MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

26 YOM SHOT IN (L) FOOT/LEG ON (L) [illegible] 12 JUN 06 ADMITTED FOR IVF

PMH - Ø

PSH - ?

WORK: 2 PACKS/DAY

PHYSICAL EXAMINATION

HT/WT

GSW - SMALL PUNCTURE WOUND (L) CALF W/ EXIT WOUND

(L) FOOT - MULTIPLE WOUNDS WITH SHRAPNEL OVER TOES. MORE TOES WERE

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

(L) GSW

(L) IFD [illegible] 3

b(6)-2

SIGNATURE OF P[redacted] | DATE 7 JUN 06 | IDENTIFICATION NO. | ORGANIZATION

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

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7AUG03	1430. Assumed care @ 1415. VSS. LR infusing @ 125cc/hr. GSW to (L) elbow & (L) ankle. 1 inch open wound to (L) ankle. No drainage noted. Dressing inplace, dry & intact. On call to OR.
	1600: To x-ray via crutches.
	1620: Returned from x-ray via crutches.
	[redacted] b(6)-2
7 AUG 03 1935	On the Op Note. Pre-Op Dx: GSW (L) ankle with open talus fracture. Post Op Dx: Same. Procedure: I+D (L) ankle, application of splint. Surgeon: [redacted] Anes: Plexus. Anes-MAC. EBL-2 cc. Plexus 200 cc. Irrigation - Open Fx, 12 days old, some purulent material from talus neck fracture. Plexus: 8 vials + 6 mm NPB @ 8 psi. Wounds: I+D 9 cm.
	[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.

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

0045 8Aug03 — Pt care assumed @ 2100. VSS, alert and aware. 3 c/o pain. Lung sands CTA, pulses + (unable to assess IIe), b-s-s x4. IV in RUE running @ 125cc, IV ABX. Pt returned from OR today S/P I+D, scheduled for another I+D on 9 Aug. LLE Dsg CDI, elevated. Pt able to wiggle toes and @ capillary refill. UOPC x(), no complaints. Will continue to monitor. [redacted] Alumia b(6)-2

0100 — As per CRNA pt with penrose drain, under dsg. [redacted] Alumia b(6)-2

8Aug03 0700 — Pt. awake & alert c/o @ LE pain, IV tylenol given. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. IVL in @ wrist S s/s of infection. VSS. Ace wrap to @ LE CDI. Dime size wound on back upper (R) side open, 2x2 applied. All other assessment findings WNL. Pt. S other complaints @ this time. Will continue to monitor. [redacted] b(6)-1 EPW

8 AUG03 1330 — Assumed care @ 1300. Alert & oriented. VSS. C/o mild pain in @ foot. Tylenol 650 mg PO given. Lung sounds clear. Ace wrap to @ LE. 1 cm wound to inner @ elbow. 1½ cm wound to (R) upper back. 2x2 dressing applied. Sm amount purulent drainage noted. SL patent. Will continue to monitor. [redacted] b(6)-1 EPW

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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WARD NO. CW2

[redacted] EPW b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD PROGRESS notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0350 10Aug03	SV infiltrated. Restarted Rt hand 20 Gauge, one stick Pt assisted to stretcher for OR case. [redacted] b6-2
10Aug03 0445	Anes Op Note Pre Op Dx - Open (L) tibia fracture Post Op Dx - same Procedure: I&D, (L) tibia fracture Surgeon [redacted] b6-2 Anes - MAC Tourn - 350 Lr Findings - Wound clean Plan: 2D resp changes b(4)-2 [redacted]

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.)*

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WARD NO. ICU2

#[redacted] b(4)-4

PROGRESS notes

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

Medical Record

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FIRMR (41 CFR) 201-9.202-1

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b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/8/03 2105	Pt. care assumed @ 2100. HR reg, lungs CTA, ABD soft ~ BS ⊕ x4. ⓁLE ~ cast intact. ⓁUE toes warm ~ brisk cap refill, ⊕ sensation, ⊕ ROM. UTA pulse 2° dsrp. will cont. to monitor. [redacted]
~~9Aug03 0540~~	~~Assume pt care @ 0500. Pt Awake and Alert. No c/o pain. NPO for on call to OR. HL to Ⓛ wrist ⊕ flush ~ redness/infiltration. VSS. HR reg. Lungs CTA. Abd Soft BSx4. [redacted]~~
	~~VSS. HR reg. Lungs CTA. Abd tender to palpate to BLQ BSx4. No BM x 10 days. Foley to gravity Clear yellow UOP ~ sediment noted. [redacted]~~
9Aug03	0540 Assume pt care @ 0500. pt Awake and Alert. No c/o pain. NPO (for OR today. HL to Ⓛ wrist ⊕ flush ~ redness/infiltration. VSS. HR reg. Lungs CTA. Abd soft BSx4. ⓁLE ace wrap CDI. ⊕ movement ⊕ sensation to toes. Ⓑ upper back sm dime sized wound covered ~ 2x2. Will continue to monitor [redacted]
9AUG03 1445	Assumed care @ 1300. VSS. Lung sounds clear. BSx4. SL in Ⓛ wrist patent. Dressing to ⓁLE. Good capillary refill. c/o tingling in Ⓛ toes, sensation present, able to move. Δ'd dressing on Ⓑ upper back ~ 2x2 dressing. On call to OR, NPO. [redacted]
2155	Pt. care assumed @ 2100 VSS Pt. NPO for surgery tonight. Pt caught eating ½ bag trix. Pt. reinforced on NPO status. Pt. given food by neighboring Pt. IVF infusing @ DSW to Ⓡ A. HR Reg, lungs CTA, BS ⊕ x4. ⓁUE ~ splint CDI. Brisk cap refill, ⊕ sensation, ⊕ ROM toes. MD informed of pt. p.o. intake Pt. to remain NPO for surgery in AM. [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	11 day multiple GSW shot wounds - proximal ⓡ arm ⓡ posterior chest ⓛ ankle small puncture ⓛ side chest
temp 100.1	(ⓡ chest x-ray ⓛ elbow ⓛ ~~ankle~~/ankle)
B/P 120/80	5 gunshot wounds
P 110	10 mg morphine IM 2115
Spo2 98	
Do nods	11 day old injury
~~RD AA~~	Head - graze wound
	Rt Axilla-ecchymosis
	ⓛ leg
	ⓛ Ankle - fracture
	Lung - clear CXR - [redacted] b(6)-2
	Abdm - soft
	~~Back~~ - ⓛ
	ⓛ elbow - wound x-ray - NAD
	ⓛ ankle - entry wound -
	ⓛ leg - wound - no pain
	A - multiple gunshot
	P - to ER ⓛ foot/ankle wounds

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] b(6)-2
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.)*

[redacted] EPW b(6)-4

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Medical Record
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

2335 Adjusted bandage (L) foot x tight ∫ R & L CMS (+)

7 Aug 03 0420 Orders noted. Pt awake + conversing. To be transferred to CSH in am [redacted] SPC

0500 Pt C/O ankle wrap being too tight. Pedal pulse and capillary refill fine. Readjusted top of bandage slight [redacted] SPC

1034 Ok to eat

b(6)-2 All

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

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

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b(6)-2 A11

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)*
10 Aug 03	0610 ~~Assum~~ Received pt from ICU2 S/p I+D of LLE. Condition Stable. Resume previous orders ∈ daily dsg D's beginning 11 Aug. C/O pain to LLE, percocet given. VSS. LR @ 125cc/hr to (R) FA ∈ redness/infiltration. HR reg. Lungs CTA. Abd soft BS×4 no c/o pain or tenderness ∈ palpation. Ace wrap and dsg to LLE CD+I. (R) movement (R) sensation to toes. Will continue to monitor — [redacted] SI/MMP
1400	Pt Awake at this time. AAOx3. PERRLA. Lungs CTA bilat, (Ø) resp distress. NSR. Card Soft, non-tender, bowel sounds active ×4 quads. (L) LE wrapped ∈ bandages and ace wrap, Ø new drainage noted to dsg. Strong pulse and brisk cap refill to (R) foot. Ø Complaints — [redacted] MP.
10 Aug 03 21:23	Rec'd c/o pt @ 21:00. Restraints x 2 (R) wrist/Ankle. VSWR per ES, PT. sleeping in bed. awakens easily to verbal stimuli. Skin W/D. PERRLA (R) WR. LCTA (R) HRRS, S1, S2. BS (+) x4. (+) PP (R) DLE ACE wrap dsg scant amt drainage noted mid-calf. Wound to (R) upper aspect of back approximately 1½cm × 1cm. well approx. healing tissue noted. Ø c/o pain @ this time. HL (R) hand patent. will cont. to mon. [redacted] /AD

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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b(6)-2
A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Addendum	@ROM@Sensation@<3sec cap refill@warmth to@foot digits [redacted] /AD
asst 11 Aug 03 05-0900	c/o pain @LE ii Tylenol given. will cont. to mon [redacted] BP verbal in bed. @ leg in ACE dressing. BP pts bkr post, medicated PO for pain. Dressing changed done to @ leg. Inner foot wound has serous drainage and site clean - upper leg two small entry wounds, area also clean. BK site cleaned and new dressing applied. BP tolerated procedure well. Pt asst and ambulated x3 [redacted]
11AUG03	1950: Assumed Care @ 1300. VSS. Lung sounds [redacted] clear bilat, BSx4. Dime-size wound to @ upper back sm amt purulent drainage, dressing to @ lower extremity dry & intact. Hep-lock to @ FA patent. Denies pain or discomfort @ this time. Will continue to monitor [redacted]
2234	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS@X4. Dsngs to @ LE CDI. NV checks @ LE WNL. Pt. c/o pain, to @ LE, given #1 percocet po. Will cont. to monitor. [redacted] CTAB
12 Aug 03 5-12p.	BP VSS stable, medicated PO for pain discomfort. BP dsng @ leg clean. Site clean and no drainage nor odor present. BP ate lunch just and resting comfortably in bed [redacted]
12AUG03	1410: Assumed pt care @ 1300. VSS. HR-regular [redacted] ung sounds clear bilat. BSx4. SL @ FA patent. [redacted] dressing to @ LE dry & intact. No c/o pain or discomfort @ this time. Will continue to monitor. [redacted]

b(6)-2) A11

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Aug 03 2308	Pt care assumed @ 2100. VSS, alert and awake [redacted] C slight c/o pain in lle. Lungs CTA, pulses ⊕x4, bs⊕. Dsg on lle CDI, patent cap wiggle toes and has positive pulse. IV on ⓡFA patent, IVABX ↺ will continue to monitor. [redacted] RN/MC
13 Aug 03	0540 Assume pt care @ 0500. Pt awake and alert. c/o pain @ HL site, HL dcid. c/o pain to Ⓛ ankle, tylenol given. VSS. HR reg. Lungs CTA. Abd soft non tender non distended BSx4. Dsg to ⓁLE CD+I. ⊕ROM ⊕sensation of toes, sm amt swelling noted. Will place new HL and cont to monitor. [redacted] SN/MC
	0655 HL placed in ⓡFA + flush ⓢ redness infiltration. [redacted] SN/MC
13 Aug 03 2019	Assumed care @ 1900. Alert + oriented X3. VSS. c/o pain in ⓁLE. Tylenol 650mg PO given @ 1820. Dressing Δ done c Dakin's solution. Sm amt drainage noted. c/o some tingling in Ⓛ toes. Will continue to monitor. [redacted] RN/MC

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.)* [redacted] REGISTER NO. WARD NO.

b(6)-1

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

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8-13-03 2248	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, Abd soft & BS ⊕ x4. ⊖ CVE dsng CDI Toes ⊖ ft & brisk cap refill, ⊕ sensation, ⊕ ROM. Will cont. to monitor. [redacted] CTA/N
14 Aug 03 0615	Pt. awake & alert in bed. ∅ complaints @ this time. HR Regular, lung sands clear bilat, bowel sands ⊕ x4 quads. VSS. HL in ⊖ FA ∅ s/s of infection. Ace wrap to ⊖ LE CDI, limited ROM in digits, pt. unable to rotate ankle, (+) sensation in digits, ≤ 3 sec cap refill, pt. states that ROM in digits is painful. All other assessment findings WNL. Will continue to monitor. [redacted] AN
0900	DSG D'd to ⊖ inner aspect of ankle & Betadine solution w/ D. Sutures to wound intact, dime size open wound ∅ s/s of infection, pink & moist. [redacted]
1330	alert and oriented. PERRLA. Lungs CTA bilat, ⊘ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. DSG to ⊖ ankle and foot CDI. Pt ambulating & crutches. To have dsg to Betadine this evening. [redacted]
1830	Dsg to ⊖ ankle changed. Wound open, serosanguinous noted to dsg. W/DTC 1/4 Betadine soln then wrapped & Kerlix and ace wrap. ⊘ complaints [redacted] D/Dr
2345	Pt care assumed @ 2300. VSS, AOX3, c/o ang Tylenol given for pain in Ankle. Lung sands CTA, p/s 60s+x4, BS ⊕. Pt ambulated & crutches x1 to BSC, had BM. Dsg to lle CDI ⊕ pulse and sensation. HL in RFA intact. Will continue to monitor. [redacted] Mcmy

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b(a)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03 0550	Pt. awake & alert in bed c/o pain in (L) foot, Tylenol given. HR Reg, lung sands clear bilat, bowel sounds (+) x 4 quads. DSG to (L) LE CDI, cap refill < 3 sec, (+) sensation, mild swelling noted in digits. HL in (R) FA S/S of infection. Pt. c/o other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] RN/A
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Dsg to (L) ankle CDI. Pt c (L) foot elevated. Ambulating well with crutches. Ø complaints [redacted]
1630	Dsg Δ done to (L) ankle. Suture line CDI. Wound c/s/d serosanguinous drainage. Ø purulent drainage noted. Dr. [redacted] to remove sutures tomorrow and cast (L) leg. Ø complaints. 1/4% Donkers Boen used c W→D dog. [redacted] RN/A
2200	Care assumed @ 2100. VSS, A+O x 3 c c/o slight pain in (L) ankle. Lungs CTA bilaterally, pulses (+) x 4, BS (+). HL in RFA intact, Ø S/S infection, IV ABX. Dsg on (L) ankle intact. Patient O/C to OR in am to remove sites and cast leg. No complaints at this time, continue to monitor. [redacted] RN/ma

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.)*

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WARD NO. 1 EW 2

EPW [redacted]

b(a)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
160520 Aug 03	NURSING NOTE: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ± distention, NPO for OR today. BS@x4. Voids spontaneously. PROM-L neurovascularly intact to BLE and RLE. LLE has drsg to ankle (ACE wrap) that is CDI. PROM-R neurovascularly intact to LLE & RUE [redacted]
16Aug03 1330	Alert and oriented PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) ankle CDI. Strong pedal pulses and brisk Cap refill to bilat LE. Ø complaints [redacted]
2011	Care assumed @2100. VSS, A&Ox3, 650 Tylenol given for pain @2100. Lung sands CTA, pulses (+)x4, bs. Pt scheduled to have cast put on in ~72° on RLE. Pt ambulated x5 minutes ± pain. Dsg on RLE CDI, pt able to wiggle toes and has rom in RLE. HL patent, Ø s/s infection. Will continue to monitor. [redacted] Gilmore
17Aug03 0700	Pt awake & alert in bed c/o pain in (R) foot, 1 Tylenol given. HR Regular, lung sands clear bilat, bowel sounds (+) x4 quads. HL in (R) FA ± s/s of infection. VSS. Pt removed Ace wrap & DSG to (R) LE. DSG wet ± Dakins soln applied covered ± 4x4. (R) LE pedal pulse palpable, (+) sensation, <3 sec cap refill, limited ROM in digits, Ø ROM in ankle. All other assessment findings WNL. RLE wound dime size ± s/s of infection. Will continue to monitor [redacted]
17Aug03 1500	Awake and alert in bed. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) ankle. CDI Ø c/o pain. (L) foot swollen. Strong pedal pulse and brisk cap refill to RLE [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03 1900	Dsg Δ done to Ⓛ ankle. Small amt purulent drainage noted when old dsg removed. WD Dsg done T 1/4% Dankins soln, then wrapped T Gauze. Ø complaints to [redacted] b(6)-2 via/or
2100	PT. care assumed @ 2100. HR reg, lungs CTA, BS Ⓣ x4 - Ⓛ ankle Ext dsng CDI. Ⓛ ft. T Ⓣ sensation, Ⓣ ROM, brisk cap refill, pulse 2+. Will cont. to monitor [redacted]
0520 18AUG03	PT. CARE assumed @ 0515. VSS. Lungs CTA, HRR, BS Ⓣ x4 Dressing on LLE CDI. + Pulses Quick care Refer to left foot + sensation PT complained of pain, will give meds T breakfast [redacted] b(6)-2
18Aug03 1830	Assumed care @ 1300. Lungs clear. Abd soft nondistended, BS x4. Cast to Ⓡ foot. Good cap. refill. % some tingling to Ⓡ toes. Will continue to monitor [redacted]
18Aug03 2337	Care assumed @ 2100. VSS, no complaints, Lungs CTA, b(6)-2 BS Ⓣ. Cast on lle intact, Ⓣ sensation and cap refill. PT T d/c summary and orders, continue to monitor. [redacted] b(6)-2 assumed
19 0730 Aug 03	NURSING NOTE: Assumed pt care. Alert, breathing even and unlabored, LS CTA Ⓑ. Abd soft, nontender, T distended. BS Ⓣ x4. Voids spontaneously. ROM and neurovascularly intact to Ⓑ UE and ⓇLE. Cast to ⓇLE (Cast below knee to toes). Neurovascularly intact T otherwise. ROM to UE. IV to CTA T s/s infection/inflammation. [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b(6)-2
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.)*

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WARD NO. ICU2

EPW # [redacted]

b(6)-4

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

MEDCOM - 16054

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03	1545: Dc'd to EPW comp. VSS. X-rays and Discharge [redacted] Ept.

10(c) - 2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

18 JUL 05
1415

Ortho Discharge Note - 28th CAV

26 YO with GSW to (L) foot 10 days prior to admission. Admitted 7 JUL 05 with dressing used leading to open talus fracture. Wounds I+D'd on 7 and 9 JUL. Wound closed except central 1 cm. Wet to dry dressing changes done. Now placed in short leg cast.

PLAN: Ciprofloxacin 500mg P.O. BID x 30 days #60
Percocet 1-2 P.O. Q4-6hrs PRN #30.
P/U at IBN BLDG hospital with 28th CAV in 3 weeks for post removal, wound check, radiographs

b(a)-2 [redacted]

CDR ME

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.)*

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WARD NO.

[redacted]

b(a)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 16056

b(2)-2 NSN 7540-01-075-3786

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY [redacted]
RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION
STREET ADDRESS
CITY | STATE | ZIP CODE

ARRIVAL
DATE (Day, Month, Year): 7 AUG 03 | TIME: 1240
TRANSPORTATION TO FACILITY

SEX: M
AGE: 26
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: -0-

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 LUQ (L) elbow (R) posterior chest

CATEGORY OF TREATMENT
☐ EMERGENT
☐ URGENT
☐ NON-URGENT
TIME: 1240
INITIALS: b(6)-2 [redacted]

VITAL SIGNS

TIME	1240				
BP	140/80				
PULSE	125				
RESP	18				
TEMP	98.7				
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
1300	Tetanus shot	Davis	[redacted] b(6)-2		
1300	IVFS 5mg IVP	Davis			
1300	Ancef 1g in VPB	Davis			

DISPOSITION
☐ HOME ☐ FULL DUTY
MODIFIED DUTY UNTIL
DISPOSITION QUARTERS /OFF DUTY
☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.
RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS: to ICU 2 prior to SX

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
ADMIT TO UNIT/SERVICE
TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.
PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)
b(6)-4
[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

NSN 7540-01-075-3788

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC	11.4		134 /	/ 12 / 129		SUP O2	PH	PO2	RESULTS CXR Chest- bullet fragments SQ to [redacted] Double Shattered (L)	
H/H	16.7 / 53%		3.4 / 97	/ 1.1		PCO2	SAT	OTHER		
PLT	161									
PT					U/A	DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

S) Hx shot twice in LLE 12 days ago. Pt also shot in (R) posterior chest and (L) elbow. Pt had a grazing shot to the (R) side of his head. Denies SOB. (+) pedal pulses. (+) pulses distal to (L) elbow wound. [redacted] b(6)-2

26 y/o

O: VS noted Tachycardic Afebrile Responds appro to Interpreter,
(1) Open wound to (L) elbow + erythema 2cm
(2) Small open wound to posterior chest NO crepitus
Lung fields CTA Bilateral lung fields. no use of accessory muscle. No crepitus over scapula
(3) (L) ankle, large ecchymotic painful to touch medial ext wound above (L) medial ankle +2DP pulse Heart RRR Pulses +2 Radial, DP, Brisk cap refill. Movement toes/grasp

A: GSW to Chest, elbow, ankle
P: to ICW 2 for hold until 7/14/14

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
[redacted] (ortho)	1250	Admit	
b6-2			
			PROVIDER SIGNATURE AND STAMP [redacted] Cpt FNP-C b(6)-2

DIAGNOSIS
S GSW to back, (L) elbow, (L) foot

CODES

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

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

MEDICAL RECORD	CONSULTATION SHEET	AUTHORIZED FOR LOCAL REPRODUCTION

REQUEST

TO: 3 ortho - b6-2

REASON FOR REQUEST *(Complaints and findings)*: [redacted] Gunshot wound - fractures ⑤ foot

DATE OF REQUEST: 7 Aug 03

PROVISIONAL DIAGNOSIS

b(6)-2 fracture ⑤ foot - 2° gunshot wound

[redacted] | APPROVED | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

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

[redacted]

EPW b(6)-4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 16059

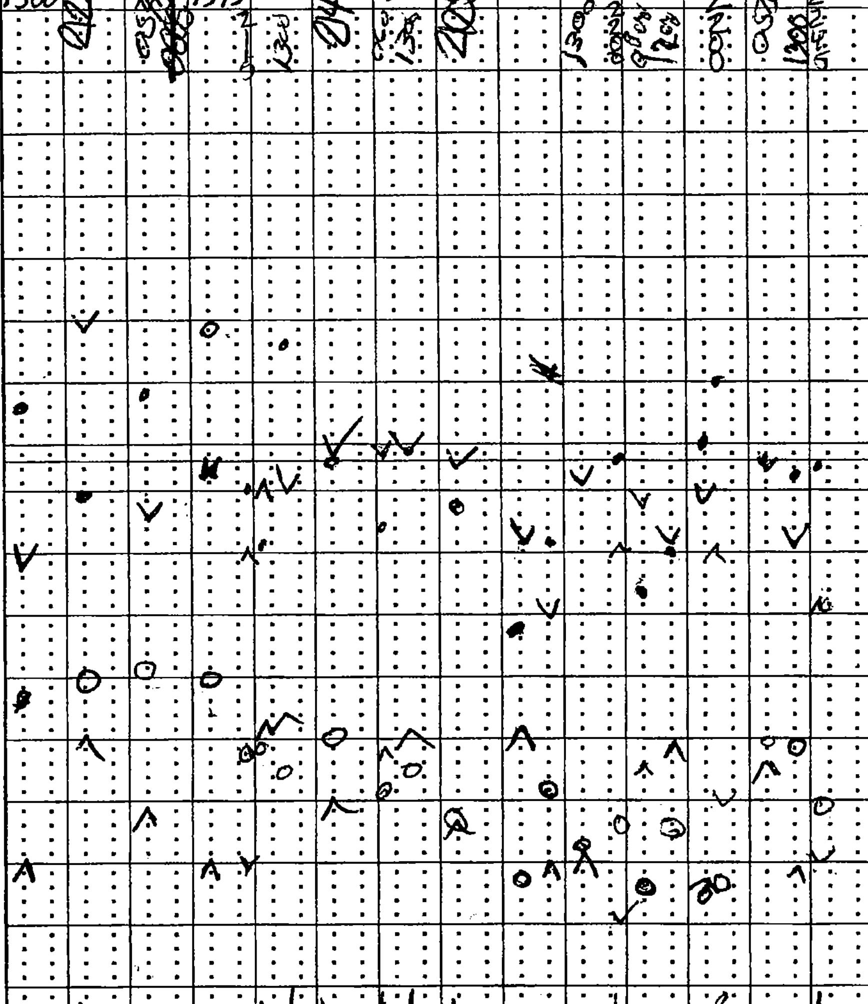
511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1
POST- DAY	OR day
MONTH-YEAR Aug	DAY: 7, 8, 9, 10, 11, 12, 13
19 2003	HOUR: 1500, 1345

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: 108/60, 124/80, 120/84, 124/76, 126/82, 122/62, 118/76, 112/56, 124/70, 112/58

HEIGHT: WEIGHT →

98%, 98%, 98%, 98%, 97%, 98%, 98%, 97%, 97%, 98%, 97%, 99

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. ICW 2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16060

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR Aug 03

DAY: 14 15 16 17 18 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°
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 →

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)

REGISTER NO.

WARD NO. ICU2

STANDARD FORM 511 (REV. 7–95) BACK

FPW # [redacted] b(6)-4

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: 26

HEIGHT:

WEIGHT: 80 kg

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

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: I&D (L) foot & (L) elbow

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco 2 ppd X 12 yrs. Body Piercing Ø Diabetes (Y) (N) ROM ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) 6D 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	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ 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	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ 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	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ 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)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0800 ! 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: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	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	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ Place and take down legs from stirrups with slow bilateral motion. ✓ 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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier - Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. b(w)-2	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] LTC, AN 7 Aug 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
Cold in OR 3 Seconds for 1 foot
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION (Signature and Ti[redacted] PREPARED BY
DATE: 7 AUG 03 TIME: 1355

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: 07 Aug 03 TIME: 1956

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDCOM - 16063

MEDICAL RECORD — INTRAOPER[illegible]OCUMENT

For use of this form, see AR 40-66, the pro[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY OR/Anesth. personnel

2. PATIENT IDENTIFIED, REC[illegible] REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b(6)-2

3. DATE 7 Aug. 03 TIME PATIENT ARRIVED IN SUITE 1845

4. PATIENT IN ROOM TIME 1845 NUM[illegible]R 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted] CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1905 - Eoc)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION b(6)-2

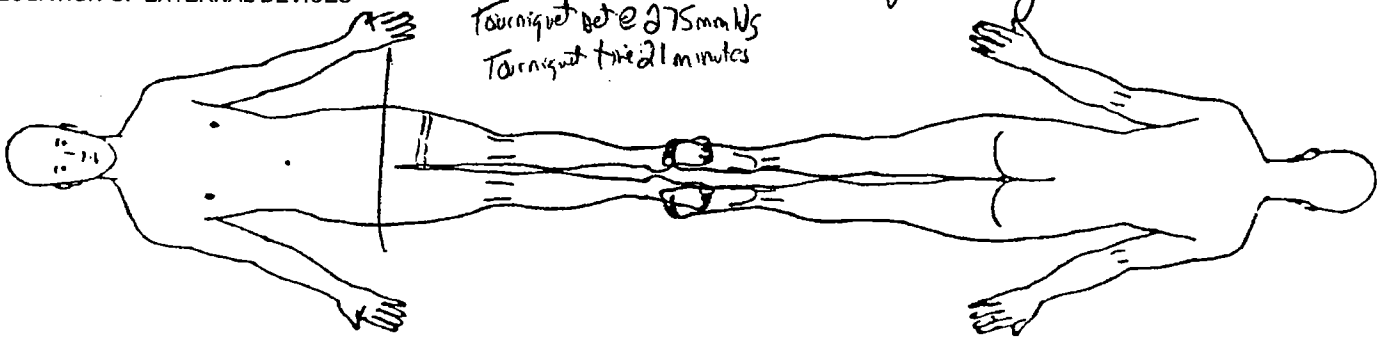
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify)
SITE: Lt. [redacted] arm BY WHOM: LTC [redacted] CPT [redacted]
SITE: Lt. [redacted] leg BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Other	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR b(6)-2
Sponge	☒ Yes	☐ No	✓				
Needle Sharp	☒ Yes	☐ No	✓	C	C	SGT [redacted]	CPT [redacted]
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

b(6)-4 [redacted]

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

☐ ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM polyhesive II
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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

MEDCOM - 16064

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 (L) Ankle 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)* Fluffs, Kerlix, webril, splint, webril, Ace

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. (L) Foot	2.	3.

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] b(6)-2 Anesthesia: (PT [redacted] (RNA Anesthesia Type: GETA

Bovie Pad site intact pre-op clear, post-op clear Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op clear: post-op clear
Tourniquet Time: Up ___ Down ___ See Block #9

20. OPERATION(S) PERFORMED
I&D (L) Foot
b(6)-2

21. PATIENT TRANSFERRED TO [redacted] LTA ICU 2 TIME 1955 METHOD Via Gurney

MEDICAL RECORD

INTRAOPERA[illegible]E DOCUMENT

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

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

2. PATIENT IDENTIFIED, [illegible] REVIEWED AND PROCEDURE VERIFIED BY: [redacted] b(6)-2

3. DATE: 10 aug 23 TIME PATIENT ARRIVED IN SUITE: 0410

4. PATIENT IN ROOM TIME: 0400 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SP [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) A mayo body elevat. arms on arm boards @ <90°

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

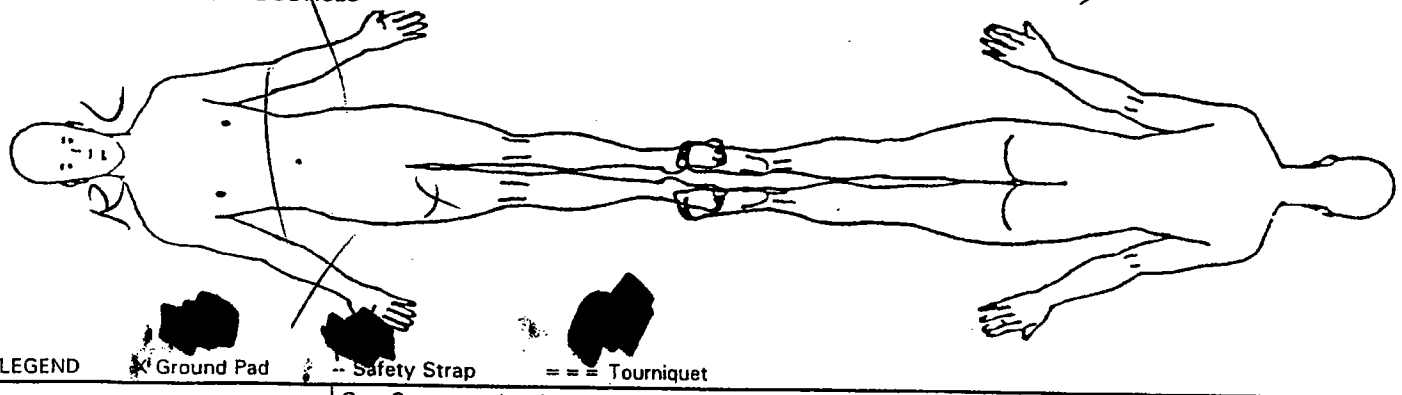
PREP SOLUTION (Specify) Beta/Beta

SITE: (L) CE BY WHOM: [redacted] b(6)-2

SITE: BY WHOM:

COMMENTS: Ø prolong

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS		C = Correct I = Incorrect: 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;)

[redacted] b(6)-4

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

☑ ESU NO: VL#4

GROUND PAD: BRAND Valleylab Bovie II

LOT NO: 689136

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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 NaCl ☒ YES ☐ NO, TYPE(S):

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	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
DCe

19. ADDITIONAL INFORMATION

[redacted] surgeon
CRNA

b6-2

Post-op-pt drowsy. Capillary Refill < 3 sec's in (L) toes. Dressing dry & intact. Drain site clear.

Masked geta

Penrose removed in surgery during prep

20. OPERATION(S) PERFORMED

I+D (L) LE

21. PATIENT TRANSFERRED TO ICU 2 b(6)-2 TIME 0454 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 16067 USAPA V1.01

i-STAT 6+

Pt: [redacted] b(a)-4

Pt Name:_____

Glu_____129 mg/dL

BUN_____14 mg/dL

Na_____134 mmol/L

K_____3.4 mmol/L

Cl_____97 mmol/L

Hct_____57 %PCV

Hb*_____19 g/dL

*via Hct

Sample Type_:

07AUG03 13:04

Oper: [redacted] b6-2

Physician:_____

Ser# 40763

Ver: JAM5046A
CLEW A93

ID: [redacted] 07-08-03
WB 13:05

				Patient Limits	
WBC	11.4	*H	x10^3/uL	4.5	10.5
RBC	5.88		x10^6/uL	4.00	6.00
Hgb	16.7		g/dL	11.0	18.0
Hct	53.9		%	35.0	60.0
MCV	91.7		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.0	L	g/dL	33.0	37.0
Plt	761.	H	x10^3/uL	150.	450.
LY%	22.0	*	%	20.5	51.1
LY#	2.5	*	x10^3/uL	1.2	3.4

[redacted]

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 7 AUG	TIME 1245	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
07/08/03 12:59
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100684

ALB	4.5	3.3-5.5	G/DL
ALP	128*	26-84	U/L
ALT	41	10-47	U/L
AMY	43	14-97	U/L
AST	29	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	10.6*	8.0-10.3	MG/DL
CHOL	243*	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	133*	73-118	MG/DL
TP	9.8*	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
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]	DATE: 7 Aug 03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN: b(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE / TIME	SSN/PSEUDO SSN:

(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		

Urinalysis

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

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh			

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 7 Aug 03	LAB ID NO.:

b(6)-2

Tobacco

MEDICAL RECORD - ANESTHES

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

NKDA

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

DRUG (Units)					
Versed (mg)	2				
Fentanyl (mcg)	50-50-100-50				
MSO4 (mg)	2-2-2-2-2				
Propofol (mg)	<100>	50	50		
( )					
VOLAT AGENT 3.50 % del	2.0	2.0	X		
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	2	2	2	10	

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

FLUIDS

LINE site		
20G (R) HAND	☐ Warmed	4R-200
	☐ 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- 133/60

HR- 90

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? JR

TIME- 0345

TIME 0400 · 30 · 0500 · 30 · 0600

SYMBOLS

BP by cuff: V ^

Heart rate: ●

Resp rate

BR (transduced)

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	—	300	300	260
f - breaths/min	—	20	IH	20
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	—	45	45	45
BP/oth	FIO2 (Frac or %)	0.60	0.60	0.60	0.60
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	available			
	N-M Block (T/4)				
Warming blkt		x1 Blanket			
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4)

TOTALS	TOTAL EBL
2	<50
250	
10	TOTAL URINE
	Ø

FLUIDS SUMMARY

CRYSTALLOID- 300

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) Jump CTAB HR RRR (-) NPO status verified.
(2) Room, mon, O2
(3) Awake, pt removed oral airway + nasal probe herself
(4) No complications to ICU RN. Report to RN.

RECOVERY AT 0455

PACU ICU (2) (Specify)

OTHER T 97.3

CONDITION: Stable, asleep, comment, extubated

RESP- 18 SpO2 96

BP- 138/70 HR- 82

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0350	0400	0500
PROC	Ready	Begin	End
	0415	0425	0445

PROCEDURES and CPT Codes: I+D (2) foot

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* OA-9mm / 34FR Nasal trumpet

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

[redacted] b(6)-4

SUR [redacted] b(6)-2

CRNA/MA

PROCEDURE LOCATION: 7

DATE: 10 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 16071 — [redacted]'S MEDICAL RECORD — USAPA V1.00

26 ♂ NKDA

MEDICAL RECORD - ANESTHE

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

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

DRUG	(Units)		TOTALS
Versed	(MG)	3	3
Fentanyl	(MCG)	50, 50, 150	250
Propofol	(MG)	150 50	200
SUX	(MG)	100	
	( )		
	( )		
VOLAT AGENT: ISO	% del	1.9 - 1.9 - 1.9	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 + 2 + 2 = 210	

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

FLUIDS

LINE site		
LR 18G (L) HA.	☐ Warmed	LR 300 + LR
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE - Not measured

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

BODY WEIGHT: 76 (KG) LB

HEMATOCRIT: 16/39

INITIAL DATA: BP- 129/67; HR- 96

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? YES; TIME- 1950

TIME → 1500 • 30 • 2000 • 30 • 2100 • 30 →

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

TR 1 2 3 4 5 TR

VENTIL / MONITORS/ACCESSORIES

VT - ml		1030	600	760	500
f - breaths/min		10	10	8	12
Peak inf pres / PEEP		20	26	27	—
MODE - S(pon), A(ssist), C(on)		S/A/C	C/I	C	A S
BP/Auto Cuff	ET CO2 (torr)	38	42	32	43
BP/oth	FIO2 (Frac or %)	86	87	188	188
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site Nas	HYM	ndys	97	97
	N-M Block (T/4)	4/4	4/4	4/4	4/4
Warming blkt					
Conv warmer					

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

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS SUMMARY: CRYSTALLOID- 400 cc; COLLOID- 0; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

1830 IP PT stent removed Anes BS Plan discussed c PT. 1845 To Room, standard monitors. 1905 Report Received CRNA to relieve. 1945 PO sgw x 2. VS stable & awake c O2 NC. To ICU c stable cond'n. Report to RN

RECOVERY AT: 1950

PACU ICU 2 (Specify)

OTHER

CONDITION: stable

RESP- 16 SpO2- 100

BP- 123/68 HR- 95

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1830	1845	1955
PROC	Ready	Begin	End
	1855	1905	1945

PROCEDURES and CPT Codes: I+D (L) Axilla

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

[redacted] b(6)-2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

Pre-ox Sats 98% IVIOI - 1 induction, easy mask/intubation DL XT miller 2 c cricoid pressure, cuffed T size 8.0 ETT

SURGEONS: 1st Lt Arp 24 cm @ lip @ 0605 ⊕ 1st Col ⊕ Off @ 0604 ALBRIGHT

ANESTHETIST: [redacted] b(6)-2 [redacted] CRNA

PROCEDURE LOCATION: Battle

DATE: 7 Nov 05

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 16072 — COPY 1 - PATIENT MEDICAL RECORD — USAPA V1.00

ANESTHESIA PLAN OF CARE and PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS (YRS) Sex (M) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (C) foot + (L) elbow
SURGICAL SERVICE: Ortho
NPO SINCE: 0800 - food

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: 5'6" IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 2pks/day
ETOH:
DRUGS:

CURRENT MEDICATIONS: Ø
( ) = ordered as premed
INER
(Y) Ancef 1gm IVPB @
(Y) MSO4 4mg IVP @ 1300
( ) _____ 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: CXR - Lungs clear

11.4 / 16.7 / 53.9 / 761
134 / 10.6 / 18 / 3.4 / 97 / 1.1 / 129

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

N/A x2
GSW (C) foot + (L) elbow; (R) posterior chest
grazed wound (R) side of head (5 days)

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 108/60 HR 88 R 18 T 97.6 98% RA
Pain Scale 0-10
HEENT - Teeth chipped (R) front tooth
Trachea midline x2 (C) collar
TMJ/Neck FROM; TMD 3
Oropharynx MP2
Nares patent
CHEST: CTA(B) w/ rales
CPT Darsis ETAT - CXR lungs clear
CARDIAC: RRR (-) MRG - USS - superficial
EXTREMITIES:
IV Access: 18G (L) arm
Ulnar Filling:
BACK:
OTHER:

NPO Since 0800

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

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

The [redacted] b(6)-2 and agrees. Questions answered.
Signed: [redacted] CRNA Date: Aug 7, 2003 Time: 1450 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted]
b(6)-4

SEDATION KEY:

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

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]

EPW

NURSING UNIT	ROOM NO.	BED NO.
ICWZ	b(6)-4	15

DATE OF ORDER 7 MAR 03 TIME OF ORDER 1345 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW-2
2. DX- GSW (L) LEG + GUNSHOT
3. CLOTHING- PAN
4. VS- NORTH
5. DIET ADAT
6. NPO

PATIENT IDENTIFICATION

[redacted]

EPW

[redacted]

DATE OF ORDER TIME OF ORDER

7. N-GR ET 125 CC/HR HOURS
8. ANCEF 1 GM IVPB Q 8 HRS (6 ZW)
9. MSO4 2-6 MG IVP Q 2 HRS
10. TO OR TODAY

NURSING UNIT	ROOM NO.	BED NO.
ICWZ		15

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 7 MAR 03 TIME OF ORDER 1945 HOURS

S/P EXP (R) LEG

1. TO ICW-2
2. CSMO/RN- STABLE
3. VS- NORTHER
4. UP AD LIB POR EPW PROTOCOL
   NWB RLE (R).
5. NURSING CARE

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

6. N-GR AT 125 CC/HR, WOP LOCK WSD HOURS
   FOLEY TO WSD
7. ANCEF 1 GM NPB Q 8 HRS
8. TYLENOL 650 MG P.O. Q 4 HRS PRN
9. PERCOCET, 1-2 P.O. Q 4-6 HRS PRN
10. PHENERGAN 25 MG N OR IM Q 6 HRS PRN
11. MSO4 2-6 MG N Q 2 HRS PRN
12. NPO AFTER MIDNIGHT FOR OR 9 MAR

Noted 0630 8 Aug 03 b(6)-2 GUNNER

038

NURSING UNIT	ROOM NO.	BED NO.
24 VS	338 CCUS 8 Aug 03	

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

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

MEDCOM - 16074

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 Aug 03	2120 HOURS	noted [redacted] 0540 9 Aug 03
1 NPO after midnight. Blood glucose.		

PATIENT IDENTIFICATION 8/9/03 2201 24 VS [redacted]

b(6)-4 [redacted]

DATE OF ORDER	TIME OF ORDER	
10 Aug 03	0450 HOURS	noted [redacted] 0540 10 Aug 03
1 Regular diet as ordered		✓
2 Regular diet		✓
3 IV - DNR at 125 cc/hr. Dilaudid PCA with loading dose and PCA settings per [redacted]		✓
4 Daily dressing changes. Culture wound if drainage. [redacted] 11 Aug 03		

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24 VS	15

PATIENT IDENTIFICATION [redacted]

EPW [redacted]

b(6)-4

DATE OF ORDER	TIME OF ORDER	
8 Aug 03 2250	1810 HOURS	Noted 12 Aug 03 1620 [redacted]
12 Aug 03	1610 HOURS	
Dakins solution dressing changes to (L) foot wound BID. [redacted]		

NURSING UNIT	ROOM NO.	BED NO.
ICW2		13

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
		HOURS
noted ¼ strength Dakins solution Dressing Changes to (L) Foot Wound BID V.O. for [redacted]		

038

NURSING UNIT	ROOM NO.	BED NO.
	24 VS	2300

A Aug 03 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

EPW [redacted]

Marked [redacted]

NURSING UNIT: 1CW2 | ROOM NO. | BED NO.: 24 V5

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
17 AUG 03	1100 HOURS	
(1) WBTHS 800 mg BID PO ⊽ 8 HRS.		
b(6)-2 [redacted]		
[redacted]		2107

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.: 24 V5 2330

DATE OF ORDER	TIME OF ORDER	
18 AUG 03	1415 HOURS	
(1) DISCHARGE TO EPW UNIT IN A.M.		
(2) CBST TO (2) LOG, WBBT.		
b(6)-2 [redacted]		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF [redacted] TIME OF [redacted] HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 RE[redacted] 1 JUL 77, WHICH MAY BE USED.

[redacted] U.S. GOV

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7 8 9 10 11 12 13 14 15 16 17 18 19
7AUG03	[redacted]	V.S. Routine	05	✓ [redacted]
			13	
			21	
7AUG03	[redacted]	Bed Rest Up Ad lib per epw protocol non weight bearing on RLE	05	✓ [redacted]
			13	
			21	
7AUG03	[redacted]	NPO	05	✓ [redacted]
10Aug03		Regular Diet	13	
			21	
10Aug	[redacted]	Daily Dsg Δ's (beginning 11Aug03) E Dakin's solution to L foot wound BID	10	✓ ✓ ✓ ✓ ✓ [redacted] D/C'D
			20	✓ ✓ ✓ ✓ ✓ [redacted]

DC'd 19Aug 1545 [redacted]

Cast to L foot 18 Aug03 [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW L Leg & elbow S/P I+D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

[redacted] b(a)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 16077

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7AUG0[redacted]	[redacted]	To ICW-2	7AUG03		1415	[redacted]
	.....	Condition: ~~Fair~~ Stable				
7AUG0[redacted]		To OR today				[redacted]
7AUG0[redacted]		NPO after breakfast + ~~XANAX~~ 8AUG, to OR 9AUG	8Aug	2400		
10		Resume previous orders	10Aug	0450	0535	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Did 19Aug 1545 AVS

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

USAPA V1.00

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

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

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7 8 9 10 11 12 13 14 15 16 17 18 19 20
7AUG03	[redacted]	IV - LR @ 125 cc/hr	05	/ [redacted]
10Aug	.....	(HL) when tolerating	13	[redacted] 21/8/03
	.....	PO well	21	
	.....			
7AUG03	[redacted]	Ancef 1 Gm IVPB Q8hrs	08	/ [redacted]
	.....		16	
	.....		24	
	.....			
7Aug03	[redacted]	VSL	05	[redacted]
	.....		13	
	.....		21	D
	.....			
	.....			
	.....			
	.....			
	.....			
	.....			
	.....			
	.....			
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	.....			
	.....			
	.....			
	.....			
	.....			

DCd 19 Aug 1545 AVL

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: GSW @ Leg + Elbow S/P I+D @ leg	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION:

[redacted] b(6)-9

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	

b(6)-2 PRN

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

ORDER DATE	CLERK/ NURSE	~~PRN RECURRING~~ MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE DISPENSED
7Aug03	[redacted]	MSO4 2-6 mg IV/IM Q 2 hrs		b(6)-2
7Aug03	[redacted]	Tylenol 650mg PO Q4° prn		8Aug 0800 #PO; 10Aug 0600; 12Aug 1800; 13Aug 0830; 13Aug 1820; 14Aug 0338; 14Aug 0800; 14Aug 1600; 15Aug 0525 #PO
7Aug03	[redacted]	Percocet 1-2 tabs PO Q4-6hrs prn		8/9 0113 #2 #5; 10Aug 0545; 11Aug 1615 PO; 11Aug 2031; 12Aug 2015; 8.17 0339 PO
7Aug03	[redacted]	Phenergan 25mg IV or IM Q6 prn		
copied	[redacted]	Tylenol 650mg PO Q4° prn		16Aug 0525 650mg PO; 17Aug 0836 650 PO; 19Aug 1050 650 PO
7Aug03	[redacted]	Motrin 800mg PO TID Q8° PRN		17Aug 1050 PO; 17Aug 1838 PO; 18Aug 0615 PO; 18Aug 1552 PO; 19Aug 0238 PO

Dc'd 19Aug03 1545 AOK

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ___

PATIENT IDENTIFICATION: #[redacted]

b(6)-4 PRN

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 - 16080

ASA 2
Tobacco
75 KG

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: 10 Aug
Time In: 1400 min
Allergies: NKDA
Pre-op V/S: 133/100 90
Procedures: I/D LLE

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

OR Intake: Crystalloid 3000 cc Colloid
OR Output: UOP 0 EBL 250
Meds/Times: 2mg versed 250 fent 10 MS04

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time																								
SaO2	96	96	100	99	96	96	96																	
FiO2	RA	RA	RA	RA	RA	RA	RA																	
Methods																								
240																								
220	138/70	140/72																						
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
20																								
RR	16	24	18	14	14	18	20																	
T	99																							
Time																								
Pain (0-10)	0																							
LOS	11																							

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	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	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)
CPT [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU2

DATE
10 Aug 03

PATIENT'S IDENTIFICATION (Type or write all entries given: Name – last, first, middle; grade; date; hospital or medical facility)
b(6)-2
EPW [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	UE	+	+	++	B	+	B
15'	UE	+	+	++	B	+	B
30'	UE	+	+	++	B	+	B
45'							
60'							
90'							
D/C							

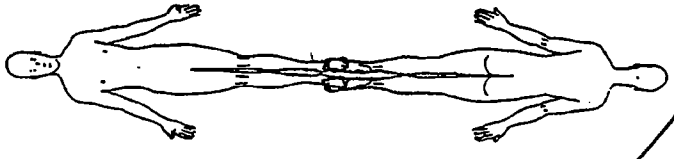
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

[redacted] received report from [redacted] at 0700. [redacted] given to [redacted] [redacted]

b(w)-2 A11

Discharge Criteria:
Date: 10 Aug **Time:** 0540 **PARS:** 10
BP: 126/60 **T:** 97.3 **HR:** 60 **RR:** 18 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: 900 **Output:** 0
Additional Data: none
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: W/C Stretcher Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP By: [redacted]
Charge Nurse Signature: [redacted]

MEDCOM - 16082

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: 7 AUG

Time In: 2111

Allergies: NKDA

Pre-op V/S: 129/67 HR=96

Procedures: I+D L ankle

Open wound drain

Anesthesia Type (Circle): General Spinal Epidural

IV Sedation Nerve Block

OR Intake: Crystalloid 400cc Colloid

OR Output: UOP 0 EBL min

Meds/Times: 250cg @ 2111

ASA II

Smoky Versus

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	20 20 20 20 20 20 10 10 10 10
SaO2	
FiO2	
Methods	
240	
220	
200	
180	
160	
140	✓ ✓
120	✓
100	
80	
60	
40	
20	
RR	24 20 20 17
T	
Time	2115
Pain (0-10)	5
LOS	

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
2000	LR	1000	L Arm		1000

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	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.	9	9	9

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): [redacted]

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 7 AUG

PATIENT'S IDENTIFICATION (For typed or written entries give: 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
2015	Sev	MS04/5mg	IV	3	E	[redacted]

NEUROVASCULAR

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

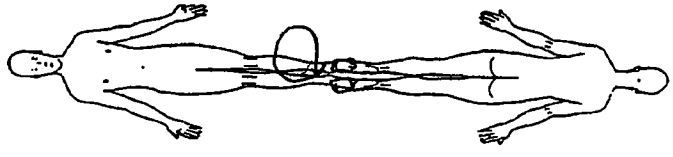
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Ankle	Brief	Ø
30'	"	"	"
60'	"	"	"
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2000	SR	NO	NO

WAMC OP 173-E

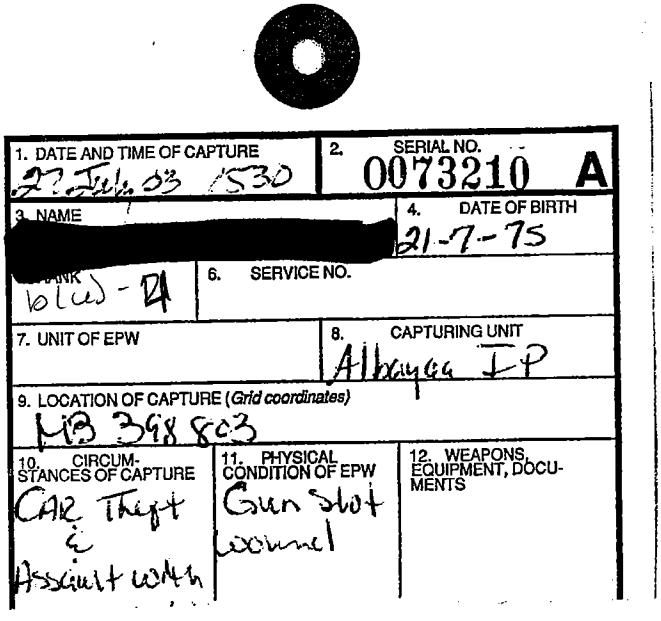
NURSING NOTES

Nursing Note: Pt. admitted to PACU #2 for recovery. Lungs clear, BS hyperactive, pulses palpable x 3 extremities, good cap refill x 4 extremities. IV to (L) hand patent. LR @ TKO. Will continue to monitor. — [redacted]

b(6)-2

Discharge Criteria:
Date: 7AUG Time: 2035 PARS: 9
BP: 144/80 T: 97.6 HR: 86 RR: ~~18~~ 24 Sa02: 96
Pain Level at D/C (0-10): 3
Intake: 0 Output: 0
Additional Data:
Transferred To: PACU #2
Report Given To: [redacted]
Transferred Via: W/C [redacted] ney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP 8-3
Charge Nurse Signature: [redacted]

b(6)-2



1. DATE AND TIME OF CAPTURE	2. SERIAL NO.
27 July 03 1530	0073210 A
3. NAME [redacted]	4. DATE OF BIRTH 21-7-75
RANK Pvt - E1	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT Albanya IP
9. LOCATION OF CAPTURE (*Grid coordinates*) MB 398 803	
10. CIRCUM-STANCES OF CAPTURE: CAR Theft & Assault with	11. PHYSICAL CONDITION OF EPW: Gun Shot wound	12. WEAPONS, EQUIPMENT, DOCU-MENTS

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
A11D1	IZ	[redacted]	SPC# [redacted] b(4)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	026	2	2	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	0240	— b(4)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICU#2	UNK
[redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
80		030819

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AFAA		030807

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

FOR LOCAL USE

DX: Gsw to (L) leg & Elbow s/p IED (L) Leg.

Dx: 82531 8750 8911 8738 88101 E9912 E9919

Pro: 7967 8628

b(4)-2 [redacted]

ADMITTING OFFICER (Signature, as req[redacted]

SIGNATURE OF ADMITTING CLERK [redacted] Inj Trauma 450 1

Dr [redacted]

DA F[redacted]

MEDCOM - 16086

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
00 14206	UNK IRAQI EPW			EPW	
4. SEX / 5. AGE / 6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M / 34y / A	MUSLIM	—	—	NO	
11. FMP	12. SSN	13. ORGANIZATION		14. WARD	
99	[redacted]	—		ICW2	
15. FLYING STATUS	16. RATING/ OSG	17. DEPT/ BEN	18. BRANCH/CORPS	18. UIC/ZIP	20. TYPE CASE
NO	b(6)-4	K78	—		WIA.

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1515	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION	ADMITTING OFFICER
—	D/C TO CAMP	14 Sep 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	
—	—	19 AUG 2003	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2			

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P ex fix (L) femur.

821.30
736.89
E991.2

78.15

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	~~44~~ 37	~~44~~ 37

36. Total Days All Facilites b(6)-2

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	[redacted]	[redacted]	37	37

SIGNATURE OF ATTENDING MEDICAL OFFICER

[redacted]

DA FORM 3647, MAY 79 MEDCOM - [redacted] USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

b(a)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	7 OCT 04		

PATIENT'S IDENTIFICATION (*For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility*)	REGISTER NO.	WARD NO.
[redacted] b(a)-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	5) Pt shot in (L) knee entrance + exit wound,
BP 110/80	Pt has broken femur. Traction splint. Pt
P 128	c/o dizziness. Pt shot 22-25 days ago.
R 16	a) Morphine 5mg IM 2033 hrs
T	2050 - 5mg MS given IM in (R) Deltoid. B/P
	110/palp a MS.
	X-ray displaced fracture @ distal femur
	Leg: splint
	Head dressing
	@ thigh wound dressed/wrapped
	by medic
	distal tibia intact
	only thigh → exit wound
	A - Comminuted wound - 20 days @
	fracture @ femur
	P - G CAB splint
	Amp (SM - [redacted] 4/12

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV	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.)* [redacted] | REGISTER NO. | WARD NO.

b(6)-2 EPW

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

deformed femur
AMP gunshot
to L. ankle

MEDCOM - 16089

[redacted] b(6)-2

2230— 1L LR TKO ——————————— SGT [redacted] 9MW

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01Aug03 1900	Pt received from ICU2 @ 1840. Pt stable at time of transfer. AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple FROM. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. W to (R) AC TLR @ 125 cc/hr. Pt drinking small amts clear flds. Refused dinner. Ex fix to (L) femur. Dsg to lower pin t minimal drainage. Ø complaints — b(6)-2 [redacted]
2030	Temp to 100.5F. Tylenol given — [redacted]
2035	Foley from ICU2 "fell out" @ 1945 due to balloon not being inflated. Replace 16Fr indwelling foley. Draining clear yellow urine in sufficient amounts Ø complaints — b(6)-2 [redacted]
2130	Pt care assumed @ 2100. T @ 100.9, 650 mg Tylenol @ 2040, will take again @ 2200. Lung sounds CTA, pulses + x4, bs + x4 quads. Ex fix with dsg on lle draining small amount of blood at lower pin site. lle T (+) pulse and sensation. Patent IV @ RFA infusing @ 125 cc/hr. Foley catheter intact, draining CYU. Will continue to monitor. — [redacted]

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

EPW [redacted] b(6)-4

RECORDS MAINTAINED AT: ▶ b(6)-2 [redacted]

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 - 16091

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

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Aug03	Pt temp taken 100.5 [redacted]
7Aug03 2230	Temp V/S to 99.5. [redacted] alumne [redacted]
080530Aug03	NURSING ASSESSMENT: Assumed care of Pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ± distention. BS@4. Voiding per foley, clear, yellow urine. RLQ and removes easily intact to (B)4E and (L)LE. (R)LE has ex-fix to lateral thigh, 4 pins, and ACE wrap to length of leg. Sensory deficit to distal two pinsites. Neurovascularly intact below pins but ROM limited by pain. IV to (R)AC ± s/s infection or infiltration. [redacted]
080820Aug03	NURSING NOTE: T↑ to 102°F. Tylenol 650mg PO given for temp. Dr. [redacted] notified PE: absence of antibiotics and temp. Ancef ordered and given. [redacted]
081000Aug03	NURSING NOTE: Pin care withheld today per Dr. [redacted] instructions. Will start pin care tomorrow. [redacted]
8AUG03 1300	-Received Pt in bed. Pt Temp ↑ 102 F. Tylenol 650mg PO Given in previous shift. Will encourage use of Incentive spirometer. Lung sounds are clear B. bilateral. BS x4. Abdomen soft + Non-tender. Pt has foley & clear odor urine noted. ex-fix to (L) leg is intact & small amount of drainage noted from (1) pin. Pt has (+) sensation to (L) foot. Will continue to monitor Temp. IVF to (R) AC flushed well & 3cc/hr will continue to monitor. [redacted]
9Aug03 0130	Pt care assumed @ 0100. VSS, alert and awake 5/10 pain. Lung sounds CTA, pulses ±X4 BS x4. IV restarted in LFA, IV ABX. foley site intact, voiding Clear yellow urine. LLE & Ace wrap ~~SBL~~ & small amount of bloody drainage @ pins. + Sensation and cap refill in lle, no new complaints, cont to monitor. [redacted] alumne

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 03	0420	Pt awake and conversing. Orders noted.
		Pt w/b transferred to CSH in am [redacted] SPC
	1059	Ok to cut [redacted] LCT SP b(6)-4

Continue on reverse side

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

[redacted]

EPW b(6)-2

REGISTER NO. | WARD NO.

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
		2126 X	1 Calexin (1g 6 hrs)
		2126 X	1g Amsef IV
		1220 X	CMS+ Distal pulse, Good motor skills babinski reflex +, [redacted]
		2140	10 mg Valium given IM per V.O [redacted] PP: 91W
2340			[redacted] + 20 to (a) - 2 6(6) - 2

U.S. GOVERNMENT PRINTING OFFICE : 1986 O - 154-830

NURSING NOTES
Standard Form 510
(Reverse)

NSN 7540-00-634-4176 600-108

HEALTH RECORD — PROGRESS notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Aug03 0900	Pt. c/o upset stomach TI Maalox tabs given. VSS. HR Reg., Lung sands clear bilat, bowel sands (+) x4 quads. HL in (L) AC flushed well c 3cc NS c s/s of infection. Ex fix to (L) femur intact, distal pin c scant amt of brown dried blood to DSG. Pt. c (+) sensation to (L) foot, cap refill <3 sec, full ROM in ankle & digits. Foley draining clear yellow urine. All other assessments WNL. Pt. c other complaints @ this time. Will continue to monitor. b(4) [redacted] RN
9Aug03 1700	assumed care @ 1300 - VSS - SL patent - (L) femur ex-fix in place, Pin-sites dressed, no drainage noted, neuro V's WNL in (L) foot - no c/o pain @ this time - foley draining QS dark yellow urine - [redacted] CRAN
9Aug03 Cont	pt. has temp of 101.9, 1g tylenol given PO, will recheck temp for results - [redacted] CRAN
9Aug03 1815	pt. temp @ this time is 100.6 F, will continue to MONITOR - [redacted]
10Aug03 0800	At care assumed @ 0800. VSS, AOx3, no c/o pain. ex-fix on lle intact, dressed around pins, no drainage noted. (+) rom and sensation of lle, no c/o pain. Lung sands c-ta, pulses + x4, bs + x4. foley intact draining clr. Will continue to monitor. [redacted] RNUMC
16Aug03 0900	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lung sands clear bilat, bowel sands (+) x4 quads. HL in (L) FA flushes

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

EPW [redacted] ICW 2

b(4)-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

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 16095

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

b(a)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	well ☐ 3cc NS ☐ s/s of infection or infiltration. ⓛLE↑ on folded blanket, ext. fix intact, insertion sites ☐ s/s of infection, small amt. of drainage noted on most distal pin, yellowish in color, (+) sensation, full ROM in ankle & digits, cap refill <3sec. Pt. c/o ⓛ ear ache, MD notified & plans to remove small amt of ear wax lodged in ear canal. Pt. ☐ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] DU/AP
10Aug03 1710	assumed care @1300 - VSS - debrox 5 gtts placed in ⓛ ear as ordered - dsg to pin sites, neuro's WNL in ⓛ foot, motor ⊕ in ⓛ foot - SL patent - no c/o pain in ⓛ leg or ⓛ ear - Foley draining lt yellow urine, BS [redacted]
2322	Pt. care assumed @ 2100. VSS. HR reg, lungs CTA, BS⊕X4. ⓛLE ex-fix intact. Pin to pin sites CDI. NV checks ⓛLE WNL. HL ⓛ EA intact, flushes ☐ diff. ⊘ s/s infection. Will cont. to monitor. [redacted] CU/AW
11Aug03	0611 Assume pt care @ 0500. Awake and Alert c/o pain to BLQ of Abd. due to foley. Will talk to MD about Discontinuing foley. VSS. HL to ⓛ FA ⊕ flush ☐ redness/infiltration. HR reg lungs CTA BSx4. ⓛthigh ex-fix intact. Dsg to pin CD+I. ⊕ ROM ⊕ pulse ⊕ sensation below pin sites. Foley to Gravity ☐ CYUOP. Will continue to monitor. No c/o pain to ⓛ ear @ this time. [redacted] MM

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	1027 Foley discontinued @ 0835 pt encouraged to drink water and void by 1230. Pin care done, percocet for pain — [redacted] pump
11Aug03 1400	assumed care @ 1300 - VSS - pt. voided b(6)-2 300cc dark amber urine @ 1350 - SL patent - abx completed - ex-fix remains on (L) thigh, no drainage noted on dressing, neurovs WNL [redacted] in (L) foot — b(6)-2 [redacted] cm
2202	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS @ x4. Pt. denies pain to (L) ear, but c/o pain to (L) LE. (L) LE ex-fix intact. Dsngs to pin sites CDI. (L) knee bent to 30° & blanket. NV checks (L) LE WNL. will cont to monitor. — b(6)-2 [redacted] /LCPAN
12Aug03	0526 Assume pt care @ 0500. Pt awake and alert. VSS. C/O sm amt of pain to (L) femur, had percocet @ 0200. HL to (L) FA (L) flush & redness/ infiltration. HR reg, lungs CTA Abd soft no c/o tenderness on palpation BS x4. Ex-fix to (L) LE intact. dsg's to pins & sm amt pink drainage. NV checks WNL (L) LE. No c/o pain to (L) ear @ this time. Will cont. to monitor — [redacted] 3/LCPAN b(6)-2

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

EDW

[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

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 16097

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03 1410	assumed care @ 1300 - VSS - Sz patent, due to be Δ'd 13Aug03 - no drainage noted from pin sites, knee & thigh remained BS edematous, neuro V's WNL in (L) foot - no c/o pain @ this time — [redacted] RN
12Aug03 2230	VSS - Alt x3 - lungs CTA BIL even unlabored. HR-NSR - BS (+) x4 quads. Pulses to upper (L) leg intact. Percocet PO given for pain. (L) leg edematous. Restraints to upper and lower extremities in place and secure. — [redacted] RN
13Aug03 05-1130	Pt complained of constipation in bed, asked to get Pt out of bed to use restroom - to toilet. Pt provided ad lib fluids. Pt had dressing down to (L) pins through femur. Pt to have procedure on left - dry dressing intact. Area still tender to touch. VSS stable [redacted]
13Aug03 1300	Pt stable. AAOx3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non tender, bowel sounds active x4 quads. (L) leg elevated, pins sites S/S infection, dsg C/D/I. Strong pulses and brisk cap refill to bilat UE. Ø complaints — [redacted] RN
2300	Pt care assumed @ 2300. VSS, A&Ox3, 5/10 percocet given prior to RAM. Lung sounds CTA, pulses + x4, BS + x4 quads. Ext fix to lle CDI, pt TC (+) sensation and cap refill. Edema noted in lle. Pt c/o pain @ HL, HL dc'd. Will continue to monitor. — [redacted] RN

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16098

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)
14Aug03	0654 Assume pt care @ 0500. Pt awake and alert. C/o pain to LLE, percocet given as ordered. VSS. HR reg. Lungs CTA. Abd soft BS x4. Ex-fix to (L) thigh intact. Dsgs C+I. +ROM +pulse b(6)-2 [redacted] +sensation below site. Will cont to monitor
14Aug03 1530	assumed care @ 1300 - VSS - no c/o pain @ this time - pt. ambulated c crutches assisted by PT - Small amount of drainage noted on top pin site dressing - new dsg applied - V's WNL in (L) foot [redacted]
14Aug03	VSS - Ahx3 - Pearla 3mm - Lungs CTA BIL - HR - NSR. BS(+) x 4 quads Pedal pulse +3 Radial +3 Pins to (L) leg intact clean & drainage. Percocet II Po given for c/o pain. b(6)-2 Restraints in place and secure. - S. pt [redacted] 1520
15 0530 Aug 03	Nursing Assessment: Assumed pt care. AAO x 3. Airway intact, breath even and unlabored LS CTA (B). Abd soft, nontender, + bowel sounds. BS(+) x 4. Voids spontaneously. Reports neurovascularly intact to (R) UE and RLE. LLE has Ex Fix to lateral thigh x 4 pins. Drsg to pin sites are CDI. Pt has limited ROM to LLE, neurovascularly intact to LLE, Scally generalized to entire leg, however. [redacted]
15 0700 Aug 03	Nursing Note: Pt awakened c/o increased pain to two most recent pin sites. Percocet II tabs given PO. Will assess site & pain care this A/M. b(6)-2 [redacted]

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. ECW2

EQW [redacted] b(6)-4

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

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
15 Aug 03	NURSING NOTE: Two most proximal pins are somewhat reddened and have some small amounts of purulent drainage to both. Two distal pins are 3 drainage at this time. MD notified, suggested PO antibiotics or dakin's solution. Awaiting new orders. [redacted]
15 Aug 03 1820	assumed care @ 1300 - VSS, T 100.2 - given 650 mg tylenol @ 1445 for (L) leg pain c good pain relief - dsg c/d/i - pin sites c/d/i - ⊕ SL neurov's WNL in (L) foot - pt. ambulated c PT using crutches - PO abx continue - [redacted]
15 Aug 03	VSS - Alert x 3 - Pins clean and intact ⊖ s/s of infection. Pedal and [illegible] HR-NSR - Lungs CTA BIL Resp Reg even. BS ⊕ x 4 quads. Pedal and Radial Pulses +3. Percocet given for c/o (L) leg pain Restraints to UE and LE in place and secure. - SAT [illegible]
16 Aug 03 0320	Resting quietly present. Percocet PO given for c/o (L) leg pain, has had ⊖ further c/o pain. Restraints to UE and LE in place and secure. - SAT [redacted]
16 August 03 0620	Pt. awake, alert sitting up in bed eating breakfast. HR Regular, lung sands clear bilat, bowel sands (+) x 4 quads. VSS. Pt. ↓ IV access. Ext. fix to (L) femur intact, distal pin draining yellowish fluid, pedal pulse (+), (+) sensation, cap refill < 3 sec, full ROM of digits & ankle, ⊖ ROM in knee Pt. c/o pain in (L) leg, ↑ tylenol given. Pt. ↓ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
16 Aug 03 1440	assumed care @ 1300 VSS - medicated c 650 mg tylenol PO prior to ambulation - scant drainage on pin site dsg close to ankle, neurov's WNL in (L) foot, (+) movement, (+) sensation - no c/o pain @ this time [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug03 2145	VSS Afebrile x3 Pearla 4mm - Lungs CTA B/L Resp even Reg HR-NSR BS(+) x4 q cards Pedal and Radial pulses +4. Pins to (D) upper leg in place & drainage on S/S of infection. Restraints in place and secure. b(6)-2 [redacted] CCO
17Aug03 0728	Assume pt care @ 0500. Pt asleep easy to awake. VSS. C/o pain to (D) thigh & fix @ 1st pin. Swelling noted to 1st pin. Dsgs CDI @ pin sites. Limited ROM below ex-fix. (+) pulse (+) sensation. HR reg. Lungs CTA. Abd soft BS x4. Will cont to monitor b(6)-2 [redacted] Glenda
1300	pin care done. discussed swelling @ 1st pin [redacted] w/ MD. Thigh elevated. b(6)-2 [redacted]
17Aug03 1530	assumed care @ 1300 - VSS - sleeping until VS taken and no c/o pain - resp VS WNL (+2) cool, no drainage noted on dsg @ pin sites, leg elevated on blanket - PT has not been in to do crutch walking c pt. today [redacted] CRAW
17Aug03	VSS - Afeb x3 Pins to (D) leg clean and in place. swelling around pin sites noted. dsgs to pins dry and intact. Pearla 3mm Lungs CTA Resp even Reg. HR-NSR BS(+) x 4 q cards. Abd soft NT. Percocet 1 tab PO given for c/o pain. Restraints. toe and leg in place and secure. — SGT [redacted] b(6)-2 CCO

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b(6)-2
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

EPW # [redacted] b(6)-4

Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

Medical Record

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

MEDCOM - 16101

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Aug03 0430	Percocet tt po given for c/o @ leg pain e2330. Ø further c/o pain or discomfort. Resting quietly @ present. Restraints to UE and LE in place and secure. [redacted]
18 Aug03 0630	Pt. asleep in bed c c/o pain in (D) femur, tt percocet given. HR Regular, Lung sands clear bilat, bowel sands (+) x4 quads. Ext fix to (D) femur intact, pin site dsgs CDI, (+) sensation, pedal pulse palpable, ROM limited in digits, ankle & knee. Pt is ambulatory access. VSS. Pt c other complaints @ this time. Will continue to monitor. [redacted]
18 Aug03 1330	assumed care @ 1300 - VSS - Small amount of drainage from pin sites, neuro V's WNL in (D) foot - PT has not been in today to do crutch walking - no c/o pain at this time [redacted]
19 Aug 0130	Care assumed @ 2100. VSS, afeb, tt percocet given for pain @ 2200. Lungs CTA, pulses x4, bs+. Pins on lle intact, Ø drainage. Pt ambulated to br x1, taking PO ABX. Will continue to monitor. [redacted]
19 Aug03	0632 Assume pt care @ 0500. Awake and Alert. c/o pain @ 1st pin site to DLE ex-fix. percocet given VSS. HR reg. Lungs CTA. Abd soft BSx4. Amb c crutches and assistance. (D) LE ex-fix intact. dsgs to pins CDI. Swelling noted @ 1st pin - elevated leg so pin would not dig into bed. Will cont to monitor. [redacted]
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd Soft, non tender, Bowel Sounds active x4 quads. Ex fix to (D) femur intact, dsgs CDI. Strong Pulses and brisk

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03 (Cont)	Capsrefilled to bilat lower extremities. [redacted]
19Aug03 2300	Care assumed @2100. VSS, AOX3, 650mg Tylenol given for pain. Lungs CTA, pulses palpable x4, DSG+. LLE C ex-fix, ex-fix insertion sites intact. Pt able to ambulate C crutches, needs assistance getting in and / out of bed. Will continue to monitor. [redacted] b(6)-2
20August03 0730	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lungs clear bilat, bowel sounds (+) x4 quads. Pt S IV access. VSS. Ext fix to (R) femur intact, DSGs to pin insertion sites CDI, pedal pulse palpable, (+) sensation, full ROM of digits & ankle, limited ROM of knee, cap refill < 3sec. Pt. S complaint @ this time. Will continue to monitor. [redacted] CNA/AO
20AUG03	Ortho Staff. Pan xrays (R) femur ex fix clear/ely. X-Ray 18AUG03 c acceptable alignment. Needs ROM exercise of knee & crutch training. [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.)* [redacted] b(6)-1

REGISTER NO.

WARD NO. CW2

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 - 16103

b(6)-2411

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex-fix to (L) femur intact pin sites ⊼ S/S infections. Dsgs CDI. Strong pulses and brisk cap refill to bilat lower extremities. Ø complaints [redacted] c/p
20Aug 2230	Care assumed @ 2100. VSS, a+ox3, no c/o pain. Lungs CTA, pulses ⊕x4, bs active x4 quads. Ex fix on lle intact, Ø s/s infection. Patient on PO ABX, will continue to monitor [redacted] 9lwm6
21Aug03 0800	assumed care @ 0500 - VSS - no c/o pain @ this time - neurovs WNL in (R) foot, pin sites dsgs c/d/i scant drainage [redacted]
21AUG03	(1625) Pt admitted to unit via litter in stable condition. Pt A/O x3, speaking Arabic. Ex fix in place on (L) thigh. Pin care done this am. Pt moves (L) leg ⊼ difficulty. ⊕ pedal pulse. Cap refill <2secs. Pt medicated c Tylenol for pain in (L) leg [redacted] c good relief. ⊕ bm. Voiding ⊼ difficulty. lungs CTA ⊕. ⊕ bs x 4 quads. VSS. Will continue to monitor. [redacted] MA
21AUG03 2240	VSS. Alert. LSCVAB. (L) leg dressed. DSG's CDI. Intact = ⊕ pulses. BS ⊕x4. ⊖ c/o pain @ this time. Able to move x's on own. ⊕ swelling to (L) thigh. No c/o pain. [redacted]

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

MEDCOM - 16104

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22AUG03	1010		Assumed care of pt @ 0700 ☩ report from night shift. Pt alert, speaking Arabic. ✆ c/o pain. Ex Fix in place on ⓡ thigh. Pin care done. ✆ S/Sx infection @ pin sites. AM care done by pt. Pt moving UE's difficulty. ⊕ pedal pulses - equal bilat. Cap refill <2secs. Voiding ŝ difficulty. 2 point restraints in place. Pt resting quietly @ this time. Will continue to monitor. RZC b(6)-2 [redacted] (MAJ)
22AUG03 2000			VSS. AO. ~~PERRLA. LSCTAB. S1, S2. ⊕ Ex Fix pins CDI ŝ c/o pain on 3/5 of infusion. UE Elevated per route. BS ⊕ x4 and moving ŝ difficulty ŝ voluntarily PO well. ⊕ pulses in all extremities.~~ b(6)-2 [redacted]
22AUG03	0915		Assumed care of pt @ 0700 ☩ report from night shift. Pt alert, speaking Arabic. Pt medicated ĉ IV Perc this am for pain in ⓡ leg ĉ good relief. Ex fix in place. Pin care done this am. ✆ S/Sx infection at pin sites. VSS. Pt voiding ŝ difficulty. AM care done by pt. 2 point restraints in place. UE elevated on blankets. Monitoring [redacted] (MAJ) b(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

EPW # [redacted] b(6)-4

NURSING NOTES
Medical Record

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

MEDCOM - 16105

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 03 2100			VSS. Denies pain @ this time. PRN's to pain ctd. @ pulse @ LUE. Performed ROM and crutch walking. Resting comfortably in bed. b(6)-2 [redacted]
24 AUG 03	1115		Received pt after report in stable condition. VSS, alert, oriented x 4 and cooperative. Medicated w/ # percocet for pain, relief noted. PT in to see pt for ROM. PRN care done, small amt of pus noted @ upper pin sites. Pt communicated that he feels less swelling bigger and pain is increased @ upper pin sites. Will notify MD. Will cont to monitor [redacted]
24 AUG 03 2000			VSS. NO. Denies pain @ this time. Ambulated x1 b(6)-2 to restroom BSC x 1 difficulty. Tolerated PO well and played cards w self. Attempted the process of smoking to patient and pt understood via interpreter. Bed alarm system use. b(6)-2 [redacted]
25 AUG 03	1100		Received pt resting in bed. Remains VSS, c/o pain) medicated x1 # percocet. Medicated w MSO4 IV during PT session and pt and tray shift. NO remarkable assessment findings. PRN care done. Site looks improved since [redacted] Will cont to monitor

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

STANDARD FORM 510 (REV. 7-91) BACK

b(6)-1

MEDCOM - 16106

MEDICAL RECORD	PROGRESS NOTES
DATE 27 Aug 0800	VSS Alert & Oriented c/o pain @ 0700 noted 3/10 Tylenol given and effective Per Care done & drainage noted around pin sites. OOB ambulate c crutches to BR with supervision. Tolerate Reg diet. Restraints removed & reapplied. will check restraints & crutches/ neuro vascular to extremities frequently [redacted]
27 Aug @2115	Pt alox3, VSS, lungs CTA(B), (+)BSx4, HRRR, [redacted] b(6)-2 ex-fix intact. c/o pain 7 Percocet given & orders noted. Skin warm & slightly tender to touch. ∅ drainage noted @ pin sites. Wrist cap refill & good pulses. circulation assessed. 2 pt restraints on. Will cont to monitor [redacted] B.
@2300	I concur above assessment. [redacted]
28 Aug @0100	Pt c/o pain. 7 Percocet given & noted [redacted] b(6)-2 Will cont to monitor [redacted] 28 Aug 06
28 Aug 1003	VSS. Alert & Oriented. Percocet given for pain. Lungs clear. Abd soft [redacted] distended. BS(+) x4 quadrants. OOB ambulate c crutches to BR. Pin care done to (L) lower extremity ex fix. Rice applied to (L) lower extremity [redacted]

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO. b(6)-2

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16107

PROGRESS NOTES

DATE	
	b(6)-2 AH
25 Aug 03 @ 2000	Pt a/o x3, VSS, medicated for pain c percocet ii. ex fix intact. (L) LE elevated. (+) pulses & cap refill to extr. voiding = difficulty. Reflex given. will cont to mon — Rhonda Son B qwm6
26 Aug 26 Aug 1000	Pt sleeping c ϕ distress noted [redacted] B VSS A&O. Ambulated c crutches to BR with supervision. Pin care done. ϕ drainage noted around pins. (L) LE c ex fix intact. (L) LE pulses palpable. (+) toes c capillary refill ≤ 3 sec. Tolerating Regular diet. No pain or distress voiced or noted [redacted] SLTS
26 Aug 03 @ 1830	Pt a/o x3, VSS, c/o pain to (L) LE. area tender to touch & warm, pin sites c ϕ drainage. ii Percocet given for pain. (L) LE elevated. pulses palpable & equal, brisk cap refill. 2 point restraints on. circulation assessed at all extr. ϕ IV access. H2O @ BS within reach. Will cont to mon — [redacted] B qwm6
26 Aug @ 2300	Pt c/o pain at ex fix site ii Percocet Given Reflex Po given. ~~Will~~ X-ray consult done on forearm. Will cont to monitor — [redacted] B qCG
@ 0115 -	I concur c above assessment. [redacted]

b(6)-2

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

[redacted] b(6)-4

MEDCOM - 16108

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 Aug @ 1930	Rt A&Ox3, VSS, HRRR, lungs CTA Ⓑ, +BS x4 qds, + 2 pulses, circulation assessed good pedal pulses, brisk cap refill, ex-fix intact. Ø c/o pain @ this time. Abx given. 2 point restraints on. encouraging H2O intake. H2O @ BS within reach. Will cont to monitor- b(6) [redacted] B 91WM6
28 Aug 03 @ 2000	I concur c above assessment [redacted]
28 Aug 03 @ 2100	Rt c/o pain to Ⓡ thigh. IR Percocet given. c/o b/c b(6) pain relief. Will cont to monitor- b(6) [redacted] B 91WM6
29 AUG 03	(0915) Assumed care of pt @ above p report from night shift. Pt alert speaking Arabic. VSS. Pain controlled c Percs. Ex fix in place on LE. Pt able to move LE. +pedal pulses equal bilat. Cap refill <3 secs. Skin warm to touch. Pin care done this am. Voiding s difficulty. Tol reg diet well. AM care done this am by pt. 2 point restraints in place. - ϕ s/sx complication c circulation/skin breek. Will cont to monitor. b(6) [redacted] MD
29 AUG 03 1945	Pt asleep, ~~VSS~~ easily aroused, VSS, c/o mild pain on Ⓛ thigh, LS CTA Ⓑ, +BS x4, Ex fix in place, LLE elevated c blanket, +pedal pulses equal Ⓑ,

Continue on reverse side

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR 141 CFR)
USAPPC V1.00

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

b(2)-2

All

PROGRESS NOTES

DATE	
Cont.	Dsg (L) thigh CDI, (L) thigh swollen compared to (R), proper circulation + skin integrity on pts. of restraint. [redacted] qWMMo
2130	Pt had a BM soft + formed [redacted] qWMM
30AUG03 (0950)	Assumed care of pt @ 0000 & report from night shift. Pt alert, speaking Arabic. Pain controlled c Percs. VSS. Ex fix in place on (L) thigh. Pin care done this am. (L) thigh swollen compared to (R). Blanket roll under knee. (+) pedal pulses equal bilat. Cap refill <3secs. ~~wet → dry dsgs Δd on (L) thigh and [redacted] calf. ϕ S/Sx infection~~ error error. Voiding s difficulty. AM care done this am by pt. Tol. reg diet well. 2 point restraints in place. - ϕ S/Sx complications c circulation/skin breakdown. Will cont. to monitor. [redacted] WDAW
30AUG03 2000	Pt resting in bed, AtOx3, VSS, LS CTA (B), (+) BS x4, c/o some discomfort but refuses medication @ this time, Ex Fix in place on (L) thigh, (L) thigh elevated c blanket, swollen compared to (R) thigh, peripheral pulses palpable equal (B), proper circulation + skin integrity on pts of restraint. [redacted] qWMM
0445	Dsg Δ, pin care given. [redacted] qWMM

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

MEDCOM - 16110

b(6)-2 All

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)*
31 Aug 03 @ 2000	Received pt resting in bed, VSS, a&ox3. Amb c/ crutches. @ thigh w/ ex fix in place, dsgs intact, thigh swollen, but consistent w/ previous assessments. Amb w/ crutches + pt rec'd see pt. medicated x1 w/ IV percet. Sgns. & other remarkable assessments noted. Will cont to monitor. [redacted]
31 Aug 03 @ 2320	Assumed care @ 1900; VSS, pt A&Ox3, NV intact, ⊕ movement & sensation, Ex-fix in place dsgs CDI, thigh maintains edematous; up amb c crutches; medicated x1 c IV perc; cont to monitor. [redacted]
01 Sept 03 @ 1130	Received pt resting in bed, VSS. A+Ox3, @ thigh ex fix in place, cap refill good, ⊕ pedal pulse. Dsgs D/d, clean. Lower pin site looks better than upper pin site. Thigh cont to be swollen, amb x1 w/ crutches. medicated per MAR for pain. Will cont to monitor. [redacted]
1 Sep 03 1900	Pt resting in bed, A+Ox3, LS CTAB, ⊕ BS x4, Dsg's Ex Fix CDI, LLE elevated c blanket, c/o pain, medicated c IV percs, proper circulation + skin integrity on pts at restraint [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

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

MEDCOM - 16111

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Sept03 0500	VSS Alert + Oriented. AM Care done c BSB Ambulate c crutches c Physical therapist. Medicated c Percocets pain. Strength. Regular diet consumed for breakfast. Pain Care done. Voids clear yellow urine. Restraints removed and replaced. Skin under restraint intact. Will check restraints, skin integrity and circulation to extremities frequently. [redacted]
2 Sep 03 1830	A+O x3, VSS, LS CTA (B), (+) BS x4, c/o pain, medicated c 2 percocets, voiding c/y urine, Ex fix on LLE, dsg CDI LLE elevated c blanket, 2 pt. restraint, proper circulation + skin integrity. [redacted] 91WM PT
3 Sept 03 0800	VSS A+O. Temp Clear (B) BS+ x4. Ambulated upon ambulating to BR c crutches. Medicated with Percocet for pain. Voids clear yellow urine. L leg external fix pin sites without drainage. Pin care done. Peripheral pulses palpable +2. Restraints removed and replaced. Skin under restraint intact. Will check restraints, skin integrity and circulation to extremities frequently. [redacted]

b(6) - 2 A 11

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Sep 03 1915	Pt A x O x 3, VSS, LS CTA (B), (+) BS x 4, S1 S2 present, peripheral pulses +2, abd soft flat non tender, Ex fix LLE, (-) thigh elevated c blanket, pt ambulates c crutches, dsg CDI, Ø c/o pain @ this time, assessed for proper circulation & skin integrity on pts of restraint [redacted] q1WM6
1920	Pt had a BM this PM [redacted] q4WM6 b(6)-2
4 Sep 03 0500	VSS Alert & Oriented Medicated c Percocet for pain @ 0630. Medication was effective. Resps clear Bilat P, BS (+) x Quad. Consumed regular diet. Peripheral pulses +2. Assessment completed. Ex fix to (L) leg pin sites without drainage or swelling. Pin care done. Restraints removed and reapplied. Pt remained under restraints. Will check restraints, skin integrity b(6)-2 [redacted] and extremities circulation frequently
4 Sep 03 @ 2000	Assumed care @ 1800; VSS, pt A & O x 3 speaking only arabic; Ø c/o pain @ this time; S1, S2, (+) pulses x 4, LS CTA (B), (+) BS x 4, pt voiding QS, clear, yellow urine; BM x 1 this shift; Ex. Fix. to (L) leg in place (-) drng noted; pt amb to BR; restraints in place, circulation & skin integrity intact; will continue to monitor [redacted] S. [illegible] RN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b(6)-2
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

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

MEDCOM - 16113

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05SEP03	(1305) Assumed care of pt d) dooo p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt amb to BR c crutches s difficulty this am. @BM. Voiding s difficulty. Tol reg diet well. Ex fix in place on @ thigh. Pin care done this am. ϕ Sx infection d) pin sites. @ pedal pulse equal bilat. Cap refill <3 secs. ~~Warm~~ Skin warm to touch. Am care done by pt. 2-point restraints in place s Sx complications c circulation/skin breakdown. Will cont. to monitor. b(6)-2 [redacted] USAF
5Sep.03 1845	Pt sitting in bed, AtOx3, VSS, LS CTA(B), @BSx4 peripheral pulses palpable, ϕ c/o pain @ this time, Ex Fix LLE, dsgs CDI, voiding c/y urine, proper circulation + skin integrity on pts of restraint. [redacted] b(6)-2 9mm6
06SEP03	(0830) Assumed care of pt a) ϕ000 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Ex fix in place on @ thigh. Pin care done this am. ϕ Sx infection. @ thigh swollen compared to @. @ pedal pulse equal bilat. Skin warm to touch. Tol reg diet well. Voiding s difficulty. Am care done by pt. 2-point restraints in place s Sx complications of skin breakdown/circulation. Will cont. to monitor [redacted] USAF b(6)-2

b(6)-2 All

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)*
6 Sep 03 1900	Pt resting in bed, AtO x3, LS CtA (B), (+) BS x4, Si Sz present, VSS, pain controlled ≤ peres, (R) LE swollen compared to (L), Ex Fix in place, thigh elevated, dsg's CDI, peripheral pulses +2, voiding c/y urine, assessed for proper circulation + skin integrity on pts of restraint. [redacted] 9/WM
2000 7 Sep 03 0001	Pt had a BM this PM [redacted] 9/WM Received pt in stable condition. VSS, AtOx3, LS CTAB, HRR, ABD SNT, NSB, pulses equal + strong. (L) thigh ex fix in place, pin care done LLE w/ pulse intact + good capillary. Amb x1 w/ crutches and safety present. DTS, reduce pn mar. Will cont to monitor [redacted]
7 Sep 03 0 1900	Assumed care @ 1800; pt A+Ox3 speaking only [redacted]; (+) movement & sensation UU intact; Ex-fix in place, (+) drainage noted; Si Sz (+) pulses / LS ctA (B); BS x4; pt voiding QS, clear, yellow urine; BM x2 this shift; pt up amb 5 difficulty; 2 point restraints in place, circulation & skin integrity intact; cont to monitor [redacted]

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.)* [redacted] b(6)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 16115

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
08Sep03 1555	Received pt resting on bed, VSS, A+OX3. (L) thigh remains swollen, Ex fix intact. Pin care done w betadine addition for infection prevention per suggestion of husband and nurse, MAS Melton. Amb x 2, BM x 2. SUGS, ∅ c/o burning on urination. No other remarkable assessments. [redacted]
8sep03@1845	Assumed care @1800; VSS; pt A+OX3; Ex-fix in place; (L) Leg remains edematous dsg CDI; ↑amb c crutch assistance x 2; ✓BM; pt voiding QS; ∅ c/o pain @ this time; 2- pt restraints in place; ~~4th~~ circ & skin integrity intact; cont to monitor [redacted]
9 Sept 1200hr	VSS. Alert & Oriented. Lungs clear. BSD x4 quad. abdomen soft non distended. Peripheral pulses palpable. Voiding clear yellow urine. c/o pain during pin care. Percocet given and effective. Ambulated c crutches to BR. Restraints removed and replaced. Skin intact under restraints. Will continue to monitor [redacted] CTR
9 Sep 03 1855	Pt sitting in bed, A+OX3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, abd soft flat non-tender, Ex Fix LLE, ext. elevated dsgs CDI, voiding c/y urine, ∅ c/o pain @ this time, ∅ skin breakdown + proper circulation on pts of restraint. [redacted] 9Sep03
	b(4)-2 All

b(6)-2 All

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)*
10Sept03 0800	VSS A&O Lungs clear. BS@ x4 quad. Perineal pulses palpable+2. Pen care done. OOB c crutches ambulates to BR. Restraints removed & reapplied after under utmost intent. Percocet given for pain [redacted]
10 Sep 03 1900	Pt sitting in bed, AtOx3, VSS, OOB to ambulate ES CTA B, @ BS x4, Ex Fix LLE, dsgs CDI, @ c/o pain @ this time, voiding c/y urine, circulation + skin integrity assessed on pts of restraint. [redacted]
11Sept03 0800	VSS AtO x3. Lungs clear B Abd soft nondist BM x1 this Am. Tolerating Regular diet. Perineal pulses palpable+2. Pen care completed. Ambulates to BR c crutches. Voiding clear yellow urine. Restraints removed & ~~re-po~~ reapplied after intact under utmost [redacted]
11Sep03	1200 Physical Therapy done. Pt c/o pain 10/10 p therapy. Percocet 1 tab po given [redacted]
11Sep03	No Repeat @ Femur Series done
11Sep03@2000	Assumed care @ 1800; VSS; pt A&Ox3, @ movement & sensation x4, strong pulses x4; NV intact; Ex-fix in place, leg remains edematous; @ drainage @ pin site; dsg CDI

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

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

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

MEDCOM - 16117

b(6)-2 ALL

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	& C/O pain or discomfort @ this time; pt voiding QS, c/y urine; restraints in place; skin integrity & circ. intact; cont to monitor — [redacted]
12 Sep 03 0700 -	Assumed care of pt. A+O x3, VSS External fixator to (L) extremity. xrays @ BS. c/o pain scheduled motrin administered. Lungs CTA HRRR swelling to (L) extremity. Active BS Tolerating PO well. Pin care this AM - Will cont to monitor — [redacted]
12 Sep 03 1915	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, Ø C/O pain, Ex Fix on LLE, dsg's CDI, (L) ~~toe~~ thigh swollen compared to (R), elevated, pt ambulates ± crutches, voiding c/y urine, proper circulation + skin integrity on pts of restraint. — [redacted] 91WM6
13 Sep 03 0700	- Assumed care of pt. awake A+O x3 VSS. Lungs CTA HRRR S1 S2 present: c/o pain to (L) LE medicated ± scheduled motrin for relief. Active BS x 4 Encourage to ambulate vrical from BS. External ficator to LLE pin care this AM minimal bleeding to sites of pins, Will cont to monitor — [redacted] WMG. (16SD) I concur ± above assessment. [redacted]
13 Sep. 03 2000	Pt recieved from OR, VSS, BP-114/54, T-98°, P-91, O2-98%, R-20, cast to LLE CDI, medicated for pain ± 11 percocet as per orders, LS CTA (B), (+) BSx4 pt to PO well, IV (L) FA HL, flushes well Ø sbx of infex, proper circulation + skin integrity on pts of restraint. — [redacted] 91WM

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 16118

(b)(6)-2 A1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Sep '13 0700	- Assumed care of pt. A+O x3. VSS S/P cast placement to LLE from hip to toes. good circulation AEB toes being warm to touch brisk capillary refill and able to wiggle toes. C/O pain scheduled motrin 800mg administer for relief will cont to monitor [redacted]
15Sep03@0015	Assumed care @ 1800; A&O x3, VSS; pt A+O x3, C/O pain, medicated ± perc x1 ~ good relief; ⊕ CMS, ~~all intact~~ x4; NV intact throughout; brisk cap Ref; cast intact; 2 point restraints in place; ⊕ circulation ⊕ skin break ↓; cont to monitor [redacted] pt amb x1 to BR, BM x1 this shift [redacted] 9 Numb
15SEP03 (0900)	Assumed care of pt @ 0900 ~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ~ Percs. LE in cast. Pt able to move toes. Cap Refill <3 secs. Pt amb ~ crutches ~ difficulty. Tol. reg diet well. Voiding ~ difficulty. ⊕ BM. SL in ⊕ arm flushes well ~ S/Sx infection/ infiltration. 2-point restraints in place ~ S/Sx complications. Will cont. to monitor. [redacted] WAW
15 Sep 03 1900	Pt sitting in bed, VSS, A+Ox3, cast to LLE intact, pain controlled ~ percs, LS CTA(B), ⊕ BS x4, pt ambulates ~ crutches, voiding ~ difficulty, proper circulation + skin integrity on pts of restraint. [redacted] 9 Numb

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST
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

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

MEDCOM - 16119

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16SEP03	(1215) Assumed care of pt @ bedside w report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled w Percs/IV morphine. LLE in cast - CDI. Pt amb. w crutches w difficulty. Pt able to move toes on LLE. Cap refill <3secs. Pt tol. reg diet well. Voiding w difficulty. Abdm. soft, non-tender. 2-point restraints in place w/ no complications. Will cont. to monitor. Awaiting trans. to EPW camp. [redacted] b(6)-2 USAF
16 Sep 03	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, cast on LLE, ambulates w crutches, ∅ c/o pain of pain @ this time, pt moves toes on LLE, cap ref <3sec, proper circulation + skin integrity on pts of restraint. [redacted] b(6)-2 USMC

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

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

558-104 b(2)-2 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER [redacted]
RECORDS MAIN [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: CPW
CITY | STATE | ZIP CODE

ARRIVAL
DATE (Day, Month, Year): 10 Aug 03 | TIME: 1241
TRANSPORTATION TO FACILITY

SEX: M
AGE: 34

DUTY/LOCAL PHONE		HOME PHONE	
AREA CODE	NUMBER	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: Cephalexin
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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT
☐ EMERGENT
☒ URGENT
☐ NON-URGENT b(6)-2
TIME: 1240
INITIALS: [redacted]

VITAL SIGNS

TIME	1240	1314				
BP	147/77	124/75				
PULSE	138	118				
RESP	18	18				
TEMP	999	98.6				
WT						

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: Met 6
BLOOD C&S X			Type & Screen

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
BID x 5 Tetanus Dtd		[redacted]	b(6)-2		
And Tylenol PO					
MSSU Early Admit PO			1310		

DISPOSITION: ☐ HOME ☐ FULL DUTY
DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS
MODIFIED DUTY UNTIL
RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
ADMIT TO UNIT/SERVICE
TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.
PATIENT'S SIGNATURE

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

[redacted] b(6)-4

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)

MEDCOM - 16121

b(6)-2

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

TEST RESULTS

CBC	SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC		SUP 02	PH	PO2	RESULTS	
H/H		PCO2	SAT	OTHER		
PLT						
PT		U/A DIP			EKG INTERPRETATION	
APTT	BHCG / ETOH / GLU	MICRO				

PROVIDER HISTORY/PHYSICAL

34 yo ♂ states he was shot in his knee x 2 days ago. PP +1. good sensation. VSS.

Pulses NC

⊕ to 66

NKDA

See MD note H&P

Abd soft NT

Chest CTAB

Warm & dry

Stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNA [redacted]

b(6)-2

PROVIDER SIGNATURE AND S [redacted]

DIAGNOSIS

(L) femur fx

CODES

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

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)

MEDCOM - 16122

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Ortho b(6)-2 [redacted] DATE OF REQUEST 7/03/03

REASON FOR REQUEST *(Complaints and findings)*

6 weeks ago wound fracture ~~[redacted]~~ femur

PROVISIONAL DIAGNOSIS

fracture ~~[redacted]~~ Femur

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted] 6/12		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO b(6)-2 PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE		DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*

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

EPW

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 16123

VA 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: 34

HEIGHT:

WEIGHT: unknown

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

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
(L) femur Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco 2 ppd X___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) 1 bottle Q.D. 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	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures. (e.g., warm blanket, touch). Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø 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	Ø Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress. Ø 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	Ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø 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)-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: Ø

6. PATIENT PROBLEMS AND NEEDS	.. PATIENT GOALS AND EXPECTED OUTCOMES	... OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ 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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier - Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ 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/N blw-2 7 Aug 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)
Ex Fix (L) Femur

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] RN blw-2
DATE: 7 Aug 03 TIME: 1350

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/N
DATE: 7 Aug 03 TIME: 1515 blw-2

REVERSE OF FORM 3179, JUN 91 MEDCOM - 16125 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: Litter BY Anesthesia
2. PATIENT IDENTIFIED, RECORDS REVIEWED AND PROCEDURE VERIFIED BY LT [redacted] b(6)-2
3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 1405
4. PATIENT IN ROOM TIME 1405 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] LT [redacted] (out @ 1440)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: proper body alignment maintained, arms at less than 90° on padded armboards, all pressure areas padded, position approved by surgeon + anesthe

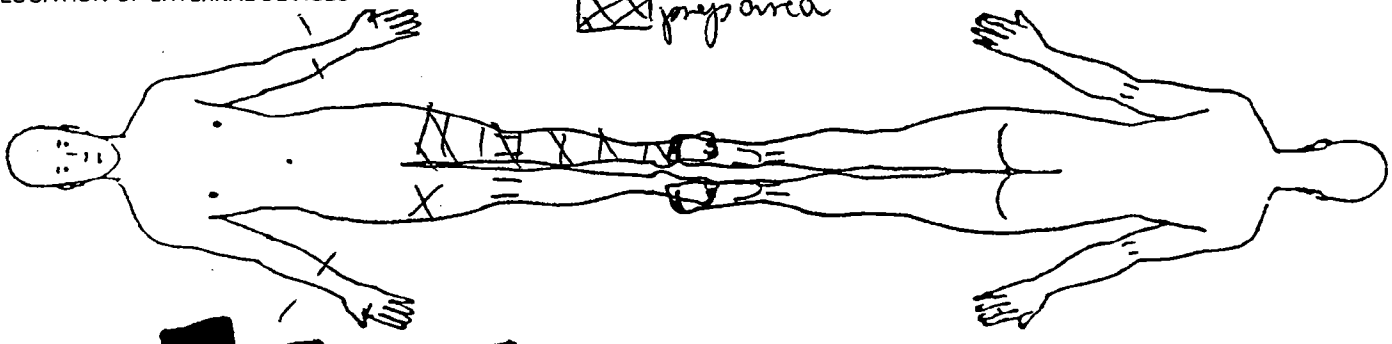
8. SKIN PREPARATION

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

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP Left thigh
COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine / Betadine [redacted]
SITE: Left Leg BY WHOM [redacted]
SITE: BY WHOM:
COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet (NIA)

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] blue

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

switch not used

☒ ESU NO: #3
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 16126 WHICH IS OBSOLETE. USAPA V1.01

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

5018-6-180 X 4
4920-2-140 X 4
4920-2-020 X 2
4920-1-010 X 4
Carbon Rods x 2
Hoffman II
Lot # 0621303

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 - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

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)*
Fluffs
Kerlix
Acewrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]

b(4)-2 KIL

- DA 5179 Initiated

20. OPERATION(S) PERFORMED
Ex-fix (L) femur

21. PATIENT TRANSFERRED TO ICU 2 TIME 1538 DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] AU [redacted] RN

REVERSE OF DA FORM 5179-1, OCT [redacted] MEDCOM - 16127 USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 13 Sept 03 TIME PATIENT ARRIVED IN SUITE 1710

4. PATIENT IN ROOM TIME 1710 NUMBER 6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1700-1720)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

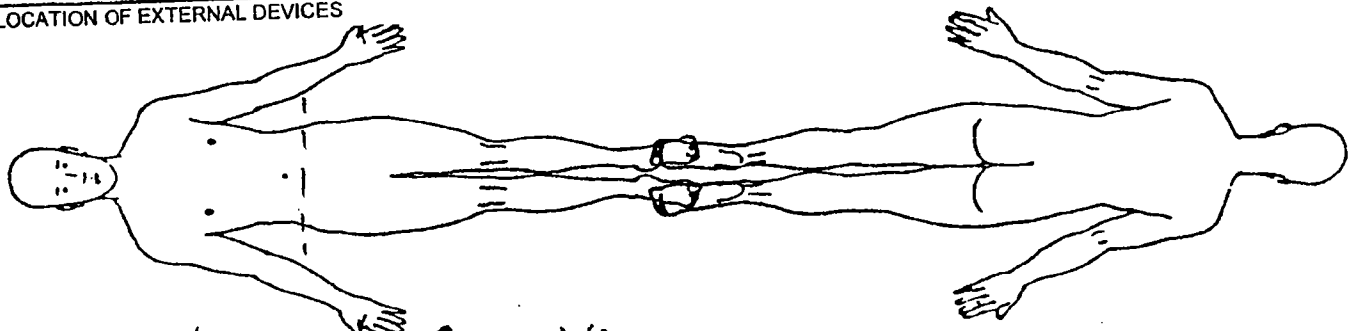
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) N/A BY WHOM:
SITE: BY WHOM:
SITE:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap [redacted] === Tourniquet N/A

10. COUNTS (C = Correct I = Incorrect)

		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;)

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

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

☐ ESU NO:
GROUND PAD: BRAND N/A
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 16128

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
N/A					

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Stockinette
Webril
[redacted] Sp Cast

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA

Bovie Pad site intact pre-op N/A, post-op_____ Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op N/A: post-op_____
Tourniquet Time: Up____ Down N/A

-5179 on chart, Ø Δ's noted

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU b(6)-2	DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT USN

MEDCOM - 16129

REVERSE OF DA FORM 3751, OCT 87 USAPA V1.01

511–119 NSN 7540–

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug DAY

19 2003 HOUR

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)*

REGISTER NO.

WARD NO. 2W2

FPW Blood

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95) Prescribed by DA DA PAM 201-9, 202-1

MEDCOM - 16130

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 8 | 9

POST- DAY

MONTH-YEAR: 10/2003 | DAY: 14 | 15 | 16 | 17 | 18 | 19 | 20

HOUR

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° / 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)

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)*

EPW [redacted] b(c)-4

REGISTER NO.

WARD NO. ICU2

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

MEDCOM - 16131

511–119 NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: B 1 2 3 4 5 6

POST- DAY

MONTH Aug DAY: 21 22 Aug 03 23 Aug 03 24 Aug 25 Aug 26

HOUR

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: 104/72 | 108/61 | 108/60 | 101/53 | 121/68 | 99/59 | 109/53 | 101/57 | P75 | 102/68 | 106/59

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)*

EPW [redacted] 6(6)-4

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16132

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

27 Aug

1030

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)

99
53

RESPIRATION RECORD

BLOOD PRESSURE

976
984
98

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.

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

MEDCOM - 16133

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 2 Sept | 2 Sept | 3 Sept

19 | HOUR: 0700 | 19 | 0 | 18

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: 107/100 | 99/58 | 107/58 | 107/58 | 97/57

79 | 88 | | | 80

97.3 | 99 | | | 97

HEIGHT: | WEIGHT →

R-16 | 97% | 97% | |

98% | | | |

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

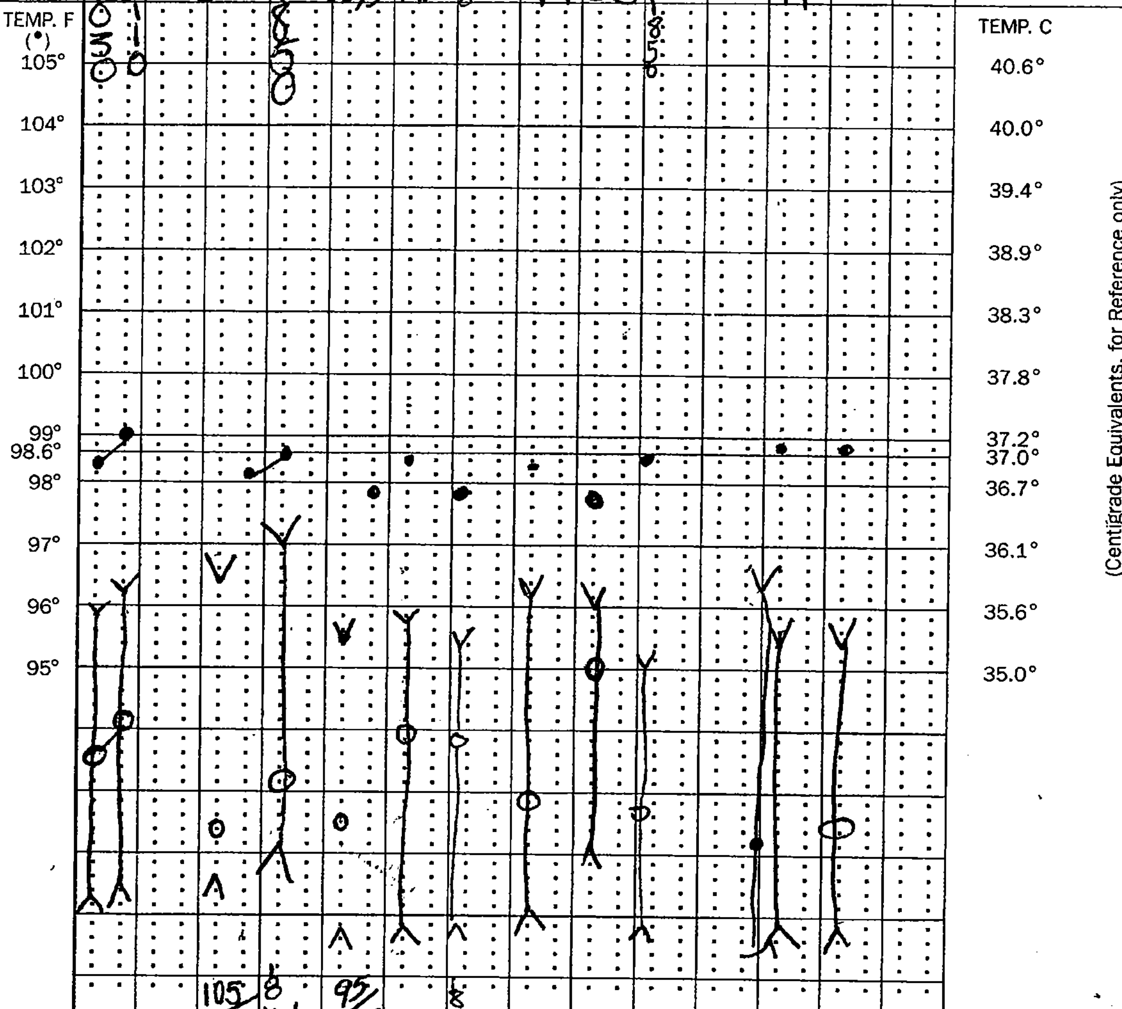
MEDCOM - 16134

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY						
POST- DAY						
MONTH-YEAR / DAY	27 Aug	28 Aug	29 Aug	30AUG03	31 AUG	1 SEPT
19 / HOUR	1 2	0900	0845 1900	8 19	0800	19

PULSE (O) — TEMP. F (•) — TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

105/56 110/62 95/47 8

BLOOD PRESSURE: 99/53 103/56 P 64 T 98.2 P 65 T 97.9 97/47 79 98.4 94/48 107/51 69 98.3 24 101/60 90 97.8 91/48 116/48 62 97.5 94/48 63 98.8

HEIGHT: WEIGHT →

(O2 sat) 98% 98% 98%(RA) 98% 98% 98%

98% 98% 98% 98% 99%

98%

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**

epvt [redacted] b(6)-4

MEDCOM - 16135

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 12 Sep 03 | 13 Sep 03 | 14 Sept | 15 Sep 03 | 16 Sep 03 | 17 Sep

DAY

19 HOUR: 0700 | 1800 | 0700 | 1715 | 1935 | 0800 | 0800 | 1800

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: 18 | 20 | 107/56 | 18 | 18 | 16

BLOOD PRESSURE: 111/60 | 94/58 | 106/50 | 080 | 107/59 | 109/65 | 108/63 | 124/68 | 101/49

P 66 | 82 | 67 | | | | | 100 | 88

T 98 | 98.6 | T 97 | T 97.6 | | | | 98.4 | 97.1 (98)

HEIGHT: | WEIGHT → 180lb

RA 97% | 98% 97% on RA | 98% (RA) | 99%

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.

[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

MEDCOM - 16136

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 4 Sept

MONTH-YEAR: 0720 | DAY: 05Sep03 | 06Sep03 | 07Sept | 9 Sept 03 | 10 Sept | 11 Sep

19 | HOUR: 0800 | 1800 | 0800 | 1800 | 0800 | 1800 | 0800 | 1800 | 0800 | 1800 | 0800 | 1800

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° / 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)

RESPIRATION RECORD

BLOOD PRESSURE

102/59	124/63	103/60	109/57	112/61	104/51	100/63	100/63		114/62	118/56	119/65	114/54
99	101/68	86		102	101/55	T97.7	T97.7			86	102/56	91
97.8		98		98		H78	H78			99		98
97%RA												
96-16	98/RA	96%	96/RA	97%	98/RA		98%		CA%	99%	98%	98%
96%RA					96%RA						98%RA	

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)*

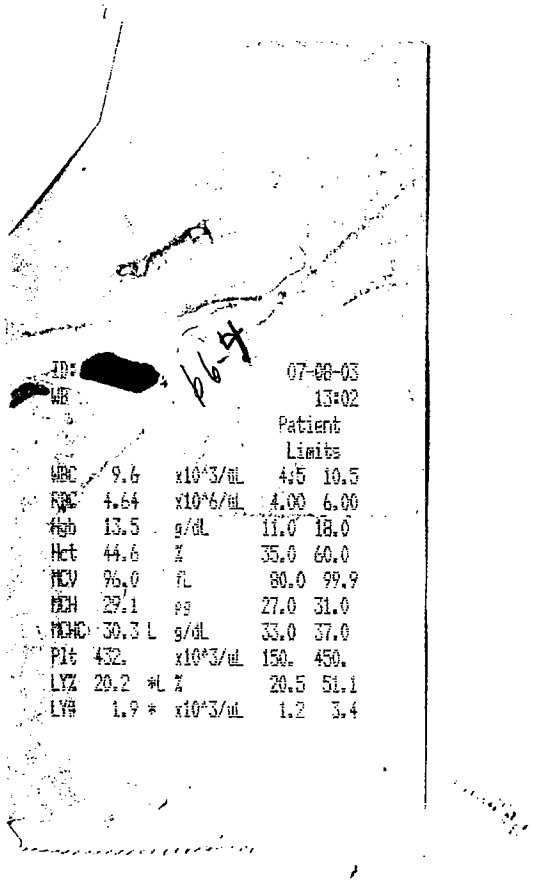
[redacted] b(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 16137



ID: [redacted] 07-08-03
WB 13:02

			Patient Limits	
WBC	9.6	x10^3/uL	4.5	10.5
RBC	4.64	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	44.6	%	35.0	60.0
MCV	96.0	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	432.	x10^3/uL	150.	450.
LY%	20.2 *L	%	20.5	51.1
LY#	1.9 *	x10^3/uL	1.2	3.4

b(6)-2

Ward/Section: EMT | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-4 | DATE: 7 Aug 03 | TIME: 1252 | 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
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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
07/08/03 13:06
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100494

GLU	105	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	206	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(Piccolo) [illegible] Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
TP		6.4-8.1 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted] | DATE: 7Aug03 | LAB ID NO.:

MEDICAL RECORD - ANESTHE[illegible]

For [illegible] of this form, see AR 40-66; the proponent [illegible]ncy is the OTSG

Zofran 4 mg 12

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)		
Propofol	(mg)	150	error 100 mg
Fentanyl	(ucg)	150	100
Versed	(mg)	2/2/1	
Lidocaine	(mg)	100	
Succinylcholine	(mg)	100	
MSO4	(mg)		
VOLAT AGENT 1.50	% del		10/10
	% e.t.	1.5/1.0/1.0/1.5/1.25/X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8/3/3/3/3/3/8	

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

FLUIDS

LINE site		
18g (R) AC	☐ Warmed	② LR 1000
	☐ Warmed	① LR 300 (500) ③ 200
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS

1 2 3 4 5 (E)

BODY WEIGHT

70 (KG) LB

HEMATOCRIT

44.6

INITIAL DATA

BP- 121/67

HR- 113

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1407

TIME

1415 1430 X 1500 X

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	730	410	270	340
f - breaths/min	10	6	7	4
Peak inf pres / PEEP	16	20	/	/
MODE - S(pon), A(assist), C(on)	S-C	A	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	49	56	59
BP/oth	✓ FIO2 (Frac or %)	.80	.90	.90	.90
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST
Gas analyzer	✓ TEMP-site SKIN	34.5	34.5	34.5	34.5
	✓ N-M Block (T/4)	4/4	4/4	4/4	
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0

TOTALS	TOTAL EBL
250	MIN
5	TOTAL URINE
20	0

FLUIDS SUMMARY

CRYSTALLOID- 800

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1348 PT ID, FORM 2400 COMPLETE

1405 Rm. O2, MOA. ON

1408 RSI/C

1510 PT RTC - 1 EET.

1516 RPT TO SGT GROVES (CHZ.

RECOVERY AT 1516

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- 8 SpO2- 98

BP- 97/44 HR- 114

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1348	1405	1523
PROC	Ready	Begin	End
	1413	1440	1510

PROCEDURES and CPT Codes:

EX FIX (L) FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

#[redacted]

b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI/C, BLAD/ E3MIL, grade I view, #8.0 ETT TO 22cm @ LIP. @ETCO2, @BBS Tube SECURED ETAPE, 49 OA in, eyes taped - TOTS

SURGEONS:

[redacted] b(6)-2

[redacted] CRNA

PROCEDURE LOCATION: 2

DATE: 7 AUG 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDCOM - 16140

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 34 **DAYS MOS YRS** **Sex** (M) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: EX FIX (L) FEMUR
SURGICAL SERVICE: ORTHO
NPO SINCE: _____

ASA Physical State 1 (2) 3 4 5 (E)
WT: 70 **KG/LB** **HT:** 69 **IN.**
ALLERGIES: NKDA

HABITS:
TOBACCO: (-)
ETOH: /
DRUGS: /

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef (1300)
( ) Unasyn (1300)
( ) Cephalexin
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:

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

13.5 / 432
9.6 / 44.6

122	101	6	105
4.3	21	.6	

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 124/72 **HR** 118 **R** 18 **T** 98.6
Pain Scale 0-10 _____
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2.5 FB / FROM
Oropharnyx MPI
Nares patent
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 18g (R) AC
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since midnight

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/[redacted] understand and agrees. Questions answered.
Signed: [redacted] CRNA **Date:** 7 AUG 03 **Time:** 1350 **Hrs**

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } **NO APPARENT ANESTHETIC COMPLICATIONS** { } **OTHER**
b(6)-2

Signed: _____ **Date:** _____ **Time:** _____ **Hrs**

Patient Identification: (Ward) _____

[redacted]
b(6)-4

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

DRUGS	(Units)	
FENTANYL	(mcg)	100, 50 (50)
PROPOFOL	(mg)	150
6IVX	(mg)	100
Nitroglycerine	(mcg)	< 300 >
	( )	
	( )	
VOLAT AGENT	% del	2.0 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 1

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS – MG / MCG / ML, + I"=CONSTANT INFUSION

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

TOTALS	TOTAL OUT
250	∅
	TOTAL URINE
	∅

FLUIDS – SUMMARY

CRYSTALLOID – 800

COLLOID – ∅

BLOOD – ∅

LINE site		
LR 18g (C) AC	☐ Warmed	500
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

REMARKS – *Code drugs with numbers, events with letters*

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 114 / 60; HR – 96

COMP CHECK: OK? – (Y) N

EXPERT SYSTEMS: OK for PROCEDURE? yes; TIME – 1720

TIME → 1715 30 • 1800 • 30 • 1900 • 30 • 2000

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	600	470	22
f – breaths/min	11	16	16
Peak inf pres / PEEP	18	17	
MODE – S(pon), A(ssist), C(on)	6/C	C	S
ET CO2 (torr)	31	41	36
FIO2 (Frac or %)	.85	.83	.77
SpO2 (%)	100	100	100
ECG	SR	SR	SR
TEMP- site	AVAC, BLR		
N-M Block (T/4)			

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

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

RECOVERY AT 1605

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP – 16 SpO2 – 99

BP – 125/63 HR – 128

	Start	Room	End
ANES	1700	1715	1600
PROC	Ready	Begin	End
	1725	1727	1600

PROCEDURES and CPT Codes: I2X-F:x Removal / Coating of (L) Leg

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* PRE-OP 5min 100%O2, Induction, NLT mi 2, Grade I view, 8.0 ETT Placed 22cm @ lip (R)BBS (B)ET CO2

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

#[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIST: STA[redacted] PT, AM, CRNA

PROCEDURE LOCATION

DATE 13 SEP 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 16142

*U.S. GPO: 2002-729-180/40137

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Repeat O femur series (not mobile)		JCW 1	
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (P[redacted] Dr		TELEPHONE/PAGE NO.
	SIGNATURE [redacted] b(6)-2		DATE REQUESTED 11 Sept 03

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

ones 9 Sept wcs too dark

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
[redacted] b(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION
ORT
MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 16143

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)-4

NURSING UNIT: TLW 2 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	7 AUG 03	1515 HOURS	
1	TO ICW-2.		
2	S/P EXT. FIX (L) FEMUR		
3	CONDITION: FAIR		
4	VS- ROUTINE		
5	UP AD LIB WITH CRUTCHES PRN		
	EPW ROUTINE		
6	CRUTCH WALK WITH PT HOURS WBAT		
7	REGULAR DIET		
8	IV - LR AT 125 CC/HR, HEP LOCK		
	WHEN TAKING PO WELL		
9	ATIVAN 1 MG P.O. Q 6 HRS X 48 HRS		
	PRN 1 MG P.O. Q 2 HRS X 24 HRS,		
	PRN 1 MG P.O Q DAY X 2 DAYS		
10	TYLENOL 650 MG P.O. Q 4 HRS PRN		
11	PERCOCET, 1-2 P.O. Q 4-6 HOURS PRN		
12	MSO4, 2-6 MG IV/IM Q 2 HRS PRN		
13	PIV CARE DAILY.		

[redacted]

b(6). 2

	DATE OF ORDER	TIME OF ORDER	
	7 Aug 03	1640 HOURS	
1	Place foley cath now		
	V.O. DR [redacted]		

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 7[illegible], WHICH MAY BE USED.

☆ U.S. GOV MEDCOM - 16144 10

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2NOV 03 1520	Ortho Op Note Pre-Op Dx - (L) femur fracture Post-Op Dx - Same Procedure: Closed red of fx, IM nail (L) femur Surgeon: [redacted] bb-2 CRNA: N/A Blood: Findings: Early callus on C-arm, ends moving together, minimal fracture motion. PLAN: Ext blk x 3-4 weeks. PT, WBAT, cruches b(6)-2 [redacted] ESR m

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.)* [redacted] b(6)-4		REGISTER NO.	WARD NO.

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

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] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW#2	24 W/S	0120

DATE OF ORDER 8Aug TIME OF ORDER 0820 HOURS — LIST TIME ORDER NOTED AND SIGN

Amcef 1gm IV q 8hrs x 3 days — Noted Sent

V.O. Dr. [redacted] (CA [redacted]

b(6)-2 All

9 Aug 03 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		9

DATE OF ORDER 10 Aug 03 TIME OF ORDER HOURS

1. Debrox 5 drops (L) ear BID x 2 days

2. Amalgan ℞ QID PRN ear pain — noted 1630

major [redacted]

DATE [redacted] ORDER [redacted] 2330

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		9

DATE OF ORDER 11 Aug 03 TIME OF ORDER 0226 HOURS

V.O.

Maalox 2-4 tablet PO x 1 now — 11 Aug 03 0226

D/C [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
038		

DATE OF ORDER 11 Aug 03 TIME OF ORDER 0830 HOURS

V.O.

D/C Foley NOW from Dr. [redacted] — Urotest [redacted] WMF 11 Aug 0935

240 W/S [redacted] 10 mg/AN 8-11 @ 2300

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

☆ U.S. GOV MEDCOM - 16146 10

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] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24 VS	2200	13 Aug 03

DATE OF ORDER 13 Aug TIME OF ORDER 2200 HOURS

VO from Dr. [redacted] to SPC [redacted]

D/C heplock

b(6)-2

LIST TIME ORDER NOTED AND SIGN

[redacted] 2200 13 Aug 03

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU2		9

DATE OF ORDER 8/15/03 TIME OF ORDER 1200 HOURS

Keflex 500mg po QID

[redacted] b(6)-2

NOTED

15 Aug 03 1140

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24 VS	015	21 Aug 03

DATE OF ORDER [redacted] TIME OF ORDER 8/15/03 2327 HOURS

8/25/01

× 1200 [redacted] PO mg, BID & 2PM

IN AM

[redacted] b(6)-2

noted 26 Aug 1830

PATIENT IDENTIFICATION

038

NURSING UNIT	ROOM NO.	BED NO.
24 VS	0345	29 Aug 03

DATE OF ORDER 29 Aug 03 TIME OF ORDER 2030 HOURS

V.O. Dr. [redacted] 2100 [redacted]

Dulcolax supp ÷ x 1 OR fleets enema for constipation - [redacted] b(6)-2

RD 29 Aug 03

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

☆ U.S. GOV MEDCOM - 16147 10

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]				3 SEP 03	1945 HOURS	
NURSING UNIT	ROOM NO.	BED NO.		(1) DIC KEFLEX V.O. DR [redacted] b(6)-2		
2W [redacted]						

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			4 SEP 03	1625 HOURS	
NURSING UNIT	ROOM NO.	BED NO.	(2) AP + LAT (2) BLOOD X 1 NOW		
			[redacted]		
			24° CHANGE 4 SEP 03 1915 RD HT/AN		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]			4 SEP 03	1625 HOURS	
NURSING UNIT	ROOM NO.	BED NO.	(2) BP + LAT (2) BLOOD X 1 NOW		
2W/2NO ASSIGNED		16	(2) NEPHROCAPS 500 MG PO BID		
			[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]			10 Sep 03	1730 HOURS	
NURSING UNIT	ROOM NO.	BED NO.	D Naprosyn to Motrin 800 mg PO TID VO Dr Oliverio [redacted] b(6)-2		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]				10 SEP 03	1630 HOURS	
			1	NSPECT @ BEDSIDE SCHEDULE ONE THERAPY WEEK TOD WORK		
NURSING UNIT	ROOM NO.	BED NO.				
2W	2100	10				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]				15 SEP 03	1645 HOURS	
			A	DISCHARGE TO PRISON CAMP TOMORROW		
			2	MOTRIN 800 mg PO PRN.		
			3	SHOWERS		
			4	RETURN IN 6 WEEKS FOR CAST, X-RAYS PRN		
NURSING UNIT	ROOM NO.	BED NO.				
ICU	[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 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 SEP 03 TIME OF ORDER 1758 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ROUTINE POST OP ORDERS
2. IV LR @ 125 cc/hr. KVO LOCK WHEN TOLERATING PO
3. REGULAR DIET
4. D/C FOLEY, TYLENOL 650 mg PO Q 8 hrs x 3 doses THEN D/C IV

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

5. ROUTINE POST OP ORDERS

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT 24 | ROOM NO. 1665 | BED NO. 03 (2002)

DATE OF ORDER 13Sep03 @ TIME OF ORDER 1645 HOURS

1) MSO4 2mg IV Q3-5min max dose of 10mg.

V.O. CRNA [redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 Sep 03 1800	Post Op Note Pre Op Dx: (1) L. femur fracture with x-ray Post Op Dx: same Procedure: (1) removal of ex-fix (2) femur (2) Application of long leg cast Surgeon: [redacted] b6-2 EBL - 0 Findings - fracture site stable, No evidence infection at pin sites Wounds irrigated. Plan: To OPW ward Tuesday Hospital [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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 Sept 03 1650	Ortho Discharge - 28th CSH Patient brought to [redacted] 62-2 on 7 Nov 03, after GSW to (L) femur 26 days previously. External fixator applied 7 Nov 03. Pod early gaiter at the time, alignment unable to be improved. Clinically shown slowly progressive healing by radiographs. On 13 Sept 03 the femoral K-pin was removed. No gross motion at fracture site. Pin sites clean. Long leg cast applied PLSU! Discharge to GPW Comp. Crutches, Cast Weight bear as tolerated, Motrin 800 mg TID prn #40. Follow ups at 28th CSH in 6 weeks for cast removal and radiographs if still a prisoner.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST b(6)-2 | SPONSOR'S ID NUMBER (SSN or Other) [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REC[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. [redacted] | WARD NO. ICU #1

#[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 08 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													
[redacted]	Percocet 1-2 tabs PO Q4-6hr PRN	D/T	4Sep 0630	4Sep 1347	4Sep 1740	4Sep 2226	5Sep 1025	5Sep 1445	5Sep 2245	6Sep 0330	6Sep 0955	6Sep 1350	6Sep 1830	10Sep 2245	7Sep 0621
		D/I	[redacted]												
[redacted]	Tylenol 650mg PO Q4-6hr PRN	D/T	5Sep 0420	5Sep 1805											
		D/I	[redacted]												
[redacted]	Amalgen 1 tab QID														
	PRN for pain														
[redacted]	Percocet 1-2 tabs	D/T	7Sep 2240	8Sep 0600	8Sep 1643	8Sep 2215	9Sep 0445	9Sep 1030	10Sep 0705	10Sep 0416	10Sep 1900	10Sep 1635	10Sep 2035	11Sep 0055	11Sep 0700
	PO Q4-6 hrs PRN	D/I	[redacted]												
	b(6)-2 All	D/T	11Sep 2200	11Sep 1600	11Sep 2236	12Sep 1000	12Sep 1700	12Sep 2100	13Sep 0935	13Sep 1245	13Sep 2000	14Sep 0534	14Sep 0926	14Sep 2020	15Sep 0620
		D/T	[redacted]												
[redacted]	~~Percocet~~ MS04 2-6mg NP Q2°PRN	D/T	12Sep 2330												
		D/I	5mg [redacted]												

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo SEP Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 07 08 09 10 11 12 13 14 15 16 17
15Aug	[redacted]	Keflex 500mg po QID	06 12 18 24	DC'd 3 Sep 03
09 Sep 03	[redacted]	Naprosyn 500mg po BID	10 22	Rx'd 10 Sep 03
10 Sep	[redacted]	motrin 800 mg PO TID	08 16 24	[redacted]
13 Sep	[redacted]	LR @ 125cc/hr. HL when TOL P.O. (NO FLUSH QSHIFT)	00 18 X	DC
13 Sep	[redacted]	Ancef + gm IVPB Q8hrs x 3 doses then DC IV	6 14 22	2) 3)
		b(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX-FIX to (L) femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [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 - 16154

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. 08 Yr. 03

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

ORDER DATE	CLERK/ [redacted]	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27 28 29 30 31 01 2 3
15	[redacted]	Keflex 500mg PO QID	6	[redacted]
			12	
			18	
			24	

D/C'd b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex-fix to L femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW [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

29 Aug 03 RD	SINGLE ORDER: Dulcolax Supp ÷ 1 x1 OR fleets enema for constipation.	D/T/I	29 AUG 2050 1/1

b(6)-2

CLINICAL RECORD

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

Mo 08 Yr 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR / DATE DISPENSED
7Aug	[redacted]	Tylenol 650 mg PO q4 PRN	
7Aug	[redacted]	Percocet 1-2 tabs PO Q4-6 PRN	D/T, D/I, E/I — see below
10Aug	[redacted]	MSO4 2-6mg IVP q2° PRN	
10Aug	[redacted]	Amalgan ii QID pm ear pain	D/T, D/I, E/I
25Aug	[redacted]	Percocet 1-2 tabs PO q4-6 prn	see below
28Aug	[redacted]	Percocet 1-2 tabs PO q4-6 PRN	D/T, D/I
		Percocet 1-2 tabs PO q4-6 PRN	D/T, D/I

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P ex fix of femur

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

PATIENT IDENTIFICATION: epw [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

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. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7 8 9 10 11 12 13 14 15 20
7 Aug	[redacted]	Ativan 1mg PO q6° x 48 hrs, 1mg PO q 12 hr x 24 hrs, 1mg PO qd x 2 days	6	[redacted]
			12	
			18	
			24	
7 Aug	[redacted]	LR @ 125 cc/hr, (HL) when taking PO well	05	[redacted] D/C
			13	
			01	
8 Aug	[redacted]	Ancef 1gm IV q 8° x 3 days	08	[redacted]
			16	
			24	
			1	
10	[redacted]	Debrox 5 gtts (2) ear BID x 2 days	10	1700 [redacted]
			22	
			1	
15	[redacted]	Keflex 500mg PO q 8°	06	[redacted]
			12	
		b(6)-2	18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to (L) femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW [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 - 16158

b(6)-2 All

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. 8 Yr. 03

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

ORDER DATE	CLERK/ NURSE	~~RECURRING MEDICATIONS, DOSE, FREQUENCY~~ PRN	HR	DATE DISPENSED
7 Aug	[redacted]	Tylenol 650mg PO q4° PRN		7 Aug 0940 650mg [redacted] ANS; 8/8 0810 [redacted]; 8/8 1245 [redacted]; AAug 10 [redacted] PO 1700; 15 Aug 1445 BID TPO; 15 Aug 2330 2D TPO; 16 Aug 0630 TPO; 16 Aug 1110 [redacted]
7 Aug	[redacted]	Percocet 1-2 tabs PO q4-6° PRN		8/10 2336 [redacted]; 11 Aug 1600 TPO; 14 Aug 1745 [redacted]; 14 Aug 2200 [redacted]; 12 Aug 2200 [redacted]; 12 Aug 0000 TPO; 12 Aug 2D TPO Kin; 13 Aug 0730 [redacted]; 13 Aug 2100 [redacted]; 14 Aug 0655 [redacted]; 14 Aug 1100 [redacted]
7 Aug	[redacted]	MSO4 2-6mg IV q2° PRN		8/17 0400 [redacted]
10	[redacted]	Amalgan TR QID PRN-ear pain		8/10 2345 [redacted]; 8/15 1030 TPO
7 Aug	[redacted]	Percocet 1-2 tabs PO q4-6hrs prn		15 Aug TPO 0710 [redacted]; 15 Aug 2330 2D TPO [redacted]; 16 Aug 0500 [redacted]; 16 Aug 2200 [redacted]
7	[redacted]	Tylenol 650mg PO q4° prn-pain		16 Aug 1335 650mg BRS [redacted]; 17 Aug 600 [redacted]

See below

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: b(6)-2

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 - 16159

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7Aug	[redacted]	Admit to ICU2 condition fair	7Aug		1730	[redacted]
11Aug	[redacted]	D/C Foley NOW	11Aug	0830	0835	[redacted]
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	.....					

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

USAPA V1.00

b(6)-2

...L RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr 03

INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (7 8 9 10 11 12 13 14 15 16 17 18 19 20)
7 Aug	[redacted]	VS routine	05 / 13 / 21	[redacted]
7 Aug	[redacted]	Up ad lib T crutches per EPW routine	05 / 13 / 21	[redacted]
7 Aug	[redacted]	Crutching walking TPT	05 / 13 / 21	[redacted]
7 Aug	[redacted]	Reg diet	05 / 12 / 17	[redacted]
7 Aug	[redacted]	Pin care daily	05	[redacted]
7 Aug	[redacted]	Foley to gravity	05 / 13 / 21	[redacted] DC'd 0830 11 Aug 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to L femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

...FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 16161

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26th	[redacted]	X-ray (R) femur, AP & LAT in AM	27th	0600	1015	[redacted]
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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USAPA V1.00

MEDCOM - 16162

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21 22 23 24 25 26 27 28 29 30 31 1 2 3
7Aug	[redacted]	Routine vitals	0	[redacted]
			19	
7Aug	[redacted]	Up Ad libz Crutches perepw routine	5	
			19	
7Aug	[redacted]	Crutch walking qPT	5	[redacted]
			19	
7Aug	[redacted]	Regular Diet	5	
			1	
			17	
7Aug	[redacted]	Pin Care Daily	8	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to (L) femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 16163

b(6)-2

b(6)-2

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4Sep	[redacted]	X-RAY APICAT (L) Femur	4Sep	Today	—	
09 SEP03		AP/LAT OF FEMUR IN AM	10 SEP03	"	0700	
10 SEP03		Repeat OF FEMUR SERIES (TODAY)	10 SEP03	11Sept 1640		
13		Resume previous orders	13Sep	—		
9/15		D/C to Prison Camp Compound	16 Sept			
9/15		Crutches	9/15	—		
9/15		Return in 6 wks, remove cast, X-rays	6 wks	Not Tod		

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

USAPA V1.00

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 09 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
7	[redacted]	Routine Vitals	6	[redacted]
			18	
7	[redacted]	up ad lib c crutches	6	
		per SAW Routine	18	
7	[redacted]	crutch walking c PT	6	
			18	
7	[redacted]	Reg diet	6	
reordered 3 SEP			18	
7	[redacted]	PIN Care Daily	08	JDC
		With Betadine	#8	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex-fix (R) femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 16165

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
6-Aug		10 mg Diazepam IM in (R) Quad.	6-Aug	2240	22:40	[redacted]	
6-Aug		Ancef 1gm IV	6-Aug	2126	2126	[redacted]	

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

☆ U.S.G.P.O.: 1986 - 491-003/43119

MEDCOM - 16166

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo.____ Yr.____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				6-Aug 7 Aug
6-Aug-05	----	Cephalexin 500mg PO QID	21	RS RS
	----		03	X RS 03
	----		09	X
	----		15	X

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 **4677**

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 16167

70kg

MEDICAL RECORD-SUPPLEMENTAL MEDICA

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: 7 Aug 03 | Anesthesia Type (Circle)): General Spinal Epidural ASA II
Time In: 1515 | IV Sedation Nerve Block
Allergies: NKDA | OR Intake: Crystalloid 150 | Colloid _____ | Ancef 1gm
Pre-op V/S: 129/67/13 | OR Output: UOP 0 | EBL min
Procedures: ex (F) (L) femur | Meds/Times: 20m 20

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

Pre Op Meds | History

Time	1515	1520	1525	1530	1545	1600	1615	1645	1730
SaO2	99	100							
FiO2									
Methods									
240									
220									
200									
180									
160									
140									
120									
100									
80									
60									
40									
20									
RR	17	14	16	22	18	14	14	18	20
T	98.2				99.4				
Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1730	NACL	150	LRA	[redacted]	—

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	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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	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 ICU #2 | DATE 07 Aug 03

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

[redacted]

b(6)-1

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

blu - 2 A11

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		None				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L leg	+	+	P	BK	W	PK
15'	"	+	+	P	BK	W	PK
30'	"	+	+	P	BK	W	PK
45'	"	+	+	P	BK	W	PK
60'	"	+	+	P	BK	W	PK
90'							
D/C	"	+	+	P	BK	W	PK

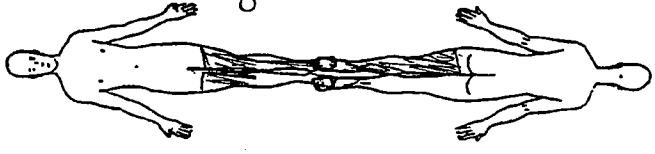
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	bulky ace ext fix	Ø
30'	(L) leg	" "	Ø
60'	(L) leg	" "	Ø
D/C	(L) leg	" "	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1730	Foley	Amber clear	975

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

34yo EPW ♂ transferred via litter to ICU 2 from OR for recovery. S/P ext fix (L) femur fx repair. PT resting c eyes closed. Color good. Aroused c verbal. VSS. IV RAC patent TKO. (L) leg ext fix skin warm. Cap refill brisk. Pulses present. LS CTA. SGT [redacted] 9 LMMS 1730 VSS sinus tach. LS CTA. A&OX3 pt able comm c/o unable to void. Abd soft, rigid, non tender. Foley 16 Fr c bag. ~975 cc amber & sediment. (L) leg dry, CDI, pedal pulses present. NVI. IV 18G (R) AC patent. Running TKO. denies pain. SGT [redacted] 9 LMMS

Discharge Criteria:
Date: 07 Aug **Time:** 1730 **PARS:** 10
BP: 122/68 **T:** 99.2 **HR:** 125 **RR:** 20 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: 150 **Output:** 975
Additional Data: None
Transferred To: ICU 2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 13Sep03
Time In: 1805
Allergies: _____ OR Intake: Crystalloid 800 Colloid _____
Pre-op V/S: 114/60 99 OR Output: UOP 0 EBL 0
Procedures: Eyelid Removal Meds/Times: 250mcg/Fentanyl

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

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

Pre Op Meds

History

Time	1805	1810	1815	1820	1825	1830	1835	1840
SaO2	100	100	99	98	100	96	98	
FiO2	/	/	/	/	/	/		
Methods	RA	RA	RA	RA	RA	RA	RA	
240								
220								
200								
180								
160								
140								
120	˚	•						
100			•	•		✓	✓	✓
80			✓	✓	✓	✓		
60					•	•		
40	^	^	^	^	^	^	^	
20								
RR	21	20	22	26	13	14	13	
T	99°			98°			99°	
Time	1840	1850						
Pain (0-10)	5/10	5/10						
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1805	LR	200	UPA	[redacted]	

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	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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.	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)

PREP[redacted] & Title) TPN b(4)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 13Sep03

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

EPW #[redacted] b(4)-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

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1850	5/10	2mg MSO4	IVP	7/10	I	[redacted]
1900	5/10	2mg MSO4	IVP	3/10	E	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Oleg	Movestoes limited	+	UTA	B	C	PK
15'	Oleg	Limited	+	UTA	B	C	PK
30'	Oleg	Limited	+	UTA	B	W	PK
45'	Oleg	Limited	+	UTA	B	W	PK
60'	Oleg	Limited	+	UTA	B	W	PK
90'							
D/C	Oleg	Limited	+	UTA	B	W	PK

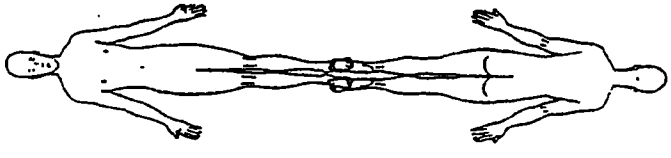
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Oleg	cast/hard	0
30'	Oleg	cast/hard	0
60'	Oleg	cast/hard	0
D/C	Oleg	cast/hard	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1920			0

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1850	SR	0	0

WAMC OP 173-E

NURSING NOTES

(1855) Pt arrived to PACU @ 1905 via litter accompanied by CRNA nurse. Pt hooked up to monitor. HR tachy but down to 80's p a while. Pt has sensation in toes, can move toes and brisk cap refill. C/O some pain to @ thigh. MSO4 2mg given. Will evaluate. [redacted] MAR

(2110) Pt given a 2nd dose of MSO4. Pain better. No c/o in @ leg @ this time. Just hungry. VSS [redacted] MAR

(1920) Report given to Spc [redacted] Pt ready for transfer. [redacted]

b(6)-2

Discharge Criteria:
Date: 13 Sept 03 Time: 1920 PARS: 10
BP: 113/63 T: 98.6 HR: 85 RR: 18 Sa02: 98
Pain Level at D/C (0-10):
Intake: 150 Output: 0
Additional Data:
Transferred To: ICW 1
Report Given To: Spc [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] MAR
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] MAR

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
A1 1D1	IZ	[redacted]	664 UNK IRAQI EPW	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	34Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1515	b(6)-2 —

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K78	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	—

NAME AND [redacted] TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
b(2)-2	—	—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
05		030914

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		030807

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 ① GSW TO (L) Femur
② S/P ex fix (L) Femur

DX-82110
T-1 E9912
I-450 PR-9359

b(6)-4 [redacted]

ADMITTING OFFICER (Signature, as required)

DR. [redacted]

SIGNATURE OF ADMITTING CLERK

[redacted] b(6)-2

DA FORM 3985 MAR 89

MEDCOM - 16172

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				

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	29	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	b(6)-4		WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
direct from ER	1320	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	d/c to camp	19 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	01 Aug 03	

29. NAME AND LOC[redacted]	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW ⓛ thb/fib ⇒ ⓛ AKA

897.2
V58.3
E991.2

84.17
86.28
86.59
93.53

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

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

29 Y.O., DRIVING TRUCK TO STEEL CAMP 12 DAYS AGO
NO PMH OTC INFECTIOUS GSW TO POSTERIOR
TIB FIB, PUS IN WOUND, LARGE MUSCLE DEFECT,
PLAN ABX IRRIG DEBRIDEMENT.

ROS - NEGATIVE EXCEPT

ALLERGIES - NKDA

PHYSICAL EXAMINATION

VS/NL
CHEST - ATRAUMATIC
ABD - SOFT
EXT - LARGE SUP ON SOFT TISSUE DEFECT,
PUS POURING FROM WOUND, LARGE QUANTITY
OF NECROTIC TISSUE

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

X-RAYS - LARGE BONY BURST WITH GAS WITHIN SOFT

SIGNATURE OF [redacted] b(6)-2	DATE 7 DEC 04	IDENTIFICATION NO.	ORGANIZATION
PATIENT [redacted] b(6)-4 *(Or other written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

MEDICAL RECORD	PROGRESS NOTES
DATE 18Aug03 1320	assumed care @1300 - VSS - no c/o pain @ this time - dsg intact on (L) AKA, Staples to be removed when order written — [redacted] cm
19 Aug 0130	Care assumed @2100. VSS, alert awake & c/o back pain from staying in an Iraqi prison. Lungs CTA, BS(+)x4. Dsg intact on (L) AKA, pt's dsg q2° b(6)-2 All 3 difficulty. Taking PO ABX, & d/c order and summary for 19Aug. Will continue to monitor. [redacted] Alum
19Aug03	0615 Assume pt care @ 0500. Pt awake and alert c/o pain to (L) AKA. percocet given @ this time. VSS. HR reg. Lungs CTA Abd soft BS x4 (L) AKA dsg CD+I. pt A's dsg q2°.5 difficulty. Amb & crutches 3 difficulty. Has discharge orders/summary meds @ pharmacy. Will cont. to monitor [redacted] Alum
	1500 Pt stable. (L) AKA wrapped. 0 complaints. To be discharged to EPW camp today. Meds and x-rays at bedside. [redacted] Cpl USA
	1545 Discharged to EPW Camp in stable condition. [redacted] Cpl USA

(Continue on reverse side)

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

EPW [redacted] b(6)-4

REGISTER NO. WARD NO. CCW 2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7Aug03 1430	Admitted from EMT @ 1415. Pt stable. AAOx3 Lungs CTA bilat, no resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Pt s/p (L) tib-fib fx. Wound wrapped c Kerlix. (L) leg elevated. Strong pulses and brisk cap refill x 4 extremities. (L) leg contorted, but most comfortable per pt. To go to OR for (L) AKA. — [redacted] w/Dr b(6)-2
7Aug03 2210	Ortho Op Note: Pre-Op Dx - Septic Gunshot Wound (L) tib-fib fx Post-Op Dx - same Procedure: (L) above knee amputation Surgeon: [redacted] b6-2 GBL - 3 U. FO TMC - 42 mins BLOSS: 1 Lit NS FINDINGS: Large loss of soft tissue of (L) proximal tibia, shattered prox. Large amount of necrotic bone in prox. No stability. Devascular

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	Lung expanding, possibly above popliteal fossa. AKA stump w/ evidence of infection at site. Tibial fracture site shaped off with stockinette sutured. Palpable pulses. Good closure of stump w/ 4-0 sutures. Today moderate clear drainage noted. Dressing changed with gentle saline irrigation.
	b(6)-2 [redacted]
8 Aug 08 0258	Rec'd T/O pt @ 22:30. Pt returned to ICU 2 via stretcher from ICU 2 recovery. VS WNL per flow sheet. Pt drowsy mildly difficult to awaken. Pupils fixed & light responsed/t Anesthesia. see intraop sheet. Lungs ⊕ Rhonchi ⓑ ↑ lobes. Diminished ⓐ bases. HRRS, S2. BSO x 4 ⊕ PP ⓑ. ① AKA C ace wrap dsg intact. H2 ⓑ AC patent. Pt tolerating P.O. H2O. Voiding ⓒ. c/o pain x 1 II Percocet given. 50 ug Fentanyl Patch placed to ↑ ⓡ shoulder. ⓐ further c/o's with man [redacted] PT/AD

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.

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	b(2)-2 [redacted] On the Discharge Summary, [redacted] 29 yo male shot in (L) leg 12 days prior to admission, placed in Iraqi jail. Brought to [redacted] 7 AUG 03 with Septic Shock III open (L) tibia and fibula fracture, with green pseudomonas type pus. Had open AKA above knee amputation performed 7 AUG 03 with washout & I&D, stump closed 11 AUG 03 Wounds have healed. Patient has been taught stump wrapping PLAN: Crutches. Stump wrapping by patient. Cipro 500 mg P.O. BID #20 ~~Phenergan~~ PERCOCET, 1-2 every 4-6 hrs PRN #30 FLAGYL 75 mg P.O. Q 8 hrs #20 F/U PRN b(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	OBTAINED AT
[redacted]			
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. ICU

GPW [redacted] b(6)-4

[redacted]

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

MEDCOM - 16179

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)*
15Aug03 2015	assumed care @1300-VSS-no c/o pain throughout shift-pt. alternating position fro-stomach-to back q1-2° as ordered-c/o diarrhea x1 this shift-Stump wrapped by pt. 3x this shift. dsg intact at this time b(6)-2 [redacted]
15Aug03 2208	USS-Alert X3-Kerlix to stump c Ace wrap is dry and clean & s/s of infection. Pearla 3mm Lungs c CTA Bil Resp even Reg. HR-NSR-BS⊕ X4 quads. ⊘ c/o diarrhea @present. Restraint to UE in place and secure. offers ⊘ c/o pain or discomfort @present. b(6)-2 Sgt [redacted] USCG
16Aug03 0330	Resting quietly @present. Percocet 1# Po given for pain. has had ⊘ further c/o pain or discomfort from ⊕ leg Amputation site. Restraints in place and secure b(6)-2 [redacted] USCG
16August03 0600	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, Lungs clear bilat, bowel sounds(+) x4 quads. Pt. ⊼ IV access. Ace wrap to ⊕ AKA CDI. Pt. ⊼ complaints @ this time. All other assessment findings WNL. Will continue to monitor. b(6)-2 [redacted] USCG/AN
16Aug03 1430	assumed care @1300-VSS-dsg in place on ⊕ AKA-no c/o pain @ this time-ambulated c crutches for 10 minutes b(6)-2 [redacted]

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. ICCU2

EPW [redacted]
b(6)-4

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

MEDCOM - 16180

b(6) - 2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 2130	VSS - Alt x3 - Pearla 3m - Lungs CTABL Resp even Reg BS @ x4 quads - HR NSR Radial and Pedal pulses +4. Stump clean Kerlix & Ace wrap dry and intact. @ c/o e present. Restraints in place and secure. — Sat [redacted]
17 Aug 03	0713 Assume pt care @ 0500. Pt asleep, easy to awake. No c/o pain. VSS. HR reg. Lungs CTA. Abd soft BSx4. (L) AKA dsg CD+I. Will cont. to mon. — [redacted]
17 Aug 03 1525	assumed care @ 1300 - VSS - no c/o pain @ this time - Staples intact, no S/S infection @ sutureline, dsg CDI on Stump - pt. ambulating C Crutches - pt. will not lie prone S much discussion and convincing [redacted] CPT, AN
17 Aug 03	VSS Alt x3 Pearl 3mm - Lungs CTA Resp Reg even HR - NSR BS @ x4 quads Pedal pulse to @ Dpt +3 Radial pulses +3. stump dsg dry and intact. Percocet 1 PO q4hr for c/o pain. Restraints to UE and LE in place and secure. — Sgt [redacted]
18 Aug 03	Percocet 1 PO q4hr 0320 for c/o Stump pain. c/o HS @ Lutha c/o pain @ present. Resting quietly. Restraints to UE and LE in place and secure. — Sgt [redacted]
18 Aug 03 0030	Nursing Note: Assumed pt care. AAOx3. Strong intact, breathing even and unlabored LS CTA @. Abd soft, nontender, + distention. BS @ x4. Voids spontaneously - flow and amount adequate. Intact to all extremities. Stump to KCE is 3 days, well approximated. Expect to remove staples today. Pt does c/o some phantom pain. Current PO meds seem to take care of that. — @ IV access. — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 16181

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03 1945	cast came off of (L) AKA stump, staples intact on stump - Dr [redacted] aware - Kerlix and ace wrap placed on stump and pt. placed prone - 650mg tylenol PO given for pain - b(6)-2 [redacted] ChAn
12Aug03	BSS-Alert x3 saline lock in place flushes 5 diff. Lungs CTAB RESP Regular. HR NSR - BS@ x4 equads. Radial & @ Pedal pulses x3. dsg to (L) stump dry and intact. Pearls Restraints to upper and lower extremities in place and secure. uses bedside urinal & bedside urinal urinary sufficient amts urine light yellow. [redacted] RN/c
13Aug03. 0500/1230	Pt slept well x3. Pt had BSC done @ (L) stump AKA. Staples intact. No exudate. Pt ambulating well. Pt ambulated to BR & use crutches & ambulate. WBAT(L) Chem-Metabolites 5, CBC. done waiting results from lab [redacted] b(6)-2
13Aug03 1300	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat [redacted] resp distress. NSR Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) AKA CDI. No complaints [redacted] RN/c

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

EPW b(6)-4 [redacted]

RECORDS MAINTAINED AT: ▶ ICW2

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

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

MEDCOM - 16182

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 0000	Care assumed @ 2100. VSS, A+Ox3, no c/o pain. Lungs CTA, BS+ x4. LBKA dsg reinforced 3x. Dsg CDI, no c/o pain, + sensation @ site. HL @ LFA infiltrated, restarted in RFA. No S/S, continue to monitor. [redacted] Alum Co
14Aug03 0730	Care assumed at 0500. VSS, A+Ox3 BSx4 Lungs CTA, heart rate reg. LBKA dressing changed @ 0700 CDI. + cap refill in all extremities. Ambulate c crutches w/o difficulty. Heparin R forearm will continue to monitor. [redacted] Pfc [redacted]
1250	New HL started in (L) FA @ flush & redness/ infiltration. [redacted] SMM6
14Aug03 1525	Assumed care @ 1300 - VSS - SL patent - ace wrap CDI on (L) AKA - pt. prone x 2° - no c/o pain @ this time - ambulated c crutches during shift. [redacted] SPAN
14Aug03	VSS - A+ox3. saline lock to (R) FA is patent no S/S of infiltration. Pearla 3mm - Lungs: CTA Bil. even rise - BR - NSR - BS+ x4 quads - Radial pulses +3 Pedal @ +3 - Ace wrap to stump dry and intact. Percocet 1 tab PO given for c/o pain. Restraints to UE & LE in place and secure. [redacted] Sgt
15Aug03 0800	Assumed pt care this AM, VSS. SL flushed & no S/S infection, dressing CDI no pain noted. PT rested & ambulated. Pfc [redacted]
15Aug03 1050	PT complained of constipation ings given MOM. Later Pt Translator explained was diarrhea cause how will inform shift change. It also very concerned about staples when they will be removed told 7-10 days was an estimate. [redacted]
15Aug03 1120	Cipro held, waiting on Dr to see if can be given PO. [redacted] Pfc [redacted]

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16183

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03	Op Note
0930	Pre-op Dx
	(L) Above Knee Amputation
	Post-op Dx
	Same
	Procedure: Dressing change, clean wound, application of skin graft (L) AKA
	Surgeon: [redacted] 66-2
	Anesthesia:
	Findings: Wound clean, skin, flaps stable, not yet sterile, staples not applied
	Plan: To OR in 1 week remove staples.
	b(6)-2 [redacted]
12 Aug 03	assumed care @ 1300 - VSS - SL patent - [redacted]
1400	cast intact on (L) AKA, bed flat & heavy blanket on stump to stretch hip flexor - pt. sleeping @ present - no c/o pain - this shift. [redacted] CHAN

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

EPW [redacted]

b(6)-2

RECORDS MAINTAINED AT: ▶ ICW2		
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

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

MEDCOM - 16184

b(6)- 2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 2200	Pt. care assumed @ 2100. VSS. HR Reg. Lungs CTA, BS@ X4. (L) AKA dsng CDI. JP bulb intact, draining bright red bloody drainage. IV to @ FA flushes ∑ diff. will cont. to monitor- [redacted]
0315	10 cc out per JP serosanguinous drainage. — [redacted]
110530 Aug 03	NURSING ASSESSMENT: Assumed care of pt, AAOx3, Airway intact, breath sounds clear bilateral, LS CTA(B). Abd soft, nontender, ∑ distention BS@x4. Voids spontaneously. AFOM and neurovascular intact to (B)UE and (B)LE. LLE stump dsg is ACE ∑ gauze, CDI. [redacted] twice folded towel for comfort. IV to (L)FA ∑ s/s infection or infiltration. — [redacted]
1123o Aug 03	NURSING NOTE: 20cc serosang drng from JP drainage — [redacted]
2200	Pt. care assumed @ 2100. VSS. Pt - c/o pain. 1 percocet given PO HR Reg, lungs CTA. BS@ X4. (L) AKA dsng CDI, JP drain patent draining scant amt, bright red bloody drainge. IV HL to @ FA intact, flushes ∑ difficulty. Ø s/s infection or infiltration. will cont. to monitor. — [redacted]
0500	25 cc bloody → serosanguinous drainage per JP. [redacted]
120530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breath sounds clear bilateral, BS ∑ S CTA(B). Abd soft, nontender, ∑ distention. BS@x4. Voids spontaneously. AFOM and neurovascularly intact to (B) UE and (B)LE. (L)LE has stump ∑ Kerlix/Gauze dsg that is CDI. JP to wound pulls serosang/sanguinous drng. IV to (L)FA flushes well, ∑ s/s infection or infiltration. — [redacted]

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16185

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 03 0938	Ortho Op Note Pre Op Dx - (L) AKA, OPW Post Op Dx - same Procedure - I+D (L) AKA stump Surgeon - [redacted] Findings - done serous drainage. No necrotic tissue. Will leave open. Plan wound I+D, DPC home. b(6)-2 A11 [redacted]
9 Aug 03 1645	assumed care @ 1300. VSS, T 100.3°F - SL patient dsg intact on (L) AKA, no drainage noted on ace wrap - no c/o pain @ this time - pt. to be NPO p MN tonight for OR in AM - [redacted]
10 Aug 03 0145	Pt care assumed @ 2100. VSS, A+Ox3, ~~II~~ percocet given for pain. Lung sands CTA, BS (+) x4. Dsg on LAKA c/d/i, good ROM. Pt seen by Dr. [redacted] NPO p MN for OR in AM for I+D, and closure of wound. [redacted] qumo

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

EPW

[redacted]

b(6)-4

RECORDS MAINTAINED AT: ICW2

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

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

MEDCOM - 16186

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug03 0800	Ortho Op Note Pre Op Dx - (L) AKA Post Op Dx - (L) AKA Procedure: I+D (L) AKA DPC of stump Surgeon: [redacted] EBL - min Findings - Clean wound. Closed in layers over drain. b(e)-2 All [redacted]
10 August03 1000	Pt. back from OR via litter. DSG i acc wrap to (L) AKA CDI. HR Regular, Lung sands clear bilat, bowel sands (+) x4 quads. Pt. 5 complaints @ this time. All other assessment findings WNL. Will continue to monitor [redacted] ART/AN
10Aug03 1900	assumed care @ 1300 - VSS - medicated c tylenol 650mg PO @ 1830, pt. sleeping at present - 75mcg Fentanyl in place on pt's (R) upper back - SL patent - dsg CDI on (L) AKA, JP c 35 cc output, Serosang drainage - xray done of (L) stump as ordered [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

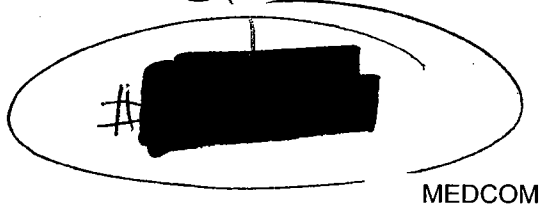
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	ⓛ AK47 - 1 deep caga enter back of upper calf, exit distal to Knee ⓛ PMH
BP 132/64	
P 118	ⓛ 1cm puncture posterior upper calf lg cavitating ext wound prox
R 16	tibia just distal to Knee on ⓛ leg. Ⓡ leg normal. Edema
T 101.7	present ⓛ foot. Dorsalis Pedis + posterior tibial pulses present &
SPO2 95	strong.
	X-Ray ⓛ leg. tibia just distal to tibial plateau is shattered. ⓛ arm
Meds	A) CSW ⓛ upper leg. shows scattered shrapnel from elbow to
1 shot 3 deep @	hand. ⓛ Fx.
Bacitracin 1/2 Inch ut	P) IV to hold eng in waiting for transfer to CSH
Keflex appropriate	Continue IV fluids
NKA	Ancef 1gm IV q 8°. Give 2g now
2100	MS 10mg IM Dose
	Clean & dress wound, place splint
	Notify [redacted] 2LT, SP
2107	Morphine Inj. 10mg IM B. O'Neill 9/W
2114	Ancef 2g IV Bag b(6)-2 BOneill

Betadine Scrub brush to ⓛ leg, clean areas. Rotated leg applied SAM Splint with Ace bandages to ⓛ leg, ~~Fx~~ Betadine Scrub brush to ⓛ arm affected areas.

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

REGISTER NO. | WARD NO.



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

MEDCOM - 16188

Stitches still app t in wounds. Dress gs applied to (L) leg prior to Splinting. Pulses apparent prior to and after splinting Leg.

Spc [redacted] 9/4

2200 | L NS spiked TKO

b(6)-2 [redacted] 9/4/11

[redacted] b(2)-2

NSN 7540-01-075-3788

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY: Dyess | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 7 Aug | TIME: 1250

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
AGE	HOME PHONE		PRP			
29	AREA CODE	NUMBER	FLYING STATUS			
			MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1250

INIT: b(6)-2 [redacted]

VITAL SIGNS

TIME	1250				
BP	129/74				
PULSE	114				
RESP	14				
TEMP	100°				
WT 96 K	99%				

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	☒ BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		☒ CHEM: MET 8
☒ BLOOD C&S X			

X-RAY ORDERS

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

(Tib/Fib)

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	50 Fentanyl [redacted] b6-2	1255			
	50mg Ertapenem	1300			
	Td - Tdap IM	1300			
	Anuf Tgn SV				

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

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

[redacted] EPW

b(6)-2

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

[redacted] b(2)-2

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP O2	PH	PO2	RESULTS	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

29 y/o ♂ sent fr Unknown PST term. Pt 5/y GSW x ⓛ post hip/KG 10 d ago
Unclear ht. Pt c/o L foot/leg — ⓛ foot/leg
Gun shot left right

Pulse NC
ΦMEDIA

O: Awake/A+O x no distress. VSC
chest ⊖ lung clear/nt w/o R/R
Pelvis stable Abd Soft Chest CTAB CV: RRR T1/T2 sem ΦGT
MSK
ⓛ lower ext: ⊕ lg open wound post tib c extruding pus/open fx
↓ sensation to touch/hot/cold/pin ↓ movement ⊕ edema to ⓛ knee

A/P Open fx/GSW post ⓛ → Admit b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAT

PROVIDER SIGNATURE AND STA [redacted]

DIAGNOSIS

CODES

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)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: Ortho

[redacted] Col USMC | DATE OF REQUEST 9 Dec 13

REASON FOR REQUEST *(Complaints and findings)*

Gunshot wound Otten – b(4)-2
fracture

PROVISIONAL DIAGNOSIS

fracture Otten

DOCTOR'S SIGNATURE [redacted] M | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

b(4)-2

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

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

[redacted]

b(4)-4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 16192

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
08 Aug 03	1030		Pt alert & oriented lying in bed. HL to (R) AC → patent. AKA covered & Ace wrap, (Ø) drainage noted. Small, round wound to (R) anterior ankle. Some purulent drainage on old dsg. New dsg applied. VSS, temp 100°, lungs CTA, HR reg, BS (+), Pulses (+) x3. IS given. Grave Pencoset II for pain. Will continue to monitor. [redacted]
8 Aug 03		1300	- Recvd pt alert in bed. Pt has Temp 101.2. Pt has been encouraged to cough & deep breath. Also c incentive spirometer use. Gave pt Tylenol 650 mg PO. b(6)-2 HHR: BS x4. Lung sounds clear bilateral. (L) leg stump noted drainage. Will notify MD. [redacted]
8 Aug		1730	- MD notified about stump drainage. MD stated to reinforce if drainage per outside sheets. Otherwise he will be up to ASU tomorrow, [redacted]
9 Aug		0130	Pt care assumed @ 2100. T @ 103.2 at 2130, 650 mg Tylenol, blankets taken off. At 2200 T @ 101.2, Ice pack applied, H2O encouraged. At 2300 T @ 100.1. Other vss, patient awake and alert 3 c/o pain. Lung sounds CTA, BS x4. Dsg on LBKA intact, drainage noted to posterior distal portion. IV @ RAC not patent,

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICU

b(6)-4

epw [redacted]

NURSING NOTES
Medical Record

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

MEDCOM - 16193

b(a)-2 A11

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9Aug03	0130		Restarted in LFA. IV ABx. Pt npo, O/C to OR in AM, will continue to monitor. [redacted] Gillum's
9August03	0830		Pt. awake & alert c complaints. HR Regular, Lung sands clear bilat, bowel sands (+) x 4 quads. VSS, slight temp of 99.9°. Hl in (L) FA c s/s of infection, flushed well. Ace wrap c small amt of bright red blood on (L) AKA, site marked c date & time. Pt. c 1 suture to (L) base of pinky finger. All other assessment findings WNL. Will continue to monitor. [redacted]
	0900		Pt. to OR via litter [redacted]
	1100		Pt. back from OR, DSG to (L) AKA CDI, pt stable [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 16194

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 03	0430	Pt resting quietly. Orders noted. Transfer to [redacted] SPC
		CSH in am
7 Aug 03	0645	#18 IV to (R) AC. IL NS c 1 gm Ancef
		running @ ≈ 200 [redacted] — DJG
	1040	Ok to def [redacted] ret 80 b(4)-2 A11
	1100	Pt ate part of noon meal [redacted] SPC
	1151	Cont 1000 cc NaCl IV [redacted] SPC

Continue on reverse side

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

[redacted]

EPW

b(4)-4

REGISTER NO.

WARD NO.

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

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: 29
HEIGHT:
WEIGHT: unknown

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

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: (L) AKA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco 3 ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) ½ QD 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	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures. (e.g., warm blanket, touch). Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø 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	Ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress. Ø 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	Ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø 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(a)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0900 ! 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: CB

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	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ 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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier - Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ 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. blw-2 All	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] 07AUG03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☑ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☑ Moves Upper Extremities BREATHING EASY: (Y)(N)

☑ Transferred to liter with sheet ~~pillow~~ due to spinal

12. PREOPERATIVE EVALUATION (Signature and Ti[redacted] PREPARED BY

DATE: 7AUG03 TIME: 1350

13. POSTOPERATIVE EVALUATION PRE[redacted] BY (Signature and Ti[redacted] CRNA

DATE: 07AUG03 TIME: 2212

b(6)-2 A11

MEDICAL RECORD — INTRAOPER 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: Wheeled litter — BY: MAJ [redacted] MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE — VERIFIED BY: CPT [redacted] / CPT [redacted]

3. DATE: 07 AUG 03 — TIME PATIENT ARRIVED IN ROOM: 2020

4. PATIENT IN ROOM — TIME: 2020 — NUMBER: 2-6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify) Ption: padded OR Bed Head on foam doughnut. Arms ext. out to sides <90° in CAP, secured to padded armboards c safety straps.

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

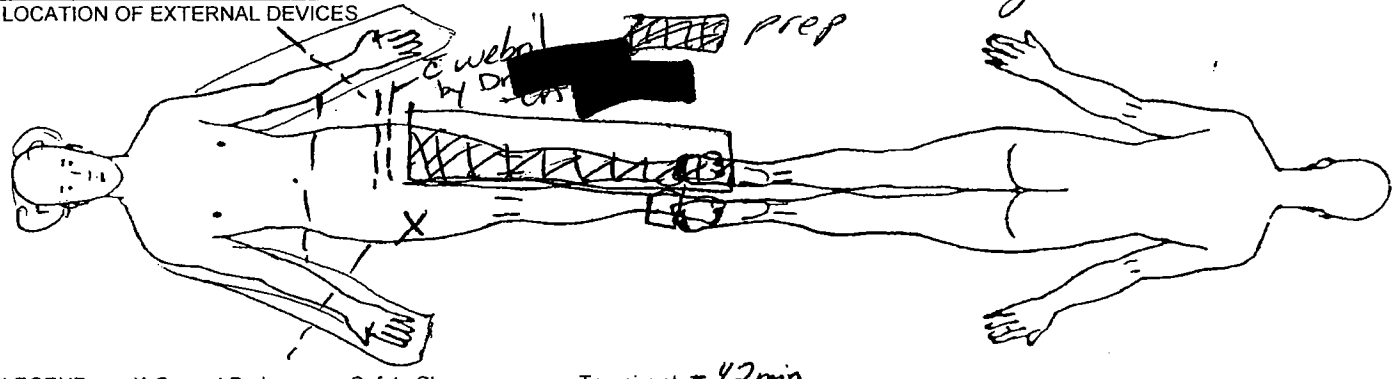
COMMENTS: Folded towel under (R) heel - LLE prepped into sterile field. Proper body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☒ NURSING UNIT CPT Holcher
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Beta/Beta [redacted]
SITE: LLE (as below) BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of solution noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet - 42min

10. COUNTS — C = Correct I = Incorrect

		Initial / Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C		C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C		C		
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

b(6)-2

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

☒ ESU NO: 3 SN# [redacted] b6-4
GROUND PAD: BRAND Valley Lab RTM Polyhesive II
LOT NO: 65706/2004-11

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

☐ BIPOLAR NO: _____

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

MEDCOM - 16198

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
N/A		

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)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. 1 inch penrose	2. N/A	3. N/A
SITE	1. surgical site (L) AKA	2. "	3. "

19. ADDITIONAL INFORMATION

WC IV

Surgeons: Dr [redacted] Assist

Anesthesia: MAJ [redacted] Anesthesia Type: Gen/Endotracheal

Bovie Pad site intact pre-op yes; post-op yes Bovie Settings: Coag/Cut 40/40 Blend-1

Tourniquet site OK post-op

20. OPERATION(S) PERFORMED

(L) AKA, bilateral I&D

21. PATIENT TRANSFERRED TO ICU 2 TIME 2212 METHOD wheeled litter

22. REGISTERED NURSE SIGNATURE [redacted] Tom

REVERSE OF DA FORM 5179-1, OC

USAPA V1.01

MEDCOM - 16199

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: Gurney BY: Anesth.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: ILT [redacted]

3. DATE: 9 Aug 03 TIME PATIENT ARRIVED IN SUITE: 0900

4. PATIENT IN ROOM TIME: 0900 NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(a)-2 A11

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

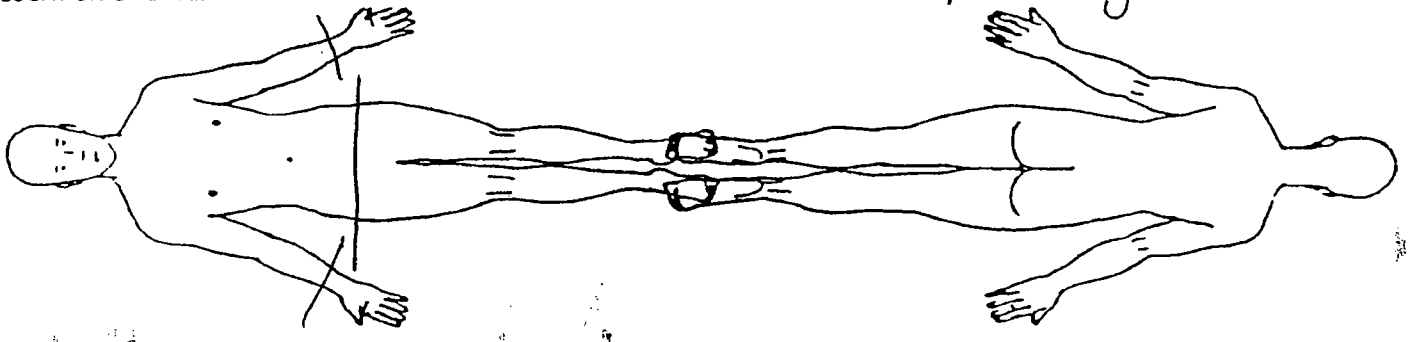
COMMENTS: Body in correct anatomical alignment

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine soap/sol.
SITE: Lt. BY WHOM: LTC [redacted]
SITE: BY WHOM:
COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	Spc [redacted]	LTC [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;)

[redacted]
b(6)-4

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

☒ ESU NO: Valleylab Force 2 #4
GROUND PAD: BRAND REM polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	moist kerlix x2		
SITE	Lt. AKA stump wound		

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
kerlix roll
ACE

19. ADDITIONAL INFORMATION
DA 5179 In Chart

20. OPERATION(S) PERFORMED
I+D Lt. AKA stump

21. PATIENT TRANSFERRED TO		TIME	METHOD
b/w 2	ICU 2	0945	Litter

22 [redacted] LTC, AN

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

MEDCOM - 16201

MEDICAL RECORD — **INTRAOPERA[redacted] OCU[redacted]ENT**

For use of this form, see AR 40-66, [redacted] Office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia (MAJ [redacted])

2. PATIENT [redacted] VIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 10-Aug 03 TIME PATIENT ARRIVED IN SUITE 0715

4. PATIENT IN ROOM TIME 0715 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

blw-2 A11

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] CRT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure & pad under head. (3) arms on padded arm boards less 90°

☒ 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:

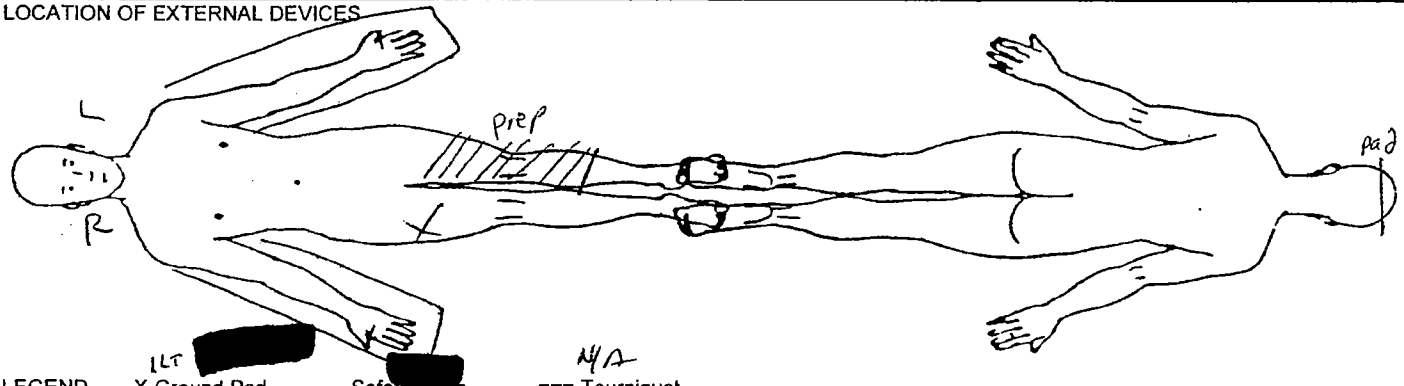
PREP SOLUTION (Specify) Betn/Beta

SITE: (L) Stump BY WHOM: CPT [redacted] AN

SITE: XX See #5 BY WHOM:

COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Count	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	/	/	
Needle Sharp	☒ Yes	☐ No	/	/	
Instrument	☐ Yes	☒ No	/	/	
Other	☐ Yes	☒ No	/	/	

SCRUB	CIRCULATOR
LCT [redacted] / PFC [redacted]	
PFC [redacted]	CPT [redacted]

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

[redacted]
ICU-2
blw-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO NOT USED

☒ ESU NO: #4

GROUND PAD: BRAND Valley Lab

LOT NO: 68936/2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES [illegible] MEDCOM - 16202 [illegible]CH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. Jp 10mm	2.	3.
SITE	1. (L) stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ABD
ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General (EMA)

Bovie Pad site intact pre-op YES ; post-op YES Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A : post-op NA
Tourniquet Time: Up N/A Down NA

b(6)-2 A11

20. OPERATION(S) PERFORMED
I+D (L) AKA c Delayed Primary closure

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2	0830	1. Her c or

22. REC[redacted]D NURSE S[redacted] CPT/An

REVERSE OF DA FORM 3179-1, OCT USAPA V1.01

MEDCOM - 16203

b(6)-2 All

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

For use of this form, see AR 40-66, the propon[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia [redacted]	2. PATIENT IDENTIFIED [redacted] VED AND PROCEDURE VERIFIED BY Staff [redacted] CPT IAW
3. DATE 12 Aug 03 TIME PATIENT ARRIVED I[illegible] 0845	4. PATIENT IN ROOM TIME 0845 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

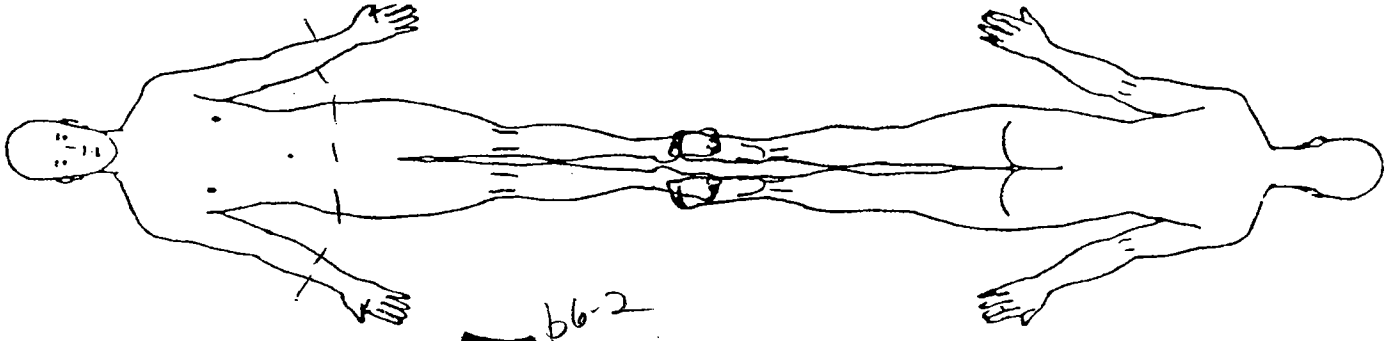
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: proper body alignment maintained, arms at less than 90° on padded armboards, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* N/A SITE: BY WHOM: SITE: BY WHOM: COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



b6-2

LEGEND: X Ground Pad -- Safety Strap [redacted] Tourniquet

10. COUNTS		C = Correct I = Incorrect				
		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;)*

[redacted] b(6)-4

ICW-2

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

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

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

☐ BIPOLAR NO: _____

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):

OTHER ORDERS	TIME	CARRIED OUT BY
none		

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)* Fluffs Kerlix Webril Cast Accuwrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: general mask
b(6)-2

Bovie Pad site intact pre-op_____; post-op_____; Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op _____: post-op_____ N/A
Tourniquet Time: Up____ Down_____

- DA 5179 on chart

20. OPERATION(S) PERFORMED
Drsg. Δ and Stump cast

21. PATIENT TRANSFERRED TO	TIME sent	METHOD
Recovery b(6)-2	DA 7389	litter c safety strap in place

22. REGISTERED NURSE SIGNATURE [redacted] CPT, AN

REVERSE OF DA FORM [illegible] OCT 87 USAPA V1.01

MEDCOM - 16205

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST-	DAY																		
MONTH-YEAR	DAY	8-6-07																	
19	HOUR	2200																	
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°	O																	35.6°
90	95°																		35.0°
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD		18																	
BLOOD PRESSURE		128																	
		78																	
HEIGHT:	WEIGHT→																		

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

[redacted] b(a)-4

REGISTER NO.

WARD NO.

511-112

VITAL SIGNS RECORD

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

USGPO 1981-381-646/8699

MEDCOM - 16206

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 4

POST-OP DAY: DOS 1 2 3

MONTH-YEAR: August 2003

DAY: 7 8 9 10 11 12-13 13 14

HOUR

PULSE (O) / TEMP. F (°)

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)*

EPW [redacted] b(6)-4

REGISTER NO.

WARD NO.

JCW

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16207

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 8

POST- DAY

MONTH-YEAR: AUG 04 | DAY: 14 | 15 | 16 | 17 | 18 | 19

19 20 | HOUR

PULSE (O) | TEMP. F (•)

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

	14	15	16	17	18	19
	130/80	130/80	105/65	120/80	130/80	110/80
	120/70	120/70	100/64		120/60	
	98	98	98	100	98	98

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)*

EPW [redacted]

b(6)-4

REGISTER NO.

WARD NO. ICWZ

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

MEDCOM - 16208

-STAT 6+

Pt: [redacted] b(a)-4

Pt Name:_____

Glu_____94 mg/dL

BUN_____<3 mg/dL

Na_____133 mmol/L

K_____3.3 mmol/L

Cl_____110 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

Sample Type_:

07AUG03 13:15

Oper: [redacted] 66-2

Physician:_____

Ser# 40763

Ver: JAMS046A
CLEW A93

66-4

ID [redacted] 07-08-03
WB 13:07
Patient
Limits

WBC	13.7	*H	x10^3/uL	4.5	10.5
RBC	3.69	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	34.4	L	%	35.0	60.0
MCV	93.1		fL	80.0	99.9
MCH	28.0		pg	27.0	31.0
MCHC	30.1	L	g/dL	33.0	37.0
Plt	635.	H	x10^3/uL	150.	450.
LY%	16.0	*L	%	20.5	51.1
LY#	2.2	*	x10^3/uL	1.2	3.4

Ward/Section: Emf	REQUEST[redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 27Aug	TIME 1255	SSN/PSEUDO SSN:

(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 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**		**Blood Bank**
Sed Rate			Cell Count		**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**
Other			Directigen	Negative	ABO/Rh ∅ ANEG

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:		
REPORTED BY: b(6)-2 [redacted]	DATE: 27Aug03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
07/08/03 13:03
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

GLU	100	73-118	MG/DL
BUN	3*	7-22	MG/DL
CRE	0.4*	0.6-1.2	MG/DL
CK	161	39-380	U/L
NA+	♦♦♦	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	105	98-108	MMOL
tCO2	19	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]	DATE: 7 Aug 03	LAB ID NO.:

b(4)-4

Ward/Section: 1W2	REQUESTI: [redacted] b(4)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8 Aug	TIME: 0400 SSN/F: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	20.0	4.8-10.8 x 10^3
RBC	3.50	4.7-6.1 x 10^9
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.6	42-52% (M) 37-47% (F)
MCV	93.6	80-94 fl (M) 81-99 fl (F)
Plt	688	130-500 x 10^3 verified
Lymph %	6.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(4)-2 **DATE:** 8 Aug 03 **LAB ID NO.:**

b(4)-4

Ward/Section: TCW 2	REQUESTING PHYSICIAN: Dr. [redacted] b(4)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 13/8/03	TIME: 1106	SSN/PSEUDO SSN: [redacted]

(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

======= PICCOLO =======
13/08/03 11:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

GLU	93	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	143	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS: b(4)-2

REPORTED BY: [redacted] **DATE:** 13Aug03 **LAB ID NO.:**

b(4)-4

Ward/Section: LC 00 2	REQUESTING PHYSICIAN: [redacted] b(4)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8/13/03 TIME: 1160	SSN/PSEUDO SSN: [redacted]

(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		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

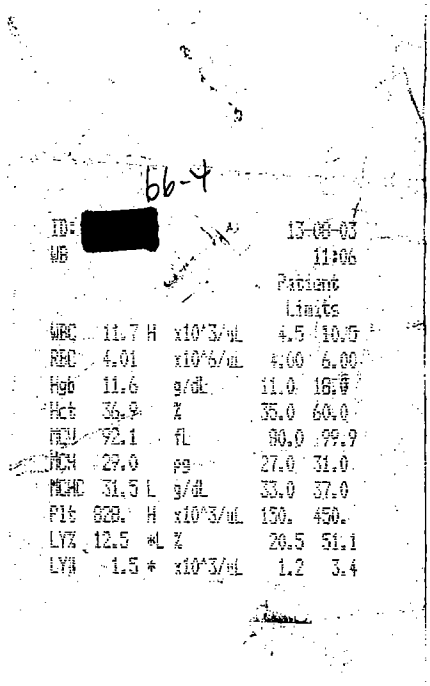
Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 13 Aug 03	LAB ID NO.:

b(4)-2



66-4

ID: [redacted] 13-08-03
WB 11:06

				Patient Limits	
WBC	11.7	H	x10^3/uL	4.5	10.5
RBC	4.01		x10^6/uL	4.00	6.00
Hgb	11.6		g/dL	11.0	16.0
Hct	36.9		%	35.0	60.0
MCV	92.1		fL	80.0	99.9
MCH	29.0		pg	27.0	31.0
MCHC	31.5	L	g/dL	33.0	37.0
Plt	628.	H	x10^3/uL	150.	450.
LY%	12.5	*L	%	20.5	51.1
LY#	1.5	*	x10^3/uL	1.2	3.4

MEDICAL RECORD - ANESTHES

MKDA

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

procedure verified

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

DRUG (Units)									
Lidocaine (MG)	40								
Fentanyl (UG)	250								
Morphine (MG)	150								
Versed (MG)	100								
MSO4 (MG)			10		2	5	3		
VOLAT AGENT 150 % del		2.0	2.0	2.0	2.0	2.0	2.0	X	
% e.t.									
AIR L/Min									
N2O L/Min									
O2 L/Min	8	3	2	2	2	2	2	2	2

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

FLUIDS

LINE site		
LH	☑ Warmed	LR
AC	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG / LB)

HEMATOCRIT:

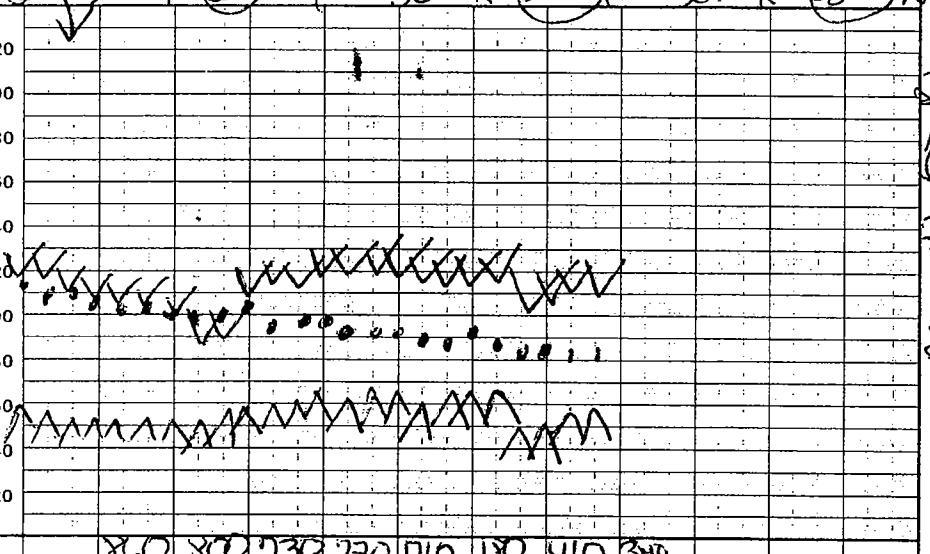
INITIAL DATA: BP- 120/60; HR- 110

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y); TIME- 2000

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

TIME → 2005 30 X (21W) X 30 X (22W) X 30 X (23W) X



VENTIL

VT - ml		860	800	730	720	710	180	410	310
f - breaths/min		7	7	6	6	6	13	8	15
Peak inf pres / PEEP		22	22	21	21	21			
MODE - S(pon), A(ssist), C(on)		SV	CV	CV	CV	CV	CV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	30	31	30	30	40	42	42
BP/oth	FIO2 (Frac or %)	.87	.87	.87	.87	.87	.87	.85	.85
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS
Gas analyzer CO	TEMP-site	skin	35	35	35	35	35	35	35	35
	N-M Block (T/4)		4/4 ST						
Warming blkt		head up/warm blanket							
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → N arms 90 abducted/padded

TOTALS: 2520 MG; TOTAL EBL; TOTAL URINE 1200 ML

FLUIDS SUMMARY: CRYSTALLOID- LR – 500; COLLOID- —; BLOOD- —

REMARKS

Code drugs with numbers, events with letters

2020 Pat to OR - on wand - MKJ
place electrodes
Preop dose
2025 - On room
monitors on
Induction/intub
2043 TOURN - 2045
42 11
2212 -
Spont resp
breath sounds
extubated
to ICU

RECOVERY AT: PACU (ICU) (Specify); OTHER Stretcher

CONDITION: RESP- 19 SpO2- 93% BP- 142/79 HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2000	2005	2212
PROC	Ready	Begin	End
	2025	2100	2210

PROCEDURES and CPT Codes: (L) AKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA - #8 ETT tape @ 22 cm teeth #4 NGT. OGT to suction. Eyes taped - soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 Direct laryngoscopy - BST - CXR view. ETT placement confirmed - BBSE/CTA. Atraumatic

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

[redacted] b(6)-4

SURGEON [redacted] b(6)-2 COL

ANES [redacted]

PROCEDURE # 2 C

LOCATION:

DATE: 17AUG05

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 16216 — COPY [redacted] MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

For u... of this form, see AR 40-66; the proponent agency ... OTSG

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

DRUG (Units)					TOTALS
phenergan (mg)	25/i				10
MSO4 (mg)	5/i	4			
propofol (mg)		150			
sux (mg)		100			
( )					
( )					
VOLAT AGENT Iso % del / % e.t.		1.5	2.0	1.0X	
AIR L/Min					
N2O L/Min					
O2 L/Min	6 — 2 — 2 — 2 — 6				
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	(1)(2)		(3)		

TOTAL EBL: 10 min

TOTAL URINE: Ø

FLUIDS

LINE site 20g LFA ☐ Warmed — LR —— 300

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS / URINE -

FLUIDS SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

No Δ in pt status since prior anesthetic char ✓. OK to proceed c̄ GETA.

(1) To room via litter, preO2, SOC monitors

(2) Smooth IV induction & intubation.

(3) Suctioned & extubated. To recovery stable, report given.

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 35.6

INITIAL DATA: BP- 146/88 HR- 112

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? ✓ TIME- 0845

smoker

29 yrs old

NKDA

TIME → x 09 x 30 x 10 x 30 x 11 x 30

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

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

VENTIL

VT - ml	600	250	320	280
f - breaths/min	16	17	17	20
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	44	38	37	48
BP/oth	✓ FIO2 (Frac or %)	0.8	0.8	0.8	0.8
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST
Gas analyzer	TEMP-site skin		96	96	96
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT: PACU (ICU) [illegible] (Specify) OTHER

CONDITION: RESP- 10 SpO2- 95 BP- 120/67 HR- 106

ANESTHESIA / PROCEDURE TIMES

ANES	Start 0845	Room 0855	End 0935
PROC	Ready 0905	Begin 0917	End 093[illegible]

PROCEDURES and CPT Codes: I&D L AKA Stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, 2 miller DL x 1 s̄ trauma, ⊕ EtCO2 BSEB. Secured 22cm @ teeth.

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

EPW #[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

AN[redacted] MAJ CRNA

[redacted] ATIENT'S MEDICAL RECORD

PROCEDURE LOCATION: 1-1

DATE: 8/9/03

PAGE 1 OF 1

USAPA V1

DA FORM 7389, FEB 1998 MEDCOM - 16217

09 yo - ♂ A- since 7 AUG 03

NKDA

MEDICAL RECORD - ANESTHESIA

Fr ... form, see AR 40-66; the proponent agency is th... G

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

DRUG	(Units)	
MSO4	(Mo)	6 2 2
Propofol	(Mo)	200
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	150 % del	2-2-2-2-1.0
	% 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 → 1 Induction

FLUIDS

LINE site	#1 (20)	☐ Warmed
	PIC	☐ Warmed
		☐ Warmed
		☐ Warmed

LR

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

INITIAL DATA

BP- 120/60

HR- 102

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? (Y) TIME- 0710

TIME 0700 0715 30 45 (0800) + 30 +

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VENTIL

VT - ml		210	210	160	410	490	660
f - breaths/min		10	6	6	9	6	8
Peak inf pres / PEEP		—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)		SV	S/	S/	S/	S/	S/

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		41	50	50	55	53	48
BP/oth	FIO2 (Frac or %)	.64	.64	.64	.64	.63	.64	.64
ART line	SpO2 (%)	99	99	99	99	99	99	99
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS
Gas analyzer	TEMP-site	Skin		35	35	35	35	X
	N-M Block (T/4)							
Warming blkt		wool blanket/head wrap						
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → cl — arms ≤90 abducted/padded.

TOTALS 1000 — **TOTAL EBL** MSi — **TOTAL URINE** —

FLUIDS SUMMARY

CRYSTALLOID- LR-500

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

0700 Mdl/10d Procedure Verified Prep done Chart rev'd 0710 - Dr Nam → monitors on

0723 spont resp Opened eyes Nods D/C TO ICU for recovery

RECOVERY AT

PACU (ICU) (Specify)

OTHER Stable

CONDITION:

RESP- 10 SpO2- 99% 97

BP- 149/78 HR- 91C

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0710	0710	0845
PROC	Ready	Begin	End
	0000	0740	0825

PROCEDURES and CPT Codes: R-D LAKA / DPC

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: General/Knee block; 20" tourniquet → Eyes taped. Soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Preoxy → LMA #4 inserted X1 attempt → atraumatic.

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

#[redacted] b(4)-4

SURGEONS: [redacted] b(4)-2

[redacted] b(4)-2

PROCEDURE# / LOCATION: /

DATE: 10 AUG 03

PAGE / OF /

DA FORM 7389, FEB 1998 — MEDCOM - 16218 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

Versed 2mg Pre-op
fentanyl 100mcg

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)		
Versed	(mg)	1	Versed 3mg
fentanyl	(mcg)	50	fentanyl 150mcg
propofol	(mg)	150	
	( )		
	( )		
	( )		
VOLAT AGENT ISO	% del	2	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6-3-3	

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

FLUIDS

LINE site		
LR	☐ Warmed	300
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1/2/3/4/5/E

BODY WEIGHT 70 (KG/LB)

HEMATOCRIT: —

INITIAL DATA

BP- 109/55

HR- 93

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 0843

TIME 0845 0900X

SYMBOLS

BP by cuff: V ^

Heart rate: ●

Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-⊙

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VENTIL

VT - ml	SV 680
f - breaths/min	TO 10
Peak inf pres / PEEP	
MODE - S(pon), A(ssist), C(on)	S S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	45
BP/oth	FIO2 (Frac or %)	.89	.8
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	SR	SR
Gas analyzer	TEMP-site	Available	
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

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

TOTALS — TOTAL EBL: 0

Versed 3mg
fentanyl 150mcg

TOTAL URINE: 0

FLUIDS SUMMARY

CRYSTALLOID- 300ml

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

Pt IVd - to OR. Monitored.

Pt taken to PACU in stable condition. Report given

RECOVERY AT

PACU ICU _____(Specify)

OTHER Stable, A&A

CONDITION:

RESP- 18 SpO2- 100

BP- 117/70 HR- 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0843	0916
	Ready	**Begin**	**End**
PROC	0847	0853	0908

PROCEDURES and CPT Codes:

Dressing Δ / Stump Cast to (L)

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Mask GA

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

Mask

SURGEON [redacted] b(6)-2

ANESTH [redacted] MD

PROCEDURE LOCATION: 1

DATE: 12 AUG 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 16219 [redacted]'S MEDICAL RECORD USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 29 DAYS MOS (YRS) Sex (M) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 70 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: GSW (L) LEG
SURGICAL SERVICE: ORTHO
NPO SINCE: 10 Am

HABITS:
TOBACCO: Smoker
ETOH: (+)
DRUGS: (-)

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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 ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth POOR DENTITION
Trachea MID LINE
TMJ/Neck 3(+)
Oropharnyx MP 2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: ____
IV Access: (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 10 Am Now 1435

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2

The patient/[redacted] stand and agrees. Questions answered.
Signed: [redacted] Date: 07 Aug 03 Time: ____ 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) ICU2 / ICU2

[redacted] b(6)-4

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)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	7 JUL 04	1320 HOURS	
1	ADMIT TO ICW-2		
2	DX- OPLY, LUNGS (L) PNEUMO FOLLOWING		
3	CONDITION- STABLE		
4	VS- ROUTINE		
5	NPO		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
6	BO REST	HOURS	
7	IV - LR AT 125 CC/HR.		
8	ANCEF 1 GRAM IVPB Q 8 HRS		
9	MSO4, 2-6 MG IVP Q 2 HRS		
10	TO OR TODAY		

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	7 JUL 04	2210 HOURS	b(6)-2
6	TO ICW-2 ✓		
7	S/P (L) ABOVE KNEE AMPUTATION ✓		
8	CONDITION STABLE ✓		
9	VS- ROUTINE ✓		
5	BED REST, ROLE PHONE Q 2 HRS ✓		
6	REGULAR DIET ✓		
4	IV LR AT 125 CC/HR. HEP LOCK ✓		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	FOLEY PD	WBC ✓ HOURS	
8	CBC IN AM ✓		
9	ANCEF 1 GRAM IVPB Q 8 HRS ✓		(8,16,24)
10	CEFAZOLIN 400 MG IVPB Q 12 HRS ✓		(10,22)
11	PERCOCET 1-2 TABS PO. Q 4-6 HRS PRN ✓		
12	MSO4 - 4-8 MG IVP Q 2 HRS PRN ✓		
13	TYLENOL 650 MG PO. Q 4 HRS PRN ✓		
14	FENTANYL PATCH 75 MG NOW ✓		

038

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 [redacted] ✓ CHA[redacted]

[redacted]

☆ U.S. GO MEDCOM - 16221 3-710 b(6)-2

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(4)-4

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

DATE OF ORDER 8 AUG 03 TIME OF ORDER 2120 HOURS

LIST TIME ORDER NOTED AND SIGNED

[redacted] noted 0130

(1) NPO AFTER MIDNIGHT

(2) TO OR IN AM

b(4)-2 [redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICWD	24 V/S	0145

DATE OF ORDER 9 AUG 03 TIME OF ORDER 0940 HOURS

b(4)-2 noted 9 Aug 1100 [redacted]

(1) RESUME PREVIOUS ORDERS

(2) RESUME DIET, NPO AFTER MIDNIGHT

(3) IV-LR AT 125 cc/hr. HEP LOCK WHEN FLUIDS P.O. WELL

(4) TO OR IN A.M. 10 AUG 03

(5) RESPIRATORY TREATMENTS PRN

PATIENT IDENTIFICATION

EPW

[redacted]

b(4)-4

NURSING UNIT	ROOM NO.	BED NO.
		10 Aug 1230

DATE OF ORDER 10 AUGUST 03 TIME OF ORDER 0823

[redacted] b(4)-2

(1) RESUME PREVIOUS ORDERS

(2) REGULAR DIET

(3) N.S. LR AT 125 cc/hr. HEP LOCK WHEN TOLERATING P.O. WELL

(4) EMPTY SO FOLEY DRAIN Q SHIFT

noted

PATIENT IDENTIFICATION

038

NURSING UNIT	ROOM NO.	BED NO.

b(4)-4

(5) CHEST AP, LAT, ABDOMEN X-RAY, TODAY [redacted] b(6)-2

[redacted]

24 V/S [redacted] CTAN. 8/10/03 2200

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

☆ U.S. G MEDCOM - 16222 3-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT: ICW 4th | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8/12	0630 HOURS	
NPO for OR tod.		
V.O. Dr. Albrecht [redacted] EPW		
X		b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT: ICW 4th | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
8/12/03	0908 HOURS	
1. Routine postop orders [redacted] EPW		
2. Regular diet		
3. N-2L ST NS c KCl 40 mEq/L @ 150 cc/hr x 24 hrs then change to D5 1/2 NS c KCl 40 mEq/L @ 125 cc/hr x 24 hrs 1200 8/13 EPW		
4. Drain D/C'd [redacted]		

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 8

DATE OF ORDER	TIME OF ORDER	
8/13/03	0830 HOURS	b(6)-2
1. CBC, Electrolytes & TSH [redacted]		
2. [redacted] 240 NS IVTAN @ 44 gtts/min.		

PATIENT IDENTIFICATION

038

NURSING UNIT: | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
8/15/03	0830 HOURS	b(6)-7
1. Mom 30 cc PO x 1 Now		
Again in 2 hrs and then PRN constipation		
2. Colace 1 PO BID [redacted]		

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

☆ U.S. G MEDCOM - 16223 3-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

b(6)-2 All

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		8

DATE OF ORDER 8/.5/.3 TIME OF ORDER ____ HOURS

- D/L IN Ars λ
- Start Cipro 500 mg po BID
- Ambien 5 mg PO q hs

[redacted] Notified

15/1450

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU2		8

DATE OF ORDER 5/15/03 TIME OF ORDER 1613 HOURS

- repeat order
1. Ambien 10 mg PO Q 9 PM PRN insomnia
2. Kadian 60 mg PO - PRN

[redacted] Notified 1650

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU2		8

24 VS [redacted] DATE OF ORDER 8/18/03 TIME OF ORDER 1400 HOURS

1. STUMP WRAPPING 3 PATIENT Q 2 HOURS 1490
2. MS CONTIN 30 mg PO Q12 PRN pain
3. KLONOPIN 75 mg P.O. Q [redacted] 19Aug

[redacted] Notified

24 VS 0130

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

b(6)-2 +11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7 8 9 10 11 12 13 14 15 16 17 18 19 20
7 Aug	[redacted]	VS routine	05	[redacted]
			13	
			21	
7 Aug	[redacted]	NPO	06	D/C
			12	
			17	AW
7 Aug	[redacted]	Activity: bedrest Roll Prone Q 2 hr	05	[redacted] D/C 7 Aug 03
			13	AW
			21	CM
7 Aug	[redacted]	Regular Diet	07	[redacted]
			12	
			17	
9 Aug	[redacted]	Reinforce DSG PRN	06	[redacted]
			14	
			22	
10 Aug	[redacted]	Empty JP drain QShift	06	[redacted] DC'd 12 Aug 03 JF
			14	
			22	
18	[redacted]	Stump wrapping	05	[redacted]
RSAW		92° by pt.	13	
			21	

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) post tib/fib/S/P (2) AKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW# [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 16225

DCW2 - A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7Aug	[redacted]	Admit to ICW2	7Aug		1430	[redacted]
7Aug		To OR today	7Aug		Done	
7Aug		Admit to ICW2 Condition stable	7Aug		Done	
7Aug		CBC in AM	8Aug	0400	Done	
8Aug		NPO ☩ midnight, OR in AM	9Aug	0001	Done	
9Aug		NPO ☩ MN, to OR in Am 10Augos	10Aug	0000	0700	
10Aug		Hand AP, LAT, Oblique xray today	10Aug	today		
12		NPO for OR today	12	Now	0230	
12		Resume Previous Orders	12	Now		
13		CBC & MET 8	13/8	1100	1015	
15Aug		MOM 30mL PO now and qam in 2hrs	15Aug	0830	0830	
18		discharge to EPW Camp 19Aug	19Aug			
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Mo. ____ Yr. ____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/6	8/7
8-6-03	[redacted]	Ancef 1Gm IV Q8h	06	[redacted]	
			14		
		b(a) - 2	20	[redacted]	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(a) - 4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 16227

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
6-Aug		Morphine Sulfate 10mg IM	6-Aug	2107	2107	[redacted]	b(6)-7

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

☆ U.S.G.P.O.: 1985 - 491-003/43119

MEDCOM - 16228

b(a)-2 All

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. 8 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (7–20)
7 Aug / 12 Aug	[redacted]	LR @ 125 cc/hr (HL) when taking PO	08 / 13 / 21	[redacted] DC'd 15 Aug 03 [redacted]
7 Aug	[redacted]	Ancef 1 gm IVPB q8°	08 / 14 / 22	ERR [illegible] Δ'd see below
8 Aug	[redacted]	Ancef 1 gm IVPB q8°	08 / 16 / 24	[redacted] DC'd 15 Aug 03 [redacted]
7 Aug	[redacted]	Ciprofloxacin 400mg IVPB Q12°	10 / 22	[redacted]
15 AUG	[redacted]	Colace PO bid	10 / 22	[redacted] held held held [redacted] D/C [redacted] 19 Aug
15 Aug	[redacted]	Cipro 500mg PO BID	10 / 22	[redacted]
15	[redacted]	Ambien 5mg PO qHS	22	[redacted]
18	[redacted]	elavil 75mg PO qhs	22	/ / withheld

ALLIERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW Posterior (L) tib fib / S/P (L) AKA

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

PATIENT IDENTIFICATION:
EPW [redacted]
b(a)-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 - 16229

b(6)-2 All

b(6)-2 All

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~~ PRN	HR	DATE DISPENSED
7 Aug	[redacted]	MS04 2-6mg IVPB q2° prn		
7 Aug	[redacted]	Percocet 1-2 tabs PO q4-6° PRN		
7 Aug	[redacted]	Tylenol 650mg PO q4° PRN		
15	[redacted]	MOM 30cc pm constipation		
15	[redacted]	Kaopectate PO PRN-diarrhea		
7 Aug	[redacted]	Percocet 1-2 tabs PO, q4-6° pm		
		One Time Orders Medications		
7 Aug	[redacted]	75ug/h Fentanyl Patch x1 now		Time Done 0246 7 Aug 05

DC 19 Aug 05

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 [redacted]

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

MEDCOM - 16230

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: 07 Aug 03 Anesthesia Type (Circle): General Spinal Epidural
Time In: 2215 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 1000 Colloid
Pre-op V/S: 120/60 OR Output: UOP 60 EBL minimal
Procedures: R AKA Meds/Times:

20mg MSO4
250mg fentanyl

Drains: Hemovac, NG, JP, T-tube, Foley, TLS, ~~Penrose~~ 1

Airway: ~~Nasal~~, Oral, ETT, ~~Trach~~, Other

Pre Op Meds

History

Time	2215	2220	2225	2230	2245	2300	2315
SaO2	99	100	100	100	100	99	96
FiO2	4L	4L	4L	4L	4L	4L	NC
Methods	SM	SM	SM	SM	SM	NC	

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RR	19	17	15	22	10	14	16
T	97.3	97.8	98.1				

Pacu Intake

Time	Solution	Amount	Site	B	Infused
2215	LR	200cc	(L) AC	[redacted]	100cc
				66-2	

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	2	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	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	8	9

Codes

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

V/S: X = A-line BP, ° = Cuff BP, = Pulse

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

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

Time	Patient teaching done: Wound Care, Pain Management,
Pain (0-10)	T, C, & DB.. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*: [redacted] CRT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 07 Aug 03

PATIENT'S IDENTIFI[redacted] *give:* *Name – last, first, middle; grade; date; hospital or medical facility)* b(6)-2

EPW

[redacted] b(6)-4

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

DA FORM [redacted], MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDCOM - 16231

b(6)-2 All

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		[redacted]				
		None				

NEUROVASCULAR

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

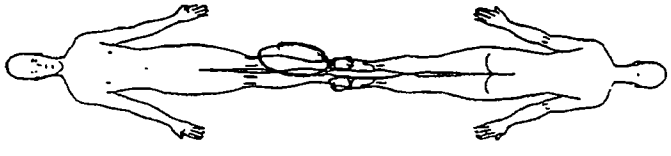
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) LE	CDI	Ø
30'	(A) LE	Ace	CDI
60'	(B) LE	ACE	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2315	[redacted]		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
	[redacted]		

WAMC OP 173-E

NURSING NOTES

Admitted to ICU2-PACU @ 2315, received on 'Letter. Or weaned off, sats >95% RA, resp even unlabored. Awakens to voice touch. Follows commands. HR/BP Stable, pulses palpable, DSG CDI. Ø C/O pain @ this time. 18G IV in (R) AC c LR @ 100 cc/o. New bag @ 2300. Report given to ICU2. [redacted]

* CIPRO 400mg IV given @ 0315

Discharge Criteria:
Date: 7 AUG Time: 2315 PARS: 9
BP: 1:98 HR: 94 RR: 15 Sa02: 98
Pain Level at D/C (0-10):
Intake: 100 cryst Output: Ø
Additional Data: DSG CDI
Transferred To: ICU2
Report Given To: [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] CPT(NN)

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: 9 Aug 03
Time In: 0943
Allergies: NKDA
Pre-op V/S:
Procedures: Stump wash out

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 LR Colloid
OR Output: UOP 0 EBL Minimal
Meds/Times:

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

Pre Op Meds

History

Time	0945	0950	0955	1000	1015	1030
SaO2	95	95	94	95	97	97
FiO2						
Methods	NA	NA	NA	NA	NA	NA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	23	19	15	13	13	11
T	98				100	

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	1	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	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	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	12	12

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

Time	Patient teaching done; Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 9 Aug 03

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 9 Aug 03

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

EPW [redacted] b(6)-4
29 4/0

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

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

USAPPC V2.00

MEDCOM - 16233

BLW-2A11

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

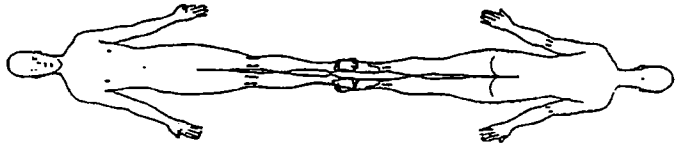
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	② stump	Ace wrap	Ø
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

(0945) pt to ICU 3 for recovery from surgery, VSS SaO2 95% on Room Air [redacted]
0955 pt drowsy due to Phenergan given prior to xfer to ICU 3. VSS [redacted]
(1015) pt awake & alert audible VSS [redacted] Gurney
(1030) pt VSS, SaO2 97 on room air will be transfered to ICU 2 [redacted] Gurney

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:

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: 10 AUG 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block LMA

Time In: 0930

Allergies: NKDA OR Intake: Crystalloid LR-500 Colloid —

Pre-op V/S: 122/60 OR Output: UOP — EBL min

Procedures: I&D LOAKA DPC Meds/Times:

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

Pre Op Meds History

Time							
SaO2							
FiO2							
Methods							
240							
220							
200							
180							
160							
140	V	V	V	V	V	V	V
120	V						
100							
80							
60							
40							
20							
RR							
T							
Time	1634						
Pain (0-10)	0	0					
LOS							

Pacu Intake b(4)-2

Time	Solution	Amount	Site	[redacted]	Infused
0844	LR	700	RFA	[redacted]	300

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	/	/	/
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) [redacted]

DEPARTMENT/SERVICE/CLINIC: FCU-2

DATE: 10 Aug 03

PA... (first ... grade; date; hospital or medical facility) Name — last, b(4)-2

[redacted] b(4)-4

- ☐ 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							
15'							
30'							
45'							
60'							
90'							
D/C							

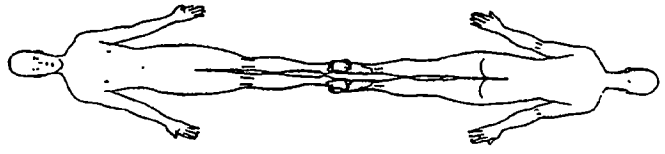
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	[redacted]	[redacted]	[redacted]
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
[redacted]	[redacted]		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
[redacted]	[redacted]	[redacted]	[redacted]

WAMC OP 173-E

NURSING NOTES

0840. Received from [redacted] ambulatory. Denies pain. Denies nausea. Denies dizziness. Ambulated to bathroom with steady gait. Denies headache. Denies blurred vision. Denies shortness of breath. Denies chest pain. Denies smoking. 0900 pt transported to [redacted] via wheelchair with husband. 0905 VSS. Denies dizziness. Denies headache. [redacted]

blood-2
All

Discharge Criteria:
Date: [redacted] Time: 0940 PARS: 10
BP: [redacted] T: [redacted] HR: 80 RR: 18 Sa02: 99
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Rec[redacted]
Charge Nurse Signat[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

Date: 12 Aug 03
Time In: 0815
Allergies: NKDA
Pre-op V/S:
Procedures: Arm I.D. + Stump

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

OR Intake: Crystalloid 300 cc Colloid
OR Output: UOP 0 EBL minimal

Meds/Times: 5mg Morphine 150 mcg Versed

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

Pre Op Meds / History

Time	0815	0820	0825	0830	0845
SaO2	99	98	100	100	100
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	V	V	V	V	
100					
80	A		A		
60		A		A	
40					
20					
RR	15	14	11	15	
T					

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	~~1~~	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
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	V/S X = A-line BP ° = Cuff BP = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
Circulation (Peds < 6 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	9	9	

Time	Patient teaching done; Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: , SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] CRNA | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 12 Aug 03

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

[redacted]

b(6)-2

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

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

MEDCOM - 16237

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							

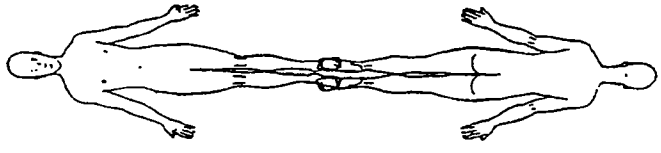
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Ostamy	gauze	none
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

Arrived from OR via gurney drowsy but arousable. VS stable on RA. Dsg [redacted] BKA C.S. + Incont. Pt stable. Alert. IV to [redacted] Ambulated

b(6)-2
A 11

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:

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 (1) D (1)	F Z	[redacted]	EPW # [redacted] b(6)-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
Z Z Z Z Z Z Z Z	2 9 Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1320	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		1	YEAR [ ] NO [X]

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

NA[redacted]Y	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
b(2)-2	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
5 Ø		Ø 3 Ø 8 1 9	UNK

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		Ø 3 Ø 8 Ø 7

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

GSW (L) tib/fib → (L) AKA

DX-8972
E9912
T-1
I-450
PR-8417
8622

b(6)-2

ADMITTING OFFICE [redacted]

[redacted] ERK

DA FORM 3985 MAR 89 MEDCOM - 16239

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER [redacted]	2 NAME (Last, First, MI) [redacted]			3 GRADE NA	ADMISSION REMARKS
4 SEX M	5 AGE 46	6 RACE UNK	7 RELIG UNK	8 MPS NA	9 BLOOD NA
10 PREVIOUS ADMISSION NO					
11 POP 99	12 SSN [redacted]	13 ORGANIZATION NA		14 WARD IQW2	
15 MARITAL STATUS NA	16 MILITARY OCC SPEC	17 DATE OF BIRTH NA	18 BRANCH/CORPS NA	19 UIC/DSP b(6)-4	20 TYPE CASE NBI
21 SOURCE OF ADMISSION; AUTHORITY FOR ADMISSION DIRECT FROM EMT			22 HOURS OF ADMISSION 2010	23 CLINIC SERVICE AEAA	25 SSN [redacted]
24 NAME RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25 TYPE DISPOSITION 50	26 DATE OF DISPOSITION 25 AUG03	
27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b TELEPHONE NO.	28 DATE OF THIS ADMISSION 07 AUG03	ADMITTING OFFICER b(6)-7 OR [redacted]
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30 DATE OF INITIAL ADMISSION	32 COMPONENT TRANSFUSED

31 SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO (L) LOWER FEMUR

(L) FEMUR FX

35. Total Days This Facility

a ABSENT SICK DAYS	b OTHER DAYS	c CONV LWOOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0	0	18	18

36 Total Days All Facilities

a ABSENT SICK DAYS	b OTHER DAYS	c CONV LWOOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0 b(6)-2	0	18	18

SIGNATURE OF ATTENDING PHYSICIAN [redacted] Dr [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] for

DA FORM [illegible] MAY 75 EDITION OF 1 AUG 75 IS OBSOLETE APPD V

MEDCOM - 16240