CHEST. HYPOACTIVE BOWEL SOUNDS x4. S1-S2 STRONG AND REGULAR. PULSES PALPABLE IN ALL EXTREMITIES. CAP REFILL <3. WILL CONTINUE IV ANTIBIOTIC THERAPY (UNASYN 3gm). WILL REINFORCE MEALS WITH ENSURE/CARNATION. IV LR @ 100cc/hr. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT, LPN
	1830 Received pt this pm awake eating. Pt on regular diet. Dsg to Ⓛ side of neck. CDI. ⊖ Drainage noted. No c/o pain at this time. ⊖ SOB ⊖ N/V. lung sounds CTA x4 lobes. Chest expansion full and equal. Pulses equal and palpable. Pt voids in urinal. No distress noted at this time will continue to monitor (b)(6)-2 91WMO SPC USA
	2030 - Pt c/o H/A ṫi Percocet given will monitor (b)(6)-2 SPC USA
	2400 Meds given Pt easily arousable No distress noted will continue to monitor (b)(6)-2 91WMO SPC USA
	0530 Pt sleeping easily arousable. Meds given for 0600 IV site patent No distress noted will give report to oncomming shift (b)(6)-2 91WMO SPC USA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

[redacted] (b)(6)4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7119

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sep 03 1030	Nutrition Note S: Nursing staff reports pt eating approximately 50% of meals and drinking a total of 2 carnation instant breakfasts everyday. O: Diet: Regular c̄ Ensure supplements A/P pt tolerating regular diet and staff is encouraging use of supplements. agree c̄ current diet and will encourage use of supplements as PO intake improves. (b)(6)-2 MAJ, SP RD/LDN
13 Sep 03	- 1100 - A&O x3, PERRLA, LUNGS CTA BILAT, S_1-S_2 STRONG REG, (+) BS x4. Ø c/o PAIN. CONTINUES IV ANTIBIOTIC THERAPY. OOB TO BR. ATE 30-50% OF DIET BOTH BREAKFAST + (b)(6)-2 LUNCH. CARNATION x2. WILL CONTINUE TO MONITOR.
14 Sep 3 1900	Nursing Notes: Assumed care of Pt Sleepy but easily aroused. Pt had no c/o pain received 1800 toradol. Pt able to ambulate to BR without complain or complication. Steri Strips on wound at (L) side of neck clean dry and intact Ø obvious odor or drainage Ø S/S of infection at this time. IV fluids infusing Ø S/S of infiltration at IV site. Will continue to monitor status (b)(6)-2 MGK.
15 Sep 03	Nursing: Shift note Pt. bright + alert Speech clear, poor appetitite, slight cough + tickling in his throat. Upper Resp. wheezing. Given IS @ 30 min (cat)

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 7120

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15Sep03 1725	Nursing: Cont. Explored diet preference this shift. Pt. prefers strawberry carnation & fruits. Pt. states he is use to native food. Pt. additionally states that he is getting negative / smart remarks of some type from guards. Will inform 1SG of escorting unit that EPW's are patients. Continue to assess. (b)(6)-2 CPT AN
15Sep03 20:03	Pt. sleeping in bed easily awakened to verbal stimulus. Skin warm/dry/intact (+)PERRLA WNL. (+)EOM WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+)x4. Abdomens soft/nontender. (+)Radial pulses (B) (+)2 strength. Steri-strips/sutures to (L) side neck C/D/I. s̄ s/s infection. pt. c/o pain to sacral area & noted redness. PIV (L) AC patent infusing LR @ 100cc/hr. Will continue to monitor —— (b)(6)-2 LT/AN
2205	Pt. c/o pain to Sacrum. ii Percocet given
16Sep03	Assessment - 1340 - A&O x3, [illegible], Ø c/o pain. Steri strips to neck C,D,I. Tolerates 100% of reg diet. IV LR continues 00670 BN. Will continue to monitor —— (b)(6)-2 SGT

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7121

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Sep 03	Nurses Notes: Assumed care of Pt ATO.
1900	breathing intact ∅ SOB or Labored breathing
	Pt able to move all extremities s̄ pain or
	complication. Tolerated regular diet OK
	∅ N/V. wound in neck c̄ Steri Strips clean
	dry and intact ∅ bleeding ∅ drainage
	∅ Odor. Pt voids spontaneously. ∅ c/o
	pain at this time. Will continue to monitor
	status —— (b)(6)-2
2300	changed IV tubing. IV infusing s̄ blockage
	—— (b)(6)-2
17Sep03	Nursing ~~Shift~~ Discharge Pt. bright + alert, tolerating
1445	p.o., speech clear in native tongue. Sutures
	removed from neck line + steri-stripped.
	Pt. pain meds given to escort. X-Ray given also
	Pt escorted off ward by responsible unit —— (b)(6)-2

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 7122

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Sept 03	NARRATIVE SUMMARY Iraqi male EPW
1430	who was shot in (L) side of the Neck
	on 09 Sept 03. He underwent Left Neck
	exploration on 09 Sept 03 w/ [illegible]
	Exploration revealed no injury to vital
	structures. 2 penetrating wounds underwent
	delayed primary closure 11 Sept 03. He had
	antibiotic coverage for 3 days w/ Unasyn.
	Currently having minimal pain, ambulating and
	tolerating regular diet.
	NKDA PMH/PSH: otherwise (-)
	MEDS- 1) MOTRIN 800 - po TID w/ Food 2) PERCOCET -
	1 po q 4° prn/pain
	DIET- Regular
	ACTIVITY- Ad lib
	A S/P NECK EXPLORATION FOR ZONE II GSW
	P DISCHARGE TO MP'S.
	(b)(6)-2 (b)(6)-2 , MD
	MAJ, MC USA
	CHIEF, DOS
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; ...irth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7123

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
09	09	03	1413

RTATION TO HOSPITAL ..r enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☐ OTHER (Specify)

CURRE... ication: ⊖

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Spec.)

ALLERGIES NKDA.

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) GSW to Neck. TOI 1300.

SEX M

AGE ~25

POSSIBLE THIRD PARTY PAYER ☐ YES ☐ NO

TIME SEEN BY PROVIDER 1418

VITAL SIGNS

TIME	1413
BP	116/90
PULSE	73
RESP.	18
TEMP.	⊖
WT. (Child)	RA PO 100%.

CATEGORY (See reverse)
☒ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: Pt is ~25 yo Iraqi ♂ EPW who was shot to Ⓛ neck by M-16 from US forces whom he was firing upon at an ammo storage site N. of Tikrit. C/o Hoarseness to voice.

PMHx ⊖
PSHx ⊖.

O: WDWN in mod-sev dist 2° to GSW. GCS 15 min
~~Respir dist~~ ⊕ hoarseness.
HEENT: NC/AT PERRL EOMI ⊖ Bld in A/W.
Neck: Ⓛ lat neck - thru/thru GSW c̄ Tracheal devi to Ⓡ.
⊖ Stridor ⊖ SQ emphy. ⊕ mod swelling to Ⓛ neck.
Chest: Ⓑ eq CTA
Cor RRR ⊖
Abd: ⊕ BS, S, NT ND ⊖ Flo
Ext: all NT FROM. NV intact
Neuro: II-XII intact 5/5 Motor, moves all 4 M Sens

142 | 10? | 8
4.1 | 23 | .4 | 102

17.8 > 12 / 36 < 266

PT/PTT: 15/39 INR 1.59

T&C x 4u:

C-spine: ⊖ fx
⊕ mult frags to Ⓑ neck.
⊕ Ant Spinal ST swelling
Intubated.

EDC: Initiated RSI for Emergent A/W control due to Expanding Ⓛ Neck Hematoma → Trach Devi Brought to OR for Intubation & Surgical A/W back up

ASSESSMENT/DIAGNOSIS

GSW to Ⓛ Neck Zone 2.

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic) Gen Surg.
☒ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

..ME OF RELEASE: 1417.

..TIENT'S IDENTIFICATION (Mechanical imprint) ..R WRITTEN ENTRIES GIVE: Name - last, first, middle; ..; DOB, service status, name and relation of sponsor or next ..in. (IMPORTANT: LIST FACILITY HOLDING TREAT..NT RECORD).

(b)(6)-4

SIGNATUR (b)(6)-2

INSTRUCT...red, any limitations and follow-plans)

To OR for Intubation with Surgical Backup

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.
Prescribed by GSA and ICMR

MEDCOM - 7124

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: unknown
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Lt neck exploration

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing____ Diabetes (Y) (N) ROM____ ASA/Motrin w/72 hrs (Y) (N)
ETOH____ Implants____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS (b)(6)-2
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes X language barrier	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Emergent ~~GSW to~~ error Nickel-size wound and Quarter-size wound at Lt neck region.	c Allow pt. to verbalize freely (b)(6)-2 c ~~Explain OR environment and answer questions regarding surgery.~~ N/A c Offer comfort measures. (e.g., warm blanket, touch). c ~~Explain all nursing procedures before they are done.~~ N/A c Remain with pt. whenever possible. c Maintain family interface. Parents to ~~stay with pt.~~ N/A
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. (b)(6)-2	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. (b)(6)-2 c Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas). (b)(6)-2	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment (b)(6)-2 o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
(b)(6)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since____ ! Jewelry Removed
! UHCG/LMP____ ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:____

EMERGENCY

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 7125

6. PATIENT PROBLEMS AND NEEDS	.IENT GOALS AND EXPECTED OUTCOM	.NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning ___ 3) Existing Disease X 4) Safety Devices ___ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue (b)(6)-2 perfusion (e.g., color, warmth, pedal pulse	o ~~Check for support stockings or ace wraps. If none, check with doctors.~~ N/A o Check that safety straps are correctly applied. (b)(6)-2 o ~~Offer pillow for under knees.~~ N/A o ~~Place and take down legs from stirrups with slow bilateral motion.~~ N/A o. Check that rings and all body piercing has been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ___ 1) Pain ___ 2) Intraoperative Hazards ___ 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery X 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort. (b)(6)-2	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning. (b)(6)-2
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. X Potential for decreased communication due to: ___ 1) Diminished Hearing X 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. c Pt. will be transferred safely to OR tabl (b)(6)-2 c Pt. will be able to understand instructio o Minimize danger of injury during intrao period.	c Introduce self. Keep pt. informed (b)(6)-2 (b)(6)-2 where he/she is and what is happening. 'Inform pt. in which direction to move d assist if necessary (b)(6)-2 ~~Speak clearly and slowly.~~ N/A c ~~Address pt. from ______~~ N/A c ~~Validate pt.'s understanding of verbal communication.~~ N/A c ~~Verify removal of dentures.~~ N/A
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES: Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

(b)(6)-2

9 SEP 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities BREATHING EASY. [✓ (Y)] (N)

☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) none

DATE: 9 SEP 03 TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (b)(6)-2 , MAJ, AN

DATE: 9 SEP 03 TIME: 1632

REVERSE OF FORM 5179, JUN 91

MEDCOM - 7126

USAPA V1.0

MEDICAL RECORD | **INTRAOPER/ ›OCUMENT**

For use of this form, see AR 40-66, the prop ncy is the (b)(6)-2 eral.

PATIENT TRANSPORTED TO OPERATING litter BY CPT (b)(6)-2, CRNA

2. PATIENT IDENTIFIED, RECORD RE (b)(6)-2 URE VERIFIED BY (b)(6)-2 l w/m

DATE ? SEP 03

TIME PATIENT ARRIVED IN SUITE 1417

4. PATIENT IN ROOM TIME 1417 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

OMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2, 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT (b)(6)-2, AN, 66E MAJ (b)(6)-2, AN, 66F	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: arms tucked; head on foam

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

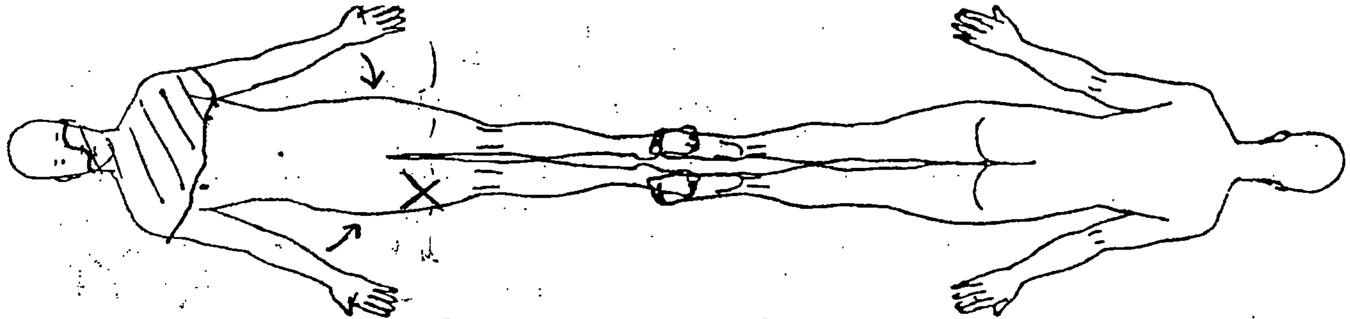
PREP SOLUTION *(Specify)* Beta & Beta

SITE: Ⓛ neck - nose to nipples - to Ⓡ ear BY WHOM: 1Lt (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ESC -- Safety Strap ESC === Tourniquet N/A \\\ = prep

Put by (b)(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect				
Sponge	☒ Yes	☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes	☐ No	C	C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

Setting 30/30

☒ ESU NO: VL 000442 Force II

GROUND PAD: BRAND VL REM

LOT NO: 69671 Exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 7127

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Tetanus Toxoid 0.1 m	0.1 mg	1435	IM	EMT Staff	Dr. (b)(6)-2 [redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2 [redacted]

PHYSICIA

15. X-RA

YES ☒ NO ☐ IF YES, SITE neck + head

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☐	NAME (A) foreign bodies, Lt neck (s)	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME given to surgeons	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley 16FR	1/4" Iodoform Gauze	
SITE	bladder	Lt neck wound	

18. DRESSING/IMMOBILIZATION *(Specify)*
Benzoin
~~Steristrips~~
4 x 8 dressing sponges
Towel
Coverall

9. ADDITI (b)(6)-2 [redacted]

Dr. CPT (b)(6)-2 [redacted] CRNA

. OPERATION(S) PERFORMED

Lt neck exploration, D+I, and foreign body removal

PATIENT TRANSFERRED TO ICU

TIME 1632 METHOD litter

REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] (b)(6)-2 [redacted]

USAPA V1.01

MEDCOM - 7128

MEDICAL RECORD | **INTRAOPER DOCUMENT**

For use of this form, see AR 40-66, the ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN VIA litter BY CPT (b)(6)-2 [redacted] , CRNA

2. PATIENT IDENTIFIE ECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 [redacted] , MAJ, AN

3. DATE 11 SEP 03 TIME PATIENT ARRIVED IN SUITE 0803

4. PATIENT IN ROOM TIME 0803 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Alert, Arabic-speaking. See previous pre-op NPO status maintained

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 [redacted] AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Beach chair. Back elevated to 30°. Pillow under knees. Knees bent. ~~at~~ Ⓑ arms abducted less than 30° at side of bed on padded armboards.

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

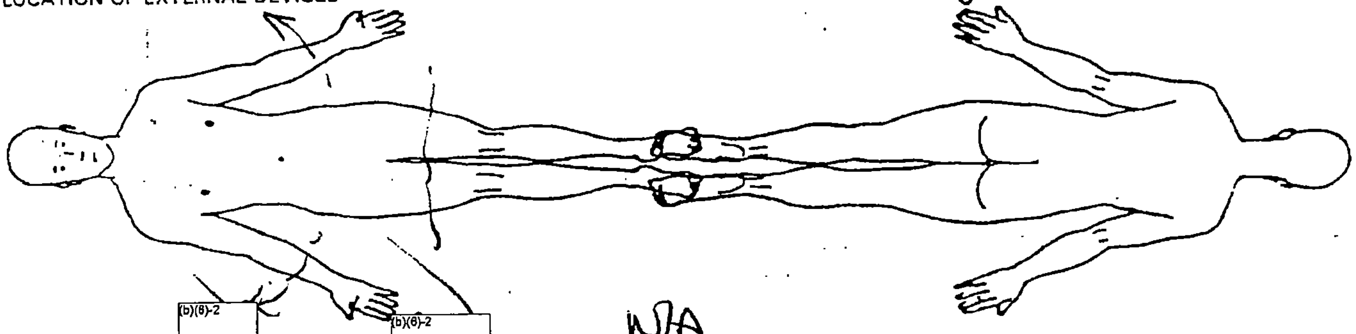
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Lt face + neck + shoulder BY WHOM: (b)(6)-2 [redacted]
SITE: BY WHOM:
COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted] (b)(6)-2 [redacted]

N/A

LEGEND X Ground Pad -- Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect Init by (b)(6)-2 [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4 [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

Settings 20:20

☒ ESU NO: VL 000442 Force II
GROUND PAD: BRAND VL REM
LOT NO: 69671 EXP 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 7129

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUME MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

Hibiclens & NSS - wounds by Dr. (b)(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN (b)(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/4" Iodoform gauze packing	2:	3.
SITE	1. Lt neck wounds	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Benzoin / Steris
4X8 dressing sponges
Kerlix

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2

CPT (b)(6)-2, CRNA

Foley (from ICU)

20. OPERATION(S) PERFORMED

Debridement & Irrigation, Lt neck wounds.

21. PATIENT TRANSFERRED TO ICU

TIME 0905

METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

USAPA V1.01

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 7130

MEDICAL RECORD — **INTRAOP[illegible] DOCUMENT**

For use of this form, see AR 40-66, th[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN[illegible]OOM VIA litter BY anesthesia

2. PATIENT I(b)(6)-2 ROCEDURE VERIFIED BY Ut/m

3. DATE 12 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT I TIME 08^15 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Ⓛ arm tucked, head on pillow

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

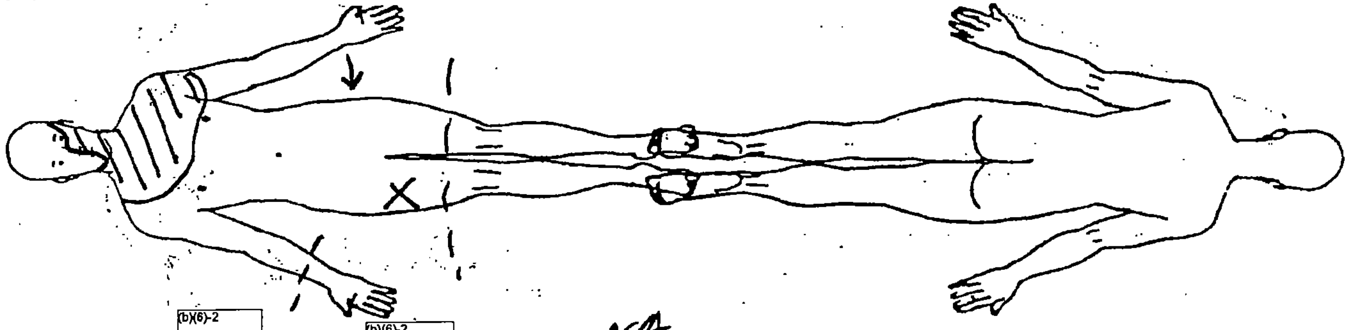
PREP SOLUTION *(Specify)* Beta/Beta

SITE Ⓛ neck to Right neck BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: Ø pooling or irritatin

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 === Tourniquet N/A \\\ = prep

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

LOT NO: 69671 exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 7131

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) [✓ YES ☒] NO ☒ (b)(6)-2

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Surgicel	QS	I/O	Topical	MFR	(b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
1) NSS
2) Hibiclens

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN (b)(6)-2

15. X-RAY IN OPE
YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
Benzoin
Steri Strips
4x8
coverall

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

maj (b)(6)-2 CRNA / CPT (b)(6)-2 CRNA / SSG (b)(6)-2 RT

20. OPERATION(S) PERFORMED
I+D, DPC Ⓛ neck wounds

21. PATIENT TRANSFERRED TO ICU TIME 0935 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT
USAPA V1.01

MEDCOM - 7132

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY	12Sep03														
MONTH-YEAR	DAY	Friday														
19	HOUR	06	07	08	09	10	11	12	13	14	15	16	17	18	19	
PULSE (O)	TEMP. F (•)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°	(•)														36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70		(o)														
60																
50																
40																
RESPIRATION RECORD		12														
BLOOD PRESSURE NBP		129/73														
Heart rate		72														
~~Temp~~ A line (MSE)		154/77														
HEIGHT:	WEIGHT →															
O2 Sat		98%														
LR		100/100	/	/	/	/	/	/	/	/	/	/	/	/	/	
PO																
Urine		400/400	/	/	/	/	/	/	/	/	/	/	/	/	/	

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

INPUT

OTPUT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

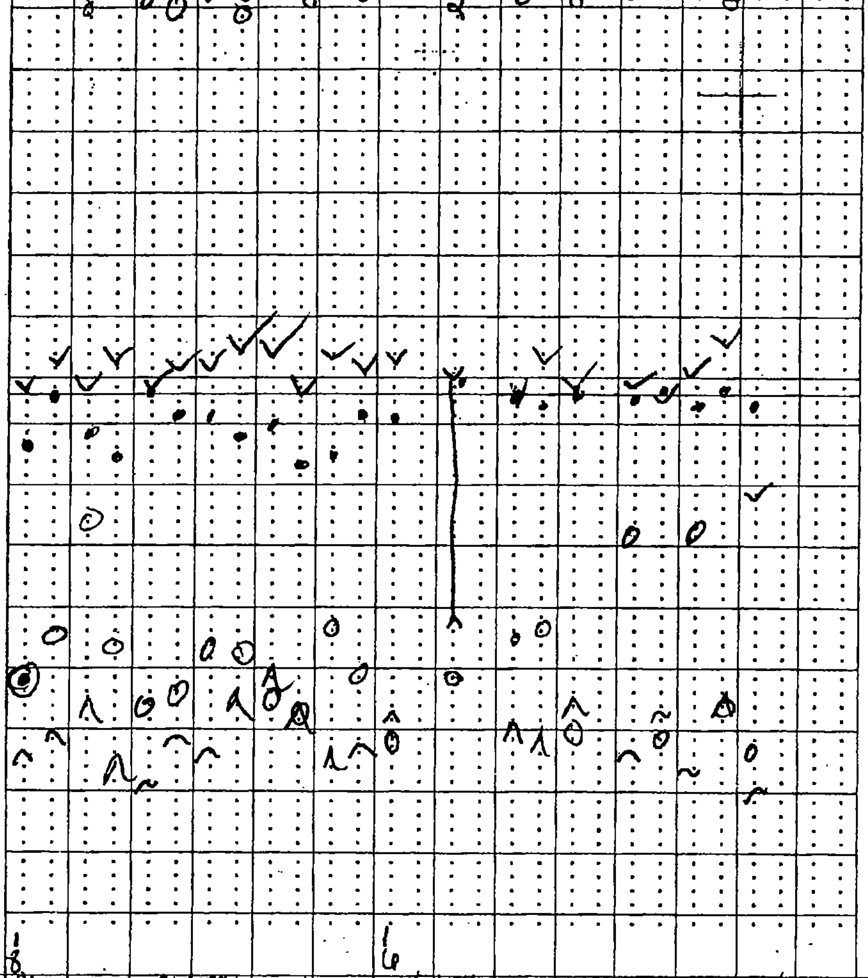
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7133

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	~~4~~ 3				
POST- DAY								
MONTH-YEAR SEP 03 / DAY	12	13	14	~~15~~ 14	15	16	17	
19 / HOUR	[illegible]	[illegible]	[illegible]	1445 / [illegible]	[illegible]	[illegible]	[illegible]	



RESPIRATION RECORD 18 16

Record special data only when so ordered

BLOOD PRESSURE 128/69 128/75 128/61 132/67 133/80 131/67 130/70 108/58 125/72 137/74 139/68 130/64 108/60

133/69 132/64 132/64 137/78 128/72 132/70 120/69 124/70 135/77

HEIGHT: WEIGHT → 98% 98% 96 97 98% 98% 98% 97%

97% 98% 97 97% 99% 98% 99% 97% 98 98 99% 98

98%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7134

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ________ HOURS
TO ________ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
~~60~~	H20	600	600
	milk	250	850

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1100	1L	LR	1L	1830	1000
1200	100	unisyn	100		1100
1830	1000	LR			

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 7135

106

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1400	400	400			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade;*

(b)(6)-4

[redacted]

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* ..	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL.....	240
COFFEE CUP	160	LARGE WATER GLASS...	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER......	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) ...'L 72 WHICH MAY BE USED.

USAPPC V1.00

MEDCOM - 7136

Ward/Section: ICU	Requesting Physician: DR (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 9 Sept 03	TIME 1800	SSN/PSEUDO SSN: –

Hematology (CBC)

TEST	RESULT	REF RANGE
WBC	19.3	4.8-10.8 x 10
RBC	4.09	4.7-6.1 x 10
Hgb	11.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	35.6	45-52% (M) 37-47% (F)
MCV	87.2	80-94 fl (M) 81-99 fl (F)
Plt	272	130-500 x 10 Verified
Lymph %	7.5	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

[redacted] Chem7

TEST	RESULT	REF. RANGE
GLU	126	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
[redacted]	[redacted]	[redacted]
NA*	129	128-145 mmol/l
K*	3.7	3.3-4.7 mmol/l
CL*	104	98-108 mmol/l
CO2	23	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry ~~12~~ 10

Test	Result	Ref Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

CBC, Chem 7

Remarks:

(b)(6)-2	DATE: 9 Sept 03	LAB ID NO:	(b)(6)-4 [redacted]

MEDCOM - 7137

Ward/Section: ENT	Re' 'i' Physican: (b)(6)-2 (b)(6)-2		BORATORY RESULT FORM ject to the Privacy Act of 1974)
Name: (b)(6)-4	Date: 9Sep03	Time: 1421	Patient # (b)(6)-4

Chemistry 7		
Test	Result	Ref. Range
GLU	102	73 - 118 mg/dL
BUN	8	7 - 22 mg/dL
Creat	0.4	0.6 - 1.2 mg/dL
Na	142	128 - 125 mmol/L
K	4.1	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
tCO2	23	18 - 33 mmol/L

Chemistry 12/LFT		
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)		
Test	Result	Ref. Range
WBC	17.8	4.8 - 10.8 x 1E3
RBC	4.07	4.7 - 6.1 x 1E6
Hgb	11.8	14 - 18 g/dL (M); 12-16 (F)
Hct	35.8	45 - 52% (M); 37 - 47% (F)
MCV	87.5	80 - 99 fL
Plt	266	130 - 500 1E3
Lymph%	15.1	20.5 - 51.1 %

Hematology Manual Diff	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT	15.0	9.8 - 13.6 sec
aPTT	39.0 ~~1.59~~	51 21 - 34 sec
INR	~~39~~	N/A 1.59

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions: Type + Cross, PT PTT

Reported By (b)(6)-2	Date 9Sep03	Lab ID # 607

MEDCOM - 7138

Ward/Section: ICU	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	10 Sep 03	TIME
SSN/PSEUDO SSN: (b)(6)-4		

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.1	4.8-10.8 x 10
RBC	4.03	4.7-6.1 x 10
Hgb	11.6	14-18g/dl (M) 12-16 g/dl (F)
Hct	35.4	45-52% (M) 37-47% (F)
MCV	87.7	80-94 fl (M) 81-99 fl (F)
Plt	302	130-500 x 10 Verified
Lymph %	10.1 %	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU	122 *	73-118 mg/dl
BUN	5 *	7-22 mg/dl
CRE	0.5 *	0.6-1.2 mg/dl
[redacted]		
NA*	129	128-145 mmol/l
K*	4.3	3.3-4.7 mmol/l
CL*	100	98-108 mmol/l
CO2	26	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 10 Sep 03	LAB ID NO:

MEDCOM - 7139

Ward/Section: ICU	Requesting Physician: DR (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 11 Sept 03	TIME 0945	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.3	4.8-10.8 x 10
RBC	3.85	4.7-6.1 x 10
Hgb	11.5	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	87.1	80-94 fl (M) 81-99 fl (F)
Plt	307	130-500 x 10 Verified
Lymph %	9.4	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Chem 8 [redacted]

TEST	RESULT	REF. RANGE
GLU	~~165~~ SA	73-118 mg/dl 98
BUN	~~3.15~~ SA	7-22 mg/dl 6
CRE	0.7	0.6-1.2 mg/dl

[redacted]

NA*	128	128-145 mmol/l
K*	4.1	3.3-4.7 mmol/l
CL*	100	98-108 mmol/l
CO2	26	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

b(6)2 **Malaria Smear**

Results:

Microscopic UA

Results: CBC Chem 8

Remarks:

Reported by: (b)(6)-2	DATE: 11 Sept 03	LAB ID NO: 07

MEDCOM - 7140

Ward/Section: ICU	Requesting Physician: Dr (b)(6)-2 [redacted]	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4 [redacted]	12Sep03	TIME 0455	SSN/PSEUDO SSN: (b)(6)-4 [redacted]

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	9.9	4.8-10.8 x 10
RBC	3.45	4.7-6.1 x 10
Hgb	10.1	14-18g/dl (M) 12-16 g/dl (F)
Hct	30.0	45-52% (M) 37-47% (F)
MCV	87.1	80-94 fl (M) 81-99 fl (F)
Plt	265	130-500 x 10 Verified
Lymph %	22.7	20.5-51.1%

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Chem 7 [redacted]

~~TEST~~	RESULT	REF. RANGE
GLU	91	73-118 mg/dl
BUN	5 ↓	7-22 mg/dl
CRE	0.4	0.6-1.2 mg/dl
[redacted]	[redacted]	[redacted]
NA*	134	128-145 mmol/l
K*	3.9	3.3-4.7 mmol/l
CL*	97	98-108 mmol/l
CO2	25	18-33 mmol/l

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2 [redacted]	DATE: 12 Sep 03	LAB ID NO:

MEDCOM - 7141

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG	Units							TOTALS
Midazolam	(mg)	2						2mg
fentanyl	(mcg)	150	50					200 mcg
STP	(mg)	250						250mg
Succ/Zem	(mg)	100	30	20	10	10		100/70mg
Neostigmine/glycopyrolate mg		4/0.6						4/0.6
	( )							

VOLAT AGENT										
Sevo	% del	1.5	1.5	1.0	1.7	1.5	1.5	1.5	0.6	X
	% e.t.									
AIR	L/Min									
N2O	L/Min									
O2	L/Min	8 – 2 – 2 – 2 – 2 – 2 – 2 – 2 – 8 – 15								

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL 100cc

TOTAL URINE 550cc

FLUIDS – SUMMARY

CRYSTALLOID– LR 900cc

COLLOID– X

BLOOD–

FLUIDS

LINE site LR (cc) 18g LAC	☐ Warmed	150	200	350	
	☐ Warmed				
LR (cc) 16g RH	☐ Warmed	100	200	550	
Ancef 1gm 20cc NS	☐ Warmed	X	X		

LOSSES

EST BLOOD LOSS	50	100
URINE –	350	550

PHYS STATUS [✓ 1] 2 3 4 5 [✓ E]

TIME → 1415 30 45 1500 • 30 • 1600 • 30 • 1700

BODY WEIGHT ~~85~~ 80 KG LB

HEMATOCRIT 35.8

INITIAL DATA

BP – 124/69

HR – 60

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME– 1417

SYMBOLS:

Ⓛ arm BP by cuff ∨ ∧ Reg Adult

Heart rate ●

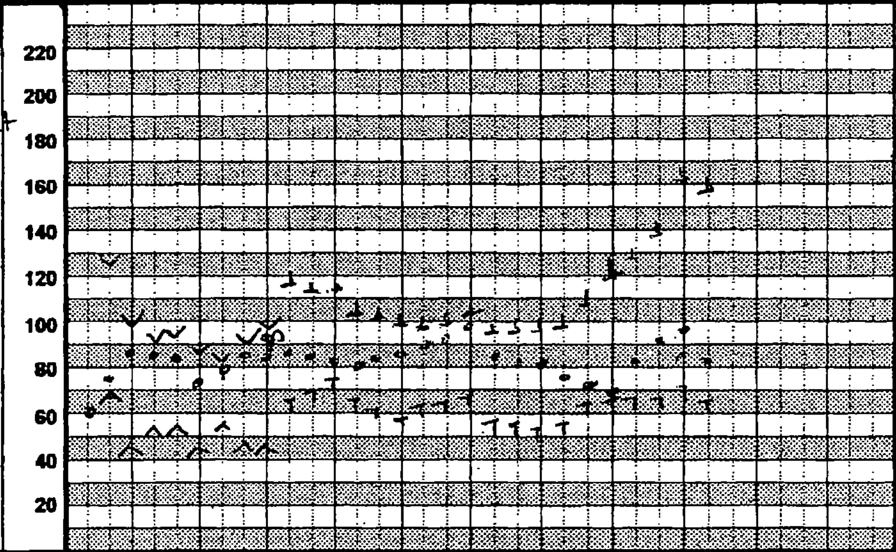
Resp rate

Ⓡ Radial BP (transduced) ⊥ ⊤

TOURNIQUET T – ~~T~~

ANES– X-X

PROC ⊙ – Ø



VENTILATION

I:E = 1:2										
VT – ml		820	840	820	830	830	820	600	>400	
f – breaths/min	16	10	8	6	6	6	6	6	14	26
Peak inf pres / PEEP		17	18	17	17	17	17	14	—	
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S	S

MONITORS / ASSESSMENTS

✓ BP/Auto Cuff	✓ ET CO2 (torr)	42	33	28	31	32	31	30	35	40	—
BP / oth	✓ FIO2 (Frac or %)	.85	.85	.84	.85	.85	.85	.85	.85	.85	0.21
✓ ART line Ⓡ rad	✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
✓ Gas analyzer O2	✓ TEMP- site Axill										
	N-M Block (T/4)	4/4 0/4 4/4	1/4	1/4	1/4	4/4 ē 5T					
Warming blkt		✓✓									
Conv warmer											

Mark with letters & symbols, explain under REMARKS **EVENTS** Ⓛ arm tucked/padded Ⓡ arm <90° secured on padded Armboard.

Position → 0-L ⟶ ⟶ ⟶ ⟶

REMARKS

Code drugs with numbers, events with letters

1410→ In EMT, greeted pt ē GSW to Ⓛ neck. Tracheal deviation to Ⓡ noted ē mild bleeding noted @ GSW site. SaO₂ 100 on RA. Mild stridorous upper airway noises noted upon auscultation of lungs. To OR→ immed.

1417 In OR 1-1. PreO₂. Monitors on. See airway note below. IV induction eyes taped shut.

1455 Ⓡ hand 16g IV placed. Ⓡ radial Aline placed under sterile techniques.

1628 Resp even/ Reg, TV>400. Airway reflexes intact. Opens eyes. Oral Sxn. Extubated, pos pressure breath

1632 To ICU via litter Pt stable. VSS. Report to MAJ Walker RN.

RECOVERY AT 1632

PACU [✓ ICU] (Specify)

OTHER T 95.5 Tymp

CONDITION: Stable

RESP- 26 SpO2- 100% 15L FM

BP- 159/63 HR- 84 ( )

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1410	1417	1645
	Ready	**Begin**	**End**
PROC	1421	1430	1625

PROCEDURES and CPT Codes

Ⓛ neck Exploration & debridement & irrigation of Ⓛ neck GSW ē removal of foreign body

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA O₂ / sevo

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

RSI ē cricoid pressure. DL x 1 ē MAC 3. Grade I view VC. 8.0 ETT placed easily & secured @ 22cm @ teeth. ⊕ sight ⊕ sustained ETCO₂ ⊕ BBS = @ Bite block

PATIENT IDENTIFICATION – *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

SURGEONS: (b)(6)-2

AN (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION OR 1-1

DATE 9 SEP 01

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 7142

*U.S. GPO: 2002-729-180/40137

16.1 11.6/35.4 302   129|100|3 / 4.3|26|0.5 122   Ancef 1g 0200
MSO4 4mg 0530
NKDA   ASA I - s/p GSW to Ⓛ

MEDICAL RECORD   ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " | "=CONSTANT INFUSION

DRUG (Units)						TOTALS
midazolam (mg)	‹2›					2mg
fentanyl (mcg)	100	25	25			150mcg
Propofol (mg)	140					140
Succ / zem (mg)	100 /	20				100 / 20
neostig / glyco (mg)			3/.4			3/0.4
( )						—
VOLAT. AGENT Sevo % del	1.0	.8	.4	1.5	X	
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	8 – 2 – 2 – 2 – 2 – 6					

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: Min

TOTAL URINE: 500cc

FLUIDS — SUMMARY
CRYSTALLOID– LR = 600
COLLOID– X
BLOOD–

FLUIDS

LINE site (R)(ac) 16g RH	☐ Warmed	——— 300 ——— (600)
	☐ Warmed	
Ancef 1g in 50cc NS IVPB	☐ Warmed	X ——— X
Unasyn 3g in 100cc NS (0/6)	☐ Warmed	X ——— X

LOSSES
EST BLOOD LOSS — Min
URINE — 500

PHYS STATUS [✓ 1] 2 3 4 5 E

BODY WEIGHT ~ 45 [✓ KG] LB

HEMATOCRIT 35.4

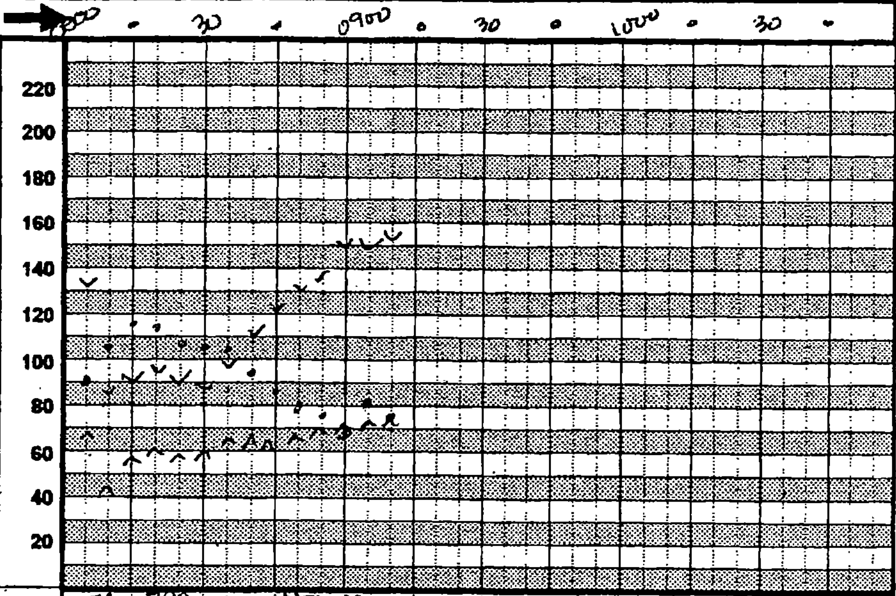
INITIAL DATA
BP – 131/69
HR – 90

EQUIP CHECK
OK?– [✓ Y] N

PATIENT PROCESS
OK for PROCEDURE Yes
TIME– 0745

TIME → 0800 • 30 • 0900 • 30 • 1000 • 30 •

SYMBOLS:
Ⓛ arm BP by cuff
V Reg / Λ Adult
Heart rate ●
Resp rate
BP (transduced) (Ⓛ Rad)
TOURNIQUET T – ⁄
ANES– X-X
PROC–⊙–Ø



REMARKS–
Code drugs with numbers, events with letters

0745 Greeted in ICU. Ⓐ NPO verified. Non-Eng speaking. No change in preop since 9/9/03. VS. Ⓡ radial A line et Bilat arm IVs patent. —

0803 to OR 1-1 via litter. Lifted to bed by 3. Monitors on. PreO2. See Airway note below.

0905 Resp even / reg. TV >400. MAE. Airway reflexes intact. Oral Sxn. Extubated c̄ pos pressure breath. Spont resp resume.

0910 To ICU via litter. VSS. Report to CPT A. Pt stable

VENT

I:E 1:2					
VT – ml	720	720	700	>450	>200
f – breaths/min	8	8	8	15	13
Peak inf pres / PEEP	17	17	17		
MODE– S(pon), A(ssist), C(on)	C	C	C	S	S

MONITORS / EQUIPMENT

✓ BP/Auto Cuff	✓ ET CO2 (torr)	Ⓔ 38	31	30	48	—	
BP / oth	✓ FIO2 (Frac or %)	.89	.90	.90	.90	RA	
✓ ART line Ⓡ rad	✓ SpO2 (%)	100	100	100	100	99%	
Steth- PC/ES	✓ ECG	ST	ST	ST	SR	SR	
✓ Gas analyzer	✓ TEMP- site Axil						
	✓ N-M Block (T/4)	4/4 0/4	4/4		4/4	4/4 SST	
Warming blkt		✓✓					
Conv warmer							

RECOVERY AT 0910
PACU [✓ ICU] (Specify)
OTHER Tc 97.1 Ax.
CONDITION: Stable
RESP– 13   SpO2– 99% RA
BP– 135/74   HR– 71

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0730	0803	0915

	Ready	Begin	End
PROC	0810	0832	0902

Mark with letters & symbols, explain under REMARKS
EVENTS Arms near torso bilat <90° secured on padded armboards
Position → Supine ———→ ——→ OES

PROCEDURES and CPT Codes
① neck wounds debridement + irrigation ~~c̄ delayed primary closure~~ (b)(6)-2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA (O2 sevo)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x 1 c̄ MAC 3 Grade 1 view VC. 8.0 OETT placed + secured @ 22cm @ teeth. ⊕ stylet ⊕ sustained ETCO2 ⊕ BBS = Soft bite block placed.

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETIST (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION OR 1-1

DATE 11 SEP 03

MEDICAL RECORD – ANESTHESIA

WAMC OP 3 EVISED
1 Jan 9.

PAGE 1 OF 1

MEDCOM - 7143

*U.S. GPO: 2002-729-180/40137

see pre-op
9/11/03
NKDA

9.9 > 10. / 30.0 <

134 | 97 | 5 / 3.9 | 25 | 0.4 < 91

Ⓡ radial a-line DC'd
c̄ pressure x 5 min.

MEDICAL RECORD ANESTHESIA

DRUG (Units)		TOTALS
Versed (mg)	2	2
Fentanyl (mcg)	100 … 25	125/125
STP (mg)	325	
Sch (mg)	100	
( )		
( )		
VOLAT AGENT Forane % del / % e.t.	1.0 .8 .6	
AIR L/Min		
N2O L/Min		
O2 L/Min	0 2 2 2 2 0	
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML "I"=CONSTANT INFUSION

TOTAL EBL: Min

TOTAL URINE: 0 –

FLUIDS – SUMMARY
CRYSTALLOID– 250
COLLOID– 0
BLOOD– 0

FLUIDS LINE site		
LR ↑ 350	☐ Warmed	250
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS
URINE –

PHYS STATUS: [✓ 1] 2 3 4 5 E

BODY WEIGHT: 45 [✓ KG] LB

HEMATOCRIT:

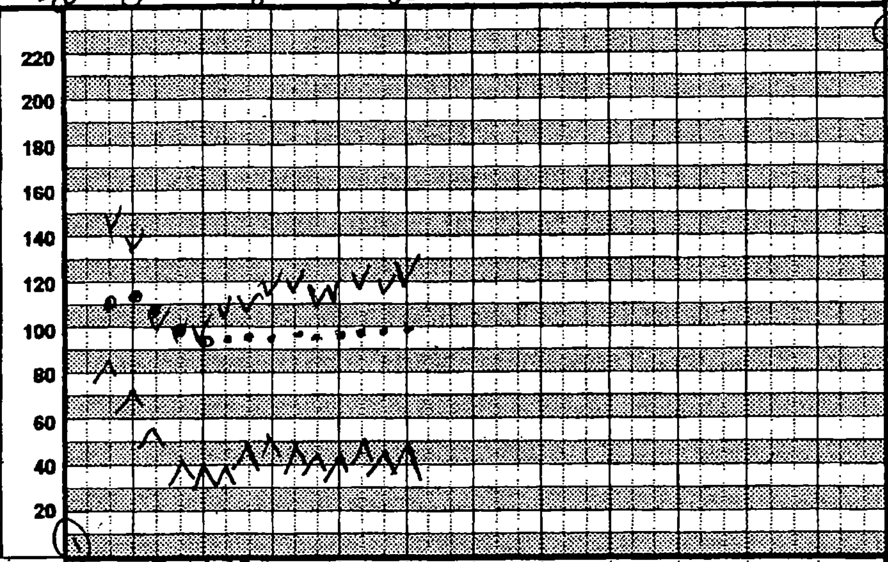
INITIAL DATA:
BP – 142/84
HR – 110

EQUIP CHECK
OK? – [✓ Y] N

PATIENT IDENTIFIED / OK for PROCEDURE? [✓ Y]
TIME – 0823

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ┬ ┴
TOURNIQUET T – ↗
ANES – X-X
PROC ⊙ – Ø

TIME → 0815 0830 · 0900 · 30



REMARKS–
Code drugs with numbers, events with letters
① → OR from ICU
Pre-O2 / monitors – ~~I~~ II.
② Sx'd / extubated c̄ g.g. p̄ SV, TV > 5 cc/kg SaO2 99%.
→ ICU for recovery ~~I~~ patient. Report given

VT – ml	510 530	
f – breaths/min	6 6 12 12	
Peak inf pres / PEEP	13	
MODE– S(pon), A(ssist), C(on)	S C C S S	
BP/Auto Cuff ☒	ET CO2 (torr)	+ 46 51 53 51
BP / oth ☒	FIO2 (Frac or %)	.96 .85 .85 .89 .89
ART line ☒	SpO2 (%)	100 100 100 100 100
Steth- PC/ES ☒	ECG	ST SR SR SR SR
Gas analyzer ☒	TEMP- site	98.6 98.6
	N-M Block (T/4)	0/4 4/4
Warming blkt		
Conv warmer		

RECOVERY AT 0934
PACU [✓ ICU] (Specify)
OTHER 97.4
CONDITION: sleepy Ⓡ
RESP– 16 SpO2– 98%
BP– 132/75 HR– 92

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0830	0822	0940
	Ready	**Begin**	**End**
PROC	0834	0850	0924

Mark with letters & symbols, explain under REMARKS
EVENTS pressure pt's padded BUE < 90.
Position → ⌐

PROCEDURES and CPT Codes
DPC neck wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Mil #2 8.0 ETT @ 22 cm Ⓡ lip ⊕ ETCO2 ⊕ BBS.
Atraumatic. Cuff ↑ extubation by SSG (b)(6)-2 CRT

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

SURGEON (b)(6)-2

ANESTHETIST
(b)(6)-2
CPT, AN
CRNA

PROCEDURE LOCATION OR 1-1

DATE 12 Sep 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99
MEDCOM - 7144

*U.S. GPO: 2002-729-180/40137

13 Sep 03 – post-op

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: ~25 HRS DAYS MOS YRS SEX: [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: Neck Exploration SURGICAL SERVICE: GS - (b)(6)-2 [redacted]

ASA PHYSICAL STAUS [1] 2 3 4 5 [E]
WEIGHT: ~45 [KG]/LB HEIGHT: ______ IN.
ALLERGIES: NKDA

HABITS:

TOBACCO: Ø
ETOH:
DRUGS:

CURRENT MEDICATIONS:

([ ]= ordered as premed)
[ ] Ø
[ ]
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:

None Yes (@ ____ Hrs) /OC
______ mg IV IM PO
______ mg IV IM PO
______ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ______ / ______
U/A:
OTHER:
17.8 / 11.8 / 35.8 / 266

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Denies (via interpreter) Emergent nature

Cardiovascular:	Hypertension	N	Y
	Angina	N	Y
	MI	N	Y
	CVA	N	Y
	Other	N	Y
Pulmonary System:	Asthma	N	Y
	Bronchitis/URI	N	Y
	COPD	N	Y
	Other	N	Y
Renal System:	Acute/Chronic RF	N	Y
Gastrointestinal:	Hepatitis	N	Y
	Hiatal Hernia	N	Y
	PUD	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	[✓ Y] GSW to (R) neck ē tracheal deviation to (R)
Familial HX		[✓ N]	Y

PAST SURGICAL/ANESTHETIC HISTORY

Ø

PHYSICAL EXAMINATION

BP ______ HR 80 RESP ______
HEENT - Teeth Intact
Trachea Deviated to (R)
TMJ/Neck FROM
Oropharynx II
Nares Patent
CHEST: CTA (B) Upper airway stridor
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: LAC 18g
Ulnar Filling:
BACK:
OTHER:

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): ______ [✓] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: (b)(6)-2 [redacted] CPT/CRNA DATE: 9 SEP 03 TIME: 1415 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ______
VITAL SIGNS: BP ______ HR ______ RESP ______ SaO$_2$ ______
RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd
MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep
[ ] Responsive [ ] Unresponsive Block Level ______
REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

[✓] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER
c/o dizziness

CPT/CRNA
Signed: (b)(6)-2 [redacted] DATE: 10 SEP TIME 1200 Hrs

PATIENT IDENTIFICATION: (Ward: ______)

(b)(6)-4 [redacted]

WAMC Form 2300
1 Aug 92 (HSXC-SU) PF MEDCOM - 7145 ☆ U.S. GPO: 1994-628-533/00102

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 09Sept03 TIME OF ORDER 1833 HOURS
LIST TIME ORDER NOTED AND SIGN (b)(6)-2 (b)(6)-2

✓ ① Z PCU - Dr. (b)(6)-2
✓ ② Dx - SP Ⓛ Neck exploration
✓ ③ Cond Stable AN [illegible]
✓ ④ VS q 1°, I+O, A-line, Monitor
✓ ⑤ Activity - Bedrest, Elevate HOB
✓ ⑥ Diet - Clear liquids
✓ ⑦ IV LR TKA 100cc/hr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS
(b)(6)-2

✓ ⑧ Ancef 1gram IVPB q 6°
✓ ⑨ Incentive SP, [illegible] 10-20x/hr
✓ ⑩ Repeat Lat Cervical Spine
✓ ⑪ CXR
✓ ⑫ CBC, Chem Now and in AM
✓ ⑬ May Chg Neck dsg if saturated
✓ ⑭ Call MD for T >101° [illegible] <60

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

>110, SBP <100 or >160, UO <30
Pulse Ox <92%, Expanding
Neck hematoma.

(b)(6)-2
MAJ, MC USA
CHIEF, DOS
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 09Sept03 TIME OF ORDER 1800 HOURS

✓ ① Morphine 2-6 mg IV q 2° PRN pain
✓ ② Phenergan 25mg IV q 4° PRN/Nausea

(b)(6)-2
(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

2200 ✓ 10Sep03 @ 0220 (b)(6)-2

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7146

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10SEPT03
TIME OF ORDER 1700 HOURS
LIST TIME ORDER NOTED AND SIGN: 10Sep 1700 SS

① NPO p̄ MN

(b)(6)-2 (b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10Sept 03
TIME OF ORDER 2247 HOURS
LIST TIME ORDER NOTED AND SIGN: noted @ [illegible] 10Sep03 (b)(6)-2

① ↑ maintenance IV ~ 125cc/hr

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

24° ✓ @11 Sep 03 @0340 (b)(6)-2 , 14 4N

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7147

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Transcribed with (b)(6)-2 0945 11 Sept 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

↓ DATE OF ORDER: 11 Sept 03 TIME OF ORDER: 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

① To ICU - Dr. (b)(6)-2 /
② Dx - SP I+D Neck Mass /
③ cond - Stable NKDA /
④ VS q 4°, I+O, A-line, monitor, SO /
⑤ ACT - Bedrest, elevate HOB /
⑥ DIET - Regular — /
NPO p̄ MN /

DATE OF ORDER TIME OF ORDER ________ HOURS

⑦ IV LR TKO 100cc/hr
⑧ UNASYN 3 grams IVPB q 6°
⑨ INCENTIVE SPIROMETRY 10-20x/hr
⑩ PERCOCET - I-II po q 4° PRN/pain /
⑪ PHENERGAN 25mg IV q 4° prn/nausea /
⑫ MORPHINE 2-6mg IV q 2° prn/pain /
⑬ CBC, chem 8 NOW and in AM ✓

DATE OF ORDER TIME OF ORDER ________ HOURS

⑭ Call MD for T > 101°, P < 60 or > 110, SBP < 100 or > 160, UO < 30cc/hr, SO < 92% ✓
⑮ May chge Neck drsg if > saturated ✓

(b)(6)-2 (b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS

DATE OF ORDER: 11 Sept 03 TIME OF ORDER: 2355 HOURS

① TORADOL 30mg IV now please — noted 2400 (b)(6)-2

(b)(6)-2 (b)(6)-2

24✓ 12 Sep 03 @ 0100 (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 7148 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 12SEPT03
TIME OF ORDER 0935 HOURS
LIST TIME ORDER NOTED AND SIGN

✓ ① To ICU then ICW - Dr. (b)(6)-2
✓ ② DX - SP E+D/DPC NECK WOUND
✓ ③ Cond Stable, NKDA
✓ ④ VS q4°, I+O
✓ ⑤ ACT - up in chair QID, Ambulate w/ assistance QID
✓ ⑥ DIET - REGULAR - Supplement w/ ENSURE (EQUIV) 1-2/meal
✓ ⑦ IV LR TRA 100cc/hr
✓ ⑧ UNASYN 3 gm IVPB q 6°
✓ ⑨ PERCOCET - Give 1-II po q 4° prn pain
✓ ⑩ TORADOL 30mg IV q 6°
✓ ⑪ ZANTAC 150mg po BID
✓ ⑫ TCDB q 1°, INCENTIVE SPIROMETRY 10-20x/hr
✓ ⑬ MULTIVITAMIN - i po q Day
✓ ⑭ call MD for T>101, P<60 or >110, SBP<100 or >160, no UO x 6°.

noted (b)(6)-2 12Sep03 1140

NURSING UNIT ROOM NO. BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2 (b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

NURSING UNIT ROOM NO. BED NO.
8LP / done (b)(6)-2 [illegible]

PATIENT IDENTIFICATION
(b)(6)-4

TIME OF ORDER
13Sep03 1723 HOURS

① DC UNASYN

[illegible] (b)(6) [illegible]

(b)(6)-2
MAJ, MC USA
CHIEF, DOS

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.
to chart / 14Sep03 @ 0145 / (b)(6)-2 [illegible]

DA FORM 4256 1 APR 79

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7149

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 17Sep03

TIME OF ORDER 17⁰⁰ HOURS

LIST TIME ORDER NOTED AND SIGN

② DC c̄ MP's

(b)(6)-2

(b)(6)-2

, MD
MAJ, MC USA
CHIEF, BOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7150

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Sept *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11
9Sept03	(b)(6)-2	VS: Q1°, IFO	06	✓	(b)(6)-2	
		Aline, Monitor, Pulse ox	18	(b)(6)-2		
9Sept03		Act: Bedrest, Elevate HOB	06			
			18	(b)(6)-2		
9Sept03		Diet: Clear Liquids	06			
			18	(b)(6)-2		
9Sept03		Incentive Spirometer	06			
		10-20 [illegible] 1hr	18	(b)(6)-2		
9Sept03		May change Neck	06			
		Dressing if saturated	18	(b)(6)-2		
9Sept03		~~Call MD for T > 101~~	06			
		~~P < 60 > 110, SBP [illegible] > 160~~	18			
	- - - - - -	~~SBP < 100 [illegible] > 160,~~				
	- - - - - -	~~U.O < 30cc/hr, Pulse ox < 92%~~				
	- - - - - -	~~Neck Hematoma~~				
9Sept03	(b)(6)-2	Call MD for T > 101	06	(b)(6)-2		
		P < 60 > 110, SBP < 100 > 160,	18			
	- - - - - -	U.O. < 30cc/hr, Pulse ox				
	- - - - - -	< 92%, Expanding				
	- - - - - -	Neck Hematoma				
	- - - - - -					
	- - - - - -					
	- - - - - -					
	- - - - - -					
	- - - - - -					
	- - - - - -					
	- - - - - -					

D/C'd s/p
1° D
and new
orders
11 Sept 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
Dx: S/P Ⓛ Neck Exploration
Cond: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
Dx: S/P Ⓛ Neck Exploration
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USE USAPA V1.00

MEDCOM - 7151

RA IC DOCUMENTATION CARE PL
(NON-MEDICATION)

Mo ______ *Yr* 2003

Verify by Initialing						
Order Date	**Clerk Nurse**	**SINGLE ACTIONS**	**Date to be Done**	**Time to be Done**	**Time Done**	**Initials**
9Sept	(b)(6)-2	To ICU → Dr (b)(6)-2	9Sept	1630	1630	(b)(6)-2
9Sept		Dx: S/P Ⓛ Neck Exploration; 2nd Stage	9Sept	1630	1630	
9Sept03		Repeat Lateral Cervical Spine	9Sept03			
9 Sept03		C x-ray				
9 Sept03		CBC, Chem, Now	9 Sept03			
9 Sept03		CBC, Chem, in am	10 Sept	0400	0515	(b)(6)-2
10 Sept03		NPO p̄ MN	10 Sep	p̄ MN	2400	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 7152

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Sept *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15									
" Sept	(b)(6)-2	Vital Signs q 4°	06	(b)(6)-2													
		A-line, PO monitor	18														
" Sept		Intake & Output q 8°	06														
			18														
" Sept		ACTIVITY = Bedrest	06														
		Elevate HOB	18														
" Sept		DIET : Regular	06														
			18														
" Sept		Incentive Spirometer	06														
			18														
" Sept		Vital Sign Parameters	06														
		NHO: T > 101°, P < 60	18														
		or > 110, SBP < 100 > 160,															
		UOP < 30cc/hr Sats < 92%															

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Ⓛ Neck GSW s/p I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED USAPA V1.00

MEDCOM - 7153

T .P IC DOCUMENTATION CARE P
(NON-MEDICATION)

Mo Sept *Yr* 2003

Verify by Initialing Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 Sept	(b)(6)-2	Admit to ICU. Dr (b)(6)-2	11 Sept	0930	0930	(b)(6)-2
		DX - SP I&D Neck ; cond: stable				
		NKDA.				
11 Sept		NPO c MN	11 Sept	2400	2400	
11 Sept		CBC/Chem 8 x 1 now	11 Sept	0930	0930	
		CBC/Chem 8 x 1 12 Sept 0500	12 Sept	0500	0455	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
11 Sept -----	(b)(6)-2	Δ Neck dressing, if	
-----	-----	saturated. Ø touch iodo-	
-----	-----	form in wnd.	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

MEDCOM - 7154

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-4
he proponent agency is the Office of The S

Mo. ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROF* *OLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12 13 14 15 16 17
12Sep	(b)(6)-2 [redacted]	Vs Q4° [illegible]	10	(b)(6)-2 [redacted]
			14	
			18	
			22	
			02	
			06	
12Sep	(b)(6)-2 [redacted]	I+O's	06	(b)(6)-2 [redacted]
			18	
12Sep	(b)(6)-2 [redacted]	ACT: UP IN CHAIR QID,	06	(b)(6)-2 [redacted]
		UP ē ASSISTANCE QID,	18	
12Sep	(b)(6)-2 [redacted]	DIET: REG - SUPPLEMENT	06	(b)(6)-2 [redacted]
		ē ENSURE 1-2 /MEAL	12	(b)(6)-2 [redacted]
			18	(b)(6)-2 [redacted]
12Sep	(b)(6)-2 [redacted]	TCDB ē IS 10-20x	06	(b)(6)-2 [redacted]
		per hour	18	
12Sep	(b)(6)-2 [redacted]	CALL MD FOR T>101,	06	(b)(6)-2 [redacted]
		P < 60 or >110, SBP <100	18	
		or >160, NO UOP in 6°		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/p I+D / DPC NECK WOUND

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ________

PATIENT IDENTIFICATION:

(b)(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 7155

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ________ *Yr* ______

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12SEP	(b)(6)-2	TO ICU → THEN ICW D.R. (b)(6)-2	12SEP	0935	1100	(b)(6)-2
12SEP		S/P I&D / DPC NECK WOUND	12SEP			
12SEP		COND'N STABLE	12SEP			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
13SEP	(b)(6)-2	Call MD for	
		T>101, P<60 >110,	
		SBP<100 >160 ō	
		u.o. in 6°	

USAPA V1.00

MEDCOM - 7156

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (*MEDICATIONS*)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* ____

VERIFY BY INITIALING			*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*					
ORDER DATE	**CLERK/ NURSE**	**RECURRING MEDICATIONS, DOSE, FREQUENCY**	**HR**	**DATE DISPENSED**				
				9	10	11	12	
9Sept03	(b)(6)-2	IV: LR TRA 100cc/hr	06	/	(b)(6)-2		D/C	I'd ~~[illegible]~~
10Sep03		↑maintenance IV to 125 cc/hr	18	(b)(6)-2		/		
9Sept03		Ancef 1 gram IVPB Q6°	02	/	(b)(6)-2			D/C'd 11Sept03
			08	/				
	------		14	(b)(6)-2		/		
	------		20					
10Sept03	(b)(6)-2	IVF: LR @ 125 cc/hr	06	/	/	(b)(6)-2		D/C'd 11 Sept [illegible] (b)(6)-2
			18	/	/			
11Sept		IVF: LR @ 100 cc/hr	06	/	/	(b)(6)-2		
			18	/	/			
11 Sept		UNASYN 3g IVBP q6°	02	/	/	(b)(6)-2		
	------		08	[illegible]	/			
	------		14	[illegible]	/	(b)(6)-2		
	------		20	/	/			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Dx: s/p Ⓛ ~~Neck Exploration~~

COND: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EX USAPA V1.00

MEDCOM - 7157

Verify by Initialing

·PEUTIC DOCUMENTATION CARE
(MEDICATIONS)

Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11 Sep 03	(b)(6)-2	Toradol 30mg IV now	11 Sep 03	Now	2400	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY											
			INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION										
			TIME/DATE DISPENSED										
9 Sep 03	(b)(6)-2	Morphine 2-6mg	DATE	9 Sep 03	9 Sep 03	10 Sep 03	10 Sep 03	10 Sep 03	10 Sep 03	11 Sep 03	11 Sep 03	11 Sept 03	11 Sep 03
		IV q 2° PRN/Pain	TIME	1815	2300	0400	1330	1610	2200	0330	0530	1300	2250
			DOSE	5mg	5mg	4mg	3mg	3mg	4mg	3mg	3mg	3mg	5mg
			initial	Sh	Sh	Sn	SS	SS	Sh	Sn	Sh	[illegible]	Sn
9 Sep 03	(b)(6)-2	Phenergan 25mg	DATE	11 Sep 03	12 Sep 03								
		IV q 4° PRN/Nausea	TIME	0210	0050								
			initial	Sh	Sh								
Sept	(b)(6)-2	Percocet i-ii tabs PO	ii (2) PO 11 Sept 1230										
		q 4° PRN pain	Headache [illegible] QE										

USAPA V1.00

MEDCOM - 7158

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED								
				12	13	14	15	16	17	18		
12Sep	(b)(6)-2	IVLR @ 100cc/hr	06	(b)(6)-2								
			08									
12Sep	(b)(6)-2	UNASYN 3gm IVPB	06		(b)(6)-2							
		q6°	12	(b)(6)-2				D/C'd 13 Sep 07				
			18					1720			(b)(6)-2	
			24									
12Sep	(b)(6)-2	TORADOL 30mg IV q6°	06	(b)(6)-2								
			12									
			18									
			24									
12Sep	(b)(6)-2	ZANTAC 150mg PO BID	6	(b)(6)-2								
			22									
12Sep	(b)(6)-2	MULTIVITAMIN i PO q day	10	(b)(6)-2								
~~[illegible]~~	(b)(6)-2											

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: S/P HD / DPC NECKWOUND

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 7159

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. ____ Yr. ____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

TIME/DATE DISPENSED

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY														
12Sep	(b)(6)-2	Percocet - Given	12Sep 1115	12Sep 2000	13Sep 0545	13Sep 1715	13Sep 1940	14Sep 0500	14Sep 2205							
		i - ii po q4° prn/pain	ii 13C	ii GM	ii PO GM	i TSC	i TSC	ii 1400	ii PO GM							

USAPA V1.00

MEDCOM - 7160

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1630	INITIALS	1900	INITIALS (b)(6)-2 [redacted]		INITIALS
NEURO	PUPILS	Pupils 3mm [illegible], [illegible]		PERRLA			
	SENSORIUM	X4. Obeys commands c̄		sleeping but wakes up			
		interpreter help. Denies		to tactile stimulus			
		pain at this time.		MAE X4. in NAD.			
RESPIRATORY	RESPIRATORY PATTERN	Even + Unlabored		easy, nonlabored.			
	BREATH SOUNDS	Lungs CTA in all fields		clear bilat.			
	SECRETIONS	diminished in bases		O_2 Sat 100% on			
		O_2 [illegible] 100% on [illegible]		R/A.			
		Venti Mask.					
SKIN	COLOR	Normal for Race		WNL			
	INTEGRITY	Ⓛ Neck Dressing D+[illegible]		Ⓛ Neck drsg D+I.			
IV SITE	LOCATION	16G to Ⓡ Hand; LR		Ⓡ HAND PIV	Ⓛ AC heplock		
	CONDITION	@ 100cc/hr. Site s̄ redness		patent + dsg	patent + dsg		
		or drainage. 18G to Ⓛ AC		intact. LR	+ site intact		
		Heplocked.		@ 100cc/hr			
				infusing			
GASTRO	ABDOMEN	Abdomen Flat s̄ distention		Flat, nontender			
	BOWEL SOUNDS	BS hypoactive of 4 Quads		⊕ BS x4 quads			
				appetite poor			
GU	URINE:	Foley to gravity, clear		Foley → gravity			
	COLOR/CLARITY	Yellow Urine		clear yellow			
				urine			
CARDIOVASCULAR	CARDIAC RHYTHM	SR PR .16 QRS .08		Sinus arrhythmia.			
		Rate 60's–70's. Pulses		pulses palpable to			
		2+ to all extremities		bilat radials + pedals			
		Cap refill less than 3					
		Seconds					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 9 Sept 2003

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 4700

MEDCOM - 7161

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line												159/65	184/70	144/75	163/78	156/76	157/81	
BP Cuff												130/65		138/75	125/69	124/66	137/69	
Temperature												95^{5}	98^{4}			99^{6}		
Pulse												82	63	84	91	94	89	
Respiratory Rate												24	17	18	12	19	18	
SaO2												100%	100%	100%	100%	100%	100%	
Method														R/A	R/A	R/A	R/A	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR												100/100	100/200	100/300	100/400	100/500	100/600	
OR									400/900									900
IVPB																50/50		
PO															150/150			
TOTALS																		

OUTPUT

		06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR / TOTAL											300/500		28/[illegible]			550/1250		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Blood EBL													100					100
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05	
V	154/81	174/83	144/78	141/74	149/97	161/86	154/88	164/79	
I	144/76	139/78	130/65	138/69	134/69	141/74	144/75	138/72	
T		99^4			99^1				
P	97	86	0	96	98	98	94	85	
R	20	18		19	20	18	14	16	
	100%	100%		99%	99%	99%	99%	99%	
	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	

	22	23	24	01	02	03	04	05	8° T
	100 700	100 800	100 900	100 1000	100 1100	100 1200	100 1300	100 1400	1400
									900
					50 100				100
									2400
		300 1550		100 1630	50 1680			275 1955	1955
									100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______

wt Today ______

INTAKE

IV ______

po ______

OUTPUT

Urine: ______

TOTAL 2400

TOTAL 2055

BALANCE 245

NURSE'S SIGNATURE

INITIALS

(b)(6)-2

(b)(6)-2

MEDCOM - 7163

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0615 INITIALS SS	1900 INITIALS (b)(6)-2 [redacted]	INITIALS
NEURO	PUPILS	3mm ē PERLA	PERRL	
	SENSORIUM	asleep but arousable,	Awake + Alert	
		follows commands,	⊕ commands, MAEs	
		moves all extremities	x 4.	
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored	even, non labored	
	BREATH SOUNDS	CTA bilaterally	clear bilat.	
	SECRETIONS	∅ noted	N/A	
			O2 Sat 99% on	
			Room air.	
SKIN	COLOR	normal for race	WNL.	
	INTEGRITY	surg incision to Ⓛ	drsg to Ⓛ Neck D+I.	
		side of neck, dsg CDI		
IV SITE	LOCATION	Ⓡ EJ, Ⓛ AC heplock	Ⓡ HAND PIV | Ⓛ AC heplock	
	CONDITION	infusing LR @ 100	site + drsg intac | small amt of	
		cc/hr - patent	LR @ 100 cc/hr | dried blood @	
			infusing | insertion site	
			patent & flush | patent flush	
			easily	
GASTRO	ABDOMEN	soft, non tender	soft, flat, nontender	
	BOWEL SOUNDS	⊕ x 4 quads, little	⊕ BS x 4 quad. poor	
		to no appetite	appetite.	
GU	URINE:	Foley to gravity	Foley → gravity	
	COLOR/CLARITY	clear, yellow	clear yellow	
			urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR - all pulses	Sinus rhythm see strip x	
		palpable - Ⓡ radial	pulses palpable x 4.	
		A-line	Ⓡ radial art line with	
			a good waveform on	
			monitor, zeroed + calibrated	

LEGEND	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_IO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
	HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2
[redacted]

(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

DEPARTMENT/SERVICE/CLINIC
ICU

DATE
10 Sep 03

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

(b)(6)-4
[redacted]

DA FORM 4700
MEDCOM - 7164

PAGE 2 O

DATE 10 Sep 03	DX S/P (L) Neck Exploration	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line	165/84	163/85	153/[illegible]	16[illegible]/79	165/78	169/82	158/78	141/70		134/70	148/73	149/75	157/75	165/74	160/78	161/79	152/76	–
BP Cuff	137/71	139/77	144/72	142/71	139/73	138/74	125/65	137/81		139/[illegible]	143/66	143/68	131/68	132/72	136/69	144/72	139/70	
Temperature	98.7					98.4									99.2			
Pulse	83	78	76	76	79	75	78	75		81	81	91	76	78	84	92	91	
Respiratory Rate	23	20	18	15	17	19	16	18		19	15	25	17	11	19	22	19	
O2 Sat	98%	100	100	100	100	100	100	100		100	98	99	98	97	99%	99%	100%	
Mode	R/A	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	R/A	R/A	R/A	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100/100	100/200	100/300	100/400	100/500	100/600	100/700	100/800		100/100	100/1000	100/1100	100/1200	100/1300	100/1400	100/1500	100/1600	
IVPB			50							50/100						50/150		
PO															100/100			100
TOTALS																		

OUTPUT

URINE HOUR/TOTAL	50/50	50/100	100/200	100/300	900/1200	100/1300	500/1800	500/2300		150/2450	100/2550	100/2650	100/2750	400/3150		150/3300		
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 7165

PAGE 3 OF

POST-OP DAY

22	23	24	01	02	03	04	05	
145/64	160/80	162/79	152/80	158/82	162/86	167/85	152/70	
133/73	137/70	140/70	144/70	124/80	141/83	136/69	138/72	
98					98^7			
89	85	76	94	97	98	83	79	
26	17	15	19	25	19	16	15	
99%	98%	98%	97%	97%	97%	97%	97%	
R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	

22	23	24	01	02	03	04	05	8° T
100 1700	125 1825	125 1950	125 2075	125 2200	125 2325	126 2450	125 2575	2575
				50 200				200
								100
								2875
150 3450		150 3600		200 3800		250 4050	100 4150	4150

4150

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

	TIME	
	MODE	
	F_iO_2	
DATA	TV	
	RATE	
	PEEP	
ABG	pH	
	PCO_2	
	pO_2	
	HCO_3	
	SAT	
	BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

TOTAL 2875

OUTPUT

Urine: ______

TOTAL 4150

BALANCE ⊖ 1275

NURSE'S SIGNATURE

(b)(6)-2

INITIALS

(b)(6)-2

MEDCOM - 7166

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0700 INITIALS [illegible]	1900 INITIALS (b)(6)-2	INITIALS
	PUPILS	2mm / 2mm Reactive	PERRLA	
	SENSORIUM	moves all extremities	A+O×3 MAE×4.	
		⊕ sensation throughout	in NAD	
		good strength ē		
		↓ op to U/L ext.		
RESPIRATORY	RESPIRATORY PATTERN	Non labored, even	easy, non labored.	
	BREATH SOUNDS	Clear throughout	clear bilat.	
	SECRETIONS	Ø —	none	
		SaO2 99% RR - 14-16	O2 Sat 98% on Room air	
		BPM	good effort ē incentive	
			spirometer	
SKIN	COLOR	NFR	WNL	
	INTEGRITY	⊕ Gauze dsg neck Ø drainage	Ⓛ neck drsg D+I	
		c/d/i		
IV SITE	LOCATION	PIV to Ⓡ hand, LR @ [illegible] cc	Ⓛ AC PIV	
	CONDITION:	⊖ evidence infiltration	intact	
		⊕ 18g PIV to Ⓛ AC - SL'd	LR @ 100cc/hr infusing	
		⊕ flush ⊖ BR.	flushes easily	
		⊕ AL to Ⓡ radial		
		zeroed, leveled, ⊕ good wave form		
GASTRO	ABDOMEN	⊕ BS x 4 Q. ⊖ distention	⊕ BS ×4 quads	
	BOWEL SOUNDS	⊖ tenderness. Pt	soft, nontender	
		NPO for procedure	appetite poor	
		in OR later this AM		
GU	URINE:	⊕ Foley to gravity, clear	Foley DC'd on previous	
	COLOR/CLARITY	yellow urine out.	shift + has not voided	
		Ø drainage ⊖ edema from meatus [illegible]	yet.	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, HR 80-90's.	NSR, Rate 98.	
		BP 150's systolically	⊕ pulse to all	
		70's diastolically	extremities.	
		A-line secured ⊕ NIBP to Ⓛ UA.		

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

1LT AN

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 11 Sep 03

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TF   MENT

DA FORM 4700, MAY 78

MEDCOM - 7167

AMC OP 375

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line	157/78	134/75		147/71	156/74	138/78		159/89		173/70	135/81			131/75			160/79
BP Cuff	135/66	140/78		137/98	138/82			159/89						123/68			120/72
Temperature	98.7	98.8		97.1						100.0	98.6			97.8			99
Pulse	77	99		74	92			126		123	125			114			89
Respiratory Rate	12	15		14	15			22		18	9			18			14
O2 Sat	97	98		99%	98%			99%		97%	96%			99%			100%
Method	R/A	RA		RA	RA			RA		RA	RA			RA			R/A
MAP		96	OR	98	96			110		82	105			95			
IS								+		+	+					10x	
							Percocet II	MSO4 - 3mg		MSO4 2mg UNASYN						Unasyn	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	125 / 125	125 / 250	100 / 950	125 / 975	100 / 1075	100 / 1175	100 / 1275	100 / 1375		100 / 1475	100 / 1575	100 / 1675	100 / 1775	100 / 1875	100 / 1975	100 / 2075	100 / 2175	
IVPB										100 / 100						100 / 200		
									PO	120 / 120	120 / 240	120 / 360	120 / 580	0 / 700			300 / 1200	1200
P.O	NPO	NPO		0	0	0	→			120 / 120	120 / 240	120 / 360	120 / 360	600	480	480	encourage	
TOTALS																		

OUTPUT

		06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
URINE	HOUR / TOTAL	40 / 40	100 / 140		75 / 215	→					→	875 / 1095	~~50 / 1125~~ void	85 / 1095	0 / 1195			
	sp gr												1130 foley				2030 = no since D/c Foley	
	S/A																	
NG	OUTPUT	N/A																
	pH																	
	GUIAC																	
EMESIS			0	OR														
STOOL			0															
DRAINS		N/A																
TOTALS																		

MEDCOM - 7168

POST-OP DAY

VITAL SIGNS

22	23	24	01	02	03	04	05	
	141/81	142/89	144/88		139/77	146/79		
	140/66	145/76	139/79		135/82	131/67		
						97¹		
	88	93	94		82	74		
	14	17	12		12	12		
	97	99	95		97%	96		
	R/A	R/A	R/A		R/A	R/A		
				unresp				

22	23	24	01	02	03	04	05	8° T
100 2275	100 2375	100 2475	100 2575	100 2675	100 2775	100 2875	100 2975	2975
				100 300				
				100 300				300
							PO	1200
								4475
325 1570								1570

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
ABG	pH								
	PCO_2								
	pO_2								
	HCO_3								
	SAT								
	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO₂								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME			
	MOUTH CARE	DW		
	BATH	DW		
	SKIN CARE	DW		
	FOLEY CARE	0700	1632	
	TRACH CARE	N/A		
	ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

TOTAL 4475

OUTPUT

Urine: ______

TOTAL 1570

⊕ BALANCE 2905

(b)(6)-2

INITIALS

(b)(6)-2

MEDCOM - 7169

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D..

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

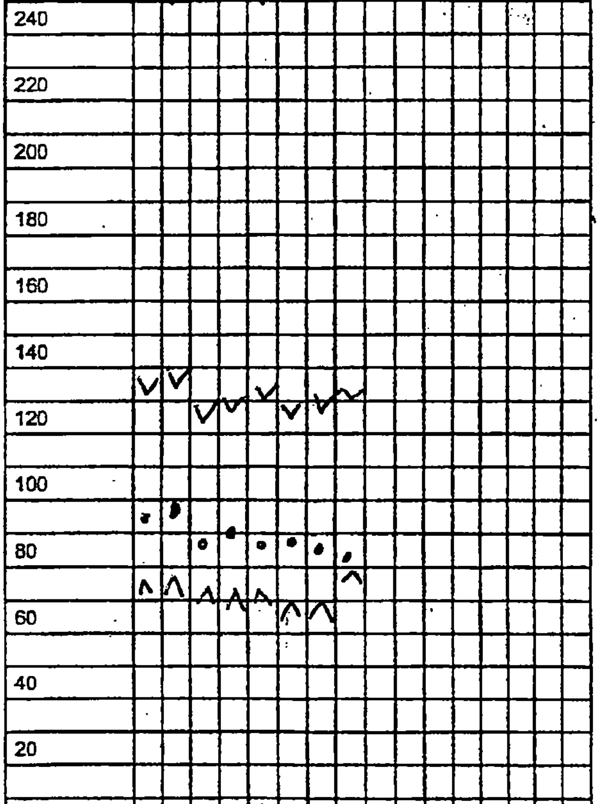
Date: 12 Sept 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 0940
Allergies: NKDA OR Intake: Crystalloid 250 Colloid 0
Pre-op V/S: 142/84 HR110 OR Output: UOP 0 EBL 0
Procedures: DPC wound neck Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	0940	0945	0950	0955	1000	1005	1020	1035								
SaO2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100								
FiO2																
Methods	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	RA	RA								



RR	12	12	16	12	14	12	13	13								
T	97.4		97.5		97.5			97.8								

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0900	LR	100	(L) AC	DS	100
1000	LR	1000	(L) AC	DS	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	11	11

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

(b)(6)-2 [redacted]

9WM6

DEPARTMENT/SERVICE/CLINIC ICU

DATE 12 Sep 03

Name — last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 7170

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

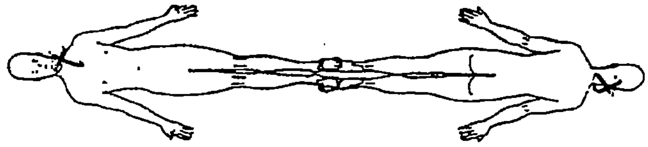
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) neck	Gauze c̄ tape	CDI
30'	(L) neck	" "	CDI
60'	" "	" "	" "
D/C	" "	" "	" "



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0940 Pt transfer to ICU for recover s/p DPC neck wound. ~~Pt~~ Monitors on USS noted on reverse side. Pt appear to be sleeping, lethegic Dsg on (L) side neck guaze c̄ tape. CDI. 18g IV infusing @ 100cc/hr s̄ difficult. Ø SOB SaO2 99%-100% on RA / (b)(6)-2

1035 Pt on litter arousable c̄ verbal c̄ touch stimuli, able to move extremities x 4 Drsg CDI / (b)(6)-2

1050 Report given to SGT Clifford, LPN Pt read for transport (b)(6)-2

1100 Pt transfer via litter to ICU c̄ transfer into bed s̄ difficulty (b)(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 126/75 **T:** **HR:** 74 **RR:** 10 **Sa02:** 100%
Pain Level at D/C (0-10):
Intake: 200cc **Output:** Ø
Additional Data:
Transferred To: ICU
Report Given To: SGT (b)(6)-2 LPN
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signatur (b)(6)-2

MEDCOM - 7171

1. Reporting MTF (b)(3)-1	2. MTF Location (b)(3)-1	**Admission an[illegible]ding Information** For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4	4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity Z
Religion UNKNOWN			
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4
Organization (Active Duty Only)	13. Marital Status Z	Hour of Admission 14:20	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission No
20. Source of Admission Direct from ER	Ward: ICU	Name / Relationship of Emergency Addressee Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: (b)(3)-1		Telephone Number of Emergency Addressee	
21. Type of Disposition DUTY	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-09-17	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-09	
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-09	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW to neck

Procedure Narrative(s): S/P neck exploration gor zowell GSW

Cause of Injury Narrative: Sustained injury while stealling ammunition on US compound

(b)(6)-2

Admitting Officer (Signature, as required)

See DA 3647 (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 7172

ACLU-RDI 1407 p.564

ADMISSION A DING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. B ATION (State or Country Code.)

7

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME (Last, First, Middle Initial)

(b)(6)-4

4. PAY GRADE

16	17

CIV

5. SEX

18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26
1	9						

7. AGE AT ADMISSION

27	28	29

8. RACE

30
X

9. ETHNIC BACKGROUND

31
Z

RELIGION UNK.

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

20

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 1420

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

POW/INT

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION (State or Country Code)

62	63
[redacted]	[redacted]

b(3)-1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA b(6)-4

71

PREV. ADMISSION b6-4

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72

WARD 1C4

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y Y Y M M D D)

81	82	83	84	85	86	87	88
2	0	0	3	0	9	1	7

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	A	

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION (Y Y Y Y M M D D)

99	100	101	102	103	104	105	106
2	0	0	3	0	9	0	9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

107	108
[redacted]	[redacted]

b(6)-4

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)

115	116	117	118	119	120	121	122

FOR LOCAL USE

GSW to Neck

S/P Neck exploration go 20well GSW

DX-8748

Trauma-1 E9912

Injury-450 PR-8605

8622

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 7173

(b)(3)-1

Automated Facsimile

INI. .IENT TREATMENT RECORD C R SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr (b)(6)-4	2. Name (b)(6)-4				3. Grade CIV	Admission Remarks
4. Sex M	5. Age	6. Race X	7. Religion MUSLIM	8. LnthOfSvc	9. ETS	10. PrevAdm NO
11. FMP 99	12. SSN (b)(6)-4	13. Organization				14. Ward ICW
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case BC
21. Source of Admission Direct from ER			22. Hour Of Adm: 00:40	23. Clinic Service ABA - GENERAL SURGERY		
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-09-15		
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-09-07	AdmittingOfficer: DR (b)(6)-2	
29. ReportingMTF (b)(3)-1				30. Date Init Adm 2003-09-07	32. Units Blood Components	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: STEALING AMMUNITION

34. Diagnosis / Operations and Special Procedures:

GSW LEFT BUTTOCKS

877.0

IRRIGATION AND DEBRIDEMENT

86.28

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
		(b)(6)-2			

Signature of Attending Medical Officer

(b)(6)-2 COL, MC

Signature of PAD or Medical Records Officer

(b)(6)-2

(b)(6)-2 SSG, PAD NCOIC

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 7061

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

25 y/o Iraqi ♂ shot by US Forces 2355 c̄ 5.56 in ammo dump, presumably for purpose of securing explosives. Wound to Ⓛ gluteus. No other inj.

PMH ∅ Rcvd Ancef & tetanus in EMT.
PSH ∅
Habits ∅
NKA
Meds ∅
ROS neg

PHYSICAL EXAMINATION

NAD
PERRL EOMI Nares & OP clear
Chest CTA
Cor RRR s̄ Ⓜ
Abd NT
Ext WNL x Ⓛ buttock c̄ T&T wound 5cm distal to iliac crest entry 1cm ant exit 4cm post. NV distally

140 | 3.5 / 164
101 | 27 \ 10/.8
UA 1.030 N
278 > 15.6 / 46.7 < 16.2

PROGRESS *(Enter date of discharge and final diagnosis)*

XR - N
A - Soft tissue GSW Ⓛ gluteus, high velocity
P - Debride in O.R.

(b)(6)-2 [redacted]

LTC, MC
ORTHOPEDIC SERVICE

(b)(6)-2 [redacted]

DATE 7 SEP 03	IDENTIFICATION NO.
ORGANIZATION	
r written entries give Name last, first, le; date; hospital or medical facility)	
REGISTER NO.	WARD NO.

(b)(6)-4 [redacted]

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 7062

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
15 SEP 03	NARRATIVE SUMMARY
28TH CSH	ADMITTED 7 SEP 03 D/C'D 15 SEP 03
TIKRIT	DX – GSW Ⓛ GLUTEUS (BUTTOCK)
IRAQ	PROCEDURES – DEBRIDEMENT Ⓛ BUTTOCK GSW
	7 SEP 03
	RESUME – 25 Y/O [illegible] SHOT 5.56 MM
	Ⓛ BUTTOCK JUST DISTAL TO ILIAC
	CREST WHILE STEALING ARTILLERY ROUNDS.
	NEUROVASCULARLY INTACT. WOUND
	PERFORATING.
	DEBRIDED EMERGENTLY c̄ FINDING
	OF ~ 6CM VIOLATION OF GLUTEUS FASCIA
	& SM AMNT MUSCLE (NONE NON-VIABLE)
	CLOSED OVER PENROSE. 72° ANCEF ABX.
	DID WELL. STAPLES OUT & STERISTRIPPED
	TODAY
	DISPO – D/C TO MP CUSTODY
	MEDS – NONE
	F/U – WOUND ✓ BY DETENTION MED PERSONNEL

(b)(6)-2
[redacted]
...C, MC
ORTHOPEDIC SERVICE

HOSPITAL OR MEDICAL FACILITY
STATUS
DEPAR...
RECORDS MAINTAINED AT
SPONSOR'S NAME
SSN/ID NO.
RELATI... ...SPONSOR
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*
...TER NO.
WARD NO.

(b)(6)-4
[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7063

MEDICAL RECORD ~~CHRONOLOGICAL RECO~~ ~~AL CARE~~

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SY MS, DIAGNOSIS, TREATMENT, TREATING GANIZATION *(Sign each entry)*
12Sep03	1830 Received pt this pm awake in bed eating. Pt on regular diet tolerates. ⊖ c/o pain at this time. ⊖ Sun ⊖ N/V. Dsg to Ⓡ 6 Attack CDI. No s/s infection. Pulses equll and palpable. Lung sounds CTA x4 lobes. abdomen soft. Pt ambulates to ward. No distress noted at this time will continue to monitor
	(b)(6)-2 [redacted] 91WM6 SPC/USA
	2400 Pt sleeping at this time VSS No distress noted will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC/USA
	0520 Pt asleep at this time. Dsg CDI. No pain noted at this time. Will give report to oncoming shift
	(b)(6)-2 [redacted] 91WM6 SPC
13 Sep 03 16 30	Nursing: Shift Note Pt. bright + alert, able to complete ADL's on his own. Ⓡ hip remains intact c̄ staples. Dressing D+I. Eating + hydrating well. ⊘ signs of respiratory distress. Continue to monitor (b)(6)-2 [redacted] CPT
13Sep03 0700	S NO C/O
	O VSS
	DSG DRY
	A DOING WELL
	P D/C STAPLES & PT 15 SEP (b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV [redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP T NSOR	

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 [redacted]

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sep 03 1850	Nurses Notes! Assumed care of Pt A&O. Pt able to answer appropriately to questions asked c̄ nod of head or verbally yes/NO. Breathing intact c̄ ∅ SOB or Labored breathing. ∅ IV access. Dressings dry and intact ∅ bleeding or obvious drainage. Pt Ambulates to Bath Room on outside. Tolerates it well. Abd soft and non tender. Tolerated regular diet - ate approximately 85% of meal. ∅ N/V Voids spontaneously able to move all extremities without complain or complications. ∅ complains of pain at this time will Continue to monitor —— (b)(6)-2
11 Sep 2003 0900	Nursing Assessment: Pt awake, ∅ c/o pain. Pt alert, Lungs CTA, O_2 sats 98% on RA. HR 86, reg, ∅ IV access, ∅ edema to extremities. Abd soft, nontender, ⊕ BS x4. Pt tolerate reg diet. Pt ↑ to latrine outside c̄ MP escort. Drsg to Ⓛ buttock c̄ small amt. of serous shadowing, drsg intact. ↑ OOB amb s̄ assist —— (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Sep 03 1900	Nurse Notes: Assumed care of Pt AAO x3. ~~Ø~~ Ø c/o pain or discomfort. Pt sometimes sits up in bed. Tolerated regular diet Ø N/V. Abd soft and nontender. Marked area on (R) flank c̄ drainage dried Ø obvious bleeding or drainage. Breathing intact Ø SOB or labored breathing. Pt s̄ IV access. Will continue to monitor —— (b)(6)-2
12SEP03	S no c/o O VSSA wound s̄ erythema or fluctuance BBC c̄ scant drainage A doing well P D/C when wound dry (b)(6)-2
12Sep03 1450	Nursing: Pt awake, Ø c/o pain. Restraints in place x2. Pt has new drsg to (L) buttock C/D/I. Steri-strips placed to open area between staples c̄ sm. amt drainage. being C/D/I, O2 sat 98% on RA. HR 80, Ø edema noted. Ø IV access. Abd soft, nontender, pt tolerating reg diet well. ↑ OOB and to BR outside c̄ escort. Pt to be D/C once wound drainage is decreased —— 1LT (b)(6)-2 AN

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 7066

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10SEP03 -	ASSESSMENT - HBO - AAOx3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG, (+)BS x4 DSG C/D/I, 0% PAIN, OOB TO BR, RESTRAINTS, TOLERATED REG DIET CONTINUES IV ANCEF q8° WILL CONTINUE TO MONITOR — (b)(6)-2 SEE
10SEP03	POD 5 S NO C/O O VSS WND CLEAN c̄ MIN SEROUS DRAINAGE A ADNG WND P D/C ABX D/C TO CAGE WHEN WOUND DRY. (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE
10Sep03 1948	Nurse Notes: Assumed care of Pt A+O. Breaths intact ∅ SOB w labored breathing. abd soft and nontender. Pt tolerated regular diet ate small portion ∅ N/V. dressings dry and intact able to move all extremities will continue to monitor — (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7067

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sep 03	Nursing Note: Assumed care of Pt AOx3 but
2252	easily aroused. Breathing intact ∅ SOB or labored
	breathing. ∅ IV access. Vitals stable. dressings
	dry clean and intact. Will continue to monitor
	——— (b)(6)-2 [redacted], 1LT AN
14 Sep 2003 0855	Nursing Assessment: Pt awake, ∅ c/o pain at present. Pt
	alert. Lungs CTA, ∅ SOB apparent; O2 sats 98% on RA. HR 76,
	reg, ∅ edema to extremities. ∅ IV access. Abd soft, nontender,
	⊕BS x4. Pt tolerated reg breakfast. Pt ↑ OOB to BR c̄
	NP @ cont s̄ difficulty. Drsg to (L) buttock CDI. Wound has
	staples intact & steri-strip x1. Small amt. drainage present
	on drsg. ~~Wound~~ ——— 1LT (b)(6)-2 [redacted], AN
14 Sep 03	Nursing Note: Pt Alert and Oriented ∅
1850	c/o pain or discomfort. Tolerated regular
	diet. Vitals stable ∅ IV access pt
	ambulates OK. ∅ increased blood or
	drainage to wound dressings. ∅ odor
	or other signs of infection. Will
	Continue to monitor status ———
	——— (b)(6)-2 [redacted] cq/02
15 Sep 03	Nursing Assessment: Drsg change performed @ 1130. Pt tolerated
1130	drsg change. Small amount of drainage approx the size
	of a dime. New drsg CDI. Wound appears to be
	healing. Drsg was a 4x4 and tape. (b)(6)-2 [redacted] [illegible]

STANDARD FORM 600 (REV. 6-87) **BACK**
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 7068

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8SEP03	POD1
	S NO C/O
	O VSSA
	WND CLEAN, DSD c̄ MOD SEROSANG
	DRAINAGE. PENROSE OUT.
	A DOING WELL
	P 72° W ABD, THEN TO CAGE WHEN WOUND
	DRY
	(b)(6)-2
8Sep 03	Received care of pt. @ 18:00. Pt. lying in bed comfortably.
20:50	20:50 initial assessment - Awake and alert. Restraints x2
	to Ⓡ wrist/Ⓛ ankle. Skin warm, dry, intact. PERRLA ⊕ WNL
	Lungs clear to auscultate throughout Ⓑ. Heart rate regular S_1S_2 WNL
	Bowel sounds ⊕ x4 quadrants. Soft and non-tender. ⊕ Radial pulses
	⊕2 Ⓑ. IV to Ⓛ forearm patent and intact s̄ s/s infection. Dressing
	to Ⓛ Hip clean, dry, intact. & complaints of pain @ this time
	will continue to monitor (b)(6)-2
2153	Vital signs WNL per flowsheet. (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER *(SSN or Other)*

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 Sep 03	ASSESSMENT - 1400 A+O x3, PERRLA, LUNGS CTA BILAT,
	S1 S2 STRONG AND REGULAR, ⊕ BS x4. DRSG C,D,I,
	IV ANCEF 1gm CONTINUES. Ø c/o PAIN. OOB w BR
	RESTRAINTS, GUARD POSTED. TOLERATED REG DIET, WILL CONTINUE (b)(6)-2
	TO MONITOR THROUGHOUT ———
9SEP03	S NO PAIN
1700	O VSSA
	DSG DRY & INTACT
	A DOING WELL
	P IV ABX UNTIL TOMORROW
	D/C IF WOUND [illegible] TOMORROW (b)(6)-2
	(b)(6)-2
9Sep03	Received care of patient @ 1800. Awake and alert in bed. VS @
20:31	1400 WNL. Restraints x2 Ⓛ wrist/Ⓛ ankle. Skin warm/dry/intact.
	Buccal mucosa moist/pink. PERRLA ⊕ WNL. ⊕ EOM WNL. Lung sounds
	clear to auscultate throughout Ⓑ. HR regular S_1S_2 WNL. Bowel sounds ⊕
	WNL x4 quadrants. Dressing to Ⓛ Hip/buttocks clean/dry/intact. ø draining
	noted ø odor noted. ⊕ radial pulses Ⓑ +2. ø c/o pain. Will continue
	to monitor. ——— (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)*

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 7070

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECOR[illegible]EDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Sept 03	S) PT (b)(6)-4 25yrs old was Shot. time of Injury 2355. Ⓛ hip
0135	I.V. Bolus 0137. There is an exit wound to
BP 130/78	PT Foley was given). the upper Left gluteus Maxim
P 93	0130) . PT recieved a Sonogram @ 0145
Temp	ancef 1gm Piggyback I.V. 0136) PT was shot. after
RR 16	Morphin 10mg 0135 he was Shot PT went
P.Ox O2 99	Tetunus 0.5 I.M. Running.
0136	BP 134/95 ~~I.V. bolus~~ Ⓛ arm L.R. 2 bags.
NKDA	P 84
PSHX 0	RR
PMHX 0	Pox 90
Med 0	
LMI 2200 ~~1000~~pm	
49 Kg	
tob 0	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

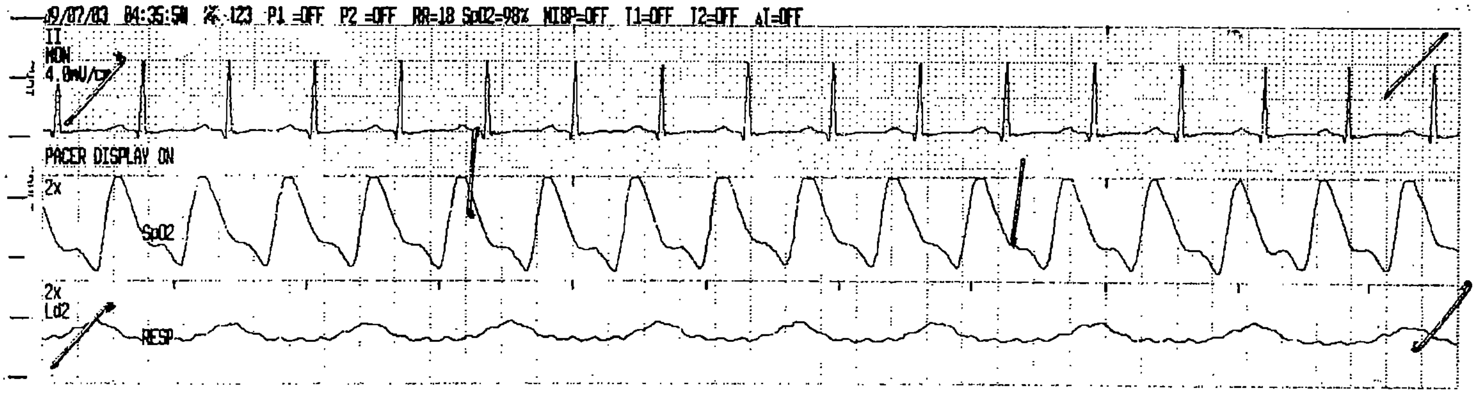
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7071

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0330 Sept 7, 03	Pt arrived to ICW via gurney c̄ guard – alert & cooperative – Bulky dsg to Ⓛ buttocks moderately soaked c̄ blood – dsg reinforced on arrival IV 18G L AC infusing NS @ 200 cc/hr via pump Pt c̄ positive +2 pedal pulses bilat – able to move all extremities – Lungs CTA bilat hypoactive BS x4 quads – Foley to Gravity draining dark yellow urine – abd soft non-distended – Pt medicated c̄ 5mg IV MSO4 for pain – will continue to monitor

(b)(6)-2


09/07/03 04:35:50 ♥ 123 P1 =OFF P2 =OFF RR=18 SpO2=98% NIBP=OFF T1=OFF T2=OFF ΔT=OFF

0530	Pt. resting s̄ complaint. VSS see flowchart Dsg to Ⓛ buttock c̄ no significant Δ

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.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

MEDCOM - 7072

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7Sep03	Report received from SGT Love, pt lying in bed awake, follows
0630	commands, moves all extremities, lungs CTA bilaterally,
	resp even & unlabored, rate 13-16, sats 97% on RA, heart
	sounds audible, sinus tachycardia, all pulses palpable, BS ⊕ x4 quads.
	NPO, entry & exit wounds to Ⓛ hip dressing soaked through c̄
	blood. Awaiting transport to OR. (b)(6)-2 [redacted] SGT/LPN
0745	Pt taken to OR for debridement of wound via litter.
	(b)(6)-2 [redacted] SGT/LPN

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1

MEDCOM - 7073

AUTHORIZED FOR LOCAL REPRODUCTIC

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7/8/03	OP NOTE
	PREOP DX GSW Ⓛ BUTTOCK
	POSTOP DX SAME
	PROCEDURE DEBRIDEMENT Ⓛ BUTTOCK WOUND
	SURG GRANVILLE
	ANES SCHMAUTZ GETA
	FLUIDS 300 LR EBL MIN UO 175
	DRAINS PENROSE SPEC Ø CX Ø
	FINDINGS - 7MM ENTRANCE, 4CM
	POST EXIT WOUNDS 6CM DISTAL TO ILIAC
	CREST 15CM WOUND TRACK, 1° SUBQ
	8CM DEEP FACIAL VIOLATION c̄ 4CM
	SUPERFICIAL GLUTEAL MUSCLE INJURY.
	NO DEVITALIZED MUSCLE OR FB.
	TO ICU TO RECOVER STABLE

[redacted] (b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

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)*

[redacted]

(b)(6)-4

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(
USAPA

MEDCOM - 7074

LAST NAME | FIRST NAME

NOTES

DATE	NOTES
7Sep2003 1040	Nursing: Admit Note: Pt received from ICU via Stretcher. Pt begins to vomit before transfer to bed of ~100cc mucoid, tan emesis. Pt given 25 mg Phenergan IV. — 1LT (b)(6)-2 AN
7Sep03 1105	Nursing: Assessment. Pt sleeping, briefly aroused c̄ tap on shoulder. Lungs CTA, O2 sats 97% on RA. Pt is tachycardic, c̄ HR of 109, ∅ edema to extremities. IV to (L)AC c̄ LR @ 75. Abd soft, ∅ indication of pain on palpation. Hypoactive BSx4
7Sep03 1655	Nursing: Pt has ∅ void in 6.5 hours. Bladder c̄ some distension on palpation. MD in OR, will consult for NO cath. — 1LT (b)(6)-2 AN
7Sep03 1705	Nursing: MD in to eval pt bladder, wants to allow pt 2 hours to void — 1LT (b)(6)-2 AN
7Sep03 1750	Nursing: Void - Pt has 950 cc of clear yellow urine out. ~~Pt as~~ — 1LT (b)(6)-2 AN
7SEP03	PT awake, PERRLA, BBS CTA, PPP x 4 ext, ∅ complaints, will continue to monitor — (b)(6)-2 91WM6
8Sep03 —	1130 - Assessment A&Ox3, PERRLA, Lungs CTA BILAT, S1 S2 strong and reg, ⊕ BSx4, c/o ∅ pain. Antibiotic IV therapy continues, VSS (b)(6)-2 Tolerated reg diet. Will continue to monitor — SGT/CN

STANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1.

MEDCOM - 7075

EMERGENCY CARE AND TMENT (Medical Record)

TREATMENT FACILITY (b)(6)-4 [redacted]

LOG NUMBER 128

ARRIVAL

DATE DAY	MONTH	YR.	TIME
07	Sep		0115

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☒ AMBULANCE
☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data) Ø

HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code) Local IRAQI.

HOME TELE. NO.

CHIEF COMPLAINT(S) (Include symptom(s), duration) GSW to Ⓛ hip Last Meal 2200

SEX M

AGE 25

POSSIBLE THIRD PARTY PAY ☐ YES ☐ NO

VITAL SIGNS

TIME	0115		
BP	130/78		
PULSE	93		
RESP.	16		
TEMP.			
WT.	94kg		

CATEGORY (See reverse)
☒ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
I.V. Bolus	2	0130
Morphine 10mg	10mg	0135
Tetunus I.M	.5	0130
Ancef piggybach	1gr	0135

ASSESSMENT/DIAGNOSIS GSW to Ⓛ Buttock.

DISPOSITION (Check all that apply)
HOME FULL DUTY
QUARTERS 24 Hrs. 48 Hrs. 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO (Indicate clinic) Ortho
EMERGENCY ☒ TODAY
72 HOURS ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0230

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER 0116

S) PT (b)(6)-4 [redacted] GSW to Ⓛ hip. Time of Injury 2355

I.V. Bolus 0137. PT was given Foley 0130. there is an exit wound to the Upper buttocks. PT recieved Soniogram for further injuries.

Ancef 1gr piggy back I.V. 0136
Morphin 10mg 0135
Tetunus .5 I.M 0136. (b)(6)-2 [redacted] 9/7/03

PSLTX Ø
PMLTX Ø
LMI 2200
Tob Ø

S: Pt is a 25 y.o Iraqi ~~[illegible]~~ who was Stealing Ammo from a US guarded Ammo dump for the presumed purpose of making IEDs. Pt sustained GSW to Ⓛ buttocks & was Still able to Run p̄ injury. ⊖ weakness, ⊖ Numbness ⊖ Other injuries

occurred Near Samarra

O: WDWN mod dist 2° to GSW to buttocks, GCS 15 ⊖ Resp distress [illegible]
HEENT: Atraumatic
COR: RR ⊖ ⓜ Lungs Ⓑ CTA
Abd: ⊕BS. S NT ND [illegible] FAST ⊖
Pelvis Stable ⊖ Crepitus
Ext: + + pp NL motor NL sens.

(CONTINUE ON SF 507, IF NEED

PATIENT'S IDENTIFICATION (Mechanical imprint) (FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; ID No. or SSN; DOB; service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD))

(b)(6)-4 [redacted]

SIGNATURE OF PROVIDER (b)(6)-2 [redacted] (b)(6)-2 [redacted]

INSTRUCTIONS (follow-up plans)

To ICU.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558
Prescribed by GSA and ICMR

MEDCOM - 7076

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 25

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
DAI, Lt GSW buttocks.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition________
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) (N)
ETOH________ Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures________ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL _X_ Potential for anxiety related to: _X_ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Info from Chart and ICU nursing Staff Arabic-speaking.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ___ Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. Semi-Emerg	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ___ Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility ___ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ___ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

VERIFICATIONS AT HOLDING AREA

! ID/Allergy Band ! Dentures Removed
! H & P JE 0130 (ER arrival) ! Contacts Removed
! NPO Since 7 SEP 03 ! Jewelry Removed
~~! UHCG/LMP~~ N/A ! Body Pierce Remove
! Consent/Blood Transfusion ~~Signed/Witnessed/Dated~~ N/A
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
~~! Family/Friend:~~ N/A

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 7077

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	~~o Check for support~~ stockings or ace wraps. ~~If none,~~ check with doctors. ✓ Check that safety straps are correctly applied. [illegible] ✓ Offer pillow for under knees. o Place ~~and take down legs~~ from ~~stirrups with slow bi~~lateral motion. ✓ Check that rings and all body piercing has been removed. [illegible] (b)(6)-2 [redacted]
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: 1) Pain ✓ 2) Intraoperative Hazards ~~3) Prosthesis~~ ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ~~3) Arthritis~~	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ~~2) W/O Glasses~~ F.2. ✓ Potential for decreased communication due to: ~~1) Diminished Hearing~~ ✓ 2) Language Barrier F.3. na Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from [illegible] side. ✓ Validate pt.'s understanding of verbal communication. ~~o Verify removal of dentures.~~
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 [redacted] CPT, AN 7 SEP 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☑ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter with roller due to spinal

BREATHING EASY. [✓ (Y)] (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] MAJ, AN

DATE: 7 SEP 03 TIME: 0705

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] CPT, AN

DATE: 7 SEP 03 TIME: 0955

REVERSE OF FORM 5179, JUN 91

MEDCOM - 7078

USAPA V1.0

MEDICAL RECC | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 4… , the … ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERAT… M
VIA litter BY OR Staff

2. PATIENT (b)(6)-2 AND PROCEDURE
VERIFIED B , MAJ, AN

3. DATE 7 SEP 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME ~~19~~ 0745 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Alert. Arabic speaking.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☑ LEFT SIDE UP ☐ RIGHT SIDE UP

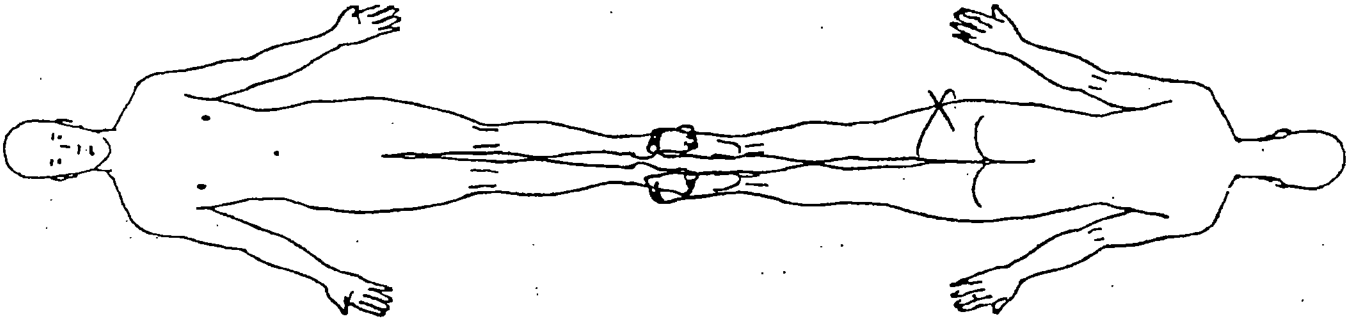
COMMENTS: Bean Bag Axillary pad arm <90° b/l.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine/[illegible]
SITE: buttocks BY WHOM: c/406
SITE: Ø BY WHOM: Ø
COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO
30/30
☑ ESU NO: 1-1
GROUND PAD: BRAND Valley Lab
LOT NO: 69263 2005-07
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 7079

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME; ID NUMBER; MA. .FACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
NACL

OTHER ORDERS	TIME	CARRIED OUT BY
∅		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. (L) buttocks area	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
4 tape.
abd pad

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
D&I Lt GSW buttocks

21. PATIENT TRANSFERRED TO ICU TIME 0955 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] CPT, AN

REVERSE OF DA FORM 5179-1, C 77 USAPA V1.01

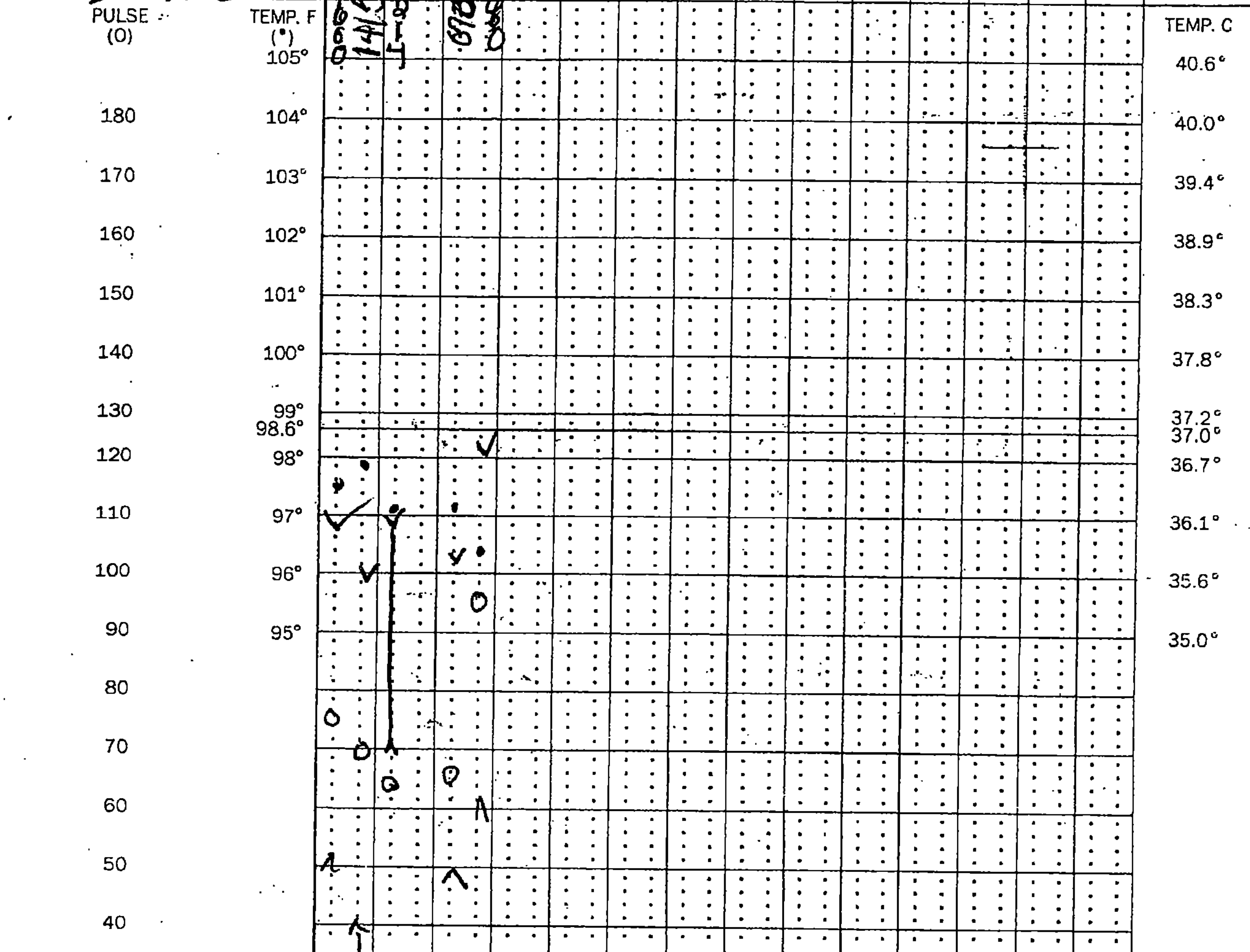
MEDCOM - 7080

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	8	9
POST- DAY	7	8
~~MONTH-YEAR~~ Sep DAY	14	15
~~19~~ 2003 HOUR	0600 1415 2214	0810 1430



ESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	108/52 100/39	108/72	103/49
HEIGHT: WEIGHT →	98%	96.	98
	97%		96%

.TIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7081

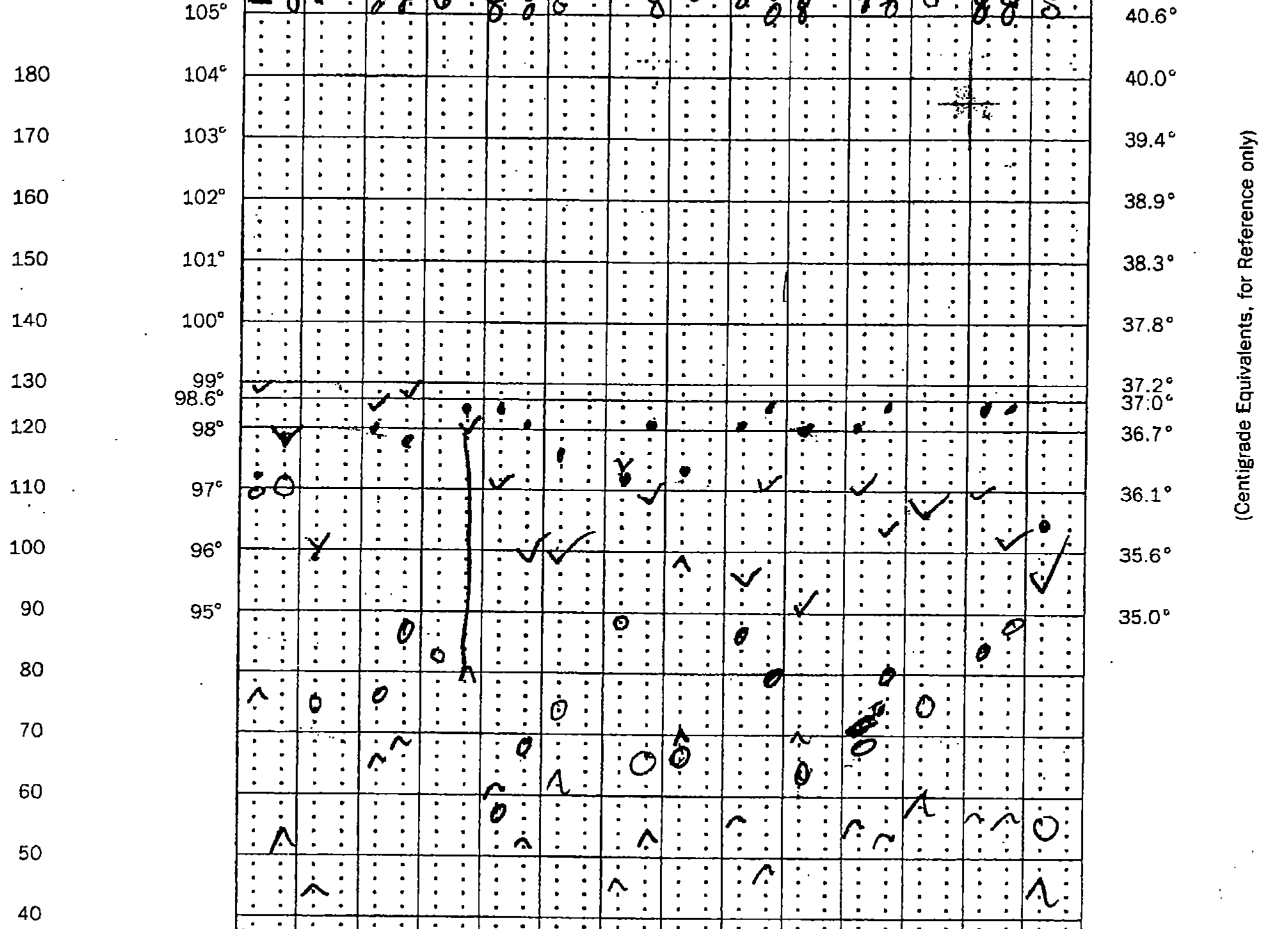
511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
POST- DAY	DOS	1	2	3	4	5	6
MONTH-YEAR Sep DAY	7	8	9	10	11	12	13
19 2003 HOUR	1600 1400 2200	0800 1400 2000	0800 1400 2000	2000 1400 2000	0900 1400 1400	0900 1400 2000	0800 1400 2000

PULSE (O) TEMP. F (•) TEMP. C



RESPIRATION RECORD 16 17

Record special data only when so ordered

BLOOD PRESSURE 126/76 100/65 124/66 111/65 98/62 114/66 98/70 95/58 90/70 110/55 106/60 109/57 93/47

118/52 106/69 99/53 106/52 111/48 103/54 108/51

HEIGHT: WEIGHT →

SpO2 97 98 98% 98 98 98. 99 97 97% 98 98% 98% 98 97 98% 98 98% 98% 99 98 98%

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7082

Iraqi EPW

Ward/Section: ICU	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE 7 Sep 03	TIME 0515	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	16.2	4.8-10.8 x 10
RBC	5.24	4.7-6.1 x 10
Hgb	15.6	14-18g/dl (M) 12-16 g/dl (F)
Hct	46.7	45-52% (M) 37-47% (F)
MCV	89.1	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10 Verified
Lymph %	9.2	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
Cl*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	(b)(6)-2	DATE: 07 Sep 03	LAB ID NO:

MEDCOM - 7083

Ward/Section: ENT	Requesting Ph (b)(6)-2 [redacted]		BORATORY RESULT FORM ect to the Privacy Act of 1974)
Nam (b)(6)-4 [redacted]	Date: 7 Sep	Time: 0115	Patient # (b)(6)-4 [redacted]

Chemistry 7 X

Test	Result	Ref. Range
GLU	164	73 - 118 mg/dL
BUN	10	7 - 22 mg/dL
Creat	0.8	0.6 - 1.2 mg/dL
Na	140	128 - 125 mmol/L
K	3.5	3.3 - 4.7 mmol/L
Cl	101	98 - 108 mmol/L
tCO2	27	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	191	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis X

Test	Result	Ref.Range
Color	Yellow	N/A
App	clear	N/A
Glu	NEG	Negative
Bili	neg	Negative
Ket	TRACE	Ace: NEG Negative
SGav.	1.030	N/A
Bld	SMALL	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	Negative

Micro UA
WBC 3-5
RBC 15-20
EPI 10-15
mucos MOD
Amorph MOD
Back Light

Venous **Blood Gas** X

ph	7.306	7.31 - 7.45
PCO2	64.5	35 - 45: Art
PO2	—	80 - 105
HCO3	32	22 - 26
TCO2	34	23 - 27
BE	6	(-2) - 3
sO2	72	95 - 100%

Hematology (CBC) X

Test	Result	Ref. Range
WBC	17.3	4.8 - 10.8 x 1E3
RBC	5.56	4.7 - 6.1 x 1E6
Hgb	16.4	14 - 18 g/dL (M); 12-16 (F)
Hct	50.6	45 - 52% (M); 37 - 47% (F)
MCV	91.0	80 - 99 fL
Plt	292	130 - 500 1E3
Lymph%	22.6	20.5 - 51.1 %

Hematology Manual Diff

Segs		Lymph	
Bands		Atyp	
Mono		Imm	
Eos		RBC Morph	
Baso		Plt. Est	

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

AB Pos

Additional Instructions:

Reported By (b)(6)-2 [redacted]	Date 7 Sept 03	Lab ID # [redacted]

MEDCOM - 7084

Ward/Section: EMT

Requesting Physican: (b)(6)-2

BORATORY RESULT FORM

ect to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 7SEP03

Time:

Patient #

[✓ Chemistry 7]		
Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L
Chemistry 12/LFT		
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL
Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

[✓ Urinalysis]		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		
[✓ Blood Gas]		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

[✓ Hematology(CBC)]		
Test	Result	Ref. Range
WBC		4.8 - 10.8 x 1E3
RBC		4.7 - 6.1 x 1E6
Hgb		14 - 18 g/dL (M); 12-16 (F)
Hct		45 - 52% (M); 37 - 47% (F)
MCV		80 - 99 fL
Plt		130 - 500 1E3
Lymph%		20.5 - 51.1 %

Hematology Manual Diff	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A
MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

WASTE:
① Fentanyl 100mcg
② STP 250mg

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS
CONTINUOUS / REPEATED DRUGS
SPECIFY UNITS – MG / MCG / ML,
" I "=CONSTANT INFUSION

DRUG	(Units)		TOTALS
midazolam	(mg)	2	2mg
fentanyl	(mcg)	100 50	150 mcg
STP	(mg)	250	250mg
Succ	(mg)	100	100mg
	( )		X
	( )		
VOLAT AGENT 150	% del	2 – 1.7 – 1.7 – X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 – 2 – 2 – 2 – 6 – 15	

TOTAL EBL: Min

TOTAL URINE: 175

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS
LINE site LR (cc) 18g LA ☐ Warmed ——— 300
☐ Warmed
Ancef 1g in 100cc NS ☐ Warmed X——X
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE –

FLUIDS – SUMMARY
CRYSTALLOID– LR = 300 cc
COLLOID– X
BLOOD–

PHYS STATUS [✓ 1] 2 3 4 5 E

BODY WEIGHT 49 [✓ KG] LB

HEMATOCRIT 46.7

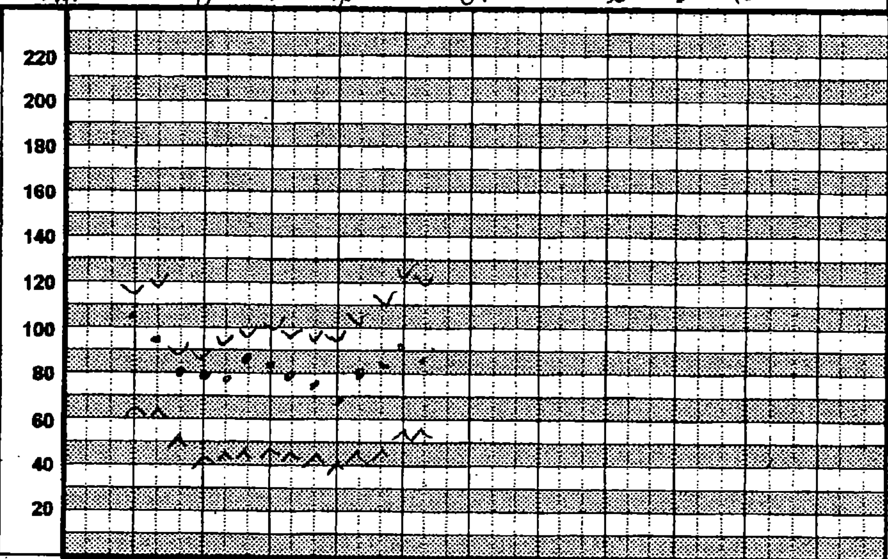
INITIAL DATA
BP – 115/63
HR– 108

EQUIP CHECK
OK?– [✓ Y] N

PATIENT ID CHECK
OK for PROCEDURE? Y/Y
TIME– 0740

TIME → 0730 · 0800 · 30 · 0900 · 30 · 1000

SYMBOLS:
Ⓛ arm BP by cuff
V Reg
Λ cuff
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T — ⊤
ANES– X-X
PROC-⊙-Ø



REMARKS–
Code drugs with numbers, events with letters

0740 Greeted pt. Preop. Labs reviewed. ⊕ IC GETA discussed via interpreter; Ø questions

0745 → In OR 1-1 via litter. PreO2. Monitors on. IV induction; eyes taped shut; see Airway note below.

0752 → Moved to RLD by All pressure pts ✓d/padded → Turned supine

0845 Resp event Reg. opens eyes. Airway reflexes intact. Oral sxn. Extubated ō pos. pressure breath

0850 Resp event Reg. To ICU for recovery. VSS. Report to SG Bunk (b)(6)-2 of status.

VENTS

I:E = 1:2 VT – ml		780	720	640	500	400		
f – breaths/min	14	8	8	6	6	12	12	
Peak inf pres / PEEP		20	20	20	–			
MODE– S(pon), A(ssist), C(on)	S	C	C	C	A	S	S	

MONITORS

✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕	34	31	34	48		
BP / oth	✓ FIO2 (Frac or %)	.87	.87	.88	.88	.89	≥.21	
ART line	✓ SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	
✓ Gas analyzer	✓ TEMP- site Axil							
	N-M Block (T/4)	4/4	4/4					
Warming blkt		✓	✓					
Conv warmer								

Mark with letters & symbols, explain under REMARKS
EVENTS: Ⓐ arm < 90° secured to padded armboard / Ⓛ arm supported on pillow/secure AX roll in place.
Position → OH Ⓡ LD → → → OH

RECOVERY AT 0850
PACU ICU ______ (Specify)
OTHER Fz96²
CONDITION: Stable
RESP– 12
SpO2– 100% O2 FM 12
BP– 120/55
HR– 86

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0730	0745	0900
	Ready	**Begin**	**End**
PROC	0752	0807	0838

PROCEDURES and CPT Codes
Debridement / Irrigation Ⓛ gluteal wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
RSI c̄ cricoid pressure. DL x1 c̄ MAC 3 grade I view VC. ⊕ stylet
8.0 oETT placed & secured @ 23cm @ teeth. ⊕ ETCO2 sustained ⊕ BBS = ⊕ soft Pilot bulb

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION OR 1-1

DATE 7 SEP 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 9

MEDCOM - 7086

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE / PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS [✓ YRS] Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: debridement (L) buttocks wound
SURGICAL SERVICE: ortho
NPO SINCE: ______

ASA Physical State 1 2 3 4 5 E
WT: 49 [✓ KG]/LB HT: 69 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: denies
ETOH: denies
DRUGS: denies

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef - ER - 0136
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ - ______ mg IV IM PO
______ - ______ mg IV IM PO
______ - ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A: ______
OTHER: ______

278 > 15.6 / 46.7 < 11.2

140 | 101 | 10 / 3.5 | 27 | 0.8 < 164

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other occ. diff breathing 2° to dust	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

All info obtained through interpreter. A. speaks ø English

ASSESSMENT
PAST SURGICAL/ANESTHETIC
ø

PHYSICAL EXAMINATION
BP 171/161 HR 112 R 18 T ___
Pain Scale 0-10 ______ 99% SaO2
HEENT - Teeth: intact
Trachea: midline
TMJ/Neck: ↑ ROM
Oropharynx: 3FB MA
Nares
CHEST: CTA (B)
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (R) 18 G [illegible]
Ulnar Filling: (L) [illegible]
BACK: ______
OTHER: ______

NPO Since ______

*apparently trying to steal ammo - fragment wound to (L) gluteus

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {X} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

(b)(6)-2
Th[redacted]rees. Questions answered.
Sig[redacted] Date: 9/17/03 Time: 0730 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward)
(b)(6)-4
[redacted]

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-…S
Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

RADIO GIC CONSULATION REQU

PATIENTS NAME: (b)(6)-4

SSN:

UNIT:

PROVIDER/ CLINIC: EMT

DATE REQUESTED: 7 Sep 03

EXAMINATION REQUESTED:

SPECIFIC REASON(S) FOR REQEST:

RADIOLOGIC REPORT:

MEDCOM - 7088

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4 [redacted]

DATE OF ORDER 10SEP03
TIME OF ORDER 1800 HOURS
LIST TIME ORDER NOTED AND SIGN

D/C ANCEF, MS, Phenergan
c̄ percocet

Noted
(b)(6)-2 [redacted]
10SEP03
1615

(b)(6)-2 [redacted]

2d' chart ✓ 10 Sep 03 @ 950
(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 15SEP03
TIME OF ORDER 1330 HOURS

D/C TO MPs
MED NONE
F/U CAMP PERSONNEL

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER
TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER
TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7089

Last Meal 22.00

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 7 Sep 03 TIME OF ORDER 0200 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ ① Admit to ICU
✓ ② Dx GSW (L) Gluteus
✓ ③ Cond Stable.
✓ ④ NKDA.
✓ ⑤ BR c̄ Armed Guard
✓ ⑥ NPO
✓ ⑦ IV NS @ 200 cc/hr
✓ ⑧ MSO4 5-10 mg IV q 2-4° prn
✓ ⑨ CBC @ 0500
✓ ⑩ Ancef 1gm IV q 8°

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2° ✓ 7Sep03 0050 (b)(6)-2 IUTAL

PATIENT IDENTIFICATION

DATE OF ORDER 7SEP03 TIME OF ORDER 0850 HOURS

✓ ADMIT ICU [illegible]
✓ DX (L) BUTTOCK GSW
✓ COND STABLE
✓ VS ROUTINE
ACT BR - DETAINEE STATUS
BRP WHEN TOLERATED
✓ NKA

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

D/C'd ICU 1015

DATE OF ORDER TIME OF ORDER HOURS

✓ REG DIET
✓ IV @ 75cc/HR, HEPLOCK WHEN PO C
D/C FOLEY
✓ ANCEF 1GM IV Q8°
✓ MS 2-4MG IV Q15' PRN VPCO 20MG/4
PERCOCET ii PO Q 4° PRN
PHENERGAN 12.5-25MG IV Q8°
IS Q1°, W/A

NURSING UNIT | ROOM NO. PR8C3 | BED NO.

(b)(6)-2
LTC, MC
ORTHOPEDIC SERVICE

[illegible] 8 Sep 03 @ 0400 Ken[illegible]

DA FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7090

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	6	7	8	9	10	11	12	13	14
7SEPT03	(b)(6)-2	Cord: Stable	06	/	(b)(6)-2							D/C
			18	(b)(6)-2								
7SEPT03	(b)(6)-2	BR c̄ armed guard	06	/	(b)(6)-2						DD	(b)(6)-2
			18	(b)(6)-2								
7SEPT03	(b)(6)-2	NPO	06	/	SS		D/C'd				7 Sept 1000	
			18	82								
7 Sept	(b)(6)-2	Vital Signs, Routine	06	/	/							
			14	/								
7 Sept	(b)(6)-2	DIET: Regular	06	/	/	(b)(6)-2				(b)(6)-2		
			11	/								
			18	/					(b)(6)-2			
7 Sept	(b)(6)-2	ACTIVITY: BR	06	/						(b)(6)-2		
		detainee status	18	/	(b)(6)-2				(b)(6)-2			
		BRP when that										
7 Sep	(b)(6)-2	VS: routine	06	/	(b)(6)-2							
			14	/		//	(b)(6)-2					
			22	/	(b)(6)-2							

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW Ⓛ Glut

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ____

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 7091

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep *Yr* 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7SEPT	(b)(6)-2	CBC ⓐ 0500	7SEPT	0500	0555	(b)(6)-2
7 Sep 03		Admit to ICU	7Sep03	/	0300	
7 Sep 03		Dx GSW Ⓛ Gluteus	7Sep 03	/	0300	
7Sept		Admit to ICW c/o Granville	7Sept			
		Dx Ⓛ Buttocks GSW				
		Condition: Stable				
7Sep	(b)(6)-2	N/O DTV by 1900	7Sep			
7Sep		D/C HEPLOCK	10Sep	1500	1615	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 7092

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED ~~06~~	07	08	09	10	11	12
7SEPT	(b)(6)-2	IV: NS @ 200 cc/hr	06	/	(b)(6)-2		D/C'd			
			18	(b)(6)-2						
7SEPT	(b)(6)-2	ancef 1 Gm Q8°	08							
			14							
			22							
7SEPT03	(b)(6)-2	Ancef 1GM	08	/						
		Q8°	16	/						
			24	/						
7 Sept	(b)(6)-2	IVF's: LR ~~75cc/hr~~	06	/	(b)(6)-2		→ ⊘ IV SITE			
		Hep lock when ⊕ PO intake	18	/						
7 Sept		ANCEF 1gm IV q8°	08	0✓						
			16							
			24							
7 Sep		Ancef 1 gm IV Q8°	08	/	(b)(6)-2		D/C'd 10Sep03			
			16	/						
			24	/						

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓛ Glut

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUS — USAPA V1.00

MEDCOM - 7093

Verify by Initialing	THE EUTIC DOCUMENTATION CARE PLA (MEDICATIONS)	Mo.____ Yr.____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED		
7 Sept 03	(b)(6)-2	MSO4 5-10 mg IV Q 2-4° prn	7 Sept 5mg ① SL	D/C	1000 AM 7 Sept
7/7 Sept	(b)(6)-2	MSO4 2-4 mg IV q 15' PRN up to 20mg/4hr		D/C	1035 8 03 1800
7 Sept	(b)(6)-2	Percocet ii tabs PO Q4° PRN			
7 Sept	(b)(6)-2	Phenergan 12.5-25mg IV q 8°	7 Sep 1145 25mg IV	D/C	1800 1035 8 03

USAPA V1.00

MEDCOM - 7094

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0330	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Perrl - 2-3mm brisk					
	SENSORIUM	alert - Quiet					
		Cooperative					
RESPIRATORY	RESPIRATORY PATTERN	RRR					
	BREATH SOUNDS	CTA bilat					
	SECRETIONS	∅ cough ∅ secretion					
SKIN	COLOR	normal for race					
	INTEGRITY	intact					
IV SITE	LOCATION	LAC PIV 18G					
	CONDITION	NS infusing @					
		200 cc/hr					
GASTRO	ABDOMEN	soft - non distended					
	BOWEL SOUNDS	hypo-active BS					
		x4 quads					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	dark yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	N S_1S_2					
		NSR					

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PF (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 7SEPT02

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 47 0 MEDCOM - 7095

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
	BP Arterial Line																		
	BP Cuff		117/61																
	Temperature																		
	Pulse		109																
	Respiratory Rate		[illegible]																

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	IV	200	200																
	TOTALS																		

OUTPUT																				
	URINE	HOUR / TOTAL	1400	400																
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

MEDCOM - 7096

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05	
						115/62		127/65	
						97^4		97^6	
						110		123	
						20		16	

22	23	24	01	02	03	04	05	8° T
					200	200	200 600	600
							800	800

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME									
MODE									
F_iO_2...									
TV									
RATE									
PEEP									
A B G pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING				
TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE

IV ____

po ____

TOTAL

OUTPUT

Urine: ____

TOTAL ____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDCOM - 7097

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 9 Sep 03 Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
Time In: 0855
Allergies: NKA OR Intake: Crystalloid 300cc Colloid
Pre-op V/S: OR Output: UOP 175cc EBL min
Procedures: ~~EB~~ Debridement of (L) buttock GSW Meds/Times: 1gm Ancef (0845) 2mg Versed 150mcg Fent Thiopental & succ for intubation
Pre Op Meds History

Drains
Hemovac
NG
JP
~~T-tube~~
[✓ ~~Foley~~]
TLS

Airway
Nasal
Oral
✓ ETT
Trach
Other

Time	0855	0900	0905	0910	0915	0930	0945	1000								
SaO2	100	100	99	99	99	99	99	99								
FiO2 mid	VM	VM	VM	VM	VM	RA	RA	RA								
Methods	15L	15L	15L	K	6L											
240	4	55	%													
220																
200																
180																
160																
140																
120	V				131	121										
				112			116									
100			113	104												
	D	95														
80		●		●	●	●										
						●	●									
60						68										
	^		50				57									
40		42		49	49			49								
20																
HR		83	86	87	84	84	77	84								
RR	18	14	12	12	13	12	12	11								
T	97.5	98			96.4			98.5								

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
		Ø			

X-rays: **Labs:**

Post-Anesthesia Recovery score

Criteria	**ADM**	**30'**	**D/C**
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˘ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Time									Patient teaching done: Wound Care, Pain Management,
Pain (0-10)									T, C, & DB., Incentive Spirometer, Comfort Measures
LOS	[redacted]								Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED b(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 7 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 4700, MAY 78 **WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)** **Previous edition is obsolete**

USAPPC V2.00

MEDCOM - 7098

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		∅				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

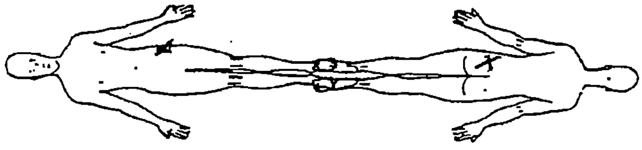
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	Foley	Clear light yellow	

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0855- Pt arrived from OR via litter. Asleep but arousable c̄ difficulty to voice, on 15 lpm venturi mask setting 99%.

0915: Physical Assessment —

Neuro: sedated c̄ versed, moves spontaneous c̄ environmental, verbal stimuli, @ this time, (+) sleepy, ∅ fully awake. Pupils 3mm/3mm, Pearl. moves all extremities, (+) sensation bilat u/l ext. (b)(6)-2 . LS clear throughout. (+) Venturi mask [illegible] Sat (b)(6)-2 RR- 12-14 [illegible]. CV: NSR - BP HR WNL ∅ peripheral-dependent edema, cap refill ≤3sec Ⓡ thumb and Ⓛ toe. Good pulses radial, pedal 2+. (b)(6)-2 (+) BS x4 q. ∅ abd distention, ∅ abd pain (b)(6)-2 Foley to gravity, clear yellow out. — (b)(6)-2 (+) PIV to Ⓛ AC, LR infusing TKO ∅ evidence infiltration — (b)(6)-2

0930: VM d/c'd ~~Oxygen~~ RA (b)(6)-2 98% 99% RR - 11-14 BPM ∅ evidence resp distress difficulties - [illegible]

1000: Pt awakens spontaneously to verbal stimuli, oriented x3 asking questions in quality about wnd. Pt sleepy, returns to rest. — (b)(6)-2

Discharge Criteria:
Date: 7 Sept 03 Time: PARS: 12
BP: 116/49 T: 96.5 HR: 81 RR: 14 SaO2: 98%
Pain Level at D/C (0-10): ∅
Intake: ∅ Output: 100cc - foley d/c'd 1015
Additional Data: c̄out problem
Transferred To: ICW
Report Given To: LT (b)(6)-2
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: (b)(6)-2 CPT

MEDCOM - 7099

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF / **2. MTF LOCATION** *(State or Country Code.)*

1	2	3	4	5	6	7	8
(b)(3)-1							

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4						

NAME *(Last, First, Middle Initial)* (b)(6)-4

4. PAY GRADE

16	17

9V

5. SEX

18
m

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
2	6	Y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION

10. LENGTH OF SERVICE

32	33	34

ETS b(6)-4

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
2

HOUR OF ADMISSION 0200

BRANCH / CORPS

14. FLYING STATUS

47	48	49
N	O	

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION *(State or Country Code)*

62	63
[redacted]	[redacted]

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
1

BC

PREV. ADMISSION b(6)-4

YEAR

☐ NO

b(3)

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
C

WARD ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
4	1

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y Y Y M M D D)*

81	82	83	84	85	86	87	88
2	0	0	3	0	9	1	5

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	A	

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(Y Y Y Y M M D D)*

99	100	101	102	103	104	105	106
2	0	0	3	0	9	0	7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
I	Z

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(Y Y Y Y M M D D)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

GSW (L) Buttocks
877.0
I+D
86.28

Dx 8770
Proc 8628
Trauma 9
Inj 569 BK
(Stealing Ammo)

ADMITTING OFFICER *(Signature, as required)*

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000 MEDCOM - 7100 USAPA V1.00

Admission and Coding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF (b)(3)-1	2. MTF Location IZ		
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4	4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9
Religion MUSLIM			
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4
Organization (Active Duty Only)	13. Marital Status Z	Hour of Admission 00:40	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee	
		Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: (b)(3)-1		Telephone Number of Emergency Addressee	
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-09-15	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-07	
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-07	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW LEFT BUTTOCKS
877.0

Procedure Narrative(s): IRRIGATION AND DEBRIDEMENT
86.28

Cause of Injury Narrative: STEALING AMMUNITION

(b)(6)-2

Admitting Officer (Signature, as required)

DR [redacted]

(b)(6)-2

Signature of Admitting Clerk

(b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 7101

ACLU-RDI 1407 p.606

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REGISTER (b)(6)-4
2. NAME (Last, First, MI) (b)(6)-4
3. GRADE
4. SEX M
5. AGE
6. RACE X
7. RELIGION ZZZ
8. LENGTH OF SVC N/A
9. ETS N/A
10. PREVIOUS ADMISSION NO
11. FMP 99
12. SSN (b)(6)-4
13. ORGANIZATION
14. WARD ICU
15. FLYING STATUS.
16. RATING/DSG
17. DEPT./BEN 91 K78
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0
22. HOURS OF ADMISSION 1215
23. CLINIC SERVICE ABMA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION DIED
26. DATE OF DISPOSITION 20030826
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 20030825

ADMISSION REMARKS

ADMITTING OFFICER DR (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1
30. DATE OF INTIAL ADMISSION
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED 0

31. SELECTED ADMINISTRATIVE DATA

PATIENT WAS PRONOUNCED DEAD AT 0512 ON 26 AUG 2003 BY COL (b)(6)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 90% BSA 949.08
TRAMATIC AMPUTATION LEFT HAND 887.0
TRAMATIC AMPUTATION RIGHT HAND 869.0

PROCEDURES: DEBRIDEMENT BURN 86.28
LEFT AND RIGHT BEA 84.03

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

(b)(6)-2 COL, MC

(b)(6)-2 CER SSG, NCOIC, PAD

DA FORM 3647, MAY 79

MEDCOM - 7033

USAPPC V1.10

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2: THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

(b)(6)-4 [redacted]

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*
0512 26082003

3. MEDICAL EXAMINER/ CORONER'S CASE
☐ YES ☒ NO

4. RELIGION
UNKNWN

5. CHAPLAIN NOTIFIED
☐ YES ☒ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH
UNKWN

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* 90% DEEP PARTIAL & FULL THICKNESS BURN	17 HR
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE
26 AUG 03

10. TYPED OR (b)(6)-2 [redacted] F MEDICAL OFFICER IN ATTENDANCE
LTC, MC
ORTHOPEDIC SERVICE

11. SIGN (b)(6)-2 [redacted] TTENDANCE

SECTION B - ADMINISTRATIVE ACT [redacted]

TYPE OF ACTION	HOUR	DAY	[redacted]	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON			[redacted]		
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*
☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPPC V2.00

MEDCOM - 7034

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

~25 y/o Iraqi national c̄ burns/blast injuries in UXO detonation while "scrapping brass" 1145 today.

PMH
PSH
All
Meds
Habits
ROS
} unavailable - intubated emergently

PHYSICAL EXAMINATION Intubated on arrival O2 sat 75% airway per anes
Full thickness burns entire anterior body
Lungs CTA
CV tachy RRR
Abd soft
GU gross hematuria
Ext blast inj (R) hand, (L) mangled BKA
(R) large thigh defect

H/H 14.9/44.9
→ 10/28

Scanned
STS,
[illegible]

PROGRESS *(Enter date of discharge and final diagnosis)*

A - 78% TBSA
blast inj BLE c̄ open fxs (R) hand &
(L) BKA
P - Admit in OR. Parkland protocol
fluid resuscitation

SIGNA[redacted] (b)(6)-2	DATE 25AUG03	IDENTIFICATION NO.	ORGANIZATION

PATI[redacted]TION (b)(6)-4 *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 7035

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 Aug 03	Time of Burn 1130
11:55	left IV 1000 ml Lac Ring. 90% Burn
11:55	Tourniquet applied
	144/88 BP 22 Pulse IV Start time 12:30
12:15	10 mg Morphine IV
12:18	Pulse: 75 BP: 71/36 100%RA
12:20	Intubated 8 French
12:20	105/56 BP 97 P
1225	Foley Secured
1229	128/57 BP 85P 100 RA
1230	1000 ml NS. Central line secured 2 mg Versed
1234	146/64 BP 95P 100 RA 99.9 T
1235	150 m Fentinal 3 mg Versed
1235	UA Complete 1000 mL LR
	Bi-lat Pulse (petal) by Doppler
1235	Vecuronium
1239	146/63 BP 89P 30 R 100 ~~RA~~ [illegible] Vent
1240	SIMV Rate of 16 Tidal vol. 700 peep of 5 O2 100%
1242	2g Ancef, .25cc Tetanus 1000 mL LR
1244	121/55 BP 80P 18R 100 Vent
1249	169/69 BP 79P 19R 100 Vent.
1249	400 mg Gentamicine

TAL OR MEDICAL FACILITY
(b)(3)-1 [redacted]

STATUS

(b)(6)-2 [redacted]

OR'S NAME

/SERVICE

SSN/ID NO.

RECORDS MAINTAINED AT

RELATIONSHIP TO SPONSOR

'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 [redacted]

REGISTER NO.

WARD NO.
EMT

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
by GSA/ICMR
CFR) 201-9.202

MEDCOM - 7036

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1254	159/68 BP 77P 19 R 100% Vent.
1255	1000 ml LR #6
1259	159/76 BP 87P 19R 100% Vent
1300	Pulses Bi-lat. pedal By Doppler
1304	142/68 BP 91P 20R 100% Vent.
1309	129/68 BP 94P 19R 100% Vent
1310	1 unit Blood Transfused
1314	131/83 BP 81P 19R 100% Vent
1317	Vecuronium 10mg
1318	1 unit Blood hung
1318	Output 300 cc
1319	1000ml LR #7
1321	2 units of Blood in, (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/5061

MEDCOM - 7037

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Aug 03	OPNOTE
1538	PRE-OP DX — 90% FULL THICKNESS BURNS
	POST-OP DX — SP BILAT Forearm Amputation, Burn Debridement, Bilat LE.
	PROCEDURE — BILATERAL FOREARM AMPUTATIONS, BURN CLEANSING
	BILATERAL LOWER EXTREMITY FASCIOTOMIES
	SURGEONS — DRS (b)(6)-2 [redacted]
	FINDINGS — 90% FULL THICKNESS BURNS, BILAT BLAST INJURY to
	BOTH HANDS + Forearms w/ Devitalized Tissue
	DESCRIPTION — GETA - Superficial burn wound debridement.
	Bilateral lower extremity Escharotomy, Forearm amputations
	were performed by (b)(6)-2 [redacted]. Multiple comminuted
	fx of Both hands and (R) Forearm + Dysvascular. 90% full
	thickness Burns.
	Pt left intubated and transported to ICU —
	Antibio - Gent 80mg, Ancef 2gm EBL - 200cc Fluids in 5L
	UO - 450cc Drains - NGT/Foley.
	(b)(6)-2 [redacted] MD MAJ, MC USA CHIEF, DOS

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 [redacted]

REGISTER NO.

WARD NO. 5L

PROGRESS NOTES
Medical Record

UO 450
EBL 200

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1.

MEDCOM - 7038

ST NAME | FIRST NAME

DATE	NOTES
25Aug 03 1700	GSW/ORTH Surg The patient sustained 90% full thickness burns in 1230 today from exploding ordnance. This is a non-survivable injury. At this point I will institute comfort care only. DCCS approval of situation.
	(b)(6)-2 MD MAJ, MC USA CHIEF, DOS
	CHIEF DOS (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 7039

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25 Aug03 @ 1800	Rpt Received, Palliative Care Assumed, Ⓛ SC c̄ LR @ 500cc/hr Fentanyl @ 100mcg/hr, Foley to Gravity, Pt Sedated on Vent (b)(6)-2 CPT/AN
2200	Pt Condition Unchanged MAP 40-45, Vented, Responds to Noxious Stimuli / (b)(6)-2 cpt/AN
0100	Pt Condition Unchanged, ⊖ U/O For last 3hrs (b)(6)-2 CPT/AN
0300	Pt B/P Now 40's/20's No Response to Painful Stimuli, ⊖ U/O For last 2hrs (b)(6)-2 CPT/AN
0435	Pt Ⓡ Pupil 5mm + Fixed, Ⓛ 3mm, B/P 32/17 (b)(6)-2
0508	Pt Fine VF Followed by Asystole ~~Dr~~ Notified (b)(6)-2
0512	DEATH NOTE CALLED TO SEE PT 2° PEA → VFIB & ASYSTOLE PULSELESS, PUPILS FIXED DILATED, ∅ CORNEAL REFLEX. EKG ASYSTOLE, PRONOUNCED 0512. CAUSE OF DEATH 90% BSA DEEP PARTIAL & FULL THICKNESS BURN.
	(b)(6)-2
	C, MC HOPEDIC SERVICE

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER *(SSN or Other)*

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 7040

(175 Kg)

10,500

15,100

LAST NAME (b)(6)-4 MIDDLE INITIAL ID NUMBER

DATE	NOTES
26 Aug 03 ~~1640~~ error	Received report on pt, assumed care. Pt admitted to
ER/OR	ICU @ 1640 on litter accompanied by ER staff, RN
Gent 1600?	anesthetist, Dr (b)(6)-2, Dr (b)(6)-2. Dopamine infusing @
↑ER	5mcg hr / LR @ free flow. Pt sedated, paralyzed
Ancef 1g	Intubated, ⊕ mechanical vent ⊕ SIMV, TV @ 700 ml;
Versed - 5mg	VR @ 14; FIO2 @ 60% Peep: 5. ETT: 27 @ Lip
	⊕ OGT to LIS. Ⓡ femoral A-Line; ⊕ foley to gravity
200 EBL	⊕ Bilat below elbow amputation. ⊕ dressing ī ace bandages
450 urine	to Bilat lower ext. ⊕ 2°-3° BSA Burn ≈90% ⊕ Ⓛ subclavian
5000 cryst. LR	cortis - single lumen c̄ dopamine infusing @ 5mcg/k/min
20 WRBC	= 7 ml/hr. LR PBing Dopamine, ∅ evidence of infiltration
Labs: H: 13.2	@ site of insertion. Full assessment to be notated on
H: 40.5	DA form 4700. (b)(6)-2
1633 → 1 liter bolus 69/38	1635: Versed 1mg IVP administered. VS unstable. See strip
76 Kg 1645 ↑ Dopa 10mcg/kg/min	attached c̄ Pt Trends. ⊕ 1 liter Bolus administered
1700 Fentanyl 10cc/hr	per VO Dr Lowry for BP 69/38. ~~No Δ in BP~~ (b)(6)-2 error
1706 - Dop stopped	1645: Dopamine ↑ to 10mcg/kg/min. Pressures remain
	unstable, unΔ'd. (b)(6)-2
	1700: Fentanyl started @ 10cc/hr = 50mcg/hr. No
	Δ's in neurologic/cardiresp status. Pressures
	≤ 50-70 systolically - 40-50's diastolically. (b)(6)-2
	1706: Dopamine stopped per verbal order dr [redacted] (b)(6)-2
	Pressures remain unΔ'd (b)(6)-2
	1715: Dr (b)(6)-2, Dr (b)(6)-2 @ BS. No Δ's in
	plan of care (b)(6)-2
LATE PA note:	1700: Burns to face ears lips chest and forearms debrided in OR, ⊕ silvadene
	to chest, bacitracin to face. Chest open to air covered only c̄ burn pad (b)(6)-2

STANDARD FORM 509 (REV. 5/1999)
USAPA V1.0

MEDCOM - 7041

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (b)(6)-4

LOG NUMBER

ARRIVAL			
DAY	MONTH	YR.	TIME
25	Aug	03	1213

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☒ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data) Unk

HISTORY OBTAINED FROM ☒ PATIENT ☐ OTHER (Spe

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code

CHIEF COMPLAINT(S) (Include symptom(s), duration) Ⓑ Hand Amputation, Burns.

SEX M AGE ~25

POSSIBLE THIRD PARTY PAY ☐ YES ☐ NO

TIME SEEN BY PROVIDER 1210

VITAL SIGNS			
TIME	1213	1229	
BP	71/36	128/67	
PULSE	22	85	
RESP.	~30	BVM	
TEMP.	99.9 TM	100%	
(O2 sat)	80 RA	~70 Kg	

CATEGORY (See reverse)
☒ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IVLR 1900 cc/hr x 7hr then 800 cc/hr x 16hr		(1230)
RSI per Anesth.		
Escharotomy.		
Ⓛ SC Cent Line		
O Pos Trans x 2u PRBC		

ASSESSMENT/DIAGNOSIS
1) 90% BSA 3° Burn
2) Ⓛ hand Amp
3) Ⓡ BB RA fx, Thumb fx
4) Rhabdomyolysis.
5) Hypovolemic Shock.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

PMHx unk

S: Pt is a ~25 yo Iraqi ♂ who was allegedly stealing ordnance that blew up + caught him on fire.
TOI (est) ~ 1130 Last meal?

O: WD Thin Iraqi ♂ Conversant in mod Resp distress GCS 15 in Severe Dist 2° to burns.
HEENT: NC c̄ Complete scalp/face burn. singed mustache.
⊖ A/w burns.
Neck: NT ERSM
Chest: Tight Eschar. Dec CTA. Emerg Escarotomy.
Abd: ⊕BS. total Eschar. FAST ⊖
Pelvis Stable NT.
Ext: Ⓡ forearm fx, Ⓛ hand Amp.
LE c̄ Ⓑ +PP.
90% BSA: sparing Ⓑ feet (4%) ½ Ⓛ UE 6% + part of face (1%)

Ⓑ Arm: Comm BB fx + Dist. Rad Base of 5th mc
Ⓛ Arm: Amp @ Carpus.
CXR: Tubes in. NGT in Esoph. Cent line in. ⊖ PTX.
Pelvis: ⊖ fx C-spine ⊖ fx.

26 > 14.9 / 44.9 < (63)
10 / 28
7.46/308/68/22/-2/100%.
138 | 103 | 10
hem | 21 | 1.4 < 223
CK 1578 ?
Alb 2.4↓ TB .8
Ap 52. Chol 70↓
ALT 25 TP 5.1↓
Amy 5
AST 123

CBC, T&C x4, Chem 7, LR, ABG
Foley, UA.
NGT.
CXR, C-spine, Pelvis, Ⓑ hands
Ancef 2gm IV
Td .5cc IM
Gent 400mg IV
Vec 10mg IV

ED Course: U̲ c̄ Red urine that cleared some c̄ IVF resus. Improved BP c̄ Resus p̄ Cent line. Easy to Bag p̄ Eschar

Intubation Note RSI c̄ success'd. # 8.0 ETT @ 24cm @ teeth - tied in place c̄ ⊕ ETCO2 ⊕ BBS. MAC 4 ~~[illegible]~~ II view. Airway edema, swelling ~~[illegible]~~

(Co [redacted] IF NEEDED)

REFERRED TO (Indicate clinic) Gen Surg / Ortho

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

ADMIT TO HOSP. UNIT/SERVICE OR → ICU

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 1330

SIGNATURE (b)(6)-2 STAMP MAJ, MC.

PATIENT'S IDENTIFICATION (Mechanical imprint) (FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; ID No.; DOB; service status; name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

INSTRUCTIONS TO PATIENT (include medications ordered, any limitations and follow-up plans)

To OR.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Re
Prescribed by GSA and ICMR

MEDCOM - 7042

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: unkn

HEIGHT: "

WEIGHT: "

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION: unknown

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
unknown

4. PROPOSED SURGICAL PROCEDURE:
Burn Debridements, Lt BEA,

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition entire body burned
Tobacco____ppd X___yrs. Body Piercing_________ Diabetes (Y) (N) ROM reduced ASA/Motrin w/72 hrs (Y) (N)
ETOH____________ Implants__________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes Intubated	o ~~Pt. verbalizes any specific anxiety~~ Intubated o Pt. Exhibits relaxed body posture. Iraqi civilian Intubated upon arrival to EMT, Emergency Procedure,	Allow pt. to ~~verbalize freel~~ (b)(6)-2 o ~~Explain OR environment a~~ questions ~~regarding surgery.~~ o Offer com (b)(6)-2 s. (e.g.. warm blanket. touch o ~~Explain all nursing procedures before they are done.~~ N/A (b)(6)-2 o Remain with pt. whenever possi o ~~Maintain family interface. Parents to stay with pt.~~ N/A
B. AERATION X Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase (b)(6)-2	o ~~Offer to elevate head of litter or~~ offer ~~pillow.~~ N/A o ~~Observe pt. while awaiting surgery~~ for sig~~ns of distress.~~ N/A JE o ~~Assist anesthesia during~~ intubation and ~~extubation.~~ N/A
C. INTEGUMENT X Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas (b)(6)-2 N/A - Impaired from (burns - entire body) burns	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignm (b)(6)-2 o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

VERIFICATIONS AT HOLDING ARE

! ID/Allergy Band
! H & P JE
! NPO Since_____
! ~~UHCG/LMP~~ N/A
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon N/A
! Contact Precautions [✓ (Y)] (N)
! Family/Friend:__________

! Dentures Remov
! Contacts Removed
! Jewelry Removed
Body Pierce Remov
N/A

DA FORM 5179, JUN 91

Previous editions are obsolete.

USAPA V1.0

MEDCOM - 7043

6. PATIENT PROBLEMS AND NEEDS	7. [cut]IENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning X 3) Existing Disease Burns ___ 4) Safety Devices X 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.) (b)(6)-2 [redacted]	o ~~Check for support stockings~~ or ~~wraps. If none, check with~~ (b)(6)-2 [redacted] o Check that safety straps are correctly applied (b)(6)-2 [redacted] ~~o Offer pillow for under knees.~~ N/A o ~~Place and take down legs~~ from stirrups ~~with slow bilateral motion.~~ N/A o. Check that rings and all body piercing has been removed (b)(6)-2 [redacted]
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ___ 1) Pain X 2) Intraoperative Hazards ___ 3) Prosthesis ___ 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery ___ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort. (b)(6)-2 [redacted]	o Have sufficient people available for transfer. (b)(6)-2 [redacted] o Insure proper body alignment (b)(6)-2 [redacted] o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
~~F. SPECIAL SENSES~~ ~~F.1. ___ Diminished visual perception due to being:~~ ~~___ 1) Pre-Medicated~~ ~~___ 2) W/O Glasses~~ F.2. X Potential for decreased communication due to: Intubated ___ 1) Diminished Hearing X 2) Language Barrier ~~F.3. ___ Potential injury due to dentures:~~ ~~___ 1) Upper~~ ___ 4) Caps ~~___ 2) Lower~~ ___ 5) Crowns ~~___ 3) Bridges~~	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period. (b)(6)-2 [redacted]	o Introduce self. Keep pt. informed as to where he/she is and what is happening. (b)(6)-2 [redacted] o Inform pt. in which direction to move and assist if necessary. ~~o Speak clearly and slowly.~~ ~~o Address pt. from ___ side.~~ N/A ~~o Validate pt.'s understanding of verbal communication.~~ (b)(6)-2 [redacted] ~~o Verify removal of dentures.~~ N/A
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER ~~PATIENT~~ GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

(b)(6)-2 [redacted] COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

, MAJ, AN 25AUG03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ~~☐ Clean and Dry~~ Severe skin burned from explos ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ~~☐ Sleepy~~ ☒ Intubated BREATHING EASY ~~(Y) (N)~~ N/A

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities Intubated

☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE (b)(6)-2 [redacted] ED BY (Signature and (b)(6)-2 [redacted] , MAJ, AN

DATE: 25 AUG 03 TIME: 1320

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] , MAJ, AN

DATE: 25AUG03 TIME: 1535

REVERSE OF FORM 5179, JUN 91

MEDCOM - 7044 USAPA V1.0

MEDICAL RECORD

INTRAOPER ... E DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT (b)(6)-2 [redacted], CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 [redacted] [illegible]

3. DATE 25 AUG 03 TIME PATIENT ARRIVED IN SUITE 1324

4. PATIENT IN ROOM TIME 1324 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER *(Specify)*

COMMENTS: pt arived to OR intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 [redacted], 91D PFC (b)(6)-2 [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT (b)(6)-2 [redacted] AN, 66E MAJ (b)(6)-2 [redacted], AN, 66E	RELIEF CIRCULATOR	SSG (b)(6)-2 [redacted], 91D

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

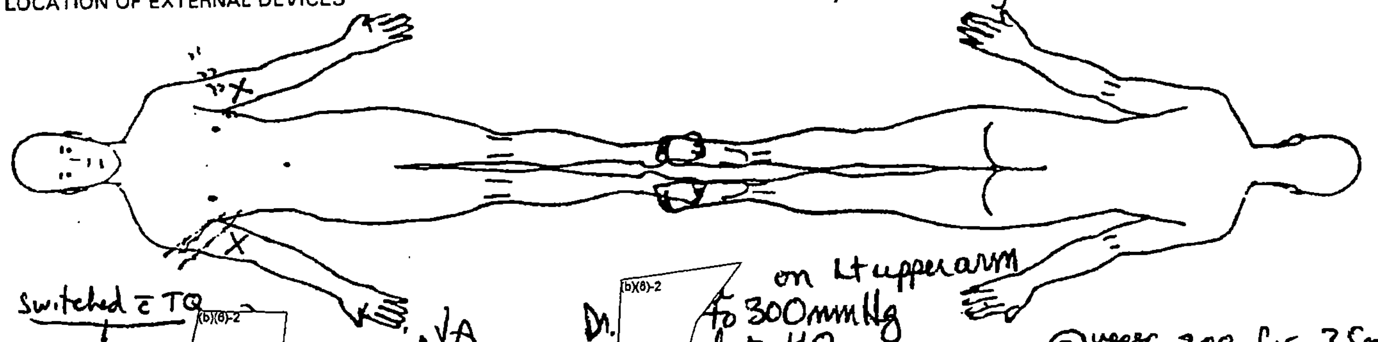
PREP SOLUTION *(Specify)* Beta/Beta

SITE: (B) arms BY WHOM: (b)(6)-2 [redacted]

SITE: Body/legs c̄ Hibiclens BY WHOM: Dr (b)(6)-2 [redacted] / (b)(6)-2 [redacted]

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



Switched c̄ TQ (b)(6)-2 [redacted]

N/A

Dr. (b)(6)-2 [redacted] on Lt upper arm to 300mmHg fat 40 min ; on (R) upper arm 300 for 35 min

LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					(b)(6)-2 [redacted]
Needle Sharp	☒ Yes ☐ No		C	C	(b)(6)-2 [redacted]	
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility:)*

(b)(6)-4 [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: VL 000442 Set at: 50/50

GROUND PAD: BRAND VL REM

LOT NO: 69671 EXP 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 7045

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Silvadene 1% cream	q8 2bottles	intra-op	topical	(b)(6)-2	(b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
nss

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU (b)(6)-2

15. X-RAY IN OPERA OOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Foley	2.	3.
SITE	1. Bladder -pt arrived ē in place	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

Ⓑ legs	Abdomen	Ⓑ arms
Fluffs Kerlix Ace Wraps	Burn Pad Back Burn Pad	Fluffs Kerlix Ace Wraps

19. ADDITIONAL INFORMATION
Dr (b)(6)-2 / (b)(6)-2 CPT (b)(6)-2 , CRNA

CPT (b)(6)-2 CRNA, CPT (b)(6)-2 , CRNA

20. OPERATION(S) PERFORMED
Lt BEA, Rt BEA
Burn Debridements Ⓑ LE, abdomen

21. PATIENT TRANSFERRED TO ICU TIME 1535 METHOD litter

22. REGISTERE (b)(6)-2 arms (b)(6)-2

REVERSE OF DA USAPA V1.01

MEDCOM - 7046

Ward/Section: EMT	Requesting Physician:	**Laboratory Result Form** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI 0108	DATE 25Aug03	TIME 1238	SSN/PSEUDO SSN: (b)(6)-4 [redacted]

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	26.1	4.8-10.5 x 10
RBC	5.15	4.7-6.1 x 10
Hgb	14.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	44.9	45-52% (M) 37-47% (F)
MCV	87.3	80-94 fl (M) 81-99 fl (F)
Plt	633	130-500 x 10 Verified
Lymph %	9.8	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	223 *	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.4	0.6-1.2 mg/dl
CK	1578 *	39-380 u/l (M) 30-190 u/l (F)
NA*	138	128-145 mmol/l
K*	Hem	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	21	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF
PRP		Ne
Mono		Ne

Chemistry 12

Test	Result	Ref.
ALB	2.4 *	3.5-
ALP	52	26-
ALT	25	10-
AMY	5 *	14-
AST	123 *	11-
TBIL	0.8	0.2-
BUN	10	7-2
CA**	7.4 *	8.0-
CHOL	71 *	100-
CRE	1.3 *	0.6-
GLU	229 *	73-
TP	5.1 *	6.4-

MISC.

Results:
pH 7.461
PCO2 30.8
PO2 661
HCO3 22
TCO2 23
BE -2
O2 100%

Microscopic UA

K+ 3.6

Results:

Remarks:

Reported by: (b)(6)-2 [redacted]	DATE: 25 Aug 03	LAB ID NO:

14
44
10
2/8

MEDCOM - 7047

Ward/Section: ICU	Requesting Physician: Dr. (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 25 Aug 03	TIME 1600	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	34.6	4.8-10.8 x 10
RBC	3.78	4.7-6.1 x 10
Hgb	11.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	91.2	80-94 fl (M) 81-99 fl (F)
Plt	242	130-500 x 10 Verified
Lymph %	4.6	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	186	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	2216	39-380 u/l (M) 30-190 u/l (F)
NA*	137	128-145 mmol/l
K* ①	4.3	3.3-4.7 mmol/l
CL*	112	98-108 mmol/l
CO2	19	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

pH	7346	O_2	100
pCO_2	37.8	HCO_3	21
pO_2	282	TCO_2	22
BE	-5		

Microscopic UA

Results: ① Hemolysis noted. K+ may be falsely elevated.

Remarks: CBC, Chemistry ABG

Reported by: (b)(6)-2	**DATE:** 25 Aug 03	**LAB ID NO:**

MEDCOM - 7048

[illegible]
1335

[illegible]				
			Patient limits	
[illegible]	11.5 H	x10^3/uL	4.5	10.5
[illegible]	[illegible]	x10^6/uL	4.00	6.00
[illegible]	[illegible]	g/dL	11.0	18.0
[illegible]	40.5	%	35.0	60.0
[illegible]	90.?	fL	80.0	100.0
[illegible]	29.4	pg	27.0	31.0
[illegible]	32.6 L	g/dL	33.0	37.0
[illegible]	325.	x10^3/uL	150.	450.
[illegible]	3.6	[illegible] %	20.5	51.1
[illegible]	1.3	x10^3/uL	1.2	3.4

---

pH 7.346
pCO_2 37.8
pO_2 282
BE -5
O_2 100
TCO_2 21
HCO_3 22

---

pH 7.335
pCO_2 44.5
HCO_3 24
TCO_2 25
O_2 38 [illegible]
BE -2

---

pH 7.329
pCO_2 40.8
pO_2 543
BE -4
HCO_3 21
TCO_2 23
O_2 100
Na 145
K 3.4

b)(6)-4

======= PICCOLO =======

08/25/03 01:51 PM
REFERENCE RANGE: MALE
PATIENT #: b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 600 DR #: [redacted] (b)(6)-2
SERIAL #: 0000100570

....

GLU	143*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	1636*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

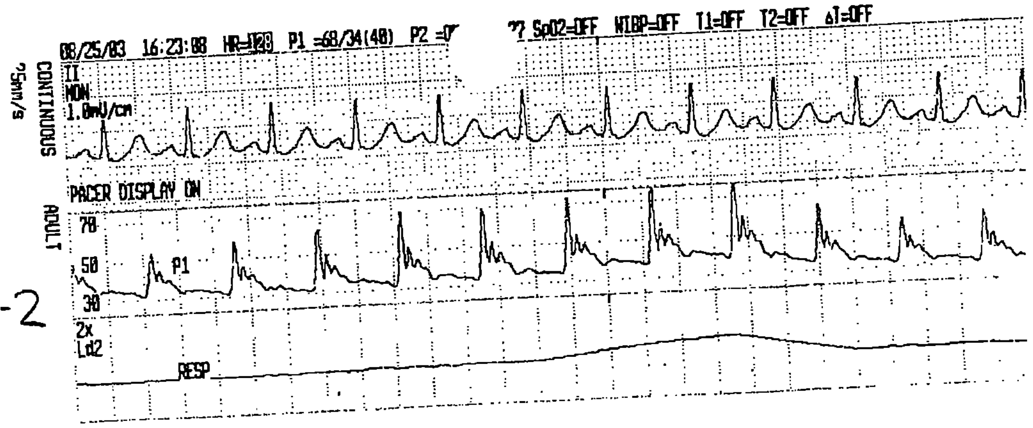
PT: 18.2

PTT: 70.7

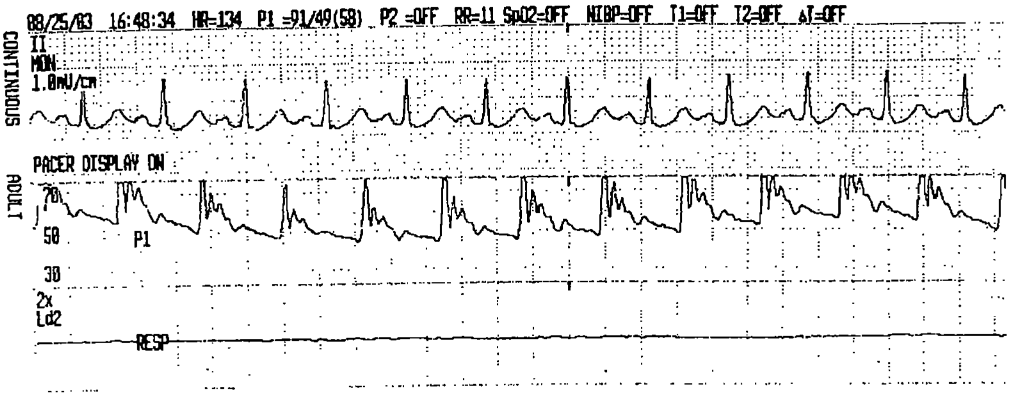
P1 TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
16:12	114	SRCH	61 / 33	39	OFF
16:10	124	SRCH	67 / 36	44	25
16:08	125	SRCH	68 / 36	43	15
16:06	124	SRCH	69 / 34	41	19
16:04	122	SRCH	67 / 38	45	14
16:02	121	SRCH	70 / 39	46	21
16:00	120	SRCH	67 / 38	44	OFF
15:58	144	SRCH	116 / 46	60	OFF
15:56	112	SRCH	60 / 35	40	15
15:54	119	SRCH	58 / 38	44	13
15:52	121	SRCH	69 / 43	50	14
15:50	125	SRCH	70 / 44	52	14
15:48	128	SRCH	72 / 42	50	14
15:46	115	SRCH	69 / 41	48	10
15:44	124	STBY	74 / 39	45	14
15:42	121	STBY	72 / 39	45	14
15:40	121	STBY	64 / 38	44	14
15:38	115	STBY	58 / 35	42	14
15:36	111	STBY	61 / 36	42	14
15:34	105	STBY	72 / 36	42	10
15:32	OFF	STBY	NOT ZEROED		OFF

08/25/03 16:23:08 HR=128 P1 =68/34(40) P2 =0 ?? SpO2=OFF NIBP=OFF T1=OFF T2=OFF ΔT=OFF



08/25/03 16:48:34 HR=134 P1 =91/49(58) P2 =OFF RR=11 SpO2=OFF NIBP=OFF T1=OFF T2=OFF ΔT=OFF



P1 TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
16:48	133	OFF	95 / 49	57	12
16:46	136	OFF	91 / 50	58	18
16:44	135	OFF	82 / 47	56	14
16:42	136	OFF	77 / 43	51	14
16:40	136	OFF	72 / 41	48	14
16:38	134	OFF	78 / 42	48	14
16:36	134	OFF	85 / 46	53	14
16:34	133	OFF	80 / 46	54	14
16:32	132	OFF	80 / 45	54	14
16:30	131	OFF	78 / 42	51	14
16:28	130	OFF	76 / 41	49	14
16:26	128	OFF	78 / 41	48	22
16:24	128	OFF	66 / 37	43	13
16:22	128	OFF	58 / 34	41	12
16:20	128	OFF	62 / 35	42	OFF
16:18	128	OFF	63 / 35	[illegible]	5
16:16	128	OFF	67 / 35	[illegible]	6
16:14	125	SRCH	64 / 36	43	13
16:12	114	SRCH	61 / 33	39	OFF
16:10	124	SRCH	67 / 36	44	25
16:08	125	SRCH	68 / 36	43	15
16:06	124	SRCH	69 / 34	41	19
16:04	122	SRCH	67 / 38	45	14
16:02	121	SRCH	70 / 39	46	21
16:00	120	SRCH	67 / 38	44	OFF
15:58	144	SRCH	116 / 46	60	OFF
15:56	112	SRCH	60 / 35	40	15
15:54	119	SRCH	58 / 38	44	13
15:52	121	SRCH	69 / 43	50	14
15:50	125	SRCH	70 / 44	52	14
15:48	128	SRCH	72 / 42	50	14
15:46	115	SRCH	69 / 41	48	10
15:44	124	STBY	74 / 39	45	14
15:42	121	STBY	72 / 39		14
15:40	121	STBY	64 / 38		14
15:38	115	STBY	58 / [illegible]	42	14
15:					

APNEA TICKET (RR) 08/25/03

TIME H:MIN:S	HR/PR BPM	SpO2 %
LAST BREATH:		
16:13:48	125	SRCH
RESUMED BREATHING:		
16:14:13	125	SRCH
ELAPSED TIME:		
00:00:25		

NIBP TREND 08/25/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM

ADULT

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " ( )"=CONSTANT INFUSION

DRUG (Units)							TOTALS
Vecuronium (mg)	10		10		10		30
Neosynephrine (mcg)	40	100	(100)	60			
Versed (mg)			2		0 1		5/0
Dopamine mcg/kg/min			3 — 5 — 5				

VOLAT AGENT: Isoflurane % del / % e.t.: 0.7 .5 .6 — .5 .2 .2 .3

AIR L/Min

N2O L/Min

O2 L/Min: 8 1.5 — 1.5 — 1.5 — 1.5 — 1.5

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

FLUIDS

LINE site: LR ☒ Warmed — (1000) (2000) — (3000) (4000) — (5000)

Ⓛ SC Cordis ☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS: 5 100/200

URINE – bloody 350 — 450

TOTAL EBL 200

TOTAL URINE 450

FLUIDS – SUMMARY

CRYSTALLOID– 5000

COLLOID– 0

BLOOD– 0

TIME ➡ 1315 . 0 45 1400 . 30 . 1500 . 30 . 1600

PHYS STATUS: 1 2 3 [✓ 4] 5 [✓ E]

BODY WEIGHT: 75 [✓ KG] LB

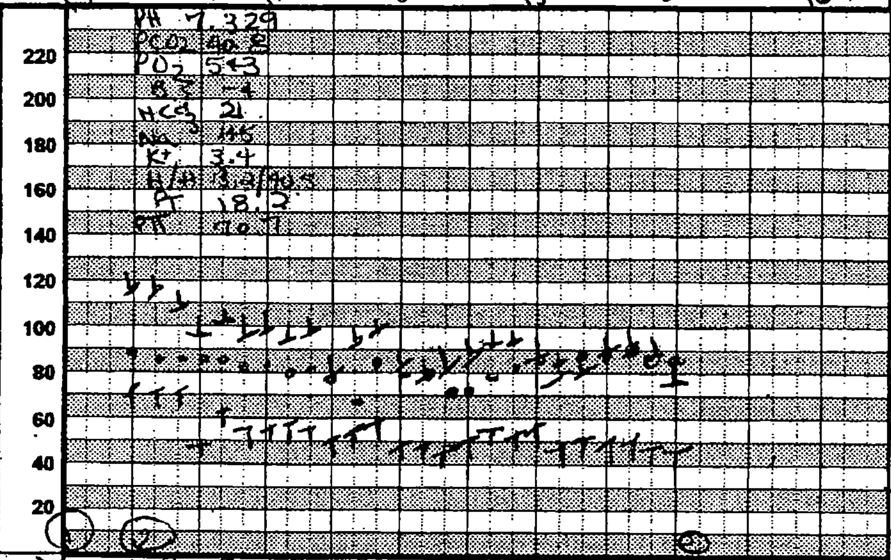
HEMATOCRIT: 46.5

INITIAL DATA: BP – 120/75 HR – 86

EQUIP CHECK: OK?– [✓ Y] N

PATIENT IDENTIFIED OK for PROCEDURE? ✓ TIME– 1325

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced) ⊥ ⊤; TOURNIQUET T — ✗; ANES– X-X; PROC– ⊙ – Ø



pH 7.329
PCO2 40.8
PO2 543
BE -4
HCO3 21
Na 146
K+ 3.4
H/H 13.2/40.5
PT 18.2
PTT 40.7

VENTILATION

1:E 1:2 VT – ml	8	8	8	8	8	8	8	8	
⊕ HME f – breaths/min	820	800	870	870	880	890	810	810	
Peak inf pres / PEEP	30/5	2?/5	32/5	33/5	33/5	35/5	35/5	32/5	
MODE– S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C

MONITORS / ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	29	29	30	28	28	27	28	28	29
BP / oth	☒ FIO2 (Frac or %)	.8	.9	.89	.89	.89	.89	.89	.91	.91
ART line	☒ SpO2 (%)	100	100	100	99	99	99	99	99	99
☒ Steth- PC/ES	☒ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
☒ Gas analyzer	☒ TEMP- site ESD		36.2	36.2	36.1	36.0	35.8	35.6	35.4	
	☒ N-M Block (T/4)	0/4	1/4	0/4		1/4				
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ⊙ pressure pts padded BUE<90° ou taped ~~[illegible]~~

REMARKS– Code drugs with numbers, events with letters

① From ER → OR; intubated; vent via Ambu bag. ② → OR table ē 5 pers. assist. Ⓡ fem A-line started Dr Dean. Iso sent. → ICU via stretcher ventilated ē Ambu bag. Ⓛ SC TLC patent. Report given.

RUE 300mmHg
1428 ↑
1503 ↓ 35min

1334
TQ LUE 300mmHg
↓1414 40min

RECOVERY AT 1535

PACU ICU ______ (Specify)

T 95.3

OTHER / CONDITION: N ~~[illegible]~~ 8/1.6 PEEP 5

RESP– 8 SpO2– 98

BP– 71/38 HR– 86

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1240	1324	1545

	Ready	Begin	End
PROC	1337	1347	1530

PROCEDURES and CPT Codes: burn debridement (superficial) Ⓛ BEA Ⓡ BEA escharotomy BLE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #8.0 ETT @24 cm @ teeth - tied ⊕ BBS ⊕ ET CO2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate,

(b)(6)-4 [redacted]

SURGEONS (b)(6)-2 [redacted]

A (b)(6)-2 [redacted] CPT

(b)(6)-2 [redacted]

CPT, AN
CRNA

PROCEDURE LOCATION OR 1-1

DATE 25 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 7051

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: burn debridement / BUE amp.
SURGICAL SERVICE: Ortho
NPO SINCE:

ASA Physical State 1 2 3 [✓ 4] 5 [✓ E]
WT: 75 [✓ KG]/LB HT: ' IN
ALLERGIES: ?
0

HABITS:
TOBACCO:
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( )
( )
( ) unknown
( )
( ) Gent ER
( ) ancef 1300

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______/______
U/A:
OTHER:

5500cc LR from ER
Calculated hrly rate per ER 1085 cc/hr

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	unknown
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	BSA
Steriods	N	Y	90%
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

?
0

PHYSICAL EXAMINATION
BP 124/75 HR 85 R __ T __
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck
Oropharnyx Intubated
Nares
CHEST: #8.0 ETT tied
CARDIAC: 24cm teeth
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK: (L) SC TLC
OTHER: #18 G (L) AC

NPO Since

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {✓} General: Mask Intubation

(b)(6)-2 [redacted]
CPT, AN
CRNA

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ar discussed with the patient/legal guardian.

(b)(6)-2 [redacted]

The p[redacted] to understand and agrees. Questions answered.

Signe[redacted] CPT Date: 8/25/03 Time: 1355 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward)

(b)(6)-4 [redacted]

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsol

MEDCOM - 7052

☆ U.S. GPO: 2002-729

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 AUG 03 TIME OF ORDER 1540 HOURS

LIST TIME ORDER NOTED AND SIGN
(b)(6)-2

① To ICU - Dr. (b)(6)-2
② Dx: S/P Bilat forearm amputations, Bilateral LE escharotomies, S/P burn wound debridement
③ Cond - Critical All - Unknown
④ VS q 1°, Monitor, A-line, Pulse Ox, I+O

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS
(b)(6)-2

⑤ N LR TRA 500 cc/hr until 2000 Hrs then 800 cc/hr
⑥ Vent - SIMV - TV - 700cc R-14, P-5
⑦ Foley to gravity
⑧ NGT to L/S
⑨ Dopamine gtt to run at 5 µg
⑩ Fentanyl gtt - titrate to effect
⑪ Do Not Resuscitate for ACLS code

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS
(b)(6)-2

⑫ CBC, Chem 8, ABG now
⑬ Call MD for T >101, P <60 or >120, BP <100 or >160, UO <30cc, Sat <92%.

(b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS
(b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-4

Transcribed (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 AUG 03 TIME OF ORDER 1658 HOURS

① DC Dopamine
② Will institute comfort care measures only.

(b)(6)-2, MD
MAJ, MC USA
CHIEF, DOS
[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7053

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* ______ *Yr* 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 Aug03	(b)(6)-2	DX: S/P Bilateral Forearm Amputations	25 Aug03	Now	Now	(b)(6)-2
		Bilateral LE Escharotomies, Sup Burn				
		Wound Débridement				
25 Aug03	(b)(6)-2	Cond: Critical.	25 Aug03			
25 Aug		CBC, Chems, ABG Now	25 Aug	1630	1630	(b)(6)-2
		Call 1				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 7054

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo* Aug *Yr.* 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	
25 Aug 03	(b)(6)-2	IV: LR @ 500 cc/hr	06	(b)(6)-2		
		until 2000 hr then	18			
		800 cc/hr				
25 Aug 03	(b)(6)-2	Dopamine gtt to run	06	(b)(6)-2		D/C'd. 25 Aug 03
		at 5 mcg/kg/min	18			(b)(6)-2
25 Aug 03		Fentanyl gtt titrate	06	(b)(6)-2		
		to effect	18			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx: S/P Bilateral Forearm Amputations, Bilateral LE Escharotomies, Superficial burn wound Debridement

Cond: Critical

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 7055

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1640 INITIALS (b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	2mm/2mm nonreactive		
	SENSORIUM	comatose c̄ Ø purposeful response to pain. ⊕ generalized flaccid posture. Versed wf any administered preadmit c̄ 4mg versed admin. upon admission.		
RESPIRATORY	RESPIRATORY PATTERN BREATH SOUNDS SECRETIONS	Pt ventilated - simv FiO2 @ 60% VR @ 14 c̄ no spontaneous breathing. Peep @ 5 TV @ 700. Breath snds clear throughout, slightly diminished in bases. ⊕ nasal secretion, small amt, whitish discharge. ⊕ singeing noted to nares anteriorly, ⊕ Burns to lips ⊕ 3° Burns to chest, ⊖ escharotomy ⊕ to Bilat lateral aspects of thorax covered c̄ burn pad		
SKIN	COLOR INTEGRITY T: 93^{5}	90% 2°-3° BSA Burns to face, lips, ears neck chest, abd. legs, Arms, penis, scrotum ~~Anterior~~ & Posterior assessment unable to perform r/t pt status.		
IV SITE	LOCATION CONDITION	Ⓛ subclavian single lumen - continuous infusing Dopamine @ 5 μg/hr and LR @ 1250 cc hr. Ø evidence of infiltration @ insertion site.		
	EXTREMITIES : Body	⊕ bilat amp Below Elbow's. ⊕ drainage to Ⓡ stub ⊖ to left. ⊕ Bilat lower extremity dressings from thighs to feet. COI - OR notes state faciotomy Bilat LE to lateral aspect.		
GASTRO	ABDOMEN BOWEL SOUNDS	Ø BS x4q. ABd-hard/taut Ø abd distention (⊕ 3° Burns) ⊕ OGT to LIS c̄ minimal amt of dark brown drainage out.		
GU	URINE: COLOR/CLARITY	Foley to gravity. ⊕ Burns to penis & scrotum dressed c̄ gauze Ø bleeding noted; UOP minimal ⊕ dark tea color, clear.		
CARDIOVASCULAR	CARDIAC RHYTHM	sinus tachy on arrival c̄ HR > 120's BP = 50/40 systolic 40's diastolically - Unable to palpate pedal pulses Ø radial pulses r/t BE amputation bilaterally Cap refill big toes ~ 3-4 sec, feet cool to touch		

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPA (b)(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU

DATE

PATIENT [redacted] written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs
MEDCOM - 7056
OP 375 (Redesignated)

PAGI

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line												78/42	73/40	90/62	92/42	66/21	59/40
BP Cuff																	
Temperature														92.5			
Pulse												125	136	105	87	94	93
Respiratory Rate												10	14	[illegible]	14	14	14
												100%					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
LR									5500				100 / 5600	250 / 5850	250 / 6100	200 / [illegible]	250 / [illegible]
LR									5500				~~10[illegible]~~	250 / [illegible]	250 / 5500	250 / 5750	250 / 6000
Fentanyl													10 / 10	10 / 20	20 / 40	20 / 60	20 / 80
TOTALS									10500								

OUTPUT

		06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
URINE	HOUR / TOTAL												150 / 150	80 / 170	30 / 210	15 / 225	– / 225	– / 225
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS Blood										350								
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 7057

OST-OP DAY

22	23	24	01	02	03	04	05	
61/39	57/37	83/34	59/40	60/36	56/32	39/22	25/15	
84/14	86/14	86/12	65/14	87/14	90/14	88/19	57/14	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME							
MODE							
F_iO_2							
TV							
RATE							
PEEP							
A B G pH							
PCO_2							
pO_2							
HCO_3							
SAT							
BASE							

22	23	24	01	02	03	04	05	8° T
250/7260	250/7500	260/7700	250/8000	260/8260	—	—	—	8260
250/230	250/6500	260/6502	250/7000	250/7250	25/7275	25/7300	←	7300
30/110	30/140	30/170	40/210	40/250	20/270	20/290	←	290
5/230	—	—	—	—	—	—	—/630	238

LABORATORY DATA

TIME							
GLUCOSE							
Na/K							
Cl/CO_2							
BUN/Cr							
WBC/PLATELET							
Hct/Hgb							

(b)(6)-2 [redacted]

ACTIVITIES OF DAILY LIVING

TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

BALANCE ______

NURSE'S SIGNATURE

INITL

MEDCOM - 7058

CASUALTY FE[illegible]R REPORT (AR 6[illegible])	CONTROL NO.	CHECK APPLICABLE BOX ☐ HOS[illegible]ACTION ☒ NON[illegible]TILE ACTION

1. LAST NAME - FIRST NAME - MIDDLE INITIAL: (b)(6)

2. SERVICE NO.	3. GRADE	4. HOUR AND DATE OF INCIDENT
N/A	N/A	1145, 25 Aug 03

5. UNIT	6. GEOGRAPHICAL LOCATION (nearby town) AND GRID COORDINATES
IRAQI NATIONAL	LD 6771 0933

7. TYPE OF CASUALTY (Check applicable box(es))

☐	KILLED IN ACTION	☐	MISSING IN ACTION	☐	WOUNDED OR INJURED IN ACTION
☐	DIED OF WOUNDS OR INJURIES	☐	CAPTURED	☐	LIGHTLY WOUNDED OR INJURED IN ACTION*
☐	DIED NOT AS RESULT OF HOSTILE ACTION	☐	DETAINED	☐	SERIOUSLY INJURED OR INJURED IN ACTION*
BODY RECOVERED ☐ YES ☐ NO		☐	INTERNED	☐	SERIOUSLY INJURED NOT AS RESULT OF HOSTILE ACTION
BODY IDENTIFIED ☐ YES ☐ NO		☐	MISSING	☐	LIGHTLY INJURED NOT AS RESULT OF HOSTILE ACTION

EVACUATED TO

*To be indicated by medical personnel only.

DA FORM 1156, 1 JUN 66

REPLACES EDITION OF 1 MAY 61, WHICH WILL BE ISSUED AND USED UNTIL EXHAUSTED.

8. WITNESSES WHO SAW INCIDENT OR IDENTIFIED REMAINS. (Name, grade, service number and unit)

IRAQI [illegible]TEALING BRASS WHEN 4 A[illegible]D EXPLODED BLOWING UP HIS HANDS & BURNING 90% OF HIS BODY

9. REMARKS (Additional circumstances, any religious ministration performed, etc.)

10. FOR USE BY C.O. OR MED. OFF. (only for casualties not the result of hostile action) LINE OF DUTY: ☐ YES ☐ NO ☐ UNDETM	AUTHENTICATED BY (CO or Med. Off.)	VERIFIED BY (Pers. Off.)
UNIT (b)(6)	GRADE CSM	SERVICE NO. (b)(6)-2
DATE 25 Aug 03	SIGNATURE OF PERSON PREPARING REPORT (b)(6)-2	

U.S. G.P.O.:1998 445-777

MEDCOM - 7059

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6
(b)(3)-1					

2. MTF LOCATION *(State or Country Code.)*

7	8

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4						

NAME *(Last, First, Middle Initial)*
(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
2	5	4

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION
UNKNOWN

10. LENGTH OF SERVICE

32	33	34

ETS b(6)-4

11. FMP

35	36
~~9~~	~~9~~

20

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
~~U~~

Z

HOUR OF ADMISSION
1215

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

b(6)-4

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION
YEAR
☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD
ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
3	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y Y Y M M D D)*

81	82	83	84	85	86	87	88
2	0	0	3	0	8	2	6

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	M	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(Y Y Y Y M M D D)*

99	100	101	102	103	104	105	106
2	0	0	3	0	8	2	5

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(Y Y Y Y M M D D)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: 90% BSA 949.08
TRAMATIC AMPUTATION LEFT HAND 887.0
TRAMATIC AMPUTATION RIGHT HAND 869.0

PROCEDURES: DEBRIDEMENT BURNS 86.28
LEFT AND RIGHT BEA 84.03

CAUSE: E991

IRAQI WAS STEALING AMMO WHEN ONE EXPLODED ON 25 AUG 2003 @ 1145.

Death Z

Trauma / Injury 459

Dx:	Px:
8877	8314
94209	8628
94890	8609
9558	9670
80385	
E9228	

ADMITTING OFFICER *(Signature as required)*
(b)(6)-2
COL, MC

SIGNATURE OF ADMITTING CLERK
(b)(6)-2
(b)(6)-2 SPC, 91G10

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 7060

(b)(3)-1

INP[illegible]ENT TREATMENT RECORD COVER SH[illegible]

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 (b)(6)-4

3. GRADE

ADMISSION REMARKS

4. SEX M

5. AGE 24

6. RACE X

7. RELIGION UNK

8. LENGTH OF SVC

9. ETS

10. PREVIOUS ADMISSION NO

11. FMP

12. SSN (b)(6)-4

13. ORGANIZATION

14. WARD ICU

15. FLYING STATUS

16. RATING/DSG

17. DEPT./BEN K76

18. BRANCH/CORPS

19. UIC/ZIP

20. TYPE CASE INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0

22. HOURS OF ADMISSION 0050

23. CLINIC SERVICE AAEA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

25. TYPE DISPOSITION HOME

26. DATE OF DISPOSITION 21 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

27b. TELEPHONE NO.

28. DATE OF THIS ADMISSION 19 AUG 03

ADMITTING OFFICER COL (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

30. DATE OF INTIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: CONCUSSION
CERVICAL STRAIN
RIGHT ELBOW CONTUSION

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

SIGNATURE OF ATTENDING MEDICAL OFFICER
(b)(6)-2 , COL, MC (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
(b)(6)-2 SSG, PAD, NCOIC

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDCOM - 7002

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

26 YM syrian contractor admitted last night via ER
p̄ sustaining a fall w/ brief LOC. Distance ~ 3m.
Had residual confusion in ER.
No obvious fx by x-ray series. Neck is sore, Rt elbow hurts.

PMH/meds/SHx - unknown
NKDA.

PHYSICAL EXAMINATION

120/80, 60, 12, resting - Interpreter not available at present.
lungs CTA, Neck collar in place, Reg $S_1 S_2$ ∅ sig Ⓜ, abd soft.
Rt elbow - mild tenderness/swelling
X-ray: skull/c-spine/Rt elbow all s̄ fx. U/A - concentrated.
CBC w/ WBC 18 H/H 16/50, lytes NL.

PROGRESS *(Enter date of discharge and final diagnosis)*

Imp: ① CHI s/p fall - mild concussion - some confusion last night. Neuro ✓'s remain NL.
- continue to monitor
② Neck sprain
③ Rt elbow contusion - analgesia.

(b)(6)-2

M.C. LTC	DATE 20AUG03	IDENTIFICATION NO.	ORGANIZATION
ed or written entries give Name last, first, grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

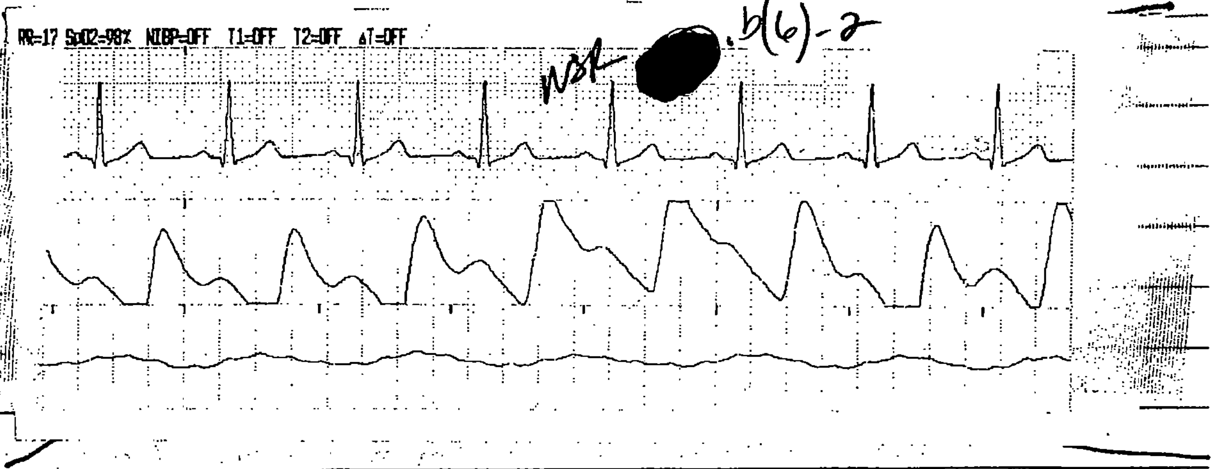
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 7003

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Aug 03 0230	Client admitted to icu on litter c̄ two staff ~~member and~~ RN. Placed on monitor, assessment and neuro checks done. see DA form 4700. Vomited x1 on admission, 25 mg Phenergan given IV. c/o H/A, 650mg tylenol PO for H/A. Pain noted to right elbow area. Dr (b)(6)-2 in to see client —— (b)(6)-2 1LT



DATE	NOTES
0300	Ice applied to right elbow. — (b)(6)-2
0300	Soft neck collar intact. —— (b)(6)-2 1LT
0400	no changes in neuro checks. —— (b)(6)-2
0500	ice reapplied to right elbow. —— (b)(6)-2
0600	Ice pack removed from Ⓡ elbow, report given to day shift RN, client in bed connected to monitor, soft c-collar intact. NS@200cc/h infusing. —— (b)(6)-2 1LT

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.

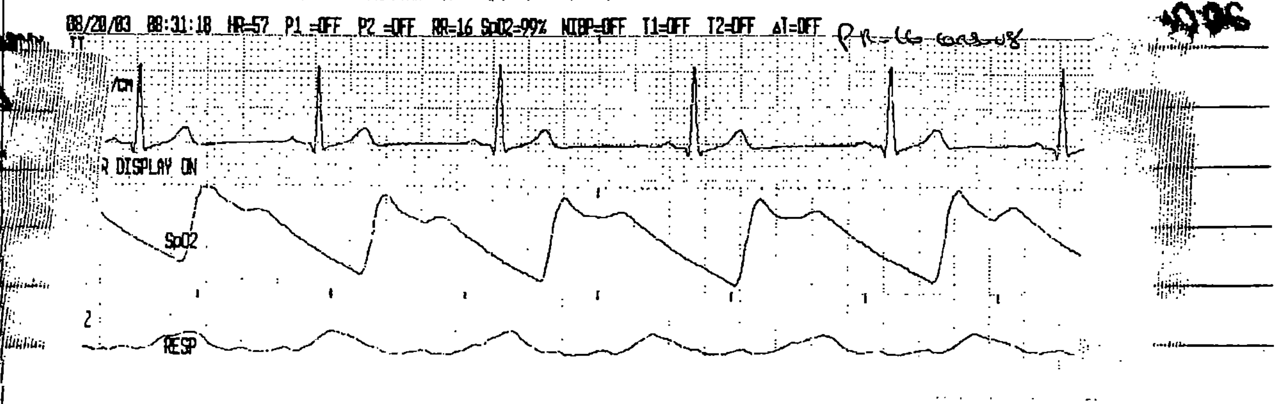
PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

MEDCOM - 7004

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



08/20/03 0800	Patient report received from previous shift. Patient lying in supine position. Given clear liquid diet, ate 1/3 of contents. C/O headache given 2 Tylenol 650mg. Neuro status unremarkable, c̄ equal hand grasps, pedal pushes equal. Pupils equal reactive to light, no nystagmus noted. Remains in SR c̄ ectopy – O2 sats 98% on monitor. Further assessments as per DA Form 4700. Plan ① Watch neuro changes q2° + record ② Notify MD of any status changes ③ Keep elbow elevated to ↓ swelling + pain (b)(6)-2
20 Aug 03 0830	U/A drawn + sent to lab as ordered. (b)(6)-2
20 Aug 03 1100	Foley D/C'd as ordered. CBC drawn, sent to lab (b)(6)-2
20 Aug 03 1200	Ice pack applied to elbow and elevated on pillow. Patient resting comfortably at present. Remains in SR (b)(6)-2
1400	Report given to CPT (b)(6)-2. Patient denies headache. Alert to name, place, person. IV infusing to Ⓛ arm. NS @ 200cc/hr. No void since foley d/c'd @ 1100. To ICW via litter. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1 00

MEDCOM - 7005

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
20 AUG 03 -	1915 - ASSESSMENT - A&Ox3, PERRLA, LUNGS CTA BILAT, S1-S2
	STRONG AND REGULAR, Ⓟ BS x4. Ø c/o PAIN, Ø c/o NAUSEA,
	C-SPINE PRECAUTIONS. PT HAS C-COLLAR. NEURO CHECKS q 2 MOTOR,
	SENSORY SKILLS INTACT. TOLERATED REG DIET. IV NS @ 250cc/hr. (b)(6)-2
	WILL CONTINUE TO MONITOR THROUGHOUT USN, CPN
	total intake = 3000cc total output = 700cc

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 21 AUG 03
	Dx - CONCUSSION
	CERVICAL STRAIN
	RT ELBOW CONTUSION
	PROCEDURES - NONE
	RESUME - 26 Y/O CONTRACT TRUCK DRIVER,
	SYRIAN, FELL 10 FT STRIKING OCCIPUT.
	AMNESTIC FOR INCIDENT, CONFUSED MSE
	ON PRESENTATION C/O Ⓡ ELBOW & NECK
	PAIN. PE TENDER OCCIPUT & PARA CERVICAL
	MUSCLES & TENDER Ⓡ DISTAL TRICEPS.
	NO - PERIPHERAL NEURO FINDINGS. NO ELBOW
	LAXITY. XR SKULL, C-SPINE, ELBOW ∅.
	SENSORIUM CLEARED & NECK FLEXION/EXTEN
	SION VIEWS ∅ OVER ENSUING 36 HR.
	DISPO - D/C
	MED - MOTRIN, TYLENOL 3
	F/U - PERSONAL PHYSICIAN AT HOME AS NEEDED
	ACT - NO DRIVING ON TYLENOL 3. NO PROLONGED
	DRIVING FOR ONE WEEK.

(b)(6)-2

(b)(6)-2

MC

ORTHOPEDIC SERVICE

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7007

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 21 AUG 03
	Dx - CONCUSSION
	CERVICAL STRAIN
	RT ELBOW CONTUSION
	PROCEDURES - NONE
	RESULT - 26 Y/O CONTRACT TRUCK DRIVER,
	SYRIAN, FELL 10 FT SUSTAINING OCCIPUT.
	AMNESTIC FOR INCIDENT, CONFUSED MSE
	ON PRESENTATION C/O (R) ELBOW & NECK
	PAIN. PE TENDER OCCIPUT & PARA CERVICAL
	MUSCLES & TENDER (R) DISTAL TRICEPS.
	NO - ABNORMAL NEURO FINDINGS. NO ELBOW
	LAXITY. XR SKULL, C-SPINE, ELBOW Ø.
	SENSORIUM CLEARED & NECK FLEXION/EXTEN
	SION VIEWS Ø OVER ENSUING 36 HR.
	DISPO - D/C
	MED - MOTRIN, TYLENOL 3
	F/U - PERSONAL PHYSICIAN AT HOME AS NEEDED
	ACT - NO DRIVING ON TYLENOL 3, NO PROLONGED
	DRIVING FOR ONE WEEK.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SP

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7008

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19AUG03	26 y/o ♂ c/o trauma to Ⓡ head, neck and
	arm. Interpreter states
	TTP to Ⓛ Ear slight deformity, TTP to
BP: 142/62	Ⓡ arm, upper, tricep area.
Pulse: 106	
Temp: 98.0	2312 - Vomited
Resp: 18	S/ HPI as above. pt Fell (possibly) 3 meters.
	hit Ⓛ occipital region ⊕ LOC < 3 mins
Allergies:	per witness c/o head/neck and Ⓡ arm
NKAD	pain.
Medications:	O/ WDWN A&O moves all extr.
Ø	eyes PERRL EOMI head - non traumatic
PMHx:	ears TM's clear Ⓑ
	mouth/throat - clear
PSHx:	neck - ⊕ midline ~~TTP~~ Ø step offs
	lungs - CTAB insp/exp
Tobacco:	CVS RRR S1S2 s̄ Ⓜ
	ABD - ⊕ BS soft NT ND Ø masses.
ETOH:	extr - Ⓡ arm - ⊕ TTP mid and ~~[illegible]~~ distal
	1/3 humerus Ø sensory ↓
	Radial pulses = Ⓑ CR ≤ 2 sec
	Ø deformity, ecchymosis but pt

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Ironhorse Consolidated Aid Station; Tikrit, Iraq			over →
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
(b)(6)-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 7009

19 Aug 03 extremity TTP

pelvis - stable

LE - ⊘TTP ⊘ laterality

Imp 26 y/o CIV sub contractor fell approx 3 meters ⊕ LOC, ⊕ emesis x1 in [illegible] neurologically intact. closed head injury and Ⓡ arm injury c̄ c-spine tenderness

plan ① evac to CSH For further Treatment and evaluation

[redacted]

CPT [redacted]

MEDCOM - 7010

DATE			TIME	TRANSPORTATION		CURRENT MEDS.	HISTORY OBTAINED FROM
MONTH	YR			☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)			☐ PATIENT ☐ OTHER
Aug	03		0045	AIR		⊘	ALLERGIES NKDA

(b)(6)-4

ZIP Code)

HOME TELE. NO.

fall from Height TOI ~2300

SEX m

AGE 24

POSSIBLE THIRD PARTY PAYER ☐ YES ☐ NO

TIME SEEN BY PROVIDER 0045

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

VITAL SIGNS

Ⓝ	045	
	144/80	
	105	
	34	
	96 ⓪	98 Ⓡ
(Cont.)	SpO2 97 RA	

S: Pt is a 26 yo (b)(6)-4 who was reported to have fallen 3 meters (10 feet) c̄ ⊕ LOC. Vom x1 in Ambulance @ 2312 Seen @ Iron Horse Aid Sta in Tikrit then sent by Helo. No vom in A/C. ⊕ Repetitive questions to Interpreter. Pt thinks he is at home in Syria & doesn't remember any fall.

pmhx ⊘
pshx ⊘
tob ⊘

O: WDWN in NAD. A+O x person, Not Place, Not date. GCS ~~15~~ 14 (confused)
⊖ Respir dist NonToxic
HEENT: NC/AT. ⊖ Battles, Raccoon, ⊖ HT PERRL EOMI 4mm.
⊖ oral lesions ⊖ malocclusion. ⊕ mod occip swelling. ⊖ stepoff
Neck: ⊕ ML tend ~ C4 ⊖ stepoffs ⊖ Crep.
Chest NT Ⓑ eq CTA. Cor RRR ⊖ⓜ
Abd: ⊕ BS S. NT ND ⊖ R/G FAST ⊖
Pelvis Stable NT ⊖ Crep
GU: NL ♂ ⊖ Scrotal HT
Rectal: NT NL Pros. Brn stool guaiac ⊖.
Ext: ⊕ mild swelling to Ⓡ Supracondylar area. NV intact.
⊖ Crep. ⊖ instability.

C/spine: ⊖ fx/subl
Ⓡ Elbow ⊖ fx ⊖ eff/subl.

FAST ⊘
Hemocult ⊘

18 > 16 / 50 < 181

7.41/427/426/37/29/3/100%

Yel/Sl Cloudy/1.030/mod Bld
⊘ WBCs 10-20 RBC Hy casts Few Bact

136 | 104 | 18
4.1 | 24 | 1.0 < 139

CK 234

LFT's NL.

EDC: persisted c̄ repetitive questions with Interpreter.

CATEGORY (See reverse)

EMERGENT ✓
URGENT
NON-URGENT

ORDERS	INITS.	TIME
CBC Rpt Spin	[redacted]	0045
CBC Chem Met UA		0046
Xlay		0046
FAST ⊖		
5 morphine/hold	[redacted]	0100

ASSESSMENT/DIAGNOSIS
CHI, Neck Strain
Ⓡ elbow Contusion.

FULL DUTY

QUARTERS
24 HRS. | 48 HRS. | 72 HRS.

MODIFIED DUTY UNTIL
DAY | MONTH | YEAR

REFERRED TO (Indicate clinic)
Gen Surg.
EMERGENCY ☒ TODAY
72 HOURS ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE
ICU.

CONDITION UPON RELEASE
IMPROVED UNCHANGED
DETERIORATED

TIME OF RELEASE: 0130.

PATIENT'S IDENTIFICATION (Mechanical imprint)
(For typed or written entries give: Name - last, first, middle; ID No. or SSN; sex; date of birth; rank/grade; service; status, name and relation of sponsor or next of kin; component; unit; facility holding record)

(b)(6)-4

(b)(6)-2

SIGNATURE (IF NEEDED)

MAJ MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

To ICU.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.
Prescribed by GSA and ICMR

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1800 HOURS
TO 0001 HOURS

TOTAL HOURS COVERED

DATE 20 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H_2O	800	800

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1L	NS	1L	1820	1L
1820	1L	NS	1L	2325	2L
2325	1L	NS	500		2500
					+ 500
					3000

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

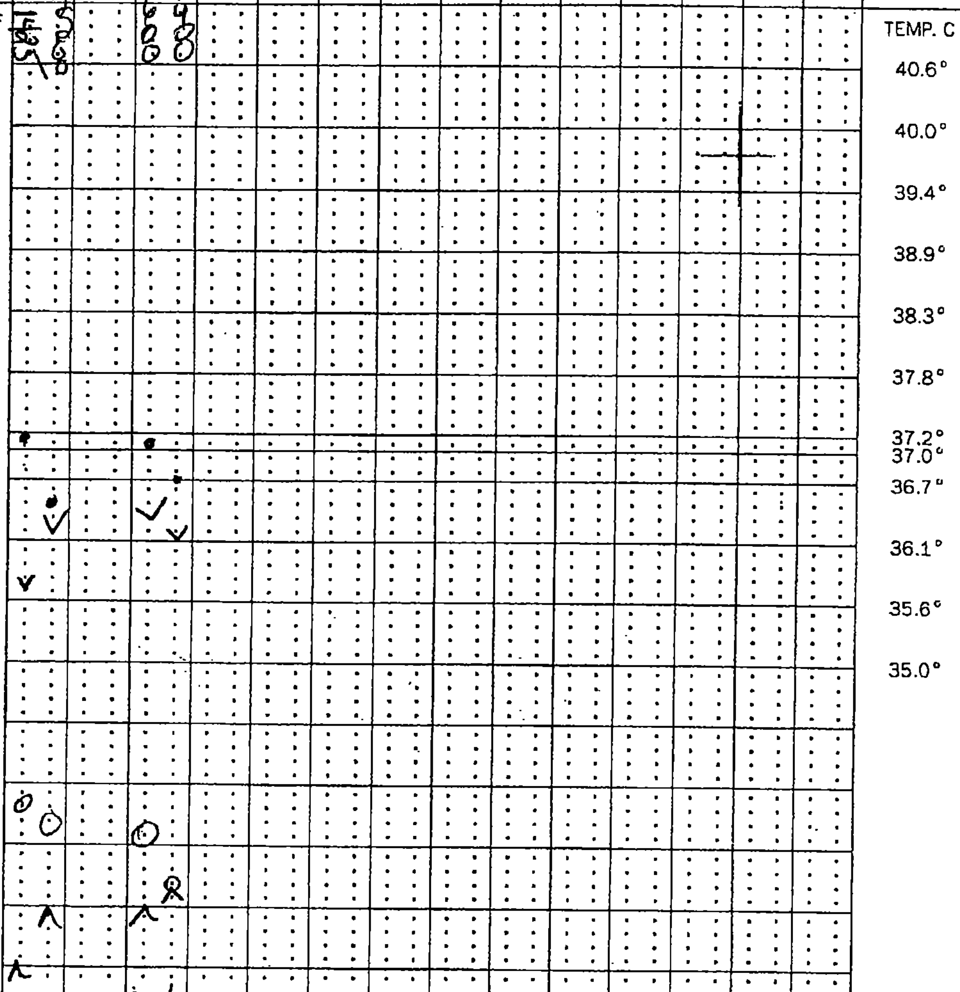
MEDCOM - 7012

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	
POST- DAY		
MONTH-YEAR Aug 2003 / DAY	20	21
HOUR	[illegible]	0600 1400



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	103/40 111/49	114/50 110/53
HEIGHT: / WEIGHT →	98%	99%
spO2	97	99%

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 7013

Ward/Section: ICU

Requesting Physician: Dr. (b)(6)-2

Laboratory Result Form
~~(Subject to~~ the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4

DATE

TIME

SSN/PSE (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	8.4	4.8-10.8 x 10
RBC	5.39	4.7-6.1 x 10
Hgb	15.1	14-18g/dl (M) 12-16 g/dl (F)
Hct	46.7	45-52% (M) 37-47% (F)
MCV	86.7	80-94 fl (M) 81-99 fl (F)
Plt	160	130-500 x 10 Verified
Lymph %	15.9	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	trace	Negative
pH	7.0	N/A
Prot	neg	Negative
Urob	norm	~~0.2-1.0~~
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANG
~~PRP~~		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		~~8.0-10.3 mg~~
CHOL		100-200 mg
~~CRE~~		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: Inadequate specimen to perform microscopic UA.

Remarks:

R (b)(6)-2

DATE: 20 Aug 03

LAB ID NO:

MEDCOM - 7014

Ward/Section: [illegible]	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

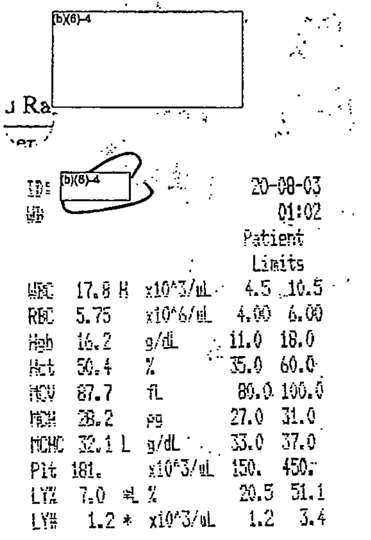
LAST, FIRST, MI (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	17.8	4.8-10.8 x 10
RBC	5.75	4.7-6.1 x 10
Hgb	16.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	50.4	45-52% (M) 37-47% (F)
MCV	87.7	80-94 fl (M) 81-99 fl (F)
Plt	181	130-500 x 10 Verified
Lymph %	7.0	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		



```
(b)(6)-4
ID: (b)(6)-4                      20-08-03
WB                                   01:02
                                  Patient
                                   Limits
WBC  17.8 H  x10^3/uL     4.5  10.5
RBC  5.75    x10^6/uL     4.00  6.00
Hgb  16.2    g/dL        11.0  18.0
Hct  50.4    %           35.0  60.0
MCV  87.7    fL          80.0 100.0
MCH  28.2    pg          27.0  31.0
MCHC 32.1 L  g/dL        33.0  37.0
Plt  181.    x10^3/uL    150.  450.
LY%  7.0 *L  %           20.5  51.1
LY#   1.2 *  x10^3/uL     1.2   3.4
```

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Sl cloudy	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	MOD	Negative
pH	5.0	N/A
Prot	Small	Negative NEGA Small
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk		Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	129	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	241	39-380 u/l (M) 30-190 u/l (F)
NA*	136	128-145 mmol/l
K*	4.1	3.3-4.7 mmol/l
CL*	104	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB	4.3	3.5-5.5 g/dl
ALP	94 ↑	26-84 u/l
ALT	22	10-47 u/l
AMY	13	14-97 u/l
AST	32	11-38 u/l
TBIL	1.2	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA**	9.2	8.0-10.3 mg/dl
CHOL	171	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	132	73-118 mg/dl
TP	7.3	6.4-8.1 g/dl

MISC

Results:

Microscopic UA

ws - (b)(6)-2

ph - MOD

t - few

Reported by: (b)(6)-2	DATE: 20 Aug 03	LAB ID NO:

MEDCOM - 7015

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
C-Spine Flex/Ext

AGE
SEX M
SSN *(Sponsor)* (b)(6)-4
WARD/CLINIC ICW
REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☑ NO

REQUESTED BY *(Print)* (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE OF EXAMINATION *(Month, day, year)*

DATE OF REPORT *(Month, day, year)*

DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
MEDCOM - 7016 RD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 Aug 03
TIME OF ORDER: 0130 HOURS
LIST TIME ORDER NOTED AND SIGN

↓		LIST TIME ORDER NOTED AND SIGN
✓①	Admit to ICU	
✓②	Dx CHI, Cervical Strain, Ⓡelbow Contusion	S/p Fall
✓③	Cond Stable	
✓④	VS q Shift	Noted
✓⑤	NKDA.	
✓⑥	Clear Liq Diet.	
✓⑦	IV NS @ ~~125~~ 200 cc/hr	(b)(6)-2
✓⑧	MSO4 5mg IV q 2-4° prn	
✓⑨	Neuro ✓'s q 2° ✓Foley, ✓Ice to Ⓡelbow.	
✓⑩	C-Spine Flex/Ext XRays in AM.	ICT RN
✓⑪	UA @ 0800	
✓⑫	Tyl 325 mg T-ii po q 4-6° prn (b)(6)-2	20 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 AUG
TIME OF ORDER: 0210 HOURS

V.O Dr (b)(6)-2 / 1LT (b)(6)-2
Phenergan 25 mg IV q 8°
PRN nausea
(b)(6)-2 ICT AN
20 AUG 03
0210

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 AUG 03
TIME OF ORDER: 1030 HOURS

① D/C Foley. CBC X1 today
(b)(6)-2

③ advance diet to regular
V.O. Dr (b)(6)-2 | (b)(6)-2 (b)(6)-2 1LW

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.
MEDCOM - 7017

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 Aug 03
TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ ① Transfer to ICW
✓ ② Resume Previous Orders
V.O. Dr (b)(6)-2 [redacted] / (b)(6)-2 [redacted] mgn
(b)(6)-2 [redacted]

noted (b)(6)-2 [redacted] 20 AUG 03 1820

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 AUG 03
TIME OF ORDER: ______ HOURS

D/C
MOD - MOTRIN, TYLENOL 3
ACT - NO DRIVING WHILE TAKING TYLENOL 3

Noted (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 7018

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON- [illegible]DICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo AUG Yr 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	
20AUG	(b)(6)-2	VS q Shift	06	/ (b)(6)-2			
			18	(b)(6)-2			
20AUG	(b)(6)-2	Clr Liq Diet	06	/	(b)(6)-2		
			18	(b)(6)-2			
20AUG	(b)(6)-2	Neuro √'s q 2°	06	/	(b)(6)-2		
			18	(b)(6)-2			
20AUG	(b)(6)-2	Foley Care q Shift	06	/	(b)(6)-2		D/C'd @ 1100
			18	(b)(6)-2			
20AUG	(b)(6)-2	Ice to (R) elbow	06	/ (b)(6)-2			
			18	(b)(6)-2			
20Aug03	(b)(6)-2	Advance diet to Regular	06	/ (b)(6)-2			
			18	/ (b)(6)-2			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: CHI Cervical Strain, (R) Elbow Contusion s/p Fall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 7019

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*				*Mo* 08 *Yr* 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Aug	(b)(6)-2	Admit to ICU	20AUG	20AUG	0210	(b)(6)-2
20AUG	(b)(6)-2	Cond Stable	20AUG	20AUG	0210	
20AUG	(b)(6)-2	C-Spine Flex/Ext Xrays in AM	20AUG	0700	[illegible]	
20AUG		UA @0800	20AUG	0800	0800	
20Aug		CBC x I	20Aug	1130	1130	
20Aug03		Transfer to ICW	20AUG	1400	1400	
20Aug03		Resume Previous Orders	20AUG	1400	1400	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 7020

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. AUG Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21
20 AUG	(b)(6)-2 [redacted]	IV NS @ 200 cc/hr	06	/ (b)(6)-2 [redacted]		
			18	(b)(6)-2 [redacted]		
26		[illegible]				

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
CHI, Cervical Strain, (R) elbow Contusion S/P Fall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4 [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14
E 15 16 17 18 19 20 21 22
N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 7021

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.*______ *Yr.*______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
20 AUG	(b)(6)-2	MSO4 5mg IV q2-4°	D T													
		PRN pain	Dose													
			I													
20 AUG	(b)(6)-2	Phenergan 25mg IV	D T	20 Aug 0210												
		q6° PRN nausea	Dose	IVP 25mg												
			Initial	SL												
20 Aug 03	(b)(6)-2	Tylenol 325mg i-ii	D T	20 Aug 0210	20 0830	20 Aug 1925										
		PO q4°-6° PRN	(b)(6)-2	ii	i	i										
			I	SL	[illegible]											

PAGE 1 OF

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS (b)(6)-2 [redacted]		INITIALS		INITIALS
NEURO	PUPILS	Pupils 3mm react.					
	SENSORIUM	A&O x3. Responds to					
		commands appropriately					
		MAE x4. C/o claim c̄					
		(R) elbow pain					
RESPIRATORY	RESPIRATORY PATTERN	Even & unlabored.					
	BREATH SOUNDS	Lungs CTA in all fields					
	SECRETIONS	ʋ̄ oxb on R/A 40%					
		Ø secretions					
SKIN	COLOR	Pink, No evidence of					
	INTEGRITY	breakdown, Ø abrasions					
IV SITE	LOCATION	I.V. #18G to (L)					
	CONDITION	Patent. NSS infusing					
		@ 200cc/hr s̄ infiltration					
GASTRO	ABDOMEN	BS x4 Quadrants.					
	BOWEL SOUNDS	Ø evidence of nausea					
		at this time. No tenderness					
		or guarding c̄ palpation					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	Clear yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	S Brady in 50's					
		PR .16 QRS .10 Ø					
		ectopy. Pulses 2+ to					
		all extremities.					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_IO_2 - Fraction of inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature [redacted] (b)(6)-2 1LT A

DEPARTMENT/SERVICE/CLINIC ICU

DATE 20 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
MEDCOM - 7023 1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY | PAGE

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff	111/44	115/56	113/39	114/46	115/40	112/50	117/40	118/38									
Temperature	96^4					97^3											
Pulse	63	66	64	59	63	58	68	71									
Respiratory Rate	13	13	20	13	13	17	15	18									
O2 Sat	99%	99%	99%	97%	99%	99%	97%	96%									
Oxygen	RA	RA	RA	RA	RA	RA	RA	RA									

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
NS	200 (b)(6)-2	200	200	200	200	200	200 (b)(6)-2	200									
TOTALS																	

OUTPUT

URINE	HOUR / TOTAL	200 / 650	150 / [illegible]														
	sp gr																
	S/A																
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL																	
DRAINS																	
TOTALS																	

MEDCOM - 7024

ST-OP DAY

22	23	24	01	02	03	04	05	

22	23	24	01	02	03	04	05	8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		TIME
		MODE
		F_iO_2
		TV
		RATE
		PEEP
ABG	A	pH
		PCO_2
		pO_2
	B	HCO_3
		SAT
	G	BASE

LABORATORY DATA

TIME
GLUCOSE
Na/K
Cl/CO$_2$
BUN/Cr
WBC/PLATELET
Hct/Hgb

ACTIVITIES OF DAILY LIVING

TIME
MOUTH CARE
BATH
SKIN CARE
FOLEY CARE
TRACH CARE
ROM EXERCISES

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday

wt Today

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE________

NURSE'S SIGNATURE

INITL

(b)(6)-2

(b)(6)-2

NEUROLOGICAL ASSESSMENT

	HOURS		06	08	10	12	14	16	18
EYES OPEN	SPONTANEOUSLY	4		✓	✓	✓	✓		
	TO SPEECH	3	✓						
	TO PAIN	2							
	NO EYE OPENING	1							
BEST VERBAL RESPONSE	ORIENTED	5		✓	✓	✓	✓		
	CONFUSED	4	✓						
	VERBALIZES	3							
	VOCALIZES	2							
	NO VOCALIZATION	1							
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓	✓	✓	✓		
	LOCALIZES PAIN	5							
	FLEXION WITHDRAWAL	4							
	ABNORMAL FLEXION	3							
	EXTENSION TO PAIN	2							
	NO MOTOR RESPONSE	1							
ARMS	NORMAL POWER		✓	NL		NL	NL		
	MILD WEAKNESS								
	SEVERE WEAKNESS								
	ABNORMAL FLEXION								
	ABNORMAL EXTENSION								
	NO RESPONSE								
LEGS	NORMAL POWER		✓	NL		NL	NL		
	MILD WEAKNESS								
	SEVERE WEAKNESS								
	ABNORMAL FLEXION								
	ABNORMAL EXTENSION								
	NO RESPONSE								
RIGHT	SIZE		4	4		3	3		
	REACTION		++	++		++	++		
LEFT	SIZE		4	4		3	3		
	REACTION		++	++		++	++		

PIL SCALE ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

REBRAL PERFUSION PRESSURE

LEGEND

C Close by swelli

T Trach/E
S Slurring
D Dyspha
R Recepti
E Express

R Right
L Left

Record separately there is a difference between t two sides.

++ Bris
+ Slo
- No Respo

+ Intact
- Abnorm

VASCULAR ASSESSMENT

HOURS		06	08	12	14
Radials	R	++	++	++	++
	L	++	++	++	++
Pedals	R	++	++	++	++
	L	++	++	++	++
	R				
	L				
	R				
	L				
	R				
	L				

LEGEND

++ Norm
+ Wea
- Abse
D Doppl
R Right
L Left

MEDCOM - 7026

PAGE 1 OF

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0230	INITIALS [redacted] b(6)-2	INITIALS
NEURO	PUPILS	PERRL		
	SENSORIUM	repetitive questions		
		memory appears		
		short term.		
RESPIRATORY	RESPIRATORY PATTERN	easy, nonlabored		
	BREATH SOUNDS	clear bilat		
	SECRETIONS	Ø		
		R/A, O2 sat 98%.		
SKIN	COLOR	WNL		
	INTEGRITY	intact		
IV SITE	LOCATION	Ⓛ forearm | AC heplock		
	CONDITION	dsg+site intact | dsg site		
		NS @ 200cc/h | intact		
		⊕ blood return | flushes easily		
		flushes easily | ⊕ blood return		
		18 gauge | 18 Gauge		
GASTRO	ABDOMEN	soft flat nontender		
	BOWEL SOUNDS	⊕ BS x4 quads		
		N/V, Phenergan IV		
		given for emesis.		
GU	URINE:	foley → gravity		
	COLOR/CLARITY	clear yellow		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR s̄ ectopy		
		⊕ pulses x4		

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

1LT Ar

DEPARTMENT/SERVICE/CLINIC
ICU

DATE
19–20 August

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 **4700**
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
MEDCOM - 7027 1 Apr 90 (HSXC-NU)

DATE

DX

PAGI

HOSPITAL DAY

VITAL SIGNS																	
TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff																	
Temperature																	
Pulse																	
Respiratory Rate																	
O_2 Sat																	
Oxygen Method																	

INTAKE																	
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
NS																	
TOTALS																	

OUTPUT																		
URINE	HOUR / TOTAL																	
	SP G																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 7028

(b)(6)-4

ST-OP DAY

22	23	24	01	02	03	04	05	
				130/54		119/44	119/41	
				99				
				93	72	73	62	
				18	15	13	14	
				98%	99%	98%	99	
				R/A	R/A	R/A	R/A	
				R/A	[illegible]	R/A	R/A	

22	23	24	01	02	03	04	05	8° T
				200 200	200 400	200 600	200 800	800
								800
					150 150		425 1075	1075
				Phenergan [illegible]				
				125 [illegible]				125
								1200

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME								
MODE								
F_iO_2								
TV								
RATE								
PEEP								
ABG pH								
ABG PCO_2								
ABG pO_2								
ABG HCO_3								
ABG SAT								
ABG BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

TIME				TURN	TIME
MOUTH CARE					
BATH					
SKIN CARE					
FOLEY CARE				SUCTION	
TRACH CARE					
ROM EXERCISES					

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE

IV ____

po ____

TOTAL 800

OUTPUT

Urine: ____

TOTAL 1200

BALANCE (0400)

NURSE'S SIGNATURE

[redacted]

MEDCOM - 7029

NEUROLOGICAL ASSESSMENT

	HOURS		02	04
EYES OPEN	SPONTANEOUSLY	4	✓	
	TO SPEECH	3		✓
	TO PAIN	2		
	NO EYE OPENING	1		
BEST VERBAL RESPONSE	ORIENTED	5		
	CONFUSED	4	✓	✓
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1		
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO MOTOR RESPONSE	1		
ARMS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
LEGS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
RIGHT	SIZE		3-4	4
	REACTION		++	++
LEFT	SIZE		3-4	4
	REACTION		++	++
IPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm			
			NA	N/A
REBRAL PERFUSION PRESSURE			NA	NA

LEGENI

C Clos by swelli

T Trach/E
S Slurring
D Dyspha
R Recepti
E Express

R Right
L Left

Record separately there is a difference between t two sides.

+ + Bris
+ Slov
- No Respor

+ Intact
- Abnorn

VASCULAR ASSESSMENT

HOURS		02	04
Radial	R	++	++
	L	++	++
Pedal	R	++	++
	L	++	++
	R		
	L		
	R		
	L		
	R		
	L		

LEGEND

+ + Norm
+ Weal
- Abse
D Doppl
R Right
L Left

MEDCOM - 7030

D FORM 1 MAR 63 689 PREVIOUS EDITIONS ARE OBSOLETE.

INDIVIDUAL SICK SLIP

☐ ILLNESS ☒ INJURY

DATE 21 AUG 03

LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT (b)(6)-4

ORGANIZATION AND STATION

SERVICE NUMBER/SSN

GRADE/RATE

UNIT COMMANDER'S SECTION

IN LINE OF DUTY

REMARKS

SIGNATURE OF UNIT COMMANDER

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY

DISPOSITION OF PATIENT ☐ DUTY ☐ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☒ OTHER *(Specify)*:

REMARKS NO DRIVING WHILE TAKING TYLENOL 3. NO PROLONGED DRIVING FOR ONE WEEK

(b)(6)-2

(b)(6)-2

LTC, MC

DIC SERVICE

SIGNAT

MEDCOM - 7031

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. LOCATION *(State or Country Code.)*

7	8

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME *(Last, First, Middle Initial)*

(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
	2	4

y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION

UNK

10. LENGTH OF SERVICE

32	33	34
Z	Z	Z

ETS b(6)-4

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(6)-4

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
U

HOUR OF ADMISSION

0050

BRANCH / CORPS

14. FLYING STATUS

47	48	49
Z	Z	Z

15. BENEFICIARY CATEGORY

50	51	52
K	7	~~6~~ 8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

b6)4

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD

ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(6)-4

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
0	~~5~~ 8

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y Y Y M M D D)*

81	82	83	84	85	86	87	88
2	0	0	3	0	8	2	1

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(Y Y Y Y M M D D)*

99	100	101	102	103	104	105	106
2	0	0	3	0	8	2	0

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(Y Y Y Y M M D D)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX:CONCUSSION
CERVICAL STRAIN
R ELBOW CONTUSION

Dx: 85011
8470
92311
E882

Inj Trauma
919 8

ADMITTING OFFICER *(Signature, as required)* For

(b)(6)-2 , LTC, MC

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

SSG, PAD, NCOIC

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

MEDCOM - 7032

(b)(3)-1

INP NT TREATMENT RECORD COVER SHE

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
4. SEX M	5. AGE 23	6. RACE X	7. RELIGION UNK
8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD ICW
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS
19. UIC/ZIP	20. TYPE CASE BC		
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0	22. HOURS OF ADMISSION 0400	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION HOME	26. DATE OF DISPOSITION 20 AUG 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 19 AUG 03	ADMITTING OFFICER COL (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

ADMISSION REMARKS

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

This 23 y/o Iraqi ambulance driver was wounded in the right calf at 2330 on 18 Aug 03 when enemy forces attempted to use his vehicle as cover to attack a US check point in Tikrit.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: FRAGMENT WOUND RIGHT CALF PROCEDURES

PROCEDURES: WOUND IRRIGATION

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 COL, MC (b)(6)-2	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2 SG, PAD, NCOIC

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 6985

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

(b)(6)-4

PHYSICAL EXAMINATION

(b)(6)-4

PROGRESS *(Enter date of discharge and final diagnosis)*

	IDENTIFICATION NO.	ORGANIZATION

MEDCOM - 6986

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug	
0322	CBC, met8
0327	X-ray (R leg)
	5g morphine refused
19AUG03 @ 0420	Nsg admission note: Pt was transferred from ER via stretcher. Appears A+O x 4 (spoke w/ interpreter). Has an ace bandage wrapped around his rt leg where he apparently received a fragment wound from a "crossfire" incident. Pt to be NPO until seen by Dr (b)(6)-2 Denies any pain @ this time. VS are WNL. Dressings are clean/unclosed, sats are 98% on RA (b)(6)-2
19Aug03 1600	Nurses Shift note Pt. received in lying position w/ FOB↑. Pt. surgery cancelled on IV antibiotic. Dressing A'd by physician. Visitors this shift. Cont. comfort (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19AUG03 @2330	NSG shift assessment: Pt denies any current pain. Has been very quiet throughout shift. Leg is still elevated. Breath sounds are clear resps even + unlabored. Cap refill to (R) toes WNL. Will continue to monitor (b)(6)-2
20AUG03 0600	S NO C/O O VSSA WND BENIGN NVI A DOING WELL P D/C SEE NARSUM (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/60618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 20 AUG 03
	DX - FRAGMENT WOUND RIGHT CALF
	PROCEDURES - WOUND IRRIGATION - 19 AUG 03
	RESUME - THIS 23 Y/O IRAQI AMBULANCE
	DRIVER WAS WOUNDED IN THE RIGHT
	CALF AT 2330 18 AUG WHEN ENEMY
	FORCES ATTEMPTED TO USE HIS VEHICLE
	AS COVER TO ATTACK A US CHECKPOINT
	IN TIKRIT. PE SHOWED A SINGLE 1/2 CM
	WOUND OF THE DISTAL POSTERO MEDIAL
	CALF. THE LIMB WAS NEUROVASCULARLY
	INTACT. XRAY SHOWED SEVERAL SMALL
	METALLIC FRAGMENTS IN THE DISTAL
	TRICEPS SURAE. HE WAS TREATED WITH
	WOUND TRACK IRRIGATION IN EMT
	AND ADMITTED FOR 24° IV ABX. HIS
	COURSE WAS UNREMARKABLE.
	DISPO - D/C TO HOME F/U- (b)(3)-1 PRN
	ACTIVITY - PWB CRUTCHES x 1 WK
	MEDS - KEFLEX 500 QID x 7D, TYLENOL 3 PRN (b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

LTC, MC
ORTHOPEDIC SERVICE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6989

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) EMT

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
19			0319

TRANSPORTATION TO HOSPITAL (Attach ... enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☐ OTHER (Specify)

CURRENT MEDS. (...ication and other data)
Amlot @ 0805 ⊖.

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Spec

ALLERGIES
NKDA.

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
gun shot wound Ⓡ leg

SEX M

AGE 23

POSSIBLE THIRD PARTY PAYER ☐ YES ☐ NO

TIME SEEN BY PROVIDER 0300

VITAL SIGNS

TIME	0319		
BP	179/97		
PULSE	98		
RESP.	16		
TEMP.	98.4		
SPO2	99%		

CATEGORY (See reverse)
EMERGENT
X URGENT
NON-URGENT

ORDERS	INITS.	TIME
X-RAY		0327
CBC, Met 8	[redacted]	0322
5g morphine	Refused	
Irrig ale 2L wound		

ASSESSMENT/DIAGNOSIS
frag to Ⓡ lower leg.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S- 23 yo ♂ Iraqi c/o GSW to Ⓡ leg distal calf. His vehicle was being used as a sheild and he got caught in the cross fire. Pt is an Iraqi Ambulance driver, Not an EPW. occurred downtown Tikrit near Palace. ~~near 122 area.~~
? if bullet or fragment.

Last meal 2230.
TOI ~~2330~~ 2330

O- pt appears to be in no distress
NonToxic A&O×4, ⊖ Respir dist.
HEENT: NCAT PERRL EOMI.
Lungs Ⓑ CTA
Cor RRR ⊖⊖
Abd: ⊕BS S. NT ND ORG
Ext: Ⓡ LE ē medial calf posterior to Tibia frag wound
NL sensation ++PP 3x phase doppler pulses

PMHx ⊖.
PSHx Appy

Intramuscular frags. ⊖ Fx.

13 > 17/52 < 266

139 | 103 | 9
4.9 | 24 | 1.1 < 103
Hemolyzed.

DISPOSITION (Check all that apply)
HOME | FULL DUTY
QUARTERS
24 Hrs. | 48 Hrs. | 72 Hrs.
MODIFIED DUTY UNTIL:
DAY | MONTH | YEAR
REFERRED TO (Indicate clinic)
Ortho
EMERGENCY | X TODAY
72 HOURS | ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
X IMPROVED | UNCHANGED
DETERIORATED
TIME OF RELEASE: 0406

PATIENT'S IDENTIFICATION (Mechanical imprint)
(FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; ... DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

(b)(6)-2

...NEEDED)

...AMP
MAJ MC.

...(...dications ordered, any limitations and follow-up plans)
To ICW

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.
Prescribed by GSA and ICMR

MEDCOM - 6990

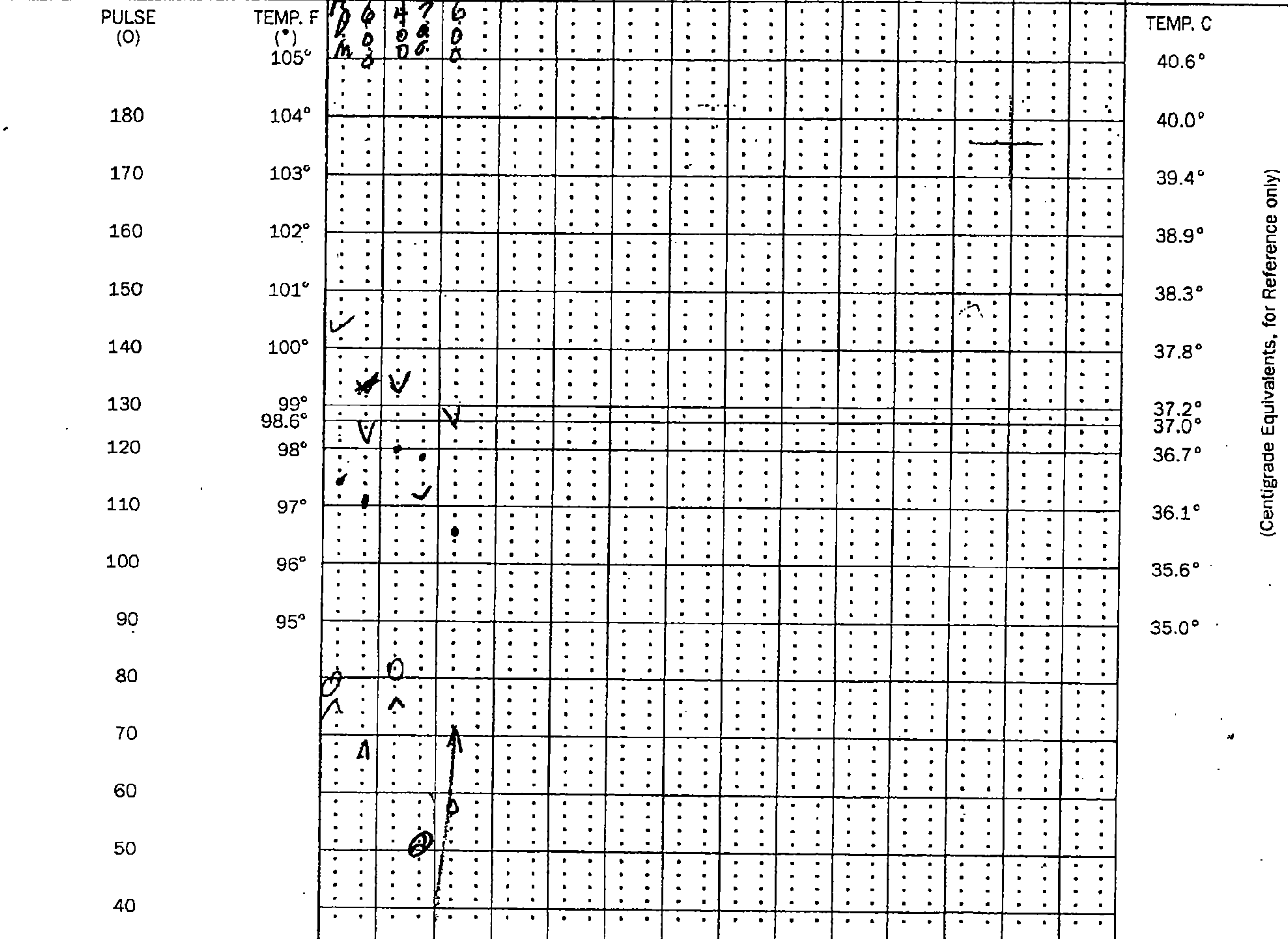
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
POST- DAY	~~PO~~						
MONTH-YEAR AUG03 / DAY	~~8~~ 19	20	21	22	23	24	25
19 / HOUR	ADM 0600 1400 2200	0600					



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	141/75 124/69	133/76 111/51	125/71				
HEIGHT: / WEIGHT →							
SpO2	98 98%	100					

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6991

Ward/Section: EMT	Requesting Physician: DL (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 19 AUG	TIME 0322	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	13.6	4.8-10.8 x 10
RBC	6.05	4.7-6.1 x 10
Hgb	17.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	52.1	45-52% (M) 37-47% (F)
MCV	86.2	80-94 fl (M) 81-99 fl (F)
Plt	258	130-500 x 10 Verified
Lymph %	126	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	126	39-380 u/l (M) 30-190 u/l (F)
NA*	139	128-145 mmol/l
K*	① 4.9 ↑	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANG
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Rang
ALB		3.5-5.5 g/d
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg
BUN		7-22 mg/dl
CA**		8.0-10.3 m
CHOL		100-200 m
CRE		0.6-1.2 mg
GLU		73-118 mg
TP		6.4-8.1 g/d

MISC

Results:

Microscopic UA

Results:

Remarks: ① Specimen Hemolyzed - MAY Falsely ↑ K+

Reported by: (b)(6)-2	DATE: 19 Aug 03	LAB ID NO:

MEDCOM - 6992

RADIOLOGIC CONSULATION REQUEST

PATIENTS NAME: (b)(6)-4

SSN:

UNIT:

PROVIDER/ CLINIC: EMT IDR (b)(6)-2

DATE REQUESTED: 19 Aug 03

EXAMINATION REQUESTED:

Ⓡ leg

SPECIFIC REASON(S) FOR REQEST:

GSW

RADIOLOGIC REPORT:

MEDCOM - 6993

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 Aug 03 TIME OF ORDER 0400 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW
2. Dx frag wound to Ⓡ Leg.
3. Cond Stable
4. VS q Shifts
5. NKDA-
6. Actv: BR c̄ BRP.
7. Nursing: wound Care, Elevate Ⓡ LE

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

8. IV NS @ 125 cc/hr
9. NPO until seen by Dr (b)(6)-2 then Reg Diet
10. MSO4 5-10 mg IV q 2-4° prn.
11. Ancef Ī gm IV q 8° Last dose ~ 0100

(b)(6)-2

Noted 19AUG (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 19 AUG 03 TIME OF ORDER 0815 HOURS

REG DIET

ANCEF Ī GM IV NOW, THEN

BEGIN q 8° DOSING AT 1400

(b)(6)-2

(b)(6)-2 CMar 19AUG03 0815

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

210 [illegible] 20 AUG 03 [illegible]

20 AUG 03 0500

D/C HOME - MUST BE AT GATE AT 1000,
PLEASE COORDINATE c̄ 1SG

CRUTCH TRAIN Ā D/C

MEDS - KEFLEX, TYLENOL 3, BACITRACIN

PROVIDE 4X4S & COBAN FOR DSG AS

(b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE U

MEDCOM - 6994

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug *Yr.* 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
			X	19	20	21	22	23									
19AUG	(b)(6)-2	IV NS @ 125cc hr	06	(b)(6)-2													
			14														
			22	(b)(6)-2													
~~19AUG~~	(b)(6)-2	~~NPO until seen~~	~~06~~														
		~~by Dr Granville~~	~~14~~														
		~~then Regular~~	22														
19AUG	(b)(6)-2	Ancef 01 Gm	06	(b)(6)-2													
		IV Q8 resume	14														
		Q8 at 1400	22														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Frag wound to (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 6995

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* ______ *Yr* ______			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION*													
			TIME/DATE COMPLETED													
18AUG	(b)(6)-2	MSO4 5-10mg														
.....	.....	IV Q2-4° PRN														
.....	.....	(b)(6)-2														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 6996

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Aug *Yr* 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
			X	19	20	21	22	23									
19AUG	(b)(6)-2	VS Q shift	06	(b)(6)-2													
			14														
			22														
19AUG	(b)(6)-2	Activity: Bedrest	06														
		c̄ BRP	14														
			22														
19AUG	(b)(6)-2	Nursing: wound	06	(b)(6)-2													
		care, elevate	14														
		(R) LE	22	(b)(6)-2													
17AUG	(b)(6)-2	NPO until seen	06														
		by Dr (b)(6)-2	12			D/C											
		then Reg Diet	18	(b)(6)-2													
19Aug	(b)(6)-2	Reg diet	6	/													
			12	(b)(6)-2													
			17														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Frag wound to (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6997

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN

(MEDICATIONS)

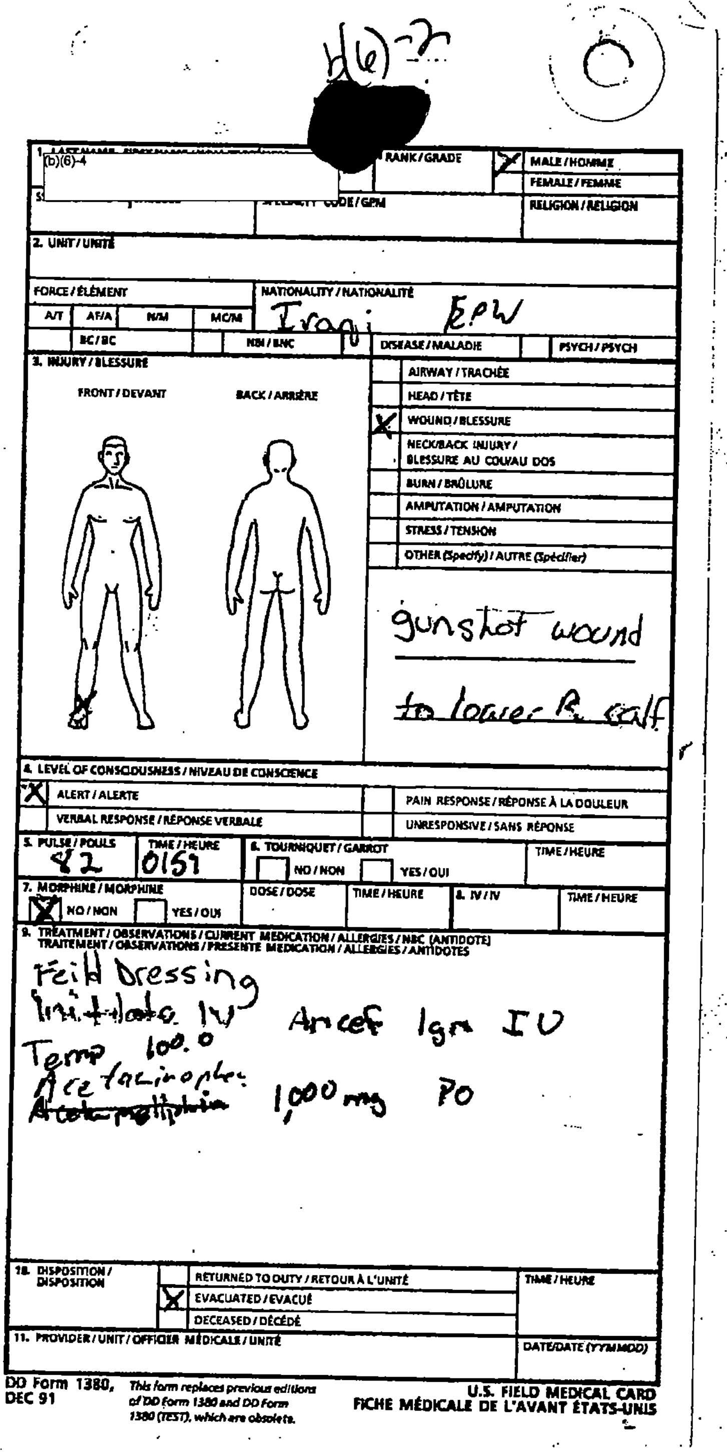
*Mo.*________ *Yr.*______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Admit to ICW				
		Dx: Frag wound to Ⓡ leg				
		Condition: Stable				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION*													
			TIME/DATE DISPENSED													

USAPA V1.00

MEDCOM - 6998



b(6)-2

[redacted]

1. LAST NAME, FIRST NAME / NOM, PRÉNOM (b)(6)-4

RANK/GRADE

☒ MALE/HOMME

☐ FEMALE/FEMME

SPECIALTY CODE/GPM

RELIGION/RELIGION

2. UNIT/UNITÉ

FORCE/ÉLÉMENT

A/T	AF/A	N/M	MC/M
	BC/BC		NBI/BNC

NATIONALITY/NATIONALITÉ Iraqi EPW

☐ DISEASE/MALADIE ☐ PSYCH/PSYCH

3. INJURY/BLESSURE

FRONT/DEVANT BACK/ARRIÈRE

☐ AIRWAY/TRACHÉE

☐ HEAD/TÊTE

☒ WOUND/BLESSURE

☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS

☐ BURN/BRÛLURE

☐ AMPUTATION/AMPUTATION

☐ STRESS/TENSION

☐ OTHER (Specify) / AUTRE (Spécifier)

gunshot wound

to lower R calf

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☒ ALERT/ALERTE

☐ VERBAL RESPONSE/RÉPONSE VERBALE

☐ PAIN RESPONSE/RÉPONSE À LA DOULEUR

☐ UNRESPONSIVE/SANS RÉPONSE

5. PULSE/POULS 82 TIME/HEURE 0159

6. TOURNIQUET/GARROT ☐ NO/NON ☐ YES/OUI TIME/HEURE

7. MORPHINE/MORPHINE ☒ NO/NON ☐ YES/OUI DOSE/DOSE TIME/HEURE

8. IV/IV TIME/HEURE

9. TREATMENT/OBSERVATIONS/CURRENT MEDICATION/ALLERGIES/NBC (ANTIDOTE)
TRAITEMENT/OBSERVATIONS/PRÉSENTE MÉDICATION/ALLERGIES/ANTIDOTES

Feild Dressing

Initiate IV Ancef 1gm IV

Temp 100.0

Acetacinophen

~~Acetamelliphin~~ 1,000 mg PO

10. DISPOSITION/DISPOSITION

☐ RETURNED TO DUTY/RETOUR À L'UNITÉ

☒ EVACUATED/ÉVACUÉ

☐ DECEASED/DÉCÉDÉ

TIME/HEURE

11. PROVIDER/UNIT/OFFICIER MÉDICALE/UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 6999

12. REASSESSMENT/RÉASSESSMENT

DATE/DATE (YYMMDD) 03 08 14		TIME OF ARRIVAL/HEURE D'ARRIVÉE 0130		
TIME/HEURE	0154	[illegible]		
BP/PS	172/90	169/91		
PULSE/POULS	82	69		
RESP/RESP	17	24		

DATE/TIME
DATE/HEURE

13. CLINICAL COMMENTS/DIAGNOSIS
INFORMATION MÉDICALE/DIAGNOSTIQUES

S: 23 y.o. c̄ GSW to Ⓡ ~~medial~~ retrolat/ lat distal calf.
O: Lying down in NAD, A+O, VS BUT
HEENT: Eyes clear PERRL
Ear clear
Throat clear
Neck clear.

14. ORDERS/ANTIBIOTICS (Specify)/TETANUS/IV FLUIDS
DIRECTIVES MÉDICALES/ANTIBIOTIQUES (Spécifier)/TÉTANOS/IV FLUIDE

HEART: S1 S2 / RRS w/o m
LUNGS: CTA Ⓑ on insp/exp
ABD: ⊕ BS soft, NTND
UE: ∅ Fx / dislocation
pulses +2
LE: Ⓡ leg: Entrance wound
Ⓡ ~~medial~~ redial ~~lateral~~ distal
calf ∅ active bleeding
NVI
Ⓛ leg: ∅ Fx / dislocat.

(b)(6)-2

(b)(6)-2

(b)(3)-1

DATE/DATE (YYMMDD) 03 08 19

16. DISPOSITION/ DISPOSITION	☐	RETURNED TO DUTY/RETOUR À L'UNITÉ	TIME/HEURE
	☐	EVACUATED/EVACUÉ	
	☐	DECEASED/DÉCÉDÉ	

17. RELIGIOUS SERVICES/ SERVICES RELIGIEUX	☐	BAPTISM/BAPTISÉ	☐	PRAYER/PRIÈRE
	☐	ANOINTING/ONCTION	☐	COMMUNION/COMMUNION
	☐	CONFESSION/CONFESSION	☐	OTHER/AUTRE

CHAPLAIN/CHAPELAIN

DD Form 1380, DEC 91 (Back)

MEDCOM - 7000

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. MTF LOCATION

7	8

(State or Country Code.)

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME *(Last, First, Middle Initial)* EPW

(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
2	3	y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS b(6)-4

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(3)-1

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 0400

BRANCH / CORPS EPW

14. FLYING STATUS

47	48	49
Z	Z	Z

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

b(6)-4

17. UNIT LOCATION *(State or Country Code)*

62	63
[redacted]	[redacted]

b(3)-1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
~~1~~ 9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
O

WARD ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
0	1

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y Y Y M M D D)*

81	82	83	84	85	86	87	88
2	0	0	3	0	8	2	0

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(Y Y Y Y M M D D)*

99	100	101	102	103	104	105	106
2	0	0	3	0	8	1	9

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

b(3)-1

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(Y Y Y Y M M D D)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: FRAGMENT WOUND RIGHT CALF

PROCEDURES: WOUND IRRIGATION

Dx: 8911 Proc: 9659
E9919

Inj Trauma
443 1

ADMITTING OFFICER *(Signature, as required)*

(b)(6)-2 , COL,MC

For

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2 SSG, PAD, NCOIC

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 7001

(b)(3)-1

IN[illegible]NT TREATMENT RECORD COVER S[illegible]

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
4. SEX M
5. AGE
6. RACE X
7. RELIGION
8. LENGTH OF SVC
9. ETS
10. PREVIOUS ADMISSION NO
11. FMP 99
12. SSN (b)(6)-4
13. ORGANIZATION
14. WARD ICU
15. FLYING STATUS
16. RATING/DSG
17. DEPT./BEN K65
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0
22. HOURS OF ADMISSION 2130
23. CLINIC SERVICE ABMA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION HOME
26. DATE OF DISPOSITION 20030809
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 20030807

ADMISSION REMARKS

ADMITTING OFFICER DR (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1
30. DATE OF INTIAL ADMISSION
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED 0

31. SELECTED ADMINISTRATIVE DATA
PATIENT WAS DISCHARGED HOME ON 9 AUG 2003

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 40% BSA BURNS 2ND DEGREE
BURN RIGHT FOREARM
BURN LEFT SHOULDER
BURN RIGHT ABDOMEN

DX-94321
94127
94223
94840
E9242

Trauma-9
Injury-989

PR-8628

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2, LTC, MC (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2 SSG, NCOIC, PAD

DA FORM 3647, MAY 79 N OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 6958

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

28 yo civilian Turkish male – splash burn from radiator water and fall from 15'. c/o pain (R) ankle, back + (L) shoulder, forehead, forearm (R)

PMHx ∅
Meds ∅
All ∅
PSHx ∅

PHYSICAL EXAMINATION

156/85 94 92 RA
HEENT: clear, Broken blister; forehead
Chest CTA CV RRR
Abd benign
Skin (L) shoulder / deltoid area 1-2° burn c blisters, NT, bleeding
(R) ankle wrapped, ecchymosis.
(R) forearm 1-2 blisters.

WBC 17k
UA 1030 (-)
Cr 1.3

PROGRESS *(Enter date of discharge and final diagnosis)*

A/ Fall accident
~10% burn – scalding

P/ Admit
Debridement

(b)(6)-2

SIG	DATE	IDENTIFICATION NO.	ORGANIZATION
	8/7		

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 6959

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
10 Aug 03	Nursing: Shift & Pt. dressing change this shift.
1630	Some bleeding but pt healing. Premeded w/ Percocet
	Ambulating with crutches, USS, Speech clear,
	∅ signs of resp. distress. Slept most of day.
	Continue to monitor ——— (b)(6)-2 CPT AN
10 Aug 03	2250 - A&O x3, PERRLA, LUNGS CTA BILAT, S_1-S_2 STRONG + REG,
	⊕ BS x4. DRSG Δ'd C, D, I. PT RECEIVED MOTRIN 800mg FOR
	PAIN. OOB c̄ CRUTCH ASSISTANCE. VSS, ∅ c/o PAIN BESIDE WHEN
	DRSG Δ PERFORMED. TOLERATED REG DIET. WILL CONTINUE TO MONITOR ——— (b)(6)-2 SGT, LPN
11 Aug 03	Nursing: Shift Note Pt. w/o change this shift.
1615	VSS. Pt. desires release from hospital. Pt. had
	2 male visitors to come in w/ hospital escorts.
	Visit appeared comforting to pt. Dressing change
	this shift. Site appears to be healing as expected
	Continue to monitor ——— (b)(6)-2 CPT AN
11 AUG 03	– ASSESSMENT – 0150 – A&O x3, PERRLA, LUNGS CTA BILAT, S_1-S_2
	STRONG AND REGULAR, ⊕ BS x4 DRSG Δ'd @ 2230 C, D, I.
	∅ c/o PAIN BESIDES DURING DRSG Δ. OOB c̄ CRUTCH ASST
	TOLERATED REG DIET. WILL CONTINUE TO MONITOR ——— (b)(6)-2 SGT, LPN
12 AUG 03	NSG: Pt A&O x3. Spoke w/ interpreter,
@ 2030	Smiling at times. Gait is improving,
	and is currently at a physical
	TX session. VS WNL, no complaints
	at this time (Continue on reverse side) (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.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6960

PROGRESS NOTES

DATE	
13 Aug	PT awake, VSS, Ø complaints will continue to monitor. —— (b)(6)-2 SGT [illegible], WMG
13 Aug 03 - 2200	Assessment - A&O x3. PERRLA, lungs CTA bilat, S1-S2
	strong and regular, (+)BS x4. VSS, DSG AID. C,D,I.
	C/O PAIN DURING DSG A. PERCOCET x1. TOLERATING REG DIET
	OOB c̄ CRUTCH ASST. (R) LEG ELEVATED. —— (b)(6)-2 SGT, LPN
14 Aug 03	Nursing Assessment: Pt sleeping, easily aroused, Pt alert,
0015	Ø c/o pain @ present Pt rec. Motrin TID. lungs CTA, RR 16 bpm
	O2 Sat @ 94% on RA. HR 66, reg. +2 ~~pulse~~ bil. radial pulse, +2 DP
	pulse to (L) foot. (R) toes c̄ brisk cap refill, +2 poplitical pulse.
	Abd soft, flat, (+)BS x4. Ø c/o tenderness to abd. Ø n/v.
	Pt has not voided ON this shift yet. Pt has burns to
	forehead, Ø drainage noted, open to air. Dsg to (R) arm CDI,
	drsg to (L) shoulder CDI, Cast to (R) LE intact. brisk cap
	refill, Ø ↑ pain c̄ toe movement. Ø IV access —— 1LT (b)(6)-2 AN
1005	Nursing: ADL - Pt ↑ in chair for am care. Perform
	bath & wash hair —— LT (b)(6)-2 AN
10 Aug 03	

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6961

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Aug 03 2200	23 yo Turkish ♂ admitted to ICU c̄ ≤10% BSA burns 1-2°.
-0015.	NS infusing TKO to (R) 18g PIV. O_2 per RA. Pt awake alert oriented x3.
	Admitted via stretcher accompanied by ER staff x2. Pt non English
	speaking, awaiting translator to cont. assessment and complete c̄ full
	admission to ward. (+) Burns - Blisters x2 to forehead, (L) shoulder, (R) arm
	(R) shoulder. Blisters lanced per VO Dr (b)(6)-2, washed c̄ ~~silvadene~~ hibiclens error
	coated c̄ silvadene and dressed c̄ super sponges and gauze
	dressing. MSO4 10mg IV administered, 5mg @ 2215 pre-
	debridement phase, 5mg @ 2230 during debridement. All burns
	bright red, partial thickness. Complete bed bath given.
	(+) ACE wrap to (R) ankle Ø drainage, C/D/I, (+) movement
	(+) swelling to ankle - Ankle elevation, ice. Neurologically:
	As Above. A&O x3 all questions answered, plan of care discussed.
	Pupils 3mm/3mm PERRLA. Moves all extremities, good sensation
	x4 ↓ strength c̄ pain/tenderness to (R) ankle. CV: NSR.
	VSWNL recorded on SF 511. S1S2 present. I: cap refill
	index bilat U/E <3sec; Ø pitting edema noted. Resp: BS CTA
	chest movement symmetrical. GI: (+) BS x4 (-) abd distention (-) tenderness
	GU: (+) Foley to gravity, amber, clear urine out. (~~illeg~~ error) PIV to (R)
	AC Reinforced (-) infiltration noted, placed in EAT upon
	admission. LATE ENTRY - during debridement forehead
	washed with Hibiclens, bacitracin applied to forehead—

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6962

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03 (WS)	left open to air. Comfort measures provided. Pt made comfortable. H_2O, provided s/p oral care. 480 cc's consumed. Pt resting —— (b)(6)-2
VS stable–0230	Pt sleeping quietly. No evidence pain discomfort [redacted] b(6)2
0415.	Pt awake, no complaints, denies pain. IVF's @ 150cc. Foley draining amber clear urine. Will cont to monitor —— (b)(6)-2
0600.	Pt AWAKE. Report given to SGT [redacted] b(6)-2. Care transferred over @ this time. (b)(6)-2
8Aug03 0630	Assumed care of pt Rcvd report from off going shift. Pt in bed IV to Ⓡ AC infusing LR @ 150cc/hr, foley → gravity NAD at this time —— (b)(6)-2 SGT USA
0800	Pt in bed refused breakfast. Intial assessment complete. 23 YO ♂ admitted to the ICU last night c̄ 2° burn to shoulder. Neuro: pt alert c̄ oriented. Language barrier for communication. able to move all extremities. Pt c/o pain ii percocet given po. Resp. RR 18 even, non-labored. LS: CTA Ø SOB, Ø secretions. Color: normal for race. Cardiac: NSR S_1 S_2 normal Ø murmur noted (+) peripheral pulses x4 (+) color sensation c̄ movement x4. Ⓡ ankle (+) swelling (+) tenderness (+) pain. ankle wrapped c̄ ace and ice applied, elevated. Gastro: abd. flat, non-distended (+) BS x4 quads. Ø BM recorded. GU. D/C'd foley this AM pt given urinal Ø urine output

STANDARD FORM 600 (REV. 6-97) **BACK**

*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6963

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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8AUG03 0800	cont/ at this time. IV site (R) 18g IV infusing LR @ 100cc/hr c̄ difficulty. IV site ⊝ S/s of redness or infiltration. Pt in bed appears comfortable will monitor (b)(6)-2 91W20 SGT/USA
8Aug03 0840	Burn Care done to (L) Upper Shoulder and (R) Arm by SGT Smith. Upper Deltoid and Shoulder c̄ 2nd degree burn, no evidence of eschar or full thickness areas, pink, warm to touch. Cleansed c̄ Hibiclens and Silvadene applied. (R) arm c̄ 25¢ size area of 2nd Degree burns, cleansed c̄ Hibiclens and Silvadene applied. No areas of necrotic tissue noted. Face cleansed c̄ NSS and Bacitracin applied to dime sized areas along forehead noted 2nd degree burns along forehead and above (R) eye. Will reassess with rounds with physicians @ 1600. (b)(6)-2
1200	Ortho SGT [redacted] in to look at (R) ankle recommend ice, elevation and Physical therapy will be back to re-evaluate for crutches c̄ therapy. Pt denies pain at present time will monitor (b)(6)-2 91W20 SGT USA
1400	Ø urine output since d/c of foley. Dr (b)(6)-2 aware will monitor. Pt able to ambulate c̄ crutches c̄ assist. will monitor (b)(6)-2 91W20 SGT USA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6964

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24Jun03 1530	Pt Ambulated c̄ crutches. Generator went down & AC. Pt voided 800cc amber urine Pt Sweating c/o dizziness. sat pt. down, bolus IV fluid cool cloth c̄ fan. Pt ambolated ~~to~~ crutches btb. T 100.4. cool cloth apply to head c̄ fan. VSS. Complete power failure Ø AC Pt evacuated outside. 1.5 Liter of H_2O given encourage to drink. Bolus 1L LR. Will monitor —— (b)(6)-2 SGT USA
1700	Pt evac → EMT c/o pain to shoulder dressing off will monitor (b)(6)-2 SGT USA
1710	2mg MSO4 given IVP for pain reinforced drsg to Ⓛ shoulder VS 115/53 P 82 SaO2 99% RA Pt appears comfortable — (b)(6)-2 SGT USA
1750	VS T 101.4 107/60 83 14 SaO2 96% RA pt appears to be resting will continue to monitor —— (b)(6)-2 SGT USA
1800	Pt transferred back to ICW via litter, pt refused dinner will report to oncoming shift. —— (b)(6)-2 SGT USA
1800	Assumed care of pt S/P report from SGT [redacted] b6-2 Pt. supine in bed HOB @ 45°. Awake alert oriented appearing hot and tired. IVF's LR infusing @ 100cc hr to Ⓡ AC. O_2 per RA. Ø evidence of resp difficulties. ⊕ cont. N.B.P in place. —— (b)(6)-2
1930: UOP ~500cc	Pt OOB to ward commode amb c̄ assistive devices - crutches and assist of staff. ⊕ UOP. Pt OOB to chair for R/R. No c/o pain @ this time, pt appears tired, ⊕ calm ⊕ cooperative. ⊕ Temp 101.1 Tympanic H_2O provided, PT top removed, [illegible]

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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 AUG03	Assumed care of pt. Rec'd report
0700	from off going shift. Pt in bed c̄ HOB ↑
	45° angle. 800mg motrin given po c̄ meal
	report given that 800mg motrin given @
	0600. Will inform MD. VS 102/52, 65, 18, SAO2 100% RA
	Pt ↑ ambulated c̄ crutches to commode s̄ difficulty
	will monitor —— (b)(6)-2 SGT USA
0735	MD aware of motrin 800mg extra given to
	Pt. —— (b)(6)-2 SGT USA
0800	D/C'd 18g IV to (R) AC (b)(6)-2 SGT USA
0900	Initial Assessment Complete c̄ am care
	Neuro: pt alert oriented able to communicate
	via translator, able to move all extremities
	ii percocets given po at 0915 for pain c̄ gd effect
	Resp: RR 18 SAO2 100% on RA even, unlabored
	LS: CTA. Cardiac: NSR (+) peripheral pulses
	x 4 extremities (+) swelling to (R) ankle pt
	able to ambulate c̄ crutches. (+) color, sensation
	c̄ movement to extremities. Skin: Splash burns
	to (R) shoulder 2° c̄ 3° to (L) shoulder wounds cleans
	c̄ Hibiclens rinse c̄ sterile H_2O c̄ silvadene applied
	Cover c̄ gauze c̄ tape 2° burns to (R) arms in spots

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6966

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9AUG03	cont. Cleanse c̄ Rinse, silvadine applied and wounds
0900	covered c̄ gauze. Gastro: ⊕ BS x 4 quad Abd
	soft non-distended Ø BMs this shift. GU. Pt
	able to urinate qd amount 200-400cc of clear
	dark yellow urine. Pt ↑ this am and wash
	at sink. Plan: Transfer to ICW
	(b)(6)-2 SGT USA 91WM6
1030	Pt transfered to ICW Report given to Lt (b)(6)-2 AN
	Pt ambulated c̄ crutches s̄ difficulty
	(b)(6)-2 SGT USA 91WM6
9Aug03	Nursing: Pt received from ICU, ambulatory. Ø c/o pain
1035	A+O x3 Pt has swelling to Ⓡ foot, warm, dry c̄ brisk
	cap refill. Dsg to R/L UE CDI. 1Lt (b)(6)-2 /AN
9 Aug 03	Nursing Notes: Assumed care of Pt A+O
1800	Sitting up in bed. Pt Returned from ICU
	in stable condition. Ambulated without
	pain or complication. Dressing on arm
	and shoulders intact Ø signs or symptoms
	of infection & odor. Ø drainage visible.
	Ø IV Access. Abd soft and non tender
	Pt had Ø complains of pain at this
	time. Will continue to monitor status
	(b)(6)-2
2219	Dressing change complete. Wound debride
	also completed. Motrin 800 mg PO given
	prior to dressing change. Pt tolerated
	it well. Ø other complains. Will continue
	To monitor (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

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MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
8/14	D/C Summary
	Admit date 8/9
	D/C Date 8/14
	Diagnoses: ① (B) calcaneus Fx
	② Scald burn (L) shoulder
	Hosp Course: Pt admitted w/ fall/scald burn to ICU, wound debrided, wound care daily, wound is 1°, 2°, 3° [illegible] c only small 3° on shoulder, not amenable to STSG. Pt calcaneus Fx casted. Pt ready for D/C. [illegible]
	Dispo: to [illegible]
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6968

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	placed near pt. Eval pending. Dr (b)(6)-2 on unit
	aware. Assessment as follows:
-	NEURO: A&O ×3, speech-clear, appropriate. Pupils
	2mm/2mm PERRLA. Moves all extremities purposefully
	⊕ sensation Bilat U/L EXT. ↓ strength to Ⓡ leg r/t
	ankle injury. ↓ ROM to same extremity. ⊕ 2+
	swelling, warm, tender to touch.
-	CV: NSR VS WNP notated on Standard F 511. 2+ pulses
	dorsalis pedis bilat, radial bilat. Cap refill bilat U/L digits
	≤3 sec. + Edema to Ⓡ Ankle, 2+ non pitting. Resp 11-15 BPM,
	SaO2 97-100%. BS clear throughout ⊖ use of accessory muscle
	⊖ cough, chest movement equal/symmetrical. No comp
	of SOB/dyspnea on exertion or @ Rest. GI/GU: ⊕ BS ×4Q
	Last BM unknown. ⊖ Abd tenderness, pain, distention. Pt
	tol Po fluids and solids, consumed app 50% every
	meal c̄/out N/V. GU: pt voiding per urinal c̄ ward
	commode. clear yellow urine 750cc/h. Skin: dressing
	to R/L shoulder and arms Bacitracin to forehead.
	Dressing Δ'd pending. ⊖ discoloration to ankle or
	foot. ⊕ inflammation to Ⓡ Ankle. Ankle elevated
	15°. PIV to Ⓡ AC 18g placed ~~&~~ by in ER. Patent
	good blood return ⊖ evidence infection, infiltration.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Monitoring to cont throughout shift, cont debridment
	of burns, maintain elevated Ⓡ ankle, Promote
	H_2O consumption and solid food intake.
	Maintain good pain control! Monitor Temp. (b)(6)-2
2000:	Pt c/o ankle pain, throbbing – Percocet 2 tabs
	PO administered eval pending. — (b)(6)-2
2100:	Debridement of wnds pending effect of MSO_4 4mg IV
	administered @ this time. — (b)(6)-2
2115	Pt not tol debridement c/o pain MSO_4 2mg IV
	administered. Will attempt debridment s/p intervention
2140:	Pt c/o pain, ⊕ facial grimmacing MSO_4 2mg
2000 117/64 78	administered. ⊕ 2° burns noted to Ⓡ arm, shoulder
T:100.0 15RR 100%	neck and left upper arm/shoulder. ⊕ 3° burn patch
	app 10 cm in diameter to Ⓛ forehead noted. Dr (b)(6)-2
	@ BS. Burns to body washed c̄ hibiclens, rinsed
	c̄ NS dried c̄ sterile gauze s/p application
	of silvadene. Burns to forehead washed dried
	as above, bacitracin applied, left open to air.
2245:	MSO_4 14mg IV administered between 2100 and 2245.
	for pain control during debridement. Dressing ∆'d to
	IV site. LR infusing @ 100 cc/h.
0015	UOP = 600 cc clear yellow to urinal. Pt resting. (b)(6)-2
0200:	Pt awake snacking on potato chips and granola bar.
	450 cc H_2O consumed. UOP = 300 cc clear yellow. (b)(6)-2
0400:	Pt sleeping quietly, Ø evidence discomfort. (b)(6)-2
0425:	Pt awake PO H_2O intake = 440. Returns to sleep.
0600:	Report given on pt to Major [redacted] (b)(6)-2. Care of pt transferred
	@ this time. Pt awake, sitting in bed c̄ Ø complaints. — (b)(6)-2

BED # 3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2025	23 y/o Turkish civ arrived via 5 ton - partial thickness burn to Ⓛ shoulder
	Ⓡ forearm, Ⓡ abdomen Ⓡ forehead post neck - time of injury 1600
	Pt arrived w/Ⓡ arm bandaged - A/O x3 -
2028	NRB
2030	EKG leads on - FST exam
2035	P - 79 BP 156/84 PO_2 90 R 18
2037	IV establish Ⓡ AC - LR
2037	X-ray Ⓡ ankle
2040	Blood draw - lab - CBC - met 8
2050	morphine 10mg
2050	P 82 PO_2 100
2055	Foley
2055	BSA ↓10%
2055	Ice on Ⓡ ankle
2100	P - 89 BP 168/85 PO_2 100 R 18
2105	UA
2115	P 88 BP 145/81 R - 18
2110	Surgeon in
2130	P - 80 BP 141/71 PO_2 95

HOSPITAL OR MEDICAL FACILITY (b)(3)-1	STATUS civilian	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO. (b)(6)-4	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO. (b)(6)-4	WARD NO. ER

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 6971

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 Aug 03	PT fell from a refrigerating truck while working on
	a motor. PT stated it was like 15 feet fall. PT
BP - 118/72	fell from his head, arms. PT also twisted his leg
P - 80	(R) Leg. Probably had radiator unit blew up on him.
T -	S - PT has burns on his (L) shoulder PT has
R - 20	a huge bump on his head! Laceration on both
	elbows. PT Ø LOC c̄ fall. c/o burns to
Med	both arms, scalp, forehead and post neck. Ø
Allergy } unknown	other facial involvement. Ø inhalation injuries.
PMH	Unwitnessed. Non English speaking. Turkish and just
	arrived today.
	G - Awake Alert.
	H - NCAT x̄ scattered burns to scalp and under forehead.
	Ø singed nasal hairs/brows or soot in mouth. Airway
	patent s̄ edema/erythema
	N - supple FAROM Ø c-spine TTP
	S - superficial partial thickness burns to post neck and
	upper back, (L) shoulder and upper arm, (R) elbow and
	forearm
	E - diffuse swelling, TTP (R) ankle
	(over)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1
USAPA V2.00

MEDCOM - 6972

DATE | IPTOMS, DIAGNOSIS, TREATMENT, TREATING OF ON *(Sign each entry)*

Wounds cleaned and dressed c̄ silvadene cream
3 tyl #3 and 800 mg motrin given po
tetanus needed but we don't have
ACE wrap to Ⓡ ankle

Assess: Ⓡ ankle sprain
8-10% BSA superficial partial thickness burns

plan: to CSH for surg consult, debridement of burns
and pain control
xray Ⓡ ankle if non wt bearing

(b)(6)-2

(b)(6)-2

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): (b)(3)-1 [redacted]

LOG NUMBER:

ARRIVAL — DATE: DAY 7 MONTH Aug YR. 03 — TIME: 2023

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) 5TCN

CURRENT MEDS (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): [redacted] 8TH TOB

(b)(6)-4

HOME TELE. NO. (Incl. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): 2nd degree burn to Ⓛ shoulder Ⓡ forearm

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0825

VITAL SIGNS			
TIME	2024		
BP	150/89		
PULSE	94		
RESP.	13		
TEMP.	98.8		
~~WT. (Child)~~ O2	97 RA		

CATEGORY (See reverse):
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
morphine - 10mg	[redacted]	2050
X-RAY Ⓡ ankle		2045
FOLEY		2054
Labs CBC, Chem, UA		2040
IV LR 440cc/hr x 8hr		2020
then IV LR 100cc/hr x 16hr		

(b)(6)-2

ASSESSMENT/DIAGNOSIS:
Ⓡ Ankle Sprain.
10% 2nd Degree BSA Burn

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Ⓢ 23 y/o Turkish civilian ♂ fell from reefer truck @ 1600
2nd degree burn to Ⓛ shoulder Ⓡ forearm Ⓡ abdomin
Also laceration to elbow - injury to Ⓡ ankle and
Ⓡ forehead

Ⓞ A/O x3 - interpreter present / Blisters Ⓛ shoulder
Ⓡ forearm Ⓛ forearm edema Ⓛ ankle

PMH None

PSH None

S: Pt is a 23 y/o Turkish ♂ Contractor who fell off reefer & was presumably burned by radiator fluid by reefer van fell ~15 feet. Sent from BAS 7 hr away ⊖ LOC C/o Ⓡ ankle pain & burns to face, scalp, Ⓑ shoulders & back of neck ~10% BSA by report. burned by hot water ⊖ confined space ⊖ smoke inhalation.

O: [illegible] mild distress 2° to burns A/O x3 GCS 15 [illegible]
HEENT NC ⓒ 2° burns to scalp edge, forehead ⊖ [illegible] compromise
Healed burn/scar on Ⓛ [illegible]
Neck 2° burns to post neck above tank top line
Chest: Ⓑ [illegible] CTA
Cor [illegible]
Abd ⊕BS S NT ND
GU WNL
Ext 2° burns to Ⓛ deltoid area & Ⓡ distal dorsal forearm
N/V intact

Orders
- 6 [illegible]

X Ray Ⓡ Ankle [illegible]

16 / 175 / 48 / 247

130 | 101 | 24 / 4.6 | 10 / 13 / 100

CK 278

UA DK yel Clr 1.030 5 Tr Bld [illegible]

4 x 83K x 10% BSA = ~~1660~~ 3320

1/2 = 1660

1660 / 8 hr = 450cc/hr x 8hr (Estimated burned)

1660 / 16 hr = 100cc/hr x 16hr

DISPOSITION (Check all that apply): HOME / FULL DUTY / QUARTERS: 24 Hrs. 48 Hrs. 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO (Indicate clinic): Gen Surg

EMERGENCY [✓ TODAY] 72 HOURS ROUTINE

ADMIT TO HOSP. UNIT/SERVICE: ICU

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 2130

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4 [redacted]

SIGNATURE: (b)(6)-2 [redacted] (b)(6)-2 [redacted] MAJ MC

INSTRUCTIONS: ... ordered, any limitations and follow-up plans

To ICU

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 9-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 6974

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

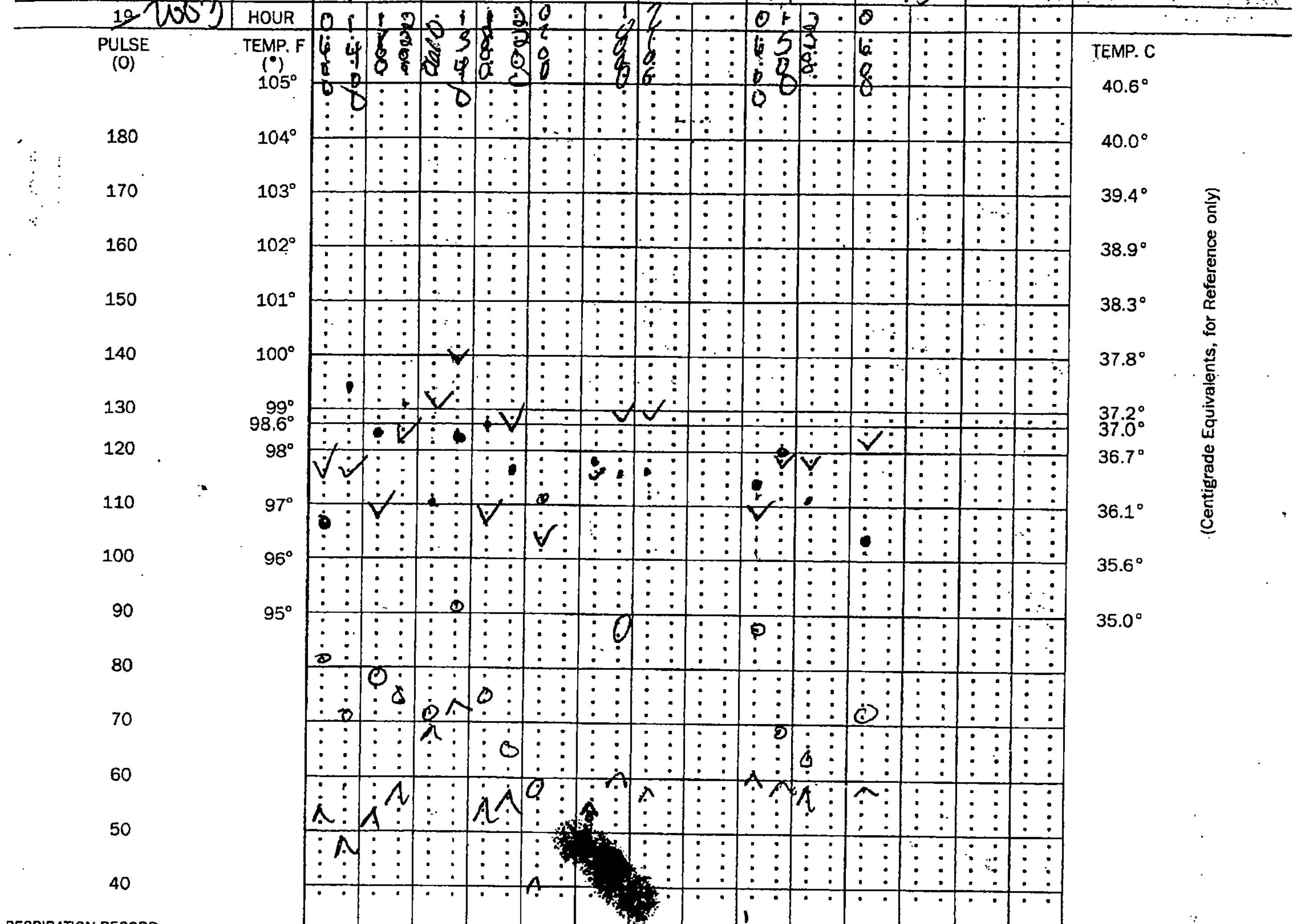
VITAL SIGNS RECORD

HOSPITAL DAY 8

POST- DAY

MONTH-YEAR Aug 19 2007 DAY 11 12 14 15

HOUR



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE 117/60 108/53 129/80 107/54 105/44 145/95 124/58 108/60 118/51 122/58

144/44 123/59 131/74 125/58 128/60 115/59

HEIGHT: WEIGHT →

O2 96 97% 98 97% 97 97% 94%

96 96% 97 97% 98 97% 97% 99%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

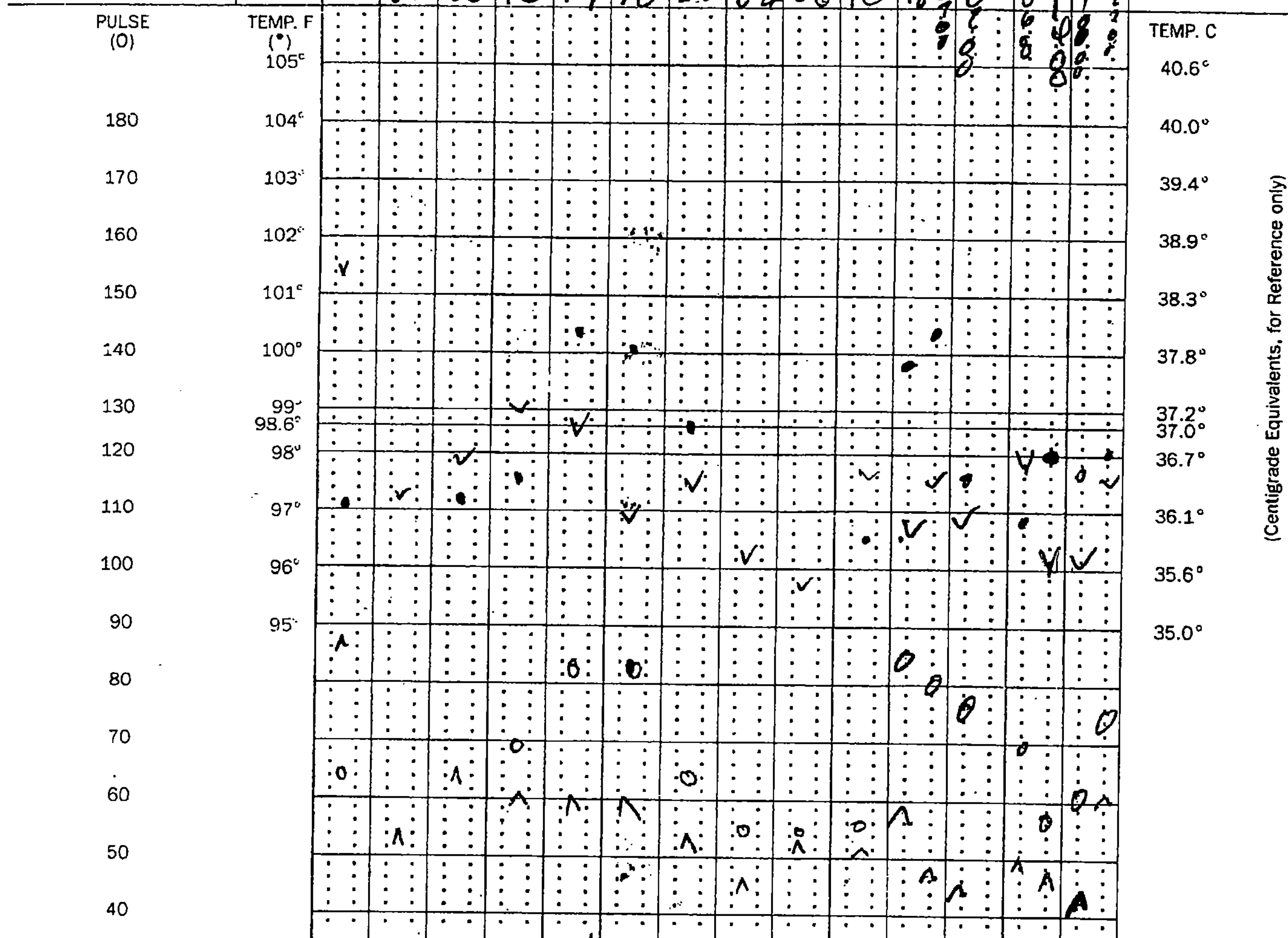
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6975

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	7	8 August												
MONTH-YEAR DAY												10		
19 HOUR	22	02	06	10	14	18	22	02	06	10	1800	0200	0600	1000



RESPIRATION RECORD

Record special data only when so ordered

	97.1		97.2	97.4	100.4	100.1	98.7		97.0	96.7				
BLOOD PRESSURE MAP	153/69	112/54	119/65	137/61	127/60	157/70	114/54	101/46	97/53	107/51	107/58	100/45	119/51	101/44
HR	64	55	54	68	83	83	64	54	55	62	115/48		69	
RR	13	11	15	22	18	14	14	15	14	18				
HEIGHT: WEIGHT ~~50~~	100%	100%	100%	100%	100%	96%	97%	100%	98%	100%			98%	98 98
	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA			RA	
IVFS	150cc/hr	150cc/hr	150cc/hr	200/hr	200/hr	2nd 100	100cc/hr	100	100		99	97	100/47	
PO ~~IVF~~	→	→	500cc	240	700cc	240		500						
Foley	—	—	550cc	0	0									
			31 cc/hr		~~1000~~ 850cc	400								
UOP				0	0	600	400		600					

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO. ICU

7-8 aug
1800 - 0600

INTAKE 1550
OUTPUT 550

TOTAL UOP
1600 cc clear yellow

Total Intake
IV 1200
PO 740 ~~7~~1940

Intake ~~[illegible]~~ 3940

1700 hrs / 1500cc bolus

out. 850

STANDARD FORM 511 (REV. 7-95) **BACK**

*U.S.GPO:1996-404-763/40069

MEDCOM - 6976

BFJ #3

Ward/Section: ER	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 07AUG03	TIME 082	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	17.5*	4.8-10.8 x 10
RBC	5.29	4.7-6.1 x 10
Hgb	16.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	48.1	45-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	247	130-500 x 10 Verified
Lymph %	7.7%	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	DK Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	TRACE	Negative
pH	5.0	N/A
Prot	TRACE	Negative SSA: Neg
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.3	0.6-1.2 mg/dl
CK	278	39-380 u/l (M) 30-190 u/l (F)
NA*	130	128-145 mmol/l
K*	4.6	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

MISC

Results:

Microscopic UA

Results: WBC - 1-3 Amorph Light
RBC - 5-10 Back. Light
EPI - 3-5

Remarks:
UA

Reported by:	(b)(6)-2	**DATE:** 07 Aug	**LAB ID NO:**

MEDCOM - 6977

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/7
TIME OF ORDER: 2130 HOURS
LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU ✓
(2) [illegible] ✓
(3) Diet Regular ✓
(4) IVF LR @ 150 cc/hr
(5) [illegible] < 30/hr
(6) Morphine 2-4 mg IV q 1° prn pain
(7) Percocet 1-2 tab q 4-6 prn pain

Orders Transcribed 17 July 23
(b)(6)-2

ATIENT IDENTIFICATION

DATE OF ORDER:
TIME OF ORDER: ______ HOURS

(8) Debride wounds / [illegible]
(9) ~~Silvadene for [illegible] wounds~~ bid
(10) Bacitracin to face wounds

(b)(6)-2

MA [illegible]

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER: 7 Aug 03
TIME OF ORDER: 2200 HOURS

VO Dr (b)(6)-2

1.) MSO4 5mg IV x 1 Premed for debridement. Repeat dose @ 15' prn.

Taken by (b)(6)-2 cpt

x

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER: 8 Aug 03
TIME OF ORDER: 0700 HOURS

VO DR (b)(6)-2

1) ↓ IVF to 100 cc/hr
2) D/C foley

Taken by (b)(6)-2

x

URSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 CPT 8 Aug 0745

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

240 [illegible] 150 1450 1150 (b)(6)-2 550 441

MEDCOM - 6978

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

8 Aug

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 Aug 03 TIME OF ORDER 1622 HOURS

LIST TIME ORDER NOTED AND SIGN

Motrin 800mg po TID

with each meal

V.O. Dr (b)(6)-2

1630 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

8 Aug 03

NURSING UNIT: Chart ✓ | ROOM NO. (b)(6)-2 | BED NO.

DATE OF ORDER 8 Aug TIME OF ORDER 1500 HOURS

Bolus LR 1500cc x i

V.O. Dr (b)(6)-2

1500 (b)(6)-2

0400 9 August 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8/9 TIME OF ORDER 0730 HOURS

① D/C IVF

② Tx ward

(b)(6)-2

24° Chart ✓ 10 Aug 03 @ 0315 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/19 TIME OF ORDER 0800 HOURS

(1) Ok for D/C today

(b)(6)-2

FORM 4256 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6979

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CA AN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug *Yr.* 2003

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 07	08	9	10	11	12	13	14
7 Aug	(b)(6)-2 [redacted]	Diet: Regular	06	/	(b)(6)-2 [redacted]						
			11	/			(b)(6)-2 [redacted]				
			17	/	(b)(6)-2 [redacted]						
7 Aug	(b)(6)-2 [redacted]	VS q 4° 1 QS	06	/	DS		(b)(6)-2 [redacted]				
			18	gu		(b)(6)-2 [redacted]					
7 Aug	(b)(6)-2 [redacted]	WHO for UOP <30/hr.	06	/					(b)(6)-2 [redacted]		
			18	SK		(b)(6)-2 [redacted]					
7 Aug	(b)(6)-2 [redacted]	Debride wounds BID	08	/	(b)(6)-2 [redacted]						
		silvadene to shoulders	22	gu	(b)(6)-2 [redacted]						
		arms, bacitracin to									
		forehead									
8 Aug	(b)(6)-2 [redacted]	Foley to gravity	06	/		D/C'd					
			18	gu							

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
<10% BSA 2° Burns shoulders (R) arm forehead.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
(b)(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 6980

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7 Aug	(b)(6)-2	Admit to ICU splash burns, Scalding burns	7 Aug	2200	2200	(b)(6)-2
9 Aug		TRANSFER to ICW	9 Aug	—	1025	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 6981

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION C   PLAN *(MEDICATIONS)*

For use of this form, see -407; the proponent agency is the Office of The Surgeon General.

Mo. Aug *Yr.* 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY (b)(6)-2	HR	07	08	09	10	11	12	13	14						
8 Aug	(b)(6)-2	IVF's LR @ 150 cc/hr	06	✓		DC'd 8 Aug 03											
			16	[redacted]													
7 Aug	(b)(6)-2	IVF's LR @ 100 cc/hr	06			D/C'd 9AUG03											
			18														
8 Aug	(b)(6)-2	Motrin 800mg po	06	/	/	(b)(6)-2				-							
		TID ̄c each meal	12	/	/	(b)(6)-2					reordered						
			22	/	(b)(6)-2					FJL	14 Aug						
8 Aug	(b)(6)-2	Motrin 800mg po	06							/	(b)(6)-2	D/C'd					
		TID ̄c each meal	12							/		/ not includ					
			18							/		in [illegible] 15 Aug 03					

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

<10% scalding burns to forehead, (R) arm, shoulders

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6982

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				*Mo.* Aug *Yr.* 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
-----	-----	~~Percocet~~ error [illegible]				
7 Aug	(b)(6)-2	MSO4 5mg IV x 1 predebridement	2215	7 Aug	2215	(b)(6)-2
7 Aug		MSO4 5mg IV x 1 prn during debridement	2230	7 Aug	2230	
9 AUG 03		Bolus 1500cc LR now	1530	9 Aug	1600	
9 AUG		Dc IV	—	9 Aug	Done	

2200 (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
7 Aug	(b)(6)-2	MSO4 1/2-4mg IV q 1° prn pain	5mg IV 7Aug 2215 [redacted]	5mg IV 7Aug 2230 [redacted]	4mg 2115 IV 8Aug [redacted]		2mg 2130 IV 8Aug [redacted]		2mg 2145 8Aug [redacted]	2mg 2230 8Aug [redacted]	2mg 2245 8Aug [redacted]	8Aug 2315 2mg IV [redacted]				
7 Aug	(b)(6)-2	Percocet i-ii PO q 4-6 PRN pain	8Aug ii PO 0003	8Aug ii PO [redacted]	0900 ii PO 9Aug [illegible]	1000 ii 10Aug [illegible]	11Aug 2325 ii [redacted]	12Aug 1210 ii PO [redacted]	12AUG 2300 [redacted]		12Aug 2115 ii [redacted]	14Aug 1450 ii	b(6)2			
-----	-----															
-----	-----															
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USAPA V1.00

MEDCOM - 6983

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. TION *(State or Country Code.)*

7	8

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME *(Last, First, Middle Initial)*

(b)(6)-4

4. PAY GRADE

16	17
2	2

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
2	3	y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION

UNK

10. LENGTH OF SERVICE

32	33	34

ETS b(6)-4

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(6)-4

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
U

HOUR OF ADMISSION

2130

BRANCH / CORPS

14. FLYING STATUS

47	48	49
N	O	

15. BENEFICIARY CATEGORY

50	51	52
K	~~6~~	~~5~~

78

EPW

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION *(State or Country Code)*

62	63
[redacted]	[redacted]

b(3)1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION b6-4

YEAR

☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD
ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

MEDICAL TREATMENT FACILITY

(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
0	5

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y Y Y M M D D)*

81	82	83	84	85	86	87	88
2	0	0	3	0	8	0	9

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	M	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(Y Y Y Y M M D D)*

99	100	101	102	103	104	105	106
2	0	0	3	0	8	0	7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

b(3)-1

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(Y Y Y Y M M D D)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: 40% BSA BURNS 2ND DEGREE
BURN RIGHT FOREARM
BURN LEFT SHOULDER
BURN RIGHT ABDOMEN

ADMITTING OFFICER *(Signature, as req*

(b)(6)-2

(b)(6)-2 LTC, MC

SIGNATURE OF ADMITTING CLERK

(b)(6)-2, SPC 91G10

DA FORM 2985, MAR 2000 DITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 6984

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr (b)(6)-4	2. Name (b)(6)-4				3. Grade FGN	Admission Remarks
4. Sex M	5. Age	6. Race X	7. Religion MUSLIM	8. LnthOfSvc	9. ETS	10. PrevAdm NO
11. FMP 20	12. SSN (b)(6)-4	13. Organization				14. Ward ICU
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER	18. BranchCorps	19. UIC / ZIP			20. Type Case DIS
21. Source of Admission Direct from ER		22. Hour Of Adm: 22:00	23. Clinic Service AEA - ORTHOPEDICS			
24. Name/Relation of Emergency Addressee		25. Type Disp HOME	26. Date of Disp 2003-08-09			
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm: 2003-07-31		AdmittingOfficer: DR (b)(6)-2	
29. ReportingMTF (b)(3)-1			30. Date Init Adm 2003-07-31		32. Units Blood Components	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

R elbow fx L wrist cellulitis

813.11 682.4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
(b)(6)-2 COL, MC	(b)(6)-2 SSG, PAD NCOIC

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 6912

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICA ARE

SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DATE 7/31/03

TIME: 553

BP 130/80

P 100

RESP 14

TEMP /ω.

ALLERGIES

MEDS

PMHx

PSHx

(S) Pt, high value (PW), brought to clinic after
d/t a fall which apparently occurred during interrogation
Pt brought in by SF personnel.
Pt in severe pain but composed

(O) Pt in no obvious distress
NKA
Rt elbow with obvious def and swelling
crepitus at olecranon.
bony fragment possibly palpated

Face: bruise c abrasion L side of nose.
septum displaced.
Toradol 60 IM given.

(A) Apparent Elbow Fx
possible nasal fracture

(P) Rt Elbow post splint and simple sling
L facial nose skin cleaned.
Pt w/e to (b)(3)-1 (b)(6)-2

(b)(6)-2 MAJ MC
148 44 0997

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*
(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPPC V1.00

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE: DAY 31 MONTH Jul YR. 03

TIME: 1951

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)

☑ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS (Tetanus immunization and other data): Providere

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): broken Ⓡ arm – TOI ? 1900

SEX: M

AGE: 44

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

TIME SEEN BY PROVIDER: 2000

VITAL SIGNS			
TIME	1954		
BP	137/87		
PULSE	112		
RESP.	16		
TEMP.	96.4		
WT. (Child)	98 RA	108 cm	81 kg

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

(b)(6)2

ORDERS	INITS.	TIME
Xray Ⓡ Elbow Ⓛ wr	[redacted]	
CBC, Hepatic		
Mel 7		
Ancef 1gm IV		
MSO4 5mg IV		
CXR EKG		

ASSESSMENT/DIAGNOSIS

Ⓛ wrist Cellulitis

Ⓡ Olecranon fx

DESCRIBE (1) Subjective data (Pertinent History) (2) Objective data (Examination, include results of tests and x-rays) (3) Assessment (Diagnosis) (4) Plan (Treatment/Procedures. Include medication given and follow-up)

S – 44 y/o ♂ c c/o broken Ⓡ arm pt fell Ⓛ wrist is also swollen pt has pn in back and shoulders 9/10 pt also states difficulty breathing subjective fever yesterday Ⓡ elbow deformity until today Painful Ⓛ wrist 2° to flex cuffs Ⓡ HD

PMHx Denies Non Treated PSHx Surgery 93 Motorcycle accident

⊕ Tobacco ⊕ EtoH

O VS WNL mild distress 2° elbows [illegible] Ⓛ [illegible] occas cough

HEENT WNL

Lungs Ⓑ CTA

Cor Nml

Abd ⊕ BS soft NT ND

Ext Ⓡ elbow c mod dorsal swelling + crepitus [illegible] 2° pps

Ⓛ wrist linear transverse dorsal abrasion 2° to flex cuffs c erythema and swelling

14 > 15/45 < 461

Xray

Ⓛ wrist No Cell Artifacts

Ⓡ elbow Ⓓ Cm displaced olecranon fx

DISPOSITION (Check all that apply)

- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): Ortho

☒ EMERGENCY ☐ TODAY

☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 2200

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN, DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD)

(b)(6)-4

(b)(6)-2

(b)(6)-2 AND ID STAMP 2200

(b)(6)-2 MAJ MC

(Include medications and follow-up plans)

To ICW then OR

EMERGENCY CARE AND TREATMENT

MEDCOM - 6914

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

MED 44 Y/O ♂ EPW c̄ Ⓡ ELBOW INJ. WHILE IN CUSTODY @ ~ 1900. IN CUSTODY 3D.

PMH DM ON MED   ROS - FEVER

PSH STSG ~~ABD~~ 2° MVA '93

NKA   183 CM

MED - ?   81 KG

HABITS - ETOH SOC CIGS

PHYSICAL EXAMINATION

NAD

HEENT NOSE ABRASION

CHEST CTA

CV RRR S Ⓜ

ABD SOFT NT c̄ NABS

EXT Ⓡ ELBOW c̄ OLECRANON ABRASION TENDER

STS - NO EXT AGAINST RESIST. NVI DIST

Ⓛ WRIST c̄ VOLAR ABRASION c̄ SURROUNDING

PROGRESS *(Enter date of discharge and final diagnosis)*

ERYTHEMA

XR - DISPLACED Ⓡ OLECRANON FX c̄ MILD COMMINUTION Ⓛ WRIST Ø FX CA++ RAD/ULN ART.

A - DISPLACED Ⓡ OLECRANON FX c̄ OVERLYING ABRASION & CONCOMITANT Ⓛ WRIST CELLULITIS

P - SPLINT, ADMIT FOR IV ABX, ORIF c̄ INFECTION UNDER CONTROL

(b)(6)-2 [redacted]

DATE 31 JUL 03

IDENTIFICATION NO.

(b)(6)-2 [redacted]

...r written entries give Name last, first, ...de; date; hospital or medical facility)

REGISTER NO.

(b)(6)-4 [redacted]

LEC NO

ORTHOPEDIC SERVICE

MEDCOM - 6915

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 AUG 03	NARRATIVE SUMMARY
	ADMITTED 31 JUL03
	D/C'D 9AUG03
	DXS - 1 - Ⓡ OLECRANON FX
	2 - Ⓛ WRIST CELLULITIS
	3 - DM
	PROCEDURES - ORIF Ⓡ OLECRANON FX - 2AUG03
	RESUMÉ: RHD 44 y/o EPW ♂, SADDAM
	BODY GUARD IN CUSTODY SINCE 28 JUL03 C/O
	ELBOW PAIN AT 1900 ON DAY OF ADMISSION.
	PE → ABRASION c̄ SURROUNDING TENDERNESS,
	ERYTHEMA Ⓛ WRIST & SUPERFICIAL
	ABRASION c̄ SWELLING, Ø ACT. EXT., &
	PALPABLE OLECRANON FX Ⓡ ELBOW. PMH NIDDM
	& GLUCOSE 280 ON ADMISSION.
	ADMITTED & RX'D c̄ IV UNASYN ā ORIF UNDER
	GETA ON 2AUG03. IV ABX CONT FOR 7D, THEN
	SWITCHED TO AUGMENTIN. STARTED ON GLYBURIDE
	c̄ GOOD RESPONSE. STAPLES REMOVED ON POD8.
	WILL REMAIN IN LAC UNTIL 23 AUG03.
	DISPO - D/C IN MP CUSTODY F/U 23 AUG03
	MEDS - AUGMENTIN 500 TID, GLYBURIDE 5MG QD, LORTAB PRN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SP	

(b)(6)-2

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REG | WARD NO.

(b)(6)-4

LTC MC
ORTHOPEDIC SERVICE

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6916

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL
RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
31 July 03	Admitted Pt to ICW from EMT Ambulatory
2300	in stable conditions accompanied by Staff.
	IV SL flushes well. Breathing [illegible] Ø SOB or
	labored breathing. Pt able to move all
	extremities without complications Ⓡ Elbow
	dressing intact Pt has fracture. Ø obvious
	bleeding noted on dressing. Ⓛ wrist in
	dressing for cellulitis. Pt c/o pain in Ⓡ Elbow
	Lortabs ii tabs PO given for pain. Abd soft
	and non tender. will continue to monitor
	pain status ——— (b)(6)-2 1LT/AN
2330	Pt Asleep ——— (b)(6)-2 1LT/AN
0515	Blood drawn and sent to lab results pending
	——— (b)(6)-2 1LT/AN
01 Aug 03	Received PT, PT sleeping will continue to monitor — SGT (b)(6)-2 LPN —
1 Aug 03 -	~~1805~~ ASSESSMENT - A&O×3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG + REG,
	⊕BS ×4. IV NS @ 150cc/hr to Ⓛ AC. DRSG TO BOTH UPPER EXTREMITIES,
	C, D, I, TOLERATED 2000 KCAL DIET. UNASYN GIVEN @ 1800. SOW- (b)(6)-2
	RESTRAINTS. WILL CONTINUE TO MONITOR THROUGHOUT ——— SGT, LPN
	TOTAL OUTPUT - 1000cc TOTAL INTAKE - 3150 cc

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER *(SSN or Other)*

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 6918

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 Aug 03 0900	Nursing: Pt glucose level 153 mg/dl, results on chart —— 1Lt (b)(6)-2 AN
0950	Nursing: Pt ↑ OOB to burn-out latrine c̄ MP escort. Ambulate s̄ difficulty. —— 1Lt (b)(6)-2 AN
1000	Nursing: Assessment: Pt ↑ in bed, alert. Lung CTA, HR 88 reg; ⊕BS x4. Abd soft, distended. Dsg ⓇUE CDI. ⓇUE c̄ brisk cap refill to all fingers, warm, dry. ⓁUE c̄ +2 brachial pulse, brisk cap refill, warm & dry. IV s/l to Ⓛ fa, NS infusing @ 150cc/hr. Pt scheduled to go to OR today. Pt given bath & gown Δ'd. Glucose results for this am 153 mg/dL - 1Lt (b)(6)-2
2 AUG 03	OP NOTE
	PREOP DX - Ⓛ OLECRANON FX
	POSTOP DX - SAME
	PROCEDURE ORIF - TENSION BAND - Ⓛ OLECRANON
	SURG [redacted] / [redacted] b(6)-2
	ANES GETA MONCOM
	FLUIDS 500 NS EBL MIN, TT 76' @ 250MM
	IMPLANTS 2x 1.6 MM K-WIRES | 3 STRANDS #2 SURGICAL WIRE
	FINDINGS - OSTEOPENIC BONE, COMMINUTED OLECRANON FX
	TO ICU CONDITION STABLE (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE
	nightshift I+O note Input - 3540cc output - 975cc

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7Aug03	- 1900 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR. ⊕BS x4, CAST TO Ⓡ ARM C,D,I, Ⓛ WRIST SWOLLEN, TENDER TO TOUCH. IVHL TO Ⓛ AC. OOB TO LATRINE. TOLERATED REG DIET. IS q 1°, Ø c/o PAIN. PT RESTRAINED (b)(6)-2 TO BED. WILL CONTINUE TO MONITOR [illegible] —— SSG
8Aug2003 1035	Nursing: Assessment: Pt awake, ↑ in bed, c/o little pain. Alert, Lungs CTA, HR 88, reg, ⊕BS x4, abd soft. Pt ↑ OOB amb to BR s̄ assist. Ⓡ UE ē cast CDI. Ⓡ fingers ō brisk cap refill, warm, dry. —— LT (b)(6)-2, AN
1400	Nursing VS: Pt temp 100.5. Given Tylenol PO, ~~650mg~~ 650 —— LT (b)(6)-2, AN
8Aug03 1800	Nursing Note: Assumed care of Pt sitting up in bed. Vitals stable breathing intact Ø SOB or labored breathing Ø complain. Encourage PO fluids due to down generators and ↑ heat in hospital today. Pt able to move all extremities. Ⓡ Arm wrapped Ø drainage or bleeding noted. Will continue to monitor status —— (b)(6)-2
2130	Pt c/o pain in Arm. 2 Lortabs PO given for pain. Will continue to monitor —— (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 6920

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 AUG 03	S NO C/O
	O VSSA
	WNDS CLR SO & SS, LAC APPROX
	A DOING WELL
	P D/C
	(b)(6)-2
	(b)(6)-2
	LTC, M
	ORTHOPEDIC SERVICE
9 Aug 03	Nursing Notes: Assumed care of Pt A+O
1740	sitting up in bed. tolerated ADA diet.
	Breathing intact Ø SOB or Labored breathing
	Restraints inplace. Ø IV Access. Pt able to
	move all extremities. Able to wiggle fingers
	on affected hand. Abd soft and nontender
	will continue to monitor status ——
	—— (b)(6)-2 2LT/AN
2130	Pt C/o pain in (R) Arm Lortabs II PO given
	will continue to monitor —— (b)(6)-2
10 Aug 03	Nursing Discharge Pt d/c to MP's. meds +
0800	narrative summary given. Ambulated [illegible]
	—— (b)(6)-2 CPT/AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG 03	- ASSESSMENT - 2315 - A&O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR. HYPOACTIVE BOWEL SOUNDS. S/P ORIF (R) ELBOW, CAST/DRSG C/D/I, PAIN MANAGED c̄ MSO4 IV 2-4mg. PT RESTING COMFORTABLY. IS @ 1°. UNASYN GIVEN @ 2400. WILL CONTINUE TO MONITOR THE PATIENT THROUGHOUT (b)(6)-2 SGT, LPN
4AUG03 @ 0225	NSG shift assessment; Pt c/o pain @ approx 2355. 15 minutes after admin, pt appeared to sleep. (R) arm is raised onto a pillow, and cap refill to fingers is WNL. Dressing to elbow/arm is CDI. Encouraged use of incentive spirometer while awake. No complaints at this time. will cont to monitor (b)(6)-2
4AUG03 1400	POD 2 S NO C/O O VSSA NVE NVI WND CLEAN LAC PLACED NVI A DOING WELL P FINISH 7-10 D IV ABX (b)(6)-2 (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG 03	Procedure: ORIF Ⓡ elbow
	Preop vital signs 134/80
	Meds in OR 500mg Fent 2 versed 30mg IV Toradol
	EBL – minimal Fluids in OR
	Vital Signs on arrival
	2215 158/91 P.O. 100% 10L 80-HR
	2220 138/85 P.O. 100% 10L 86-HR
	2225 132/82 P.O. 99% 5L 82-HR
	2230 137/89 P.O. 99% 5L 80-HR
	2240 146/85 P.O. 96% RA
	Hx: Chronic ETOH, Head Injury, Diabetic, Hep C
2220	On arrival to ICW from OR – Pt on litter c̄ litter straps
	O2 @ 10L P.O. 100% Vital Signs 158/91 P-67 – Pt c̄ cast and
	Dsg to Ⓡ elbow D,D and ~~intact~~ – Pt able to move all extremities
	Pt. follows verbal commands – ∅ pain noted or verbalized
	IV 18G to ~~Ⓡ FA~~ Ⓛ FA infusing NS @ TKO – Cap refill to
	Ⓡ hand brisk < 2 seconds ——— (b)(6)-2
2250	Pt. vital signs to ICW 146/85 P-72 – R-12
	P.O. 96% RA ——— (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6923

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 AUG 03	POD 1
0930	S LOCAL PAIN
	O VSSA
	(L) WRIST CELLULITIS RESOLVING
	(R) ELBOW DSG & SPLINT INTACT
	NVI DISTALLY
	A DOING WELL
	P LAC IN ~2D
	FINISH 7-10D COURSE UNASYN
	(b)(6)-2 [redacted]
	LTC, MC (b)(6)-2 [redacted]
	ORTHOPEDIC SERVICE
5 AUG 03	POD 3
	S NO C/O
	O VSSA (b)(6)-2 [redacted]
	(L) WRIST CELLULITIS RESOLVED
	(R) LAC INTACT
	A DOING WELL P Δ TO PO ABX IN [illegible]

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6924

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4AUG03		2300	NSg shift assessment: Pt c/o pain to (R) elbow at approx 2200; was given MSO4 for pain, and elbow was placed on a raised blanket for pain relief. Described adequate pain relief approx 10 minutes after above actions were taken. Pt has good cap refill to rt hand, but there is still some swelling to that hand. VS WNL, resp even + unlabored, will continue to monitor —— (b)(6)-2
5AuG03		1430	Nursing: Shift note Pt. c/o pain x1 this shift c̄ lortab. Able to ambulate w/o assist. >50% for breakfast + lunch, P.O. liquids ↓ 500cc. ↑ alertness. Able to eat w/assist. Continue to assess — (b)(6)-2
5Aug03		1800	Nursing Notes: Assumed care of Pt A+O lying in bed. Ø c/o pain. IV out will replace. Abd soft and Ø tender. Able to move all extremities. Breathing intact Ø SOB or labored breathing — (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. CW A

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6925

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 August			Nursing Notes! New SL inplace flushe
1850			well Ø S/S of infiltration IV Antibiotic
			infusing to patency. Pt denies pain
			at this time able to wiggle fingers
			on affected arms. Pt Comply when
			demonstrated to pronate and
			flex feet. Voids Spontaneously
			will continue to monitor Status
			(b)(6)-2 [redacted] [illegible]
6 Aug 03	0229		Pt c/o pain 4mg IV MSO4 given, will
			Continue to monitor status
			(b)(6)-2 [redacted] [illegible]
6AUG03			PT sleeping, VSS, will continue to monitor. —SGT (b)(6)-2 [redacted] LPN
6 Aug 03		1757	Nursing Notes: Assumed care of
			Pt alert and oriented. Pt tolerated
			Regular diet Ø N/V. Pt Sitting
			up in bed. Able to wiggle fingers
			under cast. Breathing intact Ø SOB
			or Labored breathing. Abd soft
			and non tender. Will continue to
			monitor Status (b)(6)-2 [redacted]
6 Aug		2152	Nursing Notes pt Ambulated for 10
			minutes in halls of ward and in PLX
			Corridor. Tolerated it well. ~~did~~ Some
			Stretches and deep breathing exercise
			tolerated it well. Back to bed EPW
			status in place. (b)(6)-2 [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6926

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______
TO ______

TOTAL HOURS COVERED

DATE 2 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1700	H_2O	150	150
2AUG 0000	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		NS	1000	1742	1000
1742	1000	NS	1000	2258	2000
2258	1000	NS	1000	0300	3000
2Aug 0300	1000	NS	1000	0730	1000
0730	1000	NS	1000	1140	2000
1140	↑1000	NS			
1140	↑100	Unasyn	100		
1800	↑100	UNASYN	100	1900	

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 6927

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1830	400	400			
2141	600	1000			
0300	400	400			
0950	300	700			
1910	450				

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

[illegible] [illegible] **GRAND TOTAL OUTPUT** 100

[illegible] [illegible] [illegible]

REMARKS

1000 [illegible] 300

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* ..	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	180	LARGE WATER GLASS ...	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED.

USAPPC V1.00

2 38
10 4

TWENTY-FOUR HOUR PAT NTAKE AND OUTPUT WORKSHEET

FROM ________HOURS
TO ________HOURS

TOTAL HOURS COVERED

DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2219	H_2O	150	150
2330	H_2O	150	300
0600	H_2O	150	450
1200	H_2O	150	600

INTR. US

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2200	500	NS	500	0600	500
0600	100	Unasyn	100	0630	600
0600	500	NS	500	1100	1100
1100	500	NS			1600
1300	100	Unasyn	100	1300	1700
1800	100	unasyn			1800
1800	100	Unasyn			1900
2400	1040				1040 2940
					600

IRRIGATIONS (*N/G, Bladder, etc.*)

3540

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 6929

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2045	975	975			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name.- last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* ..	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS ...	240
LARGE COFFEE MUG ...	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED.

USAPPC V1.00

TWENTY-FOUR HOUR P T INTAKE AND OUTPUT WORKSHEET

FROM 0001 HOURS
TO 2400 HOURS

TOTAL HOURS COVERED

DATE 4 AUG 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	Juice	200	200
0730	milk	250	450
1700	H_2O	150	~~300~~ 600

IN AVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0001	1000	NS			
1900	100	Unasyn	100		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

MEDCOM - 6931

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0730	400	400			
2030	1100	1500			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	180	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) JUL 72 WHICH MAY BE USED.

USAPPC V1.00

5-6

TWENTY-FOUR HOUR P IENT INTAKE AND OUTPUT WORKSHEET	FROM ________ HOURS TO ________ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2400	2400	Unasyn	100	2400	100
2400	1400	NS	1400	0700	1500
1900	100	Unasyn	100		
		Unasyn			

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 6933

TWENTY-FOU 4 R PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ________ HOURS
TO ________ HOURS

TOTAL HOURS COVERED

DATE 7 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H_2O	150	150
2100	H_2O	100	250
2230	H_2O	100	350

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	100	UNASYN	100	1900	100
2400	100	UNASYN	100		

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ________ HOURS
TO ________ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. BI, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2400	100	UNASyN	100		

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

(b)(6)-4

USAPPC V1.00

MEDCOM - 6935

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407: the proponent agency is The Office of the Surgeon General.

1. AGE: 44
HEIGHT: 183 cm
WEIGHT: 81 Kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
STSG - 93

4. PROPOSED SURGICAL PROCEDURE:
ORIF Rt elbow

5. ADDITIONAL INFORMATION: (Previous surgical and medical history)
Tobacco 1/2 ppd X many yrs.
ETOH 1 bottle/day whiskey
Glasses/Contact (Y) [✓ (N)]
Body Piercing______
Implants______
Dentures______
Diabetes [✓ (Y)] (N)
Respiratory Disease (Asthma·COPD) [✓ (Y)] (N)
Hypertension (Y) [✓ (N)]
Skin Condition back wound, scrape
ROM______
ASA/Motrin w/72 hrs (Y) [✓ (N)]
Anticoagulants (Y) (N)
Herbal Medicines (Y) (N) MEDS: none

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. JS Glucose pill occasional DM - untx'd/undx'd Hepatitis Difficulty c̄ deep breathe pain in right side Chest.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) [✓ Medical] [✓ Smoking] History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. JS Arabic Speaking	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas). JS	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
000- [redacted]
EPW
W-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since______
~~! UHCG/LMP~~ N/A
N/A ! Consent/Blood Transfusion Signed/Witnessed/Dated
N/A ! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions [✓ (Y)] (N)
! Family/Friend:______
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0
MEDCOM - 6936

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia X [illegible]	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis X 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: ____ 1) Length of Surgery X 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated unknown ____ 2) W/O Glasses F.2. X Potential for decreased communication due to: ____ 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 [redacted] MAJ AN 2 AUG 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

BREATHING EASY: [✓ (Y)] (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN

DATE: (b)(6) 2 AUG 03 TIME: 183[redacted]

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 2 AUG 03 TIME: 22 25 (b)(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 6937 USAPA V1.0

MEDICAL RECORD -

INTRAOPERAT DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 , MAJ/AN

3. DATE 2 AUG 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 20^00 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 , 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1Lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☒ RIGHT SIDE UP

COMMENTS: Bean bag; pt c̄ bean bag to bump up Ⓡ side; Ⓛ arm tucked

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

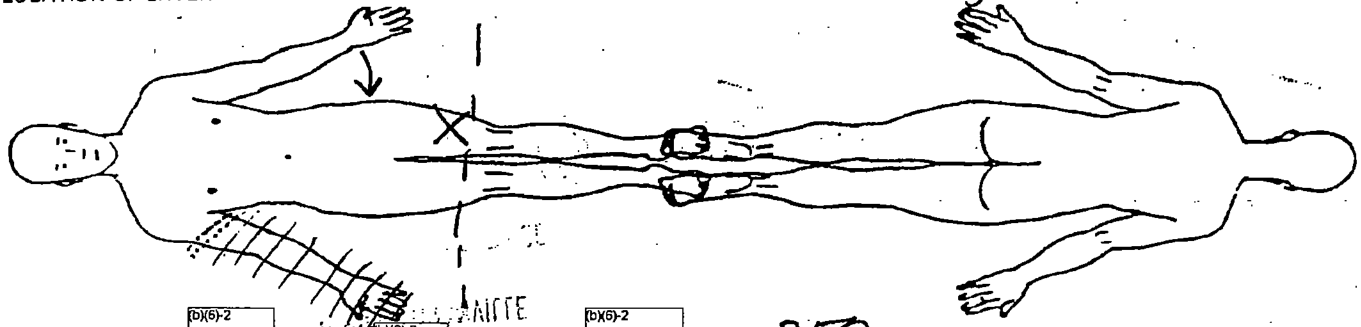
PREP SOLUTION *(Specify)* Beta / Brandt's

SITE: Ⓡ arm - hand to TQ BY WHOM: Chase

SITE: BY WHOM:

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet (b)(6)-2 @ 250 for 76 min /// = prep

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: #1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

LOT NO: 65708 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

A FORM 5179-1, OCT 87 REPLACE MEDCOM - 6938 HICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

1.6 K wires x 2   lot # 0221405

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)-2		

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATI[redacted] IF YES, SITE

YES ☒ NO [redacted] (R) elbow

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

xeroform
fluffs
webril
Splint
ace

19. ADDITIONAL INFORMATION

Dr [redacted] b(6)-2
Dr

b(6)-2
~~Dr~~ est Maj [redacted] CRNA

20. OPERATION(S) PERFORMED

(R) elbow ORIF

21. PATIENT TRANSFERRED TO ICU TIME 2215 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87   USAPA V1.01

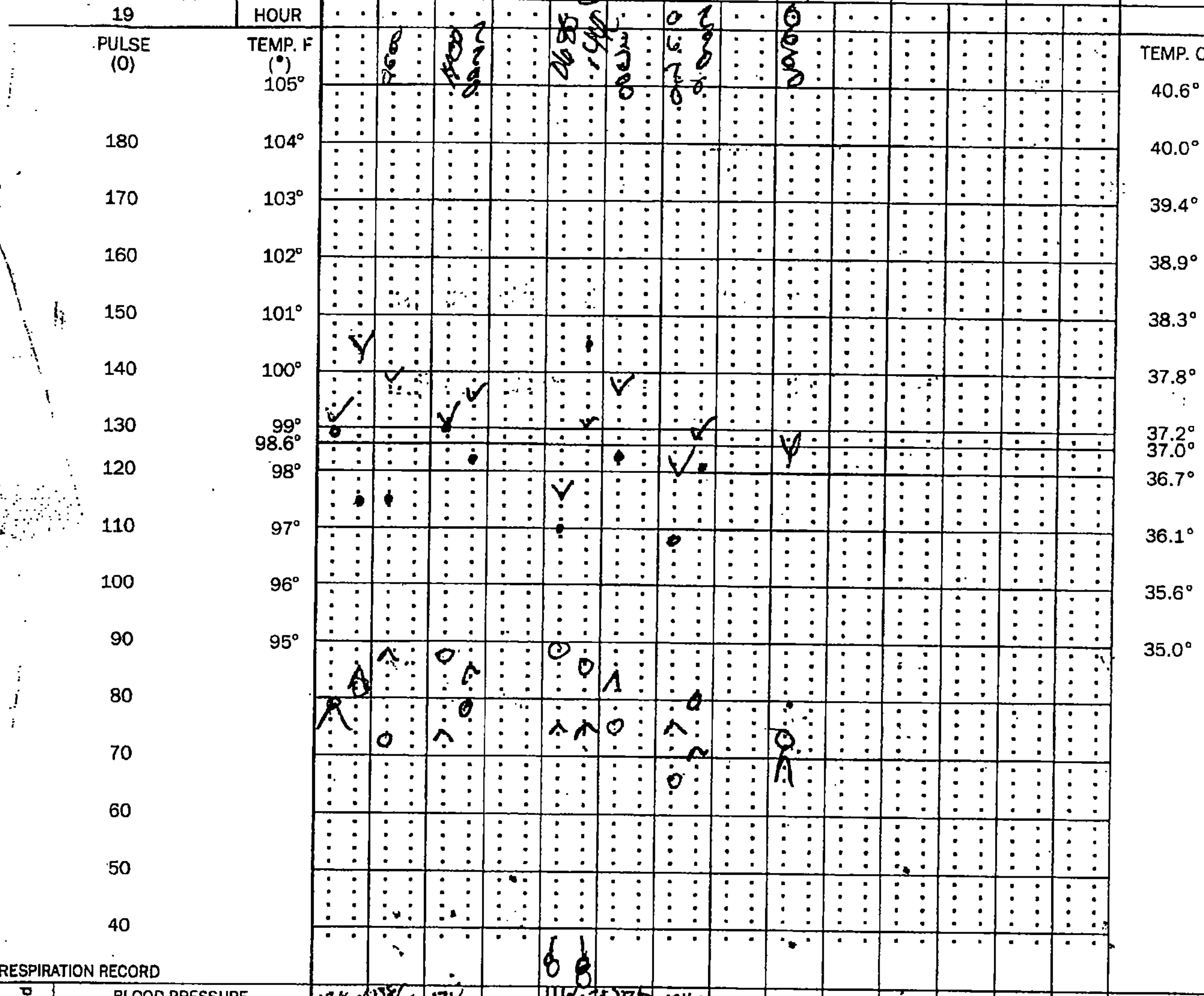
MEDCOM - 6939

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	7	8	9	10	11			
POST- DAY								
MONTH-YEAR / DAY	6	7	8	9	10			
19 / HOUR								



Record special data only when so ordered

BLOOD PRESSURE	134/78 143/84	135/88	134/91 136/93		114/73 124/77	137/83	121/74
HEIGHT / WEIGHT →		97%	98% C16			98%	98
O2	Qd 94%						(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

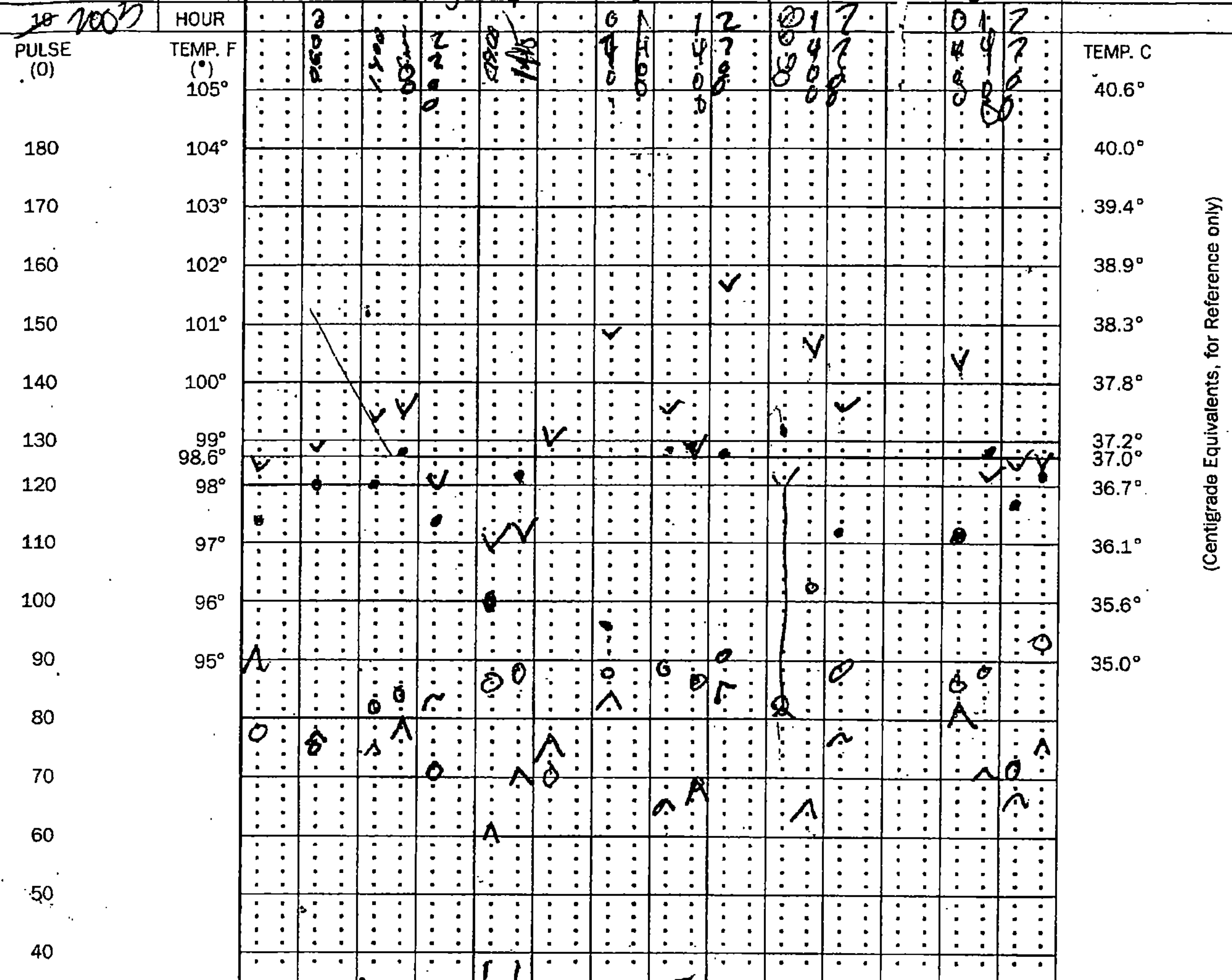
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6940

MEDICAL RECORD

VITAL SIGNS RECOF

HOSPITAL DAY	31 Jul 03	~~1~~ 2	3	4	5	6
POST- DAY						
MONTH-YEAR Jul 2003 / DAY	2200	01 Aug	02	3	4	5



RESPIRATION RECORD

Record special data only when so ordered

RESPIRATION RECORD					16			135/67					
BLOOD PRESSURE	124/62	128/77	134/75 136/80	120/98	119/102 112/70	129/78	149/84 128/69	158/86	99. 136/70	122/71	119/87	124/74
HEIGHT: / WEIGHT →	99%	98%	96% 98%	96	~~97~~ 98	98%	98%	92% 92%	95	83 97%	97 95%	96	95%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6941

[redacted] b(6)-4 ID: [redacted] b(6)-4 31-May-1997 12:27:16 [redacted]

b(3)-1

44years
Male Asian
65in 158lbs

Vent. rate 85 bpm
PR interval 162 ms
QRS duration 92 ms
QT/QTc 388/461 ms
P-R-T axes 60 22 44

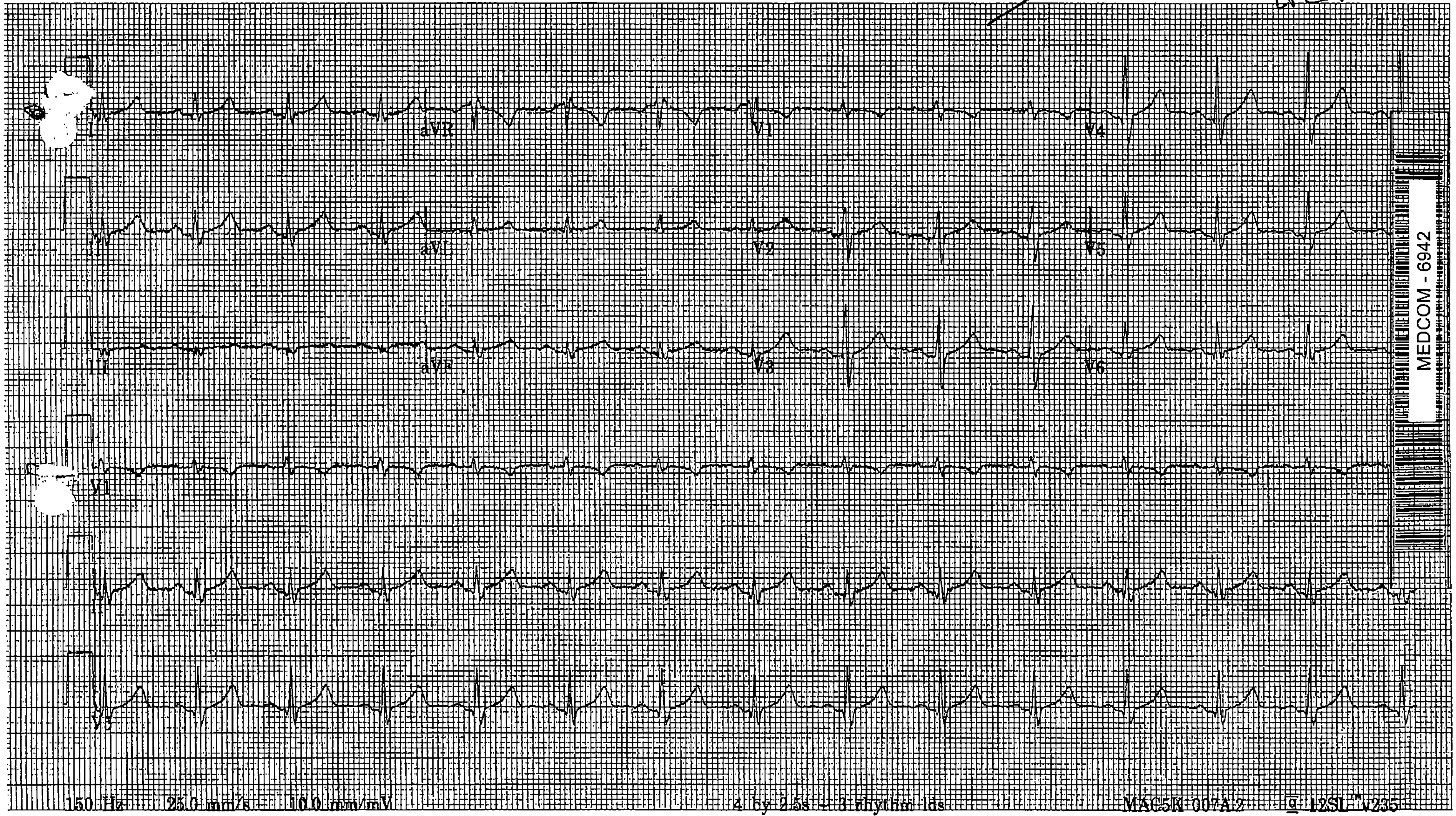
Normal sinus rhythm
Normal ECG

Technician:
Test ind:

(b)(6)-2 [redacted] (b)(6)-2 [redacted]

M.C.
mc

Unconfirmed



MEDCOM - 6942

Premium | GE Medical Systems

(b)(6)-4

ICW

MISC

SPECIMEN/LAB RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) venous

LAB ID NO.

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD DATE 02 Aug

TECH

REMARKS

TEST(S)	
SPECIMEN TAKEN DATE	2 Aug
TIME A.M. P.M.	0800
REQUESTED	Glucose
RESULTS	153 mg/dl

557-107

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

ICW

(b)(6)-4

(b)(6)-2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ VEIN ☐ CAP
☐ OTHER (Specify)

LAB. ID. NO.

PATIENT'S MED. RECORD

(b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD DATE

TECH

REMARKS CBC + ~~Renal Panel~~ Chem 12

TEST(S)	
SPECIMEN TAKEN DATE	01A[illegible]
TIME [✓ A.M.] P.M.	200
REQUESTED (X)	RESULTS
RBC COUNT	4.11
HEMOGLOBIN	13.1
HEMATOCRIT	40.0
MCV	97.7
MCH	31.8
MCHC	32.8
WBC COUNT	10.3
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	24.2
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	376
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
PT CONTROL	
PT PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

MEDCOM - 6943

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
(41-CFR) 201-45.505

549-107

SPECIMEN/LAB RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☒
☐ PRE-OP
STAT ☐

PATIENT STATUS
☒ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ VEIN ☐ CAP
☐ OTHER (Specify)

LAB. ID. NO.

PATIENT'S MED. RECORD

MD DATE

TECH

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-2

(b)(6)-2

REMARKS CBC, CHEM 12

TEST(S)	
SPECIMEN TAKEN DATE	2 Aug
TIME [✓ A.M.] P.M.	
REQUESTED (X)	RESULTS
RBC COUNT	382
HEMOGLOBIN	122
HEMATOCRIT	372
MCV	97.3
MCH	
MCHC	
WBC COUNT	99
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	283
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	348
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
PT CONTROL	
PT PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.

RESULTS	REQUESTED	(X)
462	RBC COUNT	
14.9	HEMOGLOBIN	
44.7	HEMATOCRIT	
96.7	MCV	
32.3	MCH	
33.4	MCHC	
13.8	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
138	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
461	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS
Dr. (b)(6)-2
CBC

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-2
REPORTED BY

TECH

MD DATE

[redacted] b(6)-2

EMT

HEMATOLOGY
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ VEIN ☐ CAP
☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

(b)(6)-4

MISCELLANEOUS

TEST(S)

SPECIMEN TAKEN

DATE 2 Aug TIME 1440 A.M. [✓ P.M.]

REQUESTED

Glucose

RESULTS

125 mg/dl @ 1454

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

REMARKS

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

TECH

MD DATE 02 Aug 03

MISC
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Venous

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

(b)(6)-4

ICW

CHEM I

(b)(6)-4

SPECIMEN/LAB. RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ BLOOD
☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—T (b)(6)-2 DATE
REQUESTING PHYSICIAN'S SIGNATURE
Dr. (b)(6)-2

MD DATE
TECH 31 Jul 03

LAB. ID. NO.

REMARKS
Met 8

TEST(S)	SPECIMEN TAKEN	TIME / DATE	A.M. P.M.	(X) REQUESTED / RESULTS

REQUESTED	RESULTS
GLUCOSE	226
UREA N.	24
CREATININE	1.2
URIC ACID	
SODIUM	134
POTASSIUM	4.3
CHLORIDE	93
CO₂	25
PHOSPHATE	
CALCIUM	
TOTAL PROTEIN	
ALBUMIN	
GLOBULIN	
ALKALINE PHOSPHATASE	
ACID PHOSPHATASE	
SGOT	
LDH	
CPK	97
BILIRUBIN (TOTAL)	
BILIRUBIN (DIRECT)	
CHOLESTEROL	
TRIGLYCERIDES	
AMYLASE	
LIPASE	
PROFILE (Specify)	▨

546-107
CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 6944

MEDICAL RECORD ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, ") "=CONSTANT INFUSION

DRUG	Units									
Versed	(mg)	2								
Fent	(mcg)	250			200					
STP	(mg)	300/150								
Sux//Vec	(mg)	100//10					2			
Toradol	(mg)								30	
	( )									

VOLAT AGENT ISO % del / % e.t.: X ~ 1.5 ~ 1.5 ~ 2.5 ~ 1.5 ~ 1.0 ~ 1.0 ~ 2.5 X

AIR L/Min

N2O L/Min

O2 L/Min: X - 8 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS

FLUIDS

LINE site NS ☐ Warmed — 500

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE –

TOTALS	TOTAL EBL
	Min
	TOTAL URINE
	∅

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– ∅

BLOOD– ∅

REMARKS–

Code drugs with numbers, events with letters

1945 pt ID'd ē char
Reviewed

2000 In Rm Monitors a

2005 - 2008 Inductio
ē Intubation

2012 turned to Ⓛ
side pres. points v
ē padded

2125 - [illegible]

PHYS STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 81 [✓ KG] LB

HEMATOCRIT

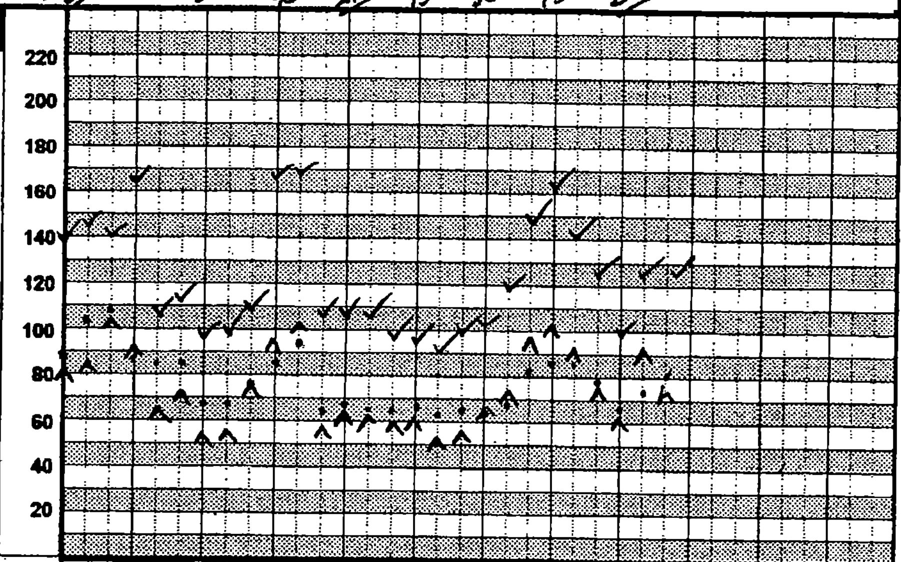
INITIAL DATA:
BP – 134/80
T-98.6 R-16
HR– 84

EQUIP CHECK OK?– [✓ Y] N

PATIENT CHECKS OK for PROCEDURE? Y
TIME– 2000

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ╪
TOURNIQUET T – ✗
ANES– X-X
PROC ⊙ – ∅

TIME → 2000 15 30 45 2100 15 30 45 2200



	2000	15	30	45	2100	15	30	45	2200
VT – ml		1000	840	820	860	840	600	840	
f – breaths/min		8	7	8	6	6	6	6	15
Peak Inf pres / PEEP		23	19	19	20	14	19	26	
MODE– S(pon), A(ssist), C(on)	S/A	C	C	C	C	C	C	C	S
ET CO2 (torr)	+	38	30	28	28	28	28	30	39
FIO2 (Frac or %)	.90	.90	.90	.89	.89	.89	.89	.88	.90
SpO2 (%)	96	98	98	98	98	99	99	98	98
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site									
N-M Block (T/4)	4/4	4/4	4/4				4/4	4/4	

BP/Auto Cuff
BP / oth
ART line
Steth- PC/ES
Gas analyzer

Tourniquet ↑ @ 250 mmHg ↑ ——— ↓ total time 73 mins

Warming blkt

Conv warmer

Mark with letters & symbols, explain under REMARKS **EVENTS** Position → ~ ↔ Ⓛ side ≈ 45°

RECOVERY AT 2215
PACU [✓ ICU] (Specify)
OTHER
CONDITION: Stable
T –
RESP– 18 SpO2– 99
BP– 158/ HR– 66

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1945	2000	2215
	Ready	Begin	End
PROC	2010	2035	2205

PROCEDURES and CPT Codes

ORIF Ⓡ elbow

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL X 1 ē 4 MAC Visulized Cords & Intubated ē 8.0 ETT to 24 cm @ lip Bilat BS / ETCO2 x 5 waves, Eyes taped

SURGEONS: (b)(6)-2 (b)(6)-2

ANESTHETISTS: (b)(6)-2
MAJ (b)(6)-2 AN, CRNA
Nurse Anesthetist

PROCEDURE LOCATION 1-1

DATE 2 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6945

*U.S. GPO: 2002-729-180/40137

ACLU-RDI 1407 p.743

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 44 DAYS MOS [✓ YRS] **Sex** [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: ORIF
SURGICAL SERVICE: Ortho — (b)(6)-2
NPO SINCE:

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 81 [✓ KG]/LB **HT:** 183cm ~~IN.~~
ALLERGIES: NKDA

HABITS:
TOBACCO: ½ PPD x many yrs.
ETOH: 1 bottle whiskey/day
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed
() ~~OMI~~ Unasyn 3g q6 hr
() Glyburide 5mg po qd.
() Lortab.
()
()
()

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ______ / ______
U/A:
OTHER:

10.3 \ 13.1 / 376 1 AUG
  / 40.0 \

134	93	18	
4.3	25	1.2	230

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y

Pulmonary System:
Asthma [✓ N] Y pain c̄ deep inspiration.
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis N [✓ Y] → untreated
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes N [✓ Y] ? takes OHA → not reliable
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y h/o head inj c̄ car accident.
Neuropathy [✓ N] Y
Other N [✓ Y]

Gynecological :
Pregnancy N Y NA

Other Significant Hx: ~~N~~ [✓ Y] Ⓡ olecranon fx
N Y
Familial HX [✓ N] Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
STSG 2° MCA 93

PHYSICAL EXAMINATION
BP 134/80 **HR** 84 **R** 16 **T** 98.6
Pain Scale 0-10
HEENT - Teeth poor dentition
Trachea midline
⊕ Beard **TMJ/Neck** FROM
Oropharnyx MP II
Nares patent
CHEST: CTA c/o pain c̄ deep breath
CARDIAC: S1 S2
EXTREMITIES: NS TKO cc/hr
IV Access: Ⓛ arm 18g LA
Ulnar Filling:
BACK:
OTHER: EKG = NSR

NPO Since

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓ General]: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patie(b)(6)-2 erstand and agrees. Questions answered.
Signed: (b)(6)-2 /CRNA **Date:** 1AUG03 **Time:** 1830 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
[✓ NO APPARENT ANESTHETIC COMPLICATIONS] { } OTHER

Signed: (b)(6)-2 CPT Davis **Date:** 3AUG03 **Time:** 1230 Hrs

Patient Identification: (Ward)

(b)(6)-4

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DC

MEDCOM - 6946

PATIENT RECORD COPY

Previous edition is obsolete

☆ U.S. GPO: 2002-729-283

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 31 JUL 03 TIME OF ORDER 2120 HOURS — LIST TIME ORDER NOTED AND SIGN

✓ ADMIT TO GRANTHAM/HUGGES ICW
✓ Dx: DM, (R) ELBOW FX, (L) WRIST CELLULITIS
✓ COND FAIR
✓ ACT - EPW RESTRAINTS
✓ NKA
✓ 2000 KCAL ADA DIET

DATE OF ORDER TIME OF ORDER HOURS

✓ FINGERSTICKS TID AC
✓ CBC, RENAL PANEL Q AM X 3D
✓ HEP LOCK
MEDS ~~NAFCILLIN 2GM IV Q4°~~
~~PERCOC~~ LORTAB 7.5 T-ii PO Q 4-6° PRN
✓ CONTACT DR [redacted] FOR FURTHER ORDERS — b(6)2
✓ UNASYN 3GM IV Q6°

DATE OF ORDER TIME OF O
(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

24° Chart ✓ 1 August 03 @ 0311

01 AUG 03 0700 — C/S
(b)(6)-2
(b)(6)-2

① IVF: NS bolus x 2L then 150 cc/hr.
② Glipizide or glyburide 5 mg po x 1 now + then qd.
③ D/C Fingersticks.

DATE OF ORDER TIME OF O(b)(6)-2 HOURS

Noted

01 AUG 03 1900 — noted (b)(6)-2

✓ ① NPO p 12 Midnight
✓ ② Hold Glyburide in AM.
✓ ③ Fingerstick: blood sugar x1 in AM (0800) + notify Anesthesia of results.

(b)(6)-2

1 Aug 03 2000

DA FORM 4256 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

MEDCOM - 6947

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2 AUG 03 TIME OF ORDER 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ADMIT C/O GRANNALE/HODGES
✓DX - Ⓡ ELBOW FX Ⓛ WRIST CELLULITIS, DM
✓COND FAIR
✓VS ROUTINE
✓ACT - [illegible] OOB CHAIR ≥ TID

noted (b)(6)-2 [redacted] 2 AUG 03 2210

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

✓NKA
✓1800 kcal ADA DIET
✓NS [illegible] 75cc/HR, HEP LOCK WHEN PO ADEQUATE
✓UNASYN 3GM IV Q8°
✓MS 2-4MG IV Q 15' PRN UP TO 16 MG/3HR
✓~~PERCOCET~~ LORTAB 7.5 ī-ii PO q4° PRN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

✓PHENERGAN 12.5-25MG IV PRN NAUSEA
✓TYLENOL 650MG PO/PR Q4° PRN
✓IS Q1° W/A
✓GLIPIZIDE OR GLYBURIDE 5MG PO QD

(b)(6)-2 [redacted]

LTC, MC
ORTHOPEDIC SERVICE

Q4° chest check 4 AUG [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

5 AUG Q4° chest check (b)(6)-2 [redacted] [illegible] HOURS

6 AUG 03 0730
D/C UNASYN
D/C HEPLOCK
AUGMENTIN 500MG PO TID

noted 6 Aug 03 (b)(6)-2 [redacted]

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

LTC, MC
ORTHOPEDIC SERVICE

Q2° Chest ✓ 7 Aug 03 0200 Hours (b)(6)-2 [redacted]

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

MEDCOM - 6948

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 AUG 03
TIME OF ORDER: 0900 HOURS
LIST TIME ORDER NOTED AND SIGN

D/C IN MP CUSTODY
MEDS - LORTAB, AUGMENTIN,
GLYBURIDE
DIET - 2000KCAL ADA
F/U - 23 AUG 03 ACC
SEND PT c̄ COPY OF NARSUM & X-RAYS

(b)(6)-2
LTC, MC
ORTHOPEDIC SERVICE

24° chart ✓ 10 Aug 03 @ 0200 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6949

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* 07 *Yr.* 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	02	3	4	5	6	7	8	9	10	11	12	13
31	(b)(6)-2	Activities: EPW	6	/	(b)(6)-2										See		
		Restraints	18	/												below	
31	(b)(6)-2	Diet: 2000 Kcal	7	/	(b)(6)-2												
		ADA diet	12	/													
			17	/													
31	(b)(6)-2	Fingersticks TID															
		AC	6	/		D/C											
			14	/													
			22														
1	(b)(6)-2	N/O VS q shift	06	/	/	(b)(6)-2											
			14	/	/												
			22	/	TJL												
2 Aug	(b)(6)-2	Act: EPW status OOB	06	/	/	/	(b)(6)-2							10			
		to chair TID	14	/	/	/											
			22		/	(b)(6)-2											
2 Aug	(b)(6)-2	IS Q1° w/A	05	/	/	/	(b)(6)-2						D	C			
			17		/	(b)(6)-2								/ 7/10			
2 Aug	(b)(6)-2	Diet: 2000 ADA	06										(b)(6)-2				
			12														
			17														

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: DM, ® Elbow Fx, (L) wrist cellulitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 6950

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	(b)(6)-2	Admit c/o (b)(6)-2 ICW		Done		(b)(6)-2
31		Condition: Fair				
31		CBC, Renal panel q AM ×3 days	1Aug03	0600		
			2Aug03	0600	0515	(b)(6)-2
			3Aug03	0600	0515	
01Aug	(b)(6)-2	2L NS bolus now	1Aug03	Now	0800	(b)(6)-2
01Aug		Glyburide 5mg PO ÷ now	1Aug03	0800	0800	
1Aug		NPO p̄ MN	1Aug03	0000	0000	
1Aug		Hold Glyburide in AM	2Aug03	0600		
1Aug		Fingerstick ×1 blood sugar (AM) + notify	2Aug03	0800	0800	(b)(6)-2
		anesthesia of results				
2Aug	(b)(6)-2	Admit c/o (b)(6)-2	2Aug	2200	2200	(b)(6)-2
2Aug		Dx: ① elbow fracture ② [illegible] cellulitis	2Aug			
2Aug		Cond: Fair	2Aug			
9Aug		D/C in MP custody				

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 6951

CLINICAL RECORD

THER PEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 7 *Yr.* 8

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	3/	1	2	3	4	5	6	7	8	9	10	11	12	13
31	(b)(6)-2	HL	6	/	(b)(6)-2												
			14	/		D/C											
			22	[illegible]													
31	(b)(6)-2	Unasyn 3gm IV	6	/	(b)(6)-2							PM	D/c'd				
		q 6°	12	/													
			18	/													
			24	[illegible]													
01 AUG	(b)(6)-2	NS @ 150cc/hr	06	/	w	[illegible]			D/c'd								
			14	/	w												
			22	/	TJC												
01AUG	(b)(6)-2	Glyburide 5mg PO ÷ QD	06	/	~~[illegible]~~	[illegible]		D/C'D									
2AUG	(b)(6)-2	NS @ 75cc/hr HL when PO ADEQUATE	06	/	/	/	(b)(6)-2				Heplocked						
			14	/	/	/	(b)(6)-2										
			22	~~[illegible]~~	/	(b)(6)-2											
2AUG	(b)(6)-2	GLIPIZIDE OR GLYBURIDE 5 mg PO ÷ QD	06	/	/		[illegible]										
5AUG	(b)(6)-2	Heplock IV	5	/	/	/	/	/	(b)(6)-2		D/c'd						
			17	/	/	/	/	/									

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: DM, Ⓡ elbow Fx, Ⓛ wrist cellulitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6952

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* 7 *Yr.* 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	PRN ~~RECURRING MEDICA~~TIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
31	(b)(6)-2	Lortab 7.5 i – ii tabs PO q 4–6° PRN		7/31 2255 ii 1kk 1Aug 1620 ii 3Aug 1135 ii 4AUG 0535 2 tabs 8Aug ii 2450 1kk 9Aug ii 2124 1k (b)(6)-2
rewritten below		MSO4 2-4mg IV Q15' PRN upto 16mg /3hr		2Aug 4mg 2215 TSL 3Aug 4mg 0340 1kk 3Aug 0815 4mg 3Aug 0830 4mg 3Aug 0845 2mg 3Aug 1135 4mg 3Aug 1150 3mg 3Aug 1205 3mg 3Aug 2210 5mg 3Aug 2355 4mg 4Aug 0200 4mg 6Aug 4mg 0228 1kk (b)(6)-2 (b)(6)-2
		Phenergan 12.5-25mg IV PRN nausea		
		Tylenol 650mg PO/PAIN Q4° PRN		3Aug 2100 ii TX
31	(b)(6)-2	MSO4 2-4mg IV q 15' PRN up to 16mg in 3 hrs		6Aug 2011 4mg 1kk 9Aug 0144 4mg 1kk
31	(b)(6)-2	Contact Dr (b)(6)-2 for further order		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 6953

CLINICAL RECORD

:RAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* ____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10											
8Aug	(b)(6)-2	Dt Augmentin 500mg	06		(b)(6)-2												
		PO TID	14		(b)(6)-2												
			22	(b)(6)-2													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6954

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	~~RECURRING MEDICATIONS, DOSE FREQUENCY~~ Single Action	HR	DATE DISPENSED Date to Given	Drug Given	Time Given	Init
8Aug	(b)(6)-2	D/C Unasyn		8Aug		0800	(b)(6)-2
8Aug		D/C Heplock		8Aug		0800	
9Aug		D/C MEDS (for D/C)					
		Lortab Augmentin,					
		Glyburide					
9Aug	(b)(6)-2	Diet 2000 ADA					
9Aug		F/U 23Aug03 ACC					
9Aug		Send c̄ copy of					
		Narr. Summary					
		& xray					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6955

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF / **2. MTF LOCATION** (State or Country Code.)

1	2	3	4	5	6	7	8
(b)(3)-1 [redacted]							

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4 [redacted]						

NAME (Last, First, Middle Initial)
(b)(6)-4 [redacted]

4. PAY GRADE

16	17

FGN

5. SEX

18
m

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26
1	9						

7. AGE AT ADMISSION

27	28	29

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION muslim

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
2	0

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4 [redacted]								

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION 22:00

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION (State or Country Code)

62	63
[redacted]	[redacted]

b(3)-1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA b(6)-4

71
9

10,5

PREV. ADMISSION
YEAR
☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
0	5

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y Y Y M M D D)

81	82	83	84	85	86	87	88
2	0	0	3	0	8	0	9

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION (Y Y Y Y M M D D)

99	100	101	102	103	104	105	106
2	0	0	3	0	7	3	1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

107	108
[redacted]	[redacted]

b(3)-1

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)

115	116	117	118	119	120	121	122

FOR LOCAL USE

Ⓡ Elbow Fx
813 - 11

Ⓛ Wrist cellulitis
682.4

25000
DX-81400
6824
Trauma - 9
injury - 989 E9889
PR-7912

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000 MEDCOM - 6956 USAPA V1.00

Admission an[illegible]oding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF: (b)(3)-1
2. MTF Location: (b)(3)-1
3. Register Number: (b)(6)-4
Name (Last, First, MI): (b)(6)-4
4. Pay Grade: FGN
5. Sex: M
6. DoB (YYYYMMDD):
7. Age at Admission:
8. Race: X
9. Ethnicity: 9
Religion: MUSLIM
10. Length of Service: ETS
11. FMP: 20
12. Social Security Number: (b)(6)-4
Organization (Active Duty Only):
13. Marital Status:
Hour of Admission: 22:00
Branch / Corps:
14. Flying Status:
15. Beneficiary Category: K78-PRISONER OF WAR/INTERNEES
16. Zip Code of Residence:
17. Unit Location:
18. MOS:
19. Trauma: DIS
Prev. Admission: NO
20. Source of Admission: Direct from ER
Ward: ICU
Name / Relationship of Emergency Addressee
Address of Emergency Addressee
Telephone Number of Emergency Addressee
Name and Location of Medical Treatment Facility: (b)(3)-1
2[illegible] Typ[illegible]f Disposition: HOME
22. MTF Transferred To:
23. Date of Disposition (YYYYMMDD): 2003-08-09
24. Clinic Svc - Admitting: AEA - ORTHOPEDICS
25. MTF Transferred From:
26. Date this Admission (YYYYMMDD): 2003-07-31
27. Location of Occurrence:
28. MTF of Initial Admission:
29. Date of Initial Admission: 2003-07-31

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: R elbow fx   L wrist cellulitis
813.11   682.4

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required): DR (b)(6)-2

Signature of Admitting Clerk

Automated Facsimile - DA FORM 2985, MAR 2000   MEDCOM - 6957

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REGISTER NUMBER (b)(3)-1	2. NAME (Last, First, MI) (b)(6)-4	3. GRADE N/A	ADMISSION REMARKS

4. SEX M	5. AGE	6. RACE N/A	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO

11. FMP 99	12. SSN (b)(6)-4	13. ORGANIZATION N/A	14. WARD ICW

15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN N/A	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE BC

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM E.R.	22. HOURS OF ADMISSION 1540	23. CLINIC SERVICE ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION XFER EPW HOLD	26. DATE OF DISPOSITION 2 AUG 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 24 JUL 2003	ADMITTING OFFICER DR (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

FRAGMENT WOUNDS
LEFT KNEE/ BACK/ FACE

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	9	9

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
(b)(6)-2		0	0	9	9

(b)(6)-2 COL, MC

(b)(6)-2 (b)(6)-2 SSG, NCOIC, PAD

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 6877

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

~40 yo male c/o fragmentation wound to back, Ⓛ shoulder, Ⓛ knee conditions ? fragmentation wound from exploding mortar or grenade. Pt ī any y/o. Denies abd pain – has h/o "ulcer" and abdomen feels like normal abdomen sx.

PMx ⊖
PSx ⊖
Meds, ∅

PHYSICAL EXAMINATION

130/78 P 92 R 20 98°
NAD, cooperative.
HEENT: Ⓛ auricle small wound OP clear
Chest CTA Ⓑ CV tachy RRR
Abd soft, NT, ND. ∅ peritoneal signs
Ext: ⊖ deltoid wound, Ⓛ and knee small wound.
Back: small frag wound Ⓡ

PROGRESS *(Enter date of discharge and final diagnosis)*

A/ Fragment wound,
stable

P/ Admit ICW
observe

[redacted]

(b)(6)-2

S

DATE 1/24

IDENTIFICATION NO.

ORGANIZATION

P

or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-108

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 JUL 03	OP NOTE
	PRE OP DX (L) OPEN KNEE, R/O INTRA PERITONEAL
	HEMORRHAGE, FACIAL LAC c̄ FB
	POST OP DX - NL ABD, EXTRAARTICULAR (L) KNEE WND, FACIAL LAC c̄ FB
	PROCEDURE - MINI EXPLORATORY LAPAROTOMY, DEBRIDEMENT,
	LT. KNEE & FACE WOUNDS
	SURGEONS - (b)(6)-2
	ANES GETA MONCOM
	FLUIDS 1300 CRYS EBL MIN UO 200 TT 17' @ 275m
	DRAINS JP (L) KNEE SPEC CX
	INDICATIONS ~~FINDINGS~~ - QUESTIONABLE FAST EXAM c̄ INTRA ABD
	FRAG ON XR - SCAN LOOK c̄ ASSESSMENT
	(L) KNEE c̄ PERIARTICULAR FRAG ON XR
	FINDINGS - NL ABD - EXTRAARTICULAR (L) KNEE FRAG
	TO [illegible] FOR RECOVERY STABLE

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-4

MEDCOM - 6879

LAST NAME	ID NUMBER

DATE	NOTES
24Jul03	Nursing Note: Received Pt from ICU via Stretcher
2240	foley to gravity. IV to gravity Pt in stable condition
	∅ c/o at this time. Breathing intact ∅ SOB
	unlabored breathing. Abd slight distended
	dressing to abd and Ⓛ leg ∅ drainage on dressing
	visible. Will continue to monitor Pt's status
	——— (b)(6)-2 1C7/AW
7/24/03	Pt c/o pain 2mg IV MSO4 given. Will continue to
2305	monitor ——— (b)(6)-2 1C7/AW
2345	Pt c/o pain 2mg IV MSO4 given for Pain. Will continue
	to monitor status ——— (b)(6)-2 1C7/AW
0019	Pt c/o pain 2mg IV MSO4 given IV PRN. Will continue
	to monitor ——— (b)(6)-2 1C7/AW
0030	Pt Asleep ——— (b)(6)-2 1C7/AW
0123	Pt c/o pain 2mg IV MSO4 given IV PRN for Pain
	Will continue to monitor ——— (b)(6)-2 1C7/A
0153	Pt c/o pain 650mg Tylenol PO given. Pt also c/o
	Nausea - 25mg Phenergan IV given. Will continue (b)2
	to monitor ——— [redacted] 1C7/AW
0200	Pt vomited liquid ∅ chunks. Pt states OK after
	vomiting. ——— (b)(6)-2 1C7/AW
0300	Pt Asleep ——— (b)(6)-2 1C7/AW
25Jul03	Nursing Assessment: Pt awake, c/o pain. Medicated c̄
0730	2mg MSO4. Pt Temp 100.4, gave 625mg Tylenol. Lungs
	CTA; assist pt @ bedside. I IS use. HR 96, reg; abd soft,
	distended, hypoactive BS x4. Mod drsg intact; covered c̄
	bloody drainage but has not ~~soak~~ seeped through gauze—Lu (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-4

MEDCOM - 6880

MEDICAL RECORD | PROGRESS NOTES

DATE

25 Jul 03 1751 Pt able to move all extremities without complication. C/o pain in abd. Vitals within Normal limits. SpO2 Range from 91-94%. will continue to monitor —— (b)(6)-2 1LT AN

2022 O2 @ 2L administered Pt SPO2 ~~at~~ 90% ↑ 94-96% continued monitoring of Sats —— (b)(6)-2

2026 Dressing changes to Back and leg completed Ø obvious bleeding or fluid excess on changed dressing. will continue to monitor. Pt's Sats now range 96-98%. O2 @ 2L via NC intact —— (b)(6)-2 [illegible] 1LT

26Jul03 1307 Nursing: Note shift. Pt alert, speech clear in native tongue. VSS x sat ↓ to ~80s; ↓90 on room air. Gave 2L then 96%. Ø resp. compromise. c/o headache & stomache this shift. ⊕BS, Ø BM this shift. Ø edema noted able to move all extremities. (b)(6)-2 ← (b)(6)-2 CPT AN

26 Jul 03 2000 ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S_1-S_2 STRONG + REG. ⊕ BS x4. DSG Δ's COMPLETE @ 1800. C/O PAIN TO ABDOMEN GIVEN PERCOCET FOR PAIN 25mg IV PHENERGAN FOR NAUSEA. TOLERATED (b)(6)-2 [illegible] SHIFT. CVHL TO ® AC. WILL CONTINUE TO MONITOR —— [illegible]

27 Jul 03 1408 Nursing: Shift assessment. Pt. bright & alert most of shift. Speech in native tongue c/o pain to abd. specifically requested Zantac; ordered & given. Physician aware. Foley d/c'd at 0900 Hrs. Cont. to monitor —— (b)(6)-2 CPT AN

(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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
2145 125/65	Client from OR via litter and gurney c̄ OR staff nurse and CRNA
2150 125/53 2155 135/43	Pt drowsy but arousable - Face mask 10L SaO2 99%-100% - Pt c̄
2200 116/58	IV in (R) AC NS @ TKO - Dsg to (L) ear c, D and intact
2215 113/56	
2230 116/58	Dsg to abd small, c, D and intact Dsg to (R) knee c, D and intact
	Procedures? DPL and knee drainage. Meds in OR 250 mcg fent,
	7mg MSO4, 2mg versed + 800 LR infused in OR - 200 urine
	out in OR. Foley to gravity draining [illegible] urine - SaO2 on
	RA 95% at time of transfer - ∅ pain medication in
	ICU recovery - report to LT, (b)(6)-2 (b)(6)-2
24 Jul ~~03~~ 25 Jul	Nursing Assessment (cont'd). Drsg to (R) inner thigh
c̄ 0730	has dime size area scn-sang. drainage,
	applied new 4x4. Drsg to (L) knee CDI. Drsg to
	(L) ear CDI. Unable to eval Pt. back, pt in
	too much pain to lean forward. Will eval
	when pain subsides ——— 1LT (b)(6)-2 AN
25 Jul 03	Nursing: UOP - Pt foley D/C'd @ 0100. Pt has not
1005	voided yet, MD want I+O cath if pt not void by
	1000. Placed 16Fr. foley, 775cc of clr. yellow urine
	out. Will leave foley until consult c̄ MD — 1LT (b)(6)-2
1400	Nursing. Pt c/o difficulty breathing, O2 sat 88% on RA.
	Placed Pt on 2L O2 NC, O2 sat ↑ to 96%. Pt Temp 100.9
	Gave 650mg Tylenol ——— 1LT (b)(6)-2
25 Jul 03	Nursing Note: Assumed care of Pt A+O. Foley
(c) 1750	to drainage clear yellow urine noted. Breathing
	intact ∅ SOB or labored breathing noted. IV NS
	infusing. ∅ S/S of infiltration at site. Pt ate 10%
	of meal, tolerated it well ——— (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6882

MEDICAL RECORD PROGRESS NOTES

DATE	
25JUN03	POD1 - ORTHO
	S NO [illegible] C/O
	O VSSA
	NVI DISTALLY
	DSG INTACT
	A DOING WELL ORTHOPAEDICALLY
	P ARMY ABX & LOCAL UNIT CARE

(b)(6)-2 [redacted]

LTC, MC
ORTHOPEDIC SERVICE

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle;

(b)(6)-4 [redacted]

REGISTER NO

WARD NO

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6883

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27 Jul 03	Nursing Notes: Assumed care of Pt Sleepy
@ 1711	easily aroused- Pt did not eat his
	dinner c/o stomach discomfort. Encourage
	pt to drink more fluids. IV SL flushes
	well. Pt given Maalox earlier for Stomach
	discomfort. Pt voids spontaneously. Breathing
	intact Ø SOB or Labored breathing. Able to
	move all extremities without complication.
	will continue to monitor status — (b)(6)-2 78.
1950	Via interpreter pt c/o impacted Stomach. Ø
	BMX 3 days. Abd distended and tender to
	touch. New order for Enema Obtained per
	Dr (b)(6)-2 - will administer —
	— (b)(6)-2 1LT/AN
2025	Pt Refuses enema. He thought He was getting
	Suppository. New Order Obtained Per Dr. (b)(6)-2
	for suppository — (b)(6)-2 1LT/AN
2201	Pt took Suppository Earlier. Attempted for BMX Ø
	Pt back to bed. Dressing changes to back
	and leg completed. Will continue to monitor
	status — (b)(6)-2 1LT/AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 6884

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Jul 03 6045	Nsg shift assessment: Pt c/o generalized body pain @ 2220 and was given MSO4 2mg to which he verbalized relief. Resps are even unlabored, VSWNL, will cont to monitor —— (b)(6)-2
29 Jul 03	2200 - Assessment - C/O Ø pain. Tolerating reg diet, DRSG C/D/I, monitoring I+O's. Resting comfortably. Complained of scab on back of head to be uncomfortable. Notified Dr. [redacted] b(6)2. —— (b)(6)-2 SGT, LPN
30 Jul 0830	Nursing Assessment: Pt awake, ↑ in bed this am for breakfast. C/o little pain to abd @ around incision site. ML abd incision c̄ staples OTA, Ø S+S infection. Pt lungs CTA, HR 72, ⊕BSx4, abd soft round. Schrapnel wound to back in several placed, replaced drsg x2 to site c̄ small amt old sero-sang. drainage noted. Bil. inner thigh c̄ schrapnel wound, Ø drainage noted. Drsg to BLE & ace wrap over gauze CDI —— LT (b)(6)-2 AN
30 Jul	2200 Assessment - A+O x3, PERRLA, lungs CTA bilat. S1 S2 strong + regular ⊕BS x4. C/O pain to abd given Percocet ii tabs. Drsg C/D/I. Tolerated reg diet, up ad lib. Will continue to monitor —— (b)(6)-2 SGT, LPN
31 Jul 03 0830	Nursing Assessment: Pt awake, ↑ in bed. C/o pain to IV site. D/C'd HL. A&A, lungs CTA bil; HR 89 reg; hypoactive BSx4, abd soft, round. Pt has multiple schrapnel wounds to back, Ø drainage noted. Bilateral inner thigh schrapnel wound s̄ drainage. Abd incision c̄ drsg CDI, 2x2 drsg to Ⓛ lateral knee CDI. —— LT (b)(6)-2 AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Jul	Nursing: Drsg Δ: Perform drsg Δ to abd. Old drsg c̄ 2 in.
1500	diameter shadowing of gauze & 2x2 packed saturated c̄
	sero-sang drainage. Reapplied 2x2 c̄ saline & covered c̄
	4x4 Kerlix gauze. Pt tolerated well ——— LU (b)(6)-2 ML
1AUG03	NSG shift assessment: Pt c/o pain @
2030	approx 2300 and was given 2 percocets
	to which he verbalized pain relief.
	Pt breath sounds are clear, resps
	even + unlabored, and sats are 95%
	on RA. A+O x4, speaking some
	words of english when he needs
	something. Currently sleeping quietly
	in bed, will cont to monitor — (b)(6)-2
1 Aug 03	Nursing: Shift Assessment Pt. with no change in
1530	resp, cardiac, or g.i. Pt. dressing changed in abd.
	w/ scant amount of drainage, pt. voiding outside
	this shift. Pt. reports BM x4. C/o pain in
	Ⓡ upper back. CXR, UA completed as orders by
	physician. Percocet x2 this shift. Am care given
	continue to monitor ——— (b)(6)-2 CPT AN
1AUG03 2200	NSG shift assessment: Dressing Δ done w/

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		
		REGISTER NO.	WARD NO.	

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1.

MEDCOM - 6886

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	minimal drainage. Has not asked for pain meds during this shift. Had a good appetite at dinner. VS WNL, resps are even + unlabored; no complaints at this time will cont. to monitor — (b)(6)-2
2AUG03 @0009	NSG: Pt c/o pain (diffuse to head and back) and received 2 percocets PRN. Will cont. to monitor — (b)(6)-2
2 August 03 1749	Nursing Note: Assumed care of ~~A~~ A+O×3 Pt tolerated Regular diet OX. Laying in bed. Breathing intact Ø SOB or labored breathing. dressing on abd c̄ Steri Strip intact Small amt of drainage noted dressing on (L) leg intact Ø drainage Ø odor. Sutures intact. Pt able to move all extremities without complication Ø IV Access. will continue to Monitor status — (b)(6)-2
2000	Ø changes at this time. Pt awake & complains of pain or discomfort — (b)(6)-2
2200	Dressing change on abd completed — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 6887

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24Jul403	
1530	pt arrives in E.R. Local national.
1532	BP 130/88 O_2sat 100 RA O_2 sat 98 c̄ O_2 p 107 Temp 98.6 R
1535	1000mL Sodium Chloride Ⓡ AC
1540	CBC, TYPE & CROSS, PTPTB was drawn from PT Ⓡ AC
1540	skull x-ray, AP/Lat, Ⓛ shoulder, Ⓛ hand, Ⓡ & Ⓛ thight
	Ⓛ knee, abdomin, chest ordered
1545	Bp 125/91 p 103 O_2 - 99 R 24
~~1545~~	~~1000mL sodium chloride~~ AD
1550	Foley was put in pt
1550	pupils Equal reactive to light, pain is 7 on 1-10 scale, eye
	movement normal, HEENT clear, Ⓛ facial shrapnel wound
	post. scalp shrapnel wound, post. Ⓛ shoulder shrapnel woun
	multiple small back shrapnel wounds, Ⓡ thigh wound, Ⓛ knee
1552	10mg morphine drawn
1553	10mg morphine administered I.V
1554	Good Bilateral dorsal pulses
1558	ancepn 1g administered I.V
1600	BP 111/68 p 110 O_2sat 100 R 24
1600	Tetnus Ⓡ shoulder .5g IM
1601	X-ray Ⓛ shoulder arrives
1602	ultrasound of pt abdomin

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 6888

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 July 03	
1610	spine board put underneath pt.
1610	ultrasound taken of pt (L) chest
1611	Bp 119/80 p 94 O2sat 100 R-20
1612	ultrasound taken of pt (R) chest
1617	BP 122/84 p. 92 O2 sat 100 (R) 24
1617	lab results in WBC 14.7 Hgb 14.1 Hct 42.8
1618	repeat of skull ~~Ap~~ Lat x-ray ordered, Ap abdomin
1618	Ap (L) shoulder and chest returned
1619	Lat Abdomin ordered
~~1620~~	~~rectal exam taken~~ AM
1620	Hemacutta taken turned into lab
1622	Hemacutt results (-) blood
1629	chest x-ray taken
1629	1000ml LR (R) wrist I.V
1630	chem lytes 8 ordered sent to lab
1637	x-rays arrive; (L) shoulder, skull, ~~abd~~ AM
1639	(R) thigh, (L) knee x-rays taken
1644	PT wounds cleaned with sodium chloride
1645	Bp 121/81 p93 O2 100 R. 24 T. 99.2
1648	Lat skull x-ray taken b(6)-2
1650	pt abdomin was palpate by Dr. [redacted], O2 was taken off pt
1658	x-rays returned to Dr. (b)(6)-2
1705	(L) ear cleaned and steri strip applied
1715 Late note	EDW presents in no acute distress — Sat 100 % RA — lungs clear — c/o pain
total IVF 2300	especially (L) ear area 8/10 — relieved c̄ 10mg MSO4 IVP. (b)(6)-2, AVISEA
out foley all to ICU	VS stable — see above + SS? Abd soft, large round — [illegible]
	[illegible] — nonspecific — all pulses 2+ — CRT < 2sec — [illegible] (b)(6)-2

oriented & appropriate behavior — MAE following commands + common [illegible] — no pt sedated [illegible] stable — [illegible] and avoid [illegible] — [illegible] + shoulder area [illegible] all areas cleaned c̄ saline, report given to ICU — Pt stable from [illegible]

abrasions [illegible] (R) thigh entrance & exit — (L) arm [illegible] — hematoma (L) [illegible] — [illegible] bleeding [illegible] (R) arm infusing well — (b)(6)-2 (b)(6)-2 [illegible]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 6889

558-103 *See Instructions on Back of this Sheet)* NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)*

LOG NUMBER

ARRIVAL
DATE: DAY 24 MONTH July YR. 03
TIME: 1530

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER *(Specify)*

CURRENT MEDS. *(tetanus immunization and other data)*: ⊖

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES: NKDA.

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*: Mult Back fragments
SEX: M
AGE: 40

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1530.

(b)(6)-2 [redacted] VITAL SIGNS

TIME	1400	1630	1530
BP	129/90	116/76	139/88
PULSE	64	92	107
RESP.	12	22	20
TEMP.			98
WT. *(Child)*			

CATEGORY *(See reverse)*
☑ EMERGENT
☐ URGENT
☐ NON-URGENT (b)(6)-2

ORDERS	INITS.	TIME
30 toradol	[redacted]	1630
chest, skull, ab, Ⓛ shoulder, hand, knee, Ⓡ thigh		1640
10mg morphine	[redacted]	1553
1g ancef	[redacted]	1558

ASSESSMENT/DIAGNOSIS: Mult fragments to Back face, Legs, Ⓛ Shoulder. Hemoperitoneum.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Last meal B-fast 10I 1400.

40 ♂ EPW c/o shrapnel wounds to back, head Ⓛ ear & Ⓡ Thigh

S: Pt is a 40yo Iraqi EPW who were in a building + fired on by .50 cal, MK19, M4 rounds. Pt sustained mult frags to Back, Ⓛ Scalp/ear, Ⓛ Shoulder + Ⓡ post. thighs. C/o some Abd pn ? if Chronic or new.

PMHx ? Colon pain.
PSHx ⊖.
⊕ TOB.

O: WDWM in min dist 2° to mult frags. ⊖ Resp in dist. Nontoxic ⊖ Diaphor. Conversant c̄ Interp. GCS 15

HEENT mult frags to Ⓛ scalp, face, ear.
Lungs: Ⓑ eq CTA.
Cor RRR ⊖ⓜ.
Abd: quiet BS. s. + gen tend. ⊖ Reb ⊖ focality ⊕ FAST
Ext: ⊕ frag to Ⓛ post deltoid. ⊖ frags @ Ⓑ mid thighs. NVI ↓
Back: Several deep frag wounds over entire back. ⊖ frags over both kidneys

15 \ 14/43 / 24
UA: yel, clr 1.030 5.0 all ⊖: ⊖ Bld.
PT/PTT 13/28 AB
146 | 109 | 12 / 3.6 | 26 | 103 LFTNL
CXR: wnl. ⊖ PTX.
Skull:
Ⓛ Shoulder
Abd: ⊕ RUQ frag.

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)*: Gen Surg
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☑ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1700

(CO (b)(6)-2 [redacted]

SIGNATURE OF P [redacted] , MAJ MC

PATIENT'S IDENTIFICATION *(Mechanical imprint)*
FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

(b)(6)-4 [redacted]

INSTRUCTIONS T [redacted] any limitations and follow-up plans)

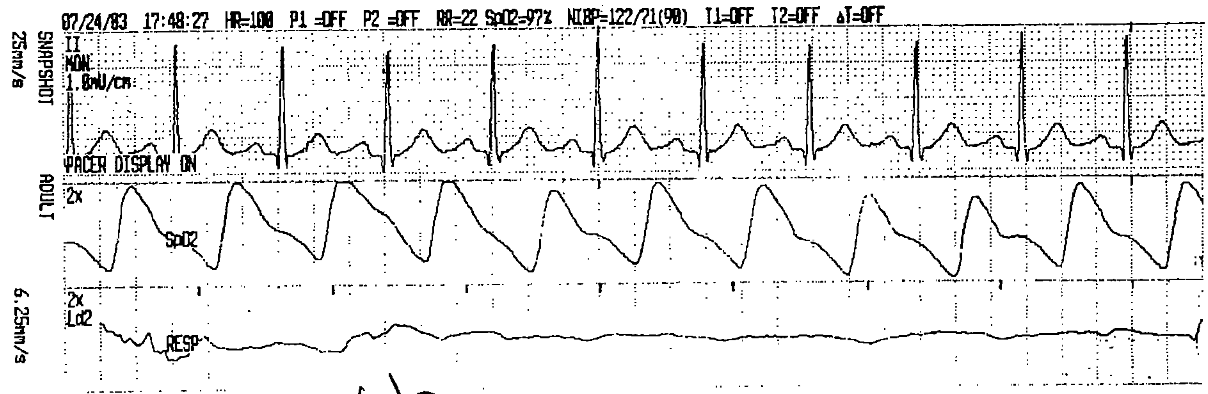
To OR.

EMERGENCY CARE AND TREATMENT
MEDCOM - 6890

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Jul 03		1730	39 yo ♂ admitted to the ICU from BMT
			via litter c̄ multiple sharpnal wounds.
			Monitor applied. VS 122/71, 102, 14, SAO2 96%
			on RA. NAD noted. Intial assesement completed
			Neuro: alert, awake, Pupil 2mm Pearl,
			Resp: Reg, non-labored, LS clear Ø secretions
			SAO2 96% on RA
			Skin: color normal for Race shrapnal wound
			to Ⓛ tempal region Ⓛ shoulder c̄ arm
			Ⓡ Thigh, Ⓛ Knee, & upper Back. Wound are clean.
			IV site. Ⓡ AC 20g saline locked. Ⓡ wrist 18g infusing
			LR @ 50cc/hr
			Gastro: BS x 4 quads Abd soft nondistended.
			GU. foley → gravity draining clear yellow urine
			Cardiac: ST, HR 100, NAD skin warm, dry
			⊕ pheripheral pulse x 4 see rithm strip


07/24/03 17:48:27 HR=100 P1 =OFF P2 =OFF RR=22 SpO2=97% NIBP=122/71(90) T1=OFF T2=OFF ΔT=OFF
SNAPSHOT
25mm/s
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
2x
SpO2
6.25mm/s
2x
Ld2
RESP

			B(6)2
			Plan: Dr [redacted] to examine at bedside
			to assess futher Tx. ~~Will report~~
			to oncoming shift
			(b)(6)-2

MEDICAL RECORD | **INTRAOPERA IV CUMENT**
For use of this form, see AR 40-66, the proponent a ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 LT/AN
3. DATE 24 Jul 03
TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 19¹⁵ NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

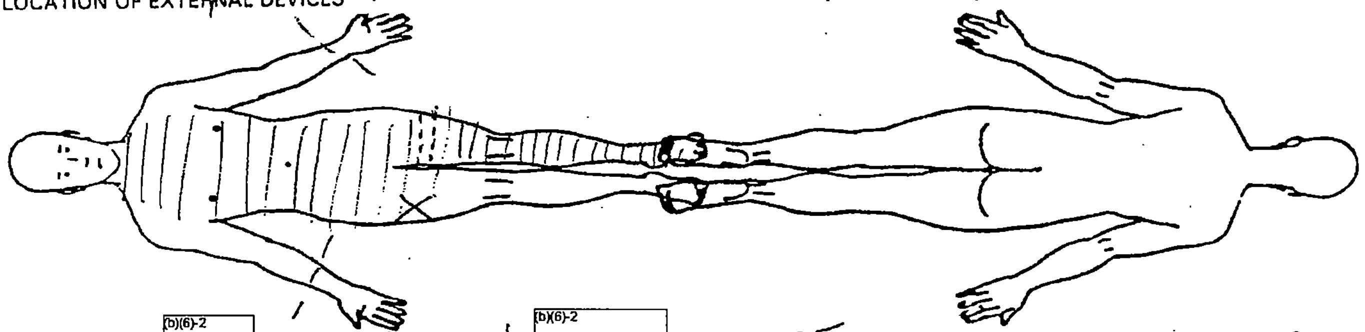
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR (b)(6)-2 ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS: Ø nicks/cuts

PREP SOLUTION *(Specify)* Beta/Beta (Brandt's Sol on leg)
SITE: ABD - neck to pubis BY WHOM: Chase
SITE: Ⓛ leg - TQ to toes BY WHOM: Chase
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 by (b)(6)-2 === Tourniquet @ 275 for 17 /// - prep

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
Other	☒ Yes ☐ No	C	C	C		

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley lab
LOT NO: 10527 exp 03-10

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 6892

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 84, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU (b)(6)-2

15. X-RAY IN OPERAT IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 fr Foley	2.	3.
SITE	1. Bladder - in place on arrival	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
xeroform
fluffy
Kerlex

19. ADDITIONAL INFORMATION
Dr (b)(6)-2
Dr
Dr

Maj (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
1) Ex-Lap
2) Ⓛ knee I+D

21. PATIENT TRANSFERRED TO ICU TIME 2148 METHOD - litter

22. REGISTERED N (b)(6)-2 [illegible]

REVERSE OF DA FO USAPA V1.01

MEDCOM - 6893

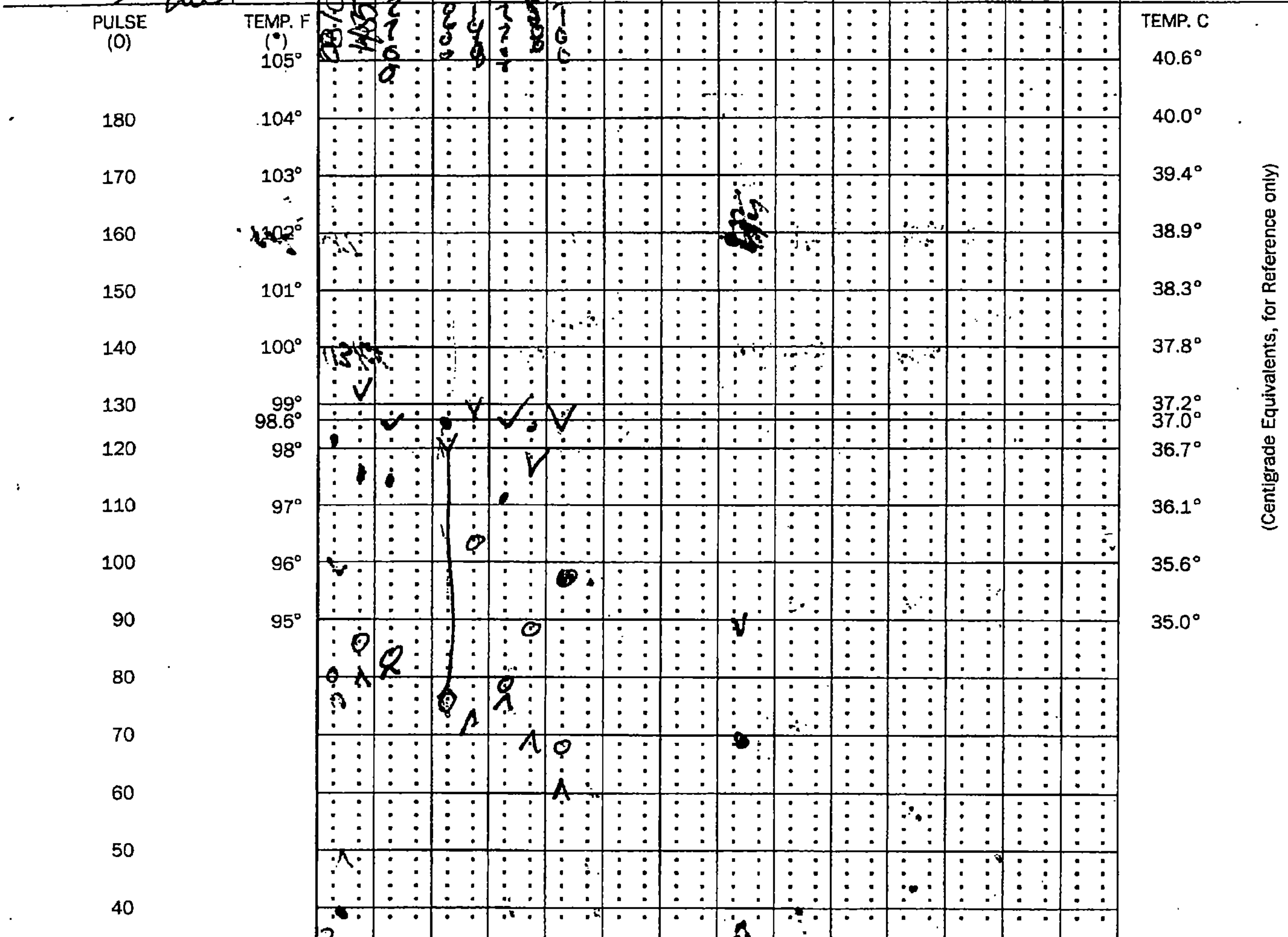
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	8			
POST- DAY				
MONTH-YEAR Jul	DAY 3		1	3
19 2003	HOUR [illegible]	[illegible]	[illegible]	[illegible]



RESPIRATION RECORD 20

Record special data only when so ordered

BLOOD PRESSURE	128/75	126/81	120/78	126/76	129/67
	132/81				
			124/71	118/70	
HEIGHT: / WEIGHT →		95	95	95	
	95/95		97	96%	98%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

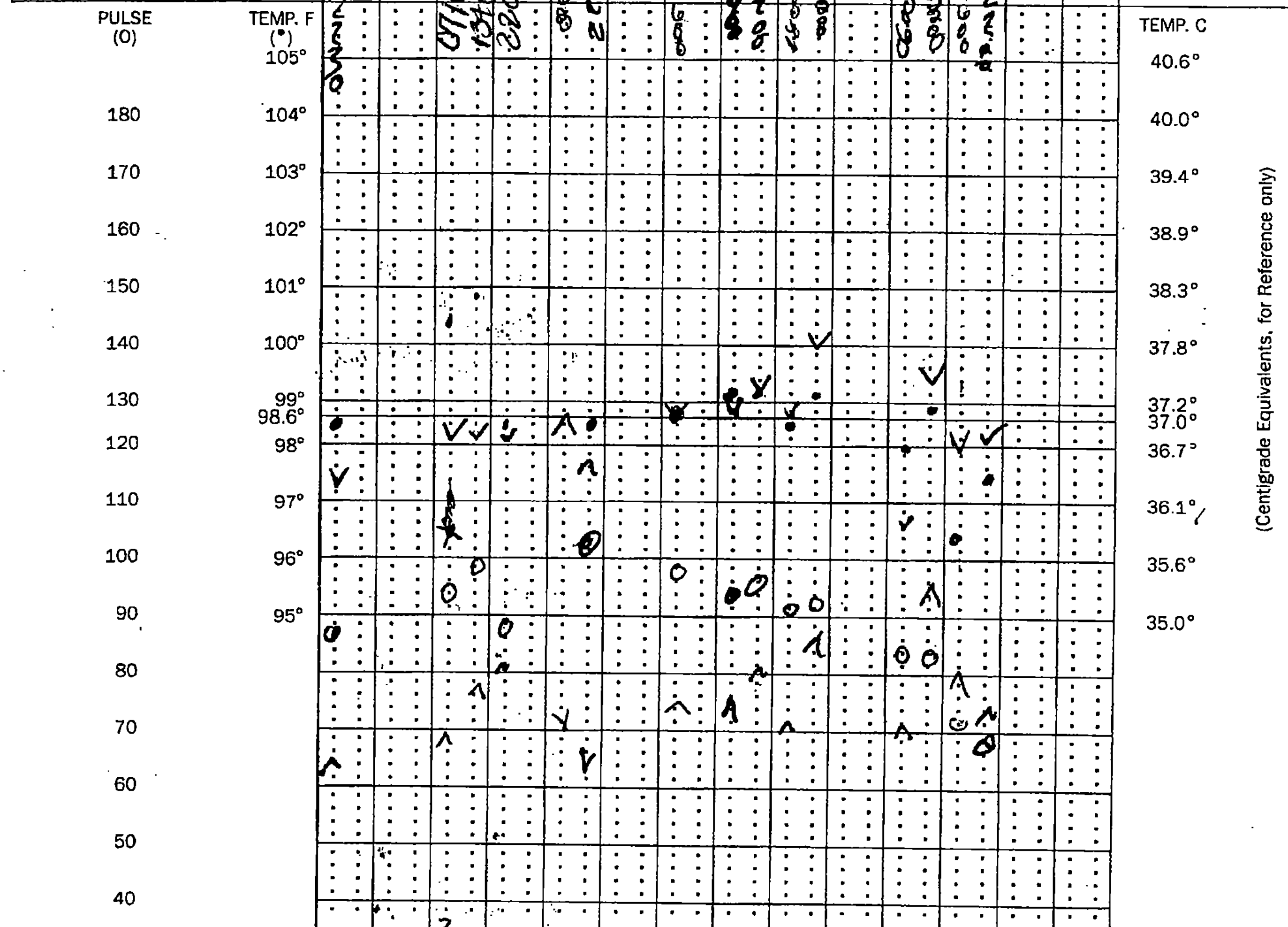
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6894

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	24		25		26		27		28		29	30	31	
MONTH-YEAR DAY	/						^							
19 HOUR	2330		0710 1340	2200	0800 2000		0600	1400 2200	1400 2000		0800 2000	0600 2220		



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	113/64		122/70 122/70	120/64	118/62		129/78	138/81	126/72 140/82		119/72 134/96	120/80 122/78		
HEIGHT: WEIGHT ⟶											99%	97?		
SpO2	92		94/	94	92		91	92 90	94%	94%	95%	95		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6895

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ________ HOURS
TO ________ HOURS
TOTAL HOURS COVERED
DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1400	water	500	500
1800	H_2O	500	1000
2100	H_2O	500	1500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2230	1000	NS	0253	1000	1000
0254	1000	NS	~~1000~~ 300	1030	1300
1630	1000	LR	600	1635	1900

IRRIGATIONS ~~(N/G, Bladder, etc~~) UOP

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1110	Foley (clr, yellow)	775	775
1635	Foley	300	1075

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC v1.00

(b)(6)-4

MEDCOM - 6896

Ward/Section: JCW	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4	DATE 1AUG03	TIME 1430	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	~~NEG~~ wr MOD.	Negative ACETEST: MOD
SG	1.030	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: WBC - 0-1 Amorph - Light
RBC - 5-10 mucus - Rare
EPI - Ø Bacteria - Few

Remarks:

Reported by:	(b)(6)-2	**DATE:** 01 Aug 03	**LAB ID NO:**

MEDCOM - 6897

(Subject to the Privacy Act of 1974)

LAST, FIRST (b)(6)-4

DATE 24Jul03

TIME

SSN/P (b)(6)-4

TEST	RESULT	REF. RANGE
WBC	14.7	[illegible]
RBC	4.86	4.7-6.1
Hgb	14.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.8	42-52% (M) 37-47% (F)
MCV	88.1	80-94 (M) 81-99 (F)
[illegible]	241	130-400 verified
Lymph %	10.6	20.5-51.1%

[illegible]

Segs		Mono	
Bands		Eos	
Lymph		Baso	
[illegible]		Imm	
RBC morph			

Hemoglobin Hematocrit		42-52% 37-47%
Sed Rate		
Other		

[illegible]

TEST	RESULT	REF. RANGE
PT	12.9	9.8-13.6 sec
APTT	28.1	21-34 sec
D dimer		<20 ug/ml
FSP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	~~NEG~~ 0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh A POS

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EACH UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS CBC, TYPE + Screen, PT PTT, UA

REPORTED BY: (b)(6)-2

DATE: 24 Jul 03

LAB ID NO.:

MEDCOM - 6898

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

DRUG	(Units)		TOTALS
Versed	(mg)	2	2 mg
Fent	(mcg)	250	250 mcg
STP	(mg)	350	350 mg
Sux // Vec	(mg)	100//6 4	100//10
MSO4	(mg)	4 3	7
	( )		

TOTAL EBL: min

TOTAL URINE: 200

VOLAT AGENT: Iso % del / % e.t. X–1.5–1.5–1.5–1.5–1.5–X

AIR L/Min

N2O L/Min

O2 L/Min X–8–2–2–2–2–2–2

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS

FLUIDS — LINE site: AS ☐ Warmed (1000)

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS

URINE – 200

FLUIDS – SUMMARY

CRYSTALLOID– 1800

COLLOID– Ø

BLOOD– Ø

PHYS STATUS: 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT: 85 [✓ KG] LB

HEMATOCRIT:

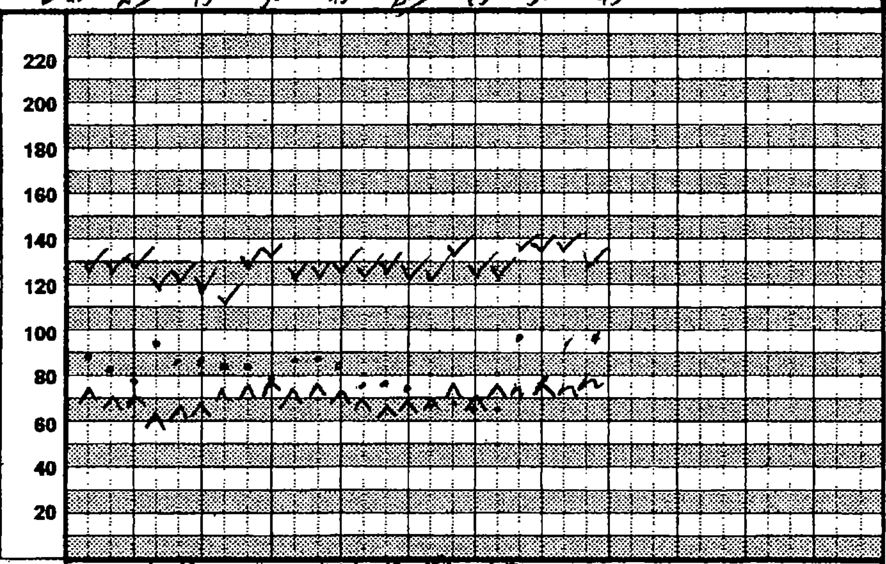
INITIAL DATA: BP – 124/80 R-24 HR– 106

EQUIP CHECK: OK? – [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 1945

TIME → 15 2000 15 30 45 2100 15 30 45

SYMBOLS: BP by cuff ∨ ∧ Heart rate ● Resp rate BP (transduced) TOURNIQUET T – ✗ ANES– X-X PROC– ⊙ – Ø



VT – ml	1000	1000	1000	1000	830	650		
f – breaths/min	10	10	8	8	8	8	11	
Peak inf pres / PEEP	20	20	21	20	21	18		
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S
ET CO2 (torr)	(+)	30	30	29	28	26	30	(+)
FIO2 (Frac or %)	.92	.92	.92	.92	.92	.91	.92	.92
SpO2 (%)	98	97	97	99	99	99	99	99
ECG	SR	SR	SR	SR	SR	SR	SC	
TEMP- site								
N-M Block (T/4)	0/4 4/4	1/4	3/4			4/4 EST		

MONITORS / ACCESSORIES: BP/Auto Cuff, BP / oth, ART line, Steth- PC/ES, Gas analyzer

Tourniquet @ 275mm Hg ↑——↓ total time 17 mins

Warming blkt

Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ○—

REMARKS– Code drugs with numbers, events with letters

1945 pt ID'd; plan of care reviewed c pt

1950 In Rm Monitor O.

1957-1959 Induction & Intubation

2050 Complet DPL

2105 started Ⓛ Knee

2140 pt SV c good TV pt Extubated c pos. pres

RECOVERY AT 2145 [✓ PACU] ICU ______ (Specify)

OTHER ______

CONDITION: Stable T-96.1 RESP– 14 SpO2– 97 BP– 125/65 HR– 104

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1945	1950	2145
	Ready	**Begin**	**End**
PROC	2000	2020	2125

PROCEDURES and CPT Codes

DPL / Ⓛ Knee Debridment

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DLX1 c 4MAC Visulized Cords; Intubated c 8.0 ETT to 21cm@lip Bilat BS; ETCO2 X5 Waves, Eyes taped

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 MAJ (b)(6)-2 AN, CRNA Nurse Anesthetist

PROCEDURE LOCATION Iso 1-1

DATE 24 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 6899

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~40 DAYS MOS [✓ YRS]   Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 82 [✓ KG]/LB HT: 170cm ~~IN.~~
ALLERGIES: NKDA

PROPOSED PROCEDURE: Ex Lap / (L) knee
SURGICAL SERVICE: Gen/ortho
NPO SINCE: H2O

HABITS:
TOBACCO: (+) 2-4 cigs/day
ETOH: soc
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Toradol 30mg 1630
( ) MSO4 10mg 1553
( ) Ancef 1g 1558
( )
( )
(✓) Takes Zantac + other med for GERD

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: /
U/A:
OTHER:

146 | 109 | 12 / 3.6 | 26 | 1.0 < 102
14.7 > 14.1 / 42.8 < 241
PT = 13 PTT = 28

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	- Colonic pain / bloating
Hiatal Hernia	[✓ N] Y	+ diarrhea - periodically
PUD/GERD	~~N~~ [✓ Y]	- Ulcer hx (+) GERD
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	N/A
Other Significant Hx:		
	[✓ N] Y	
	[✓ N] Y	
Familial HX	[✓ N] Y	

Shrapnel wounds back, (L) shoulder + (L) knee from Mark 19 grenade.

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION 90% RA
BP 128/80 HR 106 R 24 T ___
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
4FB TMD+ TMJ/Neck FROM
Oropharynx MP 2
Nares patent
CHEST: CTA (B)
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: 14g RAC
Ulnar Filling: 18g R wrist
BACK:
OTHER:

NPO Since 1800 water

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {✓} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patie(b)(6)-2 tand and agrees. Questions answered.
Signed: CPT/CRNA Date: 24 JUL 03 Time: 1905 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{✓} NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signe(b)(6)-2 CPT/CRNA Date: 25 JUL 03 Time: 0915 Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

(b)(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DO
MEDCOM - 6900
Previous edition is obso
☆ U.S. GPO: 2002-77

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/24 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Adm. P ICU
(2) VS q1°
(3) Strict I+O
(5) NPO
(6) No pain meds
(7) ~~dressing to wounds~~
(8) LR @ 150 cc/h.
(9) CBC at 2000

(b)(6)-2

1800

DATE OF ORDER TIME OF ORDER ________ HOURS

24 JULY 03 (b)(6)-2
ADMIT ICW C/O
DX FRAGMENT WOUNDS (L) KNEE
BACK & FACE
COND STABLE
VS ROUTINE
ACT EPW RESTRAINTS - OOB c̄ AID

DATE OF ORDER TIME OF ORDER ________ HOURS

NKA
REG DIET
LR @ 75 cc/HR - HEPLOCK WHEN PO OK
D/C FOLEY @ MN - STR CATH Q6° PRN
ANCEF 1 GM IV Q8° x 3 DOSES
MS 2 MG IV Q15' PRN UP TO 16 MG/4 HR
PERCOCET 1-2 PO Q4° PRN

DATE OF ORDER TIME OF ORDER ________ HOURS

PHENERGAN 25 MG IV Q8° PRN
TYLENOL 650 MG PO/PR Q4° PRN
IS Q1° W/A

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

(b)(6)-2

24° chart ✓ 25 Jul 03 @ 0100

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6901

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

noted 1430 25 Jul 03 LG

(b)(6)-2

DATE OF ORDER 25 JUL 03 TIME OF ORDER 1430 HOURS

LIST TIME ORDER NOTED AND SIGN

① Percocet i - ii tabs po q 4-6° prn pain (b)(6)-2

VO: Dr. [redacted] / LG (b)(6)-2

24° chart ✓ 26 Jul 03 @ 0024 (b)(6)-2 RN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 27 Jul 03 TIME OF ORDER 1335 HOURS

Give Zantac 150 BID po

(b)(6)-2

COL, MC

(b)(6)-2

27 Jul 03 1350

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

27 JUL 03 1630 HOURS

① Maalox or Mylanta 30cc po q4° prn indigestion.

(b)(6)-2

(b)(6)-2

27 Jul 03

27 JUL 03 1930

① ~~Dulcolax~~ Biscodyl p.R. x I now.

(b)(6)-2

(b)(6)-2

27 Jul @ 1930

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

24° chart ✓ 004 28 July

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6902

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

↓ DATE OF ORDER 7/27 TIME OF ORDER 0730 HOURS | LIST TIME ORDER NOTED AND SIGN

① D/c Foley (b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 Jul 03 @ 0015 24° chart ✓ TIME OF ORDER (b)(6)-2 HOURS

2 40 chatcheck 1 AUG 03 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 1 Aug 03 TIME OF ORDER 0930 HOURS (b)(6)-2

(1) CXR

(2) UA

(b)(6)-2

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8/3 TIME OF ORDER 1000 HOURS

(1) D/c when picked up by MPs (to custody)

(b)(6)-2

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6903

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	24	25	26	27	28	29	30	31	1	2	3			
24[illegible]	(b)(6)-2	VS - Q1°	05														
			17														
24[illegible]		Strict I&O	05														
			17														
24[illegible]		NPO	05														
			17														
24[illegible]		No Pain Meds	05														
			17														
24[illegible]		Dressing to Wounds	05	/	(b)(6)-2							(b)(6)-2	(b)(6)-2				
		Change (Nursing)	17	/													
24	(b)(6)-2	Vitals Routine	6	/	(b)(6)-2								(b)(6)-2				
			14	/													
			22	[illegible]									(b)(6)-2				
24	(b)(6)-2	Activities Ē Pw	6	/	(b)(6)-2							(b)(6)-2					
		Wrist Restraints	14	/													
		OOB TID	18	[illegible]									(b)(6)-2				
24	(b)(6)-2	Regular Diet	7	/	(b)(6)-2							(b)(6)-2					
			12	/													
			17	[illegible]									(b)(6)-2				
24	(b)(6)-2	IS While Awake	6	/	(b)(6)-2							(b)(6)-2					
			18	/									(b)(6)-2				
[illegible] 0h		[illegible] DC 1300															

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS: Fragment Wounds

Dx: Shrapnel (L) Knee Back and Face

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 6904

Verif. by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 7 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 Jul	(b)(6)-2	CBC @ 2000	24 Jul	2000	2000	(b)(6)-2
24		Admit ICW c/o Granville				
24		Condition Stable				
	-----	D/C Foley @ MN	25 Jul		0100	(b)(6)-2
25	(b)(6)-2	NIO: PTV by 1000	1000	unable		—
27		NOW DTV by 1700	27 Jul		Done	
Aug 03		CXR NOW	1 Aug	NOW	0950	(b)(6)-2
Aug 03		UA	1 Aug	ASAP		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
24	(b)(6)-2	D/c Foley @ MN	
-----	-----	and Straight Cath	
-----	-----	q 6° PRN	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

MEDCOM - 6905

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				24	25	26	27	28	29	30 31	\	1	2	3			
24	(b)(6)-2	LR @ 50cc/hr 75cc/hr	6	/	(b)(6)-2					HL							
		HL when po OK	14	/							D/C'd 31 2003						
			22	lke	(b)(6)-2	(b)(6)-2											
27 Jul 03	(b)(6)-2	Zantac 150mg po	10	/	/	/	(b)(6)-2										
		bid	22	/	/	/											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
Dx: Shrapnel Wound Ⓛ Knee
Back
Face

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 6906

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* 7 *Yr.* 08

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
24	(b)(6)-2	Ancef 1 Gm IV q 8° x 3 doses	7/24	2300	2315	(b)(6)-2
			7/25	0700	0710	
			7/25	1500	1400	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
24	(b)(6)-2	MSO4 2mg IV 15' q 2° PRN up to 16 mg in 4 hours	7/24 2305 2mg	7/24 2345 2mg	7/25 0019 2mg	7/25 0123 2mg	7/25 0735 2mg (b)(6)-	25 Jul 2mg 1300	26 Jul 2mg 1330	25 Jul 2mg 2032	26 Jul 2141 2mg	26 Jul 2222 2mg (b)(6)-2	27 2mg 2031 (b)(6)-2	28 Jul 2mg 2220	~~1 Aug 0010 2mg~~
			(b)(6)-2					(b)(6)-2							
29	(b)(6)-2	Phenergan 25mg IV q8° PRN	7/25 0153 25mg (b)(6)-2	7/25 2131 25mg (b)(6)-2	26 Jul 2210 25mg (b)(6)-2										
		D/C				22									
24	(b)(6)-2	Tylenol 650mg PO PRN q4°	7/25 II 0149 (b)(6)-2	7/25 II 1135	25 Jul 1800	28 II 2012	29 Jul 0005 650mg po (b)(6)-2	29 Jul 0045 650mg	30 Jul @ 0100 (b)(6)-2						
25 Jul	(b)(6)-2	Percocet i - ii tabs po Q4-6° prn pain	7/25 II	7/26 0900 II	7/28 2300 II	7/27 II 2340	7/30 2000 II	7/31 II 2302	2 Aug @ 0004 2 tabs	3 Aug 0330 II (b)(6)-2					

USAPA V1.00

MEDCOM - 6907

Verify by Initialing

TI IC DOCUMENTATION CARE PL
(MEDICATIONS)

Mo. 07 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
27	(b)(6)-2	Enema P.R, X1 Now	27Jul	2000	2000	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
27Jul	(b)(6)-2	Maalox or Mylanta 30cc po Q4° prn indostigestion	27Jul 1650 [illegible] 30cc

USAPA V1.00

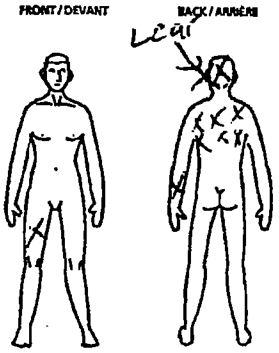
MEDCOM - 6908

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: JOHN DOE (b)(6)-4
RANK / GRADE: —
☒ MALE / HOMME
☐ FEMALE / FEMME
SSN / NUMÉRO MATRICULE: —
SPECIALTY CODE / GPM: —
RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT
A/T AF/A N/M MC/M
☒ BC/BC ☐ NBI/ENC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH
NATIONALITY / NATIONALITÉ: IRAQI CIV / EPW

3. INJURY / BLESSURE



☐ AIRWAY / TRACHÉE
☐ HEAD / TÊTE
☒ WOUND / BLESSURE
☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐ BURN / BRÛLURE
☐ AMPUTATION / AMPUTATION
☐ STRESS / TENSION
☐ OTHER (*Specify*) / AUTRE (*Spécifier*)

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
☒ ALERT / ALERTE
☐ VERBAL RESPONSE / RÉPONSE VERBALE
☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS
TIME / HEURE

6. TOURNIQUET / GARROT ☒ NO / NON ☐ YES / OUI
TIME / HEURE

7. MORPHINE / MORPHINE ☒ NO / NON ☐ YES / OUI
DOSE / DOSE
TIME / HEURE

8. IV / IV
TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRÉSENTE MÉDICATION / ALLERGIES / ANTIDOTES

BP 120/90
P 64
R 12

Lungs: CTA B [illegible]
ABD: NTTP soft
[illegible] s, s. [illegible]

10. DISPOSITION / DISPOSITION
☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
☒ EVACUATED / ÉVACUÉ
☐ DECEASED / DÉCÉDÉ
TIME / HEURE

(b)(6)-2
(b)(6)-2

DATE/DATE (YYMMDD): 03 07 20

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 6909

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	1400	1420.		
BP / PS	120/90	116/76		
PULSE / POULS	64	92		
RESP / RESP	12	22		

DATE / TIME
DATE / HEURE

**13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES**

SHRAPNEL TO BACK,
HEAD Ⓛ EXTR : Ⓡ
THIGH

**14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE**

① DRESSING
② IV NS 14g Ⓡ AC
TKO
③ TORADOL 30mg IVP

15. (b)(6)-2 [redacted] , PA.

DATE/DATE (YYMMDD) 030724

16. DISPOSITION
☐ / RETOUR À L'UNITÉ
☒ EVACUATED / EVACUÉ
☐ DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX

☐	BAPTISM / BAPTISÉ	☐	PRAYER / PRIÈRE
☐	ANOINTING / ONCTION	☐	COMMUNION / COMMUNION
☐	CONFESSION / CONFESSION	☐	OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

MEDCOM - 6910

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6

(b)(3)-1

2. [illegible]ION *(State or Country Code.)*

7	8

3. REGISTER NUMBER

9	10	11	12	13	14	15

(b)(6)-4

NAME *(Last, First, Middle Initial)*

(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

7. AGE AT ADMISSION

27	28	29
4	0	Y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION
UNK

10. LENGTH OF SERVICE

32	33	34

ETS
N/A b(6)-4

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

(b)(6)-4

ORGANIZATION *(Active Duty Only)*
N/A

13. MARITAL STATUS

46
U

HOUR OF ADMISSION
1540

BRANCH / CORPS
N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY EPW

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION *(State or Country Code)*

62	63
[redacted]	[redacted]

b(3)-1

18. MOS

64	65	66	67	68	69	70

19. TRAUMA b(6)-4

71
0 9

PREV. ADMISSION
YEAR
☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD
ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
2	8

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(YYYYMMDD)*

81	82	83	84	85	86	87	88
2	0	0	3	0	8	0	2

24. CLINIC SVC - ADMITTING

89	90	91	92
A	B	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(YYYYMMDD)*

99	100	101	102	103	104	105	106
2	0	0	3	0	7	2	4

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

b(3)-1

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(YYYYMMDD)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: FRAGMENT WOUNDS
L KNEE/ BACK/ FACE

DX-87340
8760
Trauma-1 8910
Injury-449 E9919
5411
PR-8622

(b)(6)-2

(b)(6)-2
COL, MC

SIGNATURE OF ADMITTING CLERK
(b)(6)-2
PFC, 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 6911

(b)(3)-1

TIENT 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: M
5. AGE:
6. RACE: X
7. RELIGION: 9
8. LENGTH OF SVC: N/A
9. ETS: N/A
10. PREVIOUS ADMISSION: NO
11. FMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION: N/A
14. WARD: ICW
15. FLYING STATUS: N/A
16. RATING/DSG:
17. DEPT./BEN: ~~A11~~ K78
18. BRANCH/CORPS: N/A
19. UIC/ZIP:
20. TYPE CASE: BI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM E.R.
22. HOURS OF ADMISSION: 0830
23. CLINIC SERVICE: AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
25. TYPE DISPOSITION: XFER TO EPW HOLD
26. DATE OF DISPOSITION: 26 JUL 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
27b. TELEPHONE NO.:
28. DATE OF THIS ADMISSION: 09 JUL 03
ADMITTING OFFICER: DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
30. DATE OF INITIAL ADMISSION:
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:
31. SELECTED ADMINISTRATIVE DATA:

☐ Check if Continued on Reverse

33. CAUSE OF INJURY:
34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: ~~SPP~~ GSW TO LEFT CHEST
HEMOPNEUMOTHORAX
PULMONARY CONTUSION

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	17	17

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		0	0	17	17

SIGNA

(b)(6)-2 COL, MC

(b)(6)-2
(b)(6)-2 PAD, NCOIC, PAD

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 6798

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

~30 yo Iraqi ♂ GSW chest
By report, tried to assault CP and was shot
CT placed, had 100cc upon arrival to (b)(3)-1
CXR c̄ T/T pulm contusion ∅ PTX ∅ HTX
unknown med hx

PHYSICAL EXAMINATION

120/50 P 100
c/o mild pain, hydrated
Chest ↓Ⓛ R CTA
CV tachy rr
Abd: ∅ gross peritoneal signs
Ext: moving x4

PROGRESS *(Enter date of discharge and final diagnosis)*

A/ GSW chest stable
pulm contusion/injury

P/ Stabilize ICU
serial exams

(b)(6)-2

	DATE 7/8	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL
RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

32

(b)(6)-4

MEDCOM - 6799

BSD #-1

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0830	MALE IRAQI EPW W/GSW TO CHEST ARRIVED VIA medevac - PT had
	CHEST TUBE IN ON ARRIVAL - INITIAL INJURY 0520
0833	NRB MASK - 100%
0836	FST EXAM - PLEUR-EVAC SET UP - ULTRASOUND
0837	IV Ⓛ AC
0839	4mg MORPHINE
0839	Chest X-RAY
0840	2nd line IN Ⓡ FOREARM - GPL Blood drawn for LAB
0841	ROLLED ON SIDE BACK EXAMINED - Ⓛ upper chest wound ⊖ RECTAL BLEEDING
0844	LABS SENT W/REQUEST BLOOD TRANSFUSION 2 UNITS
0846	1g Ancef AND .5 TETNUS
0848	VENUS Blood GAS AT 37C
	Na 141 mmol/L ph 7.282
	K 4.0 mmol/L pCO2 49.2 mm Hg
	TCO2 25 mmol/L PO2 79 mmHg
	KA 1.23 mmol/L HCO3 23 mmol/L
	Hct 40% PCV BEecf 4 mmol/L
	Hb 14g dr SO2 94%
0848	2 BAGS OF WARM LR
0850	BP 129/53 P-99 R-30 PO2-100
0850	Foley IN - URINALYSIS TO LAB - CLEAR yellow Fluid
0855	PT Rolled ON Ⓡ SIDE -

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6800

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0855	Chest X-RAY KUB
0856	TEMP 97.9ebl
0857	PLEUR EVAC - 60 blood
0900	P-104 BP 126/65 PO2 99% R-28
0900	4-mg morphine
0905	P-101 BP 126/81 PO2 100% R-28
0912	P 101 BP 99/67 PO2 96 R-28
0915	P-107 PO2 99 R-36
0918	PLEUR-EVAC -95ebl blood
0918	TUBING shortened from tube to Pleur Evac - R-28
0920	117/55 R-28 P-
0920	PT moved to OR
0922	PLEUR EVAC 100ebl blood
Nurses Note	Pt arived consciaus and verbal (Arabic) answred question appropriatly Obvious distress, Eyes perrla, lungs CTA on Ⓡ side. Left side deminished c̄ crepitus at entrance wound, Entrance wound in Ⓛ chest ≈ 3 or 4 i-costal space bitwen sternal margin and Mid clavicular line. Chest tube on Ⓛ side 200 cc out by transport to ICU. Abd Hard, tender on Ⓛ side mid axilary at level of umblicus. Pelvis stable, legs normal, pulls & neuro intact. Fole place 100 cc return. 18 g IV × 2 (Ⓛ AC Ⓡ wrist) 4mg morphine total Ancef 1gm, TD Toxoid .5, O² NRB at 15Lpm. Pt has intense pain on Ⓛ chest & abd. (broken rib, possible Abd bleed) ← (b)(6)-2

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 July 03	Iraqi received gunshot wound to upper Ⓡ chest -
0638	Entry/Exit wound - PT injured @ 0520.
BP: 110/60	1st IV started of Sodium-Chloride on Ⓡ AC. 2nd IV of
P: 85	Lactated Ringers started @ 0654 on Ⓛ AC. PT appears to
Resp: 24	be verbal. PT wound was cleaned with Betadine. PT
	given Xylocaine c̄ Epi on Ⓛ side. 2mg of Morphine
0650	given @ 0729. PT given another 2mg of Morphine @
BP: 120/60	0723. Incision made on Ⓛ side under armpit.
P: 100	Chest Tube entered on Ⓛ side @ 0736. PT received
Resp: 30	stitches in area where incision was made. A seal was
	made @ the base of the chest tube. Suction
	apparatus started @ 0748. Chest seal applied @
	0752 to Ⓛ side of back, flutter valve applied to
	front Ⓛ of chest.
	♂ GSW Ⓛ chest, 32f CT placed all we
	had, large blood CT clamped the CT clotted
	No large syringe to flush CT. left in place
	A/P Ⓛ hemopneumothorax c̄ likely clotted CT
	will transfer to CSH to replace CT.
	PT stable for transfer MSgt Caylo
	(b)(6)-2 [redacted] (b)(6)-2 [redacted] Do (b)(3)-1 [redacted]

HOSPITAL OR MEDICAL FACILITY	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

IRAQI EPW

(b)(3)-1 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE

9 Jan 03 0930 Nursing Patient admitted via OR to ICU S/P GSW to upper Ⓡ Chest. Transferred from litter to bed c̄ assist of 4. Patient placed on O2 at 100% c̄ 100% Non Rebreather, ECG leads placed c̄ Monitor Showing Sinus Tachycardia s̄ ectopy B/P 123/54. C/O severe pain to Ⓛ flank area upon touch. Dsg'D noted to entry wound to Ⓛ Chest entry wound vaseline gauze secured c̄ 4x4 and silk tape. Exit wound c̄ large hematoma to Ⓛ Scapula covered c̄ Vaseline Gauze and ABD Pad, Secured c̄ Hypafix. IV's flushed to Ⓡ Wrist 18G c̄ LR infusing 18G to Ⓛ AC. c̄ LR infusing, patent, Dressings changed. Foley emptied 150 cc of clear yellow urine. Ⓛ CT Dsg changed c̄ Vaseline Gauze secured c̄ 4x4 and Hypafix. Noted 128 cc of bloody drainage marked @ 0930 by Dr (b)(6)-2 No other injuries noted to lower extremities or upper extremities. Further assessments as per DA Form 4700. CT to 20 cm Continuous suction. Plan ① Medicate for pain as needed, ② Observe for further injuries to abdominal area, assess for distention and rebound tenderness, ③ Note for enlargement of hematoma to exit wound site and call Dr (b)(6)-2 for increased change. (b)(6)-2

1000 Patient c/o severe Ⓛ side pain. Medicated c̄ 4 mg Morphine IVP. Patient resting at 1030. O2 at 100% on VM 50%. Remains in ST c̄ rate 80's. Entrance Wound Dsg D+I. Exit Wound dsg D+I. Will cont monitor (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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

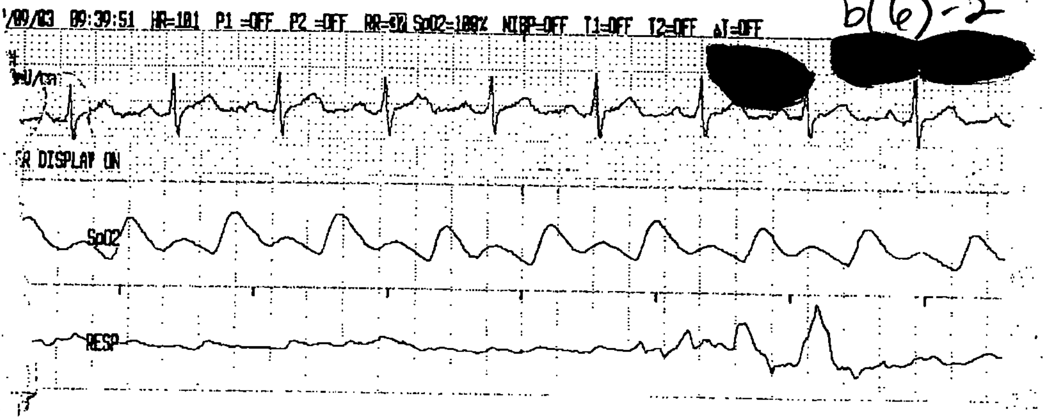
(b)(6)-4

MEDCOM - 6803

PROGRESS NOTES

DATE

b(6)-2



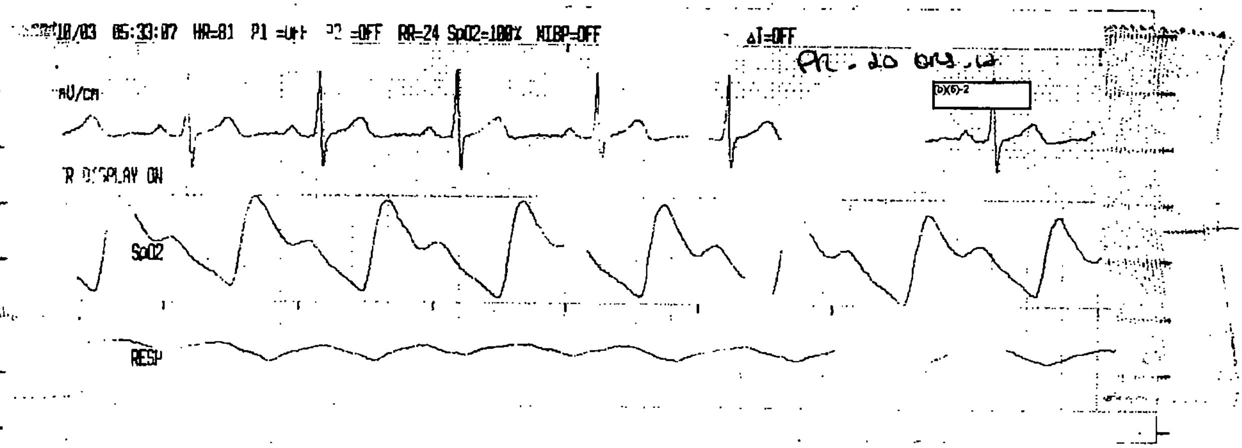
1/09/03 09:39:51 HR=101 P1=OFF P2=OFF RR=37 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
mV/cm
R DISPLAY ON
SpO2
RESP

[redacted]

09 Jul 03 1000	CBC drawn and sent. Patient denies pain at this time. Resting in Supine position. Remains in NSR ——— (b)(6)-2
09 July 03 1400	CBC results reported to Dr. (b)(6)-2. IVF decreased to 150cc/hr. ~~EK~~ Site to (R) wrist s̄ redness or drainage. Patient turned and positioned to (R) side. Encourage to use Incentive Spirometer elevating 2 balls. Denies pain at present (b)(6)-2
09 Jul 03 1600	CBC drawn + sent. Incentive Spirometer performed c̄ elevation of 2½ balls. ~~Medication c̄ 2mg Morphine~~ for pain. Remains in SR c̄ rate in 90's. O2 sats 100% on 4L NC. Dsg to external wound [illegible] wound dry and intact. Will monitor ——— (b)(6)-2
1700	CBC Returned Hgb 12.4 / HCT 38.3. Results reported to Dr. (b)(6)-2 Morphine 4mg signed over to CPT (b)(6)-2 Patient remains in NSR c̄ 80's. Will continue to monitor. (b)(6)-2
1745	Report received From MAJ (b)(6)-2, 4mg MSO4 received from her also. Pt. resting in bed c̄ HOB @ 30°. No pain noted @ this time. ——— SPC (b)(6)-2
1930	Pts. SaO2 has remained >97% since O2 was turned off at ~~1800~~ 1905, will continue to monitor ——— SPC (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 July 2115	Pt. given 4mg MSO4 for pain c̄ ⊕ effect. USS ——— SPC (b)(6)-2
2300	Pt. resting quietly in bed, easily awoken. SPC (b)(6)-2
10 July 03 0140	4mg MSO4 given for pain. O2 was put back on 2LPM via NC for SaO2 ~~sats~~ of 92%. SaO2 rose to 97% Will continue to monitor — SPC (b)(6)-2
0340	Blood drawn for pts. CBC, 0 c/o pain @ this time. USS ——— SPC (b)(6)-2
~~1730~~ 0530	Report and 4mg MSO4 given to MAJ (b)(6)-2 for pt. ——— SPC (b)(6)-2


10/03 05:33:07 HR=81 P1 =OFF P2 =OFF RR=24 SpO2=100% NIBP=OFF
ΔT=OFF
mV/CM
R DISPLAY ON
SpO2
RESP
(b)(6)-2

10 July 03 0530	Nursing: Received report from SPC (b)(6)-2 Received 4 mg MSO4 via telephone and patient given 3 mg IVP for c/o Ⓡ sided pain. IVF: LR infusing via Ⓡ wrist @ 50cc/hr. Ⓛ A/C flushed s̄ infiltration. Patient lying on Ⓛ side with bed roll for support. Chest tube to 20 cm suction as ordered. CT dressing site s̄ redness or drainage. Entry

(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
Medical Record
STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE

wound dressing to Ⓛ upper chest area dry and intact. Exit wound to
Ⓛ Scapula area dry and intact. Foley to gravity draining
clear yellow urine. Remains in SR ō ectopy. Plan: Continue to encourage
incentive spirometer q 1° for elevation of 3 balls ② Change
dressings to chest tube sites and entry + exit wounds ③ Sit patient
up in bed + turn + position q 4°. (b)(6)-2 MAJ
Further assessments as per DA Form 4700 (b)(6)-2 MAJ, A

10 Jul 03 0700 Foley discontinued at 0700 as per Dr (b)(6)-2 Patient given
complete am care ō hygiene. Dsg's changed to entrance + exit wound.
Will monitor. (b)(6)-2 MAJ

10 Jul 03 0830 Patient medicated ō 4mg Morphine IVP for c/o Ⓡ side pain. Assisted
OOB to chair and ambulated 100 feet on RA. O2 sats upon
return 91%, placed on 2L N/C. Using IS elevating 2 balls ~~ō assist~~
Sitting up ō assistance in chair, CT to 20cm suction (b)(6)-2 MAJ

10 July 03 Nutrition Note
1830 O: 30 y/o Iraqi male Dx: S/P GSW
Diet: CL advance to regular WT: estimated 80 kg
A: Pt at ↑ nutritional risk 2° GSW, diet
advancing to regular. additional supplements
will help promote recovery/healing.
P: 1) Will provide EIB TID to supplement intake
2) Will monitor intake and make recommendations PRN
(b)(6)-2 MAJ, SP RD/LD

10 Jul 03 1045 Patient c/o pain. Medicated ō Morphine IVP 4mg. Assisted back
to bed ō two person, patient tolerated activity well placed on 4L NC
for sat of 91%. Resting at 1100 (b)(6)-2 MAJ

10 Jul 03 1200 Patient given regular tray. Ate 1/3 of contents. Sleeping peacefully.
Dsg's to chest tube, chest entrance wound D+I. (b)(6)-2 MAJ

PROGRESS NOTES

DATE	
0300	Pt sleeping – VSS CT to LCS <5cc output since 2200 LR still infusing 50 cc/hr into R wrist IV cath Ø infiltration noted —— (b)(6)-2
0400	Pt sleeping Ø c/o pain CT to LCS minimal drainage Tube checked for patency (not kinked) Pulse ox 98% 4L NC – will continue to monitor —— (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

(b)(6)-4

MEDCOM - 6807

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
10 July 03	Patient ~~states~~ c/o pain at chesttube insertion site. Medicated c̄
1410	Morphine 4mg IVP. O_2 Td to 4L N/C. [redacted]
10 July 03	Patient stated to nursing inability to void. Unable to use
1530	urinal. C/o pain at chest tube site, reported to Dr [redacted],
	Toradol 30mg IV ordered now. Given as ordered. Will monitor [redacted]
10 July 03	Dr [redacted] + Dr [redacted] as needed. Using IS c̄ 2½ balls
1620	elevated. Patient expressing relief from pain. Reported
	patient's inability to void. Dr [redacted] stated he would
	return to perform ultrasound. No orders written to
	reinsert Foley. [redacted]
10 July 03 1700	Patient report given to SGT Love. Patient ~~refuses~~ to eat dinner
	Will attempt other choices. Pressure dressing and exit wound
	dry and intact. No void at this time. Signed over 8mg
10 July 03	Morphine IVP to SGT [redacted] No other issues noted. [redacted]
1730	Report recieved: Pt awake A&O Pt c̄ evening meal
	attempting to eat - Vital Signs Stable see flow sheet - Pt
	given mixed nuts and water instead of meal ⊕ intake
	Pt Lungs CTA diminished bilat (LCS) Pulse ox 98% on 4LNC
	Chest tube to Ⓛ side 20cm suction - sm leak c̄
	water seal (Dr [redacted] aware) Dsgs to site CDI
	Δ'd today ∅ drainage noted from incision site
	IV access Ⓛ AC 18G cath patent and flushed
	Ⓡ wrist 18G IV cath infusing LR @ 50ml/hr.
	Pt afebrile T-98.7 Ⓣ

(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 [redacted]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE

1930 Pt c/o (L) heel pain – padding added
to lower extremities – Pt enc to drink
fluids no void since foley d/c'd @ 0800
this am – no distension, no pain, no urge
to void – H2O at bedside – will continue to
monitor ——— (b)(6)-2

2130 1 Liter fluid bolus ordered per Dr (b)(6)-2
Pt still c̄ no void since d/c of
foley – Pt c̄ complaints of "ellam" non-
distended no urge to urinate (b)(6)-2

2230 Dr (b)(6)-2 in area – suction to chest
tube not on – unsure why suction not
working Δ'd suction apparatus CT output
since 1900 total of 30 cc serosanguinous.
Pt c̄ bilateral wheezes – albuterol treatment
ordered per Maj (b)(6)-2 / .2 cc albuterol / 5 cc
normal saline – Lungs Clear p̄ 1 X – wheezes prob related to kinked CT

2300 albuterol Treatment and Bolus done – Pt
standing at bedside attempting to urinate
950 cc dark yellow void – Vital Signs Stable
126/62 P-92 R-30 shallow Pulse Ox 98% 4L
NC ——— (b)(6)-2

2345 Pt eating orange, nuts small amt. of water
Chest tube to LCS Ø output this hour
——— (b)(6)-2

0100 Pt request pain med – pain at chest
tube insertion site – Vital Signs Stable
see flow chart Ø CT drainage

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6809

PROGRESS NOTES

DATE	
7/11/03	Repeated MSO4 2mg for continued pain.
1030	Will continue to monitor —— (b)(6)-2
7/11/03	Toradol 30mg IVP for pain.
1200	Will continue to monitor —— (b)(6)-2
7/11/03	Medicated c̄ Tylenol 650mg PO for HA
1500	Using IS, occasionally productive cough
	with old bloody mucous. Will continue
	to monitor. —— (b)(6)-2 CPT/AN
7/11/03	Ambulated patient on ward x10 minutes
1515	Tolerated well —— (b)(6)-2 CPT/AN
7/11/03	End of Shift note Ø change Report
1615	given to on coming Shift —— (b)(6)-2 CPT/AN
1730	Report received from CPT (b)(6)-2 at this
	time along c̄ 4mg MSO4. Pt. consumed
	100% of dinner, and is resting quietly
	in bed c̄ HOB @ 45°. c/o pain, 2mg of
	MSO4 given c̄ ⊕ result. —— SPC (b)(6)-2
1845	30mg Toradol given IVP in anticipation of
	pt. ambulation @ 2000 as well as pt c/o HA.
	VSS. —— SPC (b)(6)-2
2200	Pt. ambulated up and down ward x1, no apparent
	or verbal signs/symptoms of pain. Pt. also
	sat @ bedside for 1/2 hour. 3mg MSO4 given
	for pain when pt. returned to bed SPC (b)(6)-2
2245	Ⓡ wrist IV infiltrated, LR @ 50cc/HR to Ⓛ AC,
	Ⓡ IV DC'd, catheter was intact. —— SPC (b)(6)-2

MEDICAL RECORD | PROGRESS NOTES

DATE	
7/11/03 0500	Assumed care of patient. c/o pain to CT insertion site, medicated c̄ 4mg MSO4. —— (b)(6)-2 CPT/AN
7/11/03 0600	Continues to c/o pain @ CT. Medicated c̄ Toradol. Lungs have coarse BS bilat, using IS. chest xray done. BS hypoactive, Ø stool. Will get order for colace BID. Assessment completed. See DA 4700, critical care flowsheet. Plan to use toradol for pain control c̄ MSO4 for breakthru. Up to chair this am. Will continue to monitor —— (b)(6)-2 CPT/AN
7/11/03 0800	Linen + gown changed, up to chair for breakfast. Dressings D/I'ed, moderate drainage to exit wound on back, others c̄ minimal to Ø drainage. Am care done. Will continue to monitor —— (b)(6)-2 CPT/AN
7/11/03 0930	Back to bed, slight ↑ in CT output while in chair, 35cc past 2°. Medicated c̄ 2mg MSO4 for breakthru pain. Weaned off O2 currently 96% RA. Will continue to monitor —— (b)(6)-2 CPT/AN

(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
Medical Record

(b)(6)-4

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6811

MEDICAL RECORD	PROGRESS NOTES
DATE	
1241	Pt. resting quietly in bed, easily awakening, VSS. Will continue to monitor — SN (b)(6)-2
0320	Pt. c/o pain. 4 mg MSO4 given, ⊕ effect — SN (b)(6)-2
0500	3 mg MSO4 left c̄ for CPT (b)(6)-2 — SN (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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
7/12/03	Received Report, Assessment complete see DA
0530	form 4700, chest xray done Ø pain c̄ this
	time, will ask to switch ~~pt to~~ toradol
	+ percocet stop MS04, add colace 100mg BID.
	Will continue to monitor (b)(6)-2 CPT/ON
7/12/03	Up to chair x1 hour Am care + linen Δ done.
0830	At 30% breakfast + 1 carnation Instant Breakfast
	Shake. IV HL. Changed to Tylox PO, colace
	given. Will continue to monitor (b)(6)-2
7/12/03	new pleuravac container. (b)(6)-2 CPT/ON
0930	
7/12/03	Up to chair x1° for lunch, ate 50%. tolerated
1330	well, medicated c̄ tylox. (b)(6)-2 CPT/ON
7/12/03	Patient ambulated to ER and back. tolerated
1600	well up to chair now. (b)(6)-2 CPT/ON
7/12/03	end of shift note - Ø change. Report
1645	given to oncoming shift (b)(6)-2 CPT/ON
1715	Report received from CPT (b)(6)-2 Ancef 1G
	running to Ⓛ AC @ this time pt. up to bedside
	chair, ⊖ c/o pain @ this time. pt. seems to be
	having some epistaxis to Ⓡ nostril, will continue
	to monitor SPC (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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6813

PROGRESS NOTES

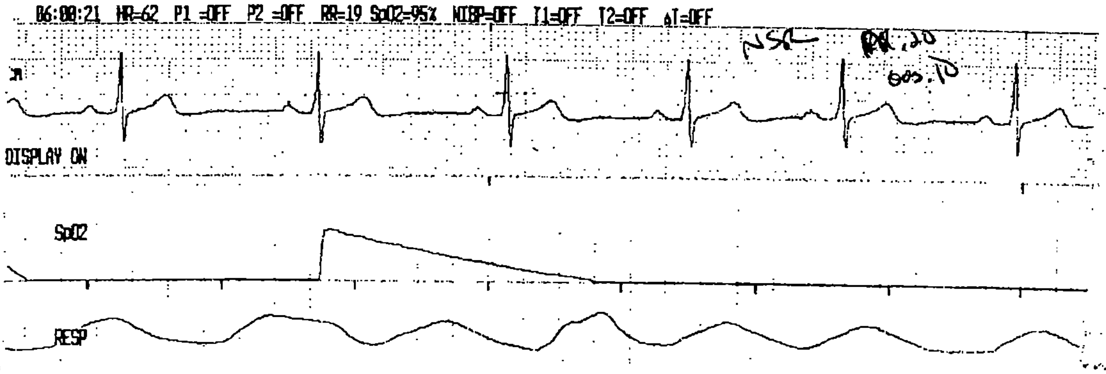
DATE	
12 Jly	Pt. ambulated up and down ward x1, while
1850	ambulating pt. developed a cough ī bloody
	secretions. ⊖ s/s of pain noted, ⊖ c/o pain either
	@ this time. Pt. returned to bed and asked
	for pain med. VSS. —— SPC (b)(6)-2
1900	2 cc's output from Ⓛ CT for a total of 40
	in container, 38 marked on container
	for 1600, 28 marked in DA 4700, ii Tylox
	given for pain @ this time —— SPC (b)(6)-2
2330	Pt. resting quietly in bed ī eyes closed, easily
	aroused. VSS —— SPC (b)(6)-2
0210	Pt. c/o pain. 30 mg Toradol given —— SPC (b)(6)-2
0500	110 cc's total Drainage to CT container. SPC (b)(6)-2
13 July 03	Reports received from SPC (b)(6)-2 Patient lying in Supine position-
0530	Xray taken and posted. Patient remains in SR s̄ ectopy via monitor.
	Smiles when asked questions due to language barrier. Denies pain at
	present time. O2 at 97% room air. Ⓛ Chest tube to 20 cm suction
	total output at this time 115. Heplock 18G to Ⓛ Arm site s̄ redness
	or drainage, dressing changed. Further assessments as per DA Form 4700
	ICU flowsheet. Plan: ① Encourage pulmonary ~~toilet~~ and assist WS
	to ambulate three times this shift. ② Medicate as needed for pain
	③ Change dressings to chest tube site and entry and exit
	wounds. —— (b)(6)-2
0630	Patient given complete am hygiene, dressing changed to entry wound
	ī vaseline gauze applied. Exit wound ī vaseline gauze applied
	Noted diameter is approx 1 inch ī serous brownish drainage at
	site. Chest tube dressing changed ī vaseline gauze reinforced
	Assisted WS to chair ī breakfast tray set up. —— (b)(6)-2

STA (b)(6)-2 EV. 7-91) BACK
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03 0730	Chest tube placed to water seal as per Dr (b)(6)-2 (b)(6)-2


06:00:21 HR=62 P1 =OFF P2 =OFF RR=19 SpO2=95% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
NSR
PR .20
QRS .10
DISPLAY ON
SpO2
RESP

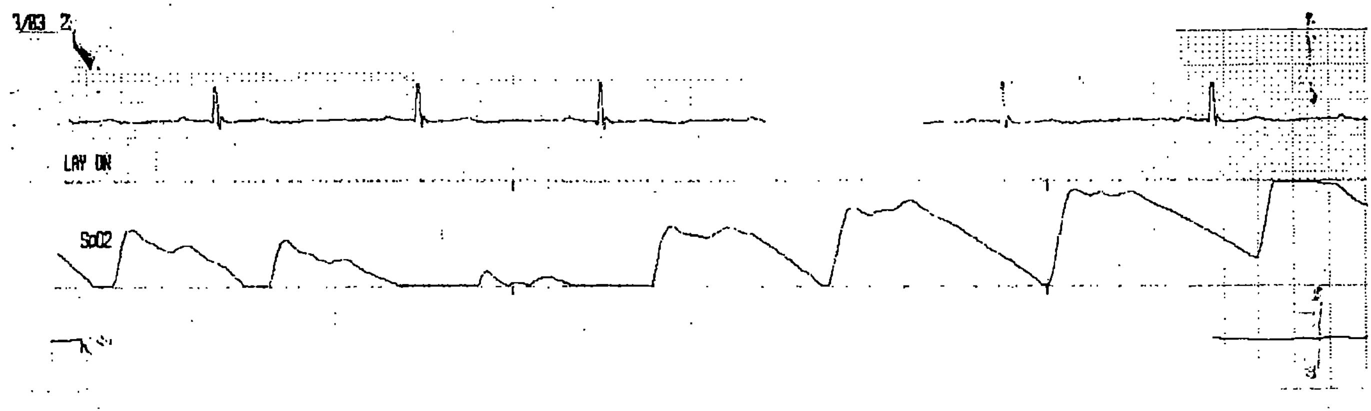
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03 0800	Patient ambulated 100 feet and assisted back to bed. c/o pain
	given Tylox 2 caps as ordered prn. (b)(6)-2
13 July 03 1000	Patient c/o Ⓛ shoulder pain. Passive ROM performed c̄ patient
	stating relief. Will monitor for further assessment (b)(6)-2
1200	Patient still c/o pain, given Toradol 30mg IV. assisted OOB to
	chair for lunch. Ate 3/4 of contents
1230	CX ray completed. (b)(6)-2
1400	Patient lying supine. No changes in assessment (b)(6)-2
1600	Physicians rounding at bedside. CX ray shows Pneumo-
	thorax. CT placed to suction O2 sat 93% on Room Air
	Will continue to monitor. (b)(6)-2
1700	Report given to SGT [illegible]. CT remains on suction 20cm. Patient
	sitting up s̄ complaints. O2 sat 93% on RA. (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO. 5	

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6815

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	13 July 03



1700	Report recieved: Pt sitting up in bed, NAD Vital Signs Stable 112/68 P-66 R-14 99% PO RA T-97.7 ⓞ CT to LCS (20 cm) CT line patent not kinked - Dsg to CT, wound, CDI - Heplock 18G IV cath Ⓛ arm patent and flushed - will continue to monitor ——— (b)(6)-2
1730	Pt assessment: Pt A+O - Perrl - Lungs clear Productive upper resp cough + BS x 4 quadrants abdomen soft - nondistended - Pt states will attempt BM soon - + peripheral pulses - no edematous extremities - no skin breakdown noted ——— (b)(6)-2
1800	Pt up to bedside commode - ⊕ BM large soft and formed - Pt ambulating and moving easily steady gait ——— (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
14 Jul 03 0700	Report received from SGT (b)(6)-2 pt resting c̄ head covered c̄ blanket. Given ii Tylox for pain discomfo Ⓛ CT to 20 cm H2O suction. Draining minimal bloody pink chest drainage. VS stable. HR 60, ∅ ectopy. RR 15. SaO2 97%. BP 98/58. ∅ respiratory distress noted. pt condition stable. Will continue to monitor — (b)(6)-2 MHJ
0715	awakened for assessment. Lungs Ⓑ CTA. Ⓛ diminish and unable to auscultated lung sound. c/o Ⓛ chest pain when asked to take deep breath. able to sit up s̄ assistance. Tender to palpation on Ⓛ chest area. Chest tube dsg dry & intact. poor inspiratory effort noted. no dyspnea noted. RR 18. SaO2 96% on room air. offered breakfast but denied eating @ this time. Will let pt rest for now. no other changes from initial assessment — (b)(6)-2 MHJ
0720	Ⓛ antecubital IV site free of signs of infection. checked for patency. unable to draw any blood but flushes s̄ any resistance. Ancef 1 gm in 100 ml NS IVPB infusing slowly. will infuse over 30'.
0800	IVPB completed. AM care done per self.
0900	pt sleeping. VS stable. (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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE

1900 Pt requesting pain medication 2 Tylox ii
administered for pain - CT still to
LCS minimal output VSS Pulse ox 99% RA
2100 Pt consumed 200 cc H2O ̄c resting in bed
talking ̄c interpreter about medical condition
possible allergy to perfume/cologne/fragrance.
Pt states through interpreter throat seems "itchy"
takes a pill back home "cortisone?" "steroid"?
Pt Lungs Clear, VSS Pulse ox 99% RA
will continue to monitor (b)(6)-2
2300 Pt sleeping VSS will continue to
monitor (b)(6)-2

0200 Pt requesting pain medication for pain
Ⓡ CT insertion site - Pulse ox 99% RA
Vital Signs Stable — Tylox ii
PO for pain — (b)(6)-2
0300 Pt sleeping Chest tube drainage < 30 cc
x 7 hours - VSS — (b)(6)-2
14Jul03@0600 Pt ↑ OOB, amb to new bed assignment ̄c steady, even gait
Ø c/o SOB or weakness. Lying in bed @ present. VSS. 98.1 T
P63 R16 BP 110/57 SpO2 97% on RA. CT Ⓛ to 20cm cont'
suction. Insertion site dsg CDI. Lungs ~~clear~~ CTA, productive cough,
⊕ use of IS. ⊕ bowel sounds. last BM 13 Jul p.m. Voids per
urinal. Cap Refills < 3 secs. SR @ 63 bpm. ⊕ pulses. Skin
w/d, intact. CXR done this a.m. HL in Ⓛ arm ̄s s/sx of
infx. Receives Ancef 1 g IVPB q 8° Will cont' to monitor (b)(6)-2 91WZL M6

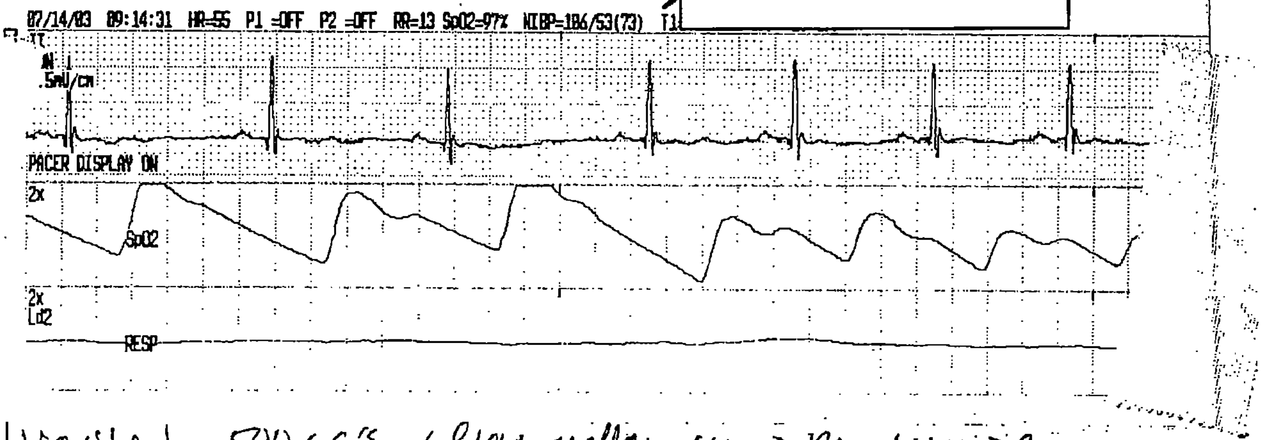
MEDCOM - 6818

STANDARD

MEDICAL RECORD | PROGRESS NOTES

DATE

14Jul03 0900 pain med effective. States pain is gone. (b)(6)-2 MAJ AN


07/14/03 09:14:31 HR=55 P1 =OFF P2 =OFF RR=13 SpO2=97% NIBP=106/53(73) T1
II
.5mV/cm
PACER DISPLAY ON
2x
SpO2
2x
Ld2
RESP

Voided 500cc's clear yellow urine per urinal —

1100. pt still asleep. VS stable. SaO2 96%
CT to 20cm H2O suction <20cc's within past
3°. HR 55, Ø ectopy, 94/42 RR16 SaO2 98%
Encouraged to use IS. able to raise all
three balls and hold for 1 sec. X 12. Small
amount of bright blood (epistaxis from Ⓡ nare).
will monitor. Temp 96.6 (b)(6)-2 MAJ AN

1130 Drsg s̄ done. ① post near scapula drsg
dry. old drsg removed. Wound approx. 2½
cm irregular wound edge s̄ erythema,
exudate, or odor. site cleaned c̄
betadine swab and rinsed c̄ saline.
Wound bed clean and dry. wet to dry -

(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 (b)(6)-2

PROGRESS NOTES MAJ AN

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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PROGRESS NOTES

DATE

14 July drsg. applied and secured it c̄ dry 4X4 and
1140 occlusive tape. Old chest tube drsg.
removed. Dry drg. tube site
free of drainage, erythema or
order. Tender to palpate. Small amt
of subcutaneous emphysema noted
near the tube site. Suture still
intact holding the tube. Site
cleaned c̄ betadine swab. occlusive
petroleum drsg applied around tube.
Secured it c̄ dry 4X4. occlusive
tape secured. Ⓛ anterior chest drsg
Δd. wound approx less than .20
cm and almost all healed & closed.
cleaned site c̄ betadine / rinsed c̄
saline. Small petroleum ~~gauze~~
gauze drsg applied. Secured it c̄
4X4 & tape. Chest tube still
remaining @ 20cm H2O suction c̄ minimal
↓t drainage. Lungs CTA bilaterally
Ⓡ > than Ⓛ. ↓ breath sound to Ⓛ
1200 lower bases. pt requesting pain
med for Ⓛ chest tube pain. pt able
to point to pain site. Tylox 2 capsule
given P.O. for pain. Will evaluate
for pain effectiveness. (b)(6)-2
HR 91 115/57 RR 57. SaO2 95%
1230 ate one orange. Refuse to eat regular food.
(b)(6)-2
(b)(6)-2

PROGRESS NOTES

DATE	
14 Jul 03	
1715	Report given to oncoming shift (b)(6)-2
1730	Pt alert and oriented, NAD, Vital Signs Stable
	106/44 P-66 R-16 Temp 98 ⓐ Lungs clear diminished
	in the left base +BS x 4 quadrants, +UO on day
	shift - Pt sitting in chair reading magazine
	Chest tube to low cont. suction, minimal output
	reported from dayshift tube patent 20cm suction
	Dsg's Clean, Dry and intact —— (b)(6)-2
1800	Pt consumed 1/2 of dinner chicken stuffing, and cake
	oral intake 150cc H_2O — (b)(6)-2
1830	Pt requested pain medication. CT insertion site ?
	Tylox x ii —— (b)(6)-2
2000	Toradol 30mg IVP for breathing pain [illegible]
2100	Pain ↓ - Pt would like something to
	make him sleepy - I believe client is
	requesting pain med for IVP, most effect
	most IV ordered has been d/c'd - will ask
	Dr (b)(6)-2 for sleep aid for client
	—— (b)(6)-2
2130	10mg ambien ordered for sleep (b)(6)-2
2300	Pt sleeping, vital signs stable 106/55 P-66
	Pulse ox 96% RA —— (b)(6)-2
0200	Pt sleeping, VSS, Chest tube to
	LSS draining, minimal amt of discharge
	tubing patent no kinks noted
	Suction machine on —— (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6821

MEDICAL RECORD | **PROGRESS NOTES**

DATE

1300 Resting in bed s̄ discomfort. pain med effective. Denies Ⓛ chest tube pain. HR 82 114/52 RR 18 SaO2 97% ———

1400 CT drainage 30 cc's since 11:00. 111/55 HR 72 RR 20. SaO2 97% ——— (b)(6)-2

1500 20 cc's CT drainage. HR 60, 113/53, RR 12 SaO2 98%. pt sleeping @ this time –

1525 Checked Ⓛ antecubital IV site. unable to draw blood but flushes s̄ resistance. Hung 1 gm ancef in 100 ml NS to be infused over 30'. pt attempting c̄ communicate by non-verbal means. Requesting IV p pain med. offered p.o. p.o. med but refused @ this time. ——— (b)(6)-2 MAJ

1600 Resting in bed. HR 75, 126/63, RR 25, 99% in RA. MD's made rounds @ bedside. plan is to transfer pt in 48 to 72°. Waiting for chest to seal.

1620 OOB. ambulated to one end of 10 section tempor and back X2 s̄ any difficulty. Denies SOB or Ⓛ chest tube pain. Sitting in a chair for now. Chest tube to 20 cm H2O seal. pt stable.

——— (b)(6)-2 MAJ

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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6822

MEDICAL RECORD | **PROGRESS NOTES**

DATE

15 Jul 03 @1746 NN: Assumed care of Patient A+O. Sitting up in bed. Pt tolerated regular diet. ate about 30% of meal. Ø C/O pain at this time. Abd soft non tender pt voids spontaneously IV SL flushes well Ø S/S of infection at IV site. PT Able to move all extremities without obstruction or complication. Chest Tube intact Ø drainage at entrance to chest wall will continue to monitor Pt's status (b)(6)-2 1LT/AN

1855 Pt C/O pain Tylenol 650 mg PO given will continue to monitor pain status (b)(6)-2

160600 July 03 Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS to (R) flank clear in apex, diminished in bases. LS to (L) flank clear in apex and absent in bases. Abd soft, nontender, ē distention. Voids spontaneously. BS⊕x4. BM x1 this AM. FROM and neurovascularly intact to all extremities. IV to (L) AC flushes well and is s̄ s/s of infection/infiltration. (b)(6)-2 1LT, AN

160730 July 03 Nursing Note: Pt would not eat breakfast. Appears that pt just didn't like the food. (b)(6)-2 1LT, AN

161530 July 03 Nursing: CT DC'd by MD. Ø c/o SOB or pain p̄ removal (b)(6)-2 1LT/AN

(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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
0400	Pt OOB to chair – 300cc dark yellow urine – Tylox x ii for pain – Pt vital signs stable 114/58 P-83 R-12 Pulse ox 99% RA – Chest tube to LCS – tubing patent – 200cc serous —— (b)(6)-2 [redacted]
15 July 03 0600	NN: assumed care of patient, assessment complete see DA 4700. Patient resting comfortably in bed p̄ receiving 2 tylox @ 0500 ∅ c/o pain. CT to 20 cm Su. Will continue to monitor —— (b)(6)-2 [redacted] CPT/AN
15 July 03 0800	NN: Patient up to chair this am. Am care done. Dressing Δ'ed, small amount of drainage to posterior chest wound, other dsg clean. CT to water seal, will do cxray @ 1200. Will continue to monitor —— (b)(6)-2 [redacted] CPT/AN
15 July 03 1200	NN: Cxray done, patient up to chair for whole am. now back in bed, using IS well. Will continue to monitor —— (b)(6)-2 [redacted] CPT AN
15 July 03 1300	Tranfered to ICW. Patient stable, pain controlled c̄ Tylox. CT to water seal, CXray in Am then plan to pull tube. Report given to ICW staff —— (b)(6)-2 [redacted] CPT AN
15 Jul 03 1325	Nursing: Tra

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

(b)(6)-4 [redacted]

MEDCOM - 6824

MEDICAL RECORD | PROGRESS NOTES

DATE	
17 JUL	A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, ⊕ BS x4. PT COMPLAINED Ø PAIN. TOLERATED REG DIET. CONTINUED ANTIBIOTIC THERAPY - ANCEF 1g. RESTING COMFORTABLY WILL CONTINUE TO MONITOR (b)(6)-2 SGT, CPN
18 JUL 03	Nursing Assessment: Pt sleeping, easily aroused. Lungs CTA bilat, HR reg, ⊕ BS x4. Ø c/o pain @ present. Drsg to Ⓛ flank x2. Anterior drsg CDI, posterior drsg c̄ lrg area dried drainage. (b)(6)-2
18 JUL 03 2200	ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR. ⊕ BS x4. Ø C/O PAIN. DRSG A'D @ 1800, C, D, I TO Ⓛ FLANK. (b)(6)-2 TOLERATED REG DIET. ANCEF 1gm @ 2200 TO BE GIVEN. WILL CONTINUE TO MONITOR SGT
19 0600 July 03	NURSING ASSESSMENT: Assumed care of pt. Pt awake, alert, O x3. Airway intact, breathing even and unlabored, LS clear to all fields Ⓑ c̄ a cough. Old CT site has sutures closing the wound completely. Wound to posterior chest has granular bed c̄ minimal purulent drainage to wound bed. Wound is approx 1 inch diameter. IV to Ⓡ FA flushes well and s̄ s/s of infection or infiltration. (b)(6)-2
20 July 03 @ 0315	NSG shift assessment: Pt has appeared to sleep throughout the shift. Denied any pain. Dressing change completed (b)(6)-2
21 July 03 @ 0230	NSG shift assessment: Dressing change done c̄ pink granulation tissue seen as well as some areas (small) of white material. (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.

(b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR 201
USAPPC V1.00

MEDCOM - 6825

21Jul03 Nursing Assessment: Pt sleeping, easily aroused. ф c/o pain.
0720 Lungs CTA, HR reg, ⊕ BS x4, abd soft, nondistended. Pt
is voiding well, BM x $\frac{-}{1}$ of loose stool. +2 pulses x 4 extremities
Pt ↑ OOB, amb s̄ ~~assist~~. Wound to Ⓛ chest c̄ stitches intact
ф drainage noted. Drsg to Ⓛ flank Δ'd. Old drsg c̄ serous
dried drainage. ~~#~~ Wound is red c̄ white straition, ф
active drainage noted. Reapplied W → D drsg. — (b)(6)-2

21 Jul 2003 Nursing: Wound: MD in to remove pt drsg to Ⓛ flank,
1615 Strm - strips placed & covered c̄ opsite — (b)(6)-2

21 July 03 Nursing Notes: Assumed care of pt A+O. Pt
@ 1752 tolerated regular diet ate about 45%. Ø c/o
pain or discomfort at this time. Breathing
intact ф SOB or labored breathing - IVSL
flushes well. Pt able to move all extremities
without pain or complication. Ø drainage
or bleeding noted on dressing to Ⓛ flank will
Continue to monitor Pt status — (b)(6)-2 (b)(6)-2 1LT/AN

1906 Pt Ambulated to BRs loose stool noted
ф c/o pain in abd. will continue to monitor
Pt's status — (b)(6)-2 1LT/AN

2155 Pt Asleep — (b)(6)-2 1LT/A

2320 Dressing changed completed. Wound weeping serous drainage
ф odor noted. — (b)(6)-2 1LT/A

2348. Pt c/o pain 30 mg Toradol IV given - will continue to monitor
pain status — (b)(6)-2

~~24~~19 Pt Asleep — (b)(6)-2 1LT/AN

MEDCOM - 6826

MEDICAL RECORD | PROGRESS NOTES

DATE	
22Jul03 0835	Nursing Assessment: Pt sleeping, Ø c/o pain. Lungs CTA, HR 72, reg, ⊕ BS x4, abd soft, flat. Stitches to Ⓡ chest intact. Drsg to Ⓛ flank, steri-strips intact, small amt. serous drainage under opsite. Pt ↑ in bed for breakfast. —— 1LT (b)(6)-2 AN
0940	Nursing: ADL: Pt ↑ in bed for am care. Δ'd pt linen on bed & pajamas. Pt ↑ OOB, amb on ward s̄ assist x2. —— 1LT (b)(6)-2 AN
23Jul03 @0300	NSG Shift assessment: Pt had a good appetite this shift eating approx 95% of dinner. Denied any pain when assessed. Resps are even + unlabored. Slept throughout shift will continue to monitor —— (b)(6)-2
24Jul03 @0015	NSG Shift assessment: Pt has spent a good deal of the shift either resting quietly in bed or smiling/talking w/ another EPW. Denied any complaints this shift —— (b)(6)-2
24Jul03 1630	Nursing: Shift note Pt. sleeping most of shift. Drsg. change per physician request. Front drsg. left open. Ø major changes this shift — (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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6827

PROGRESS NOTES

DATE

Nurses Note: Assumed care of pt Alert and
24Jul03 Oriented sitting up in bed. Breathing
1924 intact Ø SOB or labored breathing
Ø C/O pain at this time. Pt tolerated
Regular diet. Abd soft and non tender
pt able to move all extremities without
complaint. Will continue to monitor (b)(6)-2
(b)(6)-2

2200 Dressing change completed. Pt had Ø C/O
pain. Voids spontaneously. Will continue
to monitor (b)(6)-2 [illegible]

25Jul03 Nursing Assessment. Pt sleeping, easily aroused. Breakfast at bedside,
0715 pt not ready to eat at this time. VSS, lung CTA; HR 62, reg; ⊕BS
x4, abd soft, Pt has wound to Ⓛ chest, stitches intact, Ø drainage
noted. Drsg to Ⓛ flank c̄ small amt. serous drainage to 2x2.
Replaced c̄ new drsg. Ø active drainage noted — LT (b)(6)-2

25 Jul 03 Nursing Note: Assumed care of pt A+O. Tolerated
@1747 Regular diet well. Pt sitting up in bed. Breathing
intact Ø SOB or labored breathing. Ø IV Access
Ø C/O pain or discomfort at this time. Abd
soft and non tender. Pt able to move all
extremities without complication. Will continue
to monitor status (b)(6)-2

2204 Dressing change complete Ø drainage noted
on changed dressing. Will continue to monitor
(b)(6)-2

26Jul03 Nursing Discharge Pt cleared for d/c. Medical staff aware
1425 of need to provide cont care c̄ dates, [illegible] (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

558-103 See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)* (b)(3)-1

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
09	JUL	03	0830

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER *(Specify)*

CURRENT MEDS. *(tetanus immunization and other data)* ?

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES ?

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)* Iraq

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* GUNSHOT WOUND

SEX M

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

PO2 98 VITAL SIGNS 100 100

TIME	0835	0840	0850
BP	113/65	108/53	108/53
PULSE	96	94	98
RESP.	28	26	28
TEMP.			
WT. *(Child)*			

CATEGORY *(See reverse)*
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS
GSW To Chest

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)* Gen Surg
☒ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE ICU.

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER 0830

TOI 0520

S: Pt is ~30yo Iraqi ♂ S/p GSW to Ⓛ Chest by US Forces
Pt had a Ⓛ Chest Tube placed @ BAS + b/b Helo.
Pt had attempted to overrun a sniper OP and was shot in chest.

O: WD mw in severe distress 2° to GSW to Chest; mod [illegible]
HEENT: wnl
Chest Small ½ cm GSW to ant Chest wall ~4th Rib mid Clavicular
Lg 1" GSW to Ⓛ 7th Rib area, post Ax line.
Lungs: ↓ BS on Ⓛ, wet sounding BS.
Cor MRG ⊖: ⊖ pericardial effusion by U/S.
Abd: ⊖ BS, Tense, Distended + gen Tender
FAST c̄ ⊕ Fluid around Ⓡ Kidney/Liver area
⊖ Bld @ Ⓛ Kidney/Spleen.
Ext: Atraumatic N/V intact.

pm 4z?

24 > 14/42 < 353
yel, clr 1.030
Tr Bld, ⊖ neg.
139 | 107 | 7
4.2 | 22 | 1.2 < 168
CK 663.
LFT's NML
7.28/49/79/-4/94

(b)(6)-2 SF 507, IF NEEDED)

SIG ND ID STAMP (b)(6)-2

ns ordered, any limitations and follow-up

To ICU.

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

(b)(6)-4

MEDCOM - 6829 ATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 July 03		1800	NN: Assumed care of Pt Alert and Oriented. IV SL flushes well. Breathing intact ∅ SOB or Labored breathing ∅ C/O pain or discomfort at the time. dressing to chest wall intact ∅ drainage or bleeding noted. Chest tubes removed today. Pt able to move extremities without complication. Abd soft and non tender. Pt voids spontaneously clear yellow urine noted in bedside urinal. Will continue to monitor Pt's status — (b)(6)-2
		2100	Pt Asleep ∅ complain. Stable at this time — (b)(6)-2
17 Jul 03		1700	Nursing: Shift Assessment Pt. c̄ slight cough this shift. Upper airway c̄ slight wheezes, tolerating ambulating w/o SOB. CXR complete. Drsg. D+I. Continue to assess for ↓ sat, SOB, + S/S infection which are all ⊖ at present — (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.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-4

MEDCOM - 6830

NSN 7540-00-634-4124

:DICAL RECORD

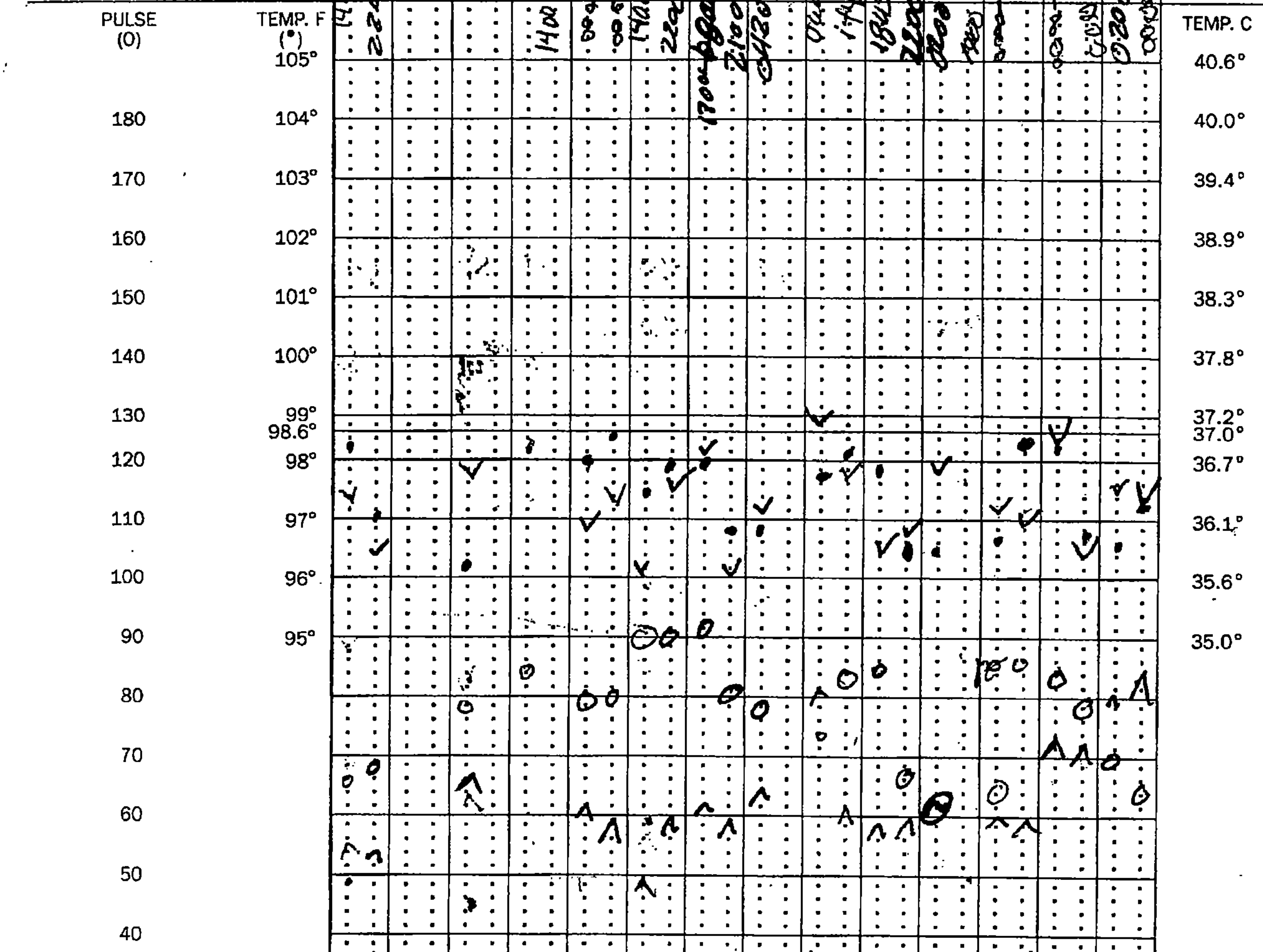
VITAL SIGNS RECO

HOSPITAL DAY

i- July DAY 15 16 17 18 18 19 20 21

NTH-YEAR 2003 DAY Tuesday Wed

19 HOUR 1400 2200 1400 0800 0600 1400 2200 1700 2100 2420 0445 1445 1845 2200 0200 0400 0600 0800 0200 0200 0800



RESPIRATION RECORD 20 19 20 12 17 16 18 19 18 18

Record special data only when so ordered

BLOOD PRESSURE 114/55 104/53 119/46 113/56 108/61 113/59 107/54 117/59 121/[illegible] 101/58 [illegible] 132/[illegible] 117/61 105/58 107/59 [illegible] 118/[illegible] 116/56 104/[illegible] 106/[illegible] 115/[illegible] 112/[illegible]

HEIGHT: WEIGHT →

O2 97% /95 95% 96% 97% 95% 96% 96 96 97 96% 97% 97 97 96 97% 96% 97 97%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

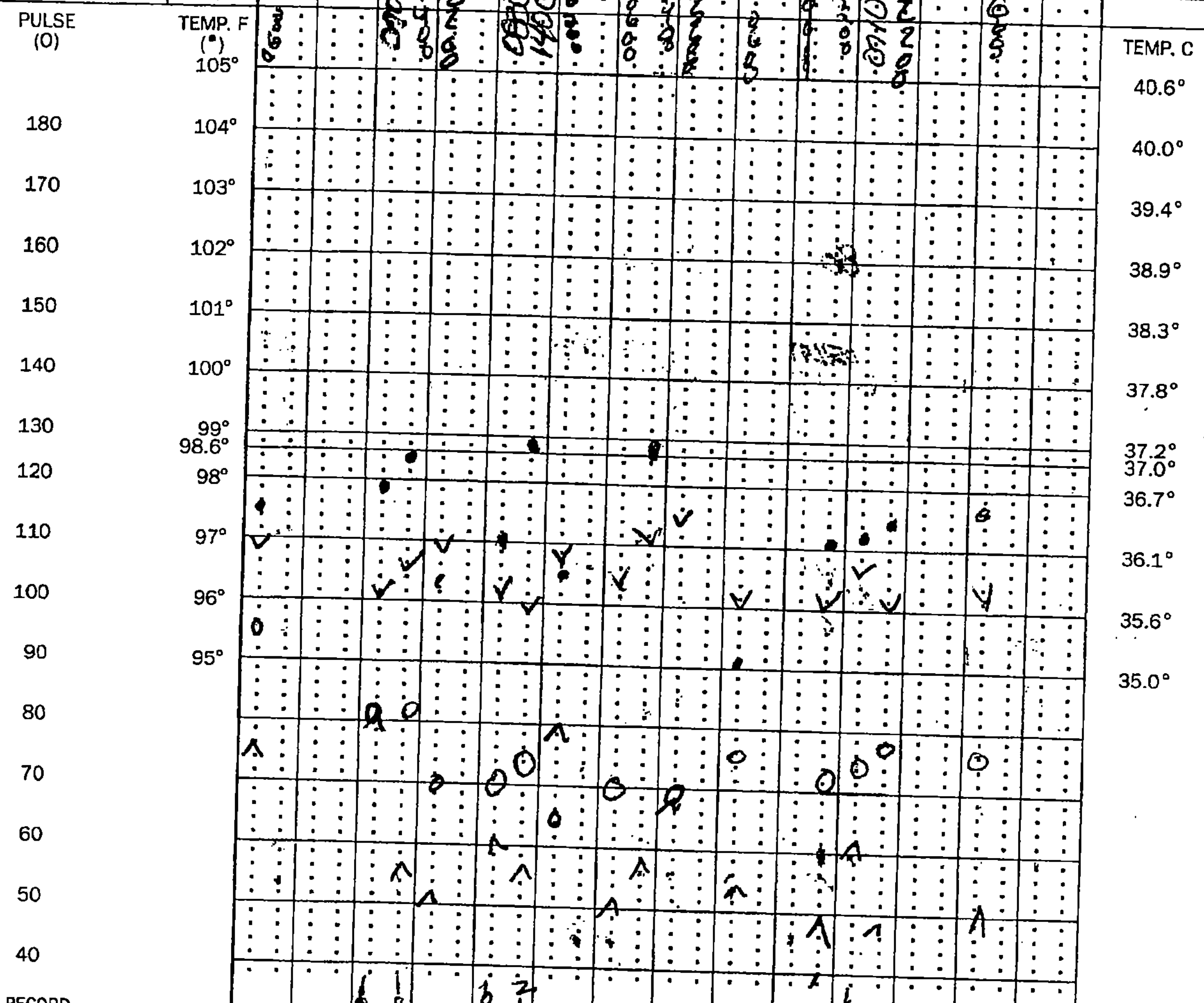
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

MEDCOM - 6831

MEDICAL RECORD

VITAL SIGNS REC

HOSPITAL DAY				14	15	16	17	
POST- DAY								
MONTH-YEAR / DAY		20th	21	22	23	24	25	26
19 / HOUR		0600	0800 1400 2200	0800 1400 2000	0600 1400 2200	0800 1200 2000	0800 2200	0600



RESPIRATION RECORD 16 19 18 21 18

Record special data only when so ordered

BLOOD PRESSURE	118/76		92/60 106/55	108/52	102/60 98/59	98/50 108/60	105/52 101/59	114/68	101/52	100/48	104/60 101/49		
HEIGHT: / WEIGHT →	96%		95 98%	97	98	98%		98	97	97%	97		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER (b)(6)-4

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6832

Ward/Section: Emt

REQU(b)(6)-2 YSICIAN: Dr

LAST, FIRST, MI. EPW (b)(6)-4

DATE 09JUL03

TIME 0830

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

SSN/PSEUDO SSN: (b)(6)-4

[illegible]

TEST	RESULT	REF. RANGE
WBC	24.2	4.8-10.8 x 10³
RBC	4.85	4.7-6.1 x 10⁹
Hgb	13.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.2	42-52% (M) 37-47% (F)
MCV	87.0	80-94 fl (M) 81-99 fl (F)
Plt	353	130-500 x 10³ verified
Lymph %	5.7	20.5-51.1%

[illegible]

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

[illegible]

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

[illegible]

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS: Type & screen

REPORTED BY:

DATE:

LAB ID NO.:

MEDCOM - 6833

Chem 12

TEST	RESULT I-Stat	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

TEST	RESULT	REF. RANGE
ALB	3.5	3.5-5.5 g/dl
ALP	54	26-84 u/l
ALT	22	10-47 u/l
AMY	18	14-97 u/l
AST	39 ↑	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	6 ↓	7-22 mg/dl
CA⁺⁺	8.4	8.0-10.3mg/dl
CHOL	115	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	169 ↑	73-118 mg/dl
TP	6.1 ↓	6.4-8.1 g/dl

TEST	RESULT Met Panel	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

TEST	RESULT Met 8	REF. RANGE
GLU	168 ↑	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	663	39-380 u/l (M) 30-190 u/l (F)
NA⁺	139	128-145 mmol/l
K⁺	4.2	3.3-4.7 mmol/l
CL⁻	107	98-108 mmol/l
tCO₂	22	18-33 mmol/l

TEST	RESULT Liver Panel	REF. RANGE
ALB	3.5~~64~~m	3.3-5.5 g/dl
ALP	54	26-84 u/l
ALT	22	10-47 u/l
AMY	18	14-97 u/l
AST	39	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
~~GGT~~		5-65 u/l
TP	6.1	6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

TEST	RESULT	REF. RANGE
roponin-I		
rug of buse		

EMARKS:

EPORTED BY: DATE: LAB ID NO.:

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU

REQUESTING PHYSICIAN: Dr (b)(6)-2

LAST, FIRST, MI. (b)(6)-4

DATE 9 Jul

TIME 1600

SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	12.5	4.8-10.8 x 10^3
RBC	4.40	4.7-6.1 x 10^9
Hgb	12.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.3	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	263	130-500 x 10^3 verified
Lymph %	12.6	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 09 Jul 03

LAB ID NO.:

MEDCOM - 6835

Ward/Section: Icu

REQUESTING PHYSICIAN: Dr. (b)(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4

DATE 9Jan03

TIME 1150

SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	18.7	4.8-10.8 x 10^3
RBC	4.47	4.7-6.1 x 10^9
Hgb	12.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.8	42-52% (M) 37-47% (F)
MCV	88.9	80-94 fl (M) 81-99 fl (F)
Plt	267	130-500 x 10^3 verified
Lymph %	6.7	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

MEDCOM - 6836

Ward/Section: ICU

REQ[illegible] Dr. (b)(6)-2

L[illegible]ATORY RESULT FORM
(Subject to the Privacy Act of 1974)

(b)(6)-4

ATE 10 Jul

TIME 0850

SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	7.4	4.8-10.8 x 10³
RBC	3.74	4.7-6.1 x 10⁹
Hgb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.0	42-52% (M) 37-47% (F)
MCV	85.6	80-94 fl (M) 81-99 fl (F)
Plt	210	130-500 x 10³ verified
Lymph %	24.7	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 10 Jul 03

LAB ID NO.:

MEDCOM - 6837

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

519-301

EXAMINATION(S) REQUESTED
PCXR

AGE

SEX
M

SSN
(b)(6)-4

WARD/CLINIC
ICU

REGISTER NO.

FILM NO.

PREGNANT
☐ YES ☐ NO

REQ
(b)(6)-2

TELEPHONE/PAGE NO.

SIG
(b)(6)-2

DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE OF EXAMINATION *(Month, day, year)*

DATE OF REPORT *(Month, day, year)*

DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

ENT'S IDENTIFICATION *(For typed or written entries give:*
— last, first, middle, Medical Facility)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 6838

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
CXR

AGE

SEX
M

SSN *(Sponsor)*
(b)(6)-4

WARD/CLINIC
ICW

REGISTER NO.

FILM NO.

PREGNANT
☐ YES ☒ NO

REQUESTED BY *(Print)*
Dr (b)(6)-2

TELEPHONE/PAGE NO.

(b)(6)-2 TOR
1074W

DATE REQUESTED
16 July 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
CT

DATE OF EXAMINATION *(Month, day, year)*

DATE OF REPORT *(Month, day, year)*

DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 6839

ATION REQUEST/REPORT

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
Chest x-ray

AGE
SEX
SSN (Sponsor) (b)(6)-4
WARD/CLINIC
REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)* (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED 17JUL03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
PT had chest tube

DATE OF EXAMINATION *(Month, day, year)*
DATE OF REPORT *(Month, day, year)*
DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION
MEDCOM - 6840

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294

619-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CXR

AGE:

SEX: M

SSN *(Sponsor)*: (b)(6)-4

WARD/CLINIC: ICW

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUESTED BY *(Print)*: Dr. (b)(6)-2

TELEPHONE/PAGE NO.

(b)(6)-2 TOR S.AN

DATE REQUESTED: 15-1-03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p CT removal

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

ed or written entries give:
y)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 6841

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

CPT/AN 1030 7/9/03

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 7/8 TIME OF ORDER HOURS

LIST TIME ORDER NOTED AND SIGN

✓ ① Admit ICU
✓ ② s/p GSW chest
✓ ③ Chest tube to -20
✓ ④ Foley to gravity
✓ ⑤ CXR qAM
✓ ⑥ Labs: CBC q 4° x 24° starting at 12 noon
✓ ⑦ NPO

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2

✓ ⑧ IVF LR @ 150cc/hr
✓ ⑨ Incentive spirometer
⑩ Ancef 1g ivp q8
⑪ Morphine 2-4 mg ivp q1° prn pain

noted

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2 MAHMOOD, MD

PATIENT IDENTIFICATION

DATE OF ORDER 7/8 TIME OF ORDER 1400 HOURS

① ↓ IVF 50/hr
② Clear diet. Advance as tolerated to regular

1400 (b)(6)-2 mgn

(b)(6)-2

MAHMOOD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9 July 03 TIME OF ORDER 1700 HOURS

D/C Q4° CBC

Obtain CBC in AM 10 July 03

V.O. Dr. (b)(6)-2 (b)(6)-2 mgn (b)(6)-2 1700 mgn

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ done (b)(6)-2 CPT AN (b)(6)-2 10 July 03

DA FORM 425 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ -383-710

MEDCOM - 6842

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 10 Jul 03 TIME OF ORDER 1530 HOURS

LIST TIME ORDER NOTED AND SIGN

① Toradol 30mg IV now + q6° prn pain.

(b)(6)-2 (b)(6)-2

1530 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 10 July 03 TIME OF ORDER 2130 HOURS

① 1 Liter Bolus x1 now

V/O Dr. (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Transcribed 8T (b)(6)-2 2305 10 July 03

DATE OF ORDER 10 July 03 TIME OF ORDER 2245 HOURS

① Neb Tx x1 (.5 albuterol/5cc NS)

V/O Dr (b)(6)-2

(b)(6)-2

NURSING UNIT 24° chart ✓ | ROOM NO. | BED NO. done

(b)(6)-2

0330 11 July

PATIENT IDENTIFICATION

DATE OF ORDER 12 July 03 TIME OF ORDER 0800 HOURS

X ① Heplock IVF

X ② Colace PO 100mg BID

X ③ Tylox 1-2 caps PO Q 4-6° prn pain.

X ④ D/C MSO4

VO: J (b)(6)-2 CPT/AN / Dr (b)(6)-2

(b)(6)-2

noted (b)(6)-2 0820 12 July 03

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE U

☆ U. MEDCOM - 6843 363-710

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER 14 Jul 03 TIME OF ORDER 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

① Ambien 10 mg ī po q HS prn insomnia (b)(6)-2 (b)(6)-2

(b)(6)-2

NURSING UNIT ICU | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 15 July 03 TIME OF ORDER 1230 HOURS

① Change VS to Q4° c̄ I+O (b)(6)-2

② Transfer to ICU

③ CT to waterseal 7/15/03

VO: Dr (b)(6)-2 / J (b)(6)-2 1230

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 15 July @ 2241 (b)(6)-2 1[illegible]

PATIENT IDENTIFICATION

DATE OF ORDER 7/16 TIME OF ORDER 0720 HOURS (b)(6)-2

① CXR now and q AM (b)(6)-2 [illegible]

(b)(6)-2

[illegible] 16 July 03 0800

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 17 July 03 @ 0105 (b)(6)-2 [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER 18 July 03 TIME OF ORDER 1140 HOURS

noted 1150 18 July [illegible] (b)(6)-2

① W-D drsg Δ bid c̄ NS

VO: Dr. (b)(6)-2 / 1LT (b)(6)-2 AN

19 July 03 0130 (b)(6)-2 [illegible] 24° ✓

20 July 03 24° chart ✓ (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

23 July 24° chart ✓ (b)(6)-2

24 July 24° chart ✓ (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ 4-363-710

MEDCOM - 6844

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/9

TIME OF ORDER 730 HOURS

LIST TIME ORDER NOTED AND SIGN 0720 (b)(6)-2 Maj

① D/C Foley

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/14

TIME OF ORDER 0700 HOURS

① D/C Ancef

② D/C X-ray

rec'd 0910 (b)(6)-2

(b)(6)-2

MAJ (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/22

TIME OF ORDER 2000 HOURS

① Ambien 10mg po tonight and qhs

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/25

TIME OF ORDER 0700 HOURS

① D/C today to EPW cmp

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ 4-383-710

MEDCOM - 6845

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 7 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	09	10	11	12	13	14	15	16	17	18	19	20	21	22
7/9/03	(b)(6)-2	Chest tube to 20cm	05	(b)(6)-2							> D/C'd						
		suction	17	(b)(6)-2													
7/9/03		foley to gravity	05	(b)(6)-2			> D/C				7/10/03						
			17	(b)(6)-2													
7/9/03		Cxray Q AM	04	/	(b)(6)-2		(b)(6)-2				See [illegible]						
			X														
7/9/03		Labs; CBC Q4°	04	/		/											
		x24° starting @	08	/		/											
	- - - - - -	1200hrs	12	(b)(6)-2	/												
	- - - - - -		16		/												
	- - - - - -		20		/												
	- - - - - -		24		/												
7/9/03	(b)(6)-2	diet: NPO (b)(6)-2	05	(b)(6)-2		> D/C 9 July 03											
		9July03	17														
7/9/03		Incentive Spirom	05	(b)(6)-2										(b)(6)-2			
			17									(b)(6)-2				(b)(6)-2	
9July03		Clear liquid diet	05											(b)(6)-2			
		Advance as tolerated to	17									(b)(6)-2					
	- - - - - -	regular															
7/15/03	(b)(6)-2	CT to water seal	05						/	(b)(6)-2		> D/C 16Jul03					
			17						/	(b)(6)-2							
15July		VS Q4° c̄ I+O	05						/	(b)(6)-2				[illegible]	Change		
			17						/			(b)(6)-2			see [illegible]		(b)(6)-2
	- - - - - -																
16	(b)(6)-2	CXR q AM	06	/	/	/	/	/	/	/	(b)(6)-2		(b)(6)-2		D/C'd		
18Jul		W-D drsg Δ BID	06											(b)(6)-2			
	- - - - - -	TNS	18									(b)(6)-2					

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/p GSW Ⓛ chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 6846

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 07 *Yr* 2003

Verify by Initialing Order Date	Verify by Initialing Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
09 Jly 20[illegible]	(b)(6)-2	CBC in am	10 Jly	0400	0340	(b)(6)-2
		DC CXR	[illegible]		0800	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 6847

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NONMEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 07 Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	20	21	22	23	24	25	26	27	28	29	30
20Jul03	(b)(6)-2	VS QShift	6	/	/	(b)(6)-2			D/C'D					
			14	/	/									
			22	(b)(6)-2										
24Jul03	(b)(6)-2	VS BID	5	/	/	/	/	(b)(6)-2						
			22	/	/	/	/							
24Jul03	(b)(6)-2	Regular Diet	6	/	/	/	/	(b)(6)-2						
			12	/	/	/	/							
			17	/	/	/	/							
24Jul03	(b)(6)-2	Act, OOB &ambulate	5	/	/	/	/	(b)(6)-2						
		EPW Prot	17	/	/	/	/							

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: S/P GSW Ⓛ chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 6848

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				09	10	11	12	13	14	15	16	17	18	19	20	21	22
7/9/03	(b)(6)-2	LR @ 150 cc/°	05	(b)(6)-2								Order Δd					
			17										03				
7/9/03		Ancef 1gm IVPB	08	(b)(6)-2											(b)(6)-2		D/C
		Q 8°	16														
			24												(b)(6)-2		
7		↓IVF: LR @ 50cc/hr	05	(b)(6)-2				D/C			7/12/03						
			17														
7/12/03		HL IVF - flush	08				(b)(6)-2										
		TID	16														
			24														
7/12/03		Colace 100mg PO	10														
		BID	20														

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/p GSW Ⓛ chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 6849

Verify by Initialing	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo. 07 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 Jul 03	(b)(6)-2	Toradol 30mg IVP now	10Jul03	1530	1530	(b)(6)-2
10 Jul		1 Liter Bolus x1 now	Done		2230	
10 Jul		Neb TX x1 now .5cc albuterol 5cc NS	Done		2300	
11Jul		D/C Ancef			0830	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9 July	(b)(6)-2	MS04 24mg	7/9 1015	9Jul 1600	9July 2115	10Jul 0140	10 Jul 0530	10 Jul 0730	10 Jul 0830	10Jul 1030	10Jul 1400	10Jul 1800	10Jul ~~2000~~ 2000	11Jul 0100	11July 0900	11Jul 0930
		IVP Q1° prn	4mg	2mg	4mg	4mg	3mg	2mg	4mg	4mg IVP	4mg IVP	4mg IVP	4mg	4mg	4mg IVP	2mg IVP
			(b)(6)-2						(b)(6)-2						(b)(6)-2	
		pain	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
10 Jul	(b)(6)-2	Toradol 30mg IV Q6°	D	7/11 0600	7/11 1200	7/11 1850	7/12 0415	7/13 0210	7/13 1030	145 2000	7/21 2248					
		prn	T	30mg IVP	30mg IVP	30mg	30mg	30mg	30mg	30mg	30mg					
			F	(b)(6)-2		(b)(6)-2										
				[illegible]	[illegible]	[illegible]	[illegible]		[illegible]							
			E													
11 July	(b)(6)-2	Tylenol 650mg	7/11 1500	7/14 (b)(6)-2	7/15 1550	7/15 1815										
		PO Q4° prn	2PO (b)(6)-2		(b)(6)-2	(b)(6)-2										
9 July	(b)(6)-2	MS04 2-4mg	10July 1030	11Jul 1730	11Jul 2130	11Jul 2200	12Jul 0315									
		IVP Q1° prn	2mg IVP	2mg	2mg	3mg	4mg									
			(b)(6)-2	(b)(6)-2												
		pain	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]									
9 July	(b)(6)-2	Tylox 1-2caps PO Q4-6° prn pain	7/12 0830	7/12 1330	7/12 1600	7/13 0145	7/13 0900	[illegible]	13 1400	13 0220	14Jul 0700	14Jul 1200	14 1820	15Jul 0500	7/15 0900	7/15 1300
			2PO	2PO	2PO	1PO	[illegible]	"	"	"	2caps	"	"	"	2PO	[illegible]
			(b)(6)-2					(b)(6)-2		(b)(6)-2	(b)(6)-2					

MEDCOM - 6850

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* ____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				23	24	25											
23Jul03	(b)(6)-2	Colace 100mg po bid	10	(b)(6)-2													
			22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P GSW Ⓛ chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 6851

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* ______ *Yr.* ______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION*													
			TIME/DATE DISPENSED													
14 Jul - - - - -	(b)(6)-2	Ambien 10mg	14 Jul 2100	22 July @ 2130 1 tab		23 July @ 2200 tab		25 Jul								
- - - - -	- - - - -	ī po QHS prn	(b)(6)-2			(b)(6)-2		(b)(6)-2 2235								
15 - - - - - July	(b)(6)-2	Tylox 1-2caps PO	7/15	7/16				(b)(6)-2								
- - - - -		Q4°-6° prn pain	ii 2347	ii po 1510												
- - - - -	- - - - -		(b)(6)-2													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

MEDCOM - 6852

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0930 INITIALS (b)(6)-2	1730 INITIALS (b)(6)-2	INITIALS
NEURO PUPILS	Pupils 3mm equal	Pupils = ⊕ 3mm	
SENSORIUM	A&O reactive to light [illegible]	pt. A + O x3	
	Ⓛ Side pain. MAE x4	language barrier,	
	Head [illegible]	interpreter present	
RESPIRATORY RESPIRATORY PATTERN	Even + ~~[illegible]~~ labored	Unlabored & even	
BREATH SOUNDS	c̄ pain. Diminished [illegible]	↓ to Ⓛ lower bases	
SECRETIONS	Ⓛ side c̄ diminished [illegible]	Ⓡ side CTA	
	[illegible]. CT [illegible]	CT to Ⓛ side on CS	
	to Ⓛ [illegible]. No evidence	O2 @ 2LPM via NC	
	of [illegible] + [illegible]. VM 35% Sat 100%	CT rub heard	
SKIN COLOR	Normal for race	Normal for race	Exit wound to Ⓛ
INTEGRITY	[illegible] Wound Cleaned	Entrance wound to	posterior chest. CDI
	Covered 4x4. [illegible] Wound	Ⓛ upper chest - 4x4 CDI	DRSG
IV SITE LOCATION	[illegible]	Ⓡ [illegible]	
CONDITION	[illegible] Cleaned [illegible] ABD	5.0cc/HR Ø s/s infiltration	
	[illegible] applied.	Ⓛ AC 18G.	
	IVS: Ⓛ AC Heplocked	saline locked, ⊖	
	Ⓡ [illegible] to LR @	s/s infiltration,	
	150cc/hr	good flush	
GASTRO ABDOMEN	BS x4, Abdomen	soft, non-distended	
BOWEL SOUNDS	[illegible], no pain upon	BS x4 ⊕, active	
	palpation, Bowel Sounds		
	hypoactive		
GU URINE:	Foley to gravity	foley to gravity	
COLOR/CLARITY	Clear yellow Urine.	clear yellow	
		urine	
CARDIOVASCULAR CARDIAC RHYTHM	Sinus Rhythm to	SR - tachy @ 99	
	Sinus to Sinus Tach	BPM	
	PR .16, QRS .08, no PVCs	⊕ pulses x4	
	noted. Pulses [illegible] to	extremities, cap	
	All extremities	refill <3 secs.	

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*: (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: [illegible] 2003

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

MEDCOM - 6853

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE

DX

HOSPITAL DAY

V I T A L S I G N S TIME	05	06	07	08	09 ~~04~~	10 ~~05~~	11 ~~06~~	12 ~~07~~		13	14	15	16	17	18	19			
BP Arterial Line																			
BP Cuff					123/54	115/55	105/48	108/54		107/52	118/60	111/53	105/57	112/50	120/72	106/50	102/48		
Temperature					989						98^{8}		98^{8}				98^{7}		
Pulse					107	85	85	75		93	96	85	90	90	109	79	78		
Respiratory Rate					24	22	21	25		24	29	20	20	26	24	17	20		
q15					130/63	110/56													
HR					107	92													
q30					134/68	107/48													
HR					96	89													
q45					134/68	89/48													
HR					104	83													
SaO2					100%	100%	100%			100%	100%	100%	100%	100%	100	100	97		
[illegible] O2 intervention					NRB 100%	VM 35%	VM 35%			35% VM	4NC	4L NC	4NC	4L	2LNC	2LNC	RA		
I N T A K E TIME	05	06	07	08	09	10	11	12	8° T	13 ~~08~~	14 ~~09~~	15 ~~10~~	16 ~~11~~	17 ~~12~~	18 ~~13~~	19 ~~14~~	~~15~~	8° T	
IV						150	150	150	450	150	50	50	50	50	50	50	50		
LR																			
TOTALS																			
O U T P U T URINE HOUR / TOTAL					150/150	150/300	150/450			200/650	200/850	100/950	50/1000	50/1050	60	100	80	1290	
URINE sp gr																			
URINE S/A																			
NG OUTPUT																			
NG pH																			
NG GUIAC																			
EMESIS																			
~~STOOL~~ CT Output							60	28		20	[illegible]	15	0	5					
DRAINS CT Total						128	182	210	[illegible]	230	270	285	285	300					
TOTALS																			

POST-OP DAY 21 22 23 24 01 02 03 04

VITAL SIGNS

16	17	18	19	20	21	22	23	
102/48	110/49	116/52	104/54	103/48	105/53	103/44		
			98²			98¹		
87	85	81	85	82	83	68		
29	24	20	23	18	22	18		
96	96	98	95	97	99	100		
RA	RA	RA	RA	2L NC	2L NC	2L NC		
21	22	23	24	01	02	03	04	

INTAKE

16	17	18	19	20	21	22	23	8° T
50	50	50	100 ~~50~~	50	50	50	50	140

OUTPUT

70	90	109	60	70	70	80	50	1780
							104	400
							400	400

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME	0830							
	MODE	[illegible]							
	F_iO_2	[illegible]							
	TV	[illegible]							
	RATE								
	PEEP								
A	pH	7.28							
	PCO_2	49							
	pO_2	79							
B	HCO_3								
	SAT	94%							
G	BASE	-4							

LABORATORY DATA

TIME	0848	1150	1600						
GLUCOSE	168								
Na/K	139/4.2								
Cl/CO_2	107/23								
BUN/Cr	7/.6								
WBC/PLATELET	24.8/353	18.7/267	12.5/263						
Hct/Hgb	40.8/13.8	38.8/12.7	38.5/12.4						

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE

IV ____

po ____

TOTAL ____

OUTPUT

Urine: ____

TOTAL ____

BALANCE ____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDCOM - 6855

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20								
COMA SCALE — EYES OPEN	SPONTANEOUSLY	4							✓																	
	TO SPEECH	3																								
	TO PAIN	2																								
	NO EYE OPENING	1																								
COMA SCALE — BEST VERBAL RESPONSE	ORIENTED	5							✓																	
	CONFUSED	4																								
	VERBALIZES	3																								
	VOCALIZES	2																								
	NO VOCALIZATION	1																								
COMA SCALE — BEST MOTOR RESPONSE	OBEYS COMMANDS	6							✓																	
	LOCALIZES PAIN	5																								
	FLEXION WITHDRAWAL	4																								
	ABNORMAL FLEXION	3																								
	EXTENSION TO PAIN	2																								
	NO MOTOR RESPONSE	1																								
LIMB MOVEMENT — ARMS	NORMAL POWER								RL																	
	MILD WEAKNESS																									
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
LIMB MOVEMENT — LEGS	NORMAL POWER																									
	MILD WEAKNESS																									
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
PUPILS — RIGHT	SIZE								[illegible]																	
	REACTION								4																	
PUPILS — LEFT	SIZE								3																	
	REACTION								+																	

PUPIL SCALE: ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

ICP																								
CEREBRAL PERFUSION PRESSURE																								

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record separately if there is a difference between the two sides.

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20								
Radial	R								++																
	L								++																
Dorsalis pedis	R																								
	L																								
	R								++																
	L								++																
	R																								
	L																								
	R																								
	L																								

LEGEND

++ Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDCOM - 6856

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0800 INITIALS (b)(6)-2	INITIALS	INITIALS
NEURO PUPILS	Pupils Symmetrical, Equal	Pupil Equal reactive	
SENSORIUM	+ Round. Alert + oriented	to light 3mm	Same as
	x3. Follows commands	A&O attempts to	prior note
	appropriately. Given 3mg	communicate	
	Morphine IVP for c/o pain	language barrier	
RESPIRATORY PATTERN	Even + Unlabored. ~~deep~~	shallow breaths	CT output 35 cc SS
BREATH SOUNDS	Lungs ō Diminished breath	Lungs CTA - diminished	x12 hours
SECRETIONS	sounds throughout all	bilat - Dsg to	
	fields. CT Inserted to	(L) side, ∅ drainage	
	(L) side. Serosanguinous	at this time.	
	drg. noted. CT Dsg D+I		
SKIN COLOR	Normal for race, no	normal for race	
INTEGRITY	evidence of skin breakdown		
	Entrance wound to chest D+I		
IV SITE LOCATION	18G to (R) Wrist ō	18G IV cath (R) wrist	1L bolus
CONDITION	LR running @ 50cc/hr.	infusing LR @ 50cc/hr	
	(L) AC Heplocked, flushed	18G IV cath (L) AC	
	+ patent	HL [illegible]	
		both sites patent	
		and flushed	
GASTRO ABDOMEN	BS x4 Quadrants.	BS hypoactive x	
BOWEL SOUNDS	abdomen ŝ distention	4 quad - [illegible]	
	tenderness upon	and H2O for dinner	
	palpation		
GU URINE:	Foley to gravity	Foley d/c'd ∅	950 void ō
COLOR/CLARITY	Clear yellow urine	void at this time 1800	Foley d/c
		will monitor	
CARDIOVASCULAR CARDIAC RHYTHM	S1 + S2 Auscultated.	NSR (+) pulses	
	PR-16 Resp-12. Cap	Throughout	
	Refill less than 3 seconds		
	[illegible] in NSR ō		
	ectopy. Pulses 2+ to all extremities		

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 mg/RN

DEPARTMENT/SERVICE/CLINIC ICU 2 West

DATE 10 July 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs
MEDCOM - 6857
WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE

DX

HOSPITAL DAY

VITAL SIGNS

TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
BP Arterial Line	05	06	07	08	09	10	11	12	E	13	14	15	16	17	18	19	20	
BP Cuff	138/60	138/68	100/58	104/56	120/57	101/51	137/54	116/59		114/57	113/49	128/61	105/57	118/68	116/57	116/52	113/55	
Temperature	97^{5}						97^{7}				97^{4}		98^{1}		98^{7}	98^{7}	98	
Pulse	83	76	98	84	93	92	76	88		78	94	89	91	98	92	93	90	
Respiratory Rate	28	26	32	27	25	24	19	19		19	22	16	22	15	25	27	30	
Sa O2	100%	100%	92%	91%	98%	98%	97%	90%		99%	99%	98%	100%	100%	99%	98%	98%	
O2 Source	2L NC	2L NC	RA	RA	2LNC	2LNC	2LNC	2LNC		2LNC	2LNC	2LNC	[illegible]	4LNC	4L	4L	4L	
													4LNC		NC	NC	NC	
pain intervention																		

INTAKE

TIME	05 ~~24~~	06 ~~01~~	07 ~~02~~	08 ~~03~~	09 ~~04~~	10 ~~05~~	11 ~~06~~	12 ~~07~~	8° T	13 ~~08~~	14 ~~09~~	15 ~~10~~	16 ~~11~~	17 ~~12~~	18 ~~13~~	19 ~~14~~	20 ~~15~~	8° T
LR	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	800
po					500				500						20		100	1220
IVPB													50					50
TOTALS				[illegible]					900									2300

OUTPUT

URINE	HOUR / TOTAL	50 / 50	25 / 75	100 / 175	/	/	/	/	/		/	/	/	/	0 /	0 /	0 /	0 /	175
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT	0		20	–	–	–	–		–	–	30		30	0	–	–	–	
	CT Total	400		420								450		480	480				480
TOTALS																			

MEDCOM - 6858

POST-OP DAY

VITAL SIGNS

16	17	18	19	20	21	22	23	
21	22	23	24	01	02	03	04	
100/46	114/54	126/62	114/55	122/60	110/53	114/51	104/53	
78	92	96	95	92	83	71	71	
22	33	30	20	26	15	17	17	
98.4	98.8	98.4	98.6	98	98.6	98.9	98.7	
4L	4L	4L	4L	4L	4L	4L	4L	
NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE

16	17	18	19	20	21	22	23	8°T
50	1000	50	50	50	50	50	50	1350
			50					
								3700

OUTPUT

0	0	0 Bolus	950	0	0	0	0	950
—								
—	30						5	515
								1465

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

TIME	0500
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	7.4/310
Hct/Hgb	22.0/10.8

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE 2300

IV ~~1350~~ 1220

PO ~~1220~~

IV ~~3700~~

PO

TOTAL 12 3520

OUTPUT

Urine: 950

CT 515

TOTAL 1465

BALANCE 2085

NURSE'S SIGNATURE | **INITIALS**

(b)(6)-2 | (b)(6)-2

(b)(6)-2

2085

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	4	15	16	17	18	19	20	21
COMA SCALE – EYES OPEN	SPONTANEOUSLY	4	4																
	TO SPEECH	3																	
	TO PAIN	2																	
	NO EYE OPENING	1																	
BEST VERBAL RESPONSE	ORIENTED	5	5																
	CONFUSED	4																	
	VERBALIZES	3																	
	VOCALIZES	2																	
	NO VOCALIZATION	1																	
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6																
	LOCALIZES PAIN	5																	
	FLEXION WITHDRAWAL	4																	
	ABNORMAL FLEXION	3																	
	EXTENSION TO PAIN	2																	
	NO MOTOR RESPONSE	1																	
LIMB MOVEMENT – ARMS	NORMAL POWER		[illegible]																
	MILD WEAKNESS																		
	SEVERE WEAKNESS																		
	ABNORMAL FLEXION																		
	ABNORMAL EXTENSION																		
	NO RESPONSE																		
LIMB MOVEMENT – LEGS	NORMAL POWER		[illegible]																
	MILD WEAKNESS																		
	SEVERE WEAKNESS																		
	ABNORMAL FLEXION																		
	ABNORMAL EXTENSION																		
	NO RESPONSE																		
PUPILS – RIGHT	SIZE		3																
	REACTION		++																
PUPILS – LEFT	SIZE		3																
	REACTION		++																
PUPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm																		
ICP																			
CEREBRAL PERFUSION PRESSURE																			

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- − No Response
- + Intact
- − Abnormal

VASCULAR ASSESSMENT

HOURS		05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
Dorsalis Pedis	R	++															
	L	++															
Posterior Tibial	R	++															
	L	++															
	R																
	L																
	R																
	L																
	R																
	L																

LEGEND

- ++ Normal
- + Weak
- − Absent
- D Doppler
- R Right
- L Left

MEDCOM - 6860

11 July

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIAL (b)(6)-2	1730	INITIAL (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3mm brisk reaction		Pupils 3mm ⊜			
	SENSORIUM	to light. Moves all ext		A+O, language			
		on command, MSO4		barrier, understands			
		for pain, toradol		simple commands			
		started this am					
RESPIRATORY	RESPIRATORY PATTERN	Resp rate 20's.		RR 20's			
	BREATH SOUNDS	even+unlabored,		even + unlabored			
	SECRETIONS	coarse throughout		rub heard to Ⓛ			
		using IS c̄ mild		chest, ↓ to Ⓛ base			
		non productive cough		Ⓡ CTA, CT to Ⓛ			
		Sats 99% on 2L		side on CS, ⊕cough ⊖secretion			
SKIN	COLOR	normal for race,		Normal for race			
	INTEGRITY	warm+dry dsg to		DRSG to Ⓛ chest			
		Ⓛ chest intact		CDI, post + ant.			
IV SITE	LOCATION	Ⓛ AC patent ÷ Hl		Ⓛ AC, patent - SL 18G			
	CONDITION	Ⓡ wrist patent - LR @ 50		Ⓡ wrist, patent, LR @			
	meds:	Ancef Q8°		50cc/HR 18G			
	tubes:	Ⓛ CT to 20cm H2O		⊝ s/s infiltration			
		Sx, bloody output		to either IV site			
		approx 5cc/°					
GASTRO	ABDOMEN	flat, firm, N/T		soft, non-distended			
	BOWEL SOUNDS	to palpation, BS		⊕ BS x4, active			
		hypoactive ⌀N/V/D					
		⌀ stool					
GU	URINE:	Voiding spont in		No urine yet			
	COLOR/CLARITY	urinal per night					
		shift.					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR rate 80's		SR @ 98, tachy			
		pulses palpable		⊕ pulses x4			
		afebrile BP stable		1477			
		c̄ MAPs 70's					
		⌀ labs ordered		(b)(6)-2			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 11 July 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 6861

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE	DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
TIME	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
~~BP Arterial Line~~																		
BP Cuff	114/55	108/50	98/50	118/57	102/49	118/63	109/54	109/58	115/57	113/51	108/55	121/64	124/65	103/46	122/62	103/46	107/53	
Temperature	97¹				97³ T				97⁷				97⁷	97¹				
Pulse	81	82	73	92	89	84	86	82	81	81	84	96	89	94	105	98	97	
Respiratory Rate	20	21	14	26	25	24	20	27	20	20	20	27	25	20	23	21	23	
O_2 sats	100	99	100	95%	97%	100%	100%	100%	99%	99%	100%	94%	97%	95	96	97	98	
source	2L	2L	2L	RA	RA	2L	2L	2L	2L	2L	2L	RA	RA	RA	RA	RA	RA	
saturation	05	06	07	08	09	10	11	12		13	14	15	16	17	18	17	20	
TIME	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
IUF	50	50	50	50	50	50	50	50	[illegible]	50	50	50	50	50	50	50	50	[illegible]
IUPB				50									50					
PO					200			[illegible]			200		~~100~~	100				
TOTALS	50	50	50	100	250	50	50	50		50	250	50	100	150 ~~100~~				
URINE HOUR / TOTAL				200 / 200				800 / 100										
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS CT#1	10	10	10	0	35	0	5	0		10	0	0	10					
DRAINS																		
DRAINS																		
TOTALS	10	10	10	200	35	0	5	800	✓	10	0	0	10					

MEDCOM - 6862

POST-OP DAY	21	22	23	24	01	02	03	04	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	116/63	126/61		113/56	117/55	132/71	132/71	112/55	
		98⁴				97⁸			
	98	94	90	95	87	88	91	96	
	25	19	18	16	16	24	20	19	
	98	99	95	97	95	96	95	97	
	RA	RA	RA	RA	RA	RA	RA	RA	
	21	22	23	24	01	02	03	04	
INTAKE	16	17	18	19	20	21	22	23	8°T
	50	50	50	100	50	50	150	50	1250
		200							700
									1950
OUTPUT		1620/1620							1620
	–								
								80	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING					TIME				
TIME				TURN					
MOUTH CARE									
BATH									
SKIN CARE									
FOLEY CARE				SUCTION					
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE OUTPUT

IV ________ Urine: ________

po ________ ________

________ ________

TOTAL ________ TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

MEDCOM - 6863

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530 INITIAL (b)(6)-2 [redacted]	INITIALS	1800 INITIALS (b)(6)-2 [redacted]
NEURO	PUPILS	Patient awake, alert		3mm (=)
	SENSORIUM	follows commands, moves		A+O, language
		all extremities well, pupils		barrier, responds
		3mm brisk reaction to light		appropriately to
		Pain controlled c̄ Toradol/MSO4		commands
RESPIRATORY	RESPIRATORY PATTERN	Rate 20's even + unlabored		Even + unlabored @20
	BREATH SOUNDS	Diminished c̄ pleural rub on Ⓛ		pleural rub on Ⓛ,
	SECRETIONS	coarse on right, occasional		coarse to Ⓛ base, Ⓡ
		productive cough c̄ bloody (old)		CTA, ⊖ cough @
		sputum Sats 96% on RA		this time, ⊖
		CT to 20cm suction 0-10cc/° output		secretions, CT to CS Ⓛ
SKIN	COLOR	warm dry, normal for race		Normal for race
	INTEGRITY	Dressing to anterior/posterior		DRSG to ant., post.
		chest and chest tube intact		chest Ⓡ CDI
IV SITE	LOCATION	18g to Ⓛ AC c̄ LR @ 50cc/°		18g to Ⓡ AC, saline
	CONDITION	patient ∅ S/S of infection		locked, ⊖ S/S infiltration
	meds →	Ancef 1gm IV Q 8°		Ancef 1G IV Q8°
	activity	ambulated last pm		pt. @ bedside chair
		will get OOB today and		
		ambulate BID		
GASTRO	ABDOMEN	Soft N/T, non distended		soft, non-distended
	BOWEL SOUNDS	Bowel sounds ⊕, ∅ N/V/D		BS ⊕ x4, ⊖ N/V/D
		∅ stool yet, ⊕ flatus		⊕ flatus, 100%
		Regular diet tolerates well		Reg. Diet consumed
GU	URINE:	Clear dark yellow urine		⊖ urine @ this
	COLOR/CLARITY	Voids 1-2 x per shift		time
		>10cc/kg c̄ each void		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR rate 80-90's		
		pulses palpable		SR @ 80-100
		cap refill <3 seconds		⊕ pulses to extremities
		∅ edema noted		x4, cap. refill <3 sec.
		afebrile.		

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 12 July 03

(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 6864

WAMC 375 (Redesignated)
Apr 90 (HSXC-NU)

DATE

DX

HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	117/55	128/61	117/56	135/74	121/67	119/57	113/51	121/55		119/63	101/50	94/44	137/49		121/64	112/57	115/55	
	Temperature	97^2				97^1					97^8					98^2			
	Pulse	89	83	86	93	103	90	85	81		81	88	66	77		84	81	92	
	Respiratory Rate	17	16	17	22	24	19	18	22		20	34	14	20		22	19	21	
	sats	96	96	96	96	96	97	97	95		95	96	94	98		98	98	96	
	Source	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA		RA	RA	RA	
	pain																		
	intervention																		
INTAKE	TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
	IUPB	[illegible]			50									50					
	IUF	50	50	50	HL														
	PO				300	240			500					200					
	TOTALS	50	50	50	350	240	0	0	500		0	0	0	250					
OUTPUT	URINE HOUR / TOTAL				420/420						650/1320					100			
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT#1	0	0	0	40	0	0	0	9		0	0	0	28		2			
	DRAINS																		
	DRAINS																		
	TOTALS																		

MEDCOM - 6865

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

21	22	23	24	01	02	03	04	
105/43	107/50	105/48	113/41	106/45	114/55	107/50	97/43	
75	71	63	61	71	69	68	58	
14	14	14	14	16	22	14	15	
95	94	94	95	97	97	94	94	
RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

21	22	23	24	01	02	03	04	8°T
			50					

OUTPUT

/	/	/	/	/	/	/	/	1120
—								
3		12	8	4	15	17	10	95

RESPIRATORY

	TIME								
VENT	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
	PCO_2								
	pO_2								
B	HCO_3								
	SAT								
G	BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING

TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	______	Urine:	______
PO	______		______
	______		______
TOTAL	______	TOTAL	______

BALANCE ______

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDCOM - 6866

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530 INITIALS (b)(6)-2	1700 INITIALS (b)(6)-2	0100 INITIALS (b)(6)-2
NEURO	PUPILS	Pupils 3mm [illegible]. Equal,	Pupils Equal Round	
	SENSORIUM	round reactive to light.	Reactive 3mm	
		[illegible] pain at chest tube site.	⊕ P pulses - [illegible]	
		MAE x4. Hand grasp	and pain at insertion	
		equal x4.	site	
RESPIRATORY	RESPIRATORY PATTERN	Even + unlabored. Clear	Even - unlabored	
	BREATH SOUNDS	[illegible] [illegible] auscultated on		
	SECRETIONS	Ⓛ side. Diminished upper		productive cough
		lowers to bases.		Lungs clear
		CT to 20cm suction		
SKIN	COLOR	No [illegible] of skin [illegible]	normal for race	
	INTEGRITY	Normal for race.	no breakdown noted	
		Dressing D+I [illegible] to Ⓛ [illegible]		
IV SITE	LOCATION	18G to Ⓛ AC. Dressing	18G to Ⓛ AC	
	CONDITION	Dry and intact. Flushed	∅ s/sx of infection	
		ō excellent blood return	IV [illegible]	
GASTRO	ABDOMEN	Bowel Sounds present x4	+ BM soft formed	
	BOWEL SOUNDS	Tenderness upon palpation	BS ⊕ x 4 ∅	
		to Upper Quadrants. No		
		BM x 2 days. [illegible]		
GU	URINE:	Voiding [illegible], clear	+ UO QS see note	+ UO QS clear
	COLOR/CLARITY	Yellow urine		yellow
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible] NSR ō ectopy, PR .16	NSR	NSR
		QRS .08. ~~[illegible]~~ [illegible] id's	+ pulses	+ cap refill
		rhythm regular ō occasional		brisk ō 2 seconds
		PAC. Pulses X 4 [illegible]		+ radial, dorsalis
		2+, Cap refill [illegible] -		pules

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*
(b)(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU 2 West

DATE
13 July 03

PATIENT'S ID (b)(6)-2 *en entries give: Name—last, first, middle; gr* *facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 6867

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE		DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20
VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
	BP Arterial Line																	
	BP Cuff	107/40		114/84	118/81	111/53	105/40	98/48	108/49		98/55	107/40	110/40	109/67	114/54	110/62	112/72	116/68
	Temperature		96^{7}						98^{2}				98^{5}					98^{7}
	Pulse	59		80	92	56	60	90	94		80	79	88	69	78	74	72	90
	Respiratory Rate	23		21	25	18	15	25	26		20	18	12	20	20	20	20	18
	SaO_2	96%		98%	95%	95	96%	98%	99%		97%	97%	100%	96%	96%	97°	97°	97
	O_2 Source			RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA
	pain intensity	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	PO			240					240					240		100			820
	IVPB								50					50					100
	TOTALS																		920
OUTPUT	URINE HOUR / TOTAL				500/520				30/80							300/1100			1100
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT						35					10		4	0	0	0	6	
	DRAINS GTube	115					150					160		164				170	
	TOTALS																		

MEDCOM - 6868

POST-OP DAY 21 22 23 24 01 02 03 04

VITAL SIGNS

16	17	18	19	20	21	22	23	/
120/68	130/66	132/66	125/62	123/64	113/56	129/68		
/	/	/						
68	66	68	69	54	62	68		
18	18	16	20	16	16	13		
97	97	97	98	98	98	96%		
RA	RA	RA	RA	RA	RA	RA		
21	22	23	24	01	02	03	04	

INTAKE

16	17	18	19	20	21	22	23	8° T
0	100	0	100	0	0	0		100
	50							50
								150

OUTPUT

150/1250	/	/	/	/	/	/	/	1250
–								
0	0	5	0	5	5	11	0	
		175		180	185	196	196	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A B G pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K	/	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING

				TURN / SUCTION					
TIME					TIME				
MOUTH CARE									
BATH									
SKIN CARE									
FOLEY CARE									
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV 920
PO 300
TOTAL 1220

OUTPUT
Urine: 1250
CT 196
TOTAL 1446

BALANCE + 226

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2

MEDCOM - 6869

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
COMA SCALE – EYES OPEN	SPONTANEOUSLY	4	4																							
	TO SPEECH	3																								
	TO PAIN	2																								
	NO EYE OPENING	1																								
COMA SCALE – BEST VERBAL RESPONSE	ORIENTED	5	5																							
	CONFUSED	4																								
	VERBALIZES	3																								
	VOCALIZES	2																								
	NO VOCALIZATION	1																								
COMA SCALE – BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6																							
	LOCALIZES PAIN	5																								
	FLEXION WITHDRAWAL	4																								
	ABNORMAL FLEXION	3																								
	EXTENSION TO PAIN	2																								
	NO MOTOR RESPONSE	1																								
LIMB MOVEMENT – ARMS	NORMAL POWER		R/L																							
	MILD WEAKNESS																									
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
LIMB MOVEMENT – LEGS	NORMAL POWER		R/L																							
	MILD WEAKNESS																									
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
PUPILS – RIGHT	SIZE		3																							
	REACTION		++																							
PUPILS – LEFT	SIZE		3																							
	REACTION		++																							
PUPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm																									
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

	HOURS	05																							
Dorsalis Pedis	R L	++ ++																							
Radial	R L	++ ++																							
	R L																								
	R L																								
	R L																								

LEGEND

++ Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDCOM - 6870

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIAL (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Pupils 2-3mm					
	SENSORIUM	brisk reaction to light					
		moves all ext well, full					
		strength Ø c/o pain					
		@ this time.					
RESPIRATORY	RESPIRATORY PATTERN	even + unlabored					
	BREATH SOUNDS	rate 20s, lungs clear					
	SECRETIONS	bilaterally ↓ in LLL					
		Sats 97% on RA.					
		CT to suction,					
		25cc/° last hour					
SKIN	COLOR	normal for race					
	INTEGRITY	warm + dry. dsg					
		CDI will A @ 1000					
IV SITE	LOCATION	Ⓛ FA. 18g. HL patent					
	CONDITION	flushes well.					
	meds IV	Ancef 1gm TID					
	PO	Tylox prn					
		Colace BID					
		tylenol/toradol prn					
GASTRO	ABDOMEN	Soft flat N/T					
	BOWEL SOUNDS	BS⊕, stool yesterday					
		Ø N/V/D, Tolerated					
		regular diet.					
GU	URINE:	voiding spont					
	COLOR/CLARITY	per urinal,					
		Clear amber QS					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR in 70's, BP					
		Stable, pulses					
		palpable, skin					
		warm + dry					
		afebrile					

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 CPT/AN

DEPARTMENT/SERVICE/CLINIC ICU ~~[illegible]~~

DATE 15 July 03

PA *For typed or written entries give: Name—last, first,* m

(b)(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

MEDCOM - 6871

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff		92/41				108/53												
Temperature		97^6				97^9												
Pulse		78				70												
Respiratory Rate		16				16												
sats		97				97												

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8° T
IVPB				50														
TOTALS																		

OUTPUT

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
URINE	HOUR / TOTAL				400 / 400													
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	CT#1		25				0											
TOTALS																		

MEDCOM - 6872

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS		INITIALS
NEURO	PUPILS						
	SENSORIUM						
RESPIRATORY	RESPIRATORY PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
I.V. SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE:						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM						

LEGEND

- Cr - Creatinine
- F_IO_2 - Fraction of Inspired O_2
- HCO_3 - Bicarbonate
- ICP - Intracranial Pressure
- PCO_2 - Pressure of Arterial CO_2
- PEEP - Positive End Expiratory Pressure
- %A - Fractional
- SAT - Saturation
- TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC ICU

DATE 14 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 1 MAY 78 **4700**

Proponent Dept of Nurs

MEDCOM - 6873

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

DATE
DX
HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff																		
	Temperature																		
	Pulse																		
	Respiratory Rate																		

INTAKE TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
															150		150	300
TOTALS																		

OUTPUT URINE	HOUR / TOTAL														200			100 / 200	200
	sp gr																		
	S/A																		
CT ~~OG~~	OUTPUT														0	0	5	0	5
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

21	22	23	24	01	02	03	04	

RESPIRATORY DATA

TIME				
MODE				
F_iO_2				
TV				
RATE				
PEEP				
A B G pH				
PCO_2				
pO_2				
HCO_3				
SAT				
BASE				

LABORATORY DATA

TIME				
GLUCOSE				
Na/K				
Cl/CO₂				
BUN/Cr				
WBC/PLATELET				
Hct/Hgb				

INTAKE

21	22	23	24	01	02	03	04	8° T
100								400

OUTPUT

21	22	23	24	01	02	03	04	8° T
100/250	0	0	0	0	0	0	0	500
0	0	10	0	10	0	0		

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	50	Urine:	500
po	400		30
TOTAL	450	TOTAL	~~8~~530

BALANCE +80

NURSE'S SIGNATURE

INITIALS

(b)(6)-2

MEDCOM - 6875

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF

1	2	3	4	5	6
(b)(3)-1					[redacted]

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER (b)(6)-4

9	10	11
0	0	0

NAME *(Last, First, Middle Initial)* (b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS N/A

11. FMP

35	36
~~9~~	~~9~~

20

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4								

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS

46
U

HOUR OF ADMISSION 0830

BRANCH / CORPS N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

b(3)-1

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
2	4

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(YYYYMMDD)*

81	82	83	84	85	86	87	88
2	0	0	3	0	7	2	6

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION *(YYYYMMDD)*

99	100	101	102	103	104	105	106
2	0	0	3	0	7	0	9

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

107	108
[redacted]	[redacted]

-b(6)-4

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION *(YYYYMMDD)*

115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: ~~SRP~~ GSW TO LEFT CHEST
HEMOPNEUMOTHORAX
PULMONARY CONTUSION

DX-8605
Trauma-1 86131
Injury-450 E9912

PR-3404

ADMITTING OFFICER *(Signature, as required)* (b)(6)-2
(b)(6)-2 COL, MC (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2 (b)(6)-2
PFC, 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 6876

~~SECRET-NOFORN – LAW ENFORCEMENT SENSITIVE~~

DEPARTMENT OF THE ARMY
366TH MILITARY POLICE DETACHMENT (CID) TEAM A
11TH MILITARY POLICE BATTALION
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
OPERATION IRAQI FREEDOM 2004-2006, FOB DANGER
APO AE 09308

CIRC-KAM 11 MAR 2005

(U) MEMORANDUM FOR SEE DISTRIBUTION

(U) SUBJECT: CID REPORT OF INVESTIGATION –CORRECTED FINAL (C) REPORT 0119-04-CID469-79667-5C1N/5Y2P9

(U) DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 21 JUL 2003/0001 – 21 AUG 2003/2400; TIKRIT, IRAQ (IZ)

(U)DATE/TIME REPORTED: 10 JUN 2004, 1500

b7c-1, b6-1, b2 b7c-1, b6-1, b2

(U) INVESTIGATED BY: SA [redacted] SA [redacted], [redacted] SA [redacted]; SA [redacted] SA [redacted] [redacted]; SA [redacted] SA [redacted]

b7c-1, b6-1, b2 b7c-1, b6-1, b2

(U) SUBJECT: 1. UNKNOWN; [ASSAULT (UNFOUNDED)]; [MALTREATMENT OF PRISONERS (UNFOUNDED)].

b7c-4, b6-4 b7c-4, b6-4

(U) VICTIM: 1. [redacted] CIV; DETAINEE NUMBER [redacted] [redacted] ZZ; NFI [ASSAULT(UNFOUNDED)]; [MALTREATMENT OF PRISONER(UNFOUNDED)]. b7c-4, b6-4

(U) INVESTIGATIVE SUMMARY:

(U) This is a Detainee Abuse Investigation.

(U) This investigation was initiated based upon information received from the United States Army Criminal Investigation Command (USACIDC) pertaining to allegations that Mr. [redacted] was abused while in the custody of U.S. Forces in Tikrit, IZ. b7c-4, b6-4

b7c-4, b6-4

(U) Investigation established probable cause to believe Mr. [redacted] suffered a heat stroke while in U.S. Forces custody and was not the victim of Assault or Mistreatment of Prisoner. Furthermore, all U.S. and Iraqi medical personnel who treated Mr. [redacted] related his comatose state was caused by a heat stroke and during their medical examination, Mr. [redacted] had no signs of external trauma when turned over to Iraqi medical personnel from the Coalition Detention Facility. b7c-4, b6-4

~~SECRET-NOFORN – LAW ENFORCEMENT SENSITIVE~~

UNCLASSIFIED WHEN SEPARATED
FROM CLASSIFIED ENCLOSURES
3 JUN 06 [redacted], Security Manager
b7c-3, b6-3

(U) SUBJECT: CID REPORT OF INVESTIGATION – CORRECTED FINAL (C) REPORT – 0119-04-CID469-79667-5C1N/5Y2P9

(U) STATUTES:

(U) Article 128, UCMJ: Assault (Unfounded)
(U) Article 134, UCMJ: Maltreatment of Prisoner (Unfounded)

(U) EXHIBITS/SUBSTANTIATION:

(U) Attached:

(U) 1. Agent's Investigation Report (AIR) of SA b7c-1,b6-1 [redacted] 2 Aug 04, detailing receipt of Request For Investigation, coordination's with medical personnel, Division Central Control Point (DCCP), statements of medical personnel, receipt of medical records and detainee packet.

(S/NOFORN) 2. Detainee packet of Mr. b7c-4,b6-4 [redacted] documenting his apprehension and interview when detained by U.S Forces in Aug 03.

(U) 3. DA Form 1594, Daily Staff Journal Log, Dated 11 – 16 Aug 03, reflecting Mr. b7c-4,b6-4 [redacted] medical treatment and transfer to North Tikrit Hospital.

(U) 4. Handwritten Statement of Dr. b7c-4,b6-4 [redacted], Director, North Tikrit Hospital, Tikrit, IZ, 28 Jun 04, detailing the treatment Mr. b7c-4,b6-4 [redacted] received at North Tikrit Hospital.

(U) 5. Iraqi Language Medical Records of Mr. b7c-4,b6-4 [redacted] 11 Aug 03, detailing the treatment and diagnoses of Mr. b7c-4,b6-4 [redacted] injuries, with English translation.

(U) 6. English language translation of Exhibit 5, completed by Mr. b7c-5,b6-5 [redacted], Interpreter, Titan-SOS, FOB Danger

(U) 7. Handwritten Statement of Dr. b7c-4,b6-4 [redacted] 2 Aug 04, detailing the treatment and diagnoses of Mr. b7c-4,b6-4 [redacted] at the Saleh Adin General Hospital, Tikrit, Iraq.

(U) 8. Handwritten Statement of Dr. b7c-4,b6-4 [redacted] 2 Aug 04, detailing the treatment and diagnoses of Mr. b7c-4,b6-4 [redacted] at the Saleh Adin General Hospital, Tikrit, Iraq.

(U) 9. AIR of SA b7c-1,b6-1 [redacted] 30 Jun 04, detailing the receipt of the RFA, interview of LTC b7c-4,b6-4 [redacted] and receipt of medical records.

(U) 10. Copy of Sworn Statement of LTC b7c-4,b6-4 [redacted] 30 Jun 04, detailing the treatment and diagnosis he provided to Mr. b7c-4,b6-4 [redacted].

(U) 11. Medical narrative of Mr. b7c-4,b6-4 [redacted] medical condition provided by LTC b7c-4,b6-4 [redacted].

(U) SUBJECT: CID REPORT OF INVESTIGATION – CORRECTED FINAL (C) REPORT – 0119-04-CID469-79667-5C1N/5Y2P9

b7c-1, b6-1

(U) 12. AIR of SA [redacted] 23 Jul 04, detailing the receipt of RFA and the interview of witness.

b7c-4, b6-4 b7c-4, b6-4

(U) 13. Sworn statement of CPT [redacted] 23 Jul 04, detailing her knowledge of Mr. [redacted]

b7c-1, b6-1

(U) 14. AIR of SA [redacted] 28 Jul 04, detailing the receipt of the RFA and witness interviews.

b7c-4, b6-4

(U) 15. Sworn statement of SGT [redacted] 27 Jul 04, detailing his knowledge of Mr. [redacted] health while in U.S. custody.

b7c-4, b6-4 b7c-4, b6-4 b7c-4, b6-4

(U) 16. Sworn statement of SSG [redacted] 27 Jul 04, detailing his knowledge of Mr. [redacted] health while in U.S. custody.

b7c-4, b6-4

(U) 17. Sworn statement of Mr. [redacted]8 Jul 04, detailing his knowledge of Mr. [redacted] health while in U.S. custody.

b7c-4, b6-4 b7c-1, b6-1

(U) 18. Copy of AIR of SA [redacted]9 Aug 04, detailing receipt of RFA and witness interviews.

b7c-1, b6-1

(U) 19. Copy of AIR of SA [redacted] 12 Aug 04, detailing receipt of RFA and witness interviews.

b7c-4, b6-4

(U) 20. Sworn statement of SSG [redacted], 5 Aug 04, detailing his knowledge of Mr. [redacted] medical condition.

b7c-4, b6-4 b7c-4, b6-4

(U) 21. Copy of sworn statement of 1LT [redacted]6 Aug 04, detailing his knowledge of Mr. [redacted]s treatment.

b7c-4, b6-4 b7c-4, b6-4

(U) 22. Copy of sworn statement of CPT [redacted]11 Aug 04, detailing her knowledge of Mr. [redacted]s treatment.

b7c-4, b6-4 b7c-1, b6-1

(U) 23. Copy of AIR of SA [redacted]13 Aug 04, detailing receipt of RFA and witness interviews.

b7c-4, b6-4

(U) 24. Copy of sworn statement of SSG [redacted] 26 Aug 04, detailing his knowledge of Mr. [redacted] medical condition and treatment.

b7c-4, b6-4 b7c-4, b6-4

(U) 25. Copy of sworn statement of SGT [redacted] Sep 04, detailing his knowledge of Mr. [redacted] injuries.

b7c-4, b6-4 b7c-1, b6-1

(U) 26. AIR of SA [redacted] Oct 04, detailing the final SJA coordination.

(U) SUBJECT: CID REPORT OF INVESTIGATION – CORRECTED FINAL (C) REPORT – 0119-04-CID469-79667/5C1N/5Y2P9

(U) Not Attached: None

(U) The originals of Exhibits 1, 4, 6 through 10 and 12 through 26 are forwarded with the USACRC copy of this report. The originals of Exhibits 2 and 3 are maintained in the files of the DCCP, 4th INF DIV, Fort Hood, TX. The originals of Exhibit 5 are maintained in the files of North Tikrit Hospital, Tikrit, IZ. The originals of Exhibit 11 are maintained in the files of the 28th Combat Support Hospital (CSH), Fort Bragg, NC.

(U) STATUS: This is a Final (C) Report. This investigation is being terminated in accordance with paragraph 4-17(4), CIDR 195-1, in that the supported Staff Judge Advocate or prosecutor is of the opinion that no crime has been committed. Leads remaining include the interview of Mr. [redacted] and his family and other interviews of those who were detained at the DCCP at the time of his detention. The commander's report of disciplinary action taken is not required.

b7c-4
b6-4

(U) Report Prepared By:

b7c-1, b6-1, b2

[redacted]

Special Agent, [redacted]

Report Approved By:

b7c-1, b6-1

[redacted]

Special Agent in Charge

(U) Distribution

1 – Director, U.S. Army Crime Records Center, U.S. Army Criminal Investigation Command, Attn: CICR-CR, 6010 6th Street, Fort Belvoir, VA 22060-5505

DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
3RD MILITARY POLICE GROUP 22ND MILITARY POLICE BATTALION,
286TH MILITARY POLICE DETACHMENT (CID)
APO AE 09392

CIRC-KAM 7 Oct 2004

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL (C) REPORT 0119-04-CID469-79667/5C1N/5Y2P9

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 21 JUL 2003/0001 – 21 AUG 2003/2400; TIKRIT, IRAQ (IZ)

DATE/TIME REPORTED: 10 JUN 2004/1500

b7c-1, b6-1, b2 b7c-1, b6-1, b2
INVESTIGATED BY: SA [redacted] SA [redacted] SA [redacted] SA [redacted], SA [redacted], SA [redacted], SA [redacted] b7c-1, b6-1, b2
b7c-1, b6-1, b2 b7c-1, b6-1, b2

SUBJECT: 1. UNKNOWN; [ASSAULT (UNFOUNDED)]; [MALTREATMENT OF PRISONERS (UNFOUNDED)].

b7c-4, b6-4 b7c-4, b6-4
VICTIM: 1. [redacted] CIV; DETAINEE NUMBER [redacted] [redacted], ZZ; NFI [ASSAULT(UNFOUNDED)]; [MALTREATMENT OF PRISONER(UNFOUNDED)].

INVESTIGATIVE SUMMARY:

This is a Detainee Abuse Investigation.

This investigation was initiated based upon information received from the United States Army Criminal Investigation Command (USACIDC) pertaining to allegations that Mr. [redacted] was abused while in the custody of U.S. Forces in Tikrit, IZ. b7c-4, b6-4

b7c-4, b6-4
Investigation established sufficient evidence to believe Mr. [redacted] suffered a Heat Stroke while in US Forces custody and was not the victim of Assault or Maltreatment of Prisoner. Furthermore, all U.S and Iraqi medical personnel who treated Mr. [redacted] related his comatose state was caused by a heat stoke and during their medical examination, Mr. [redacted] had no signs of external trauma when turned over to Iraqi medical personnel from the Coalition Detention facility.

b7c-4, b6-4

UNCLASSIFIED WHEN SEPARATED
FROM CLASSIFIED ENCLOSURES
3 JUN 05 [redacted] Security Manager
b7c-3, b6-3

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C) Report - 0119-04- CID469-79667/5C1N/5Y2P9

STATUTES:

Article 128, UCMJ: Assault (Unfounded)
Article 134, UCMJ: Maltreatment of Prisoner (Unfounded)

EXHIBITS/SUBSTANTIATION:

Attached:

b7c-4, b6-1
1. Agent's Investigation Report (AIR) of SA [redacted], 2 Aug 04, detailing receipt of Request For Investigation, coordination's with medical personnel, Division Central Control Point (DCCP), statements of medical personnel, receipt of medical records and detainee packet.

b7c-4, b6-4
2. Detainee packet of Mr. [redacted] documenting his apprehension and interview when detained by U.S. Forces in Aug 03.

b7c-4, b6-4
3. DA Form 1594, Daily Staff Journal Log, Dated 11 – 16 Aug 03, reflecting Mr [redacted] medical treatment and transfer to North Tikrit hospital.

b7c-4, b6-4
4. Handwritten Statement of Dr. [redacted], Director, North Tikrit Hospital, Tikrit, IZ, 28 Jun 04, detailing the treatment Mr [redacted] received at North Tikrit hospital.
b7c-4, b6-4

b7c-4, b6-4
5. Iraqi language Medical records of Mr. [redacted] 11 Aug 03, detailing the treatment and diagnoses of Mr. [redacted] injuries, with English translation.
b7c-4, b6-4

b7c-4, b6-4
6. English language translation of Exhibit 5, completed by Mr. [redacted] Interpreter, Titan-SOS, FOB Danger.

b7c-4, b6-4
7. Handwritten Statement of Dr. [redacted] 2 Aug 04, detailing the treatment and diagnoses of Mr. [redacted] at the Saleh Adin General Hospital, Tikrit, Iraq.
b7c-4, b6-4

b7c-4, b6-4
8. Handwritten Statement of Dr. [redacted] 2 Aug 04, detailing the treatment and diagnoses of Mr. [redacted] at the Saleh Adin General Hospital, Tikrit, Iraq.

b7c-4, b6-4
9. AIR of SA [redacted] 30 Jun 04, detailing the receipt of the RFA, interview of LTC [redacted] and receipt of medical records.
b7c-4, b6-4

b7c-4, b6-4
10. Sworn statement of LTC [redacted], 30 Jun 04, detailing the treatment and diagnosis he provided to Mr. [redacted]
b7c-4, b6-4

b7c-4, b6-4 b7c-4, b6-4
11. Medical narrative of Mr. [redacted] medical condition provided by LTC [redacted]

12. AIR of SA b7c-1, b6-1 [redacted] 23 Jul 04, detailing the receipt of RFA and the interview of witness.

13. Sworn statement of CPT b7c-4, b6-4 [redacted] 23 Jul 04, detailing her knowledge of Mr. b7c-4, b6-4 [redacted]

14. AIR of SA b7c-1, b6-1 [redacted] 28 Jul 04, detailing receipt of the RFA and witness interviews.

15. Sworn statement of SGT b7c-4, b6-4 [redacted] 27 Jul 04, detailing his knowledge of Mr. b7c-4, b6-4 [redacted] health while in U.S. custody.

16. Sworn statement of SSG b7c-4, b6-4 [redacted] 27 Jul 04, detailing his knowledge of Mr. b7c-4, b6-4 [redacted] health while in U.S. custody.

17. Sworn statement of Mr. b7c-4, b6-4 [redacted] 28 Jul 04, detailing his knowledge of Mr. b7c-4, b6-4 [redacted] health while in U.S. custody.

18. AIR of SA b7c-1, b6-1 [redacted] 9 Aug 04, detailing receipt of RFA and witness interviews.

19. AIR of SA b7c-1, b6-1 [redacted] 12 Aug 04, detailing receipt of RFA and witness interviews.

20. Sworn statement of SSG b7c-4, b6-4 [redacted] 5 Aug 04, detailing his knowledge of Mr. b7c-1, b6-1 [redacted] medical condition.

21. Sworn statement of 1LT b7c-4, b6-4 [redacted] 6 Aug 04, detailing his knowledge of Mr. b7c-1, b6-1 [redacted] treatment.

22. Sworn statement of CPT b7c-4, b6-4 [redacted] 11 Aug 04, detailing her knowledge of Mr. b7c-1, b6-1 [redacted] treatment.

23. AIR of SA b7c-1, b6-1 [redacted] 13 Sep 04, detailing receipt of RFA and witness interviews.

24. Sworn statement of SSG b7c4, b6-4 [redacted] 26 Aug 04, detailing his knowledge of Mr. b7c4, b6-4 [redacted] medical condition and treatment.

25. Sworn statement of SGT b7c4, b6-4 [redacted] 1 Sept 04, detailing his knowledge of Mr. b7c4, b6 4 [redacted] injuries.

26. AIR of SA b7c-1, b6-1 [redacted] 7 Oct 04, detailing the final SJA coordination.

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C) Report - 0119-04- CID469-79667/5C1N/5Y2P9

Not Attached: None

The originals of Exhibits 1, 4, 6 through 10 and 12 through 26 are forwarded with the USACRC copy of this report. The originals of 2 and 3 are maintained in the files of DCCP, 4th INF DIV, Ft Hood, TX. The originals of exhibit 5 are maintained in the files of North Tikrit Hospital, Tikrit IZ. The originals of Exhibit 11 are maintained in the files of the 28th Combat Support Hospital (CSH), Fort Bragg, NC.

STATUS: This is a Final (C) Report. This investigation is being terminated in accordance with paragraph 4-17(4), CIDR 195-1, in that the supported staff judge advocate or prosecutor is of the b7c-4 opinion that no crime has been committed. Leads remaining include the interview of Mr. [redacted] b6-4 and his family and other interviews of those who were detained at the DCCP at the time of his detention. The commander's report of disciplinary action taken is not required.

Report Prepared By: b7c-1, b6-1, b2

[redacted]

FOi

Special Agent, [redacted]

Report Approved By: b7c-1, b6-1

[redacted]

Special Agent in Charge

DISTRIBUTION:
1 - Director, U.S. Army Crime Records Center, U.S. Army Criminal Investigation Command, Attn: CICR-CR, 6010 6th Street, Fort Belvoir, VA 22060-5505

1 - THRU: Commander (CDR), 22nd MP Battalion (CID), Attn: Opns Officer, USACIDC, Camp Victory, APO AE 09335 (w/o exhibits) (email only)

THRU: CDR, 3D MP Group (CID), Attn: Opns Officer, 4699 North First St, Forest Park, GA 30297-5119

TO: CDR, USACIDC, ATTN: CIOP-ZA, 6010, North Sixth Street, Fort Belvoir, VA 22060-5505

1- Chief of Staff, 1st INF DIV, FOB Danger, APO AE 09392

1- SJA, 1st ID, APO AE 09392

1 - PM, DMain, 1ID, APO AE 09392

1 - File

AGENTS INVESTIGATIVE REPORT
CID REGULATION 195-1
LAW ENFORCEMENT SENSITIVE

0119-04-CID469-79667

BASIS FOR INVESTIGATION: About 1400, 10 Jun 04, this office received a Request For Investigation (RFI 0268-04-CID001) from the United States Army Criminal Investigation Command (USACIDC), Fort Belvoir, VA, requesting this office initiate a Report of Investigation pertaining to an alleged Detainee Abuse involving Mr. [redacted] An Iraqi National. b7c-4,b6-4

About 1600, 10 Jun 04, SA [redacted] b7c-1,b6-1 this office, coordinated with SSG [redacted] b7c-3,b6-3 Office of the Provost Marshal Office, FOB Danger, 1ST Infantry Division, Tikrit, Iraq, and SSG [redacted] furnished this office with Mr. [redacted] etainee packet (See attached detainee packet of Mr. [redacted] b7c-4,b6-4 b7c-4,b6-4

AGENT'S COMMENT: The RFI documents received from CID Command shows the name [redacted] b7c-4,b6-4 the attached news paper article shows the name [redacted] b7c-4,b6-4 and the Detainee packet show [redacted] b7c-4,b6-4 b7c-4,b6-4

About 1300, 11 Jun 04, SA [redacted] b7c-1,b6-1 SA [redacted] b7c-1,b6-1 and SA [redacted] b7c-1,b6-1 this office, coordinated with 1LT [redacted] 1st MP Company, FOB Danger, Tikrit, Iraq, who queried records left by 4th ID and found several documents indicating Mr. [redacted] was brought to the Tikrit Detention Center on 1 Aug 03 and released to the Tikrit Hospital on 21 Aug 03. No indication as to who may have taken him to the Tikrit hospital or which unit released him. b7c-4,b6-4

About 1130, 12 Jun 04, SA [redacted] b7c-1,b6-1 coordinated with the 67th Combat Support Hospital (CSH), FOB Speicher, Tikrit, Iraq for any medical records indicating Mr. [redacted] was hospitalized at the CSH. It was related all records returned to the rear with the 28th CSH, who returned to Fort Bragg, NC. b7c-4,b6-4

About 25 Jul 04, SA [redacted] b7c-1,b6-1 obtained the Daily Staff Journal Logs from the records of the Division Consolidated Collection Point, FOB Ironhorse, Tikrit, Iraq, which reflected Mr. [redacted] b7c-4,b6-4 treatment and care provided while he was detained at the DCCP under the care of the 1/978th MP Company, 4th INF DIVV, Fort Bliss, TX. (See Daily Staff Journal Logs for details)

About 1420, 28 Jul 04, SA [redacted] b7c-1,b6-1 obtained Mr. [redacted] b7c-4,b6-4 medical records from Dr. [redacted] b7c-4,b6-4, Director, North Tikrit hospital, Tikrit, IZ. Dr. [redacted] concurred Mr. [redacted] had no external signs of abuse (per the newspaper article), rather Mr. [redacted] injuries were consistent with heat stroke, as report by LTC [redacted] Dr. [redacted] related he would obtain statements from the Neurologist and b7c-4 b6-4 Physician who treated Mr. [redacted] at the Tikrit Hospital during the time he was treated there. (Se Iraqi medical records for detail) b7c-4,b6-4

TYPED AGENT'S NAME AND SEQUENCE NUMBER	**ORGANIZATION:**
SA [redacted] b7c-1,b6-1,b2	286th MP Det (CID), 22nd MP BN (CID)
[redacted] b7c-1,b6-4	FOB Danger, Tikrit
	APO AE 09392
SIGNATURE	**DATE** 2 Aug 04 **EXHIBIT** 1 (1 of 2)

CID FORM 94

FOR OFFICIAL USE ONLY
Protective Marking is Excluded from
Automatic Termination (Para 13, AR 34-16)
LAW ENFORCEMENT SENSITIVE

014100

000009

b7c-4, b6-4

About 1420, 28 Jul 04, Dr. [redacted] provided a written statement detailing his medical opine as to the cause of Mr. [redacted] injuries, indicating he did not notice any external injuries at the time he initially saw Mr. [redacted] (See statement of Dr. [redacted] for details)

b7c-4, b6-4

b7c-4, b6-1 b7c-4, b6-1

About 1000, 2 Aug 04, SA [redacted] and SA [redacted], this office, coordinated with Dr. [redacted] at the main gate of FOB Danger and obtained the written statements of Dr. [redacted] and Dr. [redacted] both with the Saleh Adin General Hospital, Tikrit, Iraq. b7c-4, b6-4

b7c-4, b6-4 b7c-4, b6-4 b7c-4, b6-4

Dr. [redacted] was the attending physician for Mr. [redacted] when he was at the Saleh Hospital. He related upon arrival of Mr. [redacted] at the Saleh Adin General Hospital, he was unconscious and unresponsive. He did not see any signs of trauma and the diagnosis after a neurological examination suggests a bilateral cortical affection with vegetative state. He then related Mr. [redacted] was referred to another hospital due to the needs of his relatives on 5 Sep 03. (See Statement for details) b7c-4, b6-4

b7c-4, b6-4 b7c-4, b6-4 b7c-4, b6-4

Dr. [redacted] related he examined Mr [redacted] on 27 Aug 03. Mr. [redacted] was unconscious but had spontaneous eye opening and pupils had a 3mm diameter and sluggish reaction to light. He related there were no signs of trauma to the body upon his examination. (See Statement for details)///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	**ORGANIZATION:**
b7c-1, b6-1, b2 SA [redacted]	286th MP Det (CID), 22nd MP BN (CID) FOB Danger, Tikrit APO AE 09392
SIGNATURE	**DATE** 2 Aug 04 **EXHIBIT** 1 (2 of 2)

Page(s)

11-24.

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Referred to:

U.S. CENTRAL COMMAND
7115 SOUTH BOUNDARY BLVD
ATTN: CCJ6-DM
MACDILL AIR FORCE BASE
FLORIDA 33621-5101

Master Sergeant Pamela Andrews
andrewsp@centcom.smil.mil
(813) 827-5341/2830

014102

[redacted]

* The Patient name - [redacted]

b7c-4,b6-4

* Diagnosis - Coma state resulted from central Lesion.

* The Patient admitted to our hospital as a case referred from coalition forces military hospital. At 23-Aug. 2003.

* The Patien treated in our hospital
b7c-4,b6-4
by Dr. [redacted] (neurologist),
b7c-4,b6-4
and Dr. [redacted] (Physition).
Our hospital gave him the suitable and adequate medical treatment, and and provide him by all available medical management, and a good care according to the orders of U.S.A army that fellow up the case, and cooperate with our doctors to make this Patient to be cure.

//

to Hudiatha hospital at 5-Sept-2003.

* All the details for this Patient are Present in the file box with this report

* Last thing we thank the U.S.A army for their cooperation with the health directorate of Salahddin Province, because they do their best to help Iraqi People.

b7c-4, b6-4

[redacted] [redacted]

Dr. [redacted]

manager of Salahddin hospital
Tikrit Iraq

b7c-4, b6-4

[redacted]

0119-04-CID469-79667-5C

Page(s)

27-29.

______________________________.

Withheld due to:

X____ Foreign Language

_____ Photos depicting Americans

_____ Photos depicting foreign nationals

_____ Civilian Agency Records

0114-04.CID704-19867

Page (12)

Treatment Form

AUG-24
GWING madicatun thru the stomach
ALSO Clocuse 2 x 4
3000 cc
Signed by
[redacted] b7C-4/b6-4
AUG-24

AUG-25
(medicatun cant be read)
Feed Clocuse 3000 cc
Turning over patient every 3 HR
Signed by
[redacted]
b7c-4/b6-4

AUG-27
medications (cant be read)
Clocuse 3000 cc
Also Turning over patient every 3 HR
Signed by
[redacted] MD
(b)7c-4/b6-4

0119-04-CID469-79667-5C

Page(s)

31 – 43

Withheld due to:

X Foreign Language

____ Photos depicting Americans

____ Photos depicting foreign nationals

____ Civilian Agency Records

014107

Page (34

TIME	PULSE	BP	TEMPERTURE	Respire
12 PM	110	130/80	37.5 C	18
2 PM	100	140/80	37.0 C	16
4 PM	93	130/80	37.0 C	18
6 PM	116	130/80	36.8 C	18
8 PM	100	130/90	37.0 C	16
10 PM	106	130/70	37.5 C	18
12 PM	98	130/90	37.2 C	16
2 AM	94	140/90	37.5 C	14
4 AM	92	140/90	37.6 C	11
6 AM	90	140/90	37.0 C	12

FLUids Intake

500 cc G.S	12 PM
500 cc G.S	2 PM
500 cc G.S	4 PM
500 cc G.S	6 PM
500 cc G.S	8 PM

2500 cc Intakes.

FLUids out
1400 cc
1000 cc

2400 cc. FLUids out

Signed BY
[redacted] MD
(b)7-c-4; b6-4

0119-04-CID469-79667-5C

Page(s)

45 – 61.

Withheld due to:

[✓ Foreign Language]

____ Photos depicting Americans

____ Photos depicting foreign nationals

____ Civilian Agency Records

Time	Pls	B.Press	Temp.	Resp.	Fluids in	Fluids out
1 AM	92	39.4	110/80	16	1000 potasium	1800 c
pm	78	38.6	110/80	14	500 cc G.W	Urine at 1200 night
3 pm	76	38	130/90	16	500 cc G-S 500 cc G-S	
5 pm	78	38.2	130/90	18	2500 cc Fluids	Total Fluids 2600 c
7 pm	84	37.8	110/60	16		
9 pm	88	37.5	150/90	14		
11 pm	120	37.8	160/80	12		
1 am	140	37.5	170/70	14		
3 am	150	38.6	170/110	18		
5 am	102	38.8	160/100	14		
7 am	100	38		10		

Signed by [redacted], MD

b7c4; b64

014110

EXHIBIT 3 ~~000062~~

36 of 59

Time	pls	B. Press	Temp.	Resp.	In	Fluids out
12 noon	134	150/100	37.5	22	500 cc G.S	600 earlier
2pm	115	140/90	37.5	18	500 cc G.S	
4pm	120	140/90	37.5	16	500 cc G.S 500 cc G.S	outgoing Fluids til 6:00 pm 2000 cc
6pm	105	140/90	37.5	20	500 cc G.S	
8pm	100	150/100	37.8	18	500 cc G.S	til 10:00 am 2000 cc
10pm	122	150/100	37.5	16	3000 cc	
12pm	128	140/90	37.5	16		
2am	120	150/90	37.5	18		
4am	80	150/100	37.3	18		
6am	69	140/90	37.	16		
8am	110	140/90	37.5	16		
10 am	117	150/100	37.3	18		

Signed by [redacted] M.D

b7C4 5
b64

EXHIBIT 5

Time	Pl	ress	Temp.	Resp.	In Fluids	Out Fluids
12 noon	96	160/100	37.5	18	500 cc G-S	external Fluids until 1200 600 cc
2 pm	126	150/90	38	20	500 cc G-S	
pm	120	140/90	37.5	22	500 cc G-S	800 cc 7:00 AM 900 cc
pm	86	140/100	38	16	500 cc G-S 500 cc G-S	
8 pm	116	150/90	37.5	18		1700 cc 600
10 pm	120	150/90	37.5	18		2300 cc Total External Fluids til 7:00 am
2 pm	140	160/100	38.5	18		
am	135	150/90	37.5	16		
am	110	150/90	37.5	18		
am	88	140/90	38	18		
am	87	140/90	37.8	16		

Signed by [redacted], MD
b7c4jb64

014112

EXHIBIT 5 000064
38 of 59

Time	p/s	B. Press	Temp.	Resp.	in	out

Time	Pls	B. Press	Temp.	Resp.	In	out
2 noon	122	140/80	37.8	16	500 cc G-S	
2 pm	105	140/80	37.5	18	500 cc G-S	2000 CC exterior Calories until 10:00 PM
4 pm	117	150/100	37.8	20	500 CC G-S	
6 Pm	120	150/100	37	22	500 CC G-S	
8 Pm	138	150/90	37.3	24	500 CC G-S	
	113	140/90	37.5	22	5000 CC	
	129	150/90	37.5	24		
am	120	140/90	37.3	22		
am	80	150/100	37.5	18		
am	74	150/100	37	20		
am	96	150/90	37.3	18		
10 am	105	150/90	37	18		

Signed by [redacted]

b7c4;b64

M.D

EXHIBIT 5

Time	pls	B. Press	Temp.	Resp.	In	out
2 noon	114	150/100	37.5	18	500cc G.S	1600 cc
2am	120	150/100	37	16		til 3:00 pm
4 PM	129	140/90	37.7	18		
PM	77	140/90	37.3	16	4300 cc	1200 cc til 7:00 pm
8 PM	122	150/100	37.5	20		2800 cc
0 pm	128	150/100	37.5	22		Total
2 pm	82	140/90	37.2	18		
2 am	98	140/90	37	18		
am	116	150/100	37.3	16		
am	110	150/90	37.5	20		
am	99	150/100	37.5	22		
0 am	71	150/90	37.5	18		

Signed by [redacted] M.D

b7c4; b6 4

014115

EXHIBIT 5 000067

41 of 59

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

23 - 8 - 2003

* Comatose, not respon to any painfull stimuli.
(~~[illegible]~~)
* pupil of (2 mm) diameter responce ~~to~~ slightly to to light reflex.
* Corneal reflex (+ve)
* occulo-cephalic reflex (-ve)
* Absent of joint reflex.
* both planter equivocal.

?? Hypoxic Coma
?? Cortical affection bilat
?? vegitative state

① observation carefully. التوقيع
② fluid as given by medical department
③ turn over the patient in addition to other [illegible]
q [illegible] [illegible]

Time	pls	B.Press	Temp.	Resp.	In/Fluids	out/Flu
12 noon	100	120/80	38.10	14	500 c G-S 1000 c G-S	total externa Fluids 1500 cc
2 pm	96	120/80	37.5	16	500 c G-S	
4 pm	112	150/100	37.8	12	500 cc G-S 500 cc	at Two AM 900 cc
6 pm	114	170/100	37.5	12	3000 cc	2400 cc
8 pm	126	140/80	37.5	16		Outgoing Flui
10 pm	130	140/80	38.0	18		
2 mid night	123	150/90	37.5	16		
2 am	120	140/80	37.8	14		
4 am	105	140/90	38	12		
6 am	111	150/90	38.5	18		
8 am	98	120/80	38			

Signed by [redacted], MD
b7c4;b64

Time	pls	B.Press	Temp.	Resp.	In Fluids	out Flu
2 noon	112	160/100	38	26	500 cc G-S	
2 pm	120	150/90	38.8	24	500 cc G-S	outgoing Fluids 2000 cc
4 pm	122	150/100	38.5	22	500 cc G.S	Ttl 10:00
6 pm	127	140/90	38	28	500 cc 1000 cc G-S	
8 pm	130	150/100	37.5	24	3000 cc	1100 cc Ttl 3:00 AM
10 pm	136	150/90	37.3	26	entering fluid	Total 3100 cc
2 mid night	86	140/90	37	18		outgoing Fluids
2am	125	150/100	37	24		
4am	120	140/90	37.3	22		
6 am	125	150/100	37.2	22		
8am	130	150/100	37.5	24		
10am	110	140/90	38	20		

Signed by [redacted], MD

b7c4 ; b6-4

014118

S000070

EXHIBIT 49 of 59

ime	pls	B.Press	Temp.	Resp.	in/Flu	out/Fluid
noon	130	150/100	37.5	22	500 cc G-S	600 ml
pm	126	150/90	38	24	500 cc G-S	12:00
pm	134	140/90	37.8	26	500 cc G-S 500 cc G-S	after 12:00
pm	127	140/90	37.5	22	500 cc G-S 500 cc G-S	800 cc 800 cc
pm	135	160/100	37.3	35	3000 cc	1600 cc 600
pm	160	150/100	37.5	34		2200 cc Total
mid ight	147	150/100	37.2	28		
am	120	150/100	37	24		
am	135	140/90	37.3	22		
am	112	140/90	37.5	18		
am	75	150/100	38	20		
10 am	118	160/100	37.8	18		

signed by [redacted]

MD

b7c4;b64

014119

EXHIBIT 5 000071

05 of 59

0119-04-CID469-79667-5C

Page(s)

72 – 84.

.

Withheld due to:

X Foreign Language

____ Photos depicting Americans

____ Photos depicting foreign nationals

____ Civilian Agency Records

014120

23-8-2003

* Comatose, not respon[se] to any painful stimuli.
(~~[illegible]~~
* pupil of (2 mm) diameter response slightly to to light reflex.
* Corneal reflex (+ve)
* occulo-cephalic reflex (-ve)
* Absent of joint reflex.
* both planter equivocal.

?? Hypoxic Coma.
?? Cortical affection bilat.
?? vegitative state

العلاج

① observation carefully.
② Fluid as given by medicin department
③ transfer of the patient
(medically) to other [illegible]
[illegible]) medical

Page (1)

(ECG) CHART

TIME: 10:00 AM

AUG-23-2003

Page (2)

Time: 10:00 AM

AUG-23-2003

(ECG) CHART

Page #(3)

b7C-3, b6-3

[redacted]

DATE AUG-25-2003

TIME 11:00 A

(ECG) CHART

Treatment Form

Turning over Patient every 1 1/2 HR

b7c-4, b6-4 signed BY

[redacted] MD

AUG 28

Turning over Patient every 1.1/2 HR

signed BY,

[redacted] MD

b7c-4, b6-4

Date Admitting ; AUG. 23 2003

Treatment ;

1- continuing moniter NEXT 24 HR
2- Pads.
3- Moniter the intake & out Fluids
4 Fluide Thru stomach opening
5-
6-
7 Turning over patient evey 2 HR.
8- ~~Glucose~~ GLOCUSE 3000 CC. Feed 500 cc every 4 HR.

Salah Al-deen Hospital - Tikrit

This is an admitting Patient Form

FILE # 289

SEX; MALE

b7c-4, b6-4

NAME; [redacted]

b7c-4, b6-4

DOB; [redacted]

b7c-4, b6-4

BirthPLACE - [redacted]

b7c-4, b6-4

Address: [redacted]

Admission Date: AUG-23-03

BED #; 27

FINAL Diagnosis; Loss consciousness due to central damage (coma)

TRansfer to Haditha General Hospital To Be close To His FAMILY.

signed By

[redacted] MD

b7c-4, b6-4

EXHIBIT # 6
7-6-20

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Law Enforcement Sensitive

Page (12)

Treatment Form

AUG-24
GIVING madication throu the stomach
ALSO clocure 2 & 4
3000 cc
signed by
[redacted] MD
AUG-24. b7c-4/b6-4

AUG-25-
(medication cant be read)
Feed clocuse 3000 cc
Turning over patient every 3 HR
signed by
[redacted] MD
b7c-4, b6-4

AUG-27
medications (cant be read)
clocuse 3000 cc
Also Turning over patient every 3 HR
signed by
[redacted] MD
b7c-4, b6-4

FOUO - For Official Use Only

Law Enforcement Sensitive EXHIBIT # 6
5-26

Page 12
Contd

Treatment Form

Glocuse 3000 cc

medication (cant be read)

Turning over patient 2

AUG-28 signed by

[redacted], MD

b7C-4, b6-4

Page (17)

TIME	PULSE	BP	TEMP	Respive	("Fluids"))	
12:00 Noon	98	150/90	37C	16	IN	OUT
					500 CC	
4:00 PM	113	140/80	37.2C	18	500 CC	
8 PM	138	100/60	38.9C	14	500 CC	
						2000 CC
12:00 Midnight	140	110/60	38.8C	16	500 CC IN 24 HR	
4:00 A	100	100/60	38.9C	18	2500 CC	
8:00 A	84	110/60	38.0C	14	PAds	
12:00 Noon	94	100/80	38.C	16	500 CC	
4:00 P	86	130/90	38.5C	18	500 CC	
8:00 P	100	130/80	38.0C	14	500 CC	2000
					500 CC	CC out
12:00 P	94	110/60	37.6C	18	500 CC	
8:00 A	84	110/60	37.0C	16	2500 CC INTake	

107C4,664 Signed BV

[redacted] MD

7/26

SEP 5 2003

EXHIBIT # 6

(29)

Page (27)

medication & Treatment

Moniter and Turn over the patient every Hour & HALF. ALSO ~~check~~ ~~on~~ Moniter The fluids IN take & out~~[illegible]~~ ALSO ~~check~~ observance of alienation.

Signed BY

DR: [redacted] b7C-4, b6-4

AUG 28 th

Page 28

AUG - 27

b7C-4, b6-4

[redacted] Patient

b7C-4, b6-4

DR: [redacted]

Page ⑳⑥

Date AUG 28. 2003

Medication & Treatment

Moniter and Turn over the Patient every Hour n Half. ALSO Moniter the fluide intake & out ALSO observance of alienation.

b7c-4, b6-4

Dr: [redacted]

⑥

EXHIBIT ⑤

EXHIBIT # 10 of 26

Referring Form From Salah Al-Deen Hospital
To Haditha General Hospital
TRANSFAR DATE. 9-5-03
SEP

b7c-4, b6-4
Patients Name; [redacted]
Age; 58
Date of TRANSFAR; 9-5-2003
SEP
prescribe Bed sickness; unconscious - Resulting From CENTRAL Damage.
Reason For Transfer; To Be close To His Relative
Date of Transfer; 9-5-2003
SEP

Primery physician
[redacted]
b7c-4, b6-4

Director of Hospital
[redacted]
b7c-4, b6-4

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Law Enforcement Sensitive

Page (3 [illegible])

TIME	PULSE	BP	TEMPERTURE	Respire	Fluids Intake &:
12 Noon	100	100/60	37.5C	16	500 C.C. N.S
4 PM	98	90/60	37.2C	18	ALERT SIGHN
—	1~~00~~				Took 500 CC
—	100	90/60	37.5C	14	ALERT SIGHN
12 A	92	100/60	37.8C	18	ALERT SIGHN
4:00 A	90	90/60	37.5C	16	N.S
8:00 A	92	90/60	37.2C	18	C.W

Fluids INtakes
2500 CC

FLUids OUT
2000 CC

SIGHNED BY [redacted] MD

DATE NOT CLEAR

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Law Enforcement Sensitive

EXHIBIT # 6

Page (34)

TIME	PULSE	BP	TEMPERTURE	Respire
12 PM	110	130/80	37.5 C	18
2 PM	100	140/80	37.0 C	16
4 PM	93	130/80	37.0 C	18
6 PM	116	130/80	36.8 C	18
8 PM	100	130/90	37.0 C	16
10 PM	106	130/70	37.5 C	18
12 PM	98	130/90	37.2 C	16
2 AM	94	140/90	37.5 C	14
4 AM	92	140/90	37.6 C	11
6 AM	90	140/90	37.0 C	12

FLUids Intake

500 cc G-S	12 - PM
500 cc G-S	2 PM
500 cc G.S	4 PM
500 cc G.S	6 PM
500 cc G.S	8 PM

2500 cc Intakes.

FLUids out

signed BY [redacted] MD

b7C-4, b6-4

1400 cc

1000 cc

2400 cc. FLUids o

12/26

EXHIBIT # 6

Time	pulse	BP	Temp	Respire	Fluids	
					IN	out
12:0P	120	140/90	37.5C	18	500 cc	1500 cc
2:0P	124	140/90	37.0C	20	500 cc	
4:0P	122	140/90	38.5C	22	500 cc	1000 cc
6:0P	124	130/80	39.0C	18	500 cc	2100 cc
8:0P	127	130/80	38.0C	18	2500 cc	
10 PM	130	130/90	37.5C	16	500 cc	
12:0 PM	125	130/80	37.0	18		
2:0A	—	130/90	37.5C	20		
4:0A	125	130/80	37.3C	22		
6:0A	128	130/80	38.3	20		
8:0A	130	130/80	39.0C	18		

Signed BY

[redacted] M.D

b7c-4 b6-4

014135

14/26

exhibit (5)

EXHIBIT # 6

FOUO - For Official Use Only

Law Enforcement Sensitive

Fluids

Time	pulse	BP	Temp	Respirs	IN	out
12:00P	122	140/80	37.8c	16	500 cc	
2:00A	105	140/80	37.5c	18	500 cc	
4:00P	117	150/100	37.8c	20	500 cc	
6:00P	120	150/100	37.0c	22	500 cc	
8:00P	138	150/90	37.3c	23	500 cc	
10:00P	113	140/90	37.5c	22	500 cc	
12:P	129	150/90	37.0c	24		
2:0A	120	140/90	37.0c	22		
4:0A	80	150/100	37.5c	18		
6:0A	74	150/100	37.0c	20		
8:0A	96	150/90	37.3	18		
10:0A	105	150/90	37.0c	18		

TOTAL FLuide INtake 3000 cc

TOTAL FLuide EXIT 2000 cc

Signed BY

[redacted] MD

AUG 30 b7c-4/b6-4

15/26

FOUO - For Official Use Only

Law Enforcement Sensitive

EXHIBIT # ~~2 HIRT (5)~~ 6

					Fluids	
Time	pulse	BP	Temp	Respirs	IN	out
12:00p	114	150/100	37.5c	18	500cc	1600cc
2:00p	120	150/100	37.0c	16		
4:00p	129	140/90	37.7c	18		
6:00p	77	140/90	37.3c	16		
8:00p	122	150/100	37.5c	20		
10:0p	128	150/100	37.5c	22		
12:00M.N.	82	140/90	37.2	18		1200cc
2:00A	98	140/90	37.0c	18		
4:00A	116	150/100	37.3c	16		
6:00A	110	150/90	37.5c	~~16~~20		
8:00A	99	150/100	37.5c	22		
10:00A	71	150/90	37.5c	18		

TOTAL FLUIDS intake 4300cc

TOTAL FLUIDS out 2800cc

Signed BY

[redacted] M.D

AUG-29 b7c-4,b6-4

16/26

EXHIBIT # 6

FOUO - For Official Use Only

Law Enforcement Sensitive

Time	pulse	BP	Temp	Respirs	Fluids IN	out
12:0P	134	150/100	37.5C	22	500cc	
2:0P	115	140/90	37.8C	18	500cc	
4:0P	120	140/90	37.5C	16	500cc	
6:0P	105	140/90	37.3C	20	500cc	
8:0P	100	150/100	37.5C	18	500cc	
10:0P	122	150/100	37.8	18	500 cc	
12:0P	128	140/90	37.5C	16		
2:0A	120	150/90	37.5C	16		
4:0A	80	150/100	37.3C	18		
6:0A	69	140/90	37.0C	16		
8:0A	110	140/90	37.5C	16		
10:0A	117	150/100	37.3C	18		

TOTAL FLUIds INtake 3000 CC

TOTAL Fluide Exit 2000 cc
Till 10:0 A AUG-29

b7c-4, b6-4 Signed BY
[redacted] MD
AUG-29-2003

FOUO - For Official Use Only

Law Enforcement Sensitive **EXHIBIT #** 6

17/26

FOUO - For Official Use Only

Law Enforcement Sensitive

Time	Pulse	Temp	BP	Respirs	Fluids IN	OUT
11:0A	95	39.4c	110/80	16	1000 cc potassium	
1:0p	78	38.7c	110/80	14	500 ccW	
3:0p	76	38.0c	130/90	16	500 ccGS	
5:0p	78	38.2c	130/90	18	500 ccGS	
7:0p	86	37/8c	160/60	16		
9:0p	88	37.5c	150/90	14		
11:0p	120	37/8c	160/80	12		
1:0A	140	37.5c	170/70	14		
3:0A	150	37.6c	170/110	18		
5:0A	102	37.8	170/100	14		
7:0A	100	38.0c	—	10		

TOTAL Fluids INtake 2500 cc

TOTAL Fluids EXIT 2600 cc IN 24 HR

Signed BY

[redacted]

b7c-4, b6-4

AUG-23 2003

014139

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1/2

Law Enforcement Sensi **EXHIBIT #** 6

Page 41

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Law Enforcement Sensitive

					Fluids	
Time	pulse	BP	Temp	Respirs	IN	out
12:0P	100	120/80	38.0C	14	500CC	
2:0P	96	120/80	37.5	16	1000CC	
					500 CC	1500 CC
4:0P	112	150/100	37.8C	12	500CC	
					500CC	
6:0P	114	170/100	37.5C	14		900CC
8:0P	126	140/80	37.5	16		AT 7:0A
10:0P	130	140/80	38.0	18	IN	out
12:0P	123	150/90	37.5C	16	3000CC	2400CC
2:0A	120	140/80	37.8C	14		
4:0A	105	140/90	38.0C	12		
6:0A	111	150/90	38.5C	18		
8:0A	98	120/80	38.0C	—		

Signed By
[redacted] M.D
b7c-4,b6-4

19/26

FOUO - For Official Use Only
Law Enforcement Sensitive

EXHIBIT # 6

FOUO - For Official Use Only

Law Enforcement Sensitive

Time	pulse	BP	Temp	Respire	FLuids IN	out
12:0P	112	160/100	38.0C	26	500CC	
2:0P	120	150/90	37.8C	24		
4:0P	122	150/100	38.5C	22	500CC	
6:0P	127	140/90	38.0C	28	500CC	2000CC
					500CC	
8:0P	130	150/100	37.5C	24	1000CC	
10:0P	136	150/90	37.3	26	3000CC	1100CC

TOTAL

TOTAL Fluids → 3100CC

Time	pulse	BP	Temp	Respire
12:0P	86	140/90	37.0	18
2:00A	125	150/100	37.0	24
4:0A	120	140/90	37.3	22
6:0A	122	150/100	37.2	22
8:0A	130	150/100	37.5	24
10:0A	115	140/90	38.0	20

Signed By

[redacted] M.D

b7c-4,b6-4

SEP-25

014141

20/26

6

FOUO - For Official Use Only

Law Enforcement Sensitive XHIBIT # ~~XHBT~~ (5)

Referring ~~From~~ Entry Form patient
From salah Al-dean Hospital

Number of patient: 289
SEX: MALE
Name of patient: [redacted] (b)7c-4 (b)(6)-4
Adress: Kirkuk District Al-Nassir
place of Birth: Al-Anbar
Date of Birth: 1945
Submit to: AUG 28 From the Hospital
BED #: 27

Final Diagnosis: Unconscious Resulting From central Damage - TRANSFAIR To Haditha General Hospital To Be close To his relative

Older Resident DR
[redacted] b7c-4 b6-04

Primery physician
[redacted] b7c-4 b6-4

014142

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Law Enforcement Sensitive EXHIBIT # EXHIBIT #5
2 of 26
⑥

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Law Enforcement Sensitive

Referring Entry Form patient
From salah Al-dean Hospital

Number of patient : 289
SEX : MALE
Name of patient : [redacted] b7c-4,b6-4
Address : [redacted] b7c-4,b6-4
place of Birth : [redacted] b7c-4,b6-4
Date of Birth : [redacted] b7c-4,b6-4
Submit to : AUG 28. From the Hospital
BED # : 27

Final Diagnosis : Unconscious Resulting
From central Damage - TRANSFAIR
To Haditha General Hospital To Be
close To his Relative

Older Resident DR
[redacted] b7c-4,b6-4

Primery physician
[redacted] b7c-4,b6-4

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Law Enforcement Sensitive EXHIBIT # EXHIBIT #5
20626

(52)
Page # [illegible]

MD order
Turnover the patient every 1 1/2 HR

cHeck the previous treatment Also calculate the ingoing & outgoing fluids

b7C-4, b6-4
[redacted] MD
AUG - 25

EXHIBIT # 6
22-26

[redacted]

b7C-4, b6-4

88

FOUO - For Official Use Only

Law Enforcement Sensitive

Time	pulse	BP	TEMP	Respire	Fluide IN	out
12:A	96	160/100	37.5	18	500cc	
2:0p	126	150/90	38	20	500 cc	
4:0p	120	140/90	37/5	22	500cc	
6:0p	86	140/100	38.0c	16	500cc	
8:0p	116	150/90	37/5c	18		
10:0p	120	150/90	37.5	16		
12:0	140	160/100	38.5	18		
2:0A	135	150/90	37.5	16		
4:0A	110	150/90	37.5	18		
6:0A	88	140/90	38.0C	18		
8:0A	76	140/90	37.8	16		

Fluids Exit till 12:00 600 cc
Fluide Exit At 7:00 800 cc
Fluide Exit Morning 900 cc

2300 cc

TOTAL EXIT FLuids till seven A.M

signed BY b7c-4, b6-4

[redacted] MD,

AUG 21 2003

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Law Enforcement Sensitive

EXHIBIT # 6

24/26

No Number

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Law Enforcement Sensitive

Discharge Date

SEP-5-2003 b7c-4, b6-4

Address: [redacted]

Age: 58

Diagnostic MD b7c-4, b6-4

[redacted]

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Law Enforcement Sensitive

EXHIBIT # 6

25-26

FOUO - For Official Use Only

Law Enforcement Sensitive

	Time	pulse	BP	Temp	Respire	Fluids IN	Fluids out
ort	12:0	130	150/100	37.5	22	GS 500cc	
	2:0P	126	150/90	38.0c	24	GS 500cc	
	4:0P	134	140/90	37.8	26	GS 500cc	
	6:0P	127	140/90	37.5c	22	GS 500cc	
	8:0P	135	160/100	37.3	35	GS 500cc	
	10:0P	110	150/100	37.5	34	GS 500cc	
	12:0A	147	150/100	37.2	28		
	2:0A	120	150/100	37.0c	24		
	4:0A	135	140/90	37.3c	22		
	6:0A	112	140/90	37.5	18		
	8:0A	75	150/100	38.0	20		
	10:0A	118	160/100	37.8	18		

Fluids Exit till 12:00. AUG-26 is 600 CC
Fluids Exit AFTER 12:00 800 cc
800

TOTAL Exit Fluid 2000 cc

Signed BY
[redacted] b7C-4
b6-4
AUG-26

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EXHIBIT # 6
26 of 26

Dear Dr.-

good morning.

* I receive an examine the patient at- (27-8-2003) and he was unconcious with the following examination points:-

* spontanous eye opening and both eye ball move unward.

* pupills of 3.mm diameter c slugish reacting to light

* breathing -(cheyne-stoke)

* There is (no) any sign of trama to the body and even (no) bed sore

thank you.

b6-4 b7-C4

31- [redacted] 004

-Dr- b7C-4,b6-4

[redacted]

014149

EXHIBIT 7

b7C-4, b6-4

[redacted]

FOUO - For Official Use Only Date of admission = 23. Aug. 2004
Law Enforcement Sensitive Date of discharge 5. Sep. 2004

Middle age male was referred to Salah. A. general hospital from the 28th. Combat support hospital in the morning of 23. Aug. 2004. According to medical report accompany with the patient which suggest the diagnosis of hypoxic brain injury related to Myocardial infarction and heat stroke.

On arrival he was unconscious, not response to any painfull stimuli. Blood pr. 140/80, Respiratory rate 44/min, Temp. 40 °c, Puls rate 80/min. regular, with Tracheostomy, gastrostomy for feeding & Central venous line, and there is no obvious evidence of Truma. Neurological examination suggestive of bilateral Cortical affection with vegetative State.

Available investigation include, Blood urea. Random blood Sugar no hematological test were done & apart from mild anemia no abnormal results. ECG show no evidence of Ischemic change.

During admission he was treated conservatively with I.V. fluid, antibiotic, change of position, feeding by gastrostomy tube. & monitoring, without any improvement or evidence of recovery until he referred to other hospital according to the need of his relation in 5. Sep. 2004

b7C-4, b6-4

[redacted]

EXHIBIT 8 ~~000113~~

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0475-04-CID023

PAGE 1 OF 1 PAGE

DETAILS

BASIS FOR INVESTIGATION: About 1307, 24 Jun 04, this office received a Request for Assistance from the 286th Military Police Detachment (CID). It was requested this office locate, fully identify and interview LTC [redacted], B Company, Womack Army Medical Center, Fort Bragg, NC 28307, regarding treatment he provided to Mr. [redacted] while Mr. [redacted] was detained by U.S. forces in Iraq.

b7c-4, b6-4 b7c-4, b6-4

b7c-4, b6-4 b7c-4, b6-4 b7c-4, b6-4

About 1100, 30 Jun 04, SA [redacted] interviewed LTC [redacted], who rendered a sworn statement. LTC [redacted] stated he did not notice any injuries on the feet or head of Mr [redacted] while treating him in Iraq. LTC [redacted] provided SA [redacted] with a copy of the narrative summary of treatment he prepared documenting Mr. [redacted] treatment. The summary was prepared when Mr. [redacted] was transferred from 28th Combat Support Hospital to the Tikrit Teaching Hospital. (See Sworn Statement and Narrative Summary of Treatment for details)///LAST ENTRY///

b7c-4, b6-4

b7c-4, b6-4

TYPED AGENT'S NAME AND SEQUENCE NUMBER b7c-1, b6-1, b2 SA [redacted]	ORGANIZATION 87th Military Police Detachment (CID) (DSE) Fort Bragg, NC 38310

SIGNATURE [redacted]	DATE 30 Jun 04	EXHIBIT 9

CID FORM 94
1 FEB 77

FOR OFFICIAL USE ONLY

Encl 1

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).

PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.

ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.

DISCLOSURE: Disclosure of your social security number is voluntary. b7c-4, b6-4 [redacted]

1. LOCATION Fort Bragg, NC 28310	2. DATE (YYYYMMDD [redacted] 2004/06/30 [redacted]	TIME 1157	4. FILE NUMBER 0475-04-CID023
5. LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7c-4, b6-4	6. SSN b7c-4, b6-4 [redacted]		7. GRADE/STATUS LTC/AD

8. ORGANIZATION OR ADDRESS
B Company, Womack Army Center, Fort Bragg, NC 28310

9. b7c-4, b6-4
I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

b7c-4, b6-4

I have been asked to comment about my knowledge of an Iraqi patient named [redacted]. My knowledge of this patient is limited to the fact that I treated him while in Tikrit, Iraq during August 2003 at the 28th Combat Support Hospital. The details of his medical condition and my treatment are listed in a narrative summary I prepared on 23 Aug 03 to provide to the physicians at the Tikrit Teaching Hospital where we transferred this patient.
To briefly summarize: he was transferred to my care from the aid station near the Tikrit palace for treatment of a possible seizure. Upon arrival at our facility he was found to be in full respiratory arrest and required intubation and volume rescucitation. He also experienced a cardiac arrhythmia and sustained a myocardial infarction. He was also noted to be a heat casualty with a markedly elevated core body temperature. The net result of all these conditions was that Mr. [redacted] sustained hypoxic brain injury and was in a persistant vegetative state at the time of his transfer to the civilian facility.
I have described to Agent [redacted] my phone conversation on the day after Mr. [redacted] admission with the provider at FOB Ironhorse. I do not recall her name or specific title, other than that she was a female provider who referred patients to me for further evaluation and treatment. Specifically, I recall that she and I discussed his condition on transfer which was talking and with a mildly diminished blood oxygen saturation level of ninety to ninety-one percent. She reported that she had seen him earlier in the afternoon on the day of his transfer and that he'd reported some vague chest pains, but she'd released him back to his quarters when she examined him and found him to be pain-free and with stable vital signs. Just prior to transfer he'd been brought back to her aid station after several other Iraqi detainees reported his as having shaking activity. I don't recall her saying that she witnessed any shaking, but she wanted him transferred to us for more observation given that our capabilities were greater than hers. There was no discussion of the patient's temperature and she never made mention of any interrogations of this patient.
Agent [redacted] has shown me photos from an article on the internet that allegedly shows Mr [redacted] face, back of head and feet. I do not have the ability to recall his facial appearance. Likewise, I do not recall any injuries to the back of his head, or to the soles of his feet that would be consistent with electrical injuries or wounds inflicted during torture. As a physician serving in the role of a critical care specialist, my focus in treating this patient was on his life-threatening conditions and I do not recall observing anything unusual about markings or injuries on his body.

b7c-4, b6-4 b7c-4, b6-4

Q: Do you recall anything else about Mr. [redacted] b7c-4, b6-4
A: No.
Q: Is there anything else you would like to add to this statement?
A: No///END OF STATEMENT///

014152

b7c-4, b6-4

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT [redacted]	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE

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Encl 2

EXHIBIT ~~1~~ 10
1 of 2

b7c-4,b6-4 [redacted] 0475-04-CID023

STATEMENT OF LTC[redacted] **TAKEN AT** Fort Bragg, NC **DATED** 2004/06/30

9. STATEMENT *(Continued)*

Not used

b7c-4,b6-4 [redacted]

AFFIDAVIT

I, [redacted] b7c-4,b6-4, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM [redacted] CH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF [redacted] WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, [redacted]

b7c-4, b6-4

(Signature of Pers[redacted] Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to [redacted] on authorized by law to administer oaths, this 30th [redacted] June, 2004 at Fort Bragg, NC

[redacted] b7c-1 b6-1

(Signature of Person Administering Oath)

SA [redacted] b7c-1, b6-1

(Typed Name of Person Administering Oath)

ART 136 B 4, UCMJ

(Authority To Administer Oaths)

014153

INITIALS OF PERSON MAKING STATEMENT b7c-4,b6-4 [redacted]

PAGE 2 **OF** 2 **PAGES**

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EXHIBIT ~~10~~ 000116

2 of 2

Page(s)

117-118 .

.

Referred to:

U.S. ARMY MEDICAL COMMAND
FREEDOM OF INFORMATION/
PRIVACY ACT OFFICE
ATTENTION: MCFP
2050 WORTH ROAD, SUITE 13
FORT SAM HOUSTON, TEXAS
78234-6013

MR. JOHN PETERSON
John.Peterson1@cen.amedd.army.mil
(210) 221-7826

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AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0611-04-CID034

PAGE 1 OF 1 PAGE

DETAILS

b7c-1,b6-1

About 1545, 21 Jul 04, this office received a Request for Assistance from SA [redacted], 286th Military Police (MP) Detachment (CID), 22nd MP Battalion (BN), Operation Iraqi Freedom II, APO AE 09329 to locate, fully identify, and interview CPT [redacted], Staff Judge Advocate (SJA), Fort Hood, TX 76544 (FHTX); coordinate with 28th Combat Support Hospital (CSH), FHTX to obtain medical records of MR [redacted] and identify any personnel who had contact with him. b7c-4,b6-4

b7c-1,b6-1

About 2338, 21 Jul 04, SA [redacted] this office, determined that the 28th CSH is located at Fort Bragg, NC. SA [redacted] instructed this office to disregard interviews of the 28th CSH. b7c-1,b6-1

b7c-4,b6-4 b7c-1,b6-1

About 1300, 22 Jul 04, CPT [redacted] contacted SA [redacted] and informed him that she did not conduct any detainee interviews while deployed to Iraq due to the fact that she was female. CPT [redacted] stated that CPT [redacted] 4th Infantry Division (4ID), SJA, FHTX, did conduct interviews of prisoner detainees. b7c-4,b6-4

b7c-3,b6-3 b7c-1,b6-1 b7c-4,b6-4

About 1407, 22 Jul 04, SA [redacted] contacted CPT [redacted] who stated the only interviews he conducted were of the [redacted] brothers, (NFI). One aged 16 years old and the other was 19 years old. CPT [redacted] stated he asked other attorneys in his office if they had conducted any detainee interviews while deployed to Iraq which met with negative results. He stated he had no knowledge of anyone who might have interviewed anyone who was in the custody of the 28th CSH, or who worked in the Kirkuk area. b7c-4 b6-4

b7c-1,b6-1 b7c-4,b6-4 b7c-4,b6-4

About 1153, 23 Jul 04, SA [redacted] conducted interview of CPT [redacted]. CPT [redacted] stated that the 4th MP Company, FHTX was in charge of the Tikrit Detention Facility, Iraq and she remembered the 720th MP BN was in Kirkuk, Iraq. (See Sworn Statement for details).

b7c-1,b6-1 b7c-4,b6-4

About 1435, 23 Jul 04, SA [redacted], this office, conducted interview of CPT [redacted], Commander, 4th MP Company, 4ID, FHTX who stated that he had a platoon from the 978th Military Police Company, Fort Bliss, TX who manned the Tikrit Detention Facility during the time frame of the incident. He stated they maintained records and release to medical facilities and thinks most of the information is maintained in Iraq.

b7c-1,b6-1

About 1458, 23 Jul 04, SA [redacted] contacted this office and stated her office no longer needed assistance from this office.

STATUS: The basic requirement of this request is complete and no further activity is anticipated by this office.///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER b7c-1,b6-1 SA [redacted]	ORGANIZATION Fort Hood Resident Agency, 6th MP GRP (CID), Fort Hood, TX 76544

SIGNATURE b7c-1,b6-1 [redacted]	DATE 23 Jul 04	EXHIBIT 12

CID FORM 94
(Automated)

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Automatic Termination (Para 13, AR 34-16)
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LAW ENFORCEMENT SENSITIVE
0611-04-CID034

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

b7c-4, b6-4

LOCATION Bldg 410, Fort Hood, TX 76544	DATE [redacted] 23 Jul 04	TIME [redacted] 1153	FILE NUMBER 0611-04-CID034
LAST NAME, FIRST NAME, MIDDLE NAME b7c-4, b6-4 [redacted]		SOCIAL SECURITY NUMBER [redacted]	GRADE/STATUS 03/RA

ORGANIZATION OR ADDRESS
HHC, 410 HEADQUARTERS b7c-4, b6-4

I, [redacted] [redacted] b7c-4, b6-4 ~~WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:~~

At no point during my deployment to Iraq in support of Operation Iraqi Freedom (31 May 2003 - 21 March 2004) did I ever interview an Iraqi detainee. The only interaction I ever had with any Iraqis took place during police training in Tikrit, Iraq, where I was stationed. I did, however, draft probable cause Magistrate reviews for many of the detainees, but the reviews were based off of detention packets and not off of any personal interviews with any detainees.

Q. [redacted] b7c-1, b6-1

A. [redacted] b7c-4, b6-4

Q. Do you remember what MP company was in charge at the TIKRIT Detention facility?

A: 4 MP CO Ft. Hood TX

Q: Which MP CO was in charge of the KIRKUK Detention facility?

A: I have no idea who ran that. I know the 720th MP BN, Ft. Hood, TX was in KIRKUK. b7c-4, b6-4

Q: Do you remember Mr. [redacted] detention packet?

A: NO: I did close to 400 magistrate reviews.

Q: Do you know anyone who interviewed any detainees?

A: YES. CPT [redacted], 410 HQ, ~~Trial Counsel~~ Administrative Law Attorney interviewed 2 brothers. But that's it. b7c-4, b6-4

Q: Did you ever personally see any Iraqi detainees?

A: I went down to the detention facility once to get some files. I didn't see anyone who looked injured. They were walking outside and some were sitting under a cover provided for them. That was the only time I ever saw any detainees [redacted] b7c-4, b6-4

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted]	014156 PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE ___ OF ___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 2823, 1 JUL 72 — FOR OFFICIAL USE ONLY — SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.
LAW ENFORCEMENT SENSITIVE

EXHIBIT 13 000120

[illegible] 04-CID469-79667

b7c-4, b6-4 [redacted]

[redacted] b7c-4, b6-4

b7c-4, b6-4

[redacted]

STATEMENT OF [redacted] TAKEN AT Ft. Hood, Tx 76544 File Number: 0611-04-C10034 DATED 23 JUL 04 CONTINUED:

STATEMENT (Continued)

Q: Do you have anything you wish to add to this statement?

A: NO. ///END OF STATEMENT///

b7c-4, b6-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE [redacted] ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

b7c-4
b6-4

[redacted]
(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 23 day of JULY, 2004
at FORT Hood, TX 76544

ORGANIZATION OR ADDRESS

b7c-1
b6-1

[redacted]
(Signature of Person Administering Oath)

b7c-1, b6-1

SA [redacted]
(Typed Name of Person Administering Oath)

ORGANIZATION OR ADDRESS

ART 136, UCMJ
(Authority To Administer Oaths)

014157

INITIALS OF PERSON MAKING STATEMENT [redacted] b7c-4, b6-4

PAGE 2 OF 2 PAGES

EXHIBIT 15

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0329-04-CID014

PAGE 1 OF 2 PAGES

DETAILS

BASIS FOR INVESTIGATION: On 27 Jul 04, this office received a Request for Assistance (RFA) from the 286th Military Police (MP) Detachment (Det), (CID), 22nd Military Police (MP) Battalion (Bn), Tikrit, Iraq, requesting this office locate, identify and interview SGT [redacted] 16TH MP Det, Fort Bliss, TX (FBTX), SGT [redacted] b7c-4, b6-4 978th MP Company (Co.), FBTX, and SPC [redacted] 978TH MP Co., FBTX, regarding their treatment and transfer of Mr. [redacted] b7c-4, b6-4 b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4
About 1705, 27 Jul 04, SA [redacted] interviewed SGT [redacted] who provided a sworn statement regarding his knowledge of prisoner abuse while assigned to the DCCP in Tikrit, Iraq from Jul 03 to Mar 04. SGT [redacted] provided SSG [redacted] (NFI) as the other 978th MP Co. soldier assigned to detention duties at the DCCP. (See Sworn Statement for details) b7c-4, b6-4 b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4
About 1825, 27 Jul 04, SA [redacted] interviewed SSG [redacted], 16TH MP Company, FBTX, who provided a sworn statement regarding his knowledge of prisoner abuse while assigned to the DCCP in Tikrit, Iraq from Jul 03 to Mar 04. (See Sworn Statement for details)

b7c-1, b6-1 b7c-3, b6-3
About 1124, 28 Jul 04, SA [redacted] traveled to Mr. [redacted] residence, [redacted] and attempted to make contact with Mr. [redacted] After several tries, no contact was made. b7c-3, b6-3

b7c-1, b6-1 b7c-4, b6-4
About 1230, 28 Jul 04, SA [redacted] re-interviewed SGT [redacted] regarding the Staff Journal Log for 11 Aug 03. SGT [redacted] reviewed the Staff Journal Log, and stated he remembered SGT [redacted] responded to the detainee and ordered him to be transferred to the 28th Combat Support Hospital (CSH) for further evaluation, but SGT [redacted] didn't know exactly what was wrong with him, so he told SGT [redacted] to write "seizures" in the log. Additionally, SGT [redacted] stated there were 10 soldiers from the 978th MP Co. on duty that shift; four of them were assigned to tower guard, two were in the operations office, and the other four were assigned to the detention cells, which this office had interviewed. SGT [redacted] stated of the 10 soldiers, only those four stationed at the detention cell had direct access to the detainees. b7c-4 b6-4

TYPED AGENT'S NAME AND SEQUENCE NUMBER b7c-1, b6-1, b2 SA [redacted]	ORGANIZATION ~~Ft Bliss Resident Agency (CID)~~ 11th MP Bn, USACIDC FT Bliss, TX 79916
SIGNATURE [redacted]	DATE 28 Jul 04 — EXHIBIT 14

014158

CID FORM 94
1 FEB 77

1 of 2

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1*	ROI NUMBER 0329-04-CID014 PAGE 2 OF 2 PAGES

DETAILS

b7c-1, b6-1 b7c-4, b6-4

About 1545, 28 Jul 04, SA [redacted] interviewed Mr. [redacted] who provided a sworn statement regarding his knowledge of this incident. Mr. [redacted] b7c-4 b6-4 stated he was not assigned to the DCCP, and never had occasion to go there. (See Sworn Statement for details)

All requested investigative leads were completed. This office does not anticipate further investigative activity. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER b7c-1, b6-1, b2 SA [redacted]	ORGANIZATION ~~Ft Bliss Resident Agency (CID)~~ 11th MP Bn, USACIDC FT Bliss, TX 79916	
SIGNATURE [redacted]	DATE 28 Jul 04	EXHIBIT 14

014159

FOR OFFICIAL USE ONLY 0 9-04-CID014

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS.

CID 469-79667

LOCATION Fort Bliss Resident Agency (CID)	DATE [redacted] 27 Jul 04	TIME [redacted] 1705	FILE NUMBER 0329-04-CID014
LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7C-4, b6-4	SOCIAL SECURITY NUMBER [redacted] b7C-4, b6-4		GRADE/STATUS SGT/AD

ORGANIZATION OR ADDRESS
16th Military Police Detachment, Fort Bliss, TX 79916

b7C-4, b6-4

I, [redacted] want to make the following Statement under oath:

I was assigned to the 978th Military Police Company in Dec 2000. I deployed to Iraq with the company on 7 Apr 03. I was assigned duty at the 4th Infantry Division Centralized Collection Point (DCCP), the detention facility in Tikrit, Iraq, on July 03. My primary responsibility while there was to oversee the in processing of detainees and oversee the "Alpha" and "Bravo" Category detainees. Those detainees assigned to the Alpha category were those that were Fedayeen tribesmen, "sheiks" or mayors of towns and villages loyal to Saddam Hussein, financiers, or relatives or members of the Hussein family. In addition, detainees that were captured during attacks on U.S. military personnel were assigned to the Bravo Category. Typically, my day would consist of getting up for roll call, doing a detainee head count around 0900hrs, give them food and water (during August, we gave the detainees four bottles of water at 0900hrs, 1200hrs, and 1700hrs everyday.) We fed them twice a day, at 0900 and 1700hrs, which was the basic MRE without the accessory pack. We had two headcounts, one coming on shift and one going off shift, every day.

Q: SA [redacted] b7C-1, b6-1

A: SGT [redacted] b7C-4, b6-4

Q: In what condition did the detainees typically arrive at your detention facility?

A: Depending on where they were coming from, some of them would have bleeding wounds, and some of them would have injuries to their heads, depending on who captured them. Some would have shrapnel wounds, or others would have gunshot wounds from battle. Those were the most seen injuries.

Q: Do you remember treating any detainees for heat stroke or heart attacks?

A: There was one guy sometime in late August 03, who couldn't get off one of the five-ton trucks that brought the detainees from Kirkuk because he was unconscious. Typically, the transfer truck would back right up to the detention cage. Depending on their detainee category, the prisoners would be counted, given an identification number, and then sent to their respective holding cells. This guy could not get off the truck. He was still on the truck. SSG [redacted] assigned an escort to the guy. I don't remember who his escort was. I started in processing the remaining prisoners.

b7C-4, b6-4 b7C-4, b6-4

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4, b6-4	PAGE 1 OF [redacted] PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___ CONTINUED."

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE ___ OF ___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

014160

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EXHIBIT 15

000124

b7c-4, b6-4

STATEMENT OF [redacted] var, TAKEN ON 27 Jul 04, CONTINUED

I do not know what happened to the guy after SSG [redacted] assigned his escort.
Q: Who is SSG [redacted] b7c-4, b6-4 b7c-4, b6-4
A: He was my squad leader while in Iraq. He's currently assigned to 16th MP detachment as the Ops SGT. He's white, about 6'2", large build, and balding with his hair cut short.
Q: What were the conditions at your detention facility like?
A: The welfare was good, but the buildings were terrible, until near the end of our rotation, when the engineers built wooden shelters for the detainees. Before that, the detainees were housed in rooms inside an old school house. There was concertina wire run in between the rooms, to separate the cells and the detainees.
Q: What kinds of problems did the detainees present to your unit?
A: Most of them didn't want to be there, of course. They would typically go on hunger strikes, and sometimes would pass out from lack of food and the heat. When they did that, we would have to transport them to the 28th Combat Support Hospital (CSH), located on Camp Spiecher, Tikrit, Iraq. It was about 15 minutes up the road.
Q: What were the typical reason detainees needed medical treatment?
A: Most of them had illnesses that they came to the facility with. Once we identified they had illnesses, we would take their medicines and turn them over to the aid station at my facility.
Q: Besides the individual you described, did any other detainees suffer heat stroke or heart attacks?
A: There were a couple that fell out from the heat during their hunger strikes, but I don't recall how many.
Q: Do you recall treating and then transporting a detainee that had gone comatose while at the detention facility?
A: No.
Q: Do you recall anyone treating a detainee with those conditions?
A: Not that I recall. b7c-4, b6-4 b7c-4, b6-4 b7c-4, b6-4
Q: Did you know a soldier by the last name of [redacted], or [redacted]
A: There was a SGT [redacted] who was a medic with the 4th ID who was assigned with me; there was a SPC [redacted] in 978th MP who was assigned to a different facility than I was. b7c-4, b6-4
Q: Did you know a SGT [redacted] b7c-4, b6-4
A: Yes, he was a medic with the 978th MP Company. He was assigned to the same detention facility as I was while in Iraq.
Q: Do you recall if SGT [redacted] ever treated anyone who was comatose or had suffered from a heart attack? b7c-4, b6-4
A: Not too sure. A lot of the detainees claimed to have heart problems though.
Q: Do you recall if anyone at the detention facility treated a detainee for heat stroke, heart attack, or comatose conditions?
A: Other than the guy I talked about earlier, no.
Q: Did you ever witness any acts of aggression against detainees?
A: No. A couple of the detainees got into a fight with one another, but they weren't injured by it.
Q: Did any of the detainees brought to your facility show signs of burns upon their feet, hands, or body?
A: Not burns, flesh wounds, amputation wounds, yes. There was one guy, 19 years old I think, that arrived at the detention facility with shrapnel wounds to his arm and side. I remember hearing he had fired an RPG too close to his target, and the explosion blew back onto him.

014161

Q: Did any of the detainees suffer cuts to their arms and hands?
A: One guy came to us who didn't have any hands, but those were already healed wounds. Another guy had one of his fingers cut off, but that was already healed as well.

b7c-4, b6-4

EXHIBIT 15

FOR OFFICIAL [redacted] SE ONLY 0119-0 -CID014

INITIALS OF PERSON MAKING STATEMENT PAGE 3 PAGES.

STATEMENT *(Continued)* b7c-4,b6-4 0119-04-CID469-79667

Q: Do you recall the name [redacted]

A: No. All the detainees were assigned a number and category when they arrived at the detention facility, but I don't remember that name.

Q: Do you recall any instances of prisoner abuse at the detention facility?

A: Just rumor. I didn't witness anything like that.

Q: Is this statement an accurate reflection of your spoken words?

A: Yes.

Q: Is there anything else you wish to add to this statement?

A: No. ///END OF STATEMENT//[redacted] b7c-4,b6-4

b7c-4,b6-4

AFFIDAVIT

I, [redacted] HAVE READ OR HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE___. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUCEMENT.

b7c-4
b6-4

[redacted]

(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by Law to administer oaths, this 27th day of Jul, 2004
at Fort Bliss Resident Agency (CID), Fort Bliss, TX 79916

b7c-1,b6-1

[redacted]

ORGANIZATION OR ADDRESS

(Signature of Person Administering Oath)

b7c-1,b6-1

SA [redacted]

(Typed Name of Person Administering Oath)

Article 136 (b) (4) UCMJ

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

b7c-4,b6-4 b7c-4,b6-4

014162

INITIALS OF PERSON MAKING STATEMENT [redacted] PAGE 1 OF 3 PAGES.

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EXHIBIT 15

000126

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SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

[illegible] - CID 469-79667

LOCATION ~~Fort Bliss Resident Agency (CID)~~	DATE [redacted] ~~27 Jul 04~~	TIME ~~18:25~~ [redacted]	FILE NUMBER ~~0329-04-CID014~~
LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7c-4, b6-4	SOCIAL SECURITY NUMBER		GRADE/STATUS SSG/AD

ORGANIZATION OR ADDRESS
~~16th Military Police Detachment, Fort Bliss, TX 79916~~

b7c-4, b6-4

[redacted] want to make the following Statement under oath: I was assigned to 1st Platoon, 978th Military Police (MP) Company, Fort Bliss, TX (FBTX) during our deployment for Operation Iraqi Freedom I from 7 Apr 03 to 27 Mar 04. From Jul 03 to Jan 04 I was assigned to the 4th MP Company, Fort Hood, TX and was working at the Division Centralized Collection Point (DCCP), Tikrit, Iraq, Forward Operating Base (FOB) Ironhorse. My duties while at the DCCP included Sergeant of the Guard while at the detention facility. While not working the detention facility, I worked as the NCOIC for the Quick Reaction Force (QRF). While at the detention facility as Sergeant of the Guard I ensured the day-to-day business of the detention facility was taken care of.

b7c-4, b6-4

Q: SA [redacted]

A: SSG [redacted] b7c-4, b6-4

Q: Do you recall ever observing any detainees being transferred to the 28th Combat Support Hospital (CSH) for treatment of heat stroke, heart attacks, or being comatose?

A: I think one detainee was transferred, I think for heat stroke. He was transported to the detention facility in an Light-Medium Tactical Vehicle (LMTV), in the back of the truck. He could have come from Kirkut, Iraq, or from FOB Warhorse, I don't remember exactly. It was either in August 03 or September 03. I remember that the detainee was suffering from heat stroke, I think, and he couldn't get out of the truck on his own. I wasn't out there when this occurred, so I don't know what happened to him once he arrived.

Q: Do you recall any detainees suffering from burns to their feet, hands, or cuts on their arms?

A: No.

Q: Do you recall if any detainees were injured or killed while you were at the detention facility?

A: No.

Q: Do you recall if any detainees were transported to your detention facility with injuries?

A: I do remember seeing detainees arrive at the detention facility with various combat wounds, shrapnel wounds, and the like. Most of them had been already treated for their wounds; we had to monitor their care while they were at the detention facility. Some of the detainees were also treated for heart conditions and took nitroglycerine tablets.

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted] b7c-4, b6-4	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___TAKEN AT___DATED___CONTINUED."

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___OF___PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 2823, JUL 72 SUPERSEDED DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 16

STATEMENT *(Continued)*

b7C-4, b6-4

Q: Do you recall the name of Mr. [redacted] as a detainee?
A: No. The detainees were identified by numbers while they were at the detention facility.
Q: What was the disposition of the detainee that had suffered from heat stroke in the back of the truck?
A: He was transported to the CSH, and then the CSH turned him over to the hospital somewhere, a local hospital I think. b7C-4, b6-4
Q: Did you know a soldier by the name of [redacted] or [redacted]
A: I believe [redacted] was a medic assigned to the 4th MP Company. He was at the detention facility during the time that I was there.
Q: Where is [redacted] now?
A: I don't know. He left Iraq earlier, before the units redeployed.
Q: Did you know a soldier by the name of SGT [redacted] b7C-4, b6-4
A: Yes, he was our medic. He was assigned to the 978th MP Company. I don't remember when he came to the detention facility though.
Q: Did you work with SGT [redacted] b7C-4, b6-4
A: Yes, he would come and check on the detainees that complained of medical problems to us. b7C-4, b6-4
Q: Where is SGT [redacted] now?
A: He's still in 978th MP Company, FBTX.
Q: Did you ever witness instances of detainees being injured while at the detention facility?
A: No.
Q: Did you see any detainees with burn injuries?
A: No.
Q: Is this statement a true reflection of your spoken words?
A: Yes.
Q: Is there anything else you wish to add to this statement?
A: No. ///END OF STATEMENT/// [redacted] b7C-4, b6-4

b7C-4, b6-4

AFFIDAVIT

I, [redacted] HAVE READ OR HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUCEMENT.

b7C-4, b6-4

[redacted]
(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by Law to administer oaths, this 27th day of JULY, 2004
at Fort Bliss Resident Agency (CID), Fort Bliss, TX 79916

[redacted] b7C-1, b6-1
(Signature of Person Administering Oath)

ORGANIZATION OR ADDRESS

b7C-1, b6-1
SA [redacted]
(Typed Name of Person Administering Oath)
Article 136 (b) (4) UCMJ
(Authority to Administer Oaths)

ORGANIZATION OR ADDRESS

b7C-4, b6-4

INITIALS OF PERSON MAKING STATEMENT [redacted] PAGE 2 OF 2 PAGES

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FOR OFFICIAL USE ONLY 0329-04-CID014

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is DCSOPS 0119-04-CID469-79667

LOCATION Fort Bliss Resident Agency (CID)	DATE 28 Jul 04 [redacted]	TIME 1545 [redacted]	FILE NUMBER
LAST NAME, FIRST NAME, MIDDLE NAME b7C-4 b6-4 [redacted]	SOCIAL SECURITY NUMBER [redacted] b7C-4, b6-4		GRADE/STATUS CIV

ORGANIZATION OR ADDRESS b7C-4, b6-4
[redacted]
b7C-4, b6-4

[redacted] I, [redacted], want to make the following Statement under oath:

I was assigned to 2nd Platoon, 978th Military Police Detachment, FBTX, when we deployed to Iraq in Apr 03. Once in country, my platoon and I were assigned to Camp Ashraib. I don't remember what town it was in. My primary mission was convoy escorts and security duties for the convoys moving between camps. I left Iraq in Nov 03 back to FBTX to process out of the Army. My ETS date was 25 Feb 04.

Q: SA [redacted] b7C-4, b6-4

A: Mr. [redacted] b7C-4, b6-4

Q: Were you ever assigned duty at the Division Centralized Collection Point (DCCP)?

A: No.

Q: Did you ever escort detainees to the DCCP?

A: No.

Q: Did you ever take part in raids or operations that captured detainees?

A: Yes, I was part of one raid where we took about 15 detainees. Once we had them out of the buildings, we put them on the ground, face down, and turned their heads away from each other, so they couldn't talk to one another. Then, we bound their hands with zip-ties, sat them up, and put them onto the back of an Light-Medium Tactical Vehicle (LMTV). I remember that all the detainees we captured that night were in good shape when we put them on the truck. After we loaded them onto the truck, I never saw them again.

b7C-4, b6-4

Q: Did you know of a detainee named [redacted]

A: No.

Q: Did you witness any of the detainees being struck, burned or cut?

A: No.

Q: What was your MOS in the Army?

A: 31B, Military Police.

Q: Did you ever hear of a detainee being brought to the 28th CSH in a coma or comatose state?

A: No.

Q: Is this statement an accurate reflection of your spoken words?

A: Yes.

Q: Is there anything else you wish to add to this statement?

A: No. ///END OF STATEMENT///

b7C-4, b6-4

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted]	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___ CONTINUED."
THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE ___ OF ___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

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EXHIBIT 17 ~~000129~~

INITIALS OF PERSON MAKING ST EN FOR OFFICIAL USE ONLY PAG F 2 PAGES.

STATEMENT *(Continued)*

0119-04-CID469-79667

Not USED b7C-4,b6-4 [redacted]

AFFIDAVIT

b7C-4,b6-4

I, [redacted], HAVE READ OR HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUCEMENT.

[redacted] b7C-4,b6-4

(Si[redacted] Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by Law to administer oaths, this 28TH DAY OF JULY, 2004

at Fort Bliss Resident Agency (CID)

b7C-1,b6-1

[redacted]

ORGANIZATION OR ADDRESS

(Signature of Person Administering Oath)

b7C-1,b6-1

SA [redacted]

(Typed Name of Person Administering Oath)

Article 136 (b) (4) UCMJ

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

014106

INITIALS OF PERSON MAKING STATEMENT [redacted] b7C-4,b6-4	PAGE 2 OF 2 PAGES

EXHIBIT 16

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0554-04-CID023

FC

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0119-04 CID469
0140-04-CID044

PAGE 1 OF 1 PAGES

DETAILS

b7c-4,b6-4

Basis For Investigation: About 1355, 09 Aug 04, this office received Request For/Assistance (RFA), 0268-04-CID001 requesting this office obtain medical treatment records for Mr. [redacted] and to identify any individuals from the treatment records presently in our area of operations (AOR), in order to conduct interviews regarding injuries to Mr. [redacted], specifically, injuries to his head, cuts on his arm and burn marks on the bottom of his feet. b7c-4,b6-4

b7c-1,b6-1 b7c-4,b6-4

About 1400, 09 Aug 04, SA [redacted] conducted an interview of MAJ [redacted], Chief, Data Management Branch, Patient Administration System and Biostatistics Activity (PASBA), Fort Sam Houston, Texas 78234 (FSHTX) who confirmed that the Medical Records of Mr. [redacted] Iraq, (NFI), were held in his department. MAJ [redacted] stated that he did not know Mr. [redacted] personally, nor did he ever treat Mr. [redacted] for any injuries. MAJ [redacted] further stated that Mr. [redacted] was never treated at FSHTX, and the Fort Sam Houston PASBA only enters the records into the Army Medical Record Retirement database. LTC (Dr.) [redacted], formally assigned to 28th CSH, Tikrit, Iraq, was Mr. [redacted] primary doctor in Iraq. MAJ [redacted] b7c-3, b6-3 additionally stated that LTC [redacted] has ETS'ed from the Army and possibly on terminal leave in North Carolina.

b7c-4,b6-4 b7c-4,b6-4

b7c-1,b6-1 b7c-4,b6-1

About 1500, 09 Aug 04, SA [redacted] received a copy of Mr. [redacted] medical records from Mrs. [redacted], Chief of Records, Data Management Branch, PASBA, FSHTX. (See medical records for details) b7c-3,b6-3

// Last Entry //

b7c-1,b6-1,b2

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted]	ORGANIZATION Fort Sam Houston Resident Agency (CID) Fort Sam Houston, TX 78234
SIGNATURE [redacted]	DATE 09 Aug 04
	EXHIBIT 18

014167

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AGENT'S INVESTIGATION REPORT
CID Regulation 195-1

ROI NUMBER	032[illegible]-CID014
	PAGE 1 OF 2 PAGES

DETAILS
0119-DA-CID163-79667

b7c-1, b6-1 b7c-4, b6-4

About, 1620, 5 Aug 04, SA [redacted] interviewed SGT [redacted] 978th MP Co., FBTX, who provided a sworn statement, wherein he related in Aug 03, while deployed to Kirkut, Iraq, he responded to the DCCP holding cages to assist a detainee who was suffering seizures. After transporting the detainee to the aid tent, SGT [redacted], along with other medics and doctors, unsuccessfully attempted to revive the detainee, who was unconscious, and subsequently evacuated him to the 28th CSH for further treatment. (See Sworn Statement for details)

b7c-1, b6-1 b7c-4, b6-4

About 1624, 6 Aug 04, SA [redacted] interviewed 1LT [redacted] 16th MP DET, FBTX, wherein he detailed his knowledge concerning the treatment of Mr [redacted] (See Sworn Statement for details) b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4

About 1422, 11 Aug 04, SA [redacted] interviewed CPT [redacted] Headquarters and Headquarters Battery (HHB), 1/1 ADA Bn, FBTX, who provided a sworn statement, wherein she detailed the medical treatment she provided to Mr [redacted]. (See Sworn Statement for details) b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4

About 1130, 12 Aug 04, SA [redacted] interviewed Mr. [redacted] who was formerly assigned to first Platoon, 978th MP Co, DCCP, Tikrit, Iraq. MR [redacted] stated his duties were the NCOIC of the night shift. Mr [redacted] related in Aug 03, prior to his shift, a detainee was brought to the aid station and treated. Later, during Mr [redacted] shift, the same detainee was pointed out by a fellow detainee. Mr [redacted] stated the detainee was on the ground of his tent, wrapped up in blankets. Mr. [redacted] related he conducted an initial assessment of his condition, and attempted to give the detainee water, who was conscious at the time, but his skin was cold and clammy and he was shivering. Mr. [redacted] stated he called SGT [redacted] to come check on the detainee. SGT [redacted] examined the detainee and determined he needed to be transported to the aid station for further treatment of possible heat exhaustion/heat stroke. Mr. [redacted] stated he selected other detainees, to transport him, via stretcher to the aid station. After delivering the detainee to the aid station, Mr. [redacted] never saw him again. Mr. [redacted] stated the detainee needed to go to the 28th CSH for further evaluation. Mr. [redacted] stated the detainee was physically weak, and couldn't walk on his own. However, he was conscious and responded to commands given by his fellow detainees. Further, Mr. [redacted] stated there were no visible external injuries, bruises or cuts on his arms, hands or feet. Mr. [redacted] also stated the detainee had never given him or any other guards on his shift any trouble, and was never restrained with zip-ties, blindfolded or thrown to the ground. Mr. [redacted] related tasered any detainee, and didn't remember the tasers ever being used. Mr. [redacted] did not know the detainee's name or remember his identification number.

b7c-4
b6-4

TYPED AGENT'S NAME AND SEQUENCE NUMBER b7c-1, b6-1, b2 SA [redacted]	ORGANIZATION Ft Bliss Resident Agency (CID) 11th MP Bn, USACIDC FT Bliss, TX 79916	
SIGNATURE [redacted]	DATE 12 Aug 04	EXHIBIT 19

CID FORM 94
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0119-04-CID469-79667

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1*	ROI NUMBER 0329-04-CID014
DETAILS	PAGE 2 OF 2 PAGES

AGENT'S COMMENT: Mr. b7c-4, b6-4 [redacted] declined to provide a sworn statement.

STATUS: All requested investigative leads have been completed, and no further investigative activity is anticipated by this office. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-4, b6-4	ORGANIZATION Ft Bliss Resident Agency (CID) 11th MP Bn, USACIDC Ft Bliss, TX 79916	
SIGNATURE [redacted]	DATE 12 Aug 04	EXHIBIT 19

CID FORM 94

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LAW ENFORCEMENT SENSITIVE 0329-04 CID014

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

LOCATION Fort Bliss Resident Agency	DATE 05 Aug 04 [redacted]	TIME 11:20 [redacted]	FILE NUMBER
LAST NAME, FIRST NAME, MIDDLE NAME b7c-4,b6-4 [redacted]	SOCIAL SECURITY NUMBER [redacted] b7c-4,b6-4		GRADE/STATUS E-5/AD
ORGANIZATION OR ADDRESS 978th Military Police Company, Fort Bliss, TX 79916 b7c-4,b6-4			

I, [redacted], want to make the following Statement under oath:

I was assigned to the 978th MP Co., Fort Bliss, TX (FBTX) while on deployment to Iraq. My duty station was at the Division Centralized Consolidation Point (DCCP) from Aug 03 to Dec 03. I was pulled duty in Baled, and Bakuba, Iraq, with the 978th as well. Baled was the Headquarters platoon, and Bakuba was with 4th platoon. I worked in the holding cages. I was the medic on call, in case someone was injured during my shift. My shift was 24 hours on, 24 hours off. Sometime in Aug 03, I was called down to the holding cage to look at some guy complaining of chest pains. My determination was to rule out a heart attack, so I took him over to the aid station, which was adjacent to the holding area, to have a PA or doctor take a look at him. I met with CPT [redacted] (NFI), who examined him and determined there was nothing life-threateningly wrong with him. CPT [redacted] gave him some nitroglycerine pills and we put ice packs on his body to cool him down some. He was running a fever, but he was communicating with us through the interpreter. CPT [redacted] ordered him released back to the holding cage after about an hour at the aid station.

Around twilight, SGT [redacted] (NFI), MP, 978th, was working the cage, a shift NCO, and he brought the same guy back over to the aid station. He said the guy was on the ground twitching (convulsing). CPT [redacted] yelled, "Why is this guy back here?" because she had seen him earlier that day. Either me or [redacted], I don't remember which, put our hands on the guy and noticed he was burning up. We picked him up and put him on the gurney, and took his clothes off and doused him with water to get his temperature down.

b7c-4 b6-4

Q: SA [redacted] b7c-1,b6-1

A: SGT [redacted] b7c-4,b6-4

Q: Were there any cuts or burn marks on him?

A: Not that I can remember. He was suffering more from a heat injury, like heat stroke. He was in the later stages, with the convulsions and such. The other medics tried to put a J-tube in him, in order to help him breathe, but he started gagging on it. CPT [redacted] or the other medics, I don't remember who, noticed there was blood in his airway. They suctioned the blood, and I think it was then they decided to evacuate him. He was sent over to the CSH for further treatment.

Q: That was the last you saw of him?

A: Yes, I had heard about his condition, and I heard he was on life-support. About a week after he was transported to the CSH, he was [redacted]

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted] b7c-4,b6-4	PAGE 1 OF 2 [redacted] PAGES b7c-4 b6-4

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___TAKEN AT__DATED___CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE__OF__PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

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0119-04-CID469-79667

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INITIALS OF PERSON MAKING ST MENT ______ 0319-0 PAG OF 2 PAGES 14

STATEMENT (Continued)

[redacted] leased to a local Iraqi hospital, and that was the last I heard of him. This was the information I got from a 1LT [redacted] (NFI); he works at the 16th MP Bn in the G-1 shop now, here at FBTX. b7c-4,b6-4

Q: Did you see any marks on this man's body to indicate he was injured physically in any way?

A: No, there was no marks or burns on his body.

Q: Were there any burn marks on his arms, hands or feet?

A: No.

Q: Were there any injuries to his head?

A: No. I remember this man was big, at least 5'11", maybe 250lbs., somewhere around there. Injuries like the ones you're asking about would be noticed. We had him stripped down to his underwear, so that would have definitely been seen.

Q: Describe him.

A: 5'11", about 250lbs, tanned skin, with a beard. I don't remember anything else about him. His hair was cut short, but not bald.

Q: Do you remember what this patient's ID number was, or his name?

A: No.

Q: Was there anything else about this patient that you remember?

A: No, he had all his appendages and such. He was just a big man.

Q: Is this statement a true reflection of your spoken words?

A: Yes.

Q: Is there anything else you wish to add to this statement?

A: No. ///END OF STATEMENT// [redacted] b7c-4,b6-4

b7c-4,b6-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUCEMENT.

[redacted] b7c-4 b6-4

(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by Law to administer oaths, this 5th day of August, 2004, at Fort Bliss Resident Agency (CID)

b7c-1 b6-1

[redacted]

ORGANIZATION OR ADDRESS

(Signature of Person Administering Oath)

b7c-1,b6-1

SA [redacted]

(Typed Name of Person Administering Oath)

Article 136 (b)(4) UCMJ

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

b7c-4,b6-4

b7c-4,b6-4

014171

INITIALS OF PERSON MAKING STATEMENT [redacted]

PAGE 2 OF 2 PAGES [redacted]

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EXHIBIT 20

000135

0119-04-CID469-79667

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SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS b7c-4, b6-4

LOCATION Fort Bliss Resident Agency (CID)	DATE 06 Aug 04 [redacted]	TIME 1624 [redacted]	FILE NUMBER
LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7c-4, b6-4		SOCIAL SECURITY NUMBER [redacted] b7c-4, b6-4	GRADE/STATUS 02/AD
ORGANIZATION OR ADDRESS 16th Military Police Detachment, Fort Bliss, TX 79916			

[redacted] b7c-4, b6-4 want to make the following Statement under oath: I was assigned as the 1st Platoon, 978th Military Police Company in Nov 02. We deployed to Iraq in Apr 03. We were assigned the Division Detention Camp at Tikrit, Iraq, FOB IRONHORSE, from July to Sept 03. We did our right-seat ride with the 4th MP Co., Fort Hood, TX in the last week of Jul 03. On or around the first week of Aug 03, the detainees went on a food and water strike. Their biggest complaint was when they were leaving the detention center to go back to their families. The biggest problem at that point with the detainees was they had been at the facility over 45 days, because of the influx of prisoners throughout the Operational Theater. On or around 11 Aug 03, we had a detainee complain about chest pains, around early afternoon. We had logged it in, and then I notified the 4th MP Tactical Operations Center (TOC) of our actions. I came back to the cage to resume my Officer In Charge (OIC) operations. One of my MP's came to me and told me the detainee was given some fluids and was checked out and he was taken back to the cage. While this was happening, the detainees continued to refuse water and food. However, my troops continued to supply the detainees with food and water by setting it out next to their tents. The second time, SGT [redacted] informed me the detainee that had been seen earlier was brought back to the cage appeared to be having mild convulsions. We put him onto a stretcher and myself, a couple of other soldiers from 3rd. Squad, 1st Platoon, 978th MP Co., and SGT [redacted] walked the detainee across the street to the aid station. I informed the 4th MP Co. TOC and the Provost Marshal (PM) of our actions. All of the other Physician's Assistant (PA's) was occupied with other duties. While this was happening, the detainee was placed on the stretcher in front of the aid station. At that point, he wasn't having serious convulsions, just twitching a little. I don't remember who noticed him first, but someone noticed the detainee's condition start to worsen. The detainee was placed onto a gurney and CPT [redacted] started examining him. The detainee's shirt was taken off. SGT [redacted] was assisting CPT [redacted]. The detainee's condition worsened, and CPT [redacted] was assisted by another PA. Soon, the entire PA staff was working on this one detainee. Eventually, the detainee was evacuated to the 28th CSH at Camp SPEICHER. SGT [redacted] along with another MP, escorted the detainee to the 28TH CSH. Just prior to this, I informed the TOC and the PM where the detainee was going and who was going with him. My instructions were to keep a guard on the detainee at all times, and keep the PM briefed on the status of

b7c-4
b6-4

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT [redacted] b7c-4, b6-4	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___TAKEN AT___DATED___CONTINUED."
THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___OF___PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

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EXHIBIT # ____ 000136

b7c-4, b6-4

STATEMENT OF [redacted] .7 Fort Bliss Resident Agency (CID), Fort Bliss, .6, CONTINUED.

the detainee at all times. I don't remember how many days out it was, but I kept in touch with the PA monitoring this detainee. I don't remember who that PA was. The next morning, I spoke with the doctor on duty and he told me the detainee was in a coma, and that it didn't look like he was coming out of it anytime soon. I don't recall exactly what the detainee's medical conditions were. I continued to provide a guard on the detainee. The guard was removed from the detainee when he was transported to a local civilian hospital.

Q: SA [redacted] b7c-1, b6-1

A: 1LT [redacted] b7c-4, b6-4

Q: The first time the detainee was brought to the aid tent, was he injured in any way?

A: Not physically, as far as externally. He may have been dehydrated from refusing to drink water though.

Q: Did you see any marks on this detainee?

A: I didn't notice any physical marks on him, no.

Q: Describe the detainee.

A: He appeared to be in his mid 50's, early 60's; that was the first time I had seen him up close. He was a medium size guy, maybe 5'8" to 5'9", 180 pounds. He did have facial hair, but I don't remember what color it was.

Q: When his shirt was taken off of him at the aid station, was it cut off him?

A: I believe so, yes.

Q: Was he injured during that time?

A: No.

Q: Did you see his feet?

A: No.

Q: Did you see his arms and hands?

A: No. As far as shoes go, we gave them shower shoes to walk around in, if they came to the cage from the brigades with no shoes or socks.

Q: Was this detainee ever struck in the head or on the arms at any time?

A: No.

Q: What was this detainee's condition when he was transported to the 28th CSH?

A: He was not conscious or coherent. He was definitely hurting, whatever was wrong with him.

Q: What were the conditions at the detention facility like?

A: The detainees were living in A-frame tents, and all the flaps had to be opened so the guards could see inside at all times. They were given 8 bottles of water a day, as well as 2 MRE'S a day. They were given a sleeping mat, a blanket, shower shoes, if they came to the facility without shoes or socks. We would put ice in their water blivet to keep their water cooler during the day. The medic would do two rounds a day through their areas, consisting of distribution of medication, and it gave the detainees the opportunity to express any health issues they had. All serious medical conditions, such as Diabetes, were handled in the aid station in front of the PA.

Q: Did you observe this detainee being treated or handled roughly in any way?

A: No. My platoon didn't do business that way.

Q: Did you have any equipment that could have inflicted electrocution wounds to detainees, or electrocute them?

A: No. We did have two tasers at the facility, but in order to use them, the MP's had to go through me and the platoon sergeant first. One taser was kept in the evidence locker and the other was in one of the guard towers outside the facility, in the northwest tower. We had one occasion to use a taser, and that was the second day we were at the facility. One of the detainees had gotten hold of some glass [illegible] found outside the facility and had cut his forehead and was bleeding heavily. He barricaded himself in a outhouse latrine and threatened to kill himself or anyone else

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EXHIBIT # 21

000137

STATEMENT *(Continued)*

who attempted to stop hi[illegible]m to subdue him so we could put flexicuffs on him. We then got statements from all the soldiers and two detainees who witnessed this incident. The detainee was then evaluated by the PA's to ensure he was alright.

Q: Were tasers ever used inside the facility?

A: No, never again after that incident.

Q: Could detainees get to the tasers?

A: Absolutely not.

Q: Is this an accurate reflection of your spoken words?

A: Yes.

Q: Is there anything else you wish to add to this statement?

A: No. ///END OF STATEMENT///

NOT USED [redacted]

b7C-4, b6-4

b7C-4, b6-4 [redacted]

b7C-4, b6-4

AFFIDAVIT

I, [redacted] HAVE READ OR HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUCEMENT.

[redacted] b7C-4, b6-4

(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by Law to administer oaths, this 06 day of Aug 2004
at Fort Bliss Resident Agency (CID), Fort Bliss, TX 79916

[redacted] b7C-1 b6-1

ORGANIZATION OR ADDRESS

(Signature of Person Administering Oath)

SA [redacted] b7C-1, b6-1

(Typed Name of Person Administering Oath)

Article 136 (b) (4) UCMJ

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE 1 OF 3 PAGES

EXHIBIT # 21

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS.

LOCATION Fort Bliss Resident Agency, CID	DATE 11 Aug 04	TIME b7c-4, b6-4 14:22 [redacted]	FILE NUMBER 0329-04-CID014
LAST NAME, FIRST NAME, MIDDLE NAME [redacted] b7c-4, b6-4	SOCIAL SECURITY NUMBER [redacted] b7c-4, b6-4		GRADE/STATUS CPT/AD
ORGANIZATION OR ADDRESS [redacted] b7c-4, b6-4			

I, [redacted], wish to make the following statement:

On the date in question, 11 Aug 03, I do vaguely recall seeing this patient. The patient presented to me with a medical history that included a heat injury, and a possible cardiac abnormality. The patient was obese and seemed agitated. b7c-4, b6-4

The patient was triaged by Sgt [redacted] and myself. We assessed the patient, and treated him. The patient was hydrated with water and given Nitroglycerine for chest pain with a possible cardiac etiology. The patient was then sent back to the holding cell.

Later on that evening, the patient was brought back to our aid station and was seen again for another medical complaint. He again was triaged, and it was determined at that time that the patient needed an EKG and a higher level of medical care. The medic then called in a 9 line MEDEVAC and the patient was taken to the helo-pad in our medical ambulance. The patient, as far as I know, was transported to the 28CSH in northern Tikrit/Camp Speicher.

From this point on, I am not sure what happened to this patient, nor his medical disposition.

Q: SA [redacted] b7c-1, b6-1

A: CPT [redacted] b7c-4, b6-4

Q: During your physical examination of this individual, did you notice any burns, or cuts to his hands or feet?

A: I am sorry. I cannot recall any burns on his feet or hands at this time.

Q: During your triage of this patient, for the second presentation, were his clothes removed?

A: As I recall, we did remove his shirt so that we could better listen to his heart and lungs.

Q: What was his physical appearance at that time?

A: The patient appeared to be morbidly obese. Approximately more than 250 pounds in weight. His height was approximately between 5'8 and 5'10 inches.

Q: During his transport from the holding cell to your aid station, was he dropped in any way to suggest a head injury?

A: I did not see this patient being dropped in any way that I can recall.

Q: Was the patient conscious during his second visit?

A: To the best of my knowledge, I do believe that this patient was not conscious during the second visit.

b7c-4, b6-4

EXHIBIT	INITIALS OF [redacted]NG STATEMENT	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF __ TAKEN AT __ DATED __ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE __ OF __ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

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EXHIBIT 22

b7c-4, b6-4 [redacted] 19-04-CID 469-49866

STATEMENT OF [redacted] b7c-4, b6-4 TAKEN AT 14:22 [redacted] b7c-4, b6-4 ...GE 2 OF 3 PAGES

Q: Why was the patient brought back to the aid station a second time?
A: The patient was brought back due to the worsening of his condition, per the Military Police at the holding cell.
Q: Did you treat any detainees for electrocution burns?
A: To the best of my knowledge, I do believe that I did treat a patient with electrical burns. I am not sure of this, but it is possible that I did.
Q: What type of electrical burns?
A: Of this, I am not sure.
Q: Were the injuries severe or minor?
A: The injuries were minor.
Q: Did you treat any detainees for taser burns?
A: No, I did not. b7c-4, b6-4
Q: What do you believe may have caused Mr. [redacted] condition and was it consistent with heat stroke? b7c-4, b6-4
A: The condition of MR. [redacted] was serious. To the best of my knowledge, he was not conscious, and without and EKG, we were not sure if his condition was due to a cardiac or pulmonary or other type of medical abnormality. Yes. I do believe that his condition was associated with a heat stroke.
Q: Was there any other treatment that was provided to MR. [redacted] b7c-4, b6-4
A: I am sure that an IV was started, and that oxygen was given as well as his vital signs being monitored constantly. He was transported in the most expeditious way possible. The patient was first triaged in the morning, a history was taken though a translator, and the patient was assessed by history and a physical examination. The examination did not reveal, to best of my recollection, any signs of abuse. The patient seemed distressed and was told, again through and interpreter, that he had possibly some cardiac abnormality as well as a heat injury at that time. The patient was nervous, and wanted to be treated. Water, by mouth, as well as by IV fluids was given, and nitroglycerine was given for the chest pain. The patient was then taken back to the holding cell, and instructions were given to the Military Police to bring the patient back if his condition worsened. Patient education was also given to MR. [redacted] b7c-4, b6-4
Later that evening, the patient was brought back again by the Military Police. The patient was not conscious, and immediately an IV was started, vitals taken, and a 9 line MEDEVAC was called. The patient was immediately loaded into our ambulance, and taken to the helo-pad to be transferred to the 28CSH. The CSH was notified and prepared for his arrival. This is the last that I saw of MR. [redacted] b7c-4, b6-4
Q: Have you ever seen any abuse to MR. [redacted] or any other detainee?
A: No. I have not seen he, nor any other detainee abused
Q: Have you ever seen any detainee tasered?
A: No. I have not seen any detainee tasered. b7c-4, b6-4
Q: Did you see any injuries to MR. [redacted] head? b7c-4, b6-4
A: At this time, I do not recall seeing any injuries to MR. [redacted] head.
Q: Did you take any notes, or transcribe a journal during your time in Tikrit?
A: Yes. I took notes on all patients, and EPWs that I attended to, while in Tikrit.
Q: Where are those notes now?
A: Of that, I am not sure. I do believe that 4th ID brought back the notes from Iraq with them. I will ask my former battalion, and the former division surgeon, of their whereabouts.
Q: Was this statement typed by you?
A: Yes, it was.
Q: Were these questions answered by you?
A: Yes, they were. TAGOD OFFICIAL USE ONLY

EXHIBIT 22

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b7C-4, b6-4

INITIALS OF PERSON MAKING [redacted] EMENT [redacted] PAGE 3 OF PAGES

[redacted]

STATEMENT *(Continued)*

Q: Is there anything else that you would like to add to this statement?
A: No. Not at this time. ///END OF STATEMENT///[redacted]

b7C-4, b6-4

NOT USED

[redacted]

b7C-4, b6-4

b7C-4, b6-4

AFF [redacted]

I, [redacted], HAVE READ OR HAD READ TO [redacted] IS ST [redacted] WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3 [redacted]. I FULLY UNDERSTAND THE CONTENTS OF TH [redacted] STATE [redacted] ADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALE [redacted] BOTTOM [redacted] PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OR BENEF [redacted] REWARD [redacted] THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFULENCE, OR UNLAWFUL INDUC [redacted]

b7C-4, b6-4

(Sign [redacted] ure of Person Making Statement)

WITNESSES:

Subscri [redacted] sworn to before me, a person authorized by Law [redacted] nister oaths, this 11TH day of August, 2004 at Bui [redacted] ng 13, Ft Bliss, TX 79916

[redacted]

b7C-4
b6-1

(Signature of Person Administering Oath)

ORGANIZATION OR ADDRESS

b7C-1, b6-1

FOUO - For Off [redacted]

(Typed Name of Person Administering Oath)

Article 136 (b) (4) UCMJ

(Authority to Administer Oaths)

ORGANIZATION OR ADDRESS

014177

EXHIBIT 22

INITIALS OF PERSON MAKING STATEMENT [redacted]

PAGE 3 OF 3 PAGES

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1*	ROI NUMBER 0554-04-CID023; 0119-04-CID469-79667
	Page 1 of 3 Pages

DETAILS

BASIS FOR INVESTIGATION:

About 0930, 22 Jul 04, this office was received a Request for Assistance (RFA), from the 286th Military Police (MP) Detachment (DET)(CID), 22nd MP Battalion, Operation Iraqi Freedom 2, requesting this office locate, fully identify and interview personnel assigned to the 28th Combat Support Hospital (CSH), Fort Bragg, NC 28310 (FBNC), who were involved in the treatment of Mr. [redacted] Kirkuk, Iraq. It was requested this office determine if there were any physical injuries to Mr [redacted] upon his arrival at the 28th CSH. Specific injuries in question are any to his head, cuts on his arms and burn marks on the bottom of his feet. Further it was requested this office identify and interview personnel who transported Mr. [redacted] to the hospital, and obtain all Medical Treatment Records pertaining to [redacted]

b7c-4, b6-4

b7c-4, b6-4

DETAILS:

b7c-1, b6-1 b7c-1, b6-1

About 0935, 22 Jul 04, SA [redacted], this office, coordinated with SA [redacted] this office who stated he completed a prior RFA (#0475-04-CID023) reference Mr. [redacted] in which he interviewed LTC [redacted], B Company, Womack Army Medical Center (WAMC), FBNC. LTC [redacted] was the first to treat, and was the primary care provider for Mr. [redacted], once he was transferred to the 28th CSH. LTC [redacted] did not notice injuries to Mr. [redacted] consistent with electrical injuries or wounds from possible torture. (See Sworn Statement of LTC [redacted] for details)

b7c-4, b6-4

b7c-1, b6-1 b7c-3, b6-3

About 1517, 22 Jul 04, SA [redacted] coordinated with COL [redacted] Commander, 28th CSH, FBNC, stated all treatment records pertaining to the 28th CSH at Tikrit, Iraq, were sent to Fort Sam Houston, TX, and were retained at the Patient Administration Division (PAD). COL [redacted] also stated his unit did not generally keep track of who brought patients to the 28th CSH, but the 57th Air Ambulance Company, FBNC, was used frequently.

b7c-1, b6-1 b7c-1, b6-1

About 1400, 09 Aug 04, SA [redacted] e-mailed an RFA to SA [redacted] Fort Sam Houston, Resident Agency (RA), requesting he obtain the medical records and conduct interviews pertaining to the treatment of Mr. [redacted] b7c-4, b6-4

b7c-1, b6-1 b7c-3, b6-3

About 1500, 11 Aug 04, SA [redacted] coordinated with SSG [redacted], 57th Medical Company, Air Ambulance, FBNC, who stated the ship containing the milvan, in which the medical treatment records were contained, was set to arrive in Charleston, SC, today. Additionally, SSG [redacted] stated the earliest the milvan would arrive at FBNC, would be on Monday, 16 Aug 04. b7c-3, b6-3

TYPED AGENT'S NAME AND SEQUENCE NUMBER [redacted] b7c-1, b6-1, b2	ORGANIZATION 87th Military Police Detachment (CID) (DSE) 3d MP Group, Fort Bragg, NC 28310-5000	
SIGNATURE [redacted]	DATE 13 Sep 2004	EXHIBIT 23

CID FORM [redacted]
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AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0554-04-CID023; 0119-04-CID469-79667

Page 2 of 3 Pages

DETAILS

b7c-1, b6-1 b7c-1, b6-1

About 1840, 23 Aug 04, SA [redacted] received the AIR of SA [redacted], Fort Sam Houston RA, documenting the receipt of the Medical Treatment Records. (See AIR of SA [redacted]

b7c-1, b6-1 b7c-1, b6-1

b7c-4 b6-4

AGENT's COMMENT: *The AIR of SA* [redacted] *details the receipt of the Medical Treatment Records of Mr.* [redacted] Nothing in the records was noted that would corroborate injuries to Mr. [redacted] A further check of the records, revealed treatment by 1LT [redacted] A Company, Post Anesthesia Care Unit, WAMC, FBNC. (See Medical Treatment Records for details)

b7c-1, b6-1 b7c-4, b6-4

About 1500, 26 Aug 04, SA [redacted] interviewed SSG [redacted] who provided a Sworn Statement, in which he described how he was the only flight medic who transported Mr. [redacted] from the Tikrit Palace, to the 28th CSH, Tikrit, Iraq, on 11 Aug 03. He failed to notice any injuries on Mr. [redacted] Additionally, SSG [redacted] provided SA [redacted] with a copy of the Aeromedical Evacuation Patient Care Report. (See Sworn Statement of SSG [redacted] and Care Report for details) b7c-4 b6-4

b7c-1, b6-1 b7c-4, b6-4 b7c-4, b6-4

About 1455, 27 Aug 04, SA [redacted] interviewed CPT [redacted] (previously 1LT [redacted] who provided a verbal statement, in which she stated she was unable to remember what Mr. [redacted] b7c-4, b6-4 looked like. CPT [redacted] stated she remembered one Iraqi heat stroke victim, but does not remember if it was Mr. [redacted] Upon inspection of the Medical Treatment Records, CPT [redacted] stated she admitted Mr. [redacted] to the Intensive Care Unit on 11 Aug 03, at 0100. At the time of admittance, she noted Mr. [redacted] body was warm and dry. She also noted from the Medical Treatment Record, that she had given him a bath on 12 Aug 03 and did not remark in the records any irregularities to the body of Mr. [redacted] Additionally, CPT [redacted] identified others who treated Mr. [redacted] at the 28th CSH: (CPT [redacted] Army Nurse, 28th CSH, WAMC, FBNC; SGT [redacted] (formerly [redacted] Licensed Practical Nurse (LPN), 28th CSH, FBNC; SSG [redacted] LPN, 28th CSH, FBNC; SGT [redacted] LPN, 28th CSH, FBCN; and LTC [redacted] Army Nurse, C Company, Walter Reed Army Medical Center, Washington D.C.) Finally, CPT [redacted] stated, upon further perusal of the Medical Treatment Records pertaining to Mr. [redacted] that there were no remarks or notations of any injuries to the aforementioned patient. b7c-4 b6-4

b7c-1, b6-1 b7c-4, b6-4

About 1330, 01 Sep 04, SA [redacted] interviewed SGT [redacted] who provided a verbal statement in which he stated he was unable to remember what Mr. [redacted] looked like, but he never saw a detainee or any Iraqi men with burn marks, or any injuries to the head or arms at the 28th CSH, Iraq. Upon review of the Medical Treatment Records, SGT [redacted] stated he conducted several assessments of Mr. [redacted] during his stay at the 28th CSH, Iraq, and at no time did he annotate in the treatment records any irregularities such as the aforementioned.

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-1, b6-1, b2	ORGANIZATION 87th Military Police Detachment (CID) (DSE) 3d MP Group, Fort Bragg, NC 28310-5000
SIGNATURE [redacted]	DATE 13 Sep 2004
	EXHIBIT 93

CID FORM [redacted]
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AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0554-04-CID023; 0119-04-CID469-79667

Page 3 of 3 Pages

DETAILS

b7c-1, b6-1 b7c-4, b6-4

About 1030, 01 Sep 04, SA [redacted] coordinated with SFC [redacted], Non-Commissioned Officer-in-Charge (NCOIC), S-1, 20th CSH, who stated SSG [redacted] is currently on leave in conjuncture with a PCS move to FSHT. She stated her office would alert him to contact this office to facilitate an interview of him regarding his knowledge of Mr. [redacted]. Additionally, SFC [redacted] provided a second contact number for SSG [redacted]. b7c-4 b6-4

b7c-1, b6-1 b7c-4, b6-4

About 1435, 01 Sep 04, SA [redacted] interviewed SGT [redacted], who provided a Sworn Statement in which she recalled providing treatment to Mr. [redacted] but stated she never observed any injuries to his feet, arms or head. (See Sworn Statement of SGT [redacted] for details) b7c-4, b6-4

b7c-1, b6-1 b7c-4, b6-4

About 1640, 08 Sep 04, SA [redacted] interviewed CPT [redacted], who provided a verbal statement that she did remember treating a heat casualty in Aug of 2003, at the 28th CSH in Tikrit, Iraq. CPT [redacted] stated the man she remembered was about 50 years old, 170 to 180 lbs but was unable to state for sure it was Mr. [redacted]. She stated she did not notice any injuries to the man she remembered other than some minor skin irritations which were acquired at the 28th CSH, and are common to those who are confined to a bed. b7c-4, b6-4

b7c-1, b6-1

About 1715, 13 Sep 04, SA [redacted] received e-mail verification that the investigation and interviews by this office are sufficient and that this office can terminate the RFA without the interview of SSG [redacted]. b7c-4, b6-4

This investigation is closed in the files of this office. No further investigative activities are anticipated.
//////////////////////////LAST ENTRY//////////////////////////

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA [redacted] b7c-1, b6-1, b2	ORGANIZATION 87th Military Police Detachment (CID) (DSE) 3d MP Group, Fort Bragg, NC 28310-5000
SIGNATURE [redacted]	DATE 13 Sep 2004 / EXHIBIT 23

CID FORM 94
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0554-04-CID023

SWORN STATEMENT

For use of this form, see AR 190-45; The proponent agency of the Deputy Chief of Staff for Personnel.

LOCATION Fort Bragg, NC 28310	DATE 26 Aug 2004	TIME 1500 [redacted]	FILE NUMBER 0554-04-CID023
LAST NAME, FIRST NAME, MIDDLE NAME b7c-4 b6-4 [redacted]	SOCIAL SECURITY NUMBER b7c-4 b6-4 [redacted]		GRADE/STATUS E-6/Active
ORGANIZATION OR ADDRESS 57th Medical Company, Air Ambulance, Fort Bragg, NC 28310			

b7c-4 b6-4

[redacted], want to provide the following statement, under oath:

On 11 Aug 03 I was the primary Flight Medic on duty when we received medevac request to pick up a patient from the Tikrit Palace there where 2 patients one patient was was an EPW(enemy prisoner of war that was unresponsive with a suspected close head injury upon arrival at the scene the patient in question was unresponsive with no apparent external injuries ; at this point I had the patient immobilized using a spine board and cervical collar. The patients vital signs where respirations 24, pulse 98, blood pressure 90 by palpitation and oxygen saturation of 95%. The patient did not respond to any verbal requests.. After packaging the patient an IV of Ringers Lactate at the to keep open rate oxygen at 15liters per minute via a non rebreather mask. The patient was then loaded onto the aircraft an flown to the 28th CSH at Camp Speicher, the flight was only 5 minutes in duration and the patient was transferred without incident.

Q: SA [redacted] b7c-4,b6-4

A: SSG [redacted] b7c-4,b6-4

Q: Did you know the patients name that you were transporting?

A: No. We did not have an interpreter so we called the one in the unresponsive state EPW #1. He had been classified as an EPW by the medavac requester.

Q: Do you remember what type of head injury EPW #1 had?

A: I classified it as closed, with very little pupil reaction to light.

Q: Did you notice anything else remarkable about his head region?

A: No.

Q: What was EPW #1 wearing?

A: He was wearing a full length gown.

Q: Did you ever conduct a visual check of his entire body?

A: Yes. There was no evidence of any bleeding, major deformities, or bruises.

Q: Did you notice any burn marks on the body of EPW #1?

A: No.

Q: Do you remember any other remarkable medical condition about EPW #1?

A: No.

Q: Did the flight crew help with any of the treatment of EPW #1?

A: No.

Q: Do you remember who took charge of EPW #1 at the 28th CSH?

A: No.

Q: What was the total amount of time you cared for EPW # 1?

A: It was about 15 minutes total time from the Tikrit Palace to the 28th CSH.

Q: Do you have anything to add to your statement?

A: No.///End of Statement///[redacted] b7c-4,b6-4

b7c-4,b6-4

EXHIBIT _____ INITIALS OF PERSON MAKING STATEMENT [redacted] PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _TAKEN AT __DATED __CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE __ OF __ PAGES."

DA Form 2823 (Automated)

~~0554-04-CID023~~

0 4 - CID 469-79667

00 [redacted] CID167

STATEMENT OF [redacted] TAKEN AT Fort Bragg, NC ~~GE,~~ DATED 2[redacted] Aug 04 CONTINUED: [redacted]

b7c-4, b6-4   b7c-4, b6-4

Not used

[redacted]

b7c-4, b6-4

b7c-4, b6-4

AFFIDAVIT

[redacted] HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OR PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

b7c-4, b6-4

[redacted]

(Signature of Person [redacted])

WITNESSES:

____

____

ORGANIZATION OR ADDRESS

____

____

ORGANIZATION OR ADDRESS

SUBSCRI[redacted] A PERSON BY LAW TO AD[redacted] OF August, 2004 AT [redacted]

b7c-1, b6-1

[redacted]

(Signature of Person Administering Oath)

[redacted] b7c-1, b6-1

SA [redacted]

(Name of Person Administering Oath)

Article 136, UCMJ

(Authority to Administer Oath)

b7c-4, b6-4

EXHIBIT _____   INITIALS OF PERSON MAKING STATEMENT [redacted]   PAGE 2 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE __ OF __ PAGES."

DA Form 2823 (Automated)

014182

Exh 5

FOR OFFICIAL USE ONLY

EXHIBIT 24

LAW ENFORCEMENT SENSITIVE -04-CID 469-79667

SWORN STATEMENT

0554-04-CID023

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION: Fort Bragg, NC 28310

DATE: 01 SEP 04

TIME: 1517 [redacted]

FILE NUMBER: 0554-04-CID023

LAST NAME, FIRST NAME, MIDDLE NAME: b7c-4 [redacted] b6-4

SOCIAL SECURITY NUMBER: b7c-4 [redacted] b6-4

GRADE/STATUS: E-5

ORGANIZATION OR ADDRESS: 28th Combat Support Hospital, Fort Bragg, NC 28304

[redacted] b7c-4/b6-4 WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

During the months of August in 2003, we received a patient by the name of [redacted] b7c-4/b6-4 as I recall, having suffered a heat stroke at the EPW camp in town. He arrived to the ICU intubated. I took care of him at least 3 days. During the course of his time in the 28th Combat Support Hospital ICU, I did not note any voluntary movement or responsiveness from him. He was a very large (obese) older gentleman with white hair and a full beard. During my assessments, I did not note any abnormal findings on his skin other than minimal breakdown that occurred to his back from lying in bed. There were no abnormal bruises or cuts. ~~He~~ I provided basic nursing care (ie, bathing, medication administration, line maintenance) throughout his stay. He gradually had a tracheostomy placed secondary to decreasing brain function and the realization that he would likely be in this vegetative state indefinitely.

Q: SA [redacted] b7c-1,b6-1

A: SGT [redacted] b7c-4,b6-4

Q: Do you remember any patient you treated who had bind marks to their body?

A: None to any EPWs or detainees

Q: Did Mr. b7c-4/b6-4 [redacted] have any notable injuries to his head or arms that you remember?

A: No

Q: Do you have anything to add to this statement?

A: No [redacted] b7c-4,b6-4

END OF STATEMENT

EXHIBIT

INITIALS OF PERSON MAKING STATEMENT b7c-4/b6-4 [redacted]

PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE ____ OF ____ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 2823, 1 JUL 72

SUPERSEDES DA FORM 2823, 1 JAN 65, WHICH WILL BE USED.

LAW ENFORCEMENT SENSITIVE

014133

EXHIBIT 25

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LAW ENFORCEMENT SENSITIVE 0119-04-CID469-79667

0554-04-CID023

b7c-4, b6-4

STATEMENT OF [redacted] TAKEN AT Fort Bragg, NC FILE NUMBER: DATED 01 SEP 04 CONTINUED:

STATEMENT (Continued)

Not

Used

b7c-4, b6-4

[redacted]

b7c-4, b6-4

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

[redacted] b7c-4, b6-4

[redacted] b7c-4, b6-4

(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to a[redacted] Sep, 2004, at [redacted]

[redacted] b7c-1, b6-1. b7c-1, b6-1

(Signature of Person Administering Oath)

SA [redacted]

(Typed Name of Person Administering Oath)

ORGANIZATION OR ADDRESS

Article 136(b)(4), UCMJ

(Authority To Administer Oaths)

014184

INITIALS OF PERSON MAKING STATEMENT [redacted]

PAGE 2 OF 2 PAGES

LAW ENFORCEMENT SENSITIVE

EXHIBIT 23

FOR OFFICIAL USE ONLY

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0119-04-CID469-79667

PAGE 1 OF 1 PAGES

DETAILS

b7c-1, b6-1 b7c-3, b6-3

About 0900, 7 Oct 04, SA [redacted] coordinated with LTC [redacted] Deputy Staff Judge Advocate, 1st Infantry Division, who opined there was no probable cause to believe any crimes were committed by Coalition Forces on Mr [redacted] //Last Entry///

b7c-4, b6-4

b7c-1, b6-1, b2

SA [redacted]

286th Military Police Detachment (CID) FOB DANGER, TIKRIT, Iraq APO AE 09392

014135

SIGNATURE

DATE
7 Oct 04

EXHIBIT
26

CID FORM 94
1 FEB 77