DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	⊖ s/s infection noted. Performed AROM s̄ difficulty. c/o pain x1 ii Tylenol given. Ⓡ thigh ~~AE~~ error ~~ACE~~ wrap dsg C/D/I. Will cont. to mon. [redacted] 2LT/AN (b)(6)-2
2230	DSG WSD to Ⓡ extremities done. RUE dsg old c̄ scant amt serous drainag. ~~Wou~~ error Wound well approximated c̄ healthy pink tissue noted. RLE old dsg c̄ scant ~~amant~~ greenish/yellow drainag noted. Wound c̄ healthy pink tissue well approx. noted. New WSD dsg applied Both dsgs C/D/I. Pt c/o pain to RUE i Percocet given. Will cont to mon. [redacted] 2LT/AN
(b)(6)-2	
0?0750 Aug 03	Nursing assessment: Airway intact, breathing even and unlabored, ~~BS⊕x4~~ LS clear to all fields Ⓑ. Abd soft, nontender, s̄ distention, BS⊕x4. Voids spontaneously. FROM to BLE and Ⓛ UE, also neurovascularly intact. Ⓡ UE has limited ROM to elbow ~~and hand~~ (active and passive). ROM to hand limited actively but FROM passively. Neurologically, unable to gain full movement of 1st through 3rd fingers of Ⓡ hand and grip is weak. Vascularly intact [redacted]
4 Aug 03 1345	Pt resting c̄ eyes closed, easily aroused to verbal stimuli. VSS. assessment findings WNL. RUE c̄ drsing CDI, steri strips intact, ⊕ sensation ⊕ pulse, slight movement. Ⓡ thigh drsing CDI. ⓞ complaints voiced @ this time. Will cont to monitor — [redacted] Trumble (b)(6)-2
7 Aug 03 2240	Rec'd c/o pt @ 21:00. Restraints x2 Ⓛ wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D. PERRLA ⊕ WNL. LCA Ⓑ. HRRS₁S₂ WNL. BS⊕x4. ⊕PP Ⓑ. DSG Ⓡ arm C/D/I. Ⓡ thigh dsg C/D/I. ⊕ROM ⊕sensation ⊕ <3 sec cap refill to RU/RL ext's digits. c/o pain x1 i Percocet given. Will cont. to mon. [redacted] 2LT/AN
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

Medcom 14641

ACLU-RDI 1628 p.1

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — 600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03	0620: Assumed pt care @ 0500. Pt. resting. Awaken easily. VSS. Assessment WNL. Pt. (R) elbo & dsng (R) thigh CDI. (+) movement & sensation below sites. ∅ complaints @ this time. Will continue to monitor [redacted]
8 Aug 03 1345	Pt care assumed @1300. Pt awake & alert. VSS (5)(6)-2 RUE dsng CDI, steri strips intact ∅ S/S of infection noted. LUE ∁ full ROM (+) pulses on UE. Lungs CTA and soft BS (+). (R) thigh dsng CDI (+) pulse (L)LE ∁ full ROM (+) pulse. ∅ complaints voiced @ this time. Will cont to monitor (5)(6)-2 [redacted] alarms
8 Aug 03	Rec'd c/o pt @ 2100. Restraints x 2 (L)(D) ankles. VS WNL per FS. Awake and alert in bed. Amb x 15 min ∁ difficulty. PERLA WNL. ICAB. HRRS, S1 S2 BS (+) x 4. NBD soft/non-tender. (+) PP (R). to RE's (+) sensation (+) ROM (+) <3 sec cap refill (+) warm to touch. c/o pain x 1 ∁ AROM performed ∴ Tylenol given. W→D dsg's d/d. Old dsgs for both wands to RUE and RLE ∁ scant amt. yellow/green drainage. Both wands well approx ∁ pink healthy tissue present. Tolerated procedure well. New dsgs applied c/DTI. Will cont to mon. Steri strips to RUE intact incision well approx ∁ S/S infection [redacted]
0309	C/o pain ∴ Tylenol given [redacted] (5)(6)-2

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 14642

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 03	0540: Assumed pt. care @ 0500: VSS. A&Ox3. Lungs CTA. @ 85%RA. @ Pulses x4. Disng on @ thigh & @ elbow CDI. Denies any complaints @ this time [redacted] 9 ward

(b)(6)-2

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

558-103

(See Instructions on Back of this Sheet) (5)(2)-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-01-075-3786

TREATMENT FACIL[redacted]

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
14	07	03	1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)
Ø

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
EPW # [redacted] (5)(6)-7

HOME TELE. NO. (Inc. area code)

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

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1425		
BP	113/63		
PULSE	105		
RESP.	16		
TEMP.	99.8		
WT. (Child)	98°(-		

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

ORDERS	INITS.	TIME
X-rays R thigh	[redacted]	
tetanus		1431
4MS04		1430

ASSESSMENT/DIAGNOSIS

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:

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)

Fragg S/P GSW to R forearm + thigh. ATOx3. VSS. HRRR. Lungs CTA B. Abd soft & flat non-tender. Pulses present distal to injurys

S: Shot in R forearm + R thigh last night. No pain meds c EPW. (5)(6)-2 [redacted]

O: R forearm - + swelling of prox-mid forearm. + GSW over radial head region c exit on medial aspect of forearm. Compartments soft. Radial + ulnar pulses 2+. - sensation median nerve distribution. X-ray R forearm - Pt unable to extend wrist. fx prox. radius = unable to do "ok" sign - ant. interosseous nerve injury. R thigh - + GSW c entrance c post-lat exit - compartments soft - able to flex knee to 90°/hip to 90° - DP/PT pulses - 2+ - able to wiggle toes. X-rays - - fx

A:
1. GSW c fx R prox radius
2. GSW R femur - fx
3. Median nerve injury 2° to #1

P: Recvd Iv Ancef @ 1300 hrs today. Ortho admit for wash out & fixation.

(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).

[redacted] (5)(6)-7

NAME OF PROVIDER AND ID STAMP

[redacted] MD MC (5)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up)

F/U Ortho [redacted] (5)(2)-2

EMERGENCY CARE AND TREATMENT
MEDCOM - 14644

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

ACLU-RDI 1628 p.4

DOD-028033

INSTRUCTIONS FOR COMPLETION OF THE EMERGENCY CARE AND TREATMENT FORM

NOTE: This form will be used to record all care rendered to patients in the Emergency Room and will be used in lieu of ***all*** locally prepared emergency room forms. This form is not a substitute for line of duty, accident/injury or third party liability forms, but it may be used as a basis for completing those forms.

1. Complete form for each patient entered on Emergency Room Log.
2. Complete all parts of form.
3. Enter patient's log number from Emergency Room Log.
4. Check appropriate condition in "category" block based on following definitions:
   Emergent—A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
   Urgent—A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
   Non-Urgent—A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute.
5. Use SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, to obtain authorization for any necessary procedures.
6. Orders: Provider enters orders; i.e., CBC, UA, etc. The person completing the action enters the time and his/her initials at the time of completion.
7. Give "Patient's Copy", containing instructions, to patient, sponsor (NOK) or person accompanying patient, except when patient is admitted.
8. File original in patient's treatment record (i.e., Military Health Record, Outpatient Treatment Record or Inpatient Record) as applicable.
9. Establish a treatment record for any patient who does not have a record. File and maintain treatment record in accordance with appropriate directives.

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: 35

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:
I & D Rt elbow + Rt thigh

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition wnl
Tobacco Ø ppd X___ yrs. Body Piercing N/A Diabetes (Y) (N) ? ROM ASA/Motrin w/72 hrs (Y) (N)
ETOH a little Implants N/A Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø 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 Potential for anxiety related to: 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.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c 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 .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c 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).	c Utilize pressure preventing devices on OR table and accessories. c 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)

#[redacted]
(b)(6)-1

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:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	8. 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	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. / 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.	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. N/A 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. N/A 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] MAJ AN (b)(6)-2 14 Jul 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 14 July 03 TIME: 1630

13. POSTOPERATIVE [redacted] PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 14 Jul 03 TIME: 1750

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Litter. BY: Amo. Staff

2. PATIENT IDENTIFIED, RECORD[redacted]ED AND PROCEDURE VERIFIED BY: [redacted] CRNA/AA

3. DATE: 17 Jul 03 TIME PATIENT ARRIVED IN SUITE: ICU → OR.

4. PATIENT IN ROOM TIME: 0730 (b)(6)-2 NUMBER: 21/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPOD MN.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

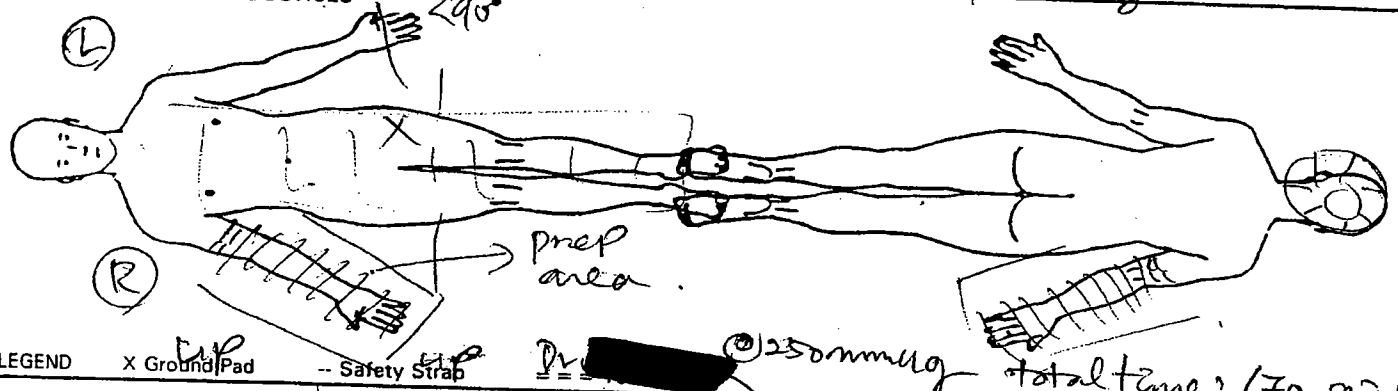
COMMENTS: (B) arms to padded arm board <90°, Body alignment maintained two arm board used to Right side.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine S/Sol
SITE: (R) arm BY WHOM: CPT [redacted] (b)(6)-2
SITE: ~ BY WHOM: ~
COMMENTS: no pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap

CAP Dr [redacted] @250mm/hg total time: 170 minutes

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

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

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

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

☑ ESU NO: Valleylab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 65706.

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

0092:30 / cut: 30

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 14648 [illegible] WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☑ YES ☐ NO MEDCOM - 14649 ER; MANUFACTURER

"Synthes" Mini fragset Lot #03B902 Screws: Cortex 202.00X(2.7mm) 18mm — 1, 24mm — 1, 20mm — 6 / Plate: 242.33, 242.08

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ C-ARM IF YES, SITE (R) arm

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs. plaster splint
Kerlix Xeroform
webril
Ace

19. ADDITIONAL INFORMATION

Dr. [redacted]
LTC [redacted] (CRNA)
(b)(6)-2

20. OPERATION(S) PERFORMED

ORIF (R) Radius.

21. PATIENT TRANSFERRED TO PACU TIME See Anes. Record METHOD Litter

22. REGISTERED N[redacted]URE CRNA

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

(b)(6)-2

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [illegible] BY: anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: Maj [redacted] AT
3. DATE: 14 JUL 03 TIME PATIENT ARRIVED IN SUITE: 1645
4. PATIENT IN ROOM TIME: 1645 (b)(6)-2 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: unable to speak/understand english language

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	Maj [redacted] 1715-60C

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: w/hip bump.

8. SKIN PREPARATION

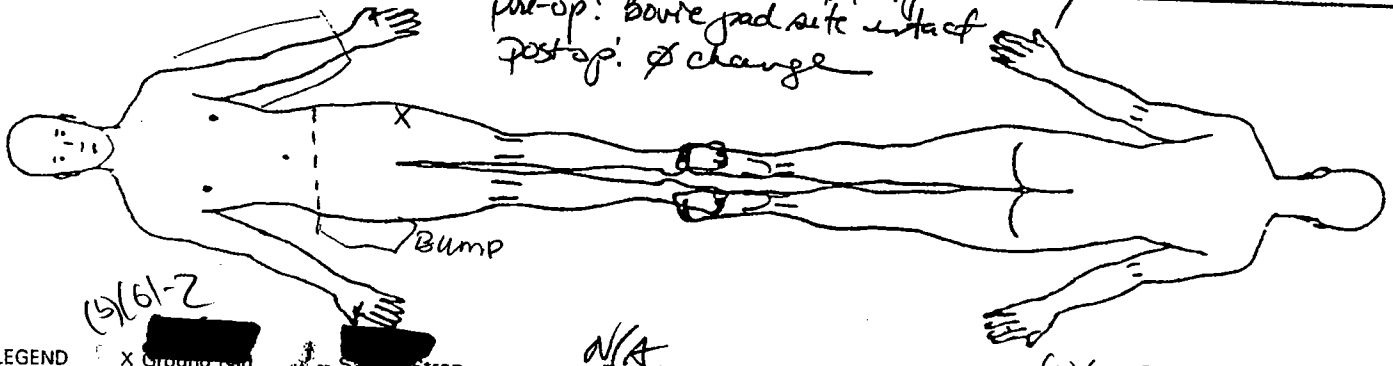
HAIR REMOVAL: ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify): Betadine scrub/sol'n
SITE: (R) forearm BY WHOM: [redacted]
SITE: (R) upper leg BY WHOM: (b)(6)-2
COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES

Pre-op: Bovie pad site intact
Post-op: Ø change



(b)(6)-2 [redacted]

LEGEND: X Ground Pad -- S[illegible] Strap = = = Tourniquet N/A

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

10. COUNTS

C = Correct I = Incorrect Neutral

		Other**	First Closing Count	Final Closing Count
Sponge	☒ [redacted] ☐ No		C	C
Needle Sharp	☒ Yes ☐ No			
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB: SSG [redacted] CIRCULATOR: MAJ [redacted]

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

[redacted] (b)(6)-4

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

Cut: 30 coag: 30

☒ ESU NO: 4 Valleylab
GROUND PAD: BRAND Valleylab
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA F[illegible] 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. MEDCOM - 14650 USAPA V4.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO MEDCOM - 14651 ER; MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION

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

Anesthesia: [redacted]

WC I

20. OPERATION(S) PERFORMED

I+D Rt arm + leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1745	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ

REV [redacted] ORM 5179-1, OCT 87 USAPA V1.01

(b)(6)-2

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 19 | DAY | HOUR

4 5 5 6 7 8 8 9 10

PULSE (0) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

511–119 NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 28 | 29 | 30 | 31 | 1 | 2–3 | 3–4

19 | HOUR

PULSE (0) | TEMP. F (°)

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

TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU2

EPW [redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECO...

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 DAY

19 HOUR

21 22 23 24 25 26 27

PULSE (O) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] (5)(6)-4

REGISTER NO.

WARD NO. ICU 2

STANDARD FORM 511 (REV. 7-95) BACK

511–119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Jul DAY 14 15 16 17 18 19 20

19 2003 HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

150/60 | 110/62 | 132/84 | 148/98 | 148/100 | 132/72 | 142/84 | 138/90 | 140/90

HEIGHT: WEIGHT →

98% | 93% 96? | 97%

Record special data only when so ordered

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

EPW

[redacted] (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

511–119

NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19 2003 — DAY 14 — HOUR 1

PULSE (0) | TEMP. F (°)

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 150/100

HEIGHT: WEIGHT →

Record special data only when so ordered

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

PWF [redacted] (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 - 14656

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

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°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

Ward/Section: EMT

TESTING PHYSICIAN: [redacted] (b)(6)-2

LAST, FIRST, MI.

DATE: 14 Jul 03 TIME: 1440

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

SSN/PSEUDO SSN: [redacted] (b)(6)-7

(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		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

TES

GLU			
BUN			
CRE			
CK			
NA^{+}			
K^{+}			
CL^{-}			
tCO_2			

======= PICCOLO =======

14/07/03 14:47

REFERENCE RANGE: MALE

PATIENT #: [redacted] (b)(6)-7

GENERAL CHEMISTRY 12

DISC LOT #: (b)(6)-2 3082AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	3.2*	3.3-5.5	G/DL
ALP	74	26-84	U/L
ALT	89*	10-47	U/L
AMY	36	14-97	U/L
AST	63*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	8	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CHOL	187	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	113	73-118	MG/DL
TP	6.8	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

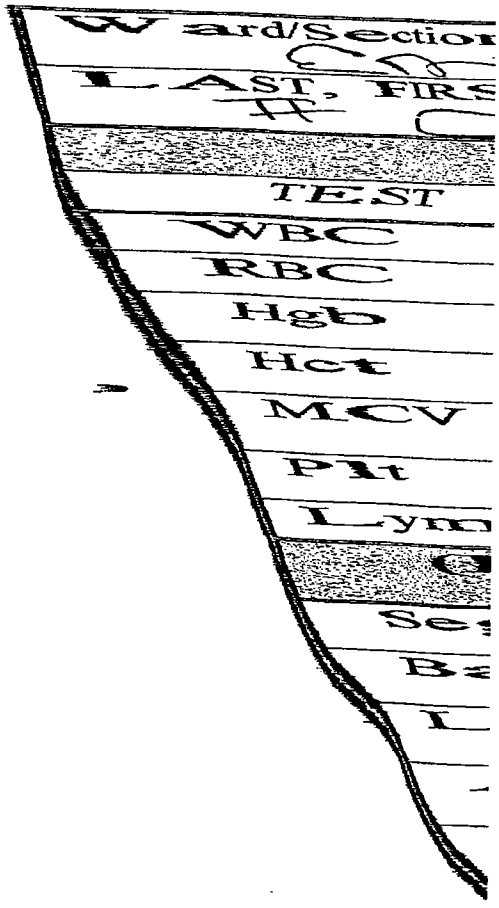
(Piccolo) Electrolyte

	RESULT	REF. RANGE
NA	143	128-145 mmol/l
K	4.0	3.3-4.7 mmol/l
CL	107	98-108 mmol/l
tCO_2	25	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
CWO	14 Jul 03	

[redacted] (b)(6)-7


Ward/Sectio
LAST, FIRS
TEST
WBC
RBC
Hgb
Hct
MCV
Plt
Lym
Se
B
L

(b)(6)-2

Ward/Section: SOOT | TESTING PHYSICIAN: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 14 JAN 03 | TIME: 1440 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

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		

REMARKS:

REPORTED BY: CS | **DATE:** 14 JAN 03 | **LAB ID NO.:**

[redacted] (b)(6)-4

MEDICAL RECORD - ANESTHESIA

For[illegible] this form, see AR 40-66; the proponent agen[illegible]e OTSG

Allergy: PCN

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)					TOTALS
Versed (mg)	2				2mg
Fent (mcg)	100	50			150mcg
Lido (mg)	20				20mg
Propofol (mg)	170				170mg
Succs (mg)	100	Reglan 10			100/10mg
( )					
VOLAT AGENT Forane Model % e.t.		2	2	X	
AIR L/Min					
N2O L/Min					
O2 L/Min	—	3	2	8	

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

TOTAL EBL: 25 cc

TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID- 450 cc.
COLLOID-
BLOOD-

FLUIDS

LINE site LR (L) FA ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES

EST BLOOD LOSS
URINE -

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

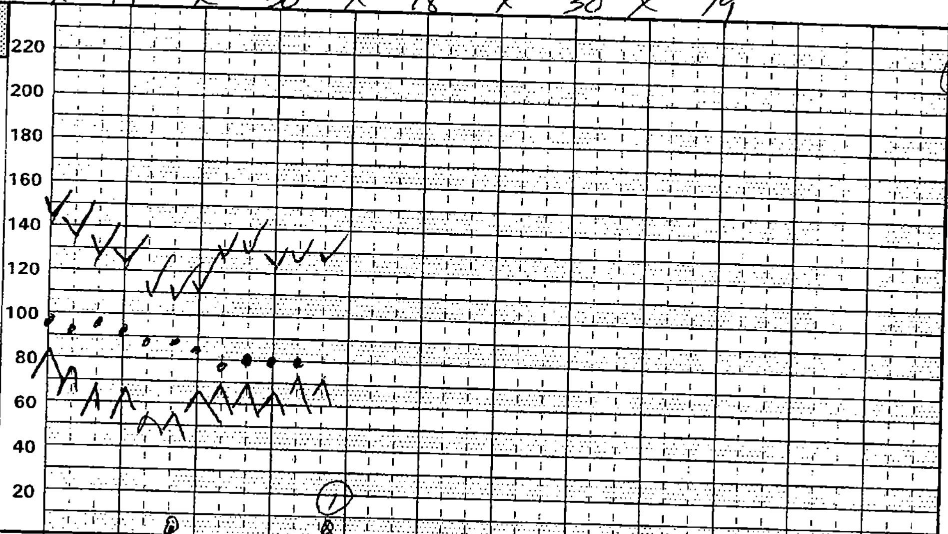
INITIAL DATA:
BP- 146/84
HR- 96

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE?
TIME- 1630

TIME → X 17 X 30 X 18 X 30 X 19

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	10 800	800	800	
f - breaths/min	10	10	9	16
Peak inf pres / PEEP	18	18	19	
MODE - S(pon), A(ssist), C(on)	S-C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	36 34	30	29	39
BP/oth	X FIO2 (Frac or %)	.83	.84	.84	.84
ART line	X SpO2 (%)	98	100	100	98
Steth- PC/ES	X ECG	SR	SR	SR	SR
Gas analyzer	X TEMP-site Skin	36[4]	37[2]	37[2]	
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (A) Supine c̄ Bilat arms on padded boards @ angles < 90° Eggcrate

REMARKS

Code drugs with numbers, events with letters

1620: ID'd pt in ICW2 & spoke to pt thru interpreter

(1) Pt extubated when awake & Reflexes returned Sustained airway no problems
To ICW2 Stable awake & talking
Report to [redacted]
(b)(6)-2

RECOVERY AT: PACU (ICU) 2 (Specify)
OTHER
CONDITION: R/A 98(%)
RESP- 16 SpO2- 92%
BP- 131/81 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1620	1640	1748
	Ready	Begin	End
PROC	1652	1712	1742

PROCEDURES and CPT Codes:
I&D (R) leg (thigh) & (R) Arm (b)(6)-2

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
EPW ICW2
[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
[redacted] / OGT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #8.0 ETT @ 22cm placed one attempt DL x1 MAC 3 Atraumatic ⊕ Bilat BS ⊕ ETCO2 modified RSI c̄ Sellick

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

ANESTHETISTS:
[redacted]

PROCEDURE LOCATION: OR #1 bed
DATE: 14 July 2003
PAGE OF

DA FORM 7389, FEB 1998

MEDCOM - 14663

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

II ? HTN
Al: PCN

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	0730	0800	X	30	X	0900	X	30	X	1000	X	30
Versed (mg)	2.5											
Fentanyl 50µ/(cc)	2	1	1									
Lido/Propofol (mg)	20/150									1	2	
Zofran (mg)	50											
Dexa/Reglan (mg)	1.25/10					10		10		10	10	10
Morphine (mg)				5		5						
VOLAT AGENT Forane % del	X1.5	+1	—	1	—	1.2	—	1.5	—	2	—	1.5
% e.t.												
AIR L/Min	LR & TOLOL mg			5		5						
N2O L/Min												
O2 L/Min	6	— 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	300	— 350	— 500	— 550	— 600	— 700	— 950
☐ Warmed							
☐ Warmed							
☐ Warmed							
☐ Warmed							

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 75 (KG) LB

HEMATOCRIT 42.4

INITIAL DATA

BP- 154/96

HR- 92

EQUIP CHECK OK?- (Y) N

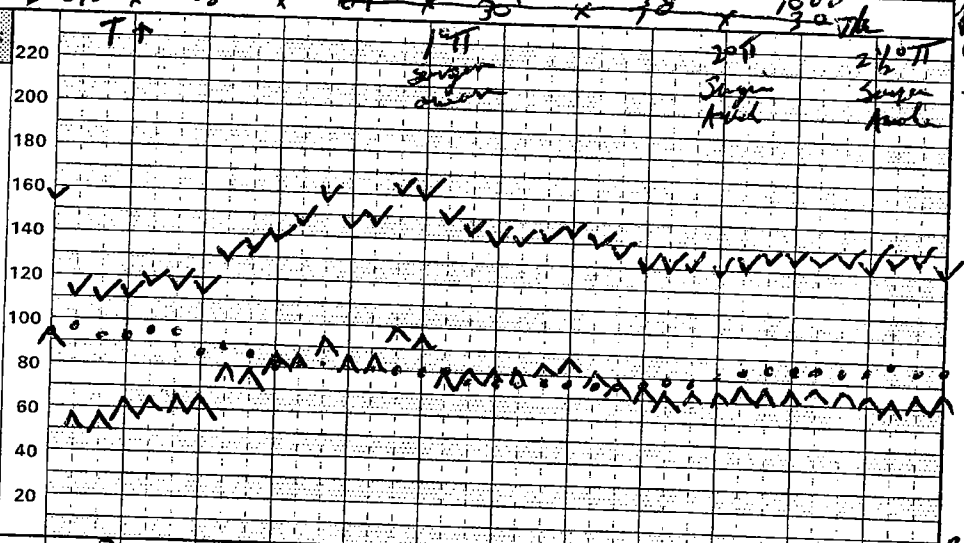
PATIENT RECHECK

OK for PROCEDURE? Yes

TIME- 0720

TIME → 0730 X 0800 X 30 0900 X 30 1000 X 30

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



VENTIL / MONITORS/ACCESSORIES

	0730	0800	0830	0900	0930	1000	1030	1100	1130	1200	1230
VT - ml	730	730	750	760	770	800	760	750	780	790	780
f - breaths/min	8	8	7	7	7	7	7	7	7	7	7
Peak inf pres / PEEP	21	21	21	21	21	21	21	21	21	21	21
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C
X BP/Auto Cuff / X ET CO2 (torr)	† 33	32	30	30	31	30	31	32	32	32	32
BP/oth / X FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	.7	.7	.7	.7
ART line / X SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / X ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / X TEMP-site Ao		36.9	36.7	37.0	37	37.1	37.3	37.4	37.6	37.7	37.8	37.8
X N-M Block (T/4)	4	0	0	1	3	1	3	3	3	3	4	
Warming (Bkt)											
Conv warmer											

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 9/T → Head/Neck Neutral

TOTALS — TOTAL EBL: 8cc / 100; TOTAL URINE: 10 / Ø

FLUIDS SUMMARY

CRYSTALLOID- LR 1300

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Preop PIV NPO agrees to GA for Rt Arm Surgery OR, O2, monitor Stella IV induction

RUE Tour @ 255
↑ @ 0756
↓ @ 1046
TT 170 min

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0720	0730	
PROC	**Ready**	**Begin**	**End**
	0740	0800	

PROCEDURES and CPT Codes:
Rt Elbow ORIF

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA easy mask, vent, 3MAC O2x1, gasEmiss, 8.0 ETT

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
@ 24 cm lips 3B = B, 4 RTC = 2, C.B.B.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
ICW2
[redacted]
(5)(6)-4

SURGEONS: [redacted] (5)(6)-2

ANESTH: [redacted] LTC CRNA

PROCEDURE LOCATION: OR 2

DATE: 17 JUL 03

PAGE 1 OF 2

DA FORM 7389, FEB 1998 — MEDCOM - 14665 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

II ? HTN
Al: PCN

MEDICAL RECORD - ANESTHES.

For this form, see AR 40-66; the proponent agen... ...ie OTSG

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

DRUG (Units)	1030	x	1100	x	30	x	1200	x	30
Propofol (mg)			10/10/10/10						
Zofran (mg)									
Fentanyl 50 mcg/ml (cc)									
( )									
Labetalol (mg)			5						
VOLAT AGENT: Forane % del	1.5		-1X						
% e.t.									
AIR L/Min									
N2O L/Min									
O2 L/Min	2		2-4		-6				

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

FLUIDS

LINE site LA	1000		1100		-1300
☐ Warmed					
☐ Warmed					
☐ Warmed					
☐ Warmed					

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

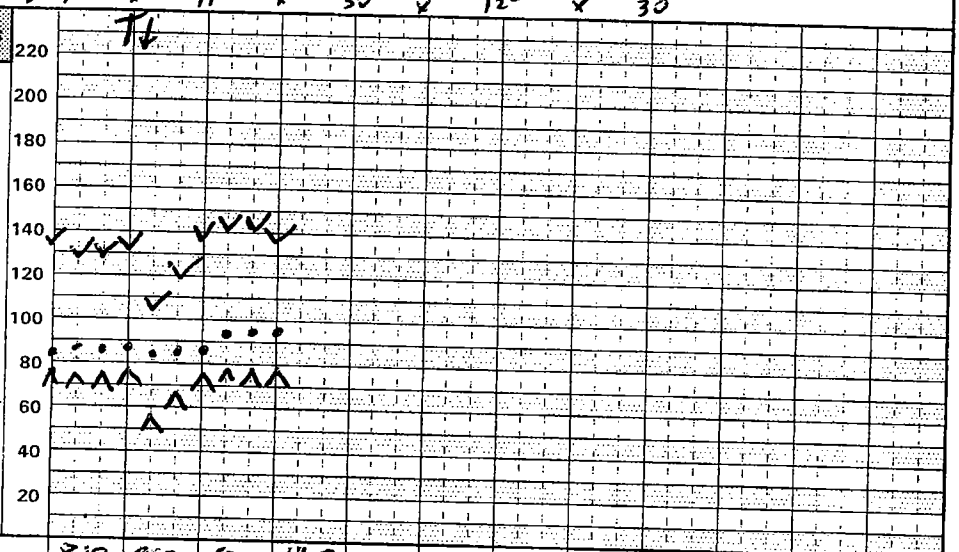
INITIAL DATA: BP- / HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 1030 x 1100 x 30 x 1200 x 30

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



VENTIL

	1030	1100		1200
VT - ml	810	860	520	460
f - breaths/min	7	7	6	8
Peak inf pres / PEEP	21	21		
MODE - S(pon), A(ssist), C(on)	C	C	S	S

MONITORS/ACCESSORIES

		1030	1100		1200
X BP/Auto Cuff	X ET CO2 (torr)	32	33	55	52
BP/oth	X FIO2 (Frac or %)	.7	.7	.7	.7
ART line	X SpO2 (%)	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR
Gas analyzer	X TEMP-site P.O.	38	38	37.7	
	X N-M Block (T/4)	4	TRT D/C'D		
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → off → pressure pts OK. Tilt 5°

TOTALS | TOTAL EBL | TOTAL URINE

FLUIDS SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

REMARKS *Code drugs with numbers, events with letters*

T to 1046
OP sheet
SV extubate
awake to
ICU # 2
for PACU

RECOVERY AT 1120
PACU (ICU) #2 (Specify)
OTHER PACU 10
CONDITION: ~ RA
RESP- 12 SpO2- 95%
BP- 153/90 HR- 106

ANESTHESIA / PROCEDURE TIMES

PROC	Start	Room	End
ANES			1130
	Ready	Begin	End
			1120

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* SAB PS 1

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

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility* ICU 2

H[redacted]
(5)(6)-4
(5)(6)-2

SURGEONS: [redacted]

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 17 JUL 03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — MEDCOM - 14667 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

ACLU-RDI 1628 p.27

DOD-028056

ANESTHESIA PLAN OF CARE PRE **EDURAL ASSESSMENT (Sedation/** **thesia)**

Age 36 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: Lt. Radius ORIF

SURGICAL SERVICE: Ortho / Trauma

NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E

WT: 75 KG/LB HT: _____ IN.

ALLERGIES: NKA.

HABITS:

TOBACCO: Occ

ETOH: Occ

DRUGS: None

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Tetanus

( ) MSO4 4mg @1430

( ) Ancef 1gm @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: _____

11.2 / 12.9 / 424 / 344

143 / 107 / 9 / 113

40 / 25 / 1.3

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 possible New?
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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 113/63 HR 105 R 16 T 99

Pain Scale 0-10 _____

HEENT - Teeth WNL Front (R) post dentition

Trachea _____

TMJ/Neck MP III

Oropharnyx _____

Nares _____

CHEST: _____

CARDIAC: _____

EXTREMITIES: _____

IV Access: (L) FA.

Ulnar Filling: _____

BACK: _____

OTHER: _____

NPO Since _____

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. Spoke through an interpreter

The patient/legal (6)(6)-7 to understand and agrees. Questions answered.

Signed: [redacted] CRNA Date: 14 July 2003 Time: 1630 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted] ICU 2

(6)(6)-7

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~~40~~ DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: ORIF (R) Elbow S/P GSW Rt thigh & forearm
SURGICAL SERVICE: Ortho
NPO SINCE: 2400

ASA Physical State 1 (2) 3 4 5 E
WT: 75 (KG/LB) HT: IN.
ALLERGIES: ~~NKDA~~ PCN

HABITS:
TOBACCO: denies
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) MSO4 IV PRN
( ) Ancef IV q6°
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 12.9 , 42.4
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	? Borderline
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
I&D both wounds 1 yr ago (easy tube)

PHYSICAL EXAMINATION
BP 128/78 HR 68 R 16 T 96
Pain Scale 0-10 sleeping
HEENT - Teeth poor
Trachea ML
TMJ/Neck MP II
Oropharnyx FROM
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access:
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 2400

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 [redacted] derstand and agrees. Questions answered.
Signed: [redacted] CRNA Date: 7/17/03 Time: 0645 Hrs

POST-ANES[redacted]ON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
(6)(6)-7
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) ICU2

[redacted] (6)(6)-4

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

PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

IDENTIFICATIO

04 Aug 03 2245

V.O.

Tylenol 650mg PO PRN

q4h

noted [redacted] 4 Aug 03 2245

(b)(6)-2

UNIT ROO SSD NO.

IDENTIFICATIO

Dr [redacted]

24 Vance Gabbert McNamara

8 Aug 03 1610

D/C to GP w comp

BID w → D unit

wound healed

noted [redacted] 4 Aug 03 1615

(b)(6)-2

NG UNIT ROC SSD NO.

IDENTIFICATIO

UNIT ROC SSD NO.

IDENTIFICATIO

NG UNIT RC SSD NO.

FORM 4 APR 79

CLINICAL RECORD - DOCTOR'S ORDERS

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

... RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ... IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

#454

[redacted]

DATE OF ORDER 18 Jul TIME OF ORDER 1130 A

- Pro-med for drg Δs c̄ 2-10 mg MSO4 IV
- BID W → D Dsg Δ (R) thigh to include packing of both wounds [redacted] MAJ [redacted]

(b)(6)-2

NURSING UNIT ICW2 | ROOM [redacted] | BED NO.

24° chart [redacted] CIVILIAN 19 July 03 0200 (b)(6)-2

PATIENT IDENTIFICATION

24° V's

[redacted] CIVILIAN DATE OF ORDER TIME OF ORDER 7-24-03 0030 HOURS

#[redacted] (b)(6)-4

DC Ancef

Keflex 500mg PO ~~6H~~ ~~TID~~ q6° q10°

V.O. Dr. Gu... [redacted]

(b)(6)-2

NURSING UNIT ICW #2 | ROOM NO | BED NO.

- QD Drg Dsg (R) elbow
- begin BID elbow → hand ROM

0910 24 Jul

[redacted] MAJ [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(b)(6)-2

NURSING UNIT | ROOM NO. 24° Vs | BED NO. 2200 26 July [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 30 July 03 TIME OF ORDER 1600

V.O. Remove staples et Steristrip

Dr. [redacted] 91WM6

(b)(6)-2 [redacted] noted 91WM6 30 July 03 1600

NURSING UNIT | ROOM NO. 24° Vs | BED NO. 2200 30 July [redacted]

MEDCOM - 14675

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: ICW2 | ROOM NO | BED NO

DATE OF ORDER: 14 Jul 03 | TIME OF ORDER: 2330 | HOURS

Verapamil 60mg PO x FNT

BP Q2° x 6 - then resume per routine

[redacted]

noted [redacted] 14 Jul 2350

[redacted] 15 JAN 7-15-03 0030

(b)(6)-2

PATIENT IDENTIFICATION [redacted]

\# [redacted]

DATE OF ORDER: 15 July 03 | TIME OF ORDER: 191[redacted]

(1) NPO > MN

noted [redacted] 15 July 03 1914

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO (b)(6)-2

24°V [redacted] [redacted] 7-16-03

PATIENT IDENTIFICATION

\# [redacted]

DATE OF ORDER: 16 Jul | TIME OF ORDER: 1740 | HOURS

NPO p MN (b)(6)-2

OR in AM

[redacted]

noted [redacted] 1756

MAT [redacted]

NURSING UNIT: ICW2 | ROOM NO | BED NO: 1

24°V [redacted] 17 July 03

PATIENT IDENTIFICATION

\# [redacted]

DATE OF ORDER: 17 July | TIME OF ORDER: 1130 | HOURS

- Post op s/p ORIF (R) elbow
- Resume prior orders (+):
- Regular diet
- 2-3 pillow elevation strictly x 72°
- NV checks RUE q 2 x 24 then q shift
- B2D w→D Ds; (R) thigh

(b)(6)-2

noted [redacted]

[redacted]

(b)(6)-2

24°V a [redacted] 18 Jul [redacted] MAT

(b)(6)-4

MEDCOM - 14677

ACLU-RDI 1628 p.37

DOD-028066

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 SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

Admit Ortho
S/p GSW (R) elbow, (R) thigh
vitals routine
Activity BR
Diet NPO
IVF D_5 ½ NS + 20 KCl @
125 cc/h
Meds Percocet 1-2 po q 4 PRN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

MSO4 2-5 mg IV q 2 PRN
Phenergan 12.5 mg IV q 4 PRN

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Post-op S/p I&D (R) elb & thigh
vitals routine
Activity As tolerated
Diet Regular
IVF D_5 ½ NS + 20 KCl @ 125 cc/h
heplock when taking PO
Meds Percocet 1-2 po q 4 PRN
MSO4 2-5 mg IV q 2 PRN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Phenergan 12.5 mg IV q 4 PRN
Ancef 1 g IV q 6

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

NURSING UNIT | ROOM NO. | BED NO.

[redacted] 24°V'S [redacted] LOTAC [redacted] 1000
(b)(6)-4
7.15.03 0030

MEDCOM - 14679

the proponent agency is the Office of The Surgeon General. M.O. 1 JAN 2003

RIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14 15 16 17 18 19 20 21 22 23 24 25
14	[redacted]	VS Routine	5 / 13 21	[redacted]
14	[redacted]	Act As TOL	5 / 13 21	[redacted]
14	[redacted]	Diet Regular	5 / 11 17	[redacted]
17	[redacted]	2-3 pillow elevation Strictly x 72°	5 13 21	XXX [redacted]
17	[redacted]	NV checks @ UE q2° x24° then Qshift.	5 13 21	XXX [redacted]
17	[redacted]	BID W-TD dsng @ thigh	10 22	XXX > See A
7R	[redacted]	BID W-TD D&D(R) thigh to include packing of both wounds	10 22	[redacted]

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D @ calf + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

ZPW [redacted] (5)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 14681

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
14	[redacted]	B/P Q2° x6 hr then Routine	14Thy	2330	—	[redacted]
15	-	NPO p MN	16 July	2400	2400	
16	-	NPO p MN for OR IN AM	17 July	2400	2400	
17	-	S/P I&D @ elbow	17July	1247	1247	
30		Remove Staples & Steristrip	30July	Done	Done	
	(b)(6)-2					(b)(6)-2

Order/ Expir Date	[illegible]	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	--		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

Verify by Initialing		TH	EUTIC DOCUMENTATION CARE PL (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8 Aug 03		D/C to EPW camp BID w-D					
		until wound heals					

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

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	DATE COMPLETED												
				26	27	28	29	30	31	1	2	3	4	5	6	7
14	[redacted]	VS Routine	5	[redacted]												
			13													
			21													
14	[redacted]	Act as tol	5	[redacted]												
			13													
			21													
14	[redacted]	Diet Regular	6	[redacted]												
			11													
			17													
17 ~~14~~	[redacted]	NV checks RUE @	5	[redacted]												
		Shift	13													
			21													
17	[redacted]	BID W→D Dsing Δ	10	[redacted]												
		(R) thigh to include	22													
		packing of both														
		wounds														
26	[redacted]	Dsgs Δ to (R) elbow qd	10	[redacted]												
26	[redacted]	ROM (passive & active) to	10	[redacted]												
		(R) elbow ~~BID~~ and hand BID	22													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 9P I & D R elb + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

EPW

[redacted] (5)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USE USA

(5)(6)-2

(5)(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. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14 15 16 17 18 19 20 21 22 23 24 25 26 27
14	[redacted]	D5½ NS +20KCL	5	[redacted]
		@125cc/hr (HL)	13	
		when tol P.O.	21	
14	[redacted]	Ancef 1 gram IV	04	[redacted]
		Q 6°	10	
			16	
			22	
78	[redacted]	Pre-med for Dsng	10	[redacted]
		IVS ± 2-10mg MSO4 IV	MSO4	5mg PRN 6mg 5mg 4mg 5 5 5mg 5mg 6
		BID	22	[redacted]
			MSO4	10mg 6mg 5mg 5mg 10mg 5mg 5mg 5mg 5mg 5mg
2c	[redacted]	Keflex 500mg PO TID QID	06	
			12	
			18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D (R) calf + thigh

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

PATIENT IDENTIFICATION:

EPW [redacted] (5)(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

(5)(6)-2

(5)(6)-2

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

MEDCOM - 14685

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
14	[redacted]	Nevapanel 60mg PO x 1 now	14 July	2130	NOT AVAILABLE	
	(b)(6)-2					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
14	[redacted]	Percocet 1-2po	14 July 2140	15 July	15 July 2155	16 July 2355	17 July	17 July	17 July 2200	18 Jul 0515	18 Jul 2040	19 July 0445	19 July	19 Jul 0135	20 Jul [illegible]	20 July
		Q4° PRN	ii PO KW	1445 ii LO	ii PO KW	ii PO KW	1425 ii LD	1810 ii LD	ii KW	ii DG	ii LD	ii PO CF	1300 ii LD	ii PO [illegible]	ii PO [illegible]	0300 [illegible]
14	[redacted]	MSO4 2-5mg	14 Jul 2045	15 July 0005	15 July 0330	15 July 0448	15 July 0710	15 July	15 July	15 July 2115	16 July 0215	16 July 0415	16 July [illegible]	16 July 2115	17 July 0230	17 Jul 1305
		IV q2° PRN	3mg IV	5mg IVP [redacted]	5mg IVP	5mg IVP	5m	1100	1900	5mg	4mg	4mg	5mg	5mg	4mg IVP	5mg IVP
14	[redacted]	Phenergan 12.5	19 July 2010	[illegible] July 2020												
		mg IV Q4° prn	5mg [redacted]													
14	[redacted]	MSO4 2-5mg	19 July 2250	18 July 0145	18 July 0400	18 Jul 1030	20 Jul 0721	22 Jul 1400								
		IV q2° PRN	6mg IV CF	5mg IVP [redacted]	5mg IVP	5mg IV	4mg	2mg								
14	[redacted]	Percocet i-ii PO q4°	24 July 0720	25 July 0200	25 July 0200	26 July 0745	26 July	27 Jul 2146								
		prn	ii PO [redacted]	ii	ii	ii PO		ii PO								

(b)(6)-2

(b)(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	31	1	2	3	4	5	6	7	8	9	10
14 July	[redacted]	IV HL	05	[redacted]										DC'd			
			13														
			21														
16 July	[redacted]	Premed for Dsg D	10	[redacted]													
		E 2-10mg MSO4	MSO4														
		BID	22	[redacted]													
			MSO4														
26 July	[redacted]	Keflex 500mg PO	06	[redacted]													
		QID	12														
			13														
			24														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D @ elb & thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EPW

[redacted] (5)(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 - 14687

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 Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
14 July	[redacted]	Percocet 1-2 PO	28 July 0930 i	28 July 1800 i	28 Jul 2000 ii	29 July 1000 i	30 July 1400	31 July 0535 ii po	31 July 1215 ii po	31 July 1945	1 Aug 1042 ii PO	1 Aug 1605 i	5 Aug 15 ii PO	5 Aug 0 i	5 Aug 0545 i PO	6 Aug 0145 i PO
.....	[redacted]	Q4' PRN	[redacted]													
14 July	[redacted]	MSO4 2.5mg IV Q2°														
.....	.....	PRN														
14 July	[redacted]	Phenergan 12.5mg														
.....	.....	IV Q4 PRN														
04 Aug	[redacted]	Tylenol 650mg PO	0245 4 Aug ii PO	0850 5 Aug ii PO	01:26 6 Aug ii PO	7 Aug 0920 i PO	[illegible] Aug ii PO	8 Aug 0035 ii PO								
.....	.....	PRN Q4°	[redacted]													
6 Aug	[redacted]	Percocet 1-2 PO	Aug 6 05:20 i PO	7 Aug 0942 ii PO	7 Aug 2232 i PO											
.....	.....	Q4° PRN	[redacted]													
.....	.....															
.....	.....															
.....	.....															

(b)(6)-2

(b)(6)-2

USAPA V1.00

#454

MEDCOM - 14689

Recopied

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 8 9 10 11 12 13 14 15 16 17 18 19 20 21
8 Aug	[redacted]	VS Routine	5	[redacted]
			13	
			21	
8 Aug	[redacted]	Actiastol	5	
			12	
			21	
8 Aug	[redacted]	Diet Regular	07	
			12	
			17	
8 Aug	[redacted]	NV VS PUE q Shift	05	
			13	
			21	
8 Aug	[redacted]	BID W→D dsg Δ's @ thigh to include posterior of both wands	10	
			22	✓
8 Aug	[redacted]	DSG Δ to @ elbow qD	10	✓
8 Aug	[redacted]	Rom (Passive+Active) to @ elbow and hand BID	08	
			20	

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D @ elb. + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EDW

[redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

MEDCOM - 14691

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													

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 - 14692

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 14 Jul 03
Time In: 1745
Allergies: [illegible]
Pre-op V/S:
Procedures: [illegible]

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 450cc Colloid
OR Output: UOP Ø EBL 25cc
Meds/Times:

[illegible handwritten margin notes]

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

Pre Op Meds

History

Time	1745	1750	1800	1815	1830	1845	1900
SaO2	98	99	99	100	100	95	95
FiO2	[illegible]	[illegible]	10L	10L	10L	RA	RA
Methods		NRB	NRB	NRB	NRB		
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	16	18	16	20	14	15	17
T	98						
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	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; ˆ = Cuff BP; = Pulse

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] CPT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 14 Jul 03

Name — last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1830		MSO4 3mg	IV			[redacted]
						(b)(6)-2

NEUROVASCULAR

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

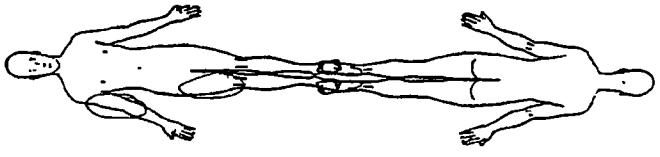
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	@leg	ace bandage	small
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt arrived on unit for recovery S/P I&D of @arm and @leg. Very groggy but responds to verbal stimuli. Lungs CTA bilaterally c O2 sats @ 100% on 10L NRB. NSR c HR in high 90's @ palpable pulses. @ BS x 4 quads. Able to move all extremities. Will continue to monitor [redacted] 05/0m

(b)(6)-2

Discharge Criteria:
Date: 14 Jul **Time:** 1900 **PARS:** 11
BP: 149/84 **T:** 99.6 **HR:** 92 **RR:** 16 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: 0 **Output:** 0
Additional Data:
Transferred To: ICU 2
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted]

ASA #2

HTN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 17 Jul 03
Time In: 1130
Allergies: PCN
Pre-op V/S: BP 94 92
Procedures: Open reduction/ORIF

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

OR Intake: Crystalloid LR 1300 Colloid
OR Output: UOP 0 EBL 100

10MS04
100 Ent
Propofol/Reglan
labetalol 25

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

Pre Op Meds / History

Time	1115	1120	1125	1130	1135	1140	1145
SaO2	99	99	99	99	99	99	99
FiO2	6L	6L	6L	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160	✓						
140		✓	✓	✓	✓		
120							
100	✓						
80	✓	✓	✓	✓	✓	✓	✓
60							
40							
20							
RR	18	20	16	18	18	18	20
T	97						99
Time							
Pain (0-10)				3/10			
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	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	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	✓	✓	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	7	9	10

Codes

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

V/S
X = A-line BP
˄ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title)

[redacted] (5)(6)1-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 17 Jul 03

[redacted] (5)(6)1-4

Name – last, date; hospital or medical facility)

- ☐ 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

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	RArm	+	+	P	B	W	PK
15'	RArm	+	+	P	B	W	PK
30'	〃	〃	〃	P	〃	〃	〃
45'	〃	〃	〃	P	〃	〃	〃
60'	〃	〃	〃	P	〃	〃	〃
90'	—	—	—	—	—	—	—
D/C	〃	〃	〃	〃	〃	〃	〃

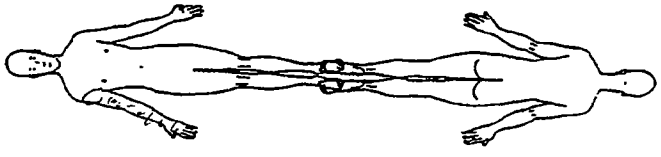
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	RArm	Ace & Splint	Ø
30'	RArm	Ace & Splint	Ø
60'	RArm	Ace & Splint	Ø
D/C	〃	〃	〃



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt easily arousable upon arrival Unable to follow commands though Sats 99-100% 4L O2. A+Ox4 VSS. 1200. Pt Awake, verbal follows commands. Sats 96-99% RA. Able to Cough & Deep Breath. Neuro checks to extrem. WNL. Pt c/o unable to urinate. [redacted] LPN - (b)(6)-2

Discharge Criteria:
Date: 17 July 07 **Time:** 1732 **PARS:** 10
BP: 142/80 **T:** 98.3 **HR:** 101 **RR:** 18 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICU2
Report Given To: Lt.
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery R[redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A [redacted]	IZ	[redacted]	(5)(6)(4) EPW # [redacted]	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	35Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99	(5)(6)-4 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	2000	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K7	—

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
—	—	1	YEAR — ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU2	UNK

	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(5)(2)-2 [redacted] MEDICAL TREATMENT FACILITY Baghdad	UNK
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
52		030808

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AJAA		030714

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

FOR LOCAL USE

GSW (R) forearm & (R) thigh

T: 9 Dx: 81315 AR: 7938
Inj: 569 8900 9688
9571
E9912

ADMITTING OFFICE [redacted] (5)(6)-2 SIGN [redacted]

DA FORM 2985, MAR 89

MEDCOM - 14697

USAPPCV1.0

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136

36. FIRST DIAGNOSIS (Principal Diagnosis)								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

44. FIRST PROCEDURE (Principal Diagnosis)								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
210	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
265	266	267	268	269	270	271	272
0	0	0	0				

PAGE 2, DA FORM 2985, MAR 89

USAPPC V1.0

(b)(6)-4

ID: [redacted] #
WB

14-07-03
, 14:49

				Patient Limits	
WBC	11.2 H	x10^3/uL		4.5	10.5
RBC	5.15	x10^6/uL		4.00	6.00
Hgb	12.9	g/dL		11.0	18.0
Hct	42.4	%		35.0	60.0
MCV	82.3	fL		80.0	99.9
MCH	25.0 L	pg		27.0	31.0
MCHC	30.4 L	g/dL		33.0	37.0
Plt	344.	x10^3/uL		150.	450.
LY%	20.3	#L	%	20.5	51.1
LY#	2.3 *	x10^3/uL		1.2	3.4

MEDCOM - 14699

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: FAW J 1938 | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

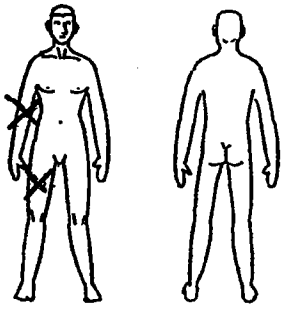
FORCE / ÉLÉMENT: A/T | AF/A | M/M | MC/M

NATIONALITY / NATIONALITÉ: T USA

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- X WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

① Open ⓕ proximal radius fx.
② Soft tissue wnd (L) Hand
③ Probable ⓡ ulnar nerve injury

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

X 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 / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Ancef 1g @ 1300

No other injuries seen on 2° Survey

10. DISPOSITION / DISPOSITION: RETURNED TO DUTY / RETOUR À L'UNITÉ | X EVACUATED / EVACUÉ (L)(L)-2 | DECEASED / DÉCÉDÉ | TIME / HEURE 1400

11. PROVIDER [redacted] | DATE / DATE (YYMMDD) 14 JUL 03

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 - 14700

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	—	W	MUS	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	—	JCW2

15. FLYING STATUS	16. DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	A78	—	—	NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0053	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	EPW Camp	030715

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	030715	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] Dahl		

31. SELECTED ADMINIS[redacted]

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (R) humerus fx. 812.40

E 819.9

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

SIGNATURE OF ATTENDING [redacted] SIGNATU[redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-3 MEDCOM - 14701

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
7.5.03 0300	Pt. to ICW #2 from EMT ambulatory. VSS. Pt. c/o pain to ® arm ☐ palpation. Neuro checks to ® arm WNL. Dsng ☐ sling to ® arm CDI. IVF infusing to ® AC @ TKO. IV site cleaned, op-site applied. HR Reg, Lungs CTA, BS ⊕ X4. Pt. NPO for poss. Surgery in A.m. Will cont. to monitor. (b)(6)-2 [redacted] CTA
15 July 0545	Pt care assumed @ 0500. Pt sleeping, aroused by verbal stimuli. Lung sounds CTA, pulses ⊕ x4, bs ⊕ x4 quads. Pt ☐ dsg and sling over rue, both colo ⊕ pulse, sensation, and ability to move fingers in rue. HL in lue, cap, flushes well. Pt to have hanging arm cast applied @ 0700, will continue to monitor. (b)(6)-2 [redacted] awmc
15 July 0620	chart reviewed (EMT wt) by 5-3, SSG Harris. Because pt has EPW tag A1197 CC 0412722 will be tx as EPW. Upon release to 116th MP Co for their determination. (b)(6)-2 [redacted] LTC, a
15 July 03 1500	assumed care @ 1300 - VSS - no c/o pain - neuro V's WNL in ® hand, hanging cast in place - SL d/c'd - pt. awaiting d/c to EPW camp [redacted]

ONSHIP TO SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUM

LAST | FIRST | MI | (SSN or Other) (b)(6)-2

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

'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. ICW #2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Jul03	pt. d/c'd to FOB camp via Helicopter c
1600	Lands boundary escort [redacted] (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): EMT

LOG NUMBER:

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DAY	MONTH	YR.	TIME	[ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) AIR	Ø	[X] PATIENT [ ] OTHER (Specify)
4	July	03	0030			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): (R) ARM PN

SEX: M AGE: 29

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 0035

VITAL SIGNS			
TIME	0031		
BP	144/99		
PULSE	95		
RESP.	16		
TEMP.	98.5		
WT. (Child)			

CATEGORY (See reverse)
- EMERGENT
- URGENT
- [X] NON-URGENT

ORDERS	INITS.	TIME
Xray (R) Arm		
CBC Chem 12 -		
LYTES PT PTT -		

ASSESSMENT/DIAGNOSIS: (R) Humerus 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)

Ø surgeries

29 y/o ♂ s/p injury 2° (car wreck?) ~~7-14 days~~ 45 days ago. Released from Iraqi jail today then Iraqi hospital said they couldn't help so he went to U.S. Air station got a splint + x-ray and sent him here. Pt ~~s~~ other complaints.

G: WD, WN, NAD, AAOx3
E: CTABL Ø r/r/w
Q: RRR Ø m/r/g
Ext: NVI, ⊕ pain c̄ ROM @ wrist/Elbow

Prev - Ø
PSH - Ø
Fx - UTD

516 / 16.6 / 53.4 < 267

140 | 107 | 10 < 98
3.7 | 31 | 1.1

PT/PTT 14/23

(R) Humerus
(R) Distal 1/3 Humerus Fx
(R) Radius - wnl

UF 15 - wnl

A/P ortho to see - Dr. [redacted] wants Xrays (L) Arm AP in AM

(b)(6)-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):
- EMERGENCY / TODAY / 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: Ward 1

CONDITION UPON RELEASE
- [X] IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0020

(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).

[redacted] EPW

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP [redacted] 26T

[redacted] edications ordered, any limitations and follow-up plans)

(b)(6)-2

EMERGENCY CARE AND TREATMENT

MEDCOM - 14704 Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Jul 03 1215	D/c Summary 29 y/o Iraqi ♂ 4-5 d s/p (L) humerus fx. Seen in ER & placed in hanging cast by Dr [redacted] (b)(6)-2 (P) D/c to EPW camp Needs F/u X/2 ~ 6 wks [redacted] MAJ (b)(6)-2

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

RECORDS MAINTAINED AT:

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR: July 1? 2003 / DAY	
HOUR	1338

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 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)

[redacted] (b)(6)-2

RESPIRATION RECORD: 16

BLOOD PRESSURE: 136/86, 130/80

HEIGHT: WEIGHT: [redacted] 97.6

(b)(6)-2

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)*

#[redacted] EPW

(b)(6)-2

REGISTER NO.

WARD NO. ICW?

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14706

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted] (5)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (5)(6)-7	DATE: 15 Jun 03	TIME: 0044

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
			Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

ID: [redacted] (5)(6)-7
15-07-03
00:56

				Patient Limits
WBC	9.2	x10^3/uL		4.5 10.5
RBC	5.66	x10^6/uL		4.00 6.00
Hgb	16.6	g/dL		11.0 18.0
Hct	53.4	%		35.0 60.0
MCV	94.4	fL		80.0 99.9
MCH	29.4	pg		27.0 31.0
MCHC	31.2 L	g/dL		33.0 37.0
Plt	267.	x10^3/uL		150. 450.
LY%	18.2 uL	%		30.5 51.1
LY#	1.7 *	x10^3/uL		1.2 3.4

CSF			Blood Bank	
Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**	
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	14.6	9.8-13.6 secs			
APTT	23.8	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 14707

(b)(6)-2

Ward/Section: ICU — ESTING PHY[redacted] — CHEMISTRY RESULT FORM (...ject to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] (b)(6)-4 — DATE 15JUL03 — TIME 0044 — SSN/PSEUDO SSN: [redacted] (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
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/l
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

(Piccolo) Chemistry 12 TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AL[illegible]		10-47 u/l
AM[illegible]		
A[illegible]		
T[illegible]		
[illegible]		

(Piccolo) Metabolic Panel TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus EST	RESULT	REF. RANGE
[illegible]LB		3.3-5.5 g/dl
[illegible]LP		26-84 u/l
[illegible]LT		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

nistry
REF. RAI

15/07/03 00:55 PICCOLO
REFERENCE RANGE:
PATIENT #: [redacted] MALE
GENERAL CHEMISTRY 12
DISC LOT #:
OPER #: [redacted] (b)(6)-2 3082AA4
SERIAL #: DR #: 000 [redacted]

ALB	3.7	3.3-5.5	G/DL
ALP	89*	26-84	U/L
ALT	75*	10-47	U/L
AMY	41	14-97	U/L
AST	56*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	7	7-22	MG/DL
CA++	9.6	8.0-10.3	MG/DL
CHOL	176	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	107	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

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

i-STAT EC8+
Pt: [redacted] (b)(6)-4
Pt Name:_____
Glu_____98 mg/dL
BUN_____10 mg/dL
Na_____140 mmol/L
K_____3.7 mmol/L
Cl_____107 mmol/L
TCO2_____31 mmol/L
AnGap_____7 mmol/L
Hct_____51 %PCV
Hb*_____17 g/dL
*via Hct
pH_____7.366
PCO2_____52.1 mmHg
HCO3_____30 mmol/L
BEecf_____4 mmol/L
Sample Type:
15JUL03 00:54
Oper: [redacted] (b)(6)-2
Physician:_____
Ser# [redacted]
Ver: JAMS046A
CLEW RAS

DATE: ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

EPW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

15 Jul 03 0052 HOURS

Admit ICU #1

Dx: (L) Humerus Fracture

condition: stable

vitals: per Nursing

ANTIBIOTICS

Meds: 4mg morphine IV Q2-4° prn pain

12.5mg phenergan IV Q4° prn nausea vomit.

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

Diet: NPO -

Activity: Bedrest

Plan - As per ortho Dr. [redacted]

- Ortho tech - needs to put on a hanging Arm CAST after 0700.

7.15.03 0320

[redacted] 2165

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

7.15.03 0324:

V.O. Dr. [redacted] (b)(6)-2

(1) Regular Diet

(2) D/C IVF

(3) Percocet 1-2 tab PO Q4-6° PRN Pain [redacted] 7AM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

15 Jul 03 1217

- D/C to EPW (b)(6)-2 comp

[redacted]

MAJ

NURSING UNIT | ROOM NO. | BED NO.

the proponent agency is the Office of The Surgeon General.

M.D. ___ Y.R 2003

RIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15 16 17 18 19 20
7-15	[redacted]	Vitals per routine.	S	
			13	
			21	
7-15	[redacted]	NPO	7	
			11	
			17	
7-15	[redacted]	Bedrest	S	
			13	
			21	
7-18	[redacted]	Reg diet	7	
			11	
			17	

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) humerus fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

#[redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 14710

Verify 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	
7-15	[redacted]	Admit to ICW #2	7-15	0245	0245	AG	
	-----	(5)(6)-2 Stable.					
7-15	[redacted]	As per Dr. [redacted] ortho tech	7-15	0700			
	-----	needs to put on a hanging					
	-----	arm cast after 0700					

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	--		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

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	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18
715	[redacted]	HCIV (b)(6)1-2	5	[redacted]			
			13				
			21				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: @ humerus fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)1-4

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
7-15	[redacted]	4mg MSO4 IV Q2-4° PRN pain.	[redacted]
7-15	[redacted]	12.5mg Phenergan IV Q4° PRN nausea, vomiting.	5/6
7-15	[redacted]	Percocet 1-2 PO Q4-6° PRN	[redacted]

(b)(6)-2

USAPA V1.00

[redacted]

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

[redacted] | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

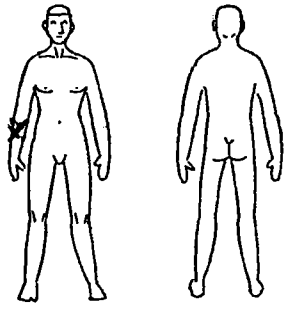
FORCE / ÉLÉMENT | NATIONALITY / NATIONALITÉ

A/T | AF/A | N/M | MC/M

BC / BC | 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
- [X] OTHER (Specify) / AUTRE (Spécifier)

② distal humerus

tx

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

[✓] ALERT / ALERTE | PAIN RESPONSE / RÉPONSE À LA DOULEUR

VERBAL RESPONSE / RÉPONSE VERBALE | UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
		[ ] NO / NON [ ] YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
[ ] NO / NON [X] YES / OUI				

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

- MORPHINE GIVEN at 2251 10mg
- Posterior splint

10. DISPOSITION / DISPOSITION		TIME / HEURE
	[ ] RETURNED TO DUTY / RETOUR À L'UNITÉ	
	[ ] EVACUATED / EVACUÉ	2249
	[ ] DECEASED / DÉCÉDÉ	

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ (1)(61-7) [redacted] | DATE/DATE (YYMMDD) 050714

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
050714	

TIME / HEURE	2249	2300		
BP / PS	118/98			
PULSE / POULS	83			
RESP / RESP	20			

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)

16. DISPOSITION / DISPOSITION		TIME / HEURE
	[ ] RETURNED TO DUTY / RETOUR À L'UNITÉ	
	[ ] 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 - 14714

1. DATE AND TIME OF CAPTURE: 12 July 03 0065	2. SERIAL: [redacted] A
3. NAME: [redacted]	4. DATE OF BIRTH: [illegible] JUN 75
5. [illegible] OCIV	
7. UNIT OF [illegible]	
[illegible] OF CAPTURE (grid coordinates) MB 385875	
10. CIRCUMSTANCES OF CAPTURE: TCP Curfew Duel	11. PHYSICAL CONDITION OF EPW: Injured
	12. WEAPONS, EQUIPMENT, DOCUMENTS: Cas papers

(5)(6)-4

DD FORM 2745, MAY 96 — REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

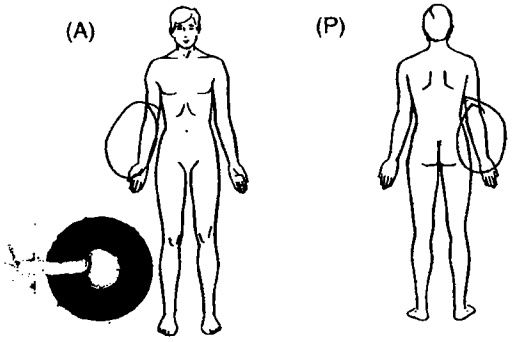
2nd [illegible] **MODERATE** [redacted]

[redacted]

DECEASED [redacted]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)



TIME	2140		
AGE		SEX	M
LUNGS	Good		
PULSE	108		
RESP.	22		
B.P.	110/70		
A	V	P	U

Patient Name (if known) (5)(6)-4 [redacted]

Notes/Treatment Poss. broken (R) Arm
Request X-RAY (R) ARM

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D	IZ	[redacted]	(b)(6)-4 EPW [redacted]		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]		Z	9	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99 (b)(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	1176	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O (b)(2)-2	ICU2	

[redacted] MENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
South	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
EPW Camp		030715	

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AAAA		030715

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

FOR LOCAL USE

Dx: ® humerus fx Dx 81220
E887
Proc 9353
Trauma 9
Inj 989

(b)(6)-2 [redacted]

ADMITTING OFFICER (Sig[redacted]required) [redacted]

SIG[redacted]F ADMITTING CLERK [redacted]

DA FORM [illegible] MAR 80 EDITION OF MAY 75 IS

MEDCOM - 14716

INPATIENT TREATMENT RECORD COVER SH

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

(b)(6)-2

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	32y	X	MUSLIM	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	—	FCW2

15. FLYING STATUS	16. [illegible] DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO		K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0700	AGAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	26. TYPE DISPOSITION	28. DATE OF DISPOSITION
UNK	D/C TO CAMP	28 JUL 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	17 JUL 03	

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

(b)(2)-2

33. CAUSE OF INJURY — ☐ Check if Continued on Reverse

Shot by US soldier after loading & firing his AK-47 @ US soldier

31. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P I&D (L) ARM/THIGH GSW WASHOUT — 812.10, 881.10, 877.1, E991.2

86.05

79.31

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	12	12

36. Total Days All Facilitas

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d.	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR [redacted]

DA FORM 3647, MAY 79

USAPPC V1.00

(b)(6)-2

MEDCOM - 14717

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

32 y/o Iraqi M Shot at US troops
Multiple GSW (L) shoulder (L) forearm
(L) Buttock

(-) meds
(-) PSHx
(-) PMHx
NKDA

PHYSICAL EXAMINATION

Intubated and sedated
HEENT wnl
Cor RRR
Pulm CTA B
Abd benign

(L) UE/LE NVI
Tender c Ent/Exit
(L) Sh/(L) Fore (L) Butt
Bullet [illegible]
[illegible]

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

A| (L) Proximal Humerus Fx, multiple GSW

P| (L) multiple I&D/Poss ORIF Prox Humerus

SIGNATURE OF [redacted] | DATE 7 Aug 03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S [redacted] or typed or written entries give Name last, first, [redacted]iddle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-2

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

AL RECORD

PROGRESS NOTES

AUTHORIZED FOR LOCAL REPR

NOTES

0800 Pt care assumed @ 0800, transferred from emt. VSS, pt c̄ c/o pain
17 July 03 in lue, no meds ordered. Lung sounds CTA c̄ equal rise and fall of chest, hrr, bs hypoactive. Pt admitted c̄ LR@100cc/hr to rfA, running s̄ s/s infiltration or infection. IV @ R external jugular dc'd p̄ 1000cc LR. Pt c̄ foley to gravity, 2400cc CYU, light urine. Two wounds on buttocks covered c̄ 4x4. Dsg on lue intact, some bloody drainage. Pt npo, to surgery today. Continue to monitor. [redacted] 91WM6

(b)(6)-2

[illegible handwritten surgical note]

[redacted]

(b)(6)-2

SHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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 ICW 2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

MEDCOM - 14719

DATE	NOTES
7 Jul 03 1700	assumed care @ 1300, pt. to Surgery and returned ~ 1600, SIP I&D (L) arm/thigh GSW washout. LR @ 100cc/hr infusing into (R) AC, site patent - dsg on (L) upper arm - marked @ 1700, dsg on buttock CDI, dsg on back CDI - lungs CTA (B) - (+) BS - dsg on back CDI - lungs CTA (B) - (+) BS - Cooled to gravity draining CVU [redacted] c/o pain @ this time [redacted] (5)(6)-2 BAR
8 Jul 03 0230	UOP 5000cc CVU [redacted] QW
7 July 03 2000	Pt - awake & alert & any complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds clear bilat. (L) shoulder DSG slightly saturating c bright red blood, noted on tape. DSG to upper back & (L) hip c small amt of bloody drainage noted. IVL to (R) FA flushes well c 3cc NSS c S/S of infection. Pt. c full ROM in (L) hand, (+) sensation, <3 sec cap refill, minimal ROM in (L) arm. All other assessment findings WNL. Foley draining clear yellow urine. Will continue to monitor (5)(6)-2 [redacted] 24 HR
18 July 03	0700 - Pt alert lying in bed. VSS; temp 99.4. Grave Tylenol for bowgade & mild pain. Lungs CTA, HR reg, BS (+) Pulses (+) c strong bilat to ↑ & ↓ extremities Dsg reinforced to (L) shoulder. Dsg to hip intact c old drainage. Pt c full ROM in (L) hand, (+) Sensation, Cap refill <3 sec. Voiding adequate [redacted] at this time. Will continue to monitor [redacted] 0715 - Foley intact draining clear amber (5)(6)-2 urine [redacted] 24 HR

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL REPRODUCTION

DATE | NOTES

18July03 1200 - Dsg Did to (L) hip. Sutures intact. (b)(6)-2 [redacted] 26 24

18July03 - Received Pt Alert + oriented. VSS. Lung sound are clear Bilateral ~ no difficulty Breathing. BS x 4. Good Pulse motor function on All extremity. HR R. Hep lock to (R) Forearm is CDI. Flushes well. Dressing to Rear (R) Shoulder dressing Light smear of Blood. Will change dressing. Will continue to Monitor Pt for comfort. [redacted] PRN (b)(6)-2

18July 2025 - Pt dressing was bright red 1½ inch in diameter, MD Cope was notified. Dressing change to (L) Arm was done. Pt is to be NPO After midnight for surgery. Will continue to Monitor. SGT [redacted] (b)(6)-2

19July03 0130 Pt. asleep in bed. HR Regular, ##Lungsands clear bilat, bowel sands (+) x 4quads. DSG to (L)shoulder, (L)hip, (L) wrist CDI. (L)arm in sling, digits ~ full ROM, <3sec cap refill, (+) sensation. HL in (R) FA flushed well ~ 3cc NS ~ S/S of infection. All other assessment findings WNL. Pt. ~ complaints @ this time. Will continue to monitor. Pt. NPO since MN. (b)(6)-2 [redacted] 27 AW

0530 - Pt alert, temp 99.4. VSS, lungs CTA, BS@, HL to (R) forearm. Dsg intact to (L) shoulder ~ old drainage Dsg to (L) hip CDI. Foley patent

TRIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
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 ICU

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41CFR) 101-1

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
	C

Cont. – draining amber urine. Voiding c complaints at this time. O/C to OR. Will cont to monitor [redacted] Hyatt

(b)(6)1-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19July03 1500	- Received PT From DACO Alert + converted to verbal Command. VSS. Breathsound Are Bilateral c (-) difficulty Breathing. BSX4 c no Abdominal distention or rebound tenderness PT has Good Pulse motor Sensory c Good ROM to all extremity. Skin is warm + Dry. Drsg to (L) Shoulder is DSI. No s/s of infection noted. JP draining 10cc of bright red blood noted. Drsg to (L) Gletas Manner is dry + INTACT. Drsg to rear neck is DSI. PT has 4 Foley to Gravity c clear yellow urine. PT has IV LR @ 100 c/hr on (R) hand Flushing well + INTACT. PT is resting well in bed + will continue to monitor.
(b)(6)-2 19July03	[redacted] LPN
2000	- PT is resting in bed (-) % pain or discomfort. [redacted] LPN
19July03 2330	Pt. awake + alert in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Foley draining clear orange colored urine. DSG to upper back, (L) shoulder + (L) outer thigh CDI. JP draining dark red bld., 30cc removed from bulb suction. Pt. c c/o pain, 4mg MSO4 given. HL to (R) FA flushed well c Bec NS c s/s of infection. VSS temp slightly ↑ @ 101.2, ii tylenol given. All other assessment findings WNL. Pt. c other complaints @ this time. Will continue to monitor.
0530.	(b)(6)-2 [redacted] SUPERVISOR
0600	JP output 10cc bright red bloody drainage - [redacted] Pt. care assumed @ 0500. VSS. Pt c/o pain (L) shoulder, ii Percocet given. Drsg to (L) shoulder CDI. (+) ↑ ext. pulses 2+ c (+) sensation (+) rem strong grip, brisk cap refill. Drsg to (L) Buttock also CDI

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

[redacted] (b)(6)-7

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

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

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

[redacted] (b)(6)-7

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 - 14724

7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 July 03	1240 15cc red tinged fluid from [redacted] (b)(6)-2
21 July 03 1305	- Assumed pt care. VSS. Lung sounds clear Bilateral BS x 4. Drsg to (L) Shoulder clean Dry + intact. JP drained, Ø cc @ start of shift. Drsg to (L) Thigh is CDI. HL to (R) hand flushes well c 3cc NS. (+) ROM on All extremity. Will cont to monitor pt. [redacted] (b)(6)-2 LPN
21 July 03 1850	- D/C HL and Restarted in (R) Arm. flushes well. Will cont to monitor [redacted] (b)(6)-2 LPN
21 July 03 2300	Pt. awake & alert in bed. JP to (L) shoulder draining clear red tinged fluid. (L) hand c full ROM, (+) sensation, cap refill < 3 sec - HL in (R) FA flushed well c 3cc NS s/s of infection. (L) arm +2 edema. HR Regular, Lungsounds clear bilat, bowel sounds (+) x 4 quads. Pt. s complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted]
22 Jul	Assumed care of pt @ 0500. Pt resting quietly. VSS. Lungs CTA. BS x 4 quads. Abd Jim. Bandage to (L) shoulder - dry and intact. JP drain to (L) shoulder draining dk red drainage. Ø c/o pain/discomfort. Will continue to monitor. - [redacted] SGT LPN
22 July 03	- Assumed pt care. Pt resting in bed c (-) c/o pain. (b)(6)-2 VSS. Lungs CTA. BS x 4. Bandage to (L) Shoulder with c 1 3/4 inch diameter blood stain. Will cont to monitor pt. [redacted] LPN

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

(b)(6)-2

ICW 2

[redacted]

(b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial) | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7-20-0300	0000 cont..: HR Reg, lungs CTA, ABD soft ~ BS@XY Foley to gravity draining CYU. JP bulb to (L) shoulder patent, draining bright red bloody drainage. HL to (R) hand intact ~ S/S infection. Will cont. to monitor. (b)(6)-7 [redacted] CYU
7-20-03 1300	- assumed Pt care. Pt is alert + oriented X3. Dsg to (L) Shoulder CDI. No S/S of infection. JP drained 20cc of bright red blood. Breathsounds clear bilateral, BS x4. HL to (R) FA Flushed well ~ NO S/S of infection. VSS. Pt has DS x4. Foley draining dark yellow urine. Good PMS on All extremity. Will continue to monitor Pt. [redacted] CYU (b)(6)-7
7-20-03 1930	- D/C Foley as per MD Quin order. [redacted] CYU
21July03 0030	Pt. awake & alert in bed ~ c/o pain. HR Regular, Lungsounds clear bilat, bowel sounds (+) x4 quads. VSS. Dsg to (R) shoulder, upper back & (R) hip CDI. JP to bulb suction draining clear red tinged fluid. HL in (R) FA flushed well ~ 3cc NS ~ S/S of infection. Pt. voided 150cc orange colored clear urine. Pt - ~ complaints @ this time. All other assessment findings WNL. Will continue to maintain. [redacted] CYU
0415	15cc red tinged fluid drained from JP (b)(6)-7 [redacted]
21July03	0620 Assume pt care @ 0500. pt awake and alert no c/o pain @ this time VSS. HR reg. Lungs CTA. Abd soft BS x4. Dsg to (L) Shoulder ~ JP drain CDI draining red fluid. Dsg to upper back and (L) hip CDI. Sm cyst noted to Lower back soft to touch. HL to (R) FA no S/S redness/infiltration ~ flush - Will continue to m[redacted] (b)(6)-7 CYU

*U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 14726

NSN 7540-00-634-4176

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
22 July 03 1900	- Reinforced dressing to (L) shoulder. Small amount of bright red blood noted. Will continue to monitor. (b)(6)-2 [redacted] CPT
22 July 03 2300	Pt care assumed @ 2100. VSS, no c/o pain at this time. Lung sounds CTA, pulses palpable x4, b/s (L) x4 quads. Dsg on LUE CDI, reinforced by prior shift. Dsg on (L) buttock c bloody drainage noted, reinforced. Pt c IV ABX. No new complaints continue to monitor. (b)(6)-2 [redacted] CPT/MC
23 July 03 0815	Pt. awake & alert up completing AM care. DSG to upper back (L) arm, (L) upper thigh D/d, all wounds c s/s of infection. (L) arm in sling, +1 edema, (+) sensation, limited ROM, cap refill <3 sec. HR Regular, Lung sands clear bilat, bowel sounds (+) x4 quads. IV in (R) FA flushed well c 3cc NS c s/s of infection. All other assessment findings WNL. Pt. c complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] CPT/MC
23 July 03 1300	- Assumed PT care, VSS Lungs are clear bilateral. BS x4. Dressing to (L) shoulder CDI. (L) elbow has small edema. Voided. HL to (R) forearm flushed well c 3cc of NS. will continue to monitor. PT is resting comfortably c bed rails up. (b)(6)-2 [redacted] CPT

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	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.)*

EPW # [redacted] (b)(6)-7

REGISTER NO.

WARD NO. ICU 2

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 - 14727

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7.23.03 2300:	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Pt. denies pain. Drsngs to (L) UE CDI. Staples to (L) shoulder OTA S/S infection. Neuro checks (L) UE WNL. Will cont to monitor. (b)(6)-2 [redacted] TCTPW
24 July 03 0700	Pt. awake & alert sitting up in bed eating breakfast. DSG to (L) UE CDI, limited ROM, <3 sec cap refill (+) sensation, radial pulses present, incision well approximated. DSG to (L) hip Δ'd, wound S/S of infection. HR Regular, bowel sands (+) x4 quads, Lung sands clear bilat. Pt. S complaints @ this time. All other assessment findings WNL. Will continue to monitor. HL in (R) EA S/S of infection. [redacted] AN LT
1000	New IV placed in (R) bicep (b)(6)-2 [redacted]
24 July 03 1300	- OT to AWAKE & Alert. VSS. Lung sounds clear B. bilat. BS x4 (+) ROM on all extremity & Good Pulse motor function on all extremity. BS x4. Dressg to (L) UE CDI. DSG to hip CDI & (-) S/S of infection. Will cont to monitor [redacted] (b)(6)-2 Cpl.
25 July 0140	Pt care assumed @ 2100. VSS, pt awake and alert S c/o pain, 1 percocet given @ 0000. Lung sounds CTA, pulses (+) x4 bs (+). Pt ambulated x1, BM x1. Dsg's on LUE CDI, both dsg's to hip/buttock CDI. IV @ (R) FA running IVF BBX no S/S infiltration. Will cont to monitor. (b)(6)-2 [redacted] awake
25 July 03 0550	Pt. asleep in bed easily aroused to verbal stimuli. HR Regular, lung sands clear bilat, bowel sands (+) x4 quads. Diagnal incision on (L) shoulder well approximated S S/S of infection. DSG to (L) shoulder CDI. DSG to (L) hip Δ'd, wounds S S/S of infection. Pt. c very limited ROM in (L) arm, pulses palpable, slight edema noted, (+) sensation,

STANDARD FORM 600 (REV. 6-97) BACK

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NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25July03 0550	cap refill <3sec. HL in Ⓡ bicep ∫ s/s of infection. Pt. ∫ complaints @this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-7 [redacted] JLT/AN
1430	Pt Stable at this time. VSS. AAOx3 PERRLA. Lungs CTA bilaterally, ∅ resp distress. VSR. Abd soft, non-tender, bowel sounds active x 4 Quads. strong pulses and brisk cap refill x 4 extremities. Ⓛ arm immobile, Sutures CDI. Dsng intact. ∅ complaints (b)(6)-7 [redacted] LT/A
1945	Pt ↑ large formed BM to BR. Pt states he has not gone in 6 days, requesting colace. Will speak ↑ MD on rounds [redacted] LT/A
2218	Pt. Care assumed @2100. VSS ✗ temp 100.8 A. HR Reg, lungs CTA, BS@ x4. Dsng to Ⓛ shoulder CDI, staples OTA∫ s/s infection. Neurovascular checks @↑E WNL. Dsng to Ⓛ buttock CDI. Will cont to monitor. (b)(6)-7 [redacted] hr
26July03 0532	Pt. awake & alert in bed. HR Regular, Lungsounds clear bilat, bowel sounds(+) x4quads. Incision on Ⓛ shoulder well approximated, 2 wounds on shoulder ∫ s/s of infection. Ⓛ radial pulse palpable, capefill <3sec, Ⓛ sensation, full ROM in hand, limited ROM in Ⓛ arm, no swelling noted. HL in Ⓡ bicep ∫ s/s of infection. Pt. ∫ complaints @ this time.

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

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

REGISTER NO.

WARD NO. ICW2

[redacted] (b)(6)-7

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 - 14729

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26July03 0532	all other assessment findings WNL. Will continue to monitor. [redacted] (b)(6)-2 SLZ/AN
0915	New IV placed in (L) hand [redacted] (b)(6)-2
1430	Pt Stable at this time. AAOx3. PERRLA. Lungs CTA bilaterally, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. (L) shoulder dsgp x2 CDI. Staples CDI open to air. Assessed by Dr. [redacted] (b)(6)-2 to D/C abx and repeat x ray. Ø complaints [redacted] 14/pr
2130:	Pt. care assumed @ 2100. VSS. Ø complaints. HK Reg, lungs CTA, BS Ø x4. HL to (L) hand intact 5s/5 infection. Prongs to (L) shoulder CDI, staples OTA 5 s/s infection. (L) UE ē pulses 2+, (L) ROM but ↓, (L) sensation, brisk cap refill. will cont. to monitor. [redacted] (b)(6)-2 TJAN
27 0000 July 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breath even and unlabored, LS clear to all fields (B). Able sit, nontender, ↑ distention. BS@x4. Vitals spontaneously FROM and neurovascularly intact to RUE and (B) LE. LLE has limited ROM 2° pain (kept in sling) and is neurovascularly intact. IV in (L) hand flushes well 5 s/s ↑ s/s infection. [redacted] (b)(6)-2 TJAN
27July03 1300	- Assumed pt care. Pt had a moderate Fever of 100.5 F. Tylenol were given. Pt Breath sounds are clear Bilateral. BS x4. (+) ROM on all extremity. Good PMS on all extremity. Dsg to (L) Shoulder CDI. Staples at CDI c (-) s/s of infectious, will cont to monitor Temp. [redacted] (b)(6)-2 LPN

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 14730

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 July 03 0550	cap refill <3sec. HL in Ⓡ bicep ∑ s/s of infection. Pt. ∑ complaints @this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-7 [redacted] RT/AN
1430	Pt Stable at this time. VSS. AAOx3. PERRLA. Lungs CTA bilaterally, ∅ resp distress. NSR. Abd Soft, non-tender, bowel sounds active x 4 Quads. Strong pulses and brisk Cap refill x 4 extremities. Ⓛ arm immobile, Sutures CDI. Drsg intact. ∅ complaints (b)(6)-7 [redacted] LVN
1945	Pt ↑ large formed BM to BR. Pt states he has not gone in 6 days, requesting Colace. Will speak ↑ MD on rounds (b)(6) [redacted] RN
2218	Pt. Care assumed @ 2100. VSS x temp 100.8 A. HR Reg, lungs CTA, BS@ x4. Drsng to Ⓛ shoulder CDI, Staples OTAJ s/s infection. Neurovascular checks ↑E WNL. Drsng to Ⓒ buttock CDI. Will cont to monitor. (b)(6)-7 [redacted]
26 July 03 0532	Pt. awake & alert in bed. HR Regular, Lungsounds clear bilat, bowel sounds (+) x 4 quads. Incision on Ⓛ shoulder well approximated, 2 wounds on shoulder ∑ s/s of infection. Ⓛ radial pulse palpable, capefill <3sec, (+) sensation, full ROM in hand, limited ROM in Ⓛ arm, no swelling noted. HL in Ⓡ bicep ∑ s/s of infection. Pt. ∑ complaints @ this time.

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.
	ICU2

#[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 - 14731

NSN 7540-00-634-4176

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	[illegible]
[illegible]	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]

[redacted]

(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.

EPW

[redacted]

(b)(6)-4

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

MEDCOM - 14732

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC 20.7; H/H 13.6/; PLT 127	SMAC: 138 | 105 | 6 / 143; 3.6 | 25 | 1.0	ABG/PULSE OX: SUP 02; PH; PO2; PCO2; SAT; OTHER	RADIOLOGY — Check if read by radiologist ☐
PT 14		U/A: DIP WNL; MICRO	RESULTS: CXR - ø pneumo ⊕ Bullet; CAT - ⊕ Bullet in soft tissue; Ⓛ Shoulder - ⊕ Humerus Fx
APTT 23	BHCG; ETOH; GLU		EKG INTERPRETATION: ABD: ø Fx / ø FA; Pelvis ø Fx:

PROVIDER HISTORY/PHYSICAL

32 y/o ♂ who was shot (3) times c̄ 9mm ≈ 4 hrs ago. The EPW had an AK47 that was confiscated then returned to him. After he was given it back he loaded it and fired on the soldiers who gave it to him. Arrived via Aerovac

G: WD, WN, NAD, A&Ox3

H: NC/AT, PERRLA, EOMI, s/p ⊖

N: supple ⊕ FB / Ecchym superficial BACK / neck

Lungs ⊕ ... BRRR ...

[illegible] Ext: ⊕ ... Ⓛ distal forearm, ⊕ Ⓛ ... Elbow / ... / ..., NT, FAROM

ABD: soft, NT, ND ⊕ BS, ø peritoneal signs

PMH - ø
PSH - ø
Imm - UTD?

FST Exam Neg

(b)(6)-2

CONSULT WITH	TIME	ACTION
[redacted]	cleared	to OR

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] 2265

DIAGNOSIS
① GSW Ⓛ Arm c̄ Humerus Fx
② GSW Ⓛ Buttock.
③ GSW Ⓛ Forearm

CODES (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)*

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDCOM - 14733

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY: EMT

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 17 Jul 03 | TIME: 0530

TRANSPORTATION TO FACILITY: Medevac

SEX: M

AGE: 32

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: none

ALLERGIES: NKda

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS: DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0532

INITIAL: [redacted] (5)(6)(7)

VITAL SIGNS

TIME	0535				
BP	149/81				
PULSE	120				
RESP	17				
TEMP	97.6				
WT	185 (43)				

LAB ORDERS

☒ CBC/DIFF	ABG	☒ PT/PTT	☒ BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		☒ CHEM: 12C lytes
BLOOD C&S X			

X-RAY ORDERS

☒ CXR PA & LAT/PORTABLE		C-SPINE
ACUTE ABDOMEN		LS SPINE
SINUS		HEAD CT
ANKLE R/L		
☒ Shoulder, L		

ORDERS

☒ PULSE OX ☒ MONITOR ☒ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0540	NS IV 1000mlx	[redacted]	[redacted]	0540	
0545	CXR PA/LAT			0530	
0540	LABS			0544	
0550	Foley Catheter			0902	

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS/OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS. (5)(6)(7)

PATIENT/DISCHARGE INSTRUCTIONS: (5)(6)(7)

MODIFIED DUTY UNTIL

RETURN TO DUTY

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted] (5)(6)(7)

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 14734

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: 21 YRS.

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
Removal of Bullet from (L) Upper Shoulder (L) Wound Washout.

4. PROPOSED SURGICAL PROCEDURE:
ORTH (L) Shoulder.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ole.
Tobacco___ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM (L) arm limited SA Motrin w/72 hrs (Y) (N)
ETOH_____ Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g.. warm blanket. touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c 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 .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c 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).	c Utilize pressure preventing devices on OR table and accessories. c 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)

BPW # [redacted] (6)(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:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. 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	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.____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.	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 ___2) W/O Glasses F.2.____Potential for decreased communication due to: ___1) Diminished Hearing ___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 table. c Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	c Introduce self. Keep pt. informed as to where he she is and what is happening. c Inform pt. in which direction to move and assist if necessary. c Speak clearly and slowly. c Address pt. from _____ side. c Validate pt.'s understanding of verbal communication. c Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 19 JUL 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 19 Jul 03 TIME: 0900 DATE: TIME:

REVERSE OF FORM 5179, JUN 91 MEDCOM - 14736 USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Cart BY: Anes & OR Staff
2. PATIENT ID VERIFIED BY: [redacted] AND PROCEDURE: CPC/PN
3. DATE: 17 Jul 03 TIME PATIENT ARRIVED IN SUITE: (CW² → OR
4. PATIENT IN ROOM TIME: 1335 (b)(6)-2 NUMBER: 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (1st Asst) (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

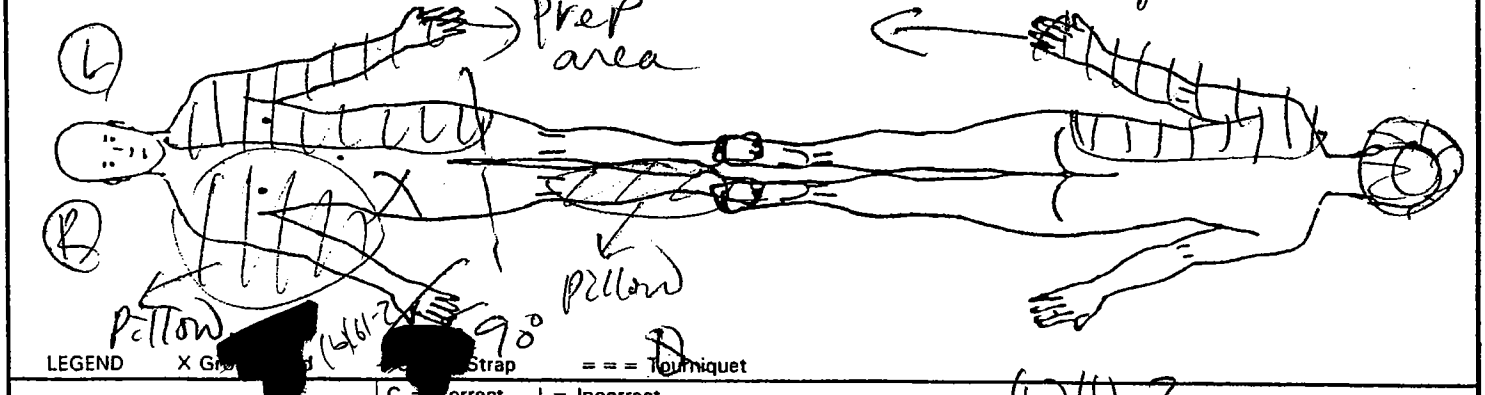
COMMENTS: Bean Bag used for position. Pillow under Rt arm & between knee

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine S/Sol
SITE: (Lt) Hip BY WHOM: CPT. [redacted] (b)(6)-2
SITE: (Lt) side & Groin
COMMENTS: ⊗ Pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Gr[redacted] Strap = = = Tourniquet

C = Correct I = Incorrect

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

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

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

GPW [redacted] (b)(6)-4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND: Polyhesive II
LOT NO: 012
☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:
☐ BIPOLAR NO:

Coag: 30 Cut: 30

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 14737 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):

0.9% Saline

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluff Gauze 4x8 Kerlix ACE Tape

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	1/2" Iodoform	penrose	
SITE	Back Hip	Shoulder	

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

Removal of Bullet from (L) Hip & Washout (L) side wd and (L) Shoulder.

21. PATIENT TRANSFERRED TO ICU TIME See Anes. Record METHOD Litter

22. [redacted] SIGNATURE [redacted] PT (AN). (b)(6)-2

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Amb. OR Staff
2. PATIENT IDENTIFIED, RECORD REVI[redacted] AND PROCEDURE VERIFIED BY [redacted] CPT/AO
3. DATE 19 Jul 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 1003 (b)(6)-2 NUMBER 2-1 / 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO pMN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] .ORT. (b)(6)-2	RELIEF SCRUB	SSG [redacted] (1FST) ~~1215~~ error
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1145-1230)

7. POSITION AND POSITIONAL AIDS (Specify) Beach chair position.

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

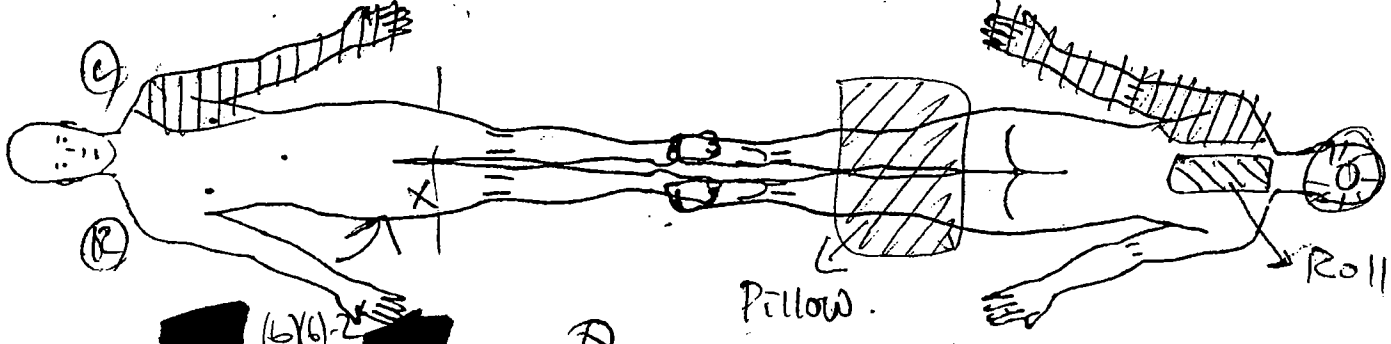
COMMENTS: Roll under (L) Shoulder. Pillow under knee, Body alignment maintained. (R) arm to @ side.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Alcohol/ Betadine s/sol
SITE: (L) Shoulder BY WHOM: CPT [redacted]
SITE: (L) arm BY WHOM:
COMMENTS: ☒ Povlings

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- Safety [redacted] = = = Tourniquet

C = Correct I = Incorrect

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

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

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

EPW # [redacted]
(b)(6)-7

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

☑ ESU NO: Valley Lab # FT000450
GROUND PAD: BRAND Polyhesive II
LOT NO: 68936.

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:
Coag 230 / Cut 230

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

Synthes Large Frag Set Plates + Screws
CMS # 06191011031920 2

4.5mm Cortex Screws
30mm x 2
42mm x 1
46mm x 1
50mm x 1

T-Plate
240.05 X 1

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ C-ARM IF YES, SITE (L) Shoulder

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	10mm J.P		
SITE	(L) Shoulder		

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs 4x8
ABD's
Tape

19. ADDITIONAL INFORMATION

Dr. [redacted] (b)(6)-2
may

20. OPERATION(S) PERFORMED

ORIF (L) Shoulder.

21. PATIENT TRANSFERRED TO (b)(6)-2 1 cc TIME See Anes. Record METHOD Litter

22. [redacted] (AN)

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 14740

USAPA V1.01

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (0)	TEMP. F (°)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99° 98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

#[redacted] (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 - 14741

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 DAY

19 HOUR

PULSE (0) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° | 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O2 Sats →

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)*

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICU2

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

MEDCOM - 14742

Ward/Section: ER

(b)(6)-7

[redacted]

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

LAST, FIRST: # [redacted] (b)(6)-4

DATE: 17 JUL 03 TIME: 0535

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		

REMARKS:

---

i-STAT EC8+

Pt: [redacted] (b)(6)-4

Pt Name:_____

Glu_____139 mg/dL
BUN_____8 mg/dL
Na_____138 mmol/L
K_____3.6 mmol/L
Cl_____105 mmol/L
TCO2_____25 mmol/L
AnGap_____13 mmol/L
Hct_____43 %PCV
Hb*_____15 g/dL
*via Hct
pH_____7.327
PCO2_____45.3 mmHg
HCO3_____24 mmol/L
BEecf_____-2 mmol/L

Sample Type_:

17JUL03 05:50

Oper: [redacted] (b)(6)-7

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(Piccolo) Metabolic Panel

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

======= PICCOLO =======

17/07/03 05:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-7
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: [redacted] (b)(6)-7 DR #: 000
SERIAL #: [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	73	26-84	U/L
ALT	18	10-47	U/L
AMY	60	14-97	U/L
AST	24	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	140	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	143*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

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

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-7		

17 July 03

(b)(6)-2

Ward/Section: Emt | R [redacted] | LA ORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST: [redacted] | DATE: 17 July | TIME: 0335 | SSN/PSEUDO SSN:

(b)(6)-4

ReDo

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³

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	
Other	

Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	13.8	9.8-13.6 secs
APTT	23.6	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(b)(6)-2

(b)(6)-2

Ward/Section: EMT

ATTENDING PHYSICIAN: Dr. [redacted]

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

LAST, FIRST, MI. [redacted] (b)(6)-7

DATE 17 JAN 03

TIME 0623

SSN/PSEUDO SSN: [redacted] (b)(6)-7

(Hematology) CBC

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 17 Jan 03

LAB ID NO.:

(b)(6)-2

ICW2 [redacted] 2LT M

EPW # [redacted] (b)(6)-4 (b)(6)-2

18 July 03 0350

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		
Hg		
Hct		
MC		
Plt		
M		
(		
Seg		
Bar		
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 [redacted] (b)(6)-2 **DATE:** 18 Jul 03 **LAB ID NO.:**

MEDCOM - 14746

Ward/Section: ICW #2

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

NAME [redacted] (b)(6)-4

DATE 20 Jul 03 TIME 0330

SSN [redacted] (b)(6)-4

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

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC			App		N/A	Mono		Negative
Hgb			Glu		Negative	**Microbiology**		
Hct			Bili		Negative	Source		
MCV					Negative	Gram Stain		
Plt			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
Segs			Prot		Negative	Malaria		
Bands			Urob		0.2-1.0	O & P		
Lymph			Nit		Negative	Other		
Atyp		1mm	Leuk		Negative	**Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)				**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Direct Ag		Negative	ABO/Rh		

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
		9.8-13.6 secs			
PTT		21-34 secs			
Fibrinogen		<20 ug/ml			
		<10 ug/ml			

REPORTED BY: [redacted] (b)(6)-2 | DATE: 20 Jul 03 | LAB ID NO.:

MEDCOM - 14747

ACLU-RDI 1628 p.107

DOD-028136

ANESTHESIA PLAN OF CARE/PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 32 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: Dc Diaphragm removal/Possible ORIF LUE

SURGICAL SERVICE: Ortho

NPO SINCE: 2200 16 Jul 03

ASA Physical Status 1 2 3 4 E

WT: 85 (KG/LB) HT:

ALLERGIES: NKDA

HABITS:
TOBACCO: 0
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) N/A
( )
( )
( )
( )
( )

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

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

T/PTT 3.8/23.6 17 Jul 03
15,5 13.8 41.3 123
130 105 3.8 139
3.6 23

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary System:		
Asthma	N	Y
Bronchitis/URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
Acute/Chronic RF	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
PUD/GERD	N	Y
Endocrine System:		
Diabetes	N	Y
Steriods	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Other	N	Y
Gynecological :		
Pregnancy	N	Y
Other Significant Hx:	N	Y
	N	Y
Familial HX	N	Y

ASSESSMENT

PAST SURGICAL/ANESTH: N/A

O-A Hx GERD

Copd

PHYSICAL EXAMINATION

BP 142/90 HR 90 R ___ T ___ 98.4

Pain Scale 0-10 ___

HEENT - Teeth: intact

Trachea: Mid

TMJ/Neck: FROM

Oropharynx: CL2, 3/6 Tkr.

Nares

CHEST: CTA

CARDIAC: S1S2 RRR

EXTREMITIES: GSW LUE/buttock

IV Access: #18 RAC

Ulnar Filling: ___

BACK: ___

OTHER: ___

NPO Since 2200 16 Jul 03

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

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

The patient/[redacted] (b)(6)-2 per Translator "Bill"

Signed: [redacted] and agrees. Questions answered.

Date: 17 Jul 03 Time: 1200 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 sedat Patient responds purposefully t verbal commands alone or accompanied by light tactile stimulation. Airway assistance necessary.
3. **DEEP SEDATION/ANALGES** Patient responds purposefully following repeated or painful stimulation. Airway assistance

Patient Identification: (Ward) _____

#[redacted] (b)(6)-4

ICW 2

ESTHESIA PLAN OF CARE P.. ROCEDURAL ASSESSMENT (Sedation-anesthesia)

» 32 DAYS MOS (YRS) Sex (X) MALE ( ) ~~FEMALE~~

)POSED PROCEDURE: ORIF (L) SHOULDER
IGICAL SERVICE: ORTHO
) SINCE:

ASA Physical State (1) 2 3 4 5 E
WT: 85 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

IITS:
BACCO: Ø
ETOH:
DRUGS:

IRENT MEDICATIONS:
ordered as premed

NA

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
—. ____ mg IV IM PO
—. ____ mg IV IM PO
—. ____ mg IV IM PO

ORATORY STUDIES:
18 July
ICT: 13.1 / 40.6
IER:

PLT 227

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary System:		
Asthma	N	Y
Bronchitis/URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
Acute/Chronic RF	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
PUD/GERD	N	Y
Endocrine System:		
Diabetes	N	Y
Steriods	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Other	N	Y
Gynecological :		
Pregnancy	N	Y
Other Significant Hx:		
	N	Y
	N	Y
Familial HX	N	Y

DENIED

ASSESSMENT
PAST SURGICAL/ANESTHETI
ORIF (L) A
Ø COMPLICATIONS

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea WNL
TMJ/Neck FROM
Oropharynx MP2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: ____
IV Access: (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since Prior to MN

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask (Intubation)

)RMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to
ussed with the patient/[redacted] (b)(6)-7
patient/[redacted] and agrees. Questions answered.
ied: [redacted] Date: 19 July 03 Time: 0540 Hrs

T-ANESTHESIA EVALUATION AND NOTE (NON ASU)
NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ied: ____ 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 n necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ent Identification: (Ward) ____

[redacted] (b)(6)-7 ICW2/ICU2

MEDICAL RECORD - ANESTHESI[A]

For [use] of this form, see AR 40-66; the proponent agenc[y is th]e OTSG

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)					TOTALS
Versed (Unit)					2
Fentanyl (mcg)	100 50		100		250 mcg
Lidocaine (mg)	10				10 mg
Zemuron (mg)	5	10			15 mg
propofol (mg)	180				180 mg
Sch (mg)	100				100 mg
Droperidol (mg)	0.625				0.625
VOLAT AGENT sevoflurane % del	3 1.2	1.2	1.2	.8 .8	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	6 2 2 2 2 2				

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

TOTAL EBL: 100 cc

TOTAL URINE:

FLUIDS

LINE site: (R) AC RL — Warmed ☐ — 100 — 600

FLUIDS SUMMARY

CRYSTALLOID- 600 cc

COLLOID-

BLOOD- ∅

LOSSES

EST BLOOD LOSS

URINE - 550

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 85 (KG) LB

HEMATOCRIT: 13.8/41.3

INITIAL DATA: BP- 122/80; HR- 114

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1335

TIME: 1330, 45, 1400, 1430, 1500, 1530, 1600

SYMBOLS: BP by cuff V ∧; Heart rate •; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-∅

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Events marked on grid: (1), (2), (3)

VENTIL

VT - ml		730	700	700	710	700	
f - breaths/min		10	10	9	9	9	
Peak inf pres / PEEP		18	19	20	20	20	16
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	S

MONITORS/ACCESSORIES

☒ BP/Auto Cuff; BP/oth; ART line; ☒ Steth (PC)/ES; Gas analyzer; Warming blkt; Conv warmer

☒ ET CO2 (torr)		32	32	34	34	34	
☒ FIO2 (Frac or %)	.67	.67	.67	.67	.67	.67	.47
☒ SpO2 (%)	100	98	99	99	99	100	.68
ECG	ST	SR	SR	SR	SR	SR	100
☒ TEMP-site Skin		36.7	36.8	36.8	36.8	37	SR
N-M Block (T/4)							

Mark with letters & symbols, explain under REMARKS

EVENTS Position → L lat [illegible] bony prominences padded + arms at <90° angles.

REMARKS

Code drugs with numbers, events with letters

Pt ID'd & interviewed (1) positioned (R) lateral c̄ bean bag & axillary roll, pillow btwn arms & pulse ox on lower +/= radial pulses, blanket btwn legs - lower bent feet off bed (2) Ancef 1 gm IVS (3) To PACU 2 p̄ extubation - no problems Pt opens eyes spontaneous Report to [redacted]

RECOVERY AT: PACU ICU 2 (Specify)

OTHER

CONDITION: RESP- 18; SpO2- 96% RA; BP- 117/72; HR- 96

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1308	1335	1510
	Ready	Begin	End
PROC	1343	1419	1453

PROCEDURES and CPT Codes: Removal Foreign bodies (L) buttock + (L) Shoulder & washout

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA 8.0 +/= BBS @ 24 (+) ETCO2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLx1 Atraumatic, MPI airway Mac 3

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

[redacted] EPW

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

SURGEON [redacted]

ANESTH[ESIOLOGIST] [redacted] CRNA

PROCEDURE LOCATION: 2 OR

DATE: 17 July 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 14750 [C]OPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ACLU-RDI 1628 p.110

DOD-028139

ASA-1
32/M NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)											TOTALS
MIDAZ (mg)	1	3									5mg
FENT (mcg)	50	100			100		200			50	500mcg
PROPOFOL (mg)		150									
( )											
( )											
Succ ROC (mg)		100			20						
VOLAT AGENT SEVO % del		3	1	1	1	1.5	1.5	1.5	0.6/0.4/X		
SEVO % e.t.		4 X	X								
AIR L/Min											
N2O L/Min											
O2 L/Min		4	2	2	2	2	2	2	6	6	6

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

TOTAL EBL: 300
TOTAL URINE: 300

FLUIDS SUMMARY
CRYSTALLOID- 800 LR
COLLOID-
BLOOD-

FLUIDS
LINE site (R)A 20G ☐ Warmed — LR, →
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE - 250/250 ; 50/300 ; 200/200, 250/300

PHYS STATUS: (1) 2 3 4 5 E
BODY WEIGHT: 85 KG
HEMATOCRIT:
INITIAL DATA: BP- 128/82 ; HR- 120
EQUIP CHECK: OK? Y N
PATIENT RECHECK: OK for PROCEDURE? TIME- 10¹⁵

TIME: 10¹⁵ 30 45 1100 15 30 45 1200 Noon 15 30 45 1300

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

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

REMARKS
Code drugs with numbers, events with letters
10⁰⁰ PreOp EVAL REVIEW — NO Δ. 20G IV → (R)A WALKED TO OR.
10¹⁵ OR #2 MONITORS ↑
(L) INTERSCALENE BLOCK (SEE BELOW)
10⁴⁰ PreO2 IND — INT
12⁴⁶ Suction Agreed to EXTUB

VENTIL

VT - ml			610	610	900	880	880	900	910	540	
f - breaths/min	16	12	10	10	6	8	8	8	8	16	
Peak inf pres / PEEP			18	18	22	22	22	22	22	16	16
MODE - S(pon), A(ssist), C(on)	S	S	C	C	C	C	C	C	C	17	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)			37	36	36	44	33	32	32	C	S
BP/oth	FIO2 (Frac or %)	RA	RA	.86	.85	.85	.84	.83	.83	.83	30	34
ART line	SpO2 (%)	97	97	98	100	100	99	98	99	.83	.83	.84
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	99	100	100	100
Gas analyzer	TEMP-site								ST	ST	ST	ST
	N-M Block (T/4)											
Warming blkt												
Conv warmer												

(L) INTERSCALENE BLOCK: BETADINE PREP TO (L) NECK, 2 IN, 22G, INSULATED, B-BEVEL NEEDLE → PNS @ 1.7mA & 1 SEC TWITCH → 0.2mA ABLATED c̄ 1cc of MIXTURE: 1:1 MIX of (1% LIDO + 0.5% BUPIV c̄ 1:200K EPI) @ 5cc/ASPIRATION FOR A TOTAL OF 40cc.

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

RECOVERY AT: PACU (ICU 2) (Specify)
OTHER
CONDITION: STABLE
Room Air
RESP 16 SpO2- 94
BP- 138/102 HR- 137

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	10⁰⁰	10¹⁵	13⁰⁵
	Ready	Begin	End
PROC	10⁴⁵	11²¹	12⁵⁰

PROCEDURES and CPT Codes: (L) Shoulder ORIF

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — (L) ISB + GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility* — # [redacted] (b)(6)-7

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — DL x1 / mac 4 8.0 ETT → VC c̄ BBS⊕, ETCO2⊕ EYES TAPED SECURED 22cm/LIPS

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

ANES [redacted]

PROCEDURE LOCATION: OR 2 28 CSH
DATE: 19 July 03
PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 14751 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

7540-01-155-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

519-301

AMINATION(S) REQUESTED

CXR PA/LAT

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
32	M		EMT	

FILM NO.

REQ [redacted]

SI[redacted]

PREGNANT ☐ YES ☐ NO

TELEPHONE/PAGE NO.

CIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE REQUESTED 17 July 03

(b)(6)-2

TE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
DIOLOGIC REPORT		

TIENT'S IDENTIFICATION *(For typed or written entries give: me — last, first, middle, Medical Facility)*

#[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

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

#1 [redacted] [redacted]

(b)(6)-2

NURSING UNIT | ROOM

7-17-03 0710

DATE OF ORDER: 17 Jul 03 TIME OF ORDER: 0710 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit ANO EPW ward ICW #2

Dx: Multiple GSW

Diet NPO

Plan for OR today

IVF LR @ 100cc/h

T&C x 2U PRBC

Activity: Bed Rest

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-5

EPW

[redacted]

DATE OF ORDER: 17 Jul 03 TIME OF ORDER: 1800 HOURS

Transfer PACU to ICW2

Dx: Post op [illegible] multiple GSW

Status: [illegible]

[illegible]

(b)(6)-2 [redacted]

Activity: [illegible]

[illegible]

Diet [illegible]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 17

PATIENT IDENTIFICATION

EPW

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

IVF LR @ 100cc/h

[illegible]

Meds: Ancef 1 gm IV q8°

MSO4 2-4 mg IV q2° prn

Gentamycin 500 mg IV [illegible]

phenergan 25 mg IV q4° prn

Tylenol 650 mg PO q4° prn

CBC in AM

[redacted]

(b)(6)-2

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 17

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

U.S. GOVERNME MEDCOM - 14753

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

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

NURSING UNIT: ICW2 | ROOM NO | BED NO. 17

DATE OF ORDER: 17 JUL 03 | TIME OF ORDER: 2010 HOURS

(1) Percocet, 1-2 p.o. Q 4° [illegible]

[redacted] (b)(6)-2

[illegible] 2100

24' chart [redacted] [illegible] /AN 18 July 0100

PATIENT IDENTIFICATION

NURSING UNIT: I.CW2 | ROOM NO. | BED NO. 17

DATE OF ORDER: 18 Jul | TIME OF ORDER: 2030 HOURS

NPO p MN

for OR [illegible] 19 Jul

noted 18 July 0100 [redacted]

(b)(6)-2 [redacted]

24' chart [redacted] [illegible] /AN 19 July [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE

MEDCOM - 14754

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

NLA

EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER: 19 May 03 | TIME OF ORDER: 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

[illegible]
[illegible]
[illegible]
[illegible]
ACT Bedrest
HOB > 30
[illegible]

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER: | TIME OF ORDER: HOURS

JP [illegible]
Reinforce DSG
TES 10x [illegible]
Adv Reg Diet
[illegible] @ 100cc/h
[illegible]
[illegible]

PATIENT IDENTIFICATION

EPW 0816 now

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER: | TIME OF ORDER: HOURS

Gentamycin [illegible]
MSO4 2-10mg IV [illegible]
Percocet [illegible]
Phenergan [illegible]
[illegible]
[illegible]
CBC in AM

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER: | TIME OF [redacted]

1500 [redacted]

24° chart ✓ [redacted] [illegible] 20 May 03 0130

DA FORM 4256, 1 APR 79

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

MEDCOM - 14755

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER 26 JUL 03 TIME OF ORDER 1300 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) X Ray - (L) Shoulder AP + Y lateral

(2) D/L Ancef

(b)(6)-2

NURSING UNIT | ROOM NO. 24 V/S | BED NO.

[redacted] ILT/AN 7-26-03 2130

PATIENT IDENTIFICATION

DATE OF ORDER 27 July 03 TIME OF ORDER 1145 HOURS

MOM 30 q4° a 2hrs prn

V.O. Dr [redacted] ILT/AN

(L)(6)-2

24°V/S [redacted] ILT/AN 7-27-03 2136

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/28/03 TIME OF ORDER 0630 HOURS

D/C to ESW Comp (b)(6)-2

[redacted]

NURSING UNIT ICW2 | 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.

the proponent agency is the Office of The Surgeon General. MO. 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17 18 19 20 21 22 23 24 25 26 27 28 29
7-17	[redacted]	Diet: NPO	7	
			11	DC'd 17 Jul 03
			17	
7/17	[redacted]	Act: Bedrest	5	
			13	
			21	
			/	
17	[redacted]	VS: routine	05	/ [redacted]
			13	
			21	
			/	
17	[redacted]	(L) UE sling	05	/ [redacted]
			13	
			21	
			/	
17	[redacted]	regular diet	07	/ [redacted]
			12	/
			14	
17July	[redacted]	Act: Ad Lib	07	/ [redacted]
			14	/
			22	
17July	[redacted]	Reg diet	07	/ [redacted]
			11	/
			17	

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D (L) arm/thigh GSW
Multiple GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (5)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 14757

Verify 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
7-17	[redacted]	Admit ortho, EPW ward.	7-17	0715	0715	[redacted]
7-17		For OR today	7-17			
7-17		T's C X2U PROC	7-17	0715	0730	[redacted]
17		Transfer PACU → ICW 2	17	—	—	
17		Condition: stable	noted			
17		CBC in AM	18	04	0400	
18		NPO p MN for OR on 19 July	19	0000		
	(5)(6)-2					

(5)(6)-2

Order/ Expir Date	Clerk Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

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	DATE COMPLETED 19 20 21 22 23 24 25 26 27 28 29 30 1
19 July	[redacted]	Vital Signs Per Ranks	05	[redacted]
			13	
			21	
19 July	[redacted]	Activity bed rest HOB 45°	05	
			13	
			21	
19 July	[redacted]	Shoulder Immobilizer	05	
			13	
			21	
19 July	[redacted]	JP to Bulb Suction	05	
			13	
19 July	[redacted]	I S 10X @ 1hr while Awake	21	
19 July	[redacted]	I S 10x @ 1hr while Awake	05	
			13	
			21	
19 July	[redacted]	Reg Diet	05	
			13	
			21	

(5)(6)-2

DC 5 days

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S1B ORIF @ Shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW # [redacted] (5)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 14759

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Jul	[redacted]	Transfer to ICU from PACU	19Jul		1500	
19	[redacted]	Stable	noted			[redacted]
28	[redacted]	X-ray (L) shoulder AP & Y lateral	28Jul	ASAP		(b)(6)-2
28	[redacted]	DC to TPW CLMP	28July	when arrive	1600	[redacted]
	(b)(6)-2					

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
19Jul07	[redacted]	Reinforce Dsg PRN	1900
-----	(b)(6)-2		2200
-----	-----		
-----	-----		
-----	--		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

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	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24
17	[redacted]	LRC100cc/hr - S2	05	/	[redacted]						
		when tol. PO	13	[redacted]		/					
	(b)(6)-2		21								
17	[redacted]	ancef 1gm IVPB	06	/	[redacted]						
		95°	14	/							
			22								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P IBD (L) arm/thigh GSW washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-2

EPW [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

Date	Nurse		be Given	be Given		
17	[redacted]	Gentamycin 500mg IV XT	17	now	2100	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
17 20	[redacted]	MSO4 2-10mg IVP q2° prn-pain	
17 20	[redacted]	Phenergan 25mg IVPB q4° -nausea	
917	[redacted]	tylenol 650mg PO q4° prn-fever	0345 18 July 0330 to PO 100.3 [redacted]
17	[redacted]	Percocet 1-11 tabs q4-6° prn	17 July 2015 1800 July 0300 11 PO; 1800 July 1500 11; 1800 July 2130 11 PO [redacted]

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 7 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 22 23 24 25 26 27 28 29 30 1 2
19 July	[redacted]	IV LR @ 100 cc/hr	05	[redacted]
		(HL) when tol. PO	13	
			21	D/C'd 27 July
19	[redacted]	Ancef 1 gm IVPB q8h	08	[redacted]
			16	D/C'd 26 July
			24	
20 July	[redacted]	Motrin 800 mg po TID	06	[redacted]
			14	D/C'd 28 July
			22	

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ORIF (L) shoulder.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

CPW# [redacted] (5)(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 - 14763

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 7 Yr. 03

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19	[redacted]	gentamycin 500mg IVPB x 1 now	19	now	1520	[redacted]
19	[redacted]	CBC in AM	20 Jul	0400	0350	[redacted] (b)(6)-2
	(b)(6)-2					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
19 Jul	[redacted]	MSO4 2-4mg IV Q2 prn pain	19 Jul 03 2200 1mg IV [redacted] — D/C 28 Jul [redacted]
19	[redacted]	Percocet i-ii tabs PO q4° prn	19 Jul ii 1540; 20 July ii po 0200; 20 July 0600 ii po; 20 July 2350 ii po; 21 July 1520 ii; 22 July 0100 ii po; 22 July 1230; 22 July 2040 ii; 23 July 1955 ii; 24 July 0400 ii; 27 July ii 0328 [redacted]
19	[redacted]	Phenergan 25mg IV Q4 prn.	D/C 28 July [redacted]
19	[redacted]	Tylenol 650 PO Q4 prn.	19 July 2100 ii po; 25 July 2130 ii po; 27 July ii 1350; 27 July 2140; 28 July 0300 [redacted] — D/C 28 July [redacted]
~~19~~	[redacted]	~~MOM 800mg TID prn.~~ [illegible]	
27	[redacted]	MOM 30cc PO q 8hrs prn	27 Jul 70cc 10 1150 [illegible] — D/C 28 July [redacted]

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

USAPA V1.00

MEDCOM - 14764

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED *(Date)*

Date: 17 JUL 03
Time In: 1505 hrs
Allergies: NKDA
Pre-op V/S: 124/80 – 114
Procedures: (L) ring Follicle biopsy washout

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block — 250 mcg Fentanyl
OR Intake: Crystalloid 600 Colloid —
OR Output: UOP 350 EBL 100 — 1gm Ancef
Meds/Times:

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

Pre Op Meds   History ASA I

Time	1505	1510	1515	1530	1545	1600
SaO2	94	95	94	96	96	96
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	16	21	21	22	21	23
T	98.4	98.2		99.3	100	

Time	1505	1535	1600				
Pain (0-10)	Ø	Ø	Ø				
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1605	LR	50	(R) AC	Emt	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8/10	9/10	9/10

Codes

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

V/S: X = A-line BP; ˇ = 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)

(b)(6)-2 PREP[redacted] CR/AN

DEPARTMENT/SERVICE/CLINIC: ICU #2
DATE: 17 JUL 03

PATIENT [redacted] *or written entries give: first, middle; grade; date; hospital or medical facility)* *Name – last,*

#[redacted] (b)(6)-4

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

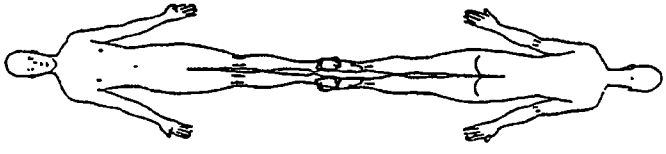
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1505	(R) Shoulder (L) outer buttocks	Pressure dsg Gauze dsg	Moderate blood Dry/Intact
30'	(L) wrist (R) Back region	Gauze/Kerlix Bulky pressure	n n Sm → mod
60'	" "	" "	" "
D/C	" "	" "	" "



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1605	Urine	yellow/cloudy	200cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(1510hrs) Arrived to PACU via litter & two person assist. Drowsy but oriented upon verbal questioning. Responds to all commands. (+) movement all four extremities & (+) palpable pulses & brisk capillary refill (<3 secs all digits). (R) shoulder dressing c moderately bloody drainage noted & marked (pressure dsg to extremity given by CRNA in initial report. Lungs CTA. RR & (n) (HR 80-90's). BP 117/72. (+) hyperactive to hyperactive bowel sounds all quads. Abd soft, flat non-distended. Foley Cath collecting yellow urine. IV LR in (R) AC patent & site flat positional. Pressure dressing to upper/mid back & small mod bloody drainage. No c/o pain. (b)(6)-2 [redacted] (1605hrs) Cleared PACU. ↑ mod bloody drainage to (R) shoulder region. Marked from previous check. No Δ in other dressings. No c/o pain or noted distress. IV remains patent, but positional. Will give report & transfer to ICU [redacted] (b)(6)-2

Discharge Criteria:
Date: 17 JUL 03 **Time:** 1605 **PARS:** 9
BP: 124/82 **T:** 100° **HR:** 94 **RR:** 23 **SaO2:** 96% RA
Pain Level at D/C (0-10): 0/10
Intake: LR 50cc **Output:** 200cc
Additional Data: 0
Transferred To: JCW 2
Report Given To: [redacted]
Transferred Via: W[redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Roo[redacted]
Charge Nurse Signature: [redacted]

(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED (Date)

Date: 19-Jan-05 | Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1320

Allergies: NKA | OR Intake: Crystalloid 800 LR Colloid

Pre-op V/S: 128/82/120 | OR Output: UOP 300 EBL 300

Procedures: L shoulder DCR | Meds/Times: 500 mg Ancef, 5 mg Vicodin

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1320	1325	1330	1335	1340	1345	1400
SaO2	94	94	94	96	96	96	97
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140	V	V	V	V			
120			V		V	V	V
100				^			
80	^	^	^		^	^	^
60							
40							
20							
RR	22	24	20	22	24	25	22
T	100	101	100.7	101	100.4	100	100
Time	1320	1345	1400				
Pain (0-10)	0	10	0				
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1200	LR	125	Hand		125

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	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	10	10	10

Codes

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

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

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

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

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) (b)(6)-2 [redacted] | DEPARTMENT/SERVICE/CLINIC: ICU2 | DATE: 19-Jan-05

PATIENT [redacted] (For written entries give: first, middle; grade; date; hospital or medical facility) Name – last,

FI [redacted] (b)(6)-4

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

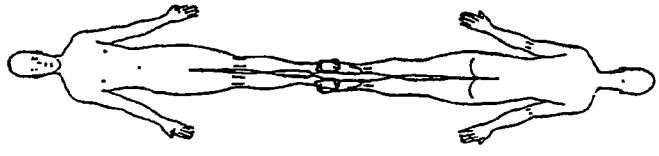
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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
1430	Foley	clear yellow ✓	100 cc
1470	JP (L)	Serous	30 cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: **W/C** **Litter** **Gurney** **Ambulance**
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

H [redacted]

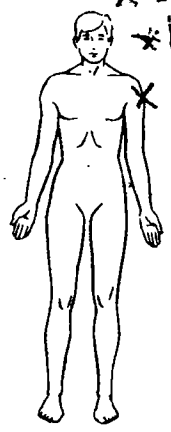
23 [redacted]02 7/17/03

H [redacted]

IRAQ EPW

GSW to (L) shoulder (deltoid)
GSW To (R) Buttocks/Hip
(L) wrist

X bullet wounded
*bullet?
X GSW



10mg MSO4
@ 0620Z

	23 [redacted]46Z	0620Z	
	135/96	137/82	/
	91	97	
	97% RA	100%	

(iv) RAC FRG NS (im) Ancef 1g 23 [redacted]12Z

0 † 0 † 0

H [redacted]

MEDCOM - 14769

REQUEST FOR PRIVATE MEDICAL INFORMATION
For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date. 16 SEPT 2008

2. Patient's Name and SSN (b)(6)-4 [redacted]

3. Medical Treatment Facility *(Name and Location)* [redacted] (b)(2)-2

4. Reason for Request.

I MEF INVESTIGATION INTO LOCATION OF Patient.

5. Private Medical Information Sought *(Specify dates of hospitalization or clinic visits and diagnosis, if known)*

Discharge & Location Information.

6. Requestor's Name, Title, Organization and SSN (b)(6)-2 [redacted] / MAJ USMC / I MEF

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☐ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date.

DA FORM 4254-R, NOV 91 DA FORM 4254-R, Jul 74 IS OBSOLETE USAPPC V1.00

MEDCOM - 14770

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
A	1	1	D	1	

2. ... LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

(b)(6)-4

NAME *(Last, First, Middle Initial)*: UNK - EPW

4. PAY GRADE

16	17
EPW	

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
U	N	K					

7. AGE AT ADMISSION

27	28	29
3	2	Y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION: Muslim.

10. LENGTH OF SERVICE

32	33	34
—		

ETS: —

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*: —

13. MARITAL STATUS

46
U

HOUR OF ADMISSION: 0700

BRANCH / CORPS: — (b)(6)-4

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
—								

17. UNIT LOCATION *(State or Country Code)*

62	63
—	

18. MOS

64	65	66	67	68	69	70
—						

19. TRAUMA

71
1

PREV. ADMISSION YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
Ø

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*: UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (SOUTH)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION (b)(2)-2

73	74
Ø	5

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	2	8

24. CLINIC SVC - ADMITTING

87	88	89	90
A	G	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	1	7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION *(Y Y M M D D)*

111	112	113	114	115	116

FOR LOCAL USE

DX: S/P IED (L) arm/thigh GSW washout

T: 9 Dx: 81210 PR: 7931

8771 8605

Inj: 569 82100

E99?

ADMITTING OFFICER *(Signature ...)*: DR [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FOR[redacted]

MEDCOM - 14771

ACLU-RDI 1628 p.131

DOD-028160

INPATIENT TREATMENT RECORD COVER S

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	16	UNK	UNK			N

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]		ICW2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—		WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
direct from ER	1830	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	21 Jul 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	19 Jul 03	(b)(6)-2 [redacted]

29. NAME [redacted]	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
Baghdad		

31. SELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW ⓛ hand

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

(b)(6)-2

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 14772

I cw 2

ABBREVIATED MEDICAL RECORD

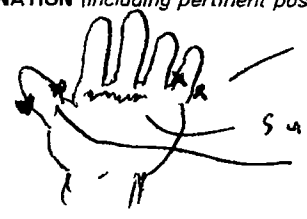
1. ADMISSION DATE (YYYYMMDD): 19 Jul 03

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

20 y/o LHTD Iraqi ♂ ~ 4 d s/p GSW (L) hand
? altercation c another Iraqi. 5 Clo.
wound noted @ EPW camp.
ϕ PM/PS/MCC/AU (F) tob.

3. PHYSICAL EXAMINATION (Including pertinent positives and negatives)

(E) hand



2-5 s/s FDS/FDP/EXT
tb/tb
LT 2
bryk CR
thumb ϕ IP F/E 2° pc's.
↓ LT to tip

4. IMPRESSION (Enter admission note with plan on progress notes)

(X-ray) comminuted thumb P1 distal 2/3 fx bryk CR
(A) 4 d s/p GSW (L) hand c fx as above
(P) OR for I+D + fixation vs cast/splint, Ancef, Tetanus

5. ADMITTING OFFICER

a. SIGNATURE [redacted] MAJ

b. DATE SIGNED (YYYYMMDD): 19 Jul 03 1824

6. DISCHARGE NOTE (Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)

7. DISCHARGE DATE (YYYYMMDD):

20 y/o ♂ as above
s/p I+D c cast/splint (L) thumb
plan return to EPW, return 2 wks
for cast ∆ + dressing check

(b)(6)-2

8. DISCHARGING OFFICER

a. [redacted] MAJ | b. GRADE: O4 | c. TITLE: MD | d. SI [redacted]

9. PATIENT IDENTIFICATION (For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)

EPW
[redacted] (b)(6)-4

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD (X when done)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 July 03 1850	Rec'd pt from EMT @ 1845, pt ambulatory, dx: GSW. (L) hand, condition stable. lungs CTA, (R) hand c dressing CDI (+) movement, (+) sensation to fingers. (R) arm c full ROM (+) pulses, SV (R) hand D5½NS c 20KCl @ 125 cc/hr infusing. S diff, abd soft nontender BS(+) x4 quads. R knee c full ROM (+) pulses. (-) c/o pain voided. pt has NPO p MN orders for OR in am. Will cont to monitor — (b)(6)-2 [redacted] 91WM6
19 Jul 03 2258	Rec'd c/o pt @ 21:00. A&O x3 sleeping in bed. Difficult to awaken. Sclera of eyes (+) reddened. PERRLA (+) WNL. LCAB BS (+) x4. (+) PPP (R). PIV (R) wrist patent c D5½NS c 20KCl infusing @ 125cc/hr. (R) Hand and FA splint intact (+) sensation (+) 2-3sec. cap refill (+) warmth (+) ROM to digits. (-) c/o pain @ this time. Will cont. to mon. —
(b)(6)-2 20 Jul 03	[redacted] PT/AOO 0540: Assumed pt. care @ 0500. Pt. A&Ox3. lungs CTA. (+) BS x4. Dressing on (R) arm CDI. (+) sensation and movement in fingers. IVF D5½NS c 20KCl @ 125 infusing in (R) hand S difficulty. (-) complaints @ this time. Will continue to monitor. [redacted] 91WM6 — (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. CSR

EPW # [redacted] (b)(6)-7

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
20 July 03 1610	Assumed pt care @ 1300. 1330 pt off to OR in stable condition. Pt returned from surgery @ 1605 via litter from ICU 2. LLE C cast + movement + sensation. R arm C full ROM + pulse. IVRA infusing D5 1/2 NS C 20 KCL @ 125 cc/hr. Orders to d/c IVF rec'd will d/c IV P pt eats dinner. lungs CTA, abd soft BS + x4. BLE C full ROM + pulse. 0 c/o pain voiced @ this time. Pt has d/c orders to return to EPW Camp when transportation available. Will cont to monitor [redacted] Gurney
20 July 03 2130	Assumed c/o pt @ 2130. Pt awake and alert in bed. PERLA +, CTA +, BS + x4. + PPB. + Hard C hard cast C/D/I. + sensation + ROM + 2-3 sec. cap refill. c/o pain will cont. to mon [redacted]
21 July 03 0710	Pt alert sitting up in bed. VSS, lungs CTA, HR reg, BS +. Cast to R arm & wrist. Able to wiggle fingers, + sensation, warm to touch. Ht to R arm. Ready to be D/C to camp. Will cont to mon. for [redacted] Gurney
21 July 03 1420	Assumed care @ 1300 - VSS - meds, x-rays, transfer summary ready - pt. awaiting transport to EPW Camp [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
20 Jul 1400	Op Note DF Crow (L) thumb, P. Fx Rx I.D contact Surgeon Guzman Anes MAC EBL ϕ

[redacted]
MAJ
(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.

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 - 14776

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT (5)(7)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: # [redacted] (5)(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 19 Jul 03 | TIME: 1740

TRANSPORTATION TO FACILITY: MEDEVAC

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?			WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: GSW (L) HAND

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1740

INITIALS: [redacted]

VITAL SIGNS

TIME	1740				
BP	115/64				
PULSE	86				
RESP	18				
TEMP	99.-				
WT					

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1740	R HAND X-RAY				

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted] (5)(6)-4

EPW

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 14777

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐	
CBC: H/H	SMAC		SUP 02	PH	PO2	RESULTS		
CBC: PLT	SMAC		PCO2	SAT	OTHER			
PT			U/A: DIP			EKG INTERPRETATION		
APTT	BHCG	ETOH	GLU	U/A: MICRO				

PROVIDER HISTORY/PHYSICAL

S: (L) thumb GSW 4 dys ago. ↑ swelling

(+) ToB

O: Proximal phalanx comminuted fx w/ jt involvement.

A: as above

P: Ortho consult for more definite fixation/treatment.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] (b)(6)-2 DO MAJ, MC

CODES

DIAGNOSIS

fx (L) proximal phalanx - thumb (4 dys dd GSW)

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 2003 DAY 19 20 21 22 23

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°	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 120/74 108/78 110/68 108/62

HEIGHT: WEIGHT → 98% 90% 97%

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)*

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. 6W2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14779

MEDICAL RECORD — INTRAOPER[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Cotter BY: Amb Staff

2. PATIENT IDENTIFIED, RECORD [illegible]ED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE: 20 Jul 03 TIME PATIENT ARRIVED IN SUITE: OR

4. PATIENT IN RO[redacted] TIME: 1340 (b)(6)1-2 NUMBER: 1-2A

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ACDA. npo

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC. [redacted] (b)(6)1-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☑ CLIP

COMMENTS:

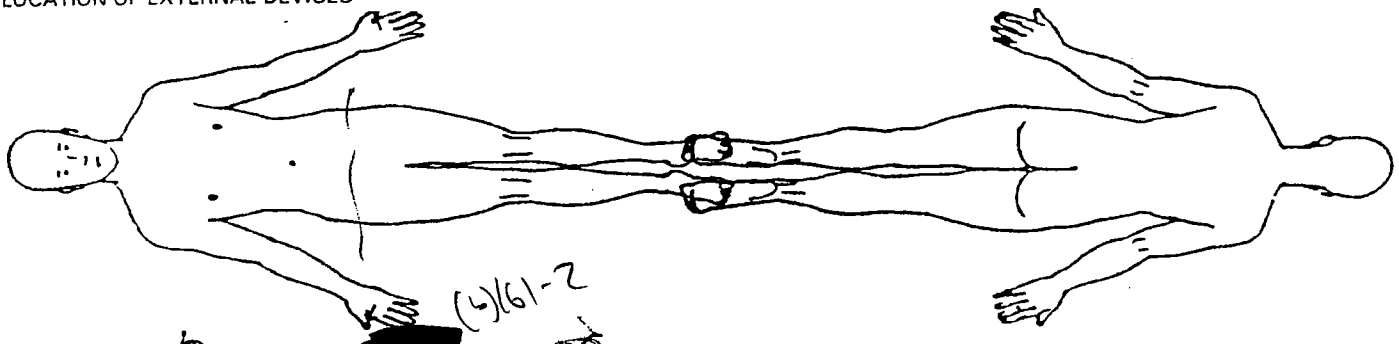
PREP SOLUTION (Specify) Hibiclens

SITE: (RT) hand BY WHOM: [redacted]

SITE: ~ BY WHOM: ~

COMMENTS: & purdue

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- S[redacted]p =/= Tourniquet

C = Correct I = Incorrect

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

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

Zpw. #[redacted] (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: _____

MEDCOM - 14780

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, 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):
0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

Rt hand. Thumb clean & cast DM

21. PATIENT TRANSFERRED TO (b)(6)-2 ICU TIME See Anes Record METHOD Litter

22. [redacted] OPT/AN

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

MEDCOM - 14781

MEDICAL RECORD - ANESTHESI

For ; this form, see AR 40-66; the proponent ager. ne OTSG

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

DRUG (Units)			
Benadryl (mg) 50			
morphine (mg) 5	3	2	
propofol (mg) 100	100		
( )			
( )			
( )			
VOLAT AGENT 150 % del	1.5	2.0	1.5 X
% e.t.			
AIR L/Min			
N2O L/Min			
O2 L/Min	6	2	2 16

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (1) (2) (3)

FLUIDS

LINE site 18g RW			
☐ Warmed	RL 1000		400
☐ Warmed			
☐ Warmed			
☐ Warmed			

LOSSES

EST BLOOD LOSS	Ø		
URINE -			

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: N/A

INITIAL DATA:

BP- 125/65

HR- 82

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 1320

TIME → 30 × 14 × 30 × 15 × 30 × 16

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	500	310	280
f - breaths/min	18	16	18
Peak inf pres / PEEP	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	(+)	(+)	(+)
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8
ART line	SpO2 (%)	99	99	99
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP-site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

TOTALS — TOTAL EBL: none; 10

TOTAL URINE: N/A

FLUIDS SUMMARY

CRYSTALLOID- 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Pt & chart √. OK to proceed.
(1) To room via litter, SOC monitors applied, preO2,
(2) Induction
(3) To recovery stable. Report given.

RECOVERY AT

PACU ICU [Specify]

OTHER

CONDITION: 96 6 98

RESP- 15 SpO2-

BP- 102/49 HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1325	1335	1420
PROC	Ready	Begin	End
	1340	1350	1410

PROCEDURES and CPT Codes:
(1) EUA lt hand, debridement, casting

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GM

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted] (5)(6)-4
20 yo ♂ ICW 2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, 30F NA placed, easy mask

SURGEONS: [redacted]

ANESTHETIST [redacted] MAS/CRNA

PROCEDURE LOCATION: 1-1

DATE: 7/20/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 14782 — PATIENT'S MEDICAL RECORD — USAPA V1.00

(5)(6)2

ANESTHESIA PLAN OF CARE PRE [illegible] EDURAL ASSESSMENT (Sedation) [illegible]

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

ASA Physical State 1 (2) 3 4 5 E

PROPOSED PROCEDURE: ORIF ms penny 6SW (D) Thumb

SURGICAL SERVICE: ORTHO 6 KIND ? Altercation fragi

NPO SINCE: PMN

WT: 71 (KG/LB) HT: ____ IN.

ALLERGIES: NKA

HABITS:

TOBACCO: (X)

ETOH: ____

DRUGS: ____

CURRENT MEDICATIONS:

( ) = ordered as premed

() ANCEF C 0400 g6

() ____

() ____

() ____

() ____

() ____

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
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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 157/78 HR 76 R 16 T 100.2

Pain Scale 0-10 8 5.9 58%

HEENT - Teeth WNL

Trachea ____

TMJ/Neck MOCI

Oropharnyx 3+MH

Nares ____

CHEST: BS CTA

CARDIAC: RRR S M

EXTREMITIES: ____

IV Access: R PIV

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since PMN

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 (b)(6)-2 seems to understand and agrees. Questions answered.

Signed: [redacted] LTC CRNA Date: 20 JUN 07 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) ____

[redacted] ICU 2

(b)(6)-4

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

MEDCOM - 14783

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

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 2		

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
Admit ✓		
Dx GSW (L) hand ✓		
vitals routine ✓		
Activity as tolerated		
Diet NPO p MN		
IVF D5 1/2 NS + 20 KCl 125 cc/hr		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 2		

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
Med Ancef ÷ 1 IV HOURS 6°		
OR in AM		
[redacted] MAJ		
(b)(6)-2 noted		
2p [redacted] 1845		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
Post-op s/p central HOURS (C)		
vitals routine ✓		
Activity as tol ✓		
Diet regular ✓ ✓		
Meds Tylenol #3 1-2 p.o. q 4 PRN		
Ancef ÷ 1 IV q 6 ✓		
D/C to EPW camp when available ✓		

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 2		

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
D/C instructions		
- D/C IV		
- D/C Ancef		
- Keflex 500 mg po QID * 7 d		
- Return for cast Δ 2 wks		
D/C [redacted] MAJ		
(b)(6)-2		

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL

MEDCOM - 14784

the proponent agency is the Office of The Surgeon General. MD. 7 V.R 2003

RIFY 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
19 July	[redacted]	Vitals Routine	6	/	[redacted]				
			13	/					
			21	pm					
19 July	[redacted]	Activity as tol	6	/	[redacted]				
			13	/					
			21	pm					
19 July	[redacted]	Diet NPO PM MN	6	/	[redacted]				
			11	/					
			17	/					
20 July	[redacted]	Diet Regular	6	/					
			11	/	[redacted]				
			17	/	NPO				

(b)(6)-2

(b)(6)-2

A'd 20 July 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) hand s/p casting @ ED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW # [redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 14785

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
19Jul	[redacted]	admit ICW 2	19Jul	NOW		
19Jul	[redacted]	Dx: GSW (L) hand				[redacted]
19July	[redacted]	NPO p MN	20July	2400	Done	
19July	[redacted]	OR in am	20July	am		(b)(6)-2
20July	[redacted]	D/C to EPW Camp when available				
	(b)(6)-2					

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

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 Y 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20
19 July	[redacted]	IVF D5 1/2 NS @ 20 KCl @ 125 cc/hr	6	/	1
			13	/	
			21	2M	
19 July	[redacted]	Ancef 1 gm IVQ 6°	4	[redacted]	
			10		
			16		
			22	2M	
20 July	[redacted]	~~Augmentin~~ Keflex 500 mg po QID x 7 days	4		[redacted]
			10		
			16		
			22		

DC'd 20 July 03

DC 20 July 03

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ⓛ hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] (5)(6)-7

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 - 14787

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 7 Yr. 05
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
22 July	[redacted]	Inderal #30 1-1-11	
.....	7/6/7-2	po q4° prn	
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

USAPA V1.00

ASA #2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 20 July 03
Time In: 1420
Allergies: NKA
Pre-op V/S: 135/65 82
Procedures: Debridement & Casting
Dorsum

Anesthesia Type (Circle)): ~~General~~ Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: 0mg MS04

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1420	1430	1445	1500	1515	45
SaO2	100	99	99	99	99	
FiO2	RA	RA	RA	RA	RA	
Methods						
240						
220						
200						
180						
160						
140						
120	✓	✓	✓	V ✓	✓	
100						
80						
60						
40						
20						
RR	14	14	12	13	15	17
T	96.4				97.3	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
		[redacted]	(b)(6)-2		

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	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	8	10

Codes

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

V/S
X = A-line BP
^ = Cuff BP
= Pulse

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

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

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

PREPARED BY (Signature & Title) [redacted] LPN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 20 July 03

PAT[redacted] entries give: first, grade; date; hospital or medical facility)

Name — last,

(b)(6)-2

[redacted] (b)(6)-4

20410

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) Arm	—	—	Cast	B	W	PK
15'	(L) Arm	+	+	Cast	B	W	PK
30'	(L) Arm	+	+	Cast	B	W	PK
45'	(L) Arm	+	+	Cast	B	W	PK
60'	(L) Arm	+	+	Cast	B	W	PK
90'							
D/C	(L) Arm	+	+	Cast	B	W	PK

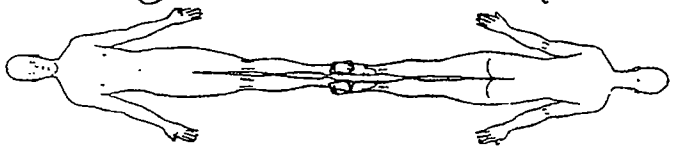
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Arm	Cast	Ø
30'	(L) Arm	Cast	Ø
60'	(L) Arm	Cast	Ø
D/C	(L) Arm	Cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

14:35 - Pt awake only to verbal or painful stimuli. Unable to follow commands. Pt VSS; Sats 99-100% on 8L O2 NRB. Cast to LUE extending from elbow down, C/D/I, Neurochecks to extremity WNL. Cap refill < 3 sec. Extremity warm to touch. Pt able to wiggle fingers. Unable to assess pulse due to cast. [redacted] LPN (b)(6)-2

1525:- 1535 - Pt awake Sats 98-100 on RA. Pt able to deep breath. Cast to LUE, C/D/I. Neurochecks to extremity WNL. [redacted] LPN

15:30 - Pt urinated 1000 cc clear yellow urine - [redacted] (b)(6)-2

Discharge Criteria:
Date: 17 July 03 **Time:** 1515 **PARS:** 10
BP: 118/67 **T:** 97.3 **HR:** 65 **RR:** 11 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICU #2
Report Given To: [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Spc [redacted] CPT (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. [illegible] LOCATION (State or Country Code.)	
1	2	3	4	5	6	7	8
A	1	1	D	(		I	Z

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	(b)(6)-7 EPW # [redacted]	16	17	18
[redacted]								—		M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND		RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31		
2	2	2	2	2	2	2	2	1	6	Y	X	9		UNK

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER									
32	33	34		35	36	37	38	39	40	41	42	43	44	45	
—			—	9	9	[redacted]									

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46	1830	(b)(6)-7
	Z		

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
—			K	7	8	—								

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	NO
—		—							9		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION		WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72			UNK
Ø		ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
			UNK
[redacted] TREATMENT FACILITY	Baqubad		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
			UNK

21. TYPE OF DISPOSITION (b)(2)-2		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)						
73	74	75	76	77	78	79	80	81	82	83	84	85	86	
5	Ø							Ø	3	Ø	7	2	1	

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)						
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	
A	E	A	A							Ø	3	Ø	7	1	9	

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)						
103	104	105	106	107	108	109	110	111	112	113	114	115	116	

FOR LOCAL USE

GSW ⓛ hand

Dx: 8822 E9289

Rx: 8083

ADMITTING OFFICER (Sig[redacted] — [redacted] PDH

SIGN[redacted] CLERK — [redacted]

(b)(6)-2

MEDCOM - 14791

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)				3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted]				EPW	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	UNKNOWN	IRAQI	UNKNOWN	~~UNKNOWN~~	—	N
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
20	[redacted]					ICW 2
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
—	K78		—			NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0750	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	TFR CIV HOSPITAL	28 JUN 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	**27b. TELEPHONE NO.**	**28. DATE OF THIS ADMISSION**
—	—	26 MAY 03

ADMITTING OFFICER: (b)(6)-2 DR [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] DOGWOOD		

31. SELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: SP EXLAP

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	32	32

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	32	32

SIGNATURE OF [redacted]

MAJ, MC

(b)(6)-2

DA FORM 3647, MAY 79 EDITION [redacted] OBSOLETE

USAPPC V1.10

MEDCOM - 14792

...PATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-2

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted]			EPW	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	40Y	IRAQI	UNKNOWN	—	—	NO
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	[redacted]		—			
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
—	K78		—			BI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0815	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	EPW CAMP	2 JUN03

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

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted]		

31. SELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW ABDOMEN

Dx: 86353
5538
55321
7288
E9912

5462 (x4)
4576
4603
46643
96599 (x4) x5
5351
8622
5462

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	20	20

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. [redacted]ENTAL	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø		20	20

SIGNATURE OF ATTENDING [redacted] RECORDS OFFICE

[redacted]

(b)(6)-2

DA FORM 3647, MAY [redacted] ...ON OF 1 A... USAPPC V1.1

MEDCOM - 14793

AUTHORIZED FOR LOCAL REPRODUCTION

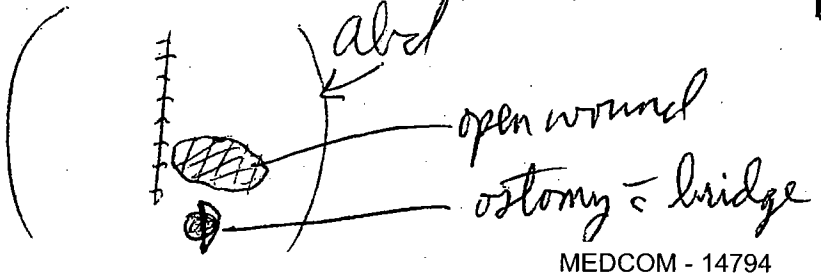
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5/14/03	0900 Surgery admit. Pt. appears comfortable; 40y/o EPW involved in skirmish, received GSW abd 2 days ago. Explore lap by FAST team c colostomy & drain placed. Foley in place. Transfered to [redacted] today. T. BP 147/79 P. 96 RR 24
(5)(2)-2	Pt. in no distress and arrives nontachy and no temp.
	PMH? PSH above Allergy NKMA
	PE HEENT & findings-
	Lungs CTA bilateral Heart RRR
	abd Flat, pain on palpation.
	Open 10cm wound left abd wall deep to rectus does not appear infected.
	Ostomy LLQ pink - nonfxn'l currently.
	Extrems good pulses, warm
	Back - 2 small skin wounds -
	A/P S/P Exploratory lap for GSW. No sign of systemic infection. Given the good appearance of ostomy & no signs of infection believe will cover c IV Abx & observe. Place ostomy bag over ostomy & wet to dry dressings to open wound.
	Keep NPO until gut works.

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. [redacted]



[redacted] STAND... 509 (REV. 5/1999)

...APA V1.00

MEDCOM - 14794

(5)(4-2 038

AST NAME | F | MIDD | NUMBER

DATE | NOTES

Surgery HD #2

5/15/03 (0825)

8 > 8.5 / 27 < 186

Pt. in no distress, looks good.
AVSS Tm 100
I/O good U.O. Ostomy bag c̄ ⊕ Flatus
Abdomen flat, soft.
Wound - no sign of infection, no granulation.
peritoneal drain - no output.

A/P ① Resp - ambulate, wean off O2
② CV - Stable, Hct 27
③ Renal - good U.O. - DC foley.
④ GI - ⊕ Flatus in bag, advance po.
if tolerates, Heplock IV

[redacted] (b)(6)-2

16MAY03 0345 UOP 280cc YELLOW ish ORANGE CLEAR FLUID - [redacted]

5/17 Surgery
Pt doing well, tol diet c̄ BM in bag.
Tm 101.6 VSS
Abd Soft, NT
Wound - obvious bowel evisceration (Hernia)
A/P Will make NPO, take to O.R. today for
Hernia reduction & fascia Repair.
Will Consider take down of bowel -

[redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 MAY 03 1900	PT vitals T 99.7 P 93 R 18 B/P 150/88 —— [redacted]
15 May 03 0100	: Assumed care of PT @ 2100. Pt. quiet, but (b)(6)-2 responsive to verbal stimuli. IV c̄ LR @ 150 cc/hr to Ⓛ EJ. Foley cath to gravity draining amber colored urine, ABD drain to gravity, sealed c̄ plastic bag intact. ostomy bag intact. ABD drsng Δ'd damp to dry. Peripheral pulses (2+) x4 extremities Bilateral hands c̄ 2+ edema. Brisk cap refill, ⊕ sensation, ⊕ ROM. HR 93, Reg c̄ S1, S2. Lungs CTA. BS ⊕ ī active x4. Pt. NPO. O2 c̄ 2L via N.C. to maintain sats > 92%. Will continue to moniter. —— (b)(6)-2 [redacted]
0400	600cc dark amber urine drained from Foley. Scant drainage from Peritoneal drain ī ostomy. Will continue to moniter. Pt. making efforts to communicate. —— [illegible]
15 0630 May 03	Pt is awake, alert, ox3. Breathing is even and unlabored. Breath sounds clear to all fields Ⓑ. Abd is soft, nondistended and tender only near wounds. Peritoneal drain to gravity, ø output at this time. Ostomy site to appliance; large amount of flatus expelled from appliance. Midline incision [illegible] and dry to Ⓛ of incision are [illegible]. Pt has Foley to gravity; amber, clear urine. BS ⊕ to Ⓡ LQ (only place able to auscultate 2° appliances). Pt remains NPO, Ⓛ EJ IV flushes well. LR @ 150 cc/hr continues. FROM & neurovascularly intact to Ⓑ LE. Ⓡ hand remains puffy c̄ ROM limited by pain; Good cap refill & fingers are warm. Ⓛ hand has good ROM, remains somewhat swollen but ø draining blisters to old [redacted] along wrists and skin discoloration. —— (b)(6) [redacted]
15 May 03 0800	PT vitals T 98.6 P 88 R 16 BP 126/66 SpO2 95 —— [redacted]
15 MAY 03 1330	PT vitals T 98.4 P 67 R 20 B/P 124/84 SpO2 90 —— [redacted]
15 May 03 1630	Assumed care of Pt @ 1300. VSS. Ⓑ LS CTA ⊕ productive cough c̄ clear sputum. ⊕ S1, S2 ⊕ cap refill > 3 sec. palpable pulses x 4. ⊕ 2 edema Ⓑ Hand. Encouraged to move fingers. EJ IV re-dressed. patent HL, c̄ IV ABX, Pt DTV, void 300cc

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STANDARD FORM 600 (REV. 6-97) BACK

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)
14MAY03 1000	Pt admitted to ICU 2 via litter from ER. Pt drowsy but arousable, O2 sat 87-90, O2 4 @ 4L/m O2 sat 94-96%. Resp distress noted. (D) EJ intact (D) IV fluids as ordered. (W) IV hand edematous, not flowing. IV D.C'd & cath intact. T 98.6 P 89 R 12 BP 128/80 O2 sat 94-96% on O2. (A) abd. dsg D&I. (R) abd. drain c small amt of red drainage to DD. Foley cath intact draining 500 cc amber urine. BBS CTA ≈ bilat., HRR. (D)% - Resting quietly @ present. [redacted]
1030	ABS (R) U+L Q. O2 sat 94-96% on 4L/m via [redacted]
1200	T 98.4, P 97, 16 BP 124/81 O2 100% on 4L & to 36 = 99% sat. (b)(6)-2 [redacted]
14MAY03 1300	PT vitals taken T 98.1 P 99 R 16 B/P 140/74 [redacted]
14MAY03 1500	PT vitals taken T 98.1 P 89 R 16 B/P 140/76 (b)(6)-2 [redacted]
14MAY03 1700	PT vitals taken T 98.3 P 92 R 20 B/P 140/80 [redacted]
14MAY03 1830	Assumed care of Pt @ 1300. VSS. (B) CS CTA, (D) WOD noted SATS 93-94% on 1L via NC, HRR, (E) +1 edema (B) hands d/t handcuffs. Hypo active BS (R) U+L Q. Ostomy bag draining scant secretions, site red + beefy, bag secure 360°. Abd surgical incision with staples OPA CDI. Open ABD WOUND WITH W-D dsg. CDI (S) I/O (I) of infection. Scant amount drainage to D.D., bag attached for collection. Foley cath draining tea colored urine ≈ 500 cc. Palpable pulses x 4. Will monitor [redacted] (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.

EPW # [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 - 14797

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 May 03 (cont)	to urinal amber urine. Ostomy draining brown liquid and gas. (+)BS abd incision to sticky CDI, w→d dsgs to abd wound CDI, 4x4 to @ old peritoneal space CDI. Pt ambulated x 1 to BR. Will cont to monitor [redacted]
15 MAY 03 1735	PT Vitals taken T 99.2 P 100 R 20 BP 138/72 SpO2 90 — [redacted] (b)(6)-2
16 May 03 0000	Pt care assumed @ 2100. Pt awake but seems withdrawn. No complaints of pain are noted. Lung sounds are CTA with equal rise and fall of chest. Pulses palpable x4, Bowel sounds present in RLQ, unable to auscultate other quadrants due to dressings and colostomy bag. Colostomy bag @ output during this shift, bag remains intact over LLQ. Abdominal incision stitches CDI. Wet → Dry done @ 2200, dressing CDI. 4x4 @ wd CDI. Pt ambulated and moved beds prior to dressing change. Pt tolerated PO intake. IV [redacted] @ [redacted] left external jugular flushes well, no S/S of infiltration or infection noted. Will continue to monitor. SPC [redacted] (b)(6)-2 91WM6
0536	PT Vitals T 99.3 P 91 R 24 BP 118/70 SpO2 96 — Spc [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

EPW [redacted] (b)(6)-7

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
15 1300 May 03	LATE ENTRY: Pt ambulated 75 feet c̄ moderate standby assist. When sitting up in bed, pt c/o dizziness and mild weakness. Pt exhibited this not with ambulation as well. Pt was somewhat diaphoretic at beginning of ambulation but condition had improved by end of walk. —— (b)(6)-2 [redacted] AN
16 0550 May 03	Pt is sleepy but arousable. Ø c/o pain. Breathing is even and unlabored. Lung sounds clear c̄ diminished in bases (B). Ab is soft, nontender (except at surgical sites), c̄ distention, BS(+) x4. Less gas out of ostomy this AM than yesterday. BS more active than yesterday however. Abd drsgs are CDI. EJ flushes well. Pt still c/o mod weakness to (B) UE. However previous shift nurse reports seeing pt using upper extremities rather frequently. —— (b)(6)-2 [redacted] AN
16 0830 May 03	Drsg to Abdomen Δ'd c̄ Betadine solution (3 iodine swabs to 1L NS). Drsg had mod amount of serosang drainage. No stool present in wound (ostomy bag separates wound from ostomy). Wound bed had no purulent drainage and was beefy red to pink. —— [redacted] AN
16 1000 May 03	Pt ambulating to Xray and returned. —— [redacted] AN
16 1230 May 03 (b)(6)-2	Ostomy bag loosened. Bag replaced. Tincture of benzoin (b)(6)-2 applied to skin to assist c̄ affixing bag. —— [redacted] AN
~~16 May 1345~~ [redacted]	
16 May 03 1445	Pt vitals taken BP 130/70, P-100, R-20, Temp 99.6 SPC [redacted] (b)(6)-2
16 May 03 1515	as [redacted] pt care @ 1300. VSS. Ostomy site Δ'd. dressing Δ'd to wound site in upper abd. lung sounds clear ↑ lobes, diminished ↓ lobes. abd soft + BS⊕4. pulses ⊕x4. EJ HL intact flushed s̄ diff. BLE ⊕ B hands swollen bilat. Δ'd dressings per MD orders wet to dry. ⊘ S/S of distress noted @ this time. —— [redacted] (b)(6)-2

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USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16May03 2023	Ostomy bag emptied. EJ HL positional, flushed well 3 diff. pt's been sleeping throughout day (b)(6)-7 [redacted] 9lWMC
16May03 2230	PT care assumed @2100. Pt resting, awoken by painful stimuli. Pt had a fever of 101.5° @2130, MD notified. Tylenol 650 mg given rectally @2200. Temperature @2230 100.8°. Wet → dry dsg abd performed. Wound is moist without S/S of infection. Colostomy site and 2x2 on abdomen CDI. Lung sounds CTA with diminished bases. Pt told to cough, Ø production. IV site @ L external jugular flushes well without signs of infiltration or infection. Pulses ⊕x4, bowel sounds present. Hands swollen w/o signs of improvement since yesterday. Will continue to monitor. SPC [redacted] 9lWMC (b)(6)-7 [redacted]
0400	Pt voided 0400 cc clear yellow urine. SPC [redacted] 9lWMC
170540 May 03	Pt is asleep but arousable. Breathing is even and unlabored. Airway is patent. Lung sounds are congested and diminished in bases. Cough & deep breathing encouraged. BS⊕x4. Abd is soft, non-tender (& where surgical sites are), some mild distention. Gas being put out through ostomy. Middle section is CDI. Ø signs of leakage from ostomy site. EJ sluggish but flushes. Will inform MD. [redacted]
17MAY03 1310	PT vitals taken T100.0 P97 R24 B/P 140/90 (b)(6)-7 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

EPW # [redacted]
(b)(6)-7

REGISTER NO.

WARD NO. TCW2

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 May 03 1330	Pt sleep easily aroused to verbal stimuli. VSS. lung sounds diminished in lower lobes, clear to upper lobes. Abd soft midline incision c stitches. Ostomy bag draining 5 diff brown loose stool. pulses ⊕. EJ IV infusing LR @125 cc/hr 5 diff. ⊖ S/S of infiltration. Pt is NPO for surgery. will cont to monitor (b)(6)-2 [redacted] 9lwm6
17 May 03 2300	Pt care assumed @ 2100. VSS, pt awake w/ that complaints of pain. Lung sounds CTA with diminished bases, pulses palpable x4, bowel sounds hypoactive. Pt has IV @ L hand infusing LR @ 125cc/hr, IV w/o signs of infiltration or infection. Pt has NG to low intermittent suction draining dark green fluid. Pt has dressing to midline abdominal, CDI. Colostomy bag @ output at this time, site is intact. Foley is draining clear yellow urine 120cc noted at this time. Wother complaints, will continue to monitor. SPC (b)(6)-2 [redacted] 9lwm6 (b)(6)-2 [redacted]
18 May 03 0430	VOP 2000cc DARK AMBER CLEAR FLUID → PC [redacted] 9lwm6
18 May 03 0430	NG drain emptied, 50cc of dark green/brown fluid noted. Will continue to monitor. SPC [redacted] 9lwm6 (b)(6)-2
18 MAY 03 0500	Assumed pt care @ 0500. T 99.1 · P92 · R 24 B/P 134/78 SAT 5.96 Pt. awake. NG tube to low suction c small brownish drainage. Dsg on abd. CDI. Foley to gravity. IV LR infusing in (L) hand 5 infiltration. Colostomy bag ⊕ output @ this time. Lungs CTA. Hypo active BS in (L) quadrants, none heard in (R) quadrants @ this time. will continue to monitor [redacted] 9lwm6
18 MAY 03	1065: HOP 2500cc dark amber urine [redacted] 9lwm6

(b)(6)-2

STANDARD FORM [illegible] 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES

5/17/03 Surgery Op. Note:

Preop Dx: Large abdominal wall hernia. S/p GSW to abdomen and previous loop colostomy.

Postop Dx: Same

Procedure: Hartman Procedure - Sigmoid end colostomy - Hartman's pouch. Repair of abd wall defect.

Surgeon [redacted] (b)(6)-7

Anesthesia: General

Finding: Intraabdominal contained abscess adjacent to loop colostomy due to leak near ostomy. Large fascial defect @ blast site. Small bowel all viable - abvious previous ~~to~~ resection and anastamosis in 2 regions. No other abnormalities. Hartmans procedure completed - difficulty. Debrided questionable fascia, subcutaneous tiss. and skin. Closure somewhat tight but adequate. Pt. tolerated well

(b)(6)-7 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted] (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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surg POD #1
5/19	Pt no distress
	AVSS E/O u.o. low.
	Incision C&D
	Abd Soft. Ostomy pink.
	A/P ① Keep NG vented putting air in bag.
	② Bolus IVF & M maintenance rate
	③ Cont. IV Abx Unasyn, Ident [redacted] (b)(6)-2
18 MAY 03 1230	NG tube 100 cc dark green/brown fluid/vented [redacted] 91 W MC
18 May 03 1320	Pt resting c eyes closed. NG tube to Suction c brown drainage noted. Lung sounds diminished in lower lobes. Abd c dressing CDI. Ostomy bag in place @ drainage noted @ this time. Foley cath to gravity c amber urine. BS hypoactive RQuad, ⊖ in LQuad. pulses ⊕. IV (R) hand infusing LR @ 150 cc/hr ⊃ diff. ⊖ S/S of infiltration noted. Will cont to monitor [redacted] 91 W MC
18 MAY 03 1347	Pt vitals taken T100.4 P109 R24 B/P 142/64 Sp02 [redacted] 91 W
18 MAY 03 1617	Pt vitals taken T99.7 P110 R28 B/P 150/76 Sp02 91 [redacted] W

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO. ICW2

CPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6)-2
18 May 03 2025	PT vitals taken T100.2 P105 R22 B/P 150/70 SpO2 95 — [redacted] 91W
18 May 03 2030	Total intake 1650cc I + 700cc O's. Emptied 500cc amber urine for the shift & 200cc brown drainage from NG. pt has been resting through out the day. (b)(6)-2 [redacted] 91W/MC
19 May 0120	Pt. placed on 4L Venturi mask for O2 sat < 93%. RR 28. Pt. denies pain. Pt. HOB@45°. Temp 100.° Pt. tol. ice chips. HR 112 ± S1 S2 present. Lungs CTA BS (+) x4 but hypoactive. Will continue to monitor. (b)(6)-2 [redacted] LTAN
0420	300cc dark yellow urine out by Foley, 600cc dark brown fluid out per N.G. Total Intake IV: 1250 PO: 120cc ice (b)(6)-2 [redacted]
19 May 03 0750	Assume pt care @ 0500. Pt awake asking for ice chips. NG tube to suction c brownish drainage. Lung Sounds clear diminished in bases. Bowel Sounds hypoactive x4. Dsg to ABD CDI. Ostomy bag in place sm. amt of drainage, brown, noted. Foley cath to gravity draining clear amber. LR @ 150cc/hr to (L) hand. no s/s redness/infiltration. Radial and pedal pulses present strong. Swelling to both hands. Will keep elevated. No signs of discomfort @ this time. Will Continue to monitor. (b)(6)-2 [redacted] 91W/MC
1000	N/G D/C'd, 500 cc output of dark brown drainage. Foley D/C'd 1600 cc clear amber UOP. Abd. dsg. D/C'd. stitches intact. no S/S Redness/Infection. Pt sucking on candy. 2mg MSO4 adm. for pain. — [redacted]
1000	pt should void within 6-8 hrs. — [redacted] (b)(6)-2

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
19MAY03 1200	pt sat up in chair for approx. 15 min. VS B/P 148/76 P 114 R 28 T 100.5 SpO_2 91 pt resting now. No c/o pain @ this time. pt requesting water. Ice chips were given 30 min ago. [redacted] (b)(6)-2
19May03 1400	Pt. vitals taken BP 160/90, P. 100, R. 22, TEMP. 100.7 SPC [redacted] (b)(6)-2
19MAY03 1800	Pt [redacted] taken BP 109/52, P. 120, R. 22 TEMP 102.0 SPC [redacted]
19may03 1930	temp [redacted] 101.4°F orally - pt. OOB ambulating and to chair x 2 this shift - tolerated CL diet - BS hypoactive - IV patent - pt. not willing to cough only deep breathing - steady on feet only c great encouragement and support - colostomy bag in place on stoma, no output this shift - staples intact on abdominal wound - [redacted] CPW (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)

[redacted] (b)(6)-2

EPW

REGISTER NO. | WARD NO. 1002

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	AME	MID.	IAL	ID NUMBER

DATE	NOTES
20 May 03	955 (cont.) LR decreased to 40cc/hr. to (R) AA. (R) Uhand swollen, encouraged pt to keep elevated. Incentive Spirometer encouraged. Pt. able to lift two balls. Will encourage q 30 min. [redacted] 9MM6
1230	INPUT 1790cc — OUTPUT 1750cc. [redacted] 9MM6
20may03 1850	T-101.9, R-24, Sat o-PA 88% while resting - pt. ambulated length of ward x2, up in chair @ bedside x 30 min - pt. needs great amount of encouragement & IS use - IV patent - NO adequate - no stool from stoma, colostomy bag intact - Staples open to air, small amt. of drainage noted when ambulating - dsg to wound on back of head intact - pt. doing more for himself & encouragement & regards to moving in bed and ambulating - lungs clear (B) - hypoactive BS - (b)(6)-2 [redacted] CBA
1930 20may03	pt. leaking fluid from abdominal wound while in chair @ bedside, staples covered & reinforced dsg & pt. placed in bed — [redacted] CBA 9MM
20may03 2215	IVP 1200cc clear yellow fluid —
20may03 2330	Pt care assumed @ 2200. Pt awake without c/o pain. (b)(6)-2 VSS, patient in no distress at this time. Lung sounds CTA, pulses palpable x4. Bowel sounds hypoactive but improved over yesterday. Dressing over staples on abd CDI, colostomy bag in place WNL, draining small amount of soft brs. (cont.

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
19may03 2300	Pt care assumed @2100. Pt is alert and aware, without c/o pain. IV @ L wrist removed, started again @ RAC. R. lobes palpable x4, bowel sounds hypoactive, lung sounds CTA with diminished bases. Pt has midline incision stapled, CDI. Colostomy bag is intact, no drainage noted at this time. No other complaints will continue to monitor. SPC [redacted] 91WM6
20may03 0000	UOP 440cc clear yellow urine [redacted] 91WM6
20may03 0400	MSO4 3mg given for pain. SPC [redacted] 91WM6
0800	Assume pt care @ 0500. Pt awake alert follows commands appropriately. No c/o pain @ this time. HR regular
BP 140/80 P94 R 28 T 100.1	Lungs CTA bilat. Short shallow respirations. Bowel sounds x 4 active colostomy bag in place small amt. of ~~tan~~ dk drainage to bag. UOP clear yellow 900 cc out this am. Abd. staples intact. No drainage noted. No s/s redness / infection. HL to (R) AC flushes well. No s/s redness / infection. ~~pt temp 100.1 F~~ and pt sweating, will ambulate this am. (b)(6)-2 [redacted] 91WM6
0955	Pt up to ambulate and to sit in chair. Drainage noted from abd. incision. Abd. dsg applied. Incision to back of head cleaned. Stitches intact, green and white around area, no odor. Non-adherent bandage applied. (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

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2330	(cont)... pt ~~resps~~ SS IV site intact without S/S infection
20 May 03	or infiltration. Will continue to monitor. SPC [redacted] qlwmc
21 May 0030	UOP 400cc CLEAR YELLOW FLUID — [redacted] qlw
21 May 0230	Pt colostomy bag emptied, unformed light brown stool with gas emptied. SPC [redacted] qlwmc (b)(6)-2
21 May 0330	UOP 350cc amber urine. SPC [redacted] qlwmc
21 0515 May 03	Pt awake in bed. Vocalizing spontaneously. Airway is patent. Lungs are clear to upper fields but diminished in bases. Abd is soft, nontender & distended. Ostomy to RUQ is putting out gas and stool. Drsgs to midline abd are CDI. Pt still c/o mild weakness to RUE. ROM to all extremities, and neurovascularly intact to all extremities. IV to R arm flushes well. [redacted] (b)(6)-2 qlw
21 May 0313	00 pt sleeping easily, aroused to painful stimuli. Lung sounds CTA to upper lobes, diminished lower lobes. Abd soft, distended, midline incision draing CDI. Ostomy bag RUQ intact & drainage noted @ this time. BUE & BLE c FROM c & strong pulses. NL to R AC & S/Sx of infection. Will cont to monitor — [redacted] qlwmc
21 May 03 0628	PT vitals taken T100.5 P102 R 24 B/P 140/72 Sp02 94 — [redacted] qlw
21 May 03 2025	PT vitals taken T100.3 P100 R 24 B/P 140/72 Sp02 94 — [redacted] qlw
21 May 03 2045	pt's I 750cc O-900. pt resting, c complaints — [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

[redacted] (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
21May03 2300:	Assumed care of PT @ 2100. Temp 100.3. Dsng to ABD changed packed c iodoform guaze. Brown, foul smelling liquid noted inside wound. PT OOB ⇒ chair x1. Linens D'd. Ostomy site c patent stoma. Ostomy Bag intact. HR Reg, Lungs CTA, using IS ✓ extremely well. Bs active x4. Pt tol. cl well. Will continue to monitor. [redacted]
0400:	Sm. soft formed stool appx ½ cup per ostomy. [redacted] (b)(6)-2
22May03 0800 B/P 130/82 P90 R 30 T99.6 Sp02 94%	Assume pt care @ 0500. Temp 99.6. HR regular. Lungs CTA throughout. Abd. dsg intact, brown drainage noted. Will be changed by MD. Ostomy bag in place draining small soft stool and liquid. Wound on back of head cleaned. stitches intact. pt tolerated sips well, adv to reg diet ~~thru~~ IV HL'd to (R) AC no s/s redness/infiltration. pt voids per urinal. 1000cc but this am clear yellow. No signs of discomfort or pain @ this time. pt sleeping Will continue to monitor. Encourage IS, and will ambulate this am. [redacted]
0850	Dsg Δ to abd. large amount of drainage noted [redacted] (b)(6)-2 Will go to OR today. [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
22-MAY-03 0300	PT VS WNL - 110/58 - 12 - 101.5 - 100% SaO2. MD [redacted] notified of PT's HOB, D/C Maintenance Fluid to 75 cc/hr LR. PT's lungs CTA(B), ABD dressing C/D/I's. Flanks are soft. 0 edema noted in extremities. PT's Fentanyl increased to 200 mcg/hr. PT was awake and responded yes when asked if he had pain. Will monitor. (b)(6)-2
22-MAY-03 0400	PT's HR ↓ 110's ↑ Fentanyl to 200 mcg/hr. Lungs CTA(B), HOB 40 cc/hr amber and clear. [redacted] (b)(6)-2
0620 RT	Pt Continues on mechanical ventilation Size 8 ETT 22cm @ lip
23May03	Parameters set SIMV RR12 TV500 PeeP 5 FIO2 50% SaO2 100 HR 108 BP 106/54 BBS coarse pt not breathing over vent [redacted] ET (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.
CIV [redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22May03	1542 - Gentamycin 450mg IV given SGT [illegible] 911mm
22May03	- late entry Gent scheduled for 10 today PT in surgery. SG [redacted] (b)(6)-2
22May03	1600 - VSS color good LS CTA ABD drg CDI Skin warm to touch, pulses present x 4. Cap refil brisk. Foley to gravity 350cc light amber ⊖ sediment noted. IV Ⓡ ac 20 g patent, IV Ⓛ wrist FA 16G patent. pt moving arms, opening eyes. ↑ versed to 5mg/hr. Will cont to monitor SG [redacted] 911mb
22May03	1639 pt moving. alert c/o pain. Fent 50mcg IV push, AND ↑ RATE TO 150MCG/HR TO CONTROL PAIN AND PROTECT AIRWAY FROM SELF EXTUBATION. VS. HR 128 INDICATING NEED FOR ANALGESIA. [redacted] (b)(6)-2
22May03	late entry 1615 Unasyn 3.0gm IV given SGT [illegible]
22MAY03 1645	↑ VERSED FROM 5MG TO 7MG TO KEEP PT SEDATED. VSS. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
1705	PT VSS. SEDATED c̄ VERSED AND FENTANYL. SIMV 12 TV 700 PEEP 5 FIO2 60%. ETT 8 22@ LIP. S1 S2 NSR-ST. GI NGT to LIS GU FTG. DRESSING INTACT Ø DRAINAGE. REPORT GIVEN TO SSG [redacted] (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

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REGISTER NO.	WARD NO.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/19/03	Surgery POD# 2 Pt. no distress AVSS afebrile w/o good u.o. NG minimal Bowel sounds + stool & air. Incision, c/d/i. A/P: DC NG, Foley Start sips clears. ambulate. Cont. Abx for now, ✓ CBC
	[redacted] (b)(6)-2
out of orders 5/20	Surgery POD# 3 Pt c temp WBC 20,000 yest, T 100 VSS Abd soft, NT, incisions healing nicely Stoma looks good + stool in bag A/P: Concern for WBC, cont. current Abx ↑ pulmonary toilet, ambulate, adv. diet
	[redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT	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. ICU2

[redacted] (b)(6)-7

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 - 14812

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5/22	Surgery Pt. comfortable, no apetite. T 99.6 VSS WBC ↓19,000 (23 yest) abd incision ~100 cc frank pus expressed. A/P/ ~~Infected~~ incisional drainage D Concern for dehiscence vs. subcut. large pocket infection. - Will take to O.R. today to explore wound/abdominal cavity to I&D, clean.

[redacted] (b)(6)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5/3/03	Op Note
	Procedure ① Ex Lap
	② Revision Hartmann ostomy LVQ → RUQ
	c resection T-colon
	③ washout
	④ placement of Bag for closure
	Surgeon Cornnolly, Martinto, Lowry
	Anes GETA.
	To ICU, intubated
	[redacted] (b)(6)-7
	[illegible], MD

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

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REGISTER NO. | WARD NO.

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MID. INITIAL	ID NUMBER

DATE	NOTES
5/23	1125 Surg Op Note Preop Dx: Large fascia defect s/p GSW Post op Dx: Same Procedure: I&D of fascia/skin/subcut. closure of peritoneal defect c sterile IV bag. approximation of skin c Retention sutures, Maturation of ostomy Surgeon: [redacted] Anesthesia: General (b)(6)-2 Findings: Defect too large to approximate the fascia c IV bag will temporarily be placed until bowel fixed and granulation begins. At that point bag will be removed and skin stapled shut. Pt. tolerated well. [redacted] (b)(6)-2
5/24	Surgery POD #7, 2, 1 Pt. awake on vent. T 100 VSS I/O (30) 7/23 <781 Bacteremia Abd. Wound looks good, no signs of infect.
A/P	Resp - V CXR, wean to extubate today CV - transfuse 1 unit pRBC Renal - good d.d., send U.A

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surgery Cont.
	ID - WBC ↑, temp, bacteremia c gnr on Urnasyn and Vent. will add Quinolone (Cipro) to broaden Abx coverage
	GI - stable.

[redacted]

(b)(6)-2

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

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 MAY 03	DR. [redacted] INSERTED CENTRAL LINE TO RSC. PT TOLERATED WELL.
0830	GIVEN [redacted] FENTANYL 96 MCG, FENT AND 4MG VERSED. CXR ORDERED FOR LINE PLACEMENT VERIFICATION [redacted] (b)(6)-2
0923	PT TAKEN TO OR. MAJ [redacted] PT UP FOR SURGERY [redacted]
1137	PT RETURNED FROM OR C MAJ [redacted] PT SEDATED BUT AROUSABLE. VS 116/60 104 12 100%. 96.4 AXILLARY. NEURO 3MM ROUND AND REACTIVE. RESP ETT @ 22@ LIPLINE SIMV 12 PEEP 5 FIO2 50%. TV 700. INLINE SUCTION SCANT AMOUNT OF DRAINAGE RHONCHI BILATERALLY. C SYMMETRICAL CHEST MOVEMENT. CV. S1, S2 Ø EDEMA 109 SINUS TACHYCARDIA. PPP x4 @ 3+. EDEMATOUS ABDOMEN. CAP REFILL ≤3 SECS. GI NGT (R) NARE TO LIS DRAINING YELLOW BROWN TINGE LIQUID. FLUID. JP x2 TO ABD TO LOW CONTINUOUS SUCTION #1 DRAWING SANGUINEOUS FLUID #2 RELEASING AIR NO FLUID NOTED IN TUBE. (R) COUSTOMY C BAG MEDIUM RED STOOL C SEROSANGUINEOUS DRAINAGE SMALL AMOUNT. BULKY DRESSING CDI WILL MONITOR FOR DRAINAGE. GU FTT VOIDING AMBER URINE Ø SEDIMENT NOTED IN TUBE OR FOLEY BAG. SKIN INTACT: LINES RSLC C LR @ 75CC, VERSED AND FENTANYL 20G PAC PATENT INTACT 18G L WRIST PATENT INTACT. PT GIVEN 50 MCG OF FENT AND 5MG OF VERSED TO CALM HIM AND PROTECT AIRWAY. WILL CONTINUE TO MONITOR [redacted]
1150	JP #1 20CC SANGUINEOUS DRAINAGE FROM BULB [redacted] DRAINAGE

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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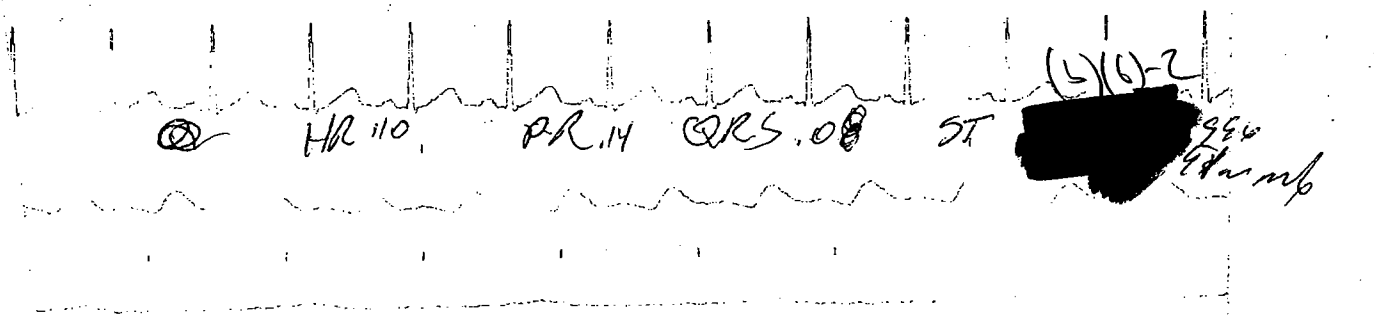
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	FOUND IN BUNK. JP TUBES 1 & 2 ▲ TO LCS. WILL CONTINUE TO MONITOR OUTPUT [redacted] (b)(6)-2

27 HR=110 P1=OFF P2=OFF RR=12 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



23 MAY 05 1728	PT admitted VS 100.8 – 117/61 – 106 – 12 – 100% spon on 50% FIO2 I.V. sites c/d/I, dressings c/d/I. See PA form 4700 dated 23 May 05 for assessment. (b)(6)-2 [redacted]
24/MAY/03	PT RECEIVING PRBC 1 UNIT. START 0900 VS 100.2
UNIT #	107 115/54. VS AS FOLLOWS FOR BLOOD TRANSFUSION.
006012	0805 98/48 107 100.1 DR [redacted] INFORMED OF BP, CONTINUE TO MONITOR.
B POS	0820 100/52 105 100.2 (b)(6)-2
	0835 101/53 102 100.1
	0905 101/59 101 100.0
	1005 154/67 ABP 111 100.4
	INFUSION OF PRBC UNIT # [redacted] COMPLETE. RECEIVED 363cc TOTAL VOLUME FOR UNIT OF PRBC. NO REACTION OBSERVED. CBC TO BE DRAWN IN
1005	A-LINE STARTED TO (R) RADIAL. PT GIVEN 5 VERSED AND 50MCG FENT IN PREPARATION FOR PROCEDURE. LIDOCAINE APPLIED LOCALLY TO SITE. PT TOLERATED WELL. SITE CDI WILL MONITOR FOR CHANGES [redacted] JN/ (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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LAST NAME	FIRST NAME	MIDDLE INIT	ID NUMBER

DATE	NOTES
cont 24MAY03 2100	(b)(6)-2 [redacted] SSL sedated, lungs CTA, will monitor
24MAY03 2300	Pt's JP drains to his ABD dislodged while dsg pt's dressing. Dr. Dixon notified. JP drains had at a total of 5cc serosanguineous fluid in 6 hrs. Pt's VSS 137/55-103-100^{S}-12-100% SpO2 on 40% FiO2. Pt's ABD wet to dsg dressing d/d. Pt ABD site irrigated and colostomy bag d/d. Serosanguineous fluid noted in colostomy bag. Minimal drainage noted from ABD site.

NOTHING FOLLOWS

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CIV [redacted] (b)(6)-4

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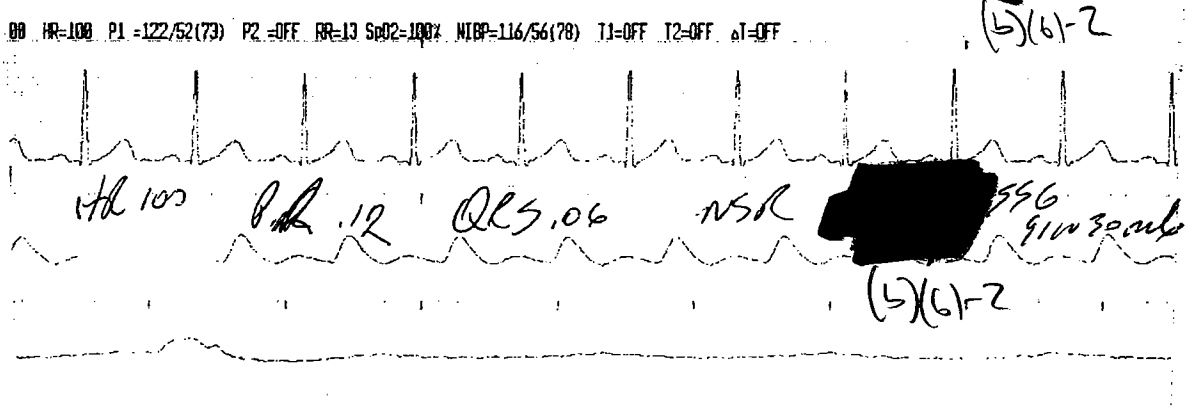
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24-MAY-03 1500	PT started 1 unit PRBC's. Unit verified [redacted] by SSG [redacted] (b)(6)-2 CPO [redacted] (b)(6)-2 Initial VS 100' - 102 - 102/52 - 12 - 100% SpO_2 on 40% F_{IO_2}. PT is ventilated. See DA form 4700 dated 24-MAY-03 for PT assessment. PT's HCT @ 1530 was 23.5. Will monitor for reactions. [redacted] SSG Given 30mls
24-MAY-03 1815	PT's VS 100° - 98 - 112/76 - 12 - 100% SpO_2 on 40% F_{IO_2} (b)(6)-2 [redacted] SSG Given 30mls
24 MAY-03 1890	PT's VS 99° - 103 - 127/61 - 12 - 100% SpO_2 on 40% F_{IO_2}, 0 reactions noted. - [redacted] SSG Given
24MAY-03 1845	PT's VS 99° - 109 - 137/64 - 100% SpO_2 on 40% F_{IO_2}, 0 reactions noted. (b)(6)-2 [redacted] SSG Given 30mls
24MAY-03 1900	PT's VS 99° - 101 - 106/50 - 100% SpO_2 on 40% F_{IO_2}, 0 reactions noted. [redacted] SSG Given 30mls
24MAY-03 1930	PT's VS 100' - 99 - 123/57 - 100% SpO_2 on 40% F_{IO_2}, 0 reactions noted. PT's intake of 1 unit PRBC complete. [redacted] SSG Given 30mls



DATE	NOTES
24MAY03 2100	PT's HCT 27.4, RBC 2.87, increased from 23.5 and 2.41 respectively. VS 100' - 97 - 130/60 - 12 - 100% SpO_2 on 40% F_{IO_2}. PT

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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.
CIV [redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE

5/25

NOTES

Surgery POD# 3, 4, 8

Pt. sedated, vented.

AVSS ABG 7.49/38/97 on 40% FIO2

I/O -2 liter

↓21 $\frac{8.2}{26}$ <639 $\frac{119/95/5}{3.5/26/0.7}$ <95

Lungs

Heart RRate 100

Abd wound clean, NO sign of infect.

Extrem +/ edema

(1) Resp - Cont vent for now, ABG good on minimal setting, ~~Consider weaning~~ will keep vented for 48 more hours then plan return to O.R. to remove IV bag and close skin. Following this will plan to extubate & knowledge he will have a large abd hernia due to no patch available here.

(2) CV - Transfuse 11 units PRBC for Hct 26 and pt. c large healing wound on vent, fighting infection.

(3) Renal - Stable

(4) ID - Improved WBC, T 6, on Day 2 Zosyn / Vent.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NO.
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MA	[redacted]

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

REGISTER NO. | (b)(6)-7

EPW #[redacted] (b)(6)-7

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 May 03	1005 124/61 100 T 100.9 tolerating well SBT [redacted]
	1010 123/61 100 T 100.9 tolerating well SBT
	1015 138/70 109 T 100.8 Tolerating well SBT
	1030 136/61 110 T 101.4 noted LS rhonchus (b)(6)-2
	~~1045~~ Suctioned lg amt yellow + clear mucus thick. 5 cc NSS to trach for suction tolerated fair. PT agitated SaO_2 93-98% bucking vent. PT relaxed after suction SaO_2 98%. LS - ~~diminished~~ rhonchus RUQ ↓ exhalation ~~LUQ~~, LLQ RL LUL LLL RLL CTA. Will suction again when PT relaxed. SBT [redacted] 9 1/2 hrs
25 May 03	1045 126/61 104 T 101.4 tolerating well [redacted]
	1100 120/60 101 T 101.3 transfusion PRBC complete tolerating well. SBT [redacted] 9 1/2 hrs
25 May 03	MD CARMODY INFORMED OF 3" WOUND C 3 SUTURES HOLDING IT CLOSED. SUTURES REMOVED AND DRY GAUZE APPLIED WITH MONITOR FOR DRAINAGE. [redacted] (b)(6)-2
25 May 03	1400 PT RECEIVED BOLUS 500CC OF FENT AND RATE ↑ TO 300MCG/HR VERSED ↑ TO 12MG/HR. PT AGITATED PRESSURES ↑ TACHYPNEIC @ 29 SaO_2 100%. PIP ↑ TO 40s-50s PT ETT SUCTIONED C A COPIOUS AMOUNT OF SECRETIONS FOUND YELLOW/WHITE. PT DID NOT TOLERATE WELL ↑ BP 190s/60s HR 30s SaO_2 91%. PT FiO_2 ↑ TO 50%. PT SATS @ 95-96% C AGGRESSIVE SUCTION VIA ETT AND ↑ IN FiO_2. WILL CONTINUE TO MONITOR. M.D. INFORMED.
(b)(6)-2	[redacted] AN
25 May 03	DR. [redacted] STATED TO OBTAIN CXR, START PT ON MUCOMYST Q4°, AND POTENTIALLY PLACE PT ON PROPOFOL TO KEEP SEDATED. WILL OBTAIN CXR

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
0800 MAY 25	DSG ▲ TO ABD DONE C DR. MASIMOTO. MIDLINE WET TO DRY - LLQ WOUND PACKED DRY DUE TO LIQUID IN WOUND. COVERED C 4 COMBINE DSG AND LARGE ABD DRESSING. M.D. NOTIFIED OF COLOSTOMY APPEARING PINK AND PALE. MONITOR FOR PROGRESSION OF STOOL FROM BAG TO INITIATE TUBE FEED. WILL CONTINUE TO MONITOR AND REPORT ▲ TO M.D. [redacted] (b)(6)-2
0805	CENTRAL L[redacted] A'D. SITE NORMAL ϕ SIGNS OF REDNESS, EDEMA, DRAINAGE. WILL CONTINUE TO MONITOR SITE. [redacted] (b)(6)-2
0900	PRBC started per MD order unit # 2452291 B pos exp date 27May03 VS 123/57 P100 T100.9 will cont to monitor SGT [redacted] (b)(6)-2 9llwmb
0905	119/57 100 T101.0 tolerating well SGT [redacted] 9llwmb
0910	121/57 100 T101.0 tolerating well SGT [redacted] 9llwmb
0915	116/56 99 T100.9 tolerating well SGT [redacted] 9llwmb
0930	116/59 99 T100.9 tolerating well SGT [redacted] 9llwmb
0945	115/58 99 T101.0 tolerating well SGT [redacted] 9llwmb
1000	112/58 100 T101.0 Tolerating well SGT [redacted]
25May 1000	- PRBC started per MD order unit # [redacted] exp 27May03 VS 112/58 100 T101.0 SGT [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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#[redacted] (b)(6)-7

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	AS SOON AS POSSIBLE, MONITOR VS AND FOLLOW MD ORDERS. (b)(6)-7 [redacted]
1445	PT HAS CALM DOWN C VS 151/50 ABP 152/72 NIBP RR 21 SaO_2 94%. HR 118. PIP 23. WILL CONTINUE TO MONITOR FOR CHANGES AND INFORM M.R [redacted] (b)(6)-7
1500	↑ UO @ 1400 450cc [redacted] 1500 550cc. VS 124/57 119 11BPM 96% SaO_2 ON 50% FiO_2. PT RESTING COMFORTABLE C ▲ IN RATE OF VERSED @ 12MG/HR AND FENT @ 300MCG/HR. CARE DUMP WILL CONTINUE TO MONITOR [redacted] (b)(6)-7 LIT AN
1545	ABG 7.447 PCO_2 39.1 [redacted] HCO_3 27 BE 3 SaO_2 93%. M.D. NOTIFIED. RT TO GIVE MUCOMYST PER M.D. ORDER. BS B/L SLIGHTLY COARSE RHONCHI, R SIDE DIMINISHED TO LOWER LOBE. VS. 113 113/56 ABP 19 97% @ 50% FiO_2. PEEP ↑ TO 8, WILL RECHECK ABG @ 1630. WILL CONTINUE TO MONITOR RESPIRATORY STATUS. [redacted] (b)(6)-7 LIT AN
1600	POST MUCOMYST 20% [redacted] ALBUTEROL TX VS 116 ~~+15/60~~ 121/63 99% RR 16. WILL CONTINUE TO MONITOR. [redacted]
1645	POST MUCOMYST 20% C ALBUTEROL TX ABG 7.4[illegible] (b)(6)-7 PCO_2 38.8 PO_2 67 HCO_3 25 BE 1 SaO_2 94%. VS 116 114/54 24 BPM 96%. CONTINUE TO MONITOR. [redacted]
1700	END OF SHIFT PUPILS EQUAL AND REACTIVE RT ETT 8 24@LIP [redacted] SIMV 12 FiO_2 50% PEEP 8 TV 700. BS COARSE RHONCHI ↓ C

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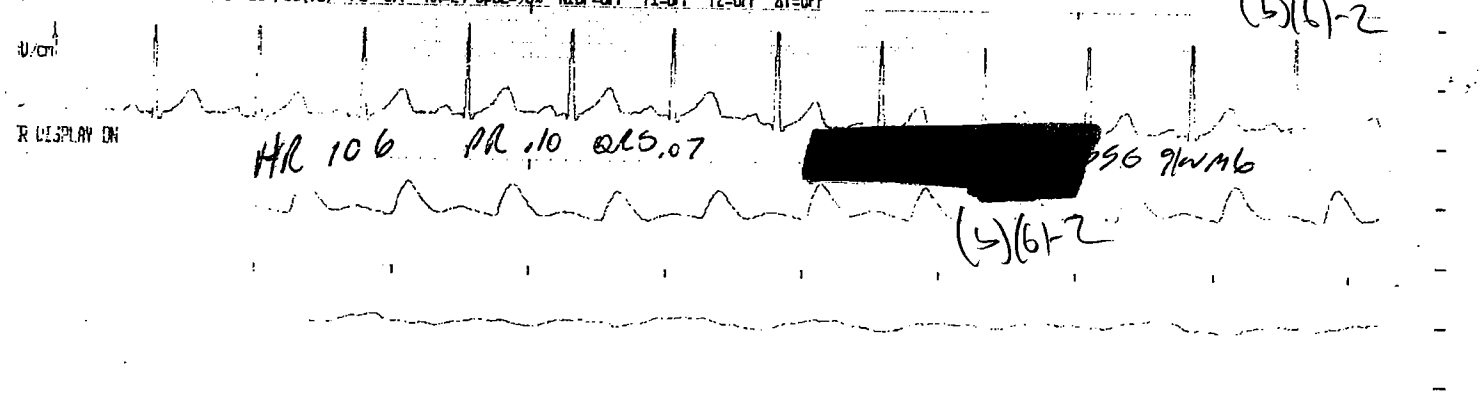
DATE	NOTES
	SUCTION DIMINISHED ON (R) SIDE. ETT INCLINE SUCTION THICK YELLOW/WHITE SECRETIONS. CV S1,S2 PRESENT ST & ECTOPY PULSES STRONG. GI NGT @ NARE DRAINING YELLOW GREEN SECRETIONS BS NOT APPREICATED (R) STOMA PAKE & FLOWS IN BAG. MD INFORMED. GU FTG AMBER URINE >130cc/HR UP TO 550 cc/HR. PT C PITTING EDEMA TO ABD AREA 2+ PITTING. DRESSING INTACT WET TO DRY. REPORT CAN TO SSG [redacted] (b)(6)-2
25-MAY-03 1730	Assumed care of [redacted] PT. PT sedated. Started Propofol gtt @ 30mcg/kg/hr. Vasoactive gtt d/c'd. VS 113/57-101-103-23-98% SaO2 on 50% FiO2. PT trach was suctioned, produced clear frothy sputum in moderate amounts. See OP 4700 dated 25 MAY 03 for assessment. — [redacted] SSG [redacted] (b)(6)-2
25-MAY-03 1830	PT suctioned, produced minimal amts of clear frothy sputum. VS 101-104-20-98% SaO2 on 50% FiO2. PT deemed to soil & rated — [redacted] (b)(6)-2 SSG [redacted]
25-MAY-03 2130	PT's temp 103 (AX). PT given 650mg Tylenol PR, and cold packs placed around patient's. Will monitor for effectiveness. — [redacted] (b)(6)-2



25-MAY-03 2230	PT's Temp 102 (AX). PT's sedated. VS 121-126/49-20-98% SpO2 on 50% FiO2. Will monitor for ↓ temp. — [redacted] SSG [redacted] (b)(6)-2

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[redacted] (b)(6)-4

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DATE	NOTES
25MAY 03 2300	PT's sgt given ABD dressing and Head Dressing Δ'd. PT's dressing to occipital area - side yellow sloughing tissue noted, Ø odor or dlc but area is mushy. Area cleaned c betadine and wet → dry dressing applied ABD dressing - Coffins yellow to brown to green colored soaked bandages removed. ABD area yellower than last night's dressing Δ. Suture sites and borders of ulc red to pink. Area irrigated c NS and wet sterile dressings applied to area. ~~with~~ sFoam Ostomy site has ~~paler~~ more pale areas ~~than~~ compared to yesterday. NO gas noted in bag but serosanguinous drainage noted there. (b)(6)-2 SG Grayson
26MAY 03 0100	PT given ~~#~~ Tylenol 650mg PR Pr Temp 103.5 ~~OPT~~ had ice packs placed around him. VS 134/53-18-25-99% sPO2 on 90% F.O2. Will monitor for ↓ Temp. — SG Grayson (b)(6)-2
26MAY 03 0330	VS 101.6-115-26-104/54 PT's NGT became dislodged while sitting up in bed. ~~EFT~~ NGT replaced. There was yellowish thick mucous in PT's mouth. ~~Oesophagus~~ Oropharynx suctioned. PT's sPO2 96% on 50% F.O2. — SG Grayson (b)(6)-2

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DATE	NOTES
26May03	0750 · pt Desat 90% p 120 BP (atrial) 148/88 Suctioned moderate yellow copious mucus - pt Sat ↑ 94-95% p 104 BP 120/56 NAD SGT [redacted] (b)(6)-2 9 1WM6
26May03	0930 T-103.2 Tylenol 650mg PR given · SGT [redacted] (b)(6)-2 9 1WM6
26 MAY 03	SPUTUM STAIN SENT TO LAB @ 0935 PER M.D. ORDER.
(b)(6)-2	[redacted] LT
1045	[redacted] BATHED. NEURO SEDATED C PROPOFOL AND VERSED. PEEP ET 8.0 246 LIFELINE THIN FROTHY SECRETIONS FROM INLINE SUCTION THICK WHITISH/YELLOW SECRETIONS ~~SUCTIONED~~ SUCTIONED GREATLY. SIMV 12 PEEP 5 TV 700 FiO_2 50% SaO_2 100% CV S1,S2 ST PPx4 CAP REFILL ≤3SECS x4. GU NGT DRAIN COLOSTOMY Ø FISTULA ABD DRESSING CDI. GU FOLEY VOIDING APPROXIMATELY AN AVERAGE 100-150cc/HR OF ORANGE URINE. SKIN INTACT JAUNDICED SCLERA LFT SENT TO LAB. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
26May03	BP 89/45 ADP [redacted]/50 NIBP M.D. [redacted] NO ACTION TAKEN @ THIS TIME CONTINUE TO MONITOR. [redacted] (b)(6)-2
26 May03	1325 BP BP cont to be low - propofol stopped @ 1300 to see if BP ↑. Actual - 91/39 87/49 NIBP. NT IO

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DATE	NOTES
26 May 03	cont servo fowler p 124 SaO2 98% SGT [redacted] (b)(6)-2
1345	PT MAPS DROP TO 50s/40s. MD DIXON INFORMED. PT GIVEN CVP ASSESSED LEVELS 6-7. MD ORDERED 1 LITER NS OVER 30 MINUTES BP 86/35 ABP 87/49 NIBP. WILL CONTINUE TO MONITOR BP STATUS. [redacted] (b)(6)-2 AN
1357	PT ↑ AGITATION PROPOFOL ↑ [redacted] MCG/KG/MIN AND 50 MCG FENT BOLUS GIVEN. WILL CONTINUE TO MONITOR FOR ↓ AGITATION. VS 136 103/39 16 93%. [redacted] (b)(6)-2 AN
1411	ABG RESULTS P ↓ SaO2 [redacted] (b)(6)-2 7.431 PCO2 30.5. PO2 46 HCO3 21 BE -4 SaO2 84%. PT SEDATION ↑ SECONDARY TO ↑ AGITATION AND BITING TUBE CONTRIBUTING TO ↓ SaO2. WILL RECHECK ABG @ 1600. [redacted] (b)(6)-2 AN
1415	UO FOR THIS HOUR 30cc DARK AMBER URINE. MD INFORMED. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2 AN
1430	T 102 given Tylenol [redacted] rectal VSS SGT [redacted] (b)(6)-2 91WM6
1500	T 103 ice packs to axilla & groin SGT [redacted] (b)(6)-2
1515	ABG RESULTS pH 7.40 pCO2 26.2 PO2 64 HCO3 16 BE -9 SaO2 93%. M.D. [redacted] INFORMED. VS 125 98/47 ABP 104/60 NIBP 23 BPM 96% SaO2. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2 AN
1517	UO FOR THIS HOUR 20cc DARK AMBER URINE. WILL INFORM MD. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2 AN
1520	UA RESULTS GLUCOSE (NEG) BILIRUBIN NEG KETONE NEG SG 1.030 BLOOD 4+ pH 6.0 PROTEIN 1+ UROB 0.2 NITRATE NEG COLOR AMBER CLOUDY. WILL INFORM M.D. [redacted] (b)(6)-2 LT AN
1605	ABP 80/38 NIBP 88/51 MAPS 50s-60s. MD [redacted] (b)(6)-2 LITER OVER 30 MINUTES. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2 LT AN.

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DATE	NOTES
26 MAY-03 18	PT Assumed care of pt. VS 105/54 - 98.3 - 122 - 15 - 95% SpO_2 on 50% F_iO_2 See assessment form DA Form 4700 dated 26-MAY-03. Noted Δ's from this a.m. was the yellow sclera in PT's eyes, and pt's MAP's beginning to D. PT's CVP 12 & 2 liter bolus 1ST shift. - [redacted] SS 6 gtts/min
26 MAY-03 1730	PT suctioned, only small amt light yellow secretions removed. — [redacted] SS 6 gtts/min
26 MAY 03 1842	PT's MAP's drop below 60 for 1st time. Informed Dr. [redacted] (b)(6)-2 he ordered for pt. to recive 500 cc NS IV Bolus and a CBC. PT's VS 98.5 - 78/47 - 108 - 100% on 50% F_iO_2, PT's CVL sent.
26 MAY 03 1930	PT's MAP . Dr. [redacted] (b)(6)-2 orders Dopamine gtt @ 3mcg/kg/min. PT [redacted] (b)(6)-2 started on gtt VS 100 - 98.5 - 84/51 - 14 - 100% ~~on~~ SpO_2 on 50% F_iO_2. [redacted] SS 6 gtts/min
26 MAY 03 2000	PT's Dr [redacted] (b)(6)-2 gave pt. bolus of Dopamine to ↑ pt BP. VS now 128/63 - 106 - 12 - 98% SpO_2 on 50% F_iO_2
26 MAY 03 2020	PT's CBC back. Hgb 9.0 HCT 29.7, PT [redacted] (b)(6)-2 noted. ∅ actions at this time. [redacted] (b)(6)-2 CLG gtts/min 30 mg
26 MAY 03 2100	VS 90/51 - 98 - 98 - 12 - 99% SpO_2 on 50% F_iO_2, PT's ABD dressing Δ'd. Lighter colored drainage noted from yesterday's dsg Δ. No greenish color just light yellow brown drainage noted in dressings Area also irrigated w NS and a moist dressing applied to ABD.
26-MAY-03 2300	Dr. [redacted] (b)(6)-2 Dopamine to 5 mcg/kg/min. VS 95 - 119/60 - 12 - 96.7 - 100% SpO_2 on 50% F_iO_2. [redacted] (b)(6)-2 SS 6 gtts/min 30 mg

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[redacted] (b)(6)-4

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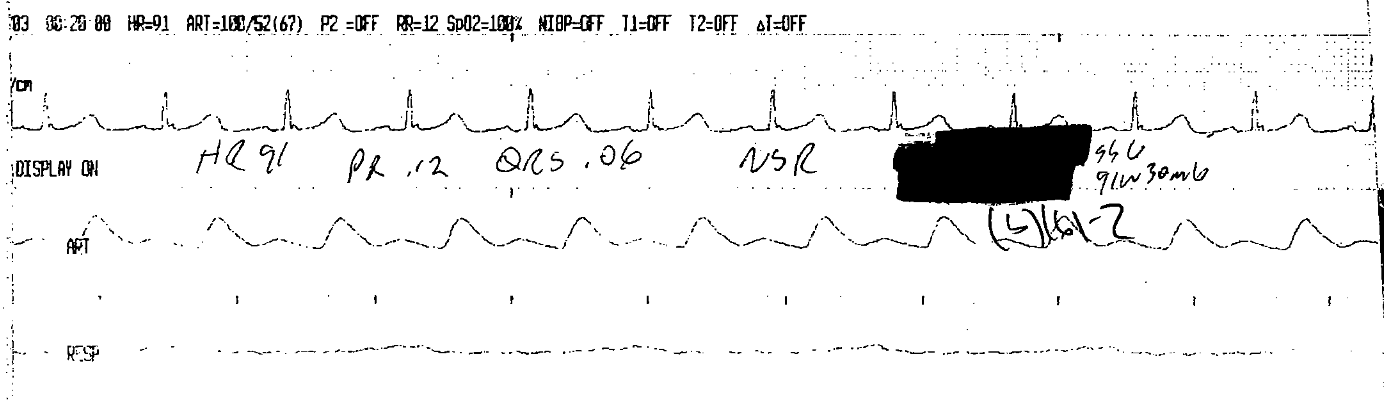
[redacted] (b)(6)-4			

DATE	NOTES
	
21 MAY 03 0145	Pt's MAP ↓ below 65. Dopamine ↑ to 6.5 mcg/kg/min. VS ↑ Dopamine ↑ 102/55-90-12- -100% SpO2 on FiO2 50%
21 MAY 03 0245	Pt's MAP ↓ below 65. Dopamine ↑ to 7 mcg/kg/min. Urinary output 90cc clear amber colored from O-Ros. VS p̄ ↑ 7 mcg 105/59-86-12-96.5 (Ax) -100% SpO2 on 50% FiO2. Will monitor
	(b)(6)-2 [redacted] SSG 91W30MC
21 MAY 03 0315	Pt VS 109/58-12-86-97.0 (Ax) -100% SpO2 on FiO2 50%. Pt unresponsive to pain stimuli. Will ↓ Propofol to 29.0 mcg/kg/min and Fentanyl to 150 mcg/hr to assess for responsiveness. Urine output 50cc; lungs ↓ lungs sounds (B).
	(b)(6)-2 [redacted] SSG 91W30MC
21 MAY 03 0330	Pt VS 112/60-86-12-97.0/Ax-100% SpO2 on FiO2 50%. Pt suctioned via inline cath, Ø secretions produced.
21 MAY 03 0500	Pt opened eyes to stimulation. VS 111/54-97.0-104/1-100% SpO2 on 50% FiO2. Pt's sedative IV meds ↑ to previous setting before assessment.
	[redacted] SSG 91W30MC (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27 May 03	Late entry:
0600	Eye opening spontaneous. Jaundiced to sclera. Reactive pupils 3mm Sedated dipnivan 30mcg/kg/min. Versed infusing @ 25mcg/hr. Equal chest expansion on vent SIMV R12 P10 FIO2 50% TV 700. SaO2 100% Palpable pulses @. Abd covered c Drsg. CDI. NGT to (R) nare LIS Placement checked c air bolus. foley cath intact c amber urine. IVF NS c 20 KCl infusing @ 150cc/hr. Continues c antibiotic therapy. VSS. Will cont. to monitor — [redacted]
1100	Pt to OR. No changes in status — (b)(6)-2
1200	Pt returned from OR. Sedated and paralyzed c TOF 4/4 upon return. IVF cont. to infuse. VSS. Warming measures taken. Will cont. to monitor Drsg to abd CPI — [redacted]
	VS: 95°, HR 103 SaO2 100% R 12 (b)(6)-2
1215	HR 93 R13 SaO2 100% BP 121/65
1225	HR 92 R 12 SaO2 100% BP 122/65
1230	HR 92 R 12 SaO2 100 BP 118/62
1600	Pt resting comfortably. Medications being titrated to effect Pupils 2mm-3mm reactive VSS. No changes in status Will cont. to monitor — [redacted] (b)(6)-2
2015:	

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DATE	NOTES
	Surgery
5/27	Pt. sedated, required Dopa for BP in evening. Tm 102 P102 BP 127/66 on 7mg Dopa
	(34) 9.2/29 (449 148/106/12/43/26 (146
	- Lungs Course sound. Heart Rate/02 RR Abd Subcutaneous tissue has some purulence and suspect.
	A/P: Ongoing infection c WBC remaining ↑ wound does not appear as clean. will take back to O.R. to ✓ and washout.
	[redacted] (b)(6)-2
5/27	Op Note Procedure: Wound Debridement Removal of Bag
	Surg [redacted] (b)(6)-2
	Anes.. Chung
	Findings: Viable fascia Viable adipose
	To ICU, critical [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27MAY03 2015	Nursing Note: Pt. opens eyes occasionally. Pupils are reactive to light. Lung sounds clear, unable to ascultate bowel sounds due to ABD dsg since it is DsI, ostomy bag intact, foley to gravity draining amber 100K urine, cap refill <3 sec. Pt. had temp of 102.2 and was given tylenol 650mg PR @ 2000. Vent setting: PS; SIMV=12; TV=700. FIO2=50%; Dopamin=4mcg/kg/min; Fent ↑ to 250mcg/hr due to pt. movement and facial expressions of pain; NS c 20K @ 100cc/hr; (R) subclavian line patent; IV to (L) and (R) AC patent. Cap refill <3sec x4 extremeties. Will continue to monitor cpt [redacted]
28MAY03 02	Pt. c temp of 103.1 given tylenol PR 650mg. ICE pack applied to axillary bilat. —— cpt [redacted]
28MAY03 04	Temp now 101.5. —— cpt [redacted]
28May03 0500	Rec'd report from previous shift. Spontaneous eye opening, reactive pupils. Sedated c fentanyl 200mg/hr and Diprivan 40mg/kg/min. Dopamine infusing c 4mg/kg/min NS c 20KCl @ 100/hr ventilated c minimal secretions. Abd c bulky dressing. Serosanguinous drainage to LLQ. NGT to LIS and foley to BSD. Colostomy to RUQ. —— [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2

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DATE	NOTES
28 May 0500 cont'd	(R) Radial A-line intact (R) SC line intact. No changes in status Will cont. to monitor [redacted] AD
5/28	Surgery Pt. looking more lucid Tm/02[5] nov 99 VSS Dopa @ 5 µg (I/O) - 1 liter (good u.o.). ↓ (13) 9.6/30 (360) 134/3.8 | 107/24 | 8/0.6 (86 Abd - wounds clean Heart RRR Lungs - Clear bilateral (1) Resp - Stable, will start to wean to extubate (2) CV - Stable on low dose Dopa. (3) Renal - good u.o. BUN/Cr stable. (4) ID - WBC ↓; temps ↓ will cont current Abx & watch closely. If respikes a temp, will Δ all lines. (5) GI - Start TF's, will ask Nutrition to see. Start low rate via NG tube [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28May03 1100	At resting comfortably, titrating dopamine and dipriuvan to effect. Explaining to pt plan of care to extubate pm interpreter. VSS. Eye opening and nodding head, follow simple commands. Will cont. to evaluate. Dsg to abd changed and ~~DATE~~ error pt noted to have a continual bleeding area in lower mid quad(L). Dr [redacted] sutured area and evaluated site. Redressed wet to dry. [redacted]
28May03 1300	Dipriuvan turned off. Slowly weaning fentanyl to awake pt. IVF continue to infuse NS c 20KCl @ 100/hr. TF on hold until extubation per Dr [redacted] Dopamine 4mcg/kg/min. Will cont. to monitor status [redacted] (b)(6)-2
28May03 1630	Eye opening, following commands. RR 12. Remains on vent. Fentanyl decreased 75mcg/hr. Dipriuvan remains off. Calm and cooperative VS remain stable, afebrile. No distress noted [redacted]
1910	Nursing Note: Pt. was extubated at 1830 s difficulty. Pt. placed on NRB c 12L. O2 Sat 100. V.S.S. Dopamine d to 3mL/h. Pt. is Alert, Pupils reactive to light, Lung Sounds clear, ~~osto~~ colostomy c liquid stool + gas. Dsg to abd intact. (L) AC IV, (R) AC IV, (R) Subclavian Patent. Dsg to abd is Dt. CAP refill

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.

EPW #[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28MAY03	X 4 extremities is WNL. Unable to determine Bowel Sounds due to dsg. Pt. resting & complaint. Will continue to monitor. [redacted]
29MAY03 2200	Pt. had Dsg D'd to abd area, wet to dry. Some bleeding occured while doing dsg D. V.S.S. Pt. tolerated D of dsg well. -[redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
30 MAY/03 0920	A-LINE D/C. PT PLACED ON RA TOLERATED FOR 2½ HOURS AND THEN SATS ↓ TO 93-94%. PT PLACED BACK ON 2L NC. SATS ↑ TO 98-99%. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
1010	DSG Δ TO ΔBD WET TO DRY. AREA RED/PINK C SOME PORTIONS OF FIBROUS TISSUE, OTHERWISE NO ~~DRAINAGE~~ [redacted] PURULENT DRAINAGE. PT TOLERATED C 25MCG OF FENTANYL IVP ΔUNG C MAINTENANCE OF 37.5 MCG/HR. OSTOMY BAG CHANGED. STOMA PINK AND INTACT PERISTOMY C SMALL AMOUNT SEROUS/PURULENT DRAINAGE. WILL MONITOR FOR CHANGES IN STOMA [redacted] (b)(6)-2
1215	PT TOLERATED PO 500 CC TANG, 120CC OF JELLO, TWO SPOONS OF BEEF C NOODLES, TWO SPOONS OF PEAS. PT PREMEDICATED C 12.5MG PHENERGAN. WILL CONTINUE TO ENCOURAGE PO INTAKE
(b)(6)-2 [redacted]	TAN
1350	TEMP (V) BECAUSE PT ↑ HR 120S ΔND ↑ RESP RATE 32, ↓ SATS 94% ON 2L NC. PT TEMP 104.1 F. MEDICATED C TYLENOL 650MG, ICE PACKS APPLIED TO ΔRM PITS AND GROIN, PT SAT C HOB 45°. PT USED IS 10 TIMES. WILL CONTINUE TO MONITOR TEMP. [redacted]
1420	TEMP [redacted] HR 110S RR 20S SATS 98% ON 3L NC. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2 TAN
1423	FENT 50 MCG IVP GIVEN [redacted] C/O PAIN "EEUM". CONTINUE DM

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

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.

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(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1450	TEMP 101.3. PT ENCOURAGE TO DRINK FLUIDS AND USE IJ. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
1531	PT UPED IJS RAISED TWO [redacted] = 900cc PER/SEC x 10 DRANK 600cc H2O. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
30MAY03 2230	Nursing Note: Pt. with V.S.S. Dsg A'd to abd, wet to dry. Pt. tolerated dsg A' well. Fent. infusing @ 50mg/hr, NSC 20K @ 100cc/hr. Pt. is Alert, tolerating PO's difficulty., Foley to gravity draining amber urine. will continue to monitor. —CPT [redacted] (b)(6)-2
31MAY03 0930	DSG ▲ DONE. DRY DRESSINGS REMOVED AREA RED/PINK & SOME AREAS SEROUS AND PURULENT DRAINAGE SMALL AMOUNTS. MILD ODOR. COVEL SPONGES SOAKED & SALINE AND ABD REDRESSED WET TO DRY. PT TOLERATED WELL. OSTOMY BAG CHANGED. STOMA APPEARS BEEFY RED PT HAVE LOOSE AND FORMED STOOL. BROWN IN COLOR Ø BLOOD NOTED. STOMA CLEANSED AND NEW BAG APPLIED [redacted]
1015	PIV IN RAC DC'D SECONDARY TO INFILTRATION. 20G PLACED (b)(6)-2 IN RW. PIV IN LAC DC'D SECONDARY TO INFILTRATION/STREAKING. WILL CONTINUE TO MONITOR AND REPLACE IV [redacted]
1130	FOLEY DC'D PER M.D. ORDER AND PT UP [redacted] FOR ONE HOUR. TOLERATED WELL VSS. NAD. [redacted] (b)(6)-2
1200	PT FIRST VOID 625 CLOUT DIFFICULTY [redacted] WITH ATE 7-8 SPOONFULLS OF NOODLES & BEEF, 2 BITES OF CAKE, COKE DANG, 4OZ H2O. WILL CONTINUE TO ENCOURAGE PO INTAKE. [redacted] (b)(6)-2
1500	PT [redacted] TO SLOW/HR PT ADEQUATE PO INTAKE AND QS UO. M.D. INFORMED [redacted] (b)(6)-2

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[redacted] (b)(6)-4

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
5/31	Surgery POD # 4 Pt looks great, alert, tolerating po Tm 104 but ↓ now 100.4 10.7) 8.6/28 (356 — + 8/0.9 (106 albumin 1.4 amylase 172 Abd - Sub Q & tissue clean Ostomy fx'ning nicely c BMs. A/P) ① Resp - Stable ② CV - Hct 28, VSS stable. ③ ID - WBC OK, Temp concerning, all central lines out, will DC foley. Cont. Abx. Temp could be foley vs. gut intermittent translocation c bacteremia. ④ GI - Advance diet and Ensure @ b/w meals. ⑤ Wound - will await dermatome to arrive and plan STSG to cover exposed bowel & Sub-Q. In mean time needs to rehab c nutrition & pulm. toilet. will start placing binder and out of bed TID to chair

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] UMBER (b)(6)-2

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31 MAY 03 1607	ATTEMPTED TO PUT PT IN CHAIR @ BEDSIDE, PT COULD NOT MAKE IT TO CHAIR. PT PLACED BACK IN BED. ENCOURAGED TO USE IS. PT ELEVATED 2 BALLS = 900cc/SEC. PT TOLERATED WELL. [redacted] (b)(6)-7
1 JUNE 03 0530	PT HAS MORE PLEASANT ATTITUDE, MORE ALERT TO HIS SURROUNDINGS. RAISED 2 BALLS 900CC/SEC C IS AND MW ENCOURAGEMENT. STRONG PULSES THROUGHOUT. Ø EDEMA TO HANDS & FEET DECREASED FROM 30 MAY 03. GI COLOSTOMY BAG INTACT STOMA BEEFY RED. GU SPONTANEOUS PUN: UP OOB AND ENCOURAGE PO INTAKE, USE OF IS. (b)(6)-2 [redacted] AN
6/1/03	Surgery Pt. alert tolerating po AVSS 12.8 $\frac{10}{28}$ < $\frac{136/100/9}{3.1}$ < I/O good u.o. Abd. - Wound cleaning nicely; granulation beginning over the bowel. Still & still requiring wet → dry. Cont. Resp. pulmonary toilet, need ambulation TID → Place ACE Binder on Abd. ② CV - Stable ③ ID - WBC ↑ slight, cont IV Abx, dressings ④ GI - Encourage PO; Start Cal Counts, nutrition to see. ⑤ Need STSG to abdomen when demo tone arrives.

[redacted] (b)(6)-7

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