MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

46 yr old Iraqi EPW - GSW - (L) thigh & (L) ~~calve~~ calve
& femur fx (L) & ? Tib-Fib fx (Left). Wounds
are 11 days ~~old~~ old

PMH: 0
Allergies: NKA
MEDS: 0 Received Ancef
T - 99.6 P - 110 B.P. 126/71 RR - 19 Pulse ox - 94%
alert HEENT
Lungs - clear HOP Heart - RR NO (M)
Abd - soft, BS - Normal No ~~masses~~

PHYSICAL EXAMINATION

Back - clear
(L) Leg - thigh - severe echymosis (L) thigh
small wound (L) lateral thigh
(L) lower leg - entrance wound & exit wound - medial
aspect - calve.

X-ray - femur fx (L) ? ~~tib fib fx (L) lower leg~~

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

A) Fx (L) femur GSW (L) femur
GSW (L) lower leg

(b)(6) - 2

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

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

REGISTER NO.	WARD NO.

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

[redacted]

MEDCOM - 16241

(b)(2)-2

EPW [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	Gunshot wounds (L) thigh - (L) calf - entry only -
	Rx - [illegible] 11 days old. denies any medical problems NKA Allergies
	[illegible]: Head Ø [illegible]
2:18 1g ANCEF IV	[illegible] - [illegible] [illegible] Ø
	Xray left femur - displaced fx of femur c̄ bullet fragments present
	left - leg gauze wound
	A 12 day old gunshot wound - (L) femur displaced fracture
	P - to C.S.H. - ortho - [illegible] A [illegible] (b)(6)-2
	1gm Ancef given now [redacted] [illegible]

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

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

REGISTER NO.	WARD NO.

EPW (b)(6)-24

[redacted]

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

MEDCOM - 16242

gl shot to L fex

ACLU-RDI 1636 p.2

DOD-029631

2200 Pt transfer to holding Unit Traction splint in place on (L) leg. Pulses present @ this time. IV infusing [redacted] CPT, AN

(b)(6) - 2

MEDCOM - 16243

ACLU-RDI 1636 p.3

DOD-029632

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 Aug 03 1455	Rec'd Pt from EMT via litter Dx: GSW ⓛ thigh, ⓛ femur fx & ⓛ tib-fib fx Condition: Stable. Pt Awake & Alert. VSS. NSR ⓛ FA infusing NS @ 200 cc/hr 3 diff, ⓓ S/Sx of infection noted. Lungs CTA, Abd Soft nontender BS⊕ Pd. ⓛ thigh c Severe ecchymosis, thigh very tight, taunt calf area c sm hole infection noted, pus, yellowish oozing from area. ⓛ foot ⊕ pulse, edema noted to ⓛ ext. RLE c full ROM ⊕ pulse. BLE c full ROM ⊕ pulses. Pt is NPO until further per MD orders. 2x2 dsg applied to hole in calf area. Pt is on call for OR. ⓓ complaint of pain voiced @ this time. Will cont to monitor [redacted] (b)(6)-2 9 IWM6
7 Aug 03	Op Note Pre-op Dx - GSW to ⓛ femur c fracture Post op - same, c hematoma ⓛ knee Effusion Surgeon [redacted] / [redacted] (b)(6)-2 Surgery - Spanning Ex-fix ⓛ femur Aspiration of ⓛ knee I&D ⓛ calf. Pt tolerated procedure well.

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

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

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

EDW

[redacted]

(b)(6)-24

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7Aug03 2005	pt returned from Surgery via ICU 2. pts (L) leg c ex-fix dsging ace wrap. Ace wrap CDI, Kerlix under Ace wrap c pinkish color drainage noted, toes swollen < 3 sec cap refill. Foley cath to gravity intact, draining, 3 diff. IV fluids A'd to D5½ NS c 20meq KCl @ 200cc/hr. Will cont to monitor [redacted] (b)(2)-2 9IWME
7Aug03 21:27	Recd c/o pt @ 21:00. Restraints x 2 (B) wrist/ankle. VS WNL ↑ temp 101.2° PO Tylenol given. Will retake Temp in 1°. Awake and alert in bed. Perrla (B) WNL. Pupils size 2. ICR (B). HR tachy S. Ss WNL. Tachy has been baseline for pt. RSS (B) x 4. (+) PP (B). (L) thigh ex-fix in place. c ace wrap dsg intact. Pin sites c copious amt. bloody drainage. (L) foot cool to touch. (B) sensation deem (B) pedal pulse + to digits. c/o pain 3mg MSO4 given will cont. to mon. [redacted] (b)(6)-2 2CT/AW
Addendum	FTG draining CYU. PIV (R) F/A infusing D5NS c 20meq KCl @ 150cc/hr [redacted] (b)(6)-2 2CT/AW (b)(6)-2 [redacted]
7Aug03	Pt. temp taken @ 2200. 101.0
7AUG03 0044	temp 99.3 [redacted] (b)(6)-2 2CT/AW
0219	3mg MSO4 given for c/o pain. (L) ex-fix pin sites dsgs c mod amt serosang drainage noted. Ecchymotic area @

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 (b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Aug03 0215	Pt care assumed @ 2100. VSS, sleeping, awakens to verbal stimuli, no pain. Lung sounds CTA, ~~pulses~~ SS bs hypoactive except in LLQ. Foley dc'd @ 2100, pt voided 300cc clear amber urine @ 2330. IVF DC/d, HL, IVABX. Dsg c̄ effy draining small amount of blood, intact. + sensation and movement of toes in lle. Pt npo p̄ breakfast, possible surgery at night. Continue to monitor. [redacted] 9Humng (b)(6)-2
9Aug03 0800	POD#2 Tm 100² HR 100 BP 120/80 Doing well Needs repeat X-ray today then to OR if need adjustment of ex-fix (b)(6)-2
9Aug03	1030 - Pt alert & oriented ~~OOB ck for~~ error on [redacted] to x-ray. Pt utilized crutches & [redacted] assistance from PT. Gave 6mg MSO4 for pain. HL to Ⓡ forearm. Ex + fix intact + Ⓛ thigh c̄ Ace wrap. Moderate drainage noted on dsg. VSS, temp 99¹, lungs CTA, BS⊕, pulses ⊕ x4. Some edema noted to Ⓛ foot + upper thigh area. Will cont to monitor [redacted] 2Lt AN (b)(6)-2

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

EPW

[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 ME[DIC]AL CARE
MEDCOM - 16246

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	superior to ACE wrap dsg. Will cont to mon.
(b)(6)-2	[redacted] DRT/MD
0415	Pt c/o tight throbbing pain to (L) thigh. 4mg MSO4 given will cont. to mon [redacted] DRT/AB (b)(6)-2
8 Aug 03	0940 - Pt alert + oriented lying bed. Ext fix to (L) thigh c Ace wrap dsg intact. Large amount of serosang fluid noted on Chux. Doctor aware of amount stating it is to be expected. Gave amg MSO4 for pain. VSS, temp 99.6, Lungs CTA, HR reg, BS@ x4, pulses @ x4, IV D5½NS c 20k @ 100cc/hr into (R) arm. Tolerated breakfast. Voicing c/ complaints at this time. Will cont to monitor. (b)(6)-2 [redacted] 2LeeRN
8 AUG 03 1300	- Rec'd Pt alert in bed. Pt is resting + resp of 100.1. Will encourage coughs + deep breathing. Hx R. BS x4. Wheezing + crackles noted ~~on~~ B. Utterly. Pt reports dyspnea. SAT 97%. Ext fix to (L) thigh with dressing CDI. NO S/S of infection noted. Pt has (+) PCM to toes, slight swelling noted on (L) foot. Pt has Foley draining yellow clear urine. IV D5½NS c 20K running @ 100cc/hr in (L) arm CDI. Will cont to monitor Pt. [redacted] cpw (b)(6)-2

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16247

ACLU-RDI 1636 p.7

DOD-029636

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

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

26 JUL 03
1930

Ortho Op Note

Pre Op Dx - (L) Femur Fracture
Post Op Dx - same
Procedure - Closed reduction (L) Femur,
Surgeon [redacted] (6)(6)-2 / Alivio
GOL - Ø
Findings - Unable to improve length
Improved AP angulation. Appears
to have ER spring in thigh. No
x-RAY evidence yet, but very firm.
PLAN - X-PIX. Will observe.

[redacted] (6)(6)-2
DD 8-6
CDL 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.)*	REGISTER NO.	WARD NO.

ID [redacted]
(6)(6)-4

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

MEDCOM - 16248

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25aug03@	Received pt resting in bed, VSS, NPO for OR. A+Ox, speaks Arabic. Amb to toilet x1 w/ Pt and Staff. Ex fix in place. No remarkable assessment findings. (L)LE warm w/ palpable pulses + brisk cap refill, c/o pain, medicated ++ Percocet. Will cont to monitor. (b)(6)-2
25aug@ 2320	Pt alox3, vss, pulses [redacted] tachy. c/o pain to (L) thigh, ex fix intact. drsg Ad to leg + thigh. Meds given. pulses to (L) leg palpable c brisk cap refill. Tol. PO well. Voiding, = difficulty. Will cont to monitor (b)(6)-2 [redacted] plumb
	Benadryl given for etchinx @ 2300 (b)(6)-2 [redacted] SR
26Aug03 CONTD	VSS. A+O. NPO on call for OR (L) LE exfix intact. Pen care done. ~~PP~~ crustation removed + moist cotton tip swab. Multi small wound to (L) LE. Dsg as ordered. Serosanguinous drainage noted on old packing. (L) LE pulses palpable (L) toes warm will capillary refill < 3sec. Tolerating. Regular diet. No pain or distress noted. SR
26 aug@ 1900	Pt back from OR - ~~PP~~ washout, A+Ox3, VSS, (L) LE fix. intact, drsgs to thigh + calf CDI, ¢ pain or distress noted. Pulses palpable, brisk cap refill to (L) LE. 2 pt restraints on, circulation assess

STANDARD FORM 509 (REV. 5/1999) BACK

[redacted]

(b)(6)-4

MEDCOM - 16249

(cont)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

23AUG03 (cont) place on (L) thigh. Pin care done. Drsgs to GSW Δd c iodoform gauze packed into wounds. Wet-dry drsgs Δd on calf. Pt voiding s difficulty. 2-point restraints in place. monitoring [redacted] WNL

23AUG03 2100 JSS. AO. (+) pulses to LUE and pedal. Warm to touch. CR ⇒ PSG's to pins c/o. Denies pain @ this time. Performed ROM. Safety completed in bed. —(b)(6)-2 [redacted] EW

24AUG03 0800 Received pt resting in bed, USS, Alert, speaking arabic, able to communicate needs via gesture. Medicated w/ tylenol for pain relief noted. Pt in to see pt for ROM/exercise. Pin care done and drsg Δ's (wet-dry on back of thigh + iodoform on front of thigh) Δ'd. 3 SIGS, restraints in place. LSCTAB, HRR, pulses equal & bilat. w/ [redacted] (b)(6)-2 to monitor

24AUG03 2000 JSS. AO. Mild c/o pain to (L) thigh, but pt tolerated it 3 medication. Ambulated x1 to BSC and back, performed BM x1. No other c/o pain, V.S.S. Safety completed. — [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, Ser. Date of Birth: Rank/Grade)		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

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

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sept 12	Received pt resting in bed. OOB + amb w/ crutches in hallways. BBM, SWS, d/c pain this shift. A+OX3, VSS. Perform dsg chg w/ pins. Restraints in place per SPH protocol, ∅ skin breakdown or circulatory issues noted. ∅ other remarkable assessments. will cont to monitor [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)*

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sep03 1845	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, pain controlled c percs, Ex Fix LLE in place dsg's on pins CDI, pt ambulates c crutches, voiding s difficulty, proper circulation + skin integrity on pts of restraint. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
16SEP03	(0600) Assumed care of pt @ 0600 c report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs/TID mdmn. Ex. fix in place on (L) thigh. Pt amb c crutches s difficulty. (+) pedal pulse equal bilat. Pin care done this am. Rom c us done by pt. Pt tol reg diet well. Voiding s difficulty. (+) BM. 2-point restraints in place s s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
16Sep.03	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, Ex Fix LLE, dsg's on pin CDI, ambulates c crutches, s difficulty, ø c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST (b)(6)-2 [redacted]

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep03 0710	Pt A&O x3. LSCTA (B), S_1 S_2 present HRRR. (+) BSx 4 quads. External fixator to (L) LE, CDI No S/S of infection noted. Denies pain at this time. Will continue to monitor [redacted] Spc. 91WM6
	(b)(6)-2
	(1700) I concur ē above assessment. [redacted]
17 Sep.03 1630	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BSx 4, abd soft flat nontender, Ex Fix LLE, dsg's on pins CDI, ∅ c/o pain @ this time, pt ambulated ē crutches s̄ difficulty, proper circulation + skin integrity on pts of restraint.
	(b)(6)-2 [redacted] 91W
	(b)(6)-2 [redacted]
18Sep03 0800	Pt Awake & A&O LS CTA (B) S_1 S_2 Present (+) BS x 4 Quads. Drsg to Ex Fix (L) LE CDI. NO S/S of Infection Noted. Denies Pain at this time. Will continue to Monitor
	(b)(6)-2 [redacted] Spc 91WM
18Sep.03 1810	Pt sitting in bed, A+Ox3, VSS, LSCTA (B), (+) BSx4, Ex Fix LLE, dsg's on pins CDI, pt ambulates ē crutches, voiding well, abd soft flat nontender, ∅ c/o pain @ this time, proper circulation + skin integrity on pts of restraint (b)(6)-2 [redacted] 91W
19Sep03 1539	Received pt resting in bed, VSS, [redacted] arabic speaking. Amb w/ crutches to x-ray this am and amb on return. X-rays of (L) femur done. Pin care done this afternoon. small amt serous drainage to pads. H_2O_2 ½ strength used

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

DATE	NOTES
CONT 19Septa1339	w/ bleeding. Medicated @ x11 for pain w/ # tabs, effect. Tol po. @ other remarkable assessments noted. WCC CONT to monitor [redacted] (b)(6)-2
20sep@0345	Assumed care@1800; All VSS; pt A&Ox3, @cms, NV intact, medicated & perc & restoril for pain, pt amb to BR x1, @BM; Ex fix in place, dsg CDI, 3 dsng; ROM completed pt voiding QS, clear yellow urine; restraints in place, @ circulation, @ skin breakd; Cont to monitor [redacted] (b)(6)-2 (b)(6)-2
20 Sept 03 @0800	VSS Alert & Oriented. Lungs clear. BS(+) x4 quad Peripheral pulses palpable +2. OOB to BR for ADL care. Ambulate c two touch wt bearing. Tolerated well. Pain care done to (L) external flap. Will continue plan of care [redacted] (b)(6)-2 CTA
20sep@2380	Assumed care@1800; VSS; AOx3, @cms, NV intact, @ c/o pain or discomfort @ this time; pt ↑ OOB to amb in hall c BR 5 difficulty; amb c two touch wt bearing; @ Δs in assessment; restraints in place; @ circulation, @ skin breakd; Cont to monitor [redacted] (b)(6)-2
21 Septa 0800	Alert & Oriented VSS. OOB ad lib to BR. Ext fix replaced to (L) thigh. Pain care done. Peripheral pulses +2. Lungs clear. BS(+) x4 quad. [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.

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

PROGRESS NOTES
Medical Record

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MEDCOM - 16254

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 Sept 1920	External fixator to left thigh intact, NO Sign of infection, tissue looks healthy. Pt walked around 15 min, with crutches. (b)(6)-2 [redacted] RN
22Sept03 1327	assumed care of pt. @ 0000 Assessment completed. PERRLA, Lungs CTA(B), NSR, voiding per toilet, Abd. soft non-tender. Pin care completed. Pt. Ambulate to BR well. ambulated X 20 mins. Performed am care. will cont. to monitor Pt [redacted] (b)(6)-2
22sep03@1944	Assumed care @1800; All VSS; pt A&OX3, (+) CMS, NV intact throughout; Ex-fix in place (-) S/Sx infection; pin care completed, dsg CDI; pt OOB to BR, amb in hall X1 for 20 min.; restraints in place, (+) circulation, (-) skin breakdown; cont to monitor [redacted] (b)(6)-2
23 sep 03 0730	Assumed care of pt. A+OX3. VSS & c/o pain or discomfort @ this time. External fixator to (L) LE ambulates c crutches pin care complete wrapped kerlix at pin insertion site with minimum drainage. Will cont to monitor [redacted] (b)(6)-2
23sep03@1840	Assumed care @1800; VSS, pt A&OX3 speaking arabic; (+) CMS, NV intact throughout ex-fix in place, (-) S/Sx of infection; pin care completed; dsg CDI; pt ambulating in

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) hall x1 for 10 min; ØΔ in assessment, cont c̄ PO abx; restraints in place, ⊕ circulation, ⊖ skinbreak ↓; cont to monitor (b)(6)-2 [redacted]
24 Sep 03 0830	-Assumed care of pt. A+O x3. Ambulated c̄ crutches to the BR VSS. Consumed 100% of breakfast this AM. c/o pain to (L) LE external fixator. Scheduled motrin 800 mg given for pain relief. Lungs clear bilat. HEKR. Voiding s̄ difficulty Will cont to monitor (b)(6)-2 [redacted]
	(1200) I concur c̄ above assessment. (b)(6)-2 [redacted]
24 SEP 03 2300	VSS. A&O. ⊕ pulses to LLE. Pins & dsg intact. Ambulate x1 to BR s̄ difficulty and returned. All other systems WNL's. (b)(6)-2 [redacted]
[illegible] 1200	Received pt resting in bed this am. VSS w/ ↑T of 103. gave ii percocet for pain w/ ↑ tylenol T↓ 101.9. Dsg Δ done w/ bacitracin on suture line gauze drsg on upper arm and pin care. Bilateral wounds on thighs covered w/ bacitracin, (R) sutures intact, (L) staples intact. pt cont to have ↓ mvmt and feeling/sensation in LLE. HL [illegible] patent, flushes easily. OOB + ambulates. Restraints in place per Cpw protocol, Ø skin breakdown or circulation issues noted. Ø other remarkable assessments at this time - Will cont to monitor [redacted] (b)(6)-2

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

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Aug03 1550	assumed care @ 1300 VSS - no c/o pain @ this time - NPO, o/c tool today - SL patent - (D) femur ex fix in place, ace wrap in place on (D) leg, small amount of drainage in calf area of ace wrap - neurov's WNL in (L) foot (b)(6)-2 [redacted] CR, AN
9Aug03 2025	LR @ 125 cc/hr infusing due to continued NPO status - medicated for pain c 4mg MSO4 IVP c good results (b)(6)-2 [redacted] Ch, AN
9 Aug 03 21:12	Paged dr pt @ 21:00. Restraints x2 @ wrist/ankle. Pt. awake and alert in bed. LCA @ HPL's Sa, BSO x4. PERRLA x pupils only dilate + contract slightly. Skin WD. (D) leg ex fix in place @ odor @ bloody and yellow drainage noted. (D) ↑ thigh @ 2 pitting edema. (D) foot @ 4 pitting edema noted. @ Pedal pulse @ warmth @ sensation @ <3 sec cap refill. PIV (L) @ KVO infusing @ D/A. x c/o pain @ this time will cont to mon (b)(6)-2 [redacted] 2nd /AN
0230	Returned from recover on ICU 2. VS WNL per FS. Voided 400cc CYU. PIV (D) FA infusing D5 1/2 NS c 20mEq KCL. (D) ex-fix S/p washout. mod amt yellow colored drainage noted @ pin site dsg's. ACE wrap dsg intact. @ 4 pitting edema noted @ PCM @ <3 sec cap refill @ Pedal pulse @ warmth. c/o pain to (L) ex-fix area 5mg MSO4 given will cont. to mon (b)(6)-2 [redacted] 2nd /AN

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

(b)(6)-4

EPW

[redacted]

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 M' . CARE

MEDCOM - 16257

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

DATE	SY	MS, DIAGNOSIS, TREATMENT, TREATING ANIZATION (Sign each entry)
10 Aug 05 0630		Pt. asleep in bed easily aroused by verbal stimuli. HR Reg, Lung sands clear x (L) upper lobe c inspiratory crackles, bowel sounds (+) x 4 quads. NPO ½ NS c 20 meq KCl @ 100 c/hr infusing c difficulty or s/s of infection or infiltration. (L) EE ext. fix ↑ on foam blanket, ace wrap CDI, (+) sensation in digits, <3 sec cap refill, minimal ROM in digits. Pt c complaints @ this time. VSS, temp slightly ↑ @ 0102, tylenol given. Will continue to monitor. (b)(6)-2 [redacted] /AA
1400		Pt stable at this time AAOx3. PERRLA. Lungs CTA bilat, ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Pt c c/o diarrhea, given Immodium. Voiding sufficient amts to urinal. (L) leg elevated, dsg CDI. Strong pulses and brisk cap refill to bilat UE. ø complaints (b)(6)-2 [redacted] ww/to
2045		Dsg to (L) leg D'd. Plain gauze wrapped to pins. Sites cleaned c 50/50 H_2O_2/H_2O soln. Small packing to wound to (L) thigh. Wrapped c Kerlix and ace wrap. Wounds x 2 to (L) calf packed c plain gauze, 4x4's applied then Kerlix c ace wrap. Wounds c serous drainage. (b)(6)-2 [redacted] LA/AW
8/10 2132		Pt. care assumed @ 2100. VSS HR Reg. lungs CTA, BS (+) x4. (L) LE ex-fix intact, dsng CDI. (L) ft edematous c pulse at, (+) ROM, (+) sensation, brisk cap refill. Will cont to monitor. (b)(6)-2 [redacted] LA/AW
2147		PO x 95% (b)(6)-2 [redacted] LA/AW

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
110530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender, + distention. BS(A)x4. Voids spontaneously, clear yellow urine. ROM and NV intact to (B) UE and RLE. LLE has ex fix (4 pins) to thigh, laterally. Pins wrapped in bulky gauze & ACE wrap (ACE from toes to groin), with moderate serous drng. Pt able to wiggle (L) toes, pulse 2+, brisk cap refill. Some mild edema noted to (L) foot. IV to (R) AC running, NS/S infection or infiltration. (b)(6)-2 [redacted] RN
111100 Aug 03	NURSING NOTE: Drsg to pins (six pins), anterior thigh (vac-pack) and posterolateral ~~mid~~ 1/3 thigh replaced. Pins wrapped in clean with ½ H_2O_2 and ½ H_2O. Redressed wounds with 4x4 gauze sponges, Kerlix roll, and ACE wrap. Drsg to posterior (L) calf not redressed or reinforced. Some serous drng noted to Kerlix at calf wound. (b)(6)-2 [redacted] RN
11Aug03 2030	assumed care @ 1300 - VSS - medicated for pain - c/o 10 Percocet @ 1700 c good results - IVF infusing as ordered - dsg Δ done to (L) leg, thigh, calf, serosang drainage noted, neuro WNL in (L) foot - [redacted] (b)(6)-2
12Aug03 0800	Pt care assumed @ 0130. VSS, alert and aware, c/o pain given for pain @ 0130. Lung sounds CTA, pulse 80s+x4. Dsg c exfix on lle CDI, + rom and wiggling of toes. No new complaints, will continue to monitor. (b)(6)-2 [redacted] 911MM6
120530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender, + distention. BS(A)x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and RLE. LLE has ex fix to thigh (Continued over)

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

RECORDS MAINTAINED AT:

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

#[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF M' . CARE

MEDCOM - 16259

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

DATE	SY[illegible]MS, DIAGNOSIS, TREATMENT, TREATING [illegible]ANIZATION *(Sign each entry)*
12 0530 Aug 03	(continued) x6 pins. Pin sites and drsg saturated c serosanguinous drg. Drsg will be changed later this AM. IV to (R) FA flowing well, s s/s infection or infiltration. (b)(6)-2 [redacted]
12Aug03 2045	assumed care @ 1300 - VSS - medicated c ii Percocet tabs PO & 5mg MSO4 prior to dsg Δ, pin care done, thigh wounds dry packed, W→D dsg done on calf wounds, Kerlix and ace wraps applied - IVF infusing as ordered, IV site patent - neuro V'S WNL in (L) foot, +2 pitting edema in same foot (b)(6)-2 [redacted]
12AUG03	VSS - Alert x3 - IV to (L) Arm of WA [illegible] s/s infiltration dsg to (L) leg dry & intact. PEARLA [illegible] - Lungs [illegible] CTA B/L [illegible] BS (+) x4 quads. Radial pulses +3 - (L) Pedal +3 (R) Pedal CMS [illegible] All other extremities >3 sec [illegible] (L) foot +4 pitting edema. Restraint to (B) arm in place and secure (b)(6)-2 [redacted]
13 Aug 03 05-1230	Pt DSG to (L) femur with ext. fixation done. Pt alert and oriented x3. Pt [illegible] DSG [illegible] 20 MSO [illegible] [illegible] IVPB. No change in VS signs. Pt [illegible] [redacted] (b)(6)-2
13Aug03 1300	Pt stable. AAO[redacted]. PERRLA. Lungs CTA bilat, Ø resp distress. NS[redacted] abd soft, non-tender, bowel sounds active x4 quads. Ex fix to (L) femur intact, dsg c minimal drainage. Dsg to (L) LE C/D/I. Strong pulses and brisk cap refill to (L) foot. Ø complaints (b)(6)-2 [redacted]

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16260

ACLU-RDI 1636 p.20

DOD-029649

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Aug03 2030	Dsg Δ done to (L) leg. W→D dsg to (L) Calf. Purulent drainage noted to wounds x2. Slight odor noted when dsg removed. W→D then wrapped t Kerlix. Pin care done, pin sites t serosanguinous drainage noted at insertion. Cleaned t H2O2/H2O. Wrapped t dry plain gauze. Wounds x 2 the (L) upper thigh t tunneling noted. Packed tightly t dry Iodoform gauze. Wounds wrapped t Kerlix and ace (b)(6)-2 [redacted]
0030 13 Aug 03	Pt care assumed @ 0100. VSS, pt awake and alert with no c/o pain. Lung sounds CTA, pulses (+) x4, bs (+) x4. Dsg on lle CDI, pt c (+) sensation and able to wiggle toes. Pt states he wants his tooth pulled at, tooth is loose in upper portion of mouth. (b)(6)-2 [redacted] stated it would be removed tomorrow. No new complaints, will continue to monitor. (b)(6)-2 [redacted] SIUM6
14 Aug 03	0615 Assume pt care @ 0500. Pt awake and alert. ~~D5½~~ NS t 20 kcl @ 100cc/hr to (D) FA c/o s/s redness/infiltration. (D)LE ex-fix intact, dsg to top pin t sm amt sed drainage. Ace wrap cont. Edema noted to (D) foot, (D) pulse. C/o pain to pin sites @ this time. VSS. HR reg. Lungs CTA. Abd soft. tender to (cont)

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

EPW

[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 ME' CARE

MEDCOM - 16261

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03 0615	(cont.) BUQ. Sm BM this am. Will cont. to monitor. (b)(6)-2 [redacted] 9/14/03
	1115 pt seen by dental. Dental says refer to Dr. [redacted] for removal - due to their supplies not available (b)(6)-2 [redacted] 9/14/03
	OMFS procedure note
14 AUG 03 @1519	Extracted tooth #9 c̄ gauze and 1cc 2% lidocaine 1:100K epi. ∅ complications. (b)(6)-2 [redacted] MAJ/DC
14Aug03 2030	assumed care @1300 - VSS - medicated c̄ percocet for pain @1515 & 1930 c̄ good results, 5mg MSO4 given @2000 prior to dsg Δ - top pin sites c̄ bloody drainage on dressing, skin around pin sites very edematous and red, dsg placed on thigh & calf wounds - SL site Δ'd to (R) FA, IVF infusing as ordered - neurov's WNL in (L) foot (b)(6)-2 [redacted] CRNA
14AUG03	VSS - Alert x3 - IV of D5 1/2 NS c̄ 20 mEq K ... (R) FA is patent ∅ s/s infiltration. Pearrla ... Lungs - CTA B/L Reg even. HR - NSR - BS ⊕ x4 quads. Radial pulses +3 Pedal (R) +3 (L) +2. Drsgs to (L) leg dry and intact small amt of blood soak through. Pins intact and ∅ drainage noted. Edema to upper thigh +4 around ankle and top of (L) foot. uses urinal urine light yellow output sufficient. Restraints to UE in place and secure. Percocet ii po given for pain. SGT [redacted] (b)(6)-2

MEDCOM - 16262

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)*
15 AUG 03	assumed PT care at 0545. PT A O X3, PT has
0700	D5 w/ 20meq KCL running into R forearm. Bowel sounds +
	lungs CTA. Heart rate reg. Pulses + in all extremeties
	edema in LLE. L leg in ext fix w/ all dressings
	C I, pt complained of pain & was given 2 percocet
	after which he ate res [illegible]. (b)(6)-2 [redacted]
15Aug03	assumed care @ 1300 - VSS - medicated c
2000	ii percocet & 5mg MSO4 prior to PT session -
	dsg D and pin care done, moderate amount of
	bloody/serosang. drainage from top pin
	sites, calf wound decreasing in size c pink
	tissue visible - IV site patent, D5½NS
	c 20meqKCl @ 100cc/hr - neuroVS WNL
	in (L) foot - pt. doing ankle mobility (b)(6)-2
	exercises as instructed by PT - [redacted]
15 AUG 03	VSS - Alert X3 IV of D5 NS @ 100ml/h to (R) FA is patent Ø s/s infiltration
2130	Percocet ii PO for c/o (L) leg pain. Dress to (L) leg dry and intact. pins
	intact and clean Ø s/s of infection. Pearla 2m - lungs CTA B/L
	Resp even Reg HR - NSR - BS (+) x 4 quads. Radial and Pedal pulses
	(+) 3 (L) foot +3 pitting edema - Pulse +2. Restraints to UE and LE
	in place and secure. Ø40 @ present. — [redacted]
	(b)(6)-2

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

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

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

REGISTER NO.

WARD NO. ICW 2

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 - 16263

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16Aug03	~~confused and agitated up till 2Am. Restless, constantly c/o pain. Awake. Xray PT in~~
0320	
16Aug03	Resting comfortably & further c/o ® leg pain. IV q- D5 ½NS
0320	@ rate infusing patent & s/s infiltration. Restraints in place (b)(6)-2
	and secure. Sgt [redacted]
16August03	Pt. awake & alert complaining of pain, tt percocet given. VSS. HR Regular.
0550	Lung sands clear bilat, bowel sands (+) x 4quads, ABD slightly distended, pt
	states that he has a lot of gas. IV in ®FA infusing @ 100cc/hr of D5 ½NS c 20meq
	KCl & s/s of infection or infiltration. Ext. fix to ® thigh intact, 2rd pin draining
	dark red bld, dsg to ® calf CDI. ®Pedal pulse palpable, (+) sensation, <3sec
	cap refill, full ROM of digits & ankle, ø ROM of ®knee. Pt 5 other complaints
	@this time. All other assessment findings WNL. Will continue to monitor (b)(6)-2 24/
1030	Pincare & packing to wounds completed. Pin insertion sites 3&4 draining moderate
	amts of clear yellowish fluid. 2 wounds on ® thigh repacked c sterile iodoform
	both sites & s/s of infection. [redacted]
16Aug03	assumed care @1300-VSS-medicated for
2020	pain-c tt Percocet prior to PT @1330 & prior
	to dsg Δ @ 1900-bloody drainage from lower
	pin sites, serosang drainage from upper
	pin sites, thigh wounds packed and W→D
	dsgs placed on calf wounds-IV site patent-
	PT did 20min pt. to 90° today-neuro's
	WNL in ® foot, edema remains +1 in
	ankle [redacted]
	(b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 16264

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)*
16Aug03 2130	VSS - Alert x 3 - IV of D5½NS @ 100ml/hr infusing to (R) FA is patent @ site of infiltration. Pearla 3mm - Lungs CTA B/L Resp reg even unlabored. HR - NSR - BS (+) x 4 quads. Radial Pedal pulses +3. Dsg to upper thigh and calf dsg intact pins intact and clear to (L) leg L foot +3 pitting edema Restraints to VE and LE in place and secure. — SGT [redacted] (b)(6)-2
17Aug03 0330	Benadryl 50mg IM Rt c/o itchy, Percocet 5mg Rt c/o pain. Resting quietly (b)(6)-2 (b)(6)-2 SGT [redacted] c ø further c/o pain or itchy.
17Aug03	Assume pt care @ 0500. Awake and alert. No c/o pain. D5½NS @ 20KCl @ 125cc/hr. to (R) FA ~ redness/infiltration. VSS. HR reg. Lungs CTA. Abd soft BS x 4 (+) c/o pain/tenderness c palpation. (L) thigh ex-fix intact. Dsg CDI. Swelling to (L) knee, +3 edema to (L) foot, elevated (L) pulse (+) sensation. Urine continue to monitor [redacted]
0650	pt c/o pain @ IV site. IV d/c'd. c/o pain @ (L) thigh around pin. ½ percocet given (b)(6)-1 [redacted]
1300	pt seen on rounds. Ace wrap from toes to thigh per doctor request. (b)(6)-2 [redacted]
17Aug03 2015	assumed care @ 1300 - VSS - medicated for pain prior to dsg Δ, upper pin SC serosang drng on dsg, thigh wounds packed, ace wrap placed from toes to thigh on (L) leg, neurovs WNL, +1 swelling in (L) ankle

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.)*

EPW [redacted]

(b)(6)-4

REGISTER NO. [redacted] (b)(2)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - 16265

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 Con't.	elevated on sheet, all pin sites have serosang drainage - no c/o pain @ this time [redacted] (b)(6)-2
17 Aug 03	VSS - A&Ox3 - Pearla 3mm Lungs CTA B/L resp reg even HR-NSR - Radial and Pedal pulses +3. Pins to (L) leg clean swelling noted to leg around pins. Percocet ii Po given for c/o pain. BS(+) x4 quads Abd soft NT. Restraints to UE and LE in place and secure. (b)(6)-2 Sgt [redacted]
18 Aug 03	Percocet ii Po given for c/o (L) leg pain @ 0330 has had ø further c/o pain @ present. Resting quietly. Restraints in place and secure. (b)(6)-2 Sgt [redacted]
180530 Aug 03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing even & unlabored, LS CTA (B). Abd soft, nontender, ø distention. BS(+)x4. Voids spontaneously. AROM and neurovascularly intact to (B) UE and RLE. LLE has limited ROM 2° ExFix to lateral thigh. ø pain. Drsg to pins (x6), anterior thigh drsg has serosang drng. Ant calf drsg is C/D/I to ACE wrap. ø IV access. Otherwise neurovascularly intact to LLE. (b)(6)-2 [redacted]
18 Aug 03 2030	assumed care @ 1300 - VSS - medicated c̄ ii Percocet PO prior to dsg Δ, pin sites c̄ small amount of serosang drainage; thigh wounds packed loosely c̄ iodoform, both wounds decreasing in depth, calf wounds c̄ granulation tissue present, size decreasing on both calf wounds - PT not in to see pt. today (b)(6)-2 [redacted]
19 Aug 0030	Care assumed @ 2100. VSS, alert and awake, c/o pain between the pin insertion sites, percocet was given @ 2000. Lungs CTA, pulses (+) x4, bs(+). Dsg c̄ exfix on lle. c/d/i, pt c̄ good ROM and (+) sensation. Pt on PO Abx, will continue to monitor. (b)(6)-2 [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 16266

ACLU-RDI 1636 p.26

DOD-029655

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)*
19Aug03	0543 Assume pt care @ 0500. pt asleep, easy to awake. NO C/O pain or discomfort @ this time. VSS. HR reg. Lungs CTA. Abd. distended non-tender BS x4. (L) thigh ex-fix intact. Swelling noted to knee and @ 1st pin site. 1st pin site dsg intact c red drainage. Dsg to (L) calf intact. (+) sensation (+) pulse limited ROM to (L) LE. No PIV site @ this time. Restraints x2 in place. Pt encouraged to keep (L) LE elevated. Will cont. to monitor (b)(6)-2 [redacted] 9MM
19Aug03 1338	Awake and alert. PERRLA. Lungs CTA bilat @ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex fix to (L) femur intact, dsgs CDI. Strong pulses and brisk cap. refill to bilat LE. @ complaints (b)(6)-2 [redacted] CA/RN
2015	Dsg to (L) leg N/d. Pin Care done to ex-fix pin sites clean. Plain gauze to pin sites. W→D dsg to (L) calf. Purulent drainage noted to old dsg. @ complaints (b)(6)-2 [redacted] LW/RN
19Aug 2300	Care assumed @2300. VSS, pt awake 3 c/o pain. Lungs CTA, (+) x4, bs (+). Dsg 35C and ex-fix on lle. N/d @2000, dsg cdi. Pt able to wiggle toes and has (+) sensation in foot.

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)(2)-2

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

[redacted]
(b)(6)-4

MEDCOM - 16267

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	lle elevated on pillow. Pt ∅ complaints at this time, will continue to monitor. (b)(6)-2 [redacted] alumo
20Aug03	1300 - Pt A&O x3. VSS, lungs CTA, BS⊕, pulses ⊕x4. Ext fix intact, pin care done by pt. Dsg x 2 Δ'd. Voiding ∅ complaints. Will cont to monitor, [redacted] (b)(6)-2
8/20/03	ortho staff
	- Pin sites clean (b)(6)-2
	- needs xr when transfer to [redacted]
	[redacted] (b)(6)-2
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, ∅ resp distress. NSR and soft, non-tender, bowel ⊕ sounds active x4 quads. Ex-fix to Ⓛ femur intact, ∅ S/S infection. Dsg to pin sites CDI. Dsg to Ⓛ calf CDI. Strong pulses and brisk cap refill to bilat LE. ∅ complaints (b)(6)-2 [redacted]
2030	Dsg Δ done to Ⓛ femur ex-fix, Ⓛ thigh and Ⓛ calf. Ⓛ calf dsg done w→D, purulent greenish drainage noted to old dsg. Ⓛ thigh wounds x2 packed c̄ Iodoform gauze and covered c̄ plain gauze. Pin care done c̄ H2O2/H2O soln. 1st, 2nd and 4th pins c̄ lge wounds. 1 & 2 packed c̄ Iodoform, pin 4 packed wet today. All pins re-wrapped [redacted] (b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 16268

ACLU-RDI 1636 p.28

DOD-029657

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)*
2350 20 Aug	Care assumed @ 2100. Vitals stable, a&ox3 c/o pain. Lung sounds CTA bilaterally, pulses ± x4, bs active x4 Quads, Ex fix c dsg on lle CDI, ptable to wiggle toes and has ± sensation in ② foot. Pt resting, will continue to monitor. (b)(6)-2 [redacted] qiump
21 Aug 03 0845	assumed care @ 0500 - VSS - medicateele ↑ percocet for c/o ② leg pain - dsg intact on ② thigh/calf, ~~pt~~ pincare site c small amt. of drainage on pindressings, neuro V's WNL in ② foot, ankle edema greatly decreased, knee remains swollen - AM dsg D and pincare to be done later in morning (b)(6)-2 [redacted]
21 AUG 03	(1615) Assumed care of pt via litter in stable condition @ 1200. Pt AAO speaking arabic. VSS. lungs CTA B. ± bs x4 quads. Pt moves ② leg c difficulty. Dsgs cd this am. Wet→dry dsgs placed on back of ② calf. GSW dsgs to ② thigh cd and packed c iodoform dsg. Pin care done. Pt tol. procedure well. Pt medicated c ↑ Percs for pain in ② leg c good relief. ± bm. Voiding c difficulty. monitoring (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. [redacted]

Ep W [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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03 2300	VSS. Alert. Denies pain @ this time. Performed pin care & PSG Δ's. LLE elevated. ⊕ pulses ⊕ swelling to thigh. Tolerating PO well. All systems WNL. PSG's CDI. Wnt pinked c̄ some serosanguinous drainage. Resting comfortably. (b)(6)-2 [redacted] RN
22AUG03	(1130) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ II Perc this am for pain c̄ good relief. Ex fix in place on Ⓛ thigh. Pin care done this am. ∅ s/sx infection @ pin sites. Ⓛ thigh slightly swollen compared to Ⓡ thigh. Wet→dry drsgs Δd on back on Ⓛ calf GSW sites packed c̄ Iodoform gauze. ∅ s/sx of infection @ sites. Pt moving Ⓛ leg s̄ difficulty. ⊕ pedal pulses equal bilat. Cap refill <2 secs. Pt voiding s̄ difficulty. Pt did own am care. 2 point restraints in place. Pt resting quietly @ this time. Will continue to monitor. (b)(6)-2 [redacted]
22AUG03 2030	VSS. AO. PERRLA. S1, S2. BS ⊕x4. LLE elevated per routine. PSG's CDI reinforced x1 WTD @ L calf belly. ⊕ pulses in all extremities. Able to move LLE s̄ difficulty. ⊖ s/s of infection @ pin sites. Voiding s̄ difficulty and resting comfortably in bed. (b)(6)-2 [redacted] RN
23AUG03	(1430) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ II Perc this am for pain in LLE c̄ good relief. LLE elevated on blankets. Pt moves LLE s̄ difficulty. ⊕ pedal pulses equal bilat, cap refill <2 secs. Ex fix in

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Aug @1900	(cont) back from OR: Tol. 60% dinner well. ØN,V noted. IVF infusing 5 D5LR unfection/infeltration. Will cont to monitor (b)(6)-2 [redacted] glumb.
26 Aug @1910	Reflex D/Cd after this dose per MD orders. ~~X-ray forms done~~ Re-eval. Will cont to monitor [redacted] glumb
26 Aug 2010	Pt c/o pain to extr. IT Percocet given. Will cont to monitor (b)(6)-2 [redacted] glumb
26 Aug 03 @2300	Pt resting in bed. IVF LR@125 infusing ~~D5LR~~ & D5LR unfection/infiltration. Will cont to mon (b)(6)-2 [redacted] glumb
26 Aug 03 @0050	Pt c/o pain @ ex-fix site. IT Percocet given (b)(6)-2 [redacted] spec-
@0115	Pain c above assessmts [redacted]
27 Aug 03 0800	Alert & Oriented VSS c/o pain @ 0700 to lower extremity rated 3/10 Tylenol 650 mg P.O given & effective. (b)(6)-2 IVFA IV D5LR locked. Tolerated Reg Diet well. Urine clear yellow in. Removed small amt of crusted from pin site. Remove & reapplied restraints. Will check restraints & circ [redacted]

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.

CPW # [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

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NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 03 @2100	Pt alox3, VSS, lungs CTA(B) ⊕BS x4qds. c/o pain to (L) thigh. ex-fix intact. Dsg to thigh & calf changed. Brisk cap refill & good pedal pulses. Tol. Reg diet. HL patent & flushing easily. (L) leg elevated. Will cont to monitor (b)(6)-2 [redacted] q1hrm6 @2300 - 1 hour to above assessment. (b)(6)-2 [redacted] CPT
28 Aug 03 1000	VSS AxOx3 Lungs clear Bilateral. BS⊕x4 quad. (L) thigh ~~(R)~~ ex-fix intact. Pen care done. Cleaned thigh & calf (L) wound and redressed as ordered. Percocet given for pain. HL D/C'd Pulses to left lower extremity palpable. Capillary refill <3 sec to toes. Restraints released and reapplied. will check restraints & circulation frequently (b)(6)-2 [redacted]
28 Aug 03 @ 1930	Pt alox3 VSS, HRRR, lungs CTA(B), ⊕BS x4qds (L) ex-fix intact. pulses to extr. palpable & brisk cap. refill. circulation assessed often. 2 pt restraints on & checked frequently. ϕ c/o pain @ this time. Dsgs changed to (L) calf & thigh. Will cont to monitor, [redacted] q1hr (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINT. [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(2)-2

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)(2)-2

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 - 16272

(b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28AUG03	PAS- I concur c above assessment. [redacted] (b)(6)-2
28Aug03 @2100	Pt c/o pain to Ⓛ thigh. IT Percocet given c relief. Will cont. to mon [redacted] (b)(6)-2 SPC
29AUG03	(0920) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt amb in hallway c crutches s difficulty. Ex fix in place on LE. ⊕ pedal pulses equal bilat. Cap refill <3secs. Ⓛ thigh swollen compared to Ⓡ thigh. LE seated on blanket. Pin care done this am. Wet→dry dsgs Ad to wounds on Ⓛ thigh and calf. Φ S/Sx infection @ wound sites. Voiding s difficulty. ⊕ BM this am. Tol reg diet well. AM care done by pt. 2-point restraints in place- Φ S/Sx complications c circulation/skin breakd. Will continue to monitor. [redacted] (b)(6)-2 DAV
29AUG03 1920	Pt A+Ox3, resting in bed, LS CTA (B), ⊕ BSx4, S, Sx present, c/o pain Ⓛ thigh, dsg on Ⓛ thigh CDI, Ex fix in place c LLE elevated, cap ref <3 sec, peripheral pulses palpable, Ⓛ thigh swollen, Φ S/Sx of infex on wound sites, proper circulation and skin integrity on pts. of restraint. [redacted] 91WY16
2100	Pt had a BM small formed soft [redacted] 91WY16 (b)(6)-2
30AUG03	(0955) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. Pain controlled c Percs. VSS. Ex fix in place on Ⓛ thigh. Pin care done this am. Ⓛ thigh swollen compared to Ⓡ. ⊕ pedal pulses equal bilat. Cap refill <3secs. Wet→dry

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(cont) dsgs Δd on ⓛ thigh and calf. Φ S/Sx infection. Pt voiding ε difficulty. Tol. reg diet well. AM care done by pt. 2 point restraints in place- Φ S/Sx complications ε circulation/skin breek. Will cont. to monitor. (b)(6)-2 [redacted] WJAN
30AUG05 2025	Pt resting in bed, Alert and speaking arabic LS CTA Ⓑ, Φ BS x4, Φ c/o pain @ this time, abd soft ƒlat nontender, had a BM this PM, Ex fix on LLE, ⓛ thigh swollen compared to Ⓡ, elevated ε blanket dsgs on Ex Fix CDI. [redacted] GIWM
0430 30aug05 1200	Dsg Δ pin care given. (b)(6)-2 [redacted] GIWM Received pt resting in bed USS, Alx Ox3. AM care provided. Ex fix ⓛ thigh in place, limb intact Φ bleeding noted pulse good, foot warm, able to wiggle toes. Φ PMH abnormal assessment findings. [redacted] Will cont to monitor pt.
(b)(6)-2	[redacted]
31Aug05 2400	Assumed care @ 1800; USS; pt A&Ox3 speaking only arabic; NV intact Ⓗ movement & sensation; Ex-fix intact ε dsgs CDI, Φ drainage.

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	S1 S2, ⊕ pulses x4 ē brisk cap Ref; LS CTA Ⓑ; ⊕ BS x4; pt voiding QS, clear yellow urine; restraints in place, circulation & skin integrity intact; medicated x1 ē II perc ē good relief; Ø c/o pain or discomfort @ this time; cont to monitor —— (b)(6)-2 [redacted]
31 Sept 1800	Received pt resting in bed, VSS, A&O x3, pin care done, Ⓛ thigh ex fix intact. Serous drainage w/ pus noted on old drsg. Swelling @ pin sites appears increased. Skin integrity + circulation good @ restraints sites, restraints in place per EPW protocol. No other remarkable assessment findings. Will cont to monitor [redacted] (b)(6)-2
1 Sep. 03 1930	Pt resting in bed, [redacted] X3, LS CTA Ⓑ, ⊕ BS x4, pt ambulated around ward, had a BM this PM, Ex Fix in place, LLE elevated ē blanket, Dsgs on LLE CDI, Ø c/o pain @ this time, proper circulation + skin integrity on pts. of restraint [redacted]
2 Sept 03 0900	VSS Pt alert & oriented, Resp clear, BS ⊕ (b)(6)-2 Alert Ambulated to BR and down hall way with Physical therapist. Medicated with Percocet prior to therapy. Pin care and W-D Dry drsg Applied to Ⓛ thigh wounds. Restraints secure and appropriate. Skin under restraints intact. Will check restraints, skin integrity and circulation to extremities frequently [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Sep. 03 1815	Pt sitting in bed, A+Ox3, LS CTA (B), (+) BS x4, Ex Fix LLE, dsg's CDI, LLE elevated, pedal pulses equal bilat, ø c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] qWM (6)(6)-2
ØbSEPØ3	(Ø91Ø) Assumed care of pt w/ ØØØØ p report from night shift. Pt alert, speaking freely. VSS Pain controlled c Percs. Ex fix in place on (L) thigh. Pin care done this am. ø s/sx infection. (+) pedal pulse equal bilat. skin warm to touch. Pt amb to BR c crutches s difficulty. (+) BM. voiding s difficulty. Tol reg diet well. Am care done by pt. wet → dry dsgs Ad on calf. wounds healing well. 2 point restraints in place. s s/sx complications of skin break/circulation. Will cont to monitor. [redacted] (6)(6)-2 WDA
6 Sep. Ø3 1930	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, pedal pulses equal (B), pain controlled c percs, Ex Fix LLE, elevated, dsg's CDI, voiding c/o urine, proper circulation + skin integrity on pts. of restraint. — [redacted] (6)(6)-2 qWM6

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] (6)(6).4

REGISTER NO.

WARD NO. [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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Sept 0200	Received pt resting in bed. VSS, A+OX3, speaks arabic. Intermittantly dozing. LS CTAB, HRR, abd soft, nontender, BS+x4. Ex fix l/o (L) thigh in place, pin care done, small amt of serosang. drainage and yellow thick drainage noted on old dsgs, current dressing c/d/i. (L) thigh swollen, cont w/o additional swelling noted. Amb to BR for BM x1, PT info see pt. Medicate per mar. No c/o burning micturation. Will cont to monitor [redacted] (b)(6)-2
7 Sep 03 @ 1920	Assumed care @ 1900, pt A&Ox3 speaking only arabic; (+) sensation/movement LN intact; Ex-fix in place; S1, S2 (+) pulses x4, LS CTA (B); (+) BSx4, s/o BM this shift; dsg clean, d, intact; sm amt serosang. drainage noted, (L) thigh remains edematous; (-) c/o pain @ this time; 2 point restraint in place, circ & skin integrity intact; Cont to monitor (b)(6)-2 [redacted]
8 Sep 03 @ 1558	Received pt this am in stable condition. VSS, A+Ox3. (L) LE w/ Ex fix intact (L) thigh. Pin care done and w to D dsgs x3 this am. Pin care done w/ additional betadine for wound infection precautions. Old dsg noted to have yellowish opaque drainage and serosang. drainage. Amb x2 BR x1 STBP no c/o burning on urination [redacted] (b)(6)-2
8 Sep 03 @ 2030	Assumed care @ 1800; VSS; pt A&Ox3, (-) c/o pain or discomfort @ this time; pt Tamb c crutch assistance x2; Ex-fix in place, (L) leg remains edematous; dsg CDI; (+) BM this shift; pt voiding QS; 2-point restraint in place; skin integrity & circ. intact; Cont to monitor (b)(6)-2 [redacted]

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)*
9 Sept 03 1200	VSS. Alert & Oriented OOB ambulated c crutch to BR Tolerated well. Lungs clear. BS (+) x4 quadrants. Abdomen soft-nondistended. Consumed Regular diet for Breakfast. AM care done. Pin care done. Betadine used as ordered. Sang drainage noted on old dsg. Percocet given for pain. Restraints removed and reapplied. Skin under restraints intact. Peripheral pulses palpable. Will continue to monitor (b)(6)-2 [redacted]
9 Sep 03 1900	Pt lying in bed, A+Ox3, VSS, LS CTA (B), ⊕ BSx4, abd soft flat nontender, Ex Fix LLE elevated, dsg's CDI, voiding c/y urine, OOB to BR, had a BM, ∅ c/o pain @ this time, proper circulation + skin integrity assessed on pts of restraint. (b)6 [redacted] 91WM6
	(b)2 (b)6
2015	Pt OOB to BR, had a [redacted] urine 91WM6
10 Sept 03 0800	VSS A&O lungs clear BS (+) x4 quad. Peripheral pulses + Pin care + drsg del to (L) Thigh. OOB ambulat c crutches to BR Percocet given for pain [redacted] removed & reapplied c skin intact under restraints [redacted]
	(b)(6)-2

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

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

[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 - 16278

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Sept 03 1915	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+)BSx4, OOB to ambulate ≈ crutches, (Ø) c/o pain @ this time, Ex Fix LLE, dsg's (D) thigh CDI, voiding c/y urine, proper circulation + skin integrity assessed on pts of restraint. (b)(6)-2 [redacted] 9/WM6
11 Sept 03 0800	WSS Alert + oriented. Lungs clear Bilaterally BS(+) x4 quadrants. Abd soft non distended. Tolerating regular diet last BM yesterday AM care completed. Pin care and wrap to L thigh completed. Restraints removed and reapplied Pt in bed under restraints — (b)(6)-2 [redacted]
11 Sept 03 0900	Ambulate with crutches ≈ toe touch weight bearing to L leg. Tolerated well. Percocet given for pain. (b)(6)-2 [redacted]
11 Sept 03 1200	Physical Therapy done Rt c/o pain 8/10 (b)(6)-2 [redacted] Percocet given Pin care done bleeding noted to distal pin site; Tp P.T. (b)(6)-2 [redacted]
11 Sep 03 @ 1930	Assumed care @ 1800; VSS, pt A+OX3, (+)movement + sensation in all extremities; NV intact @ c/o pain or discomfort @ this time; ex-fix in place, extremity remains edematous; (+) drainage @ s. te; dsg CDI; pt voiding QS, c/y urine (+)BM this shift; restraints in place, skin integrity + Circ intact; Cont to monitor [redacted] (b)(6)-2

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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)*
12 Sep 03 0700	Assumed care of pt, awake alert and oriented x3 VSS. c/o pain to (L) extremity. scheduled motrin administered external fixator applied care given to pins GSW to calf 2x2 dressing applied CDI minimal drainage lungs CTA HRRR Active BS x4 quads. Will cont to monitor [redacted] (b)(6)-2
12 Sep 03 1300	- After physical therapy pt. c/o pain to (L) leg medicated w percocet II tabs for relief. Will cont to monitor (b)(6)-2 [redacted] q4WNL
12 Sep 03 1930	Pt sitting in bed, AtOx3, VSS, LS CTA (B), (+) BS, abd soft + flat nontender, Ex Fix @ LLE, dsg's CDI, @ c/o pain, ambulates w crutches, proper circulation + skin integrity on pts of restraint. q4WNL (b)(6)-2 [redacted]
13 Sep 03 0730	Assumed care pt AtO x3 c/o pain to LLE med. w scheduled motrin for relief. LLE w external fixator pin care dressing A this morning minimal drainage from site of pin placement. Lungs CTA HRRR SISZ present. Good appetite tolerating PO well. Will cont to monitor (b)(6)-2 [redacted]
(1630)	I concur w above assessment. (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.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 16280

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Sep03 2030	Pt sitting in bed, A+Ox3, VSS, OOB to BR, LS CTA (B), ⊕BS x4, abd soft flat nontend Ex Fix LLE, dsg on pins ~~saturated~~ ⊂ on upper part of Ex Fix had blood drainage, pin care done, pt medicated for pain ⊂ 2 percs, proper circulation + skin integrity on pts of restraint. [redacted] (6)(6)-2
14 Sep 03 0700-	- Assumed care of pt. A+Ox3 VSS - Lung CTA HRRR Active BS x4 quads Tolerating PO well. Encouraged to OOB ambulation to BR ⊂ crutches. External fixator to LLE pin care complete wrapped ⊂ kerlix for minimal drainage around pin site. [redacted] (6)(6)-2 ⊖ c/o pain @ this time
15sep03@0200	Assumed care @1800 ~~p~~ receiving report from dayshift; All VSS; pt A+Ox3, pt c/o pain, medicated ⊂ percs x1 ⊂ good relief; Ex-fix in place; ⊕CMS x4, NV intact throughout; pt amb x1 to BR ⊼ difficulty ⊂ assistance from crutches; ⊕BS x4, ⊕BM this shift; ⊖drainage around pinsite; ROM completed; 2-point restraint in place; ⊕circulation, ⊖ skin breakd; Cont to monitor [redacted] (6)(6)-2
15SEP03 (1125)	Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ⊂ Percs. Ex fix in place on ⓛ thigh. Pin care done this am. Pt able to move LLE. ROM done by pt. ⊕pedal pulse equal bilat. skin warm to touch. Pt amb ⊂ crutches ⊼ difficulty. Tol. reg diet well. Voiding ⊼ difficulty. ⊕BM. 2 point restraints in place ⊼ s/sx complications. Will cont. to monitor. [redacted] (6)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

558-104 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Mohth, Year): 7 Aug 03 | TIME: 1242

TRANSPORTATION TO FACILITY: Air Evac

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
46	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN (Date)	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?			WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: Poss. Fracture RT Leg

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1242

INITIALS: [redacted] 1610Z

VITAL SIGNS

TIME	1242					
BP	125/71					
PULSE	110					
RESP	18					
TEMP	99.2					
WT	62Kg					

LAB ORDERS					X-RAY ORDERS		
☒	CBC/DIFF	ABG	PT/PTT	☐ BHCG/URINE/BLOOD/QUANT	☐	CXR PA & LAT/PORTABLE	☐ C-SPINE
☐	URINE C&S	UA MSCC/CATH		☒ CHEM: 12+Lytes	☐	ACUTE ABDOMEN	☐ LS SPINE
☐	BLOOD C&S X				☐	SINUS	☐ HEAD CT
☐					☐	ANKLE R/L	☐

ORDERS

☒ PULSE OX 93% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1430	X-RAY RT Leg	[redacted]	1430		
1300	Hot Toddi'd				
1315	Ancef 1gm				

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] EPW [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)

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			SUP 02	PH	PO2 9Jk	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT			U/A DIP			EKG INTERPRETATION	
PT			U/A MICRO				
APTT	BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

S) 11 day old GSW (L) leg (was stealing a car.)
GSW - (L) thigh
(L) calf - entrance
Fem fx (L)
Had 1 dose ancef

Allergies: 0
PMH: 0
MED: Had dose Ancef

O) T-99.6 P-110 B.P. 125/71 RR-18 Pulse ox - 92
alert HEENT Heart-RR NO (M)
lungs - no rales or rhonchi
Abd - soft, N.T B.S.-wnl
Rt leg - wnl thigh - swollen, calf swollen
(L) leg - entrance wound (L) calf
Pulse - 2+

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
[redacted] md
(b)(6)-2

DIAGNOSIS
1) GSW (L) thigh, calf Femur fx ~~Tib-Fib fx~~

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record
STANDARD FORM 558 (REV. 9-96)
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FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 16283

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
2 Sep. 03		2030	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕ BS x4, medicated for pain c̄ 2 percocets, Ex fix in places LLE, Ⓛ LE elevated c̄ blanket, dsg's CDI, voiding c/y urine proper circulation + skin integrity on pts. of restraint. ——— [redacted] (b)(6)-2
3 Sep 03	0800		VSS Alert & Oriented [illegible] clear Bil. BS ⊕ x4 [illegible]. Medicated for pain c̄ Percocet. Ⓛ thigh ext fix pins without drainage pin care completed. Ambulated to BR c̄ crutches under supervision. Restraints removed & reapplied. Skin intact under restraints. Will check restraints, skin integrity, and ext. extrem circulation frequently. (b)(6)-2 [redacted] 2LT/AN
3 Sep. 03		1900	Pt sitting in bed, A+Ox3, LS CTA Ⓑ, ⊕ BS x4, abd soft flat nontender, Ex fix in place LLE, Ⓛ leg elevated c̄ blanket, dsg's CDI, ∅ c/o pain @ this time, assessed for proper circulation + skin integrity on pts. of restraint. ——— [redacted] (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)

[redacted]

(b)(6)-4

[redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 16284

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Sept 03 0800			VSS Alert & Oriented Lungs clear BS (+) x4 quad. Consumed Regular diet Peripheral pulses +2. (L) leg External fix. pin sites with small amt of serosang drain redness Ø swelling Pin care done. AM care completed. Voiding clear yellow urine. Denies pain @ this time. Restraints removed and applied Skin intact under restraints. Will check ~~restraint~~ 2 restraints, skin integrity and circulation frequently (b)(6)-2 [redacted] 2LT
4 sep		1910	Assumed care @ 1800; VSS, pt Alert + & Oriented speaking only arabic; Ø c/o pain or discomfort @ this time; S1S2, ⊕ pulses x4; LS CTA (B); ⊕ BS x4, pt voiding QS, clear yellow urine; BM x1 this shift; Ex fix in place Ø drng noted; dsg to be Δd this evening; restraints in place, circulation & skin integrity intact; cont to monitor (b)(6)-2 [redacted]
05SEP03	0850		Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic Ø c/o pain @ this time. VSS. Pt amb to BR c̄ crutches s̄ difficulty. ⊕ BM. Voiding s̄ difficulty. Pt tol reg diet well. Ex fix in place on (L) thigh. ⊕ pedal pulse equal blat. Skin warm to touch. Pin care done this am. Ø s/sx infection @ pin sites. AM care done by pt. 2 point restraints in place s̄ s/sx complication of circulation/skin breakdown. Will monitor [redacted]

(b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
6 Aug	2340		Reapplied (R) (LE) foot splint CMS (+)
7 aug 03		0420	orders noted. Pt awake + conversing. Transfer to CSH in am. — SPC [redacted]
		1039	OK to eat [redacted] 1LT SP
			(b)(6)-2

Continue on reverse side

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

EPW

[redacted]

(b)(6)-4

EPW [redacted]

REGISTER NO	WARD NO.

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

MEDCOM - 16286

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: [redacted] (6)(6)-2 | FROM: *(Requesting physician or activity)* [redacted] CPT MC | DATE OF REQUEST 2 Aug 03

REASON FOR REQUEST *(Complaints and findings)*

fracture @ femur - 2° gunshot wound

PROVISIONAL DIAGNOSIS

fracture @ femur

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

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO (6)(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] (6)(6)2-4 EPW [redacted]

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 - 16287

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

MEDICAL RECORD

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

1. AGE: 46

HEIGHT:

WEIGHT: 62 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) leg. (L) femur Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco | ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ASA/Motrin w/72 hrs (Y) (X)
ETOH (+) Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (X) 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]

(6)(6)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since A M ! 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 OUTCOMES	8. 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 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 _____ 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.

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature [redacted] LTJG, N (b)(6)-2
DATE: 7 Aug 03 TIME: 1345

13. POSTOPERATIVE EVALUATION BY (Signature and Title) [redacted]
DATE: 7 Aug 03 TIME:

MEDICAL RECORD — **INTRAOP. DOCUMENT**

For use of this form, see AR 40-66, the propo... 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 LCT [redacted] (b)(6)-2

3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 1540

4. PATIENT IN ROOM TIME 1540 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded armboards <90°

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

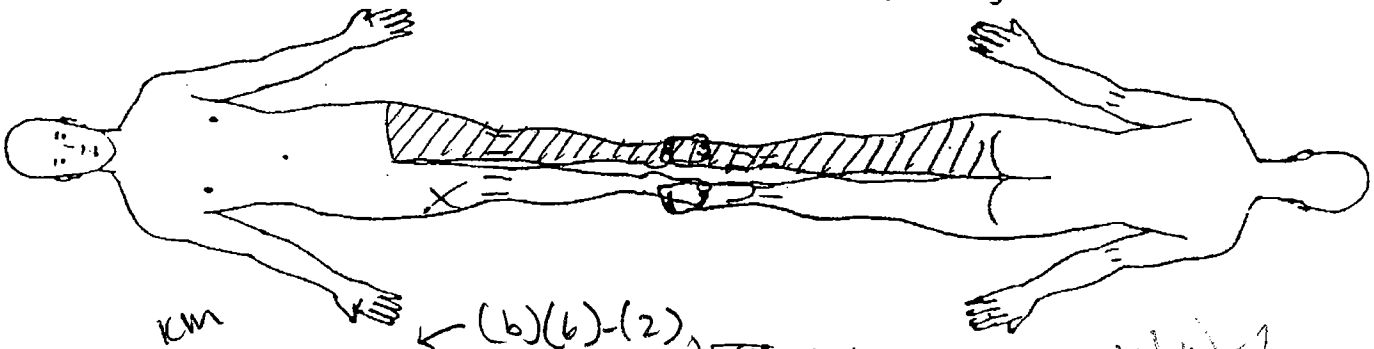
HAIR REMOVAL DONE BY: ☒ YES ☐ NO Dr [redacted] (b)(6)-2
METHOD: ☒ OR ☐ NURSING UNIT ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Left leg BY WHOM: LCT [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SSG [redacted] LT

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No				SSG [redacted]	LT [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: #3 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 689316 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 83, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 16290

13. PROSTHESIS, IMPLANTS [X] YES [ ] NO IF YES NAME: ID NUMBER; MANUFACTURER

Hoffman II Load # 0321701 5018-6-180

5018-6-180 x 6 4920-2-020 x 2

4920-2-140 x 4 5029-8-840 x 2

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Lidocaine Jelly 2% Lot 8P0669E2 Exp 10-04	20 ml	intra-op	local application	International Medication System	Dr. [redacted] (b)(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):

0.9% NaCl- 0.8.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] C-Arm IF YES, SITE Left Thigh

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

18. DRESSING/IMMOBILIZATION *(Specify)*

[redacted] (b)(6)-2

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr. [redacted] Dr. [redacted]

Anesthesia: CRNA [redacted] (b)(2)(b) Anesthesia Type: GETA

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut 30/30

12 Fr Foley cath placed by Dr. [redacted] (b)(6)-2

DA 5179 Initiated.

20. OPERATION(S) PERFORMED

I&D Left leg

Ex Fix Left femur

21. PATIENT TRANSFERRED TO [redacted] TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] (b)(6)-2 IIT/N

REVERSE OF DA FORM 5179-1, OC. MEDCOM - 16291 USAPA V1.01

MEDICAL RECOR[illegible] | **INTRAOPE. 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 Anesthesia

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

3. DATE 10 AUG 03 TIME PATIENT ARRIVED IN SUITE 0800

4. PATIENT IN ROOM TIME 0900 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB (b)(6)-2	SPC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] RN CPT [redacted] RN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) PT on Padded OR Bed Head on foam doughnut. Arms extended out to sides <90° in CAP secured c Safety Straps - LLE prepped into field.

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

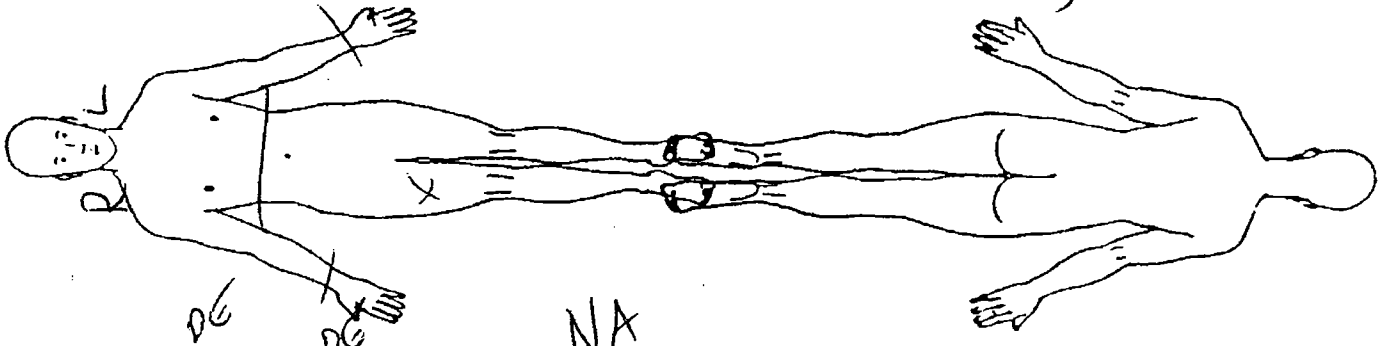
COMMENTS: correct body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: (L) LE
SITE:
BY WHOM: [redacted]
BY WHOM:
COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
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 VL Rem Poly II
LOT NO: 08936
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

FORM 5179-1, OCT 87 REPLACES D[illegible] H IS OBSOLETE. USAPA V1.01

MEDCOM - 16292

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): 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 ☐

	1.	2.	3.
TYPE/SIZE	½ x 2ft Iodoform		-
SITE	(L) leg		

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: ~~IV sedation~~ Mask/General
RN assist. (b)(6)-2
Bovie Pad site intact pre-op Y; post-op Y Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A; post-op
Tourniquet Time: Up Down
DA Form 5179 previously done on 07 AUG 03

20. OPERATION(S) PERFORMED
(L) I&D LG

21. PATIENT TRANSFERRED TO ICU-2 TIME 0938 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] (b)(6)-2

REVERSE OF DA F

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] (b)(6)-2

3. DATE 26 Aug 03 TIME PATIENT ARRIVED IN SUITE 1756

4. PATIENT IN ROOM TIME 1756 NUMBER 1 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

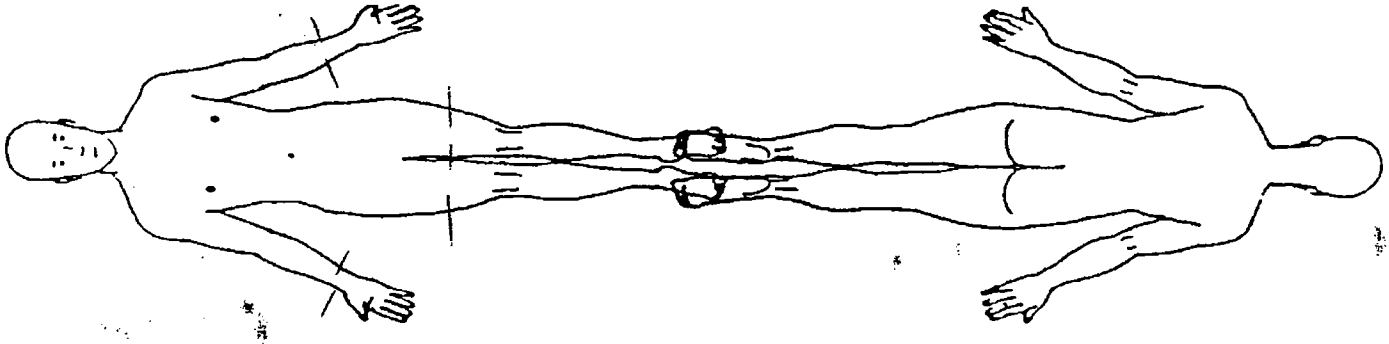
COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* None
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

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					
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)-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 (L) Femur 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)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
2x2
Kerlix
Tape

19. ADDITIONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]

- DA5179 on chart, ∅ Δ's noted

20. OPERATION(S) PERFORMED
Ex Fix Adjustment (L) Femur

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CRNA

REV [redacted] USAPA V1.01

b(6)(6)-2

MEDCOM - 16295

MEDICAL RECORD	VITAL SIGNS RECORD							
HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	7	8	9	10	11	12	13	
August ~~10~~ 2003 / HOUR								

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOCK PRESSURE

HEIGHT: WEIGHT →

SpO2 98% 98% 96% 95% 94% 93% 95% 92% 96% 98%

21 22 23 01 02 03 04 05 06

IV D5W ... 100/hr

Ancef 1gm

50

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. [redacted]

EDW [redacted]

(b)(6)-4

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

[redacted]

MEDCOM - 16296

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

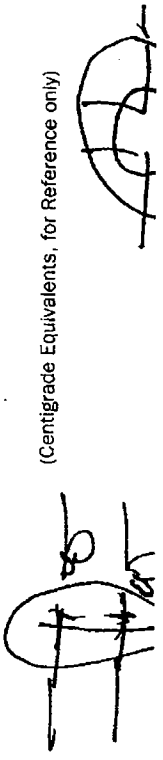
MONTH-YEAR 10/06 DAY 14 15 16 17 18 19 20

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

	14	15	16	17	18	19	20
	122/84	102/70	129/74	122/84	120/82	114/76	110/70
	100/50	100/80	110/70	124/78	128/70	150/82	106/64
	98	94	95	95	97	95	97

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. [redacted]

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16297

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 4

POST- DAY

MONTH-YEAR: 21 MAY 03 22 MAY 03 23 MAY 03 24 MAY 03 25 MAY 26th 27th

DAY / HOUR: 19 / 0600 0800 1200 1600 2000 0000

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: 110/80 124/76 110/68 110/70 111/65 112/69 116/66 116/77 124/71 124/71 116/68 120/66

HEIGHT: WEIGHT → 0j Soft

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. [redacted]

EPW [redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

MEDCOM - 16298

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY 26 | HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

105° | 40.6°
180 | 104° | 40.0°
170 | 103° | 39.4°
160 | 102° | 38.9°
150 | 101° | 38.3°
140 | 100° | 37.8°
130 | 99° 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 →

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

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

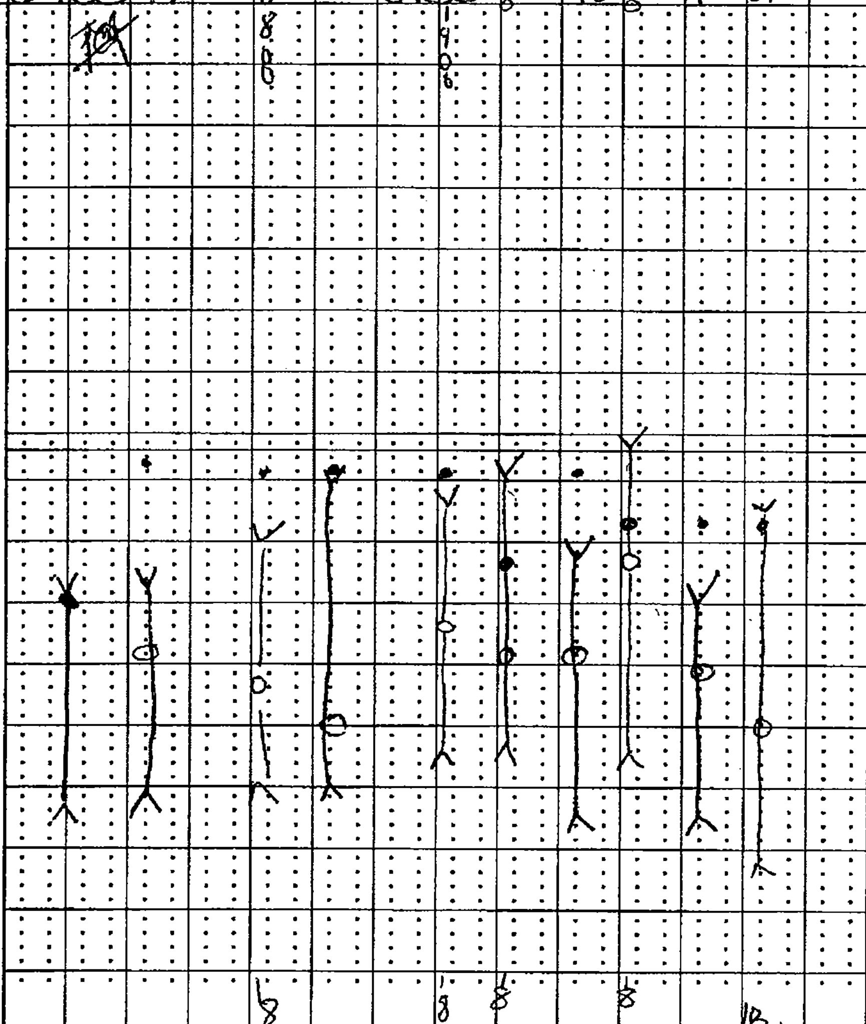
MEDCOM - 16299

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	2Sept	2Sep.	3Sep	4Sept	05SEP03		06SEP03	07Sep
19 / HOUR	0700	19	8	0730	8	18	8 / 18	09

PULSE (O) / TEMP. F (•): 180 / 104°; 170 / 103°; 160 / 102°; 150 / 101°; 140 / 100°; 130 / 99°, 98.6°; 120 / 98°; 110 / 97°; 100 / 96°; 90 / 95°; 80; 70; 60; 50; 40 (105° at top)



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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18, 18, 18, 18, 18

Record special data only when so ordered

BLOOD PRESSURE: 112/68, 113/69, 116/68, 120/70, 114/67, 129/71, 107/65, 124/76, 106/65, 113/57

101, 91, 80, 99, 115/76, 92, 88

R-16, 98.3, 98.2, 98.1, 98.2, 97.3

HEIGHT: WEIGHT →

T-98.3, 98.5 / 100 RA

96%, 97%, 97%, R-14, 96 (RA), 97%, 97 (RA), 97%, 97% RA

R-16, RA

98% 9

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.

EPW [redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16300

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY	0							
MONTH-YEAR / DAY	08Sept	09Sept03	10Sept	11 Sep	12 Sep	13 Sep	Sept 14	
19 / HOUR	18	18	0 / 18	8	0700 / 18	0730 / 18	0715	

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: 18 | 18 | 18 | 18 | 18 | 18 | 19/72

BLOOD PRESSURE: 112/71, 112/73 | 124/79, T 97.6, H 94, 97% | 124/74 | 107/82, 88, 98 | 112/63, 111/61 | 124/72, H 78, T 97.5, 99% | 109/62, 87, 98.4, 97% | 113/71, H 103, T 98.7, 98% | 112/73, 97, 97.9, 98% | P 95, 98.1, 97

Record special data only when so ordered

HEIGHT: | WEIGHT ⟶

96% RA, 97% RA | 97% | 96% | 96 | RA | RA

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**

[redacted]

(b)(6)-4

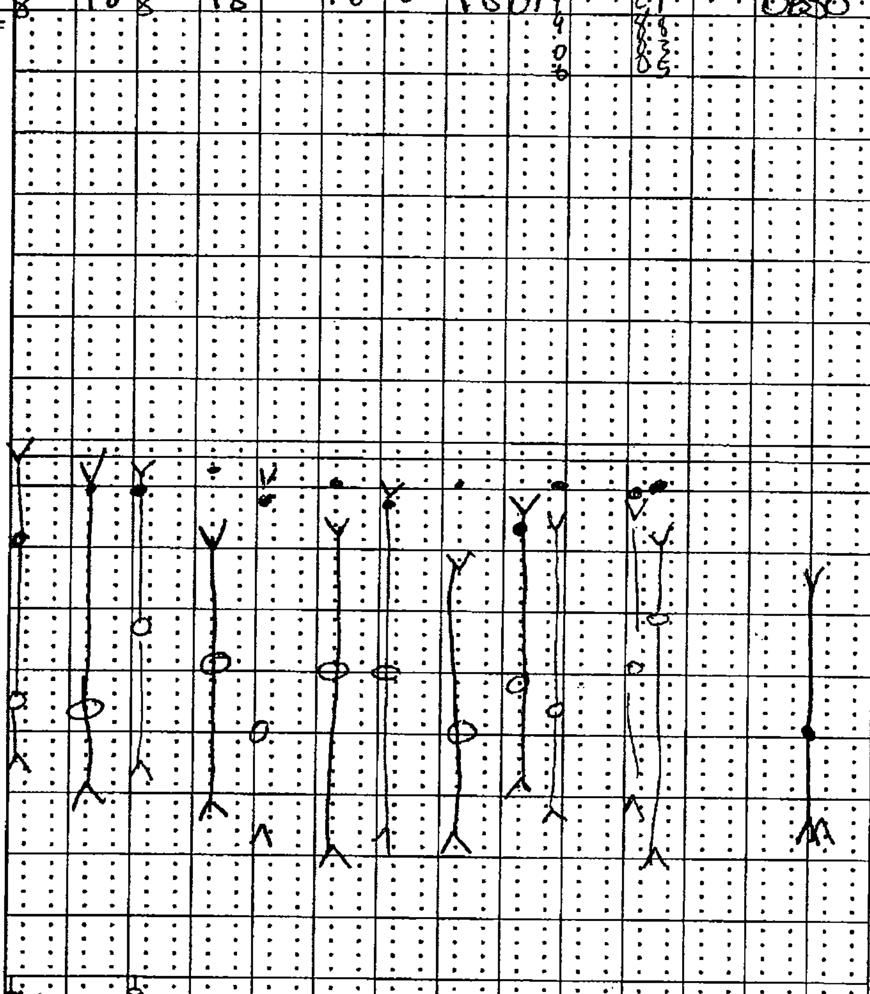
MEDCOM - 16301

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR Sep / DAY	15 Sep	16 SEP 03	17 Sep	18	19	20	21
19 2003 / HOUR	8 · 18	8 · 18	· · 18	06 · 18	07 · ·	01 · ·	0830 ·



RESPIRATION RECORD: 18 · · 18 · · · · · · 18 · · 19

BLOOD PRESSURE	125/72	120/72	122/75	110/68	129/65	113/62	119/60	97/64	116/73		118/70		105/66
		96		92	80	90	90	80			102/61		P 81
		84		98.3	96	98	97.7	98.1	114/67				R 16
HEIGHT: / WEIGHT →					96		95		96% RA				T 96.3
	O2 sat 97%		97%	96% (RA)	97%	96		96%	96% RA		98% O2 / 98% RA		95% RA

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

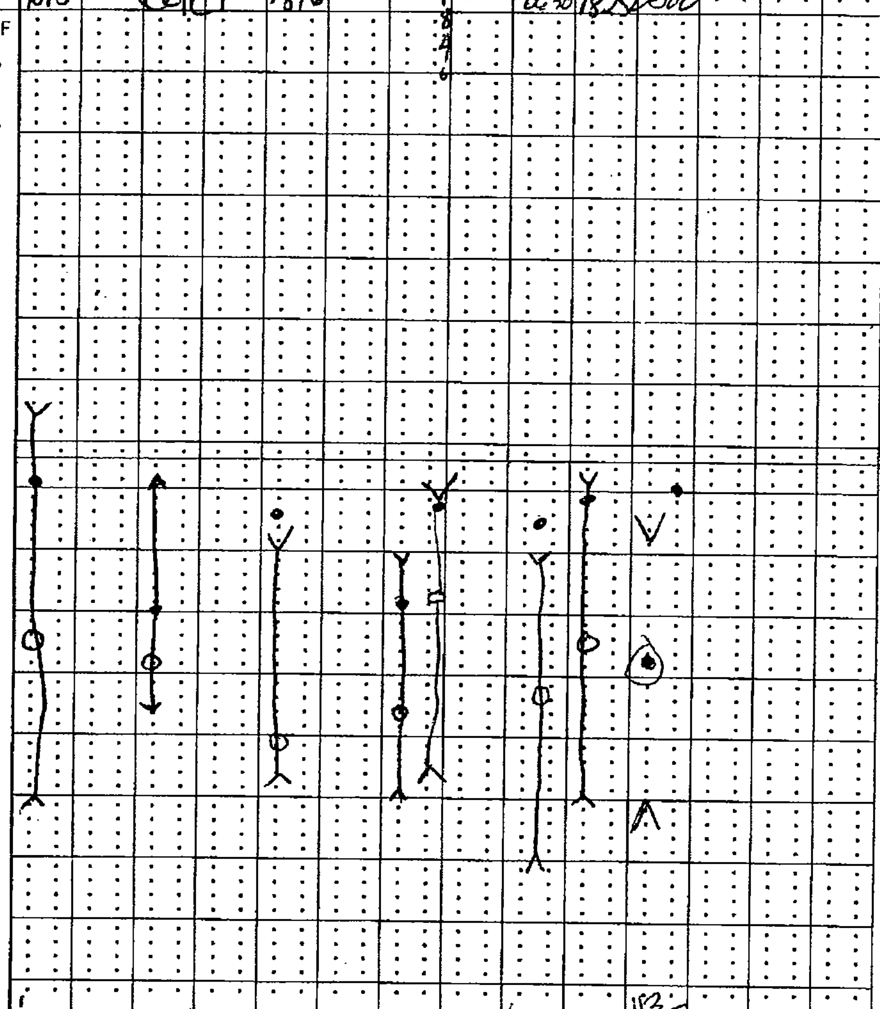
VITAL SIGNS RECORDS
Medical Record

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

MEDCOM - 16302

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	21	22Sept	22Sept	23Sept03	24 Sep	25Sept.	
19 / HOUR	1815	0921	1816		0630 1825	2300	



RESPIRATION RECORD	16				16		18 / 20
BLOOD PRESSURE	136/68	132/60	116/73	104/72	104/61	122/70	
		94	P 79	T 96.8	H 87	96	P 93
		H 91	97.5 H	H 84	T 97.5	97.5	T 98.1
HEIGHT: WEIGHT →	99.1	T 96.8		98%	97%	98%	
					RA		97% RA

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 - 16303

(b)(6)-4

ID: [redacted]
NB

07-08-03
13:09

				Patient Limits	
WBC	11.4	H	x10^3/uL	4.5	10.5
RBC	3.45	L	x10^6/uL	4.00	6.00
Hgb	10.3	L	g/dL	11.0	18.0
Hct	33.4	L	%	35.0	60.0
MCV	96.8		fL	80.0	99.9
MCH	29.8		pg	27.0	31.0
MCHC	30.8	L	g/dL	33.0	37.0
Plt	508.	H	x10^3/uL	150.	450.
LY%	19.0	*L	%	20.5	51.1
LYM	2.2	*	x10^3/uL	1.2	3.4

---

i-STAT EC8+

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

Pt Name:_____

Glu_____102 mg/dL

BUN_____11 mg/dL

Na_____132 mmol/L

K_____3.7 mmol/L

Cl_____103 mmol/L

TCO2_____31 mmol/L

AnGap_____3 mmol/L

Hct_____29 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.460

PCO2_____41.4 mmHg

HCO3_____29 mmol/L

BEecf_____6 mmol/L

Sample Type_:

07AUG03 13:15

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

Physician:_____

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

Ver: JAM5046A
CLEW A93

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	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

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

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 [redacted]

Blood Bank Unit Crossmatch (b)(6)-2
(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

Ward/Section: EMT | REQUES[redacted]N: (6)(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (6)(6)-4 | DATE: 7Aug | TIME: 1300 | 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%
BLood		(-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

(6)(6)-4

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

07/08/03 13:15

REFERENCE RANGE: MALE

PATIENT #: [redacted] (6)(6)-4

GENERAL CHEMISTRY 12

DISC LOT #: (6)(6)-3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

(6)(6)-4

ALB	2.5*	3.3-5.5	G/DL
ALP	73	26-84	U/L
ALT	26	10-47	U/L
AMY	34	14-97	U/L
AST	30	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CHOL	143	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	101	73-118	MG/DL
TP	5.8*	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
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: (6)(6)-2 [redacted] | **DATE:** 7Aug03 | **LAB ID NO.:**

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

(b)(6)-4

Glu_____117 mg/dL

BUN_____8 mg/dL

Na_____135 mmol/L

K_____4.3 mmol/L

Cl_____101 mmol/L

TCO2_____31 mmol/L

AnGap_____9 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

*via Hct

pH_____7.349

PCO2_____52.7 mmHg

HCO3_____29 mmol/L

BEecf_____3 mmol/L

Sample Type_:

15AUG03 01:57

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.3 mg/dL

Sample Type_:

15AUG03 01:59

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

Ward/Section: TCW 2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 15 Aug	TIME: 0153
SSN/PSEUDO SSN:		

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 15 Aug 03	LAB ID NO.:

PT/PTT

Ward/Section: [redacted] (b)(2)-2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 18Aug	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	15.6	9.8-13.6 secs
APTT	48.6	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

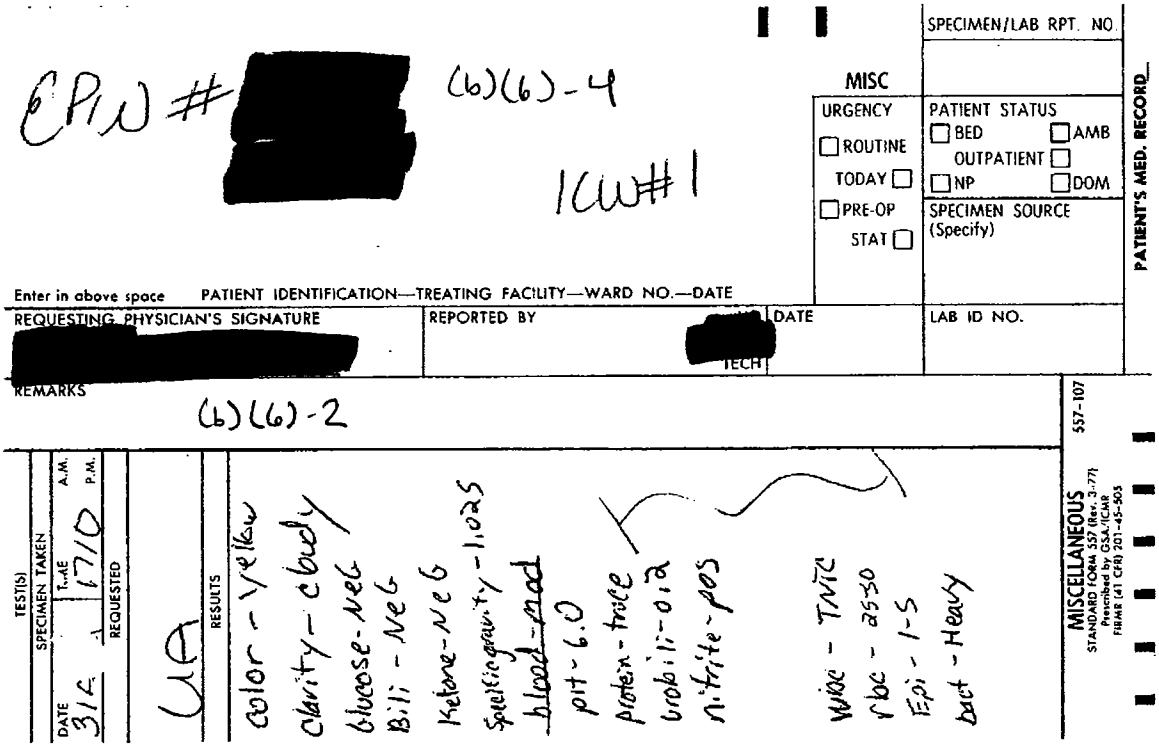
UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE 18 Aug 09	LAB ID NO.:

(b)(6)-2

MEDCOM - 16310



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

ICW#1

SPECIMEN/LAB RPT. NO.

MISC

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY [redacted] TECH

DATE

LAB ID NO.

REMARKS

(6)(6)-2

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. / P.M.	REQUESTED	RESULTS
UA	31 Aug	1710		color - yellow clarity - cloudy Glucose - neg Bili - neg Ketone - neg Specific gravity - 1.025 blood - mod pH - 6.0 protein - trace urobili - 0.2 nitrite - pos WBC - TNTC RBC - 25-50 Epi - 1-5 bact - Heavy

557-107

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

Ward/Section: [redacted]	ATTING PHYSICIAN: (b)(2)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: EPW [redacted] (b)(6)-4	DATE: 18 Aug	TIME: 1430	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.9	4.8-10.8 x 10^3
RBC	3.53	4.7-6.1 x 10^9
Hgb	10.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.6	42-52% (M) 37-47% (F)
MCV	95.2	80-94 fl (M) 81-99 fl (F)
Plt	668	130-500 x 10^3 verified
Lymph %	22.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 18 Aug 03	LAB ID NO.:

Tobacco

MEDICAL RECORD - ANESTHESI[A]

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

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)												TOTALS
Midazolam (mg)	2											2
Fentanyl (mcg)	50	200	50 50	50	50							230 400
MSO4 (mg)	4	6										10
Propofol (mg)	120	50										170
Sux (mg)	60											60
( )												
VOLAT AGENT Iso % del	1.0 ~ 1.5	~	1.5 ~ 1.5		1.5 ~ 1.7	2.0 X						
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	10 ~ 2 ~ 2		2	2	2	2	2	10				

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

TOTAL EBL: 200

TOTAL URINE: 225

FLUIDS

LINE site 18G (L) A	Warmed	LR #1 —— 500 —— 1000 #2
	Warmed	
	Warmed	
	Warmed	

FLUIDS SUMMARY
- CRYSTALLOID- 1100 mL
- COLLOID- Ø
- BLOOD- Ø

LOSSES

EST BLOOD LOSS	25	125	150	200	
URINE -	200		225		

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

BODY WEIGHT: 62 (KG) / LB

HEMATOCRIT: 28

INITIAL DATA:
- BP- 109/65
- HR- 107

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR TIME- 1530

TIME ➔ 1530 • 1600 • 30 • 1700 • 30 • 1800

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	—	650	740	740	710	700	720	750	790	600
f - breaths/min	—	10	8	8	9	9	6	2-6	6-8	12
Peak inf pres / PEEP	—	22	24	24	24	24	25			
MODE - S(pon), A(ssist), C(on)	S C	C	C	C	C	C	C	S/A	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		44	34	34	34	34	37	56	45	+
BP/oth	FIO2 (Frac or %)	0.87	0.87	0.87	0.87	0.87	0.87	0.87	0.86	0.86	0.86
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site		Nasal	——	36.6	36.9	36.7	36.6	36.4	36.5	X
	N-M Block (T/4)										
	BS	+	——		+	——	——	+			
Warming blkt	x1 Blanket		——	→	——	→	→	→			
Conv warmer											

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4) (6) (5) (7) (8)

REMARKS

Code drugs with numbers, events with letters

1. Pre-op assessment ?? counseled interpreter.
2. Room, monitors, O2, Induced eyelids taped
3. Exp. wheezing albuterol 8 puffs BS CTA = (B)
4. OG + nasal temp probe
5. 50mL of peroneal tissue separated ?
6. Dr. ?? consult for ?? placed 12FR foley. No complications. 1650 ?? 10mg IV
7. OP ?? RR <30 BPM; TV 4mL/kg ETCO2 <50. Extubated s̄ complications
8. TO ICU-2 report to RN. Hosp Course + ?

RECOVERY AT: 1742

PACU ICU 2 (Specify)

OTHER T-98.3

CONDITION: Stable

RESP- 19 SpO2- 98-100

BP- 136/89 HR- 110

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1540	1755
	Ready	Begin	End
PROC	1550	1620	1729

PROCEDURES and CPT Codes: (L) leg I&D Exfix (L) femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA — RSI c̄ cric pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x1 MAC 3 grade I view 8.0 ETT 19cm @ lip style 8mL air, no cuff +BBS, sust ETCO2

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

[redacted] (b)(6)-4

SURGEON [redacted]

[redacted] MAJ / CRNA

PROCEDURE LOCATION: 2

DATE: 7 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 16313

COPY [redacted] NT'S MEDICAL RECORD

USAPA V1.00

" (b)(6)-2 ?

Preop
MEDS
25mg Phenergan

MEDICAL RECORD - ANESTHESI

...se of this form, see AR 40-66; the proponent agenc... ...e OTSG

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

DRUG	(Units)														
Propofol	(mg)	50	50												
Fentanyl	(ucg)	100	100	100	100	50									
	( )														
	( )														
	( )														
	( )														
VOLAT AGENT	1SO % del / % e.t.	A	1.0	1.0	1.0										
AIR	L/Min														
N2O	L/Min														
O2	L/Min	3	3	3											

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

FLUIDS

LINE site															
Bag LR	☐ Warmed	LR	1000												
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														

LOSSES

EST BLOOD LOSS															
URINE -															

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 150 KG (LB)

HEMATOCRIT:

INITIAL DATA:

BP- 135 / 94

HR- 117

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 0800 × 0820

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

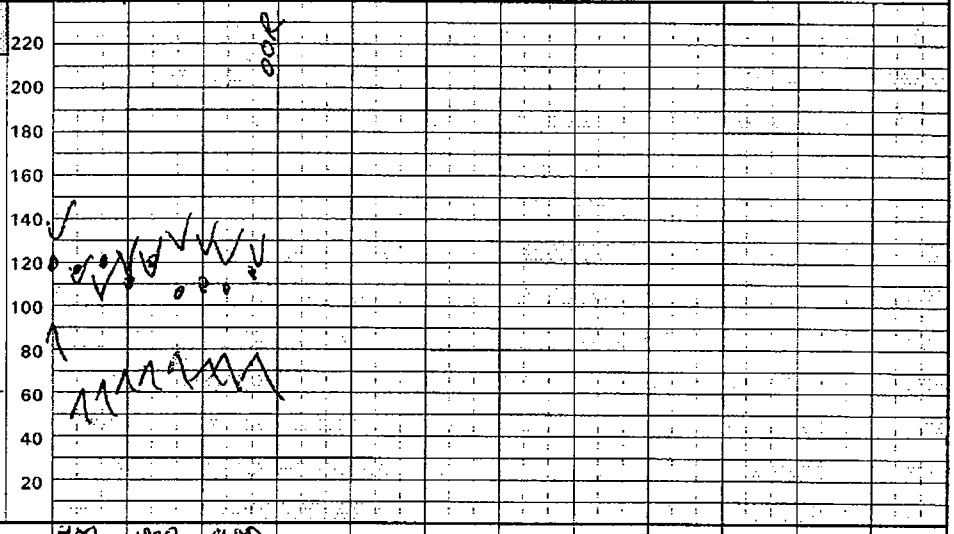
Resp rate: ∫

BR (transduced): ∩∩∩

TOURNIQUET: ╪ T—T

ANES- X-X

PROC- ⊙-∅



VENTIL

VT - ml	700	1020	900
f - breaths/min	11	9	9
Peak inf pres / PEEP	/	/	/
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	✓	ET CO2 (torr)	37	45	36
BP/oth	✓	FIO2 (Frac or %)	.89	.89	.89
ART line	✓	SpO2 (%)	100	100	100
Steth- PC/ES	✓	ECG	ST	ST	ST
Gas analyzer	✓	TEMP-site	Axil		
	✓	N-M Block (T/4)			
Warming blkt					
Conv warmer					

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

TOTALS	TOTAL EBL
100	
400	M19
	TOTAL URINE
	0

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- /

BLOOD- /

REMARKS

Code drugs with numbers, events with letters

2350 PT ID, ∅ Δ
from PREOP form
2400 RSN, O2, MCL
0002 OOR TO ICU
RPT TO CPT [redacted], RN

RECOVERY AT 0042

PACU ICU 2 (Specify)

OTHER

CONDITION: 99%

RESP- 12 SpO2- 99

BP- 124/82 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2350	0001	
PROC	Ready	Begin	End
	0007	0026	0040

PROCEDURES and CPT Codes:

I & D (L) LEG

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

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA - MASK

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* PT maintains SU & OA in place

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

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

PROCEDURE LOCATION: OR 1

DATE: 10 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 16314 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

Keflex
Lovenox
percocet

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)	1800	X	30	X	1900	X	30	X	2000	TOTALS	TOTAL EBL
Versed (mg)	(5)									5	∅
Fentanyl (cc)	1 1 : 1 1									5	
Propofol (mg)	150		20								TOTAL URINE
Zofran (mg)	40										
Decadron/Robinul (mg)			3/.4								∅
VOLAT AGENT Iso % del	X2 — 1.5 — XX1.5X										
% e.t.											
AIR L/Min											
N2O L/Min											
O2 L/Min	6 — 2 — 2 — 6										

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

FLUIDS SUMMARY
CRYSTALLOID- NS 1000
COLLOID- ∅
BLOOD- ∅

FLUIDS

LINE site	Warmed	
LA	☐ Warmed	400 — 600 — 1000
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE -

REMARKS
Code drugs with numbers, events with letters

Preop PNNPO agrees to GA OR, O2, monitor. Stable IV Induction 1800. LTC Control Relief [redacted]

OG out
Suction SV
extubated
awake
Comfortable
Cooperative

PHYS STATUS: 1 (2) 3 4 5 E

TIME ➡ 1800 X 30 X 1900 X 30 X 2000

BODY WEIGHT: 73 LB (60)

HEMATOCRIT:

INITIAL DATA:
BP- 110/60
HR- 102

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Yes
TIME- 1740

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20 (BP marks charted approx. 120/60 to 100/80)

VENTIL

VT - ml		400	570	
f - breaths/min		9	6	18
Peak inf pres / PEEP		21	16	
MODE - S(pon), A(ssist), C(on)	SC	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	+	31	37
BP/oth	X FIO2 (Frac or %)	.5	.9	.9
ART line	X SpO2 (%)	100	100	100
Steth- PC/ES	X ECG	ST	ST	ST
Gas analyzer	TEMP-site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS EVENTS Position ➡

RECOVERY AT: 1837
(PACU) ICU ____ (Specify)
OTHER
CONDITION:
RESP- 10 SpO2- 92
BP- 111/64 HR- 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1745	1755	1835
	Ready	Begin	End
PROC	1805	1810	1826

PROCEDURES and CPT Codes:
Adjust (L) Femur Ex. Fix.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
DL X1, grd I view, 8.0 ETT, 2 mac, 35 cm

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
+ ETCO2

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

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

ANESTHETISTS: [redacted] LTC ANC

PROCEDURE LOCATION: OR
DATE: 8.26.03
PAGE 1 OF 1

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

Age 46 **DAYS MOS YRS** **Sex** ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: WASHout (R) LEG ± possible Ex fix

SURGICAL SERVICE:

NPO SINCE:

ASA Physical State 1 2 3 4 5 E

WT: 62 KG/LB HT: ____ IN.

ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
( ) = ordered as premed

(√) Ancef 1gm IVPB @ 1515
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

HB/HCT: 10.9 / 28
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	abdominal hernia
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 DENTN (R) SIDE MISS
Trachea ML
TMJ/Neck 3+
Oropharnyx MP 2
Nares
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (L) A
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. (b)(6)-2

The patient/legal guardian [redacted] understand and agrees. Questions answered.

Signed: [redacted] Date: 07 Aug 03 Time: 1455 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

10 Aug 03
0000
Ø charge
10.3
33.4
[redacted]
CPT
CCN/A
(b)(6)-2

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]
[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

EPW [redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

1) Admit to ICW 2 Ortho ✓

2) Dx: GSW (L) thigh, calf
(L) Femur fracture
(L) tib-fib fx ✓
Condition stable ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

3) I.V at 200 cc/hr LR

4) Ancef 1 gm Ancef q 8 hour (last dose 1300 - 4 Aug in E.R.)

5) CBC
Chem 12
Lytes
Type & hold
X-ray L leg
done in E.R.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

6) NPO till further notice ✓

7) Activity: Bedrest ✓

8) V.S. per routine ✓

9) Notify ortho of patients room #

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

4 Aug 03

1) MSO4 2-6 mg IVP q 2 hr prn

[redacted]

[redacted]

[redacted]

[redacted]

(b)(6)-2

4 Aug 03
1525

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

☆ U.S. G MEDCOM - 16317 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

[redacted]

(b)(6)-4

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

DATE OF ORDER 07 Aug 03 TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

Admit to ICU → TCW 2s

[redacted]

(2) femur fracture s/p GSW

(3) femur Ex fix

allergies unknown

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

IVF D5 1/2 NS @ 20 mEq KCl at 100 cc/hr

Foley to gravity

Ancef 1 gm IVB q 8°

Clear liquid advance as tolerated

(1) AP + lat (3) femur ~~in a~~

(2) AP + lat full length femur

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

Bedrest

Vitals q shift routine

MSO4 2-6 mg IVP q 2° pain

Coversyl 20 mg PO qd

Phenergan 12.5 mg IVP q 4-6° n/v

(b)(6)-2 [redacted]

DX [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

noted [redacted]

(b)(6)-2 9 Aug 03

9 Aug 2010

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

CAL RECORD - DOCTOR'S ORDERS

For use ... orm, see AR 40-66, the proponent agency is O

THE DOCTOR SHALL RECORD DATE, TIM... ND SIGN EACH SET OF ORDERS. IF PROBLEM O... ENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMB... IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

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

DATE OF ORDER 5 Aug 03 TIME OF ORDER 2115 HOURS

LIST TIME ORDER NOTED AND SIGN

1) ~~[illegible]~~

2) [illegible] + L2+

3) [illegible]

[redacted]

9Aug03 0210

PATIENT IDENTIFICATION

DATE OF ORDER 8Aug03 TIME OF ORDER 2130 HOURS

V.O from Dr [redacted] SPC

D/C IVF HI TV

[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9Aug 03 TIME OF ORDER 0815 HOURS

Full length sternum (L) AP + Lat today.

[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

EPW (b)(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT	ROOM NO.	BED NO.
ICU2		6

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

☆ U.S. GC MEDCOM - 16319 1-710

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] (b)(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 6

DATE OF ORDER: 8 Aug | TIME OF ORDER: 0300 HOURS | LIST TIME ORDER NOTED AND SIGN

VO

Tylenol 650mg PO q 4-6° PRN — noted 0800 8 Aug

Dr [redacted]

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED: 6

10/Aug/03 noted @ 0830 [redacted]

DATE OF ORDER: 10 Aug 03 | TIME OF ORDER: 0830 HOURS

Admit [redacted] to ICW-2 ✓

S/P MVA without external wound ✓

Ex-Fix @ left ✓

Vital signs routine ✓

IVF D5 1/2 NS @ 100cc/hr at 100cc/hr ✓

Pt diet ✓

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 6

DATE OF ORDER: 10 Aug 03 | TIME OF ORDER | HOURS

MSO4 2-6 mg IVP q 2-4° ✓

Phenergan 12.5 mg IVP q 4° prn ✓

Ancef 2 gm IVPB q 8° ✓

Levaquin 750 mg IVPB q 24° ✓

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] noted 10 Aug 03 1130

DATE OF ORDER: 10 Aug 03 | TIME OF ORDER | HOURS

Parkview to OR this pm

please pack gauze

[redacted] p.o.

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

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

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

(b)(6)-2 noted [redacted] 10 Aug 03 1730

NURSING UNIT | ROOM NO. | BED NO.

24°V/S [redacted]

DATE OF ORDER: 10 AUG 03 TIME OF ORDER: 1723 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Percocet, 1-2 P.O. Q4-6 hrs PRN
2. Tylenol 325mg, ii tabs P.O. Q4 hrs PRN

(b)(6)-2 [redacted]

[redacted] MAN. 8/10/03 2129.

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 6

DATE OF ORDER: 12 Aug TIME OF ORDER: ______ HOURS

(b)(6)-2 [redacted] noted 1615

1. Wet-to-Dry NSS Dressings to (L) Calf change BID
2. Colace 100mg po BID ~~PRN~~ Constipation
3. Physical Therapy for ROM exercises for LLE

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER TIME OF ORDER ______ HOURS

4. Dry iodoform packing gauze to (R) Thigh change BID

(b)(6)-2

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: 24°/s | BED NO.: 6

PATIENT IDENTIFICATION

0030 14 Aug

24°VS [redacted]

EPW [redacted]

(b)(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 6

DATE OF ORDER: 15 Aug ~~2333~~ TIME OF ORDER: ______ HOURS

16 Aug 03 1600

if pt pulls out IV

1. DC IVF [redacted] noted (b)(6)-2
2. cancel [redacted] 1630
3. Keflex 500mg [redacted] per Dr [redacted]

(b)(6)-2

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MA[redacted]

☆ U.S. GO' MEDCOM - 16321 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)(6)-4

DATE OF ORDER 8-17-03 V.O. Dr [redacted] TIME OF ORDER 0137 HOURS [redacted]

LIST TIME ORDER NOTED AND

(1) 50mg Benadryl PO x1 now

[redacted]

NURSING UNIT ICW2 ROOM NO. BED NO. 6

PATIENT IDENTIFICATION

EPW (b)(6)

[redacted]

(b)(6)-2

DATE OF ORDER 7 AUG 03 TIME OF ORDER 1400 HOURS

noted [redacted] 2030

(1) CBC today
(2) PT, PTT today
(3) ~~[illegible]~~

[redacted]

NURSING UNIT ICW2 ROOM NO. BED NO. 6

2015 8/15 03 [redacted]

PATIENT IDENTIFICATION

(b)(6)4

DATE OF ORDER 8/22/03 TIME OF ORDER 1400 HOURS

(1) XR (L) femur AP+LAT

[redacted]

Noted [redacted] 22AUG03 1620

NURSING UNIT ROOM NO. BED NO.

24/2345 [redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER 8/24/03 TIME OF ORDER 1625 HOURS

(1) NPO.
(2) PO DW in A.M.

[redacted]

8/24 1700

NURSING UNIT ICW#1 ROOM NO. BED NO.

24° 8/24/03 2345 [redacted]

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

(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT PEN—PRESS FIRMLY | NO CARBON PAPER REQUIRED"

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: 25 AUG

TIME OF ORDER: 1428 HOURS

1. VO per Res duct & NOD.

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
2300	25aug03	

DATE OF ORDER: 25aug03

TIME OF ORDER: 2245 HOURS

1. Benadryl 50mg po x 1 now
   V.O. [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
0120 27AUG03		

DATE OF ORDER: 26 AUG 03

TIME OF ORDER: 1830 HOURS

1. RESUME PREVIOUS ORDERS
2. REGULAR DIET
3. IV LR AT 125 CC/HR [redacted]
   LOCK WHEN TOLERATING P.O. WELL
4. D/C [illegible] AFTER NEXT [redacted]

Noted 1900 [redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW	240	[redacted]

[redacted]

DATE OF ORDER: 31aug03

TIME OF ORDER: 1630 HOURS [redacted]

1. Send UA w/ next void
   VO per Dr [redacted]

b(6)-2

[redacted]

[illegible] PO 500 mg BID

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

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY [redacted] USE[redacted]

(b)(6)-2

MEDCOM - 16323

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] (b)(6)-4 Noted [redacted] 03 b(6)-2		9 Sept 03 1613 HOURS	
	①	DP + LAT X-RAYS ② [illegible]	
	②	Naproxen 500 mg BID	
		[redacted]	
NURSING UNIT: KWA ROOM NO.: 2 BED NO.: 1620 C		(b)(6)-2	
		24°/2125 9Sept03 [illegible]	
PATIENT IDENTIFICATION: b(6)-4 [redacted] Noted 10 Sept 03 [redacted] b(6)-2		10 Sept 03 1130 HOURS	
		Δ Naprosyn to Motrin	
		800 mg P.O TID	
		[redacted]	
NURSING UNIT: ROOM NO.: BED NO.:		(b)(6)-2	
PATIENT IDENTIFICATION: (b)(6)-2 Noted [redacted] 10 Sept 03 1630		10 Sept 03 1630 HOURS	
	①	TOE TOUCH WEIGHT BEARING	
		(b)(6)-2	
		[redacted]	
NURSING UNIT: 240/2100 ROOM NO.: BED NO.:			
PATIENT IDENTIFICATION: 10 Sept [illegible] 1630		DATE OF ORDER TIME OF ORDER HOURS	
NURSING UNIT: ROOM NO.: BED NO.:			

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

MEDCOM - 16324

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: ICW | ROOM NO. | BED NO.

DATE OF ORDER: 16 SEPT 03 TIME OF ORDER: 1700 HOURS

LIST TIME ORDER NOTED AND SIGN [redacted]

① Restoril 10 MG P.O. Q 4S PRN night pain, insomnia

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW [illegible] ROOM NO. [illegible] BED NO. [illegible]

DATE OF ORDER: 15 SEPT 03 TIME OF ORDER: 1730 HOURS

Restoril 30 mg P.O. Q 4S PRN night pain, insomnia

[redacted]

(b)(6)-[illegible]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

noted 18 Sept 03 1620

[redacted]

b(6)

NURSING UNIT: ICW | ROOM NO. | BED NO.

20 SEP 03 [redacted]

DATE OF ORDER: 15 SEPT 03 TIME OF ORDER: 1620 HOURS

① [illegible] ② [illegible]

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

DA[redacted] ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES E MEDCOM - 16325 IAY 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 24 SEPT 03 TIME OF ORDER 1405 HOURS

LIST TIME ORDER NOTED AND SIGN

1. DISCHARGE TO GPW CAMP 25 SEPT 03
2. MOTRIN 800 MG PO TID PRN
3. FOLLOW UP IN 3 WEEKS FOR X-RAY
4. PROVIDE SUPPLIES FOR PIN CARE

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(4)- TIME OF ORDER

CANCEL PATIENT CAN DO IT HOURS 1135 24SEP03

5. CIPRO 500 MG P.O. BID [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 16326

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 | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

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]	VS: per routine	06	[redacted]
			18	
7	[redacted]	ACT: BR	6	
			18	
7	[redacted]	Regular Diet	6	
			18	
12	[redacted]	W→D NSS drsg to (L)	10	
		calf ~~+ drig iodoform~~	22	
		~~packing gauze to (L)~~	X	
		~~thigh BID~~ [redacted]	X	
12	[redacted]	PT to do ROM & LLE	6	[redacted]
			18	
05 SEP 03	[redacted]	Pin care q day & betadine	10	
10 SEP 03	[redacted]	Betadine wt dressing change	R	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW-ext fix (L) leg S/P washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)(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 - 16327

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 09 Yr 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
09 SEP 03	[redacted]	AP/LAT XRAY (L) FEMUR in AM	10 SEP 03	1200		[redacted]
15 ~~SEP 03~~	[redacted]	~~Resume previous orders~~	13 SEP 03			[redacted]
27 SEP 03	[redacted]	DC to ERW camp [redacted] (b)(2)-2				

b(6)-2

b(6)-2

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

USAPA V1.00

b(6)-2 A4

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 per routine	6	/	[redacted]												
			14	/													
			21														
7 Aug	[redacted]	Activity, Bedrest	6	/	[redacted]												
			14	/													
			21														
7 Aug	[redacted]	Diet ~~ATP~~ ~~CL Advance~~ ~~as tolerated~~ Reg	6	/	[redacted]												
			12	/													
			17														
7 Aug	[redacted]	Foley to gravity	6	/	[redacted]												
			14	/													
			21	cm													
10 Aug	[redacted]	Packing to (L) thigh BID to plain packing gauze	08	/	/	/	[redacted]										
			20	/	/												
			1	/													
			1														
12	[redacted]	W→D NSS dsg to (L) calf & dry iodoform packing gauze to (L) thigh - BID	08														
			20														
			1														
			1														
			1														
12	[redacted]	PT to do ROMCLLE	QD	/	/	/	/	/									

Add See below [redacted]

ALLERGIES: [redacted] YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW (L) thigh, (L) femur fx, (L) tib fib fx S/P Ex Fix (L) leg s/p washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EDW #[redacted]

(b)(6)-2

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 - 16329

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 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 ICW 2	7Aug	today	1455	[redacted]
7Aug	[redacted]	Dx: GSW (L) thigh cav, (L) femur fracture, (L) tib-fib fx				
7Aug	[redacted]	Condition: Stable				
7Aug	[redacted]	xray AP + lat full length femur	7Aug	today		
8Aug	[redacted]	npo p̄ breakfast	9Aug	AM		
17Aug	[redacted]	50mg Benadryl PO x1 now	17Aug	0138	0138	
18	[redacted]	CBC/PT/PTT today	18	2100	2100	

(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 16330

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 — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19 20 21 22 23 24 25 26 27 28 29 30 1
07 AUG 03	[redacted]	VS per routine	06	[redacted]
			18	
07	[redacted]	ct: BR	06	
			18	
07	[redacted]	regular diet	06	
			18	
12 AUG 03	[redacted]	PT to do ROM & LE	10	
05 SEP 03	[redacted]	Ah care q day (effective	10	
10 SEP 03	[redacted]	Toe touch weight bearing (6)(6) -2	06	
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW, SK FX (L) LEG S/P WASHOUT

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

(6)(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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 SEP 03	[redacted]	AP/LAT (L) Femur in AM	24 [redacted]	0800	0830	[redacted]
24 SEP 03	[redacted]	DIC to EPW camp 25 SEP 03	25 SEP 03		(b)(6)-2	
24	[redacted]	F/U in 3 weeks for X-ray	24	NOTED		[redacted]
24	[redacted]	Provide pt supplies for pin care, ensure pt can do it himself				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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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. 08 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 21 22 23 24 25 26 27 28 29 30 31 1 2 3
7Aug	[redacted]	VS per Routine	[redacted]	
7Aug	[redacted]	Activity Bedrest	[redacted]	
7	[redacted]	~~Diet~~ Regular diet	[redacted]	
12Aug	[redacted]	W->D NSS dsg to (L) calf + dry iodoform packing gauze to (L) thigh BID	[redacted]	
12Aug	[redacted]	PT to do ROM (L) LE	[redacted]	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO NKDA

PRIMARY DIAGNOSIS: S/P exfix (L) leg S/P wound

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 - 16333

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 AUG	[redacted]	XR - Femur AP & LAT	22 AUG	1630	1630	[redacted]
8/24		NPO - To OR in AM	24 Aug	2400		
25		Benadryl 50mg PRN Q 6 hrs	25th	2200		
26		Resume prev. orders	26th		noted	
31		Send UA w/ next lab	31 Aug			
				(6)(6)(2)		[redacted]

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

USAPA V1.00

MEDCOM - 16334

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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3 4 5 6 7 8 9 10 11 12 13 14 15 16
10 Aug	[redacted]	Lovenox 70mg SQ BID	08	[redacted]
			20	
01 Sep	[redacted]	Cipro 500mg po BID	10	
			22	
09 Sep 03	[redacted]	Naprosyn 500mg BID	10	/ / / / / /
			22	/ / / / / /
10 Sept 03	[redacted]	Morfin 800 mg P.O TID	08	
			16	
			24	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ext fix Dleg S/P washout

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

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 - 16335

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
1 Aug	[redacted]	P				
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Aug	[redacted]	Percocet ½-1½ tabs PO @ 4-6hr PRN Pain	D/T	3Sep 0740	3Sep 1230	3Sep 1632	3Sep 2035	4Sep 0046	4Sep 0415	4Sep 1120	4Sep 2226	05SEP 0925	05SEP 1340	05SEP 1800	05SEP 2245	06SEP 0330	06SEP 0755	
			D/I	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	
				[redacted]														
8 Aug	[redacted]	Tylenol 650mg P.O @ 4-6 hr PRN	D/T	5Sep 1042O				(6)(6)-2										
			D/I	1½														
10 Aug 03	[redacted]	Percocet 1-1½ tabs PO @ 4-6° pm pain	D/T	06SEP 1353	6Sep 1830	6Sep 2245	7Sep 0618	7Sep 1330	7Sep 2345	8Sep 2256	9SEP 0845	9SEP 1405	10SEP 0115	10SEP 0900	10SEP 1635	10SEP 2120		
			D/I	1½	1½	1½	1½	1½	1½	1½	1½	1½	2	1½	1½	1½		
				[redacted]														
		Percocet 1-1½ tabs PO Q4-6hr PRN	D/T	11Sep 0340	11Sep 0803	11Sep 1200	11Sep 1602	11Sep 2230	12Sep 1308	12Sep 1700	12Sep 2130	13Sep 0035	13Sep 1822	13Sep 2300	14Sep 0515	14Sep 0950		
			D/I	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½		
10 Aug 03	[redacted]	Percocet 1-1½ tabs PO @ 4-6° PRN	D/T	15Sep 0620	15Sep 1510	15Sep 1905	15Sep 2315	15Sep 0338	16Sep 0740	16Sep 1155	16Sep 1755	16Sep 2210	17Aug 0505					
			D/I	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½					
				[redacted]														
9/15	[redacted]	Restoril 10mg PO QHS prn night pain, insomnia				9/15												

USAPA V1.00

b(a)-2 A11

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 Y. 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 16 17 18 19 20
7 Aug	[redacted]	IV LR @ 200cc/hr	6 / 14 / 21	} D'd 7 Aug 03
7 Aug	[redacted]	Ancef 1 gm IV q 8°	6 / 14 / 22	[redacted] 17 Aug 0650
7 Aug	[redacted]	D5 1/2 NS c 20 meq KCl @ 100cc/hr (A/L)	6 / 14 / 21	[redacted] D/C see below
7 Aug	[redacted]	Lovenox 70mg SQ q Bid	08 / 20 /	[redacted]
10 Aug	[redacted]	IVF D5 1/2 NS c 20 mEq KCl @ 100cc/hr	05 / 13 / 21 Sm	[redacted] Dc'd 17 Aug 0650
17 Aug	[redacted]	Keflex 500mg PO QID	06 / 12 / 18 / 24	[redacted]
		Cipro 500mg PO BID	10 / 22	D/C w/ discharge

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
EGW (L) thigh (L) femur fx (L) tib-fib fx
S/P ex fix (L) leg / S/P wash out (L) leg

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.* ___ *Yr.* ___

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE-FREQUENCY	HR	DATE DISPENSED
		PRN MEDS		7 / 8 / 8 / 8 / 9 / 10 / 10 / 10 / 11 / 12 / 13 / 14 / 15
7 Aug	[redacted]	MSO4 2-6mg IVP q 2° PRN pain		0139 5mg IVP / 0539 3mg IVP / 0415 8Aug 4mg / 0024 6mg / 2015 4mg / 0800 5mg IVP / 1600 10Aug 5mg / 2337 10Aug 5mg / 11Aug 5mg / 12Aug 0535 5mg / 13Aug 2030 5mg / 14Aug 2000 5mg / 15Aug 0900 [redacted]
7 Aug	[redacted]	Phenergan 12.5mg IVP q 4-6° prn		
8 Aug	[redacted]	Tylenol 650mg PO q 4-6° PRN		7Aug 2330 PO / 10Aug 0525 / 11Aug 0700 / 17Aug 0100 / 17Aug 1450 / 17Aug 2330 / 18Aug 1430 [redacted]
10 Aug	[redacted]	Immodium i tabs po prn diarrhea		10Aug 1600 [redacted]
10 Aug	[redacted]	Percocet i-ii tabs PO q4-6° prn pain		10Aug 1700 / 10Aug 2115 / 11Aug 0650 / 11Aug 1200 / 11Aug 1700 / 11Aug / 12Aug 0555 / 12Aug 1000 / 12Aug 2200 / 13Aug 8:30 / 13Aug 8:30 [redacted]
12	[redacted]	Colace 100mg PO BID PRN constipation		
10 Aug	[redacted]	Percocet i-ii tabs PO q4-6° prn pain		13Aug 1600 / 13Aug 2000 / 14Aug 1010 / 14Aug 1515 / 14Aug 1930 / 14Aug 2322 / 15Aug 0600 / 15Aug 1000 [redacted]
10 Aug	[redacted]	Percocet i-ii tabs PO q4-6° prn pain		15Aug 1700 / 16Aug / 16Aug 0520 / 16Aug 1030 / 16Aug 1400 / 16Aug 23 / 17Aug 0320 / 17Aug 0655 / 17Aug 1930 / 17Aug 2330 / 17Aug 0330 / 19Aug 0600 [redacted]
7 Aug	[redacted]	MSO4 2-6mg IVP q2° prn pain (breakthrough)		15Aug 1730 5mg IVP / 16Aug 1035 5mg IVP [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (b)(6) - 2 all

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 - 16338

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. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17 18 19 20 21 22 23 24
18 AUG 03	[redacted]	Lovenox 70mg SQ BID	10	[redacted]
			22	
01 SEP 03	[redacted]	cipro 500mg po BID	10	
			22	
18 SEP 03	[redacted]	motrin 800mg po	08	
		TID.	16	
			24	
		(b)(6)-2 all		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Washout GSW Ex Fix R leg

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO PAGE NO. 2

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 - 16339

b(6)-2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. Sept Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
/	/	/	/	/	/	/
24 SEP03	[redacted]	D/C meds: motrin 800mg po TID prn Cipro 500mg po BID	24	NOTED		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
9/15 - 9/18	[redacted]	Restoril 30mg	D/T	16Sep 2210	17Sep 2215	20Sep 0045	20Sep 2345										
		p.o. Q HS prn	D/I	i [redacted]	i	i	i										
		night pain,	/														
		insomnia	/														
10AUG03	[redacted]	Percocet i-ii tabs po q 4-6° prn	D/T	17Sep 0807	17Sep 1100	17Sep 2215	18Sep 0450	19Sep 1000	19Sep 1740	18Sep 2310	0450 19Sep	19Sep 1344	19Sep 1540	19Sep 2045	23Sep 2019	22Sep 0200	
			D/I	ii [redacted]	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii	2	2	
08AUG03	[redacted]	Tylenol 650mg po q 4-6° prn	D/T	20Sep 1000	20Sep 1700	21Sep 0630											
			D/I	650 [redacted]	650	Sp 650mg											
16AUG03	[redacted]	Percocet i-ii tabs po q 4-6° prn	D/T	22SEP 0715	23SEP 1525	23Sep 2120	24SEP 1705										
			D/I	ii [redacted]	ii	ii	ii										
		(b)(6)-2	all														

USAPA V1.00

MEDCOM - 16340

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. 08 YR 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25	26	27	28	29	30	31	1	2
7 Aug	[redacted]	Lovenox 70mg SQ Q BID	08	[redacted]													
			20														
6 Aug	[redacted]	Keflex 500mg PO QID	06	[redacted]													
			12														
			18														
			24														
26 Aug	[redacted]	IV LR @ 125cc/hr HL when TOL. PO well (Hold)	06	—													
			18	—													
01 Sept	[redacted]	Cipro 500mg PO BID	10	//	//	//	//	//	//	//	//	//	//	//	//	//	[redacted]
			22	//	//	//	//	//	//	//	//	//	//	//	//	//	//

(b)(6)-2 all

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW ex fix ⓓ leg S/P washout ⓓ leg

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 - 16341

PRN Medications

Date	Init.	Medication	Administered
7 Aug	BM	MSO4 2-6 mg IVP Q2° PRN pain	23 Aug 0800 6mg IM [redacted]; 24 Aug 0658 6mg IM [redacted]; 24 Aug 0300 6mg IM [redacted]; 29 AUG 1130 6mg IM [redacted]
Aug	BM	Phenergan 12.5 mg IVP Q4-6 PRN	
Aug	BM	Tylenol 650 mg PO Q4-6° PRN	20 Aug 0800 [redacted]; 27 Aug 03 0703 650 [redacted]; 30 AUG 1040 KAS # ; 2 Sep 1300 Kms II tabs.
Aug	BM	Percocet I-II tabs PO Q4-6° PRN pain	20 Aug 2030 II; 21 Aug 03 0820 II; 21 AUG 1600 II; 21 Aug 2300 2; 22 Aug 0400 2; 22 AUG 1040 II; 22 AUG 1650 II; 23 AUG 0102 2; 23 AUG 0935 II; 23 AUG 1700 II; 23 ... [redacted]
Aug	BM	Colace 100 mg PO BID PRN constipation	
Aug		Percoset I-II Tabs PO q4-6° PRN PAIN	24 Aug 0250 2; 24 AUG 0853 II; 24 Aug 1535 II; 24 Aug 2230 2; 25 Aug 0936 II; 25 AUG 1632 II; 25 Aug 2030 II; 25 Aug 0055 II; 26 Aug 0100 II [redacted]
12 Aug	BR	Percocet I-II PO Q4-6 PRN PAIN	28 Aug 2100 II; 28 0100 II; 28 0500 II; 28 Aug 0530 II; 28 Aug I; 28 2100 II; 29 0210 II; 29 AUG 0805 II; 29 AUG 1310 II; 29 AUG 1745 II; 29 ... 2300 II [redacted]
		Percocet I-II PO Q4-6 PRN	30 AUG 0630 II; 30 AUG 1150 II; 30 AUG 1700 II; 30 AUG 2003 II; 31 AUG 0430 II; 31 AUG 1030 II; 31 AUG 1554 II; 1 Sept 0720 II; 1 Sept 1500 II; 1 Sep 1050 II [redacted]
		Percocet I-II PO Q4-6° PRN PAIN	2 SEP II tabs 0840 Kms; 2 Sep. 1616 II [redacted]; 2 Sep. 2305 II [redacted]

(b)(6)-2 all

MEDCOM - 16342

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. 09 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓛ thigh, Ⓛ femur fx, Ⓛ tib/fib fx s/p ExFix Ⓛ leg, ...

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

Elw [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 - 16343

PRN Meds

Percocet 1-11 tabs 4-6 PO PRN PAIN	19 Aug 2015 [redacted]

(b)(6) - 2

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
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....	(6X6) - 2 all				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
10 Aug	[redacted]	Percocet i-ii tabs PO q4-6	18 Aug 0700 ii PO	18 Aug 1145 ii PO	18 Aug 2000 ii PO	19 Aug 0600 ii PO	25 1900 ii	25 0210 ii	31 Aug 2130 ii							
.....	.....	hrs prn	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
.....	.....															
.....	.....															
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MEDCOM - 16345

USAPA V1.00

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 03 Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1742
Allergies: NKDA OR Intake: Crystalloid 1100cc LR Colloid
Pre-op V/S: 109/65 HR 107 OR Output: UOP 225cc EBL 200cc
Procedures: I&D (L) leg, Ex Fix (L) femur Meds/Times: 2mg Versed, 480mcg Fent, 10mg MSO4, Alb puffs x1

Pre Op Meds History

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

Time	1742	1750	1755	1810	1830	1900	1930	2000
SaO2	94	97	100	98	97	97	96	99
FiO2	10	10	10	6	4	RA	2	RA
Methods	SF	SF	SF	NC	NC		NC	
240								
220								
200								
180								
160								
140								V
	[illegible]	V	V	V	V	V	V	
120								
		•	•		•	•	•	•
100								
								Λ
80	[illegible]	Λ	Λ	Λ		Λ	Λ	
					Λ			
60								
40								
20								
RR	10	13	16	18	12	10	16	22
T	98.3				98.9			

Time					
Pain (0-10)					
LOS					

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

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	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	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
ˇ = Cuff BP
˄ = Pulse

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 7 AUG 03

PATIENT'S [redacted] typed or written entries give: Name - last, first, middle; [redacted] 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
MEDCOM - 16346 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	(L)	Ø	+	DP	BR	COOL	NL
15'	(L)	TOES	+	DP	BR	COOL	NL
30'	(L)	TOES	+	DP	BR	COOL	NL
45'	(L)	TOES	+	DP	BR	COOL	NL
60'	(L)	TOES	+	DP	BR	COOL	NL
90'							
D/C	(L)	TOES	+	DP	BR	COOL	NL

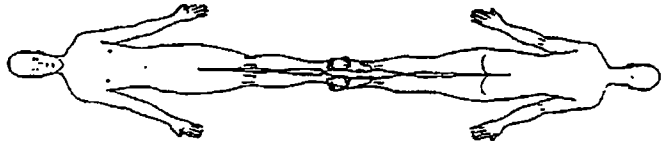
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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 & EXT	SM TO MOD
30'	(L) LEG	BULKY EXT	~~SM TO MOD~~ SANGUINEOUS
60'	(L) LEG	BULKY EXT	~~SM~~ CHANGED
D/C	(L) LEG	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Received from PACU @ 1749. Pt arousable to verbal stimula NRB @ 10L to wean to RA before transfer. IV to LFA TLR @ KVO during PACU Recovery BS ↓ to ↓ Quads. FTN ↓ straw color urine. Skin Intact. ✕ Fx to LLE on upper thigh. Pulses palpable DP 2+ - 3+. Mont and continue to wean off O2 for transfer. [redacted] LLE SWJ
Pt ↓ mod sanguineous drainage from (L) upper thigh portion. Will monitor for Δ in bleeding. [redacted] LLE SWJ
Pt placed on RA @ [redacted] SaO2 ↓ to 89-9 on RA placed on 2L NC @ 1930. Will monitor. [redacted] LLE SWJ
(b)(6)-2 a/l

(b)(6)-2 a/l

Discharge Criteria:
Date: 7AUG03 **Time:** 2000 **PARS:** 9
BP: 130/88 **T:** 98.8 **HR:** 112 **RR:** 22 **SaO2:** 95
Pain Level at D/C (0-10): Ø
Intake: 300cc PO 4hrs **Output:** 100 cc
Additional Data: Ø
Transferred To: IRW 2
Report Given To: LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: LT [redacted]
Cleared IAW Recovery Room SOP B-3
Nurse Signature: [redacted]

135/94 HR 117
$\bar{A}$ surg
5min OR time

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
Time In: OR 15 min
Allergies: NKDA OR Intake: Crystalloid ∅ Colloid ∅
Pre-op V/S: 135/94 (117) OR Output: UOP ∅ EBL minimal
Procedures: I&D LLE Meds/Times: 400 fent
25 Phenergan

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

Pre Op Meds History

Time	0048	0053	0100	0105	0110	0130	0145	0200	0215
SaO2	99	100	100	100	100	100	93	92	93
FiO2	FM	FM	FM	FM	FM	FM	RA	RA	RA
Methods	10L	10L	10L	10L	4L	4L	/	/	/
BP	134/82	114/101	128/71	105/74	115/77	117/44	123/78	128/86	128/80
RR	23	8	8	8	8	8	10	16	18
T	99.4			99.4			99.4		

Chart scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Time							
Pain (0-10)	9	0	8	8			
LOS							

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

Pacu Intake					
Time	Solution	Amount	Site	By	Infused

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	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	10	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

(Continue on reverse)

PREPARED BY *(Signatur* [redacted]
CPT

DEPARTMENT/SERVICE/CLINIC ICU2

DATE 10/8/03

PATIENT'S IDENTIFICATION *(For typed or written entries give:* (b)(6)-2 *Name — last, first, middle; grade; date; hospital or medical facility)*

EPN # [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

MEDCOM - 16348

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	LLE	UTA/+	+	+	<3sec	C	Brown
15'	LLE	UTA/+					
30'	LLE						
45'	LLE						
60'	LLE						
90'	LLE						
D/C	LLE	UTA/+	+	+	<3sec	C	Brown

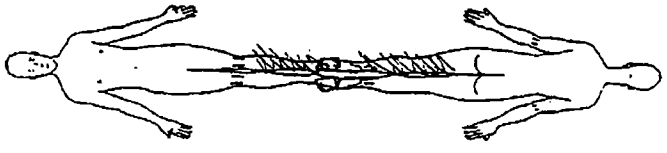
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	ACE/4x7yd	Ø
30'			
60'			
D/C	LLE	ACE/4x7yd	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt had uneventful recovery. Required 7mg IV Loc at beginning of recovery. D/C to 4L. Then D/C to RA. O2 started in high 80's when pt fell back to sleep. Pt easily arousable and SPO2 293% deep breaths. Pt moves spont. and denies pain @ this time. — CPT [redacted]

(b)(6)-2

(b)(6)-2 all

Discharge Criteria:
Date: 10/8/03 **Time:** 0215 **PARS:** 12
BP: 128/80 **T:** 99 **HR:** 104 **RR:** 18 **Sa02:** 93% RA
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: PACU 2
Report Given To: RN [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: CPT [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: 26 Aug 03
Time In: 1635
Allergies:
Pre-op V/S: 110/60 AR P OR Output: UOP
Procedures: Amputation femur
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
EBL
Meds/Times: See DA 7389

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

Pre Op Meds / History

Time	1635	1640	1645	1650	1655
SaO2	96	98	99	99	96
FiO2	2	2	2	2	2
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120	120	120	120	120	120
100					
80					
60					
40					
20					
RR	22	17	18	18	22
T	98.3				
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT/HAW

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Aug 03

(b)(6)-2

PATIENT'S IDENTIFICATION (If typed or written entry, first, middle, grade, date, hospital or medical facility)

[redacted]

(b)(6)-4

Name – last,

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	limited (+)		P	<3	warm	P
15'							
30'							
45'							
60'							
90'							
D/C	(L) leg	full ROM	(+)	P	<3	warm	P

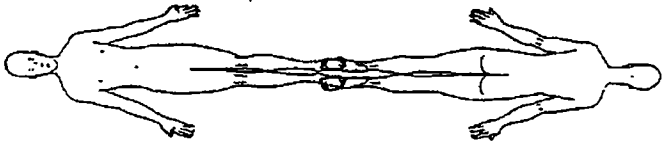
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Gauze, compression	"
30'	"	"	"
60'			
D/C	(L) leg	Gauze, staples	none



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1835	ST	no	no

WAMC OP 173-E

NURSING NOTES

1835 - Pt received from OR via gurney, accompanied by OR staff. monitors placed VSS. O2 sats > 93% RA. Awake denies pain. Dressing around pins CDI. no oozing. Will cont to monitor [redacted]
1915 - Pt meets DC criteria VSS. no issues this shift [redacted]

(b)(6) - 2

(b)(6) - 2 all

Discharge Criteria:
Date: [redacted] **Time:** 1915 **PARS:** 10
BP: 115/66 **T:** **HR:** 104 **RR:** 18 **Sa02:** 96
Pain Level at D/C (0-10): 0
Intake: 200 **Output:** 0
Additional Data: 0
Transferred To: ICU 1
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulan[redacted]
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted]

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.	
27 July 03 1530	[redacted]	A

3. NAME	4. DATE OF BIRTH
[redacted]	1957
5. RANK (b)(6)-4	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT [redacted]
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] ←(b)(2)-2	

10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS
CAR Theft & [illegible]	Gun shot wound	

DD FORM 600 1 JUL 73 [redacted] REPLACES EDITION OF 1 OCT 51 WHICH MAY BE USED

PATIENT'S BAGGAGE TAG (DO NOT DETACH)	NO A [redacted]
ORIGINATING CARRIER	
PA[redacted] (Last name-First name-Middle initial) #1	
GRADE	SSN (b)(6)-4
ORIG[redacted] FACIL[redacted]	[redacted]ING TERMINAL
THRU	
IC[redacted]#1	
TO	
DESTINATION HOSPITAL	TERMINAL

2nd PRIORI MODERATE [redacted]

DECEASED [redacted] [redacted]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

TIME	7:22	SEX	M
AGE			
LUNGS	clear		
PULSE	138		
RESP.	20		
B.P.	104/78		
A	V	P	U

(A) (P)

Patient Name (if known)

Notes/Treatment Inj: GSW poss femur fx
(L) leg GSW entry/exit distal (L) knee
(+) pedal pulse good cap refill
GSW entry (L) lateral thigh

T A# G [redacted]

To be given to: TRANSPORTATION OFFICER

Priority #	2	D
Primary Injury/Illness		
E.M.S. Unit		
Depart Time		
Hospital		

MEDCOM - 16352

ACLU-RDI 1636 p.112

DOD-029741

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.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	(b)(6) -4 [redacted]		M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	[redacted]	46y	Z	9	Unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	2010	NA

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
IZ				✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Q	ICW 2	Unk

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
50		080825

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		080807

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) FEMUR FX.

T: 1
Inj: 450

Dx: 82110, 8910, 71906, 5059, E9912

PR: 7965, 7905, 2309, 8191, 8604, 7915, 7845

891.0, 821.10, 719.06, 525.8, E991.2

78.15, 79.05, 86.28 X2, 81.91, 23.09

ADMITTING OFFICER [redacted] DR.

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 3985 MAR 89 (b)(6)-2 MEDCOM - 16353

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	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	19	—	(b)(6)-4	—	—	NO

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

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1401	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	~~50~~ 71	13 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	8 Aug 03	DR [redacted] (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL 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: ~~GSW to Abdn~~ old GSW to abdomen w/ Colostomy appliance problem

569.62
E878.3

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	4	4

36. Total Days All Facilities (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
[redacted]					

SIGNATURE OF ATTENDING PHYSICIAN: Dr [redacted]

SIGNATURE OF MEDICAL RECORDS OFFICER: [redacted]

DA FORM 3647, MAY [redacted] MEDCOM - 16354

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

19 y/o Iraqi EPW s/p GSW to abd 12 days ago (shot by Iraqi Police) Rx @ Iraqi hospital. Transfer to EPW Camp c̄ ? meds and Colosty. Unable to keep Colosty appliance on.

meds Ø NKDA PSHx PMHx Ø
- GSW abd 12 days ago s/p Exlap
- Exlap s/p Explosion 6 yrs ago

PHYSICAL EXAMINATION

Gen: well appearing c̄ NAD
NCAT
neck supple FROM
lungs clear
RRR
abd soft, NT ND, drain

Ext: tender R/flank ... intact ... staples ... needs ...

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

[redacted] Colosty appliance problem to ICW

(b)(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

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

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

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

(b)(6)-2 A

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9AUG03 1355	VS-111/63, P76, T 99.°, R 21 [redacted] Pt is an EPW who is S/P GSW and colostomy. Pt presents to the 28th CSH c c/o not being able to keep the colostomy bag on due to the heat. The medics who brought him in report that they have tried tape, tape and benzoine tincture s success. General Surgery notified. [redacted] USAN
1420	New colostomy bag placed on pt. Pt to be admitted to ward. [redacted]
9AUG03 1530	Admitted from EMT to ICW2 @1500. VSS. Denies any pain @ this time. Lung sounds clear bilat. BSX4. Colostomy clean pink, and intact. Will continue to monitor. [redacted]
10Aug03 0140	Pt care assumed @2100. VSS, A+OX3, no c/o pain. Lung sands CTA, pulses palpable x4, DSG. Colostomy site intact, no production. Will continue to monitor. [redacted] Glumco
10Aug03	0700 Assume pt care @ 0500. Asleep easy to awake. VSS. HR reg Lungs CTA Abd midline Staples intact. Colostomy bag intact to LUQ. BSx3. (R) hip/ femur pain c ambulation. No pain @ this time. Will continue to monitor [redacted] 9lu/MC
	(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]

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

10AUG03 1430: Assumed care @ 1300. VSS, Lung sounds clear c/o pain. Tylenol 650mg PO given. Relief acceptable. Colostomy bag intact, draining scant amt liquid stool. Will continue to [redacted] monitor.

2304 Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS@X4. Colostomy intact. Ostomy pink. MC ABD incision & sutures CDI. @ S/S infection. Will cont. to monitor. [redacted] TCHAN

11Aug03 0622 Assume pt care @ 0500. Asleep easily to awake. No c/o pain or discomfort. VSS. Colostomy intact. Ostomy pink BSx4. Midline Abd sutures intact - no S/S infection. Will continue to monit[redacted]

11AUG03 1423: Assumed care @ 1300. VSS, Lung sounds clear B.lat. Colostomy intact, pink. Smant. stool out. No c/o pain or d.'s comfort. Will continue to monitor. [redacted]

2219 Pt. care assumed @ 2100. VSS - HR Reg, lungs CTA, BS@X4, MC ABD incision & sutures CDI, CTA, @ S/S infection. Ostomy pink, passing scant amt. soft formed brown stool. Colostomy bag intact. Will cont. to monitor. [redacted]

12Aug03 0548 Assume pt care @ 0500. VSS. HR Reg. (b)(6)-2 Lungs CTA Abd soft non tender midline incision & sutures intact free of infection. Colostomy intact & brown soft stool. (cont.)

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

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

[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 USAPA V2.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
12Aug03	0548 (cont.) No c/o pain @ this time. Plan to have pt ambulate this am. Will cont to monit. [redacted] BSN/MS
12AUG03	1340: Assumed care @ 1300. VSS. C/o pain in R leg. Medicated c Tylenol 650mg PO. Relief acceptable. Colostomy bag intact. Colostomy pink, draining sm. amt soft brown stool. Will continue to monitor. [redacted] RN, BS
12 Aug 03 2330	Assumed care @ 2100. VSS, arox3, no complaints. Lungs CTA, pulses +x4, ~~BP~~ 55 bil. Assessment WNL. Colostomy moderate output. Pt has D/C orders and summary, continue to monitor. [redacted] alumnus
13Aug03 0733	Assume pt care @ 0500. VSS Alert [redacted]. Colostomy intact. Will place new bag before pt leaves today. Will cont. to monitor [redacted] (b)(6)-2 all

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 9

POST- DAY

MONTH-YEAR Aug 2003 | DAY: 10 | 11 | 12 | 13

19 | HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

D'c'd 12 Aug 03 1600 [redacted]

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

MEDCOM - 16359

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

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: 8/9/03 ward 1402 (?)
TIME OF ORDER: HOURS
LIST TIME ORDER NOTED AND SIGN

Admit to ~~ICW~~ ~~ICW~~ ~~ICW3~~

Condition s/p GSW to abd

(+) Colostomy @ Iraqi Hospital

VS q 8°

Diet Regular

Colostomy wafer AND bag to colostomy site

noted [redacted] 9Aug03

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER

Tylenol 650mg PO HOURS q 4° PRN

[redacted]

Please send [redacted]

plain film of [redacted]

(R) Hip and [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. 24°V/s | BED NO. 0140

10 Aug03 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER: 8/12/03
TIME OF ORDER: HOURS

Return to Camp

[redacted]

[redacted]

0503 13Aug03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER: HOURS

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S.GO' MEDCOM - 16360 710

ACLU-RDI 1636 p.120

DOD-029749

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 | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	~~RECURRING~~ PRN MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
9AUG03	[redacted]	Tylenol 650mg PO q 4° PRN		10AUG03 1400 PO [redacted]
		(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Abd/Colostomy

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 E MEDCOM - 16361 DEP. USAPA V1.00

CLINICAL RECORD

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Abd./Colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

(6)(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

b(a)-7

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	~~REQUIRING MEDICATIONS~~ Single Actions DOSE, FREQUENCY	HR	DATE DISPENSED
9AUG03	[redacted]	Adm. to ward		Date Done / Initials
	.....	Condition s/p GSW to		9AUG03 [redacted]
	.....	Abd.		
9AUG03	[redacted]	Please send for plain film of R hip & femur		9AUG03 1730 [redacted]
	.....			(b)(6)-2

Did 1600 12 Aug 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p GSW to Abd./Colostomy

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 - 16363

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN ~~(MEDICATIONS)~~ orders
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~~ actions DOSE, FREQUENCY	HR	DATE DISPENSED 9 10 11 12
9AUG03 [redacted]		V.S. q 8°	05	/ [redacted]
			13	[redacted]
			21	
9AUG07 [redacted]		Diet Regular	07	/ [redacted]
			11	[redacted]
			17	
9AUG03 [redacted]		Colostomy water & bag to Colostomy site	05	/ [redacted]
			13	[redacted]
			21	

Dcd 12 Aug 03 1600

[redacted]

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 5/8 GSW to Abd. /Colostomy

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 - 16364

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A (1) (D) 1
2. MTF LOCATION (State or Country Code.): IZ
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): EPW # [redacted] (b)(6)-4
4. PAY GRADE: EPW
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): [redacted]
7. AGE AT ADMISSION: [redacted]
8. RACE: Z
9. ETHNIC BACK-GROUND: Z
RELIGION: UNK
10. LENGTH OF SERVICE:
ETS: (b)(6)-4
11. FMP: 99
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 1401
BRANCH / CORPS:
14. FLYING STATUS: N
15. BENEFICIARY CATEGORY: K78
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code): 1Z
18. MOS:
19. TRAUMA: 9
PREV. ADMISSION: YEAR: [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 6
WARD:
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK
21. TYPE OF DISPOSITION: 05
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 030812
24. CLINIC SVC - ADMITTING: AEAA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 030808
27. LOCATION OF OCCURRENCE (Battle Casualty Only): 1Z
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

DX: GSW to Abn

Dx: V535 PR: 9729

[redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2

DA F[redacted]89 MEDCOM - 16365

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	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	20	UNK	UNK	—	—	N	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
30 ~~04~~	[redacted]		(b)(6)-4			ICU 2	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
—	—	KPB	—	—		WIA	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
direct from ER	1200	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	d/c to Camp	17 Aug 03

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

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

GSW · soft tissue ⓒ LE

Dx: 891.0, 780.6, E991.2

Px: 83.09, 88.27

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	6	6

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

SIGNATURE OF ATTENDING MED [redacted] KBL GUY

SIGNATURE OF DA[redacted] [redacted]

MEDCOM - 16366

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Aug 03 1415	PT admitted to Tent #2 via gurney. PT is ambulatory c assistance and has Dx of soft tissue injury to LLE. VS 122/73-16-20-99.8-97% SpO2 on RA. PT Alert, verbal in Arabic, NAD, Lungs CTA(B), resp even and non labored, (+) cough, CV-S1,S2, NSR c ectopy, pulses +3 in 4 extremities, Hep c IV NS TKO, GI - ABD, NO, NT, BS x 4, GU - Pt voids 450 cc clear yellow urine, Pt's skin warm, dry and his color is normal for race. PT has movement and sensation in all extremities. PT is restrained. [redacted] (b)(6)-2 SPC Green
11 Aug 1900	VS 98 133/83 20 @ 99% RA ALERT AND ORIENTED. PERRL CTA B/L c NON PRODUCTIVE COUGH. S1,S2 (+) 3+ PERIPHERAL PULSES THROUGHOUT CAP REFIL BRISK. GI BS (+) TOLERATING 50% REGULAR DIET. GU VOIDING WS LIGHT YELLOW URINE TO FOLEY ISOLE S DIFFICULTY. PIV 18G TO (L) HAND c NS @ KVO RATE. RECEIVED ANTIBIOTICS PER ROUTINE. SKIN INTACT c GSW TO LLE WRAPPED. GOOD ROM ABLE TO WIGGLE TOES (+) SENSATION. RD DSC CHANLEE WILL CONTINUE TO MONITOR.
(b)(6)-2 [redacted]	
1910	PT RECEIVED PERCOCET 1T TABS FOR PAIN TO LLE. WILL MONITOR [redacted]
12 Aug 03 0715	AE Ato x 3, VSS, Afebrile. HR 90, B/P 128/88, RR 18, SaO2 98% ↑ T. 97.3. Heart Sounds S1, S2 Present S Murmur. (b)(6)-2 Lung Sounds CTA bilaterally. + BS x 4 quadrants. VOP ↓ Voiding Spontaneously, 1475 cc clear/yellow this [redacted] AM

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S [redacted] (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.	

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 Aug 03 Continued	am. IV site ⓛ wrist infusing NS @ KVO, site ∃ S/S of infection or infiltration. Peripheral pulses 3+ throughout. Dsg to LLE C/D/I. Will Δ this am. Pt on IV Abx Tx per md orders. Tolerating Reg. diet ∃ complaint. Will continue to monitor. [redacted] LRA
0830	Dsg Δ done. Pt given 2mg MSO4 per Dr [redacted] orders ∈ Dsg Δ. Tolerated well. Will continue to monitor. [redacted]
1635	Pt c/o Pain. Given ∏ Percocet, will monitor for relief [redacted]
2000	Nursing Note: Pt. A+O, lungs clear. Hyperactive BS x 4 quad. Pt. voiding ∃ difficulty. IV to (L) arm ∈ NSCTKO. Pt. remains on IV ant. biotics. Web to dry dsg Δ done. ∅ signs of infection. Pt. medicated for ∅ sx Δ procedure. cap refill < 3 secs x 4 extremities; cold pulses x4. will continue to monitor. — [redacted] (5)(6) - 2 All

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

HEALTH RECORD — Progress — CHRONOLOGICAL RECORD OF MEDICAL CARE — 600-10

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Aug03	1200 - Pt received from ICU-II via wheelchair. VSS, lungs CTA, HR reg, BS⊕x4, pulses ⊖ + strong to ↑ + ↓ extremities, skin warm to touch, cap refill < 3 secs. PERRLA. IV NS KVO to Ⓛ forearm. Ø S/S of infx. Wound to Ⓡ ankle wet + dry dsg Ds. Ace wrap COI. Voiding Ø complaints at this time. Will cont. to monitor — (b)(6)-2 [redacted] 2hrly
13Aug03 1350	assumed pt care @ 1300. VSS. lungs CTA, abd soft nontender BS⊕x4. RLE c̄ full ROM⊕ pulses, Ⓡ ankle c̄ dsg ace wrap, dsg dry, COI, ⊕ pulse. BUE c̄ full ROM ⊕ pulse. IV @ FA infusing 3 diff. Ø complaints voiced @ this time. Will cont to monitor — [redacted] 1hrly (b)(6)-2
13Aug03 2230	Rec'd c/o pt @ 2100. Restraints x2 Ⓡ wrist/ankle. VS WNL per FS. Nurse alert in bed. Skin W/D/I. PERRLA⊕ WNL. LCA⊕. BS⊕ WNL. Abd soft/non-tender. ⊕ PP⊕. Ⓛ LE bandage C/D/I. C/o pain x1 to LLE. Percocet given. Will cont. to mon [redacted] QH/AW (b)(6)-2
14Aug03 0730	Nursing Assessment: Assumed pt care. AAOx3. Airway intact, breath even and unlabored LS CTA⊕. Abd soft, nontender ē distention. BS⊕x4. Voids spontaneously. PROM x4 neurovascularly intact to Ⓡ UE and Ⓛ LE. LLE limited ROM to ankle 2° pain but neurovascularly intact. Dsg to Ⓛ calf, Velix wrap, COZ. IV to Ⓛ FA ē S/S infxn/infiltration [redacted] (b)(6)-2

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

EPW

[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

P MEDCOM - 16369 [redacted] 1 Feb

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03 1430	pt care assumed @ 1300. pt awake & alert VSS lungs CTA to all fields abd soft nontender BS ⊕ x4. RLE c̄ full ROM strong ⊕ pulse. LLE c̄ limited ROM ⊕ pulse. drsg to LLE Kerlix CDI. BUE c̄ full ROM Hep IV site to (L)FA infusing NS @ KVO s̄ diff. ⊖ S/S of infiltration noted. ⊖ complaints voiced @ this time. Will cont to monitor — [redacted] 91WM6 (b)(6)-2
1705 30 Aug 03	Nursing Assessment: Assumed pt care. Airway intact, breathing easy, unlabored, LS CTA @ All x3. Abd soft, nontender, BS⊕ x4, s̄ distention. Voids spontaneously. FROM and neurovascularly intact to all extremities. (L) lower leg has Kerlix drsg that is CDI — ROM to (L) ankle somewhat limited by pain. IV to (L)FA flushes well s̄ s/s infiltration or infiltrating — [redacted] (b)(6)-2

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Aug 03	20 ♂ c/c bullet in (L) ankle 5 days ago. Very painful, Hurts to walk on or stand on this leg
BP 112/68	
P 105	S) Pt has an avulsed injury medial aspect (L) leg
R 16	1/4 proximal ankle to knee. Injury ~6cm long X
T 101.7	4cm wide. Appears to be made by large caliber
SPO2 95.	rifle. Wound is from just anterior to tibia and
Meds	travels in a medial to posterior direction, ~1.5 cm deep.
∅	This travels through anterior muscle bellys.
	X ray - shows soft tissues avulsed & NO periosteal
Allergies	disruption
NKA	A) GSW (L) low leg
	P) Cleaned wound c/ betadine, scrubbing softly c/ 4X4 dressings
PMH	Anesthesia c/ Xylocaine 1%, 9cc used.
ain surgery	- Area bandaged c/ folded 4X4 dressing c/ antibiotic ointment,
yrs. ago.	2nd 4X4 & covered c/ Kling dressing.
	- Keflex 500 mg po QID X 7 days given
	[redacted] 2LT, SP
	(b)(6)-2
7 Aug 03	Cleaned site w/ sterile H_2O. (+) bloody discharge. (-) Smell (+) redness T 104.2 core temp
	Applied wet → dry DSG b/c wound not healing properly w/ above Cpt
	Consulted Cpt [redacted]
	(b)(6)-2 b(2)-2

SPITAL OR MEDICAL FACILITY | STA[redacted] | ART./SERVICE | [redacted] | CORDS MAINTAINED AT

NSOR'S NAME | SSN/[redacted] | RELATIONSHIP TO SPONSOR

ENT'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.

PW

[redacted]

b(a)-4

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

US [redacted]

b(a)-2

MEDCOM - 16371

gshot wound to r

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 Aug 03	20 yo ♂
T-103.2	Pt was retrieved from ground in Iraq.
P-112	Injured wound Lt leg
R-16	Started on PO fluids but temp Pt 103.2 Tylenol
BP- 124/78	Troops assist
SpO_2-98%	Pt is alert & well oriented
	Chest clear
	CVS: S1 S2 + RRR
	Abd: Soft Nontender
	Injured wound Lt LE
	keep in holding
	IV fluids + IV antibiotics - b(6)-2
	Dr. [redacted] may
	CoB 10 gm Ancef
9 Aug 03 1820	400mg Cipro placed in 400cc LR
1823	1 g Tylenol PO
1920	Continued LR IV (Bag #2)
2042	Continued LR IV (Bag #3)
2106	Continued LR IV (Bag #4)
2337	Continued LR IV (Bag #5)
0200	Continued LR IV (Bag #6)
0308	Pt c/o headache - gave 1 Tylenol 500 mg PO

(b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	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]	SSN/ID NO.	RELATIONSHIP TO SPONSOR	REGISTER NO. / WARD NO.

b(6)-1

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	[redacted]
0700	continued LR IV
0720 10 Aug 03	Drsg change completed. Wound healing well. Ø Pus or drainage Ø red streaking noted. Granulation noted. Wound cleansed on outside c̄ Betadine. + Wet to dry sterile drsg applied [redacted]
	(b)(6)-2
10 Aug 03	[illegible]
	VS [illegible]
	[illegible]
	[illegible]
	[illegible] -20 [illegible]
	wound - [illegible]
	[illegible]
	wet - dry [illegible]
	A - [illegible] wound - 2° [illegible]
	P [illegible]
	[redacted]
	b(6)-2
11 Aug 03	T: 98⁴ P: 76 R: 24 B/P: 122/68
	Persistent fever to 103 for the past 5 days
	On hold at ASMR for 3[illegible] hrs on IV antibiotics
	Transfer to CASH for evaluation - ? osteomyelitis
	? Endocarditis Dr [redacted] Major
	b(6)-2 CO B [redacted] ASMB

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

(b)(2)-2

MEDCOM - 16373

ACLU-RDI 1636 p.133

DOD-029762

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Aug 03 0845	Seen On Aug 8th for GSW Lt ankle 5 days prior to that date Temp was 101.7 Had "Repair surgery" 4 yrs ago XRay on the 8th showed no significant comminuted elevation or rotatable fragment rearrangement. Her was started on keflex Temp spiked to 104.2 on 8th Aug 03 and was sent back to [redacted] (b)(2)-2 Switched to IV Cipro However continues to spike to 103 daily in spite of antibiotics. - Has no cardiac murmur. - Wound looks improved. (A) Since the patient has been in holding at AGMS for >48 Hrs with recurrent temp spikes of >103 will transfer to CASH for further workup - PERSISTANT FEBRILE ILLNESS ? otitis externa ? Endocarditis ? Unrelated other infection (viral syndrome / malaria). (P) - Transfer to CASH. - Routine - Ambulatory (b)(6)-2 Dr [redacted] COR [redacted] major

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(2)-2

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.

≥PW - [redacted]

L [redacted] -

b(a)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 03	0900 Change IV site from (R) Ant. cubital [redacted] (b)(6)-2 area to (L) forearm

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

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 03 1330	Ortho Consult
	20 y/o ♂ EPW ~ 8 d s/p GSW (3 Aug)
	c/o fevers @ EPW camp → transfer here.
	PMH ? "Brain surgery" '98
	Meds Cipro NKDA
	(PE) T 98.1 91 128/76
	A & O × III
	LLE Distal 1/3 medial LL
13 / 6.7 X 254 / 40	~ 10 cm wound
131 / 100 / 5 / 4.2 / 21 / 0.6	(+) granulation throughout
	(+) necrotic edges
ESR 79	∅ obvious purulence
	2+ DP/PT LTZ
	∅ pain c PROM knee/ankles
	comp soft/NT
(Xr) (-)	
(A) Soft-tissue wound LLE	
(P) I & D, W & D Dsg Δs	
	Abx

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME | STATUS | DEPART./SERVICE (b)(6)2 [redacted] MAJ [redacted] | 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.)*

SSN/ID NO.

RELATIONSHIP TO SPONSOR (b)(6)2 [redacted] OIZ T/to

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

USAPA V2.00

MEDCOM - 16376

NSN 7540-00-634-4178

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — 600-10

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Aug 03 22:32	Recd c/o pt @ 21:00. VS WDL. per ES. Awake and alert. Restraints x 2 Ⓑ wrist/ankle. Skin WD/I. PERRLND ICAB. HPRS, Sa. BS Ⓝ x4. ABD soft/non-tender. Ⓝ PPB. Kerlix dsg to LLE C/D/I. Ⓝ ROM to digits and ankle. Ⓝ <3 sec cap refill Ⓝ sensation to Ⓝ digits. Ø c/o pain @ this time. Will cont. to mon [redacted] (b)(6)-2 PT /MV
15 Aug 03	1200 - pt alert & oriented OOB x 2. VSS, lungs CTA, BS Ⓝ, pulses Ⓝ x4. Dsg d/d to Ⓛ ankle CDI. Ⓝ ROM. Ø complaints at this time. NS @ TKO into Ⓛ arm → patent. Will cont to monitor (b)(6)-2 [redacted] Nurse
15 Aug 03 1340	pt lying in bed awake & alert. VSS. assessment findings WNL. Ⓛ ankle dsg CDI, Ⓝ pulse Ⓝ movement Ⓝ sensation. Ø complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91 WMP
15 Aug 03 22:21	Recd c/o pt @ 21:00 Restraints x 2 Ⓑ ankle/wrist. VSWD per flowsheet. Lungs Ⓒ insp + exp. wheezing. HPRS, Sa. BS Ⓝ x4. Ⓝ PPB. Ⓛ 2E C kerlix dsg applied. (CDI) Ⓝ ROM to Ⓛ foot digits and ankle. <3 sec cap refill Ⓝ sensation. Will cont to mon & c/o pain @ this time. PIV Ⓛ wrist intact and
(b)(6)-2	patent. [redacted] 2ND /AD
0155	Old PIV D/C/A leaking @ insertion site. New IV initiated above old IV site. Attempts x 2. Patent, flushed easily. [redacted] 2ND AD

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

[redacted] (b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial) (b)(6)-2

RELATIONSHIP TO SPONSOR	STATUS	SEX
SPONSOR'S NAME		RANK/GRADE
	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 16377

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Aug 03	1010 Pt alert & oriented ODB x1 this Am. VSS, lungs CTA, HR reg, BS⊕, pulses ⊕x4. Dsg Did to ⊙ foot. NS ETKO w/o ⊙ firearm. Voicing ∅ complaints. Will cont to monitor [redacted]
6 Aug 03 1330	assumed pt care @ 1300. Pt awake et alert. lungs CTA, abd soft, nontender, non distented BS⊕x4. dressing to LLE CDI, LLE ō ⊕ movement, ⊕ sensation ⊕ pulse. RLE ō full ROM ⊕ pulse. BUE ō full ROM strong ⊕ pulses. IV to RFA infusing NS @ TKO ō diff, ⊙ S/Sx of infiltration. ⊙ Complaints voiced. Will cont to monitor [redacted] 9 I/WM4 (b)(6)-2
16 Aug 03 22:11	Rec'd c/o pt. @ 21:00. Restraints x 2 ⊙ wrist/Ankle. VS WNL Per flow sheet. Skin W/D. PERRLA⊕WNL. LCA⊕BS⊕x4. HPRSS2. ⊕PPB⊕ Kerlix dsg to ⊙ LEC/D/I. ⊕ Pedal pulse ⊕ sensation ⊕ <3 sec cap refill. ∅ c/o pain @ this time. Will cont. to mon [redacted] 2
17 Aug 03 1345	pt care assumed @ 1350. pt awake et alert. VSS. assessment findings WNL. LLE ō kerlix dressing CDI ⊕ movement, ⊕ sensation, ⊕ pulse. HL to ⊙ FA ⊙ S/Sx of infection noted. ⊙ Complaints voiced. Will cont to monitor [redacted] 9 I/WM4 (b)(6)-2
17 Aug 03 22:15	Rec'd c/o pt @ 21:00. Restraints x 2 ⊙ wrist/Ankle. VS WNL per Flow sheet. Awake and alert in bed. PERRLA⊕WNL. LCA⊕HPR SS2 WNL. BS⊕x4. ABD soft/non-tender. Kerlix dsg ⊙ LLE. ∅ c/o pain @ this time. From Ankle and digits to ⊕ LE. ⊕ sensation ⊕ Pedal pulse ⊕ <3 sec cap refill. Will cont to mon [redacted] 2 (b)(6)-2

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 16378

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Aug0640	pt A+O x3. pupils perla. lungs CTA. S1S2 Auscultated NSR. BS present b4 quads. Abdomen soft NT Distended bs+ x3 pulses b4 quads. IV @ wrist NS @ KVO. Pt resting. Continue to monitor — [redacted] LPN
13Aug0830	A Dressing no SIS infection. pt expressed A dressing as painful Medicated pt c 2 perc. 45 minutes prior and 2mg morphine prior to dressing A. — [redacted] LPN
13Aug0915	VSS. pt transferred to ICU 2 — [redacted] LPN

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

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

REGISTER NO.

WARD NO.

EPW # [redacted]

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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

NSN 7540-00-634-4176

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03	D/C Summary
1700	20 y/o ♂ s/p [illegible] of ~ 2 wk
	old soft tissue [illegible] (L) calf.
	On Dcharge 1/2 str [illegible] → D dressing
	Δs c̄ good response
	Plan cont dsg Δs until wound
	granulates
	[redacted]
	MAJ [redacted]
	(b)(6)-2

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

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

REGISTER NO. | WARD NO.

[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 - 16380

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
190330 Aug 03	NURSING NOTE: Assumed pt care. AAOx3. Airway intact, breath even and unlabored, LS CTA @. Abd soft, nontender, + distention. BS @ x 4. Voids spontaneously. Flow and neurovascularly intact to all extremities. Dsg to @ calf is CDI. Sm serosang drainage to @ ankle 2° pain. IV to @ FA. Pushes well and is + s/s infection or inflammation. [redacted] (b)(6)-2

NSN 7540-01-075-3786

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

STATE | ZIP CODE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

M / 20

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

ARRIVAL

DATE (Day, Month, Year): 11 AUG 03 | TIME: 1055

TRANSPORTATION TO FACILITY: MEDEVAC

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT: 11 Aug 03 | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: consultation

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1055

INITIAL: [redacted] b(6)-2

VITAL SIGNS

TIME	1055				
BP	128/76				
PULSE	91				
RESP	16				
TEMP	98.7				
WT					

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

X-RAY ORDERS

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

☑ PULSE OX 95%

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1150	X-ray left fib/ftb	[redacted]	b(6)-2		
12:05	MSO4 IV 2g				
12:05	Id Rocephin IM (R) delt				
12:05	Nafcillin 2g IV				

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 ☐ DETERIORATE

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)-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)
USAPA V1.00

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	NSN 7540-01-075-3786 TIME SEEN BY PROVIDER

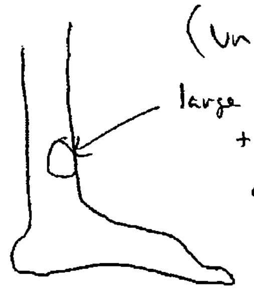
CK - 99

TEST RESULTS

CBC	SMAC	ABG/PULSE OX	RADIOLOGY	Check if read by radiologist ☐
6.7 13.3/40 254	131 | 100 | 5 / 105 4.2 | 21 | 0.6	SUP 02 / PH / PO2 PCO2 / SAT / OTHER	RESULTS ESR - 79	
	BHCG / ETOH / GLU	U/A: DIP / MICRO	EKG INTERPRETATION	

PROVIDER HISTORY/PHYSICAL 204/10 EPW s/p GSW to lower left leg from 3 Aug. Here for evaluation of wound + fevers.

O:



(Unable to ambulate

Heart - RRR ẟ ⓜ r/g, ⓢ, ⊖ rubs,

large defect, oozing, ⊕ dead tissue + granulation tissue + redness edges but not grossly warm or fluctuant (Able to wiggle toes).

Able to dorsiflex foot/ankle ẟ pain + 5/5 strength.

Distal pulses DP/PT - 2+

Ⓛ medial leg

X-ray Ⓛ lower leg
↓
⊖ fx
⊖ osteomyelitis

P:
Debride
wet/dry
IV Abx
Pain control
Ortho consult.

CONSULT WITH	TIME	ACTION

RESIDEN[redacted]L STUDENT SIGNATURE AND STAMP (b)(6) - 2

PRO[redacted]E AND STAMP MAJ MC FP/Sportsmed [redacted] (b)(2) - 2

DIAGNOSIS

A: GSW ... recurrent fevers...

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

MEDCOM - 16383

9 May 03
1815

1. Transfer to holding
2. Dx Injected wound Lt Leg
3. Condition Fair (Immediate, delay, minimal, expectant)
4. VS Q 15min Q 2° Q 4-6°
   Per Routine
   Call physician if BP>160/90 <90/60
   P >120 <50
   R >25 <10
5. Activity: ___ Bed Rest ___ With Assistance ___ Bathroom Privileges ___ Ambulate TID
6. Nursing: ___ Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids ___ Advance diet as tolerated
   ___ Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR – TKO
   ___ LR - @ 500 cc/hr x 2 Hrs then 200 cc/hr
9. Allergies (b)(6)-2
10. Pain Control
    ___ Morphine Sulfate
    ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
    ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
    ___ c. or 10-30 mg PO q 4° PRN pain
    ___ Tylenol 3 1-2 tabs PO q 4-6° PRN pain
    ___ Ibuprofen 800 mg TID PRN pain/fever
    ___ Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate ___ on next available transport
    Hold: ___ Till further notice ___ for ___ hours monitor vital signs
12. Meds • Ciprofloxacin 400mg IV BID

13. Labs /X-Ray

14. PRN Meds:
    a. Benadryl 30 mg Q 4-6° PRN insomnia
    b. MOM or Mylanta PRN for GI
    c. O_2 2 liters per mask for S & S of respiratory difficulty

6/5/03

b(6)-7

b(6)-7

b(6)-4

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

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8-10-03		1200	500 cc fluid infused. Another 500 cc hung
		1430	Ø urinatory well pt has voided [redacted] (6)(6)-2

Continue on reverse side

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

[redacted]

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CONSULTATION SHEET

REQUEST

TO: [redacted]

FROM: (Requesting physician or activity) Dr. [redacted] (b)(6)-2

DATE OF REQUEST: 11 Aug 03

REASON FOR REQUEST (Complaints and findings): Persist ant febrile illness

PROVISIONAL DIAGNOSIS: Rlo osteomyelitis Vs Endocarditis Vs melana

DOCTOR'S SIGNATURE: [redacted] Maj MC

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ NO

(b)(6)-2 all

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

TURE AND TITLE

(Continue on reverse side)

AL OR MEDICAL FACILITY

DATE

RECORDS MAINTAINED AT

ON TO SPONSOR

DEPARTMENT/SERVICE OF PATIENT

SPONSOR'S NAME (Last, first, middle)

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

SPONSOR'S ID NUMBER (SSN or Other)

REGISTER NO.

WARD NO.

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

.19

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-412

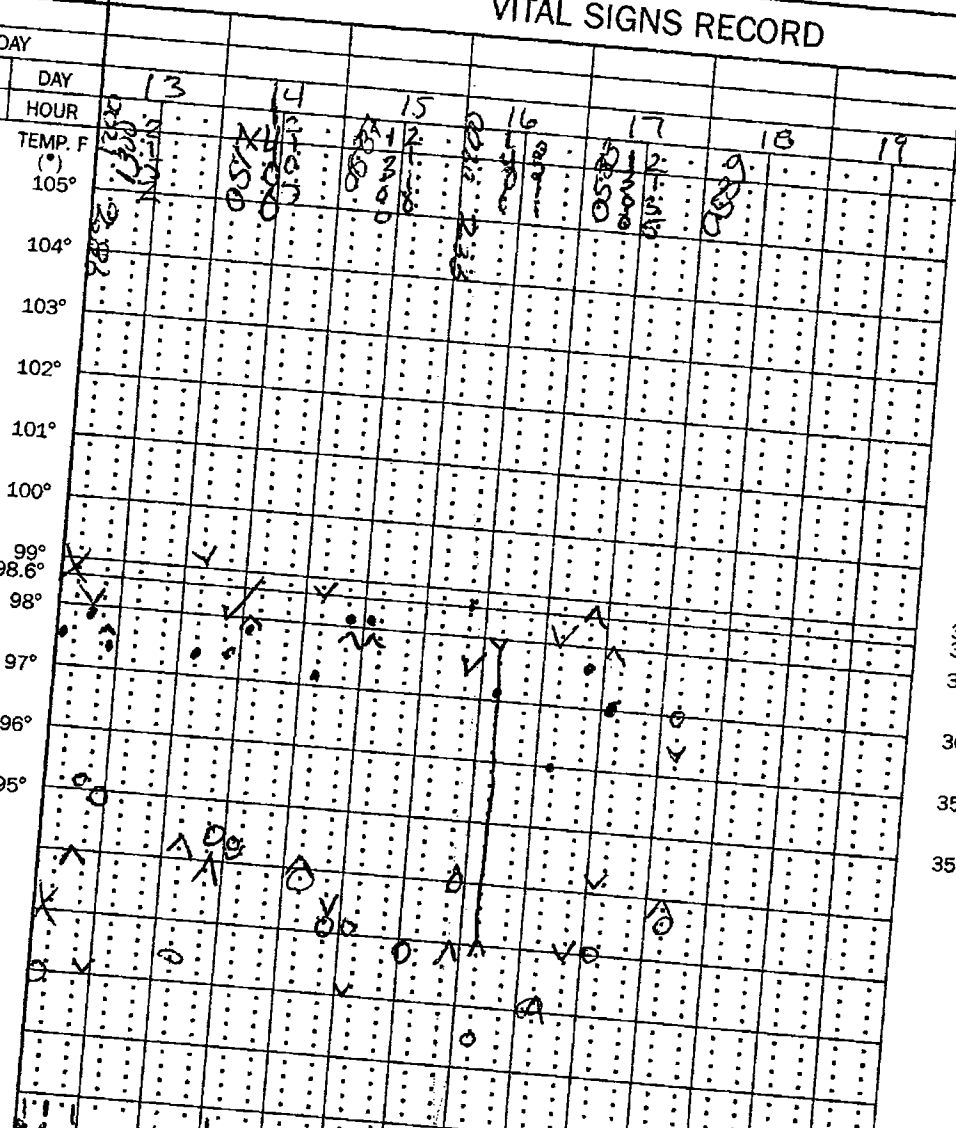
HOSPITAL DAY
POST-
DAY
MONTH-YEAR
19
DAY
HOUR

PULSE (O)

TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

120/70 | 132/80 | 120/80 | 124/80 | 116/72 | 114/70 | 120/70 | 104/78

HEIGHT: | WEIGHT →

100 | 98 | 99 | 99 | 98 | 100 | 97

98 | 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.

EPW

[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16387

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY						
POST-OP DAY						
MONTH-YEAR	DAY	9AUG03	10AUG03	10Aug03		
19	HOUR	2000	0200	1330	1700	2130	2330
PULSE (O) / TEMP. F (●)							
	105°						
180	104°						
	103°						
170							
	102°						
160							
	101°						
150							
	100°						
140							
	99°						
130							
	98.6°						
120	98°						
	97°						
110							
	96°						
100							
	95°						
90							
80							
70							
60							
50							
40							
RESPIRATION RECORD							
BLOOD PRESSURE		110/72	110/68				
HEIGHT: / WEIGHT→							
SPO2		97	98				

TEMP. C

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

(Centigrade Equivalents, for Reference only)

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)

REGISTER NO.

WARD NO.

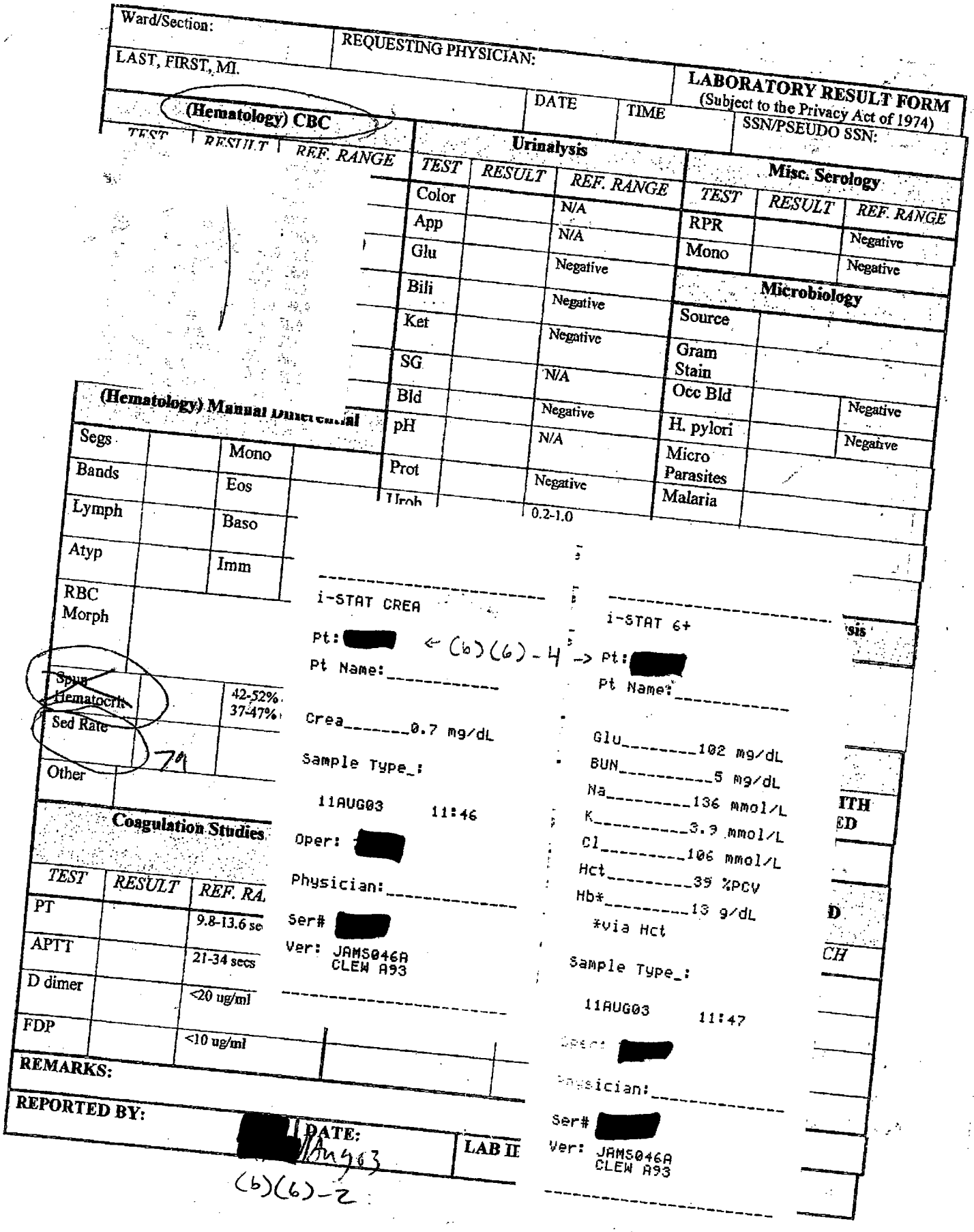
511-112

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

[redacted]

b(6)-2



Ward/Section:

REQUESTING PHYSICIAN:

LAST, FIRST, MI.

DATE

TIME

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

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% 37-47%	
Sed Rate	7		
Other			

Coagulation Studies

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

i-STAT CREA

Pt: [redacted] ← (b)(6)-4

Pt Name:_____

Crea_____0.7 mg/dL

Sample Type_:

11AUG03 11:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT 6+

-> Pt: [redacted]

Pt Name:_____

Glu_____102 mg/dL
BUN_____5 mg/dL
Na_____136 mmol/L
K_____3.9 mmol/L
Cl_____106 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

Sample Type_:

11AUG03 11:47

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

REMARKS:

REPORTED BY: [redacted] **DATE:** 11Aug03

LAB II

(b)(6)-2

SW

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

Ward/Section: EMT | REQUESTING PHYSICIAN: [redacted] (6)(6)-2 | SSN/PSEUDO SSN:

LAST, FIRST, MI. EPW # [redacted] (6)(6)-4 | DATE 11AUG03 | TIME 1100

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
11/08/03 11:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
METLYTE 8
DISC LOT #: (6)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (6)(6)-4

GLU	105	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	99	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (6)(6)-2 | **DATE:** 11 Aug 03 | **LAB ID NO.:**

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

Admit ICU #2 HOURS

DX Soft - Home meds

Vital routine

Activity BR

Diet regular

Inf KVO

Meds Ancef 1 g IV q 6

Gent 100 mg IV q 6

Tylenol 650 mg PO q 6 PRN

Percocet 1-2 PO q 4 PRN

IV → D5 1/2 NS @ 125 cc/hr

Dakins Solution

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

11 Aug 03 1445

① INF NS @ KVO

MD Or[redacted]

(b)(6)-2

0800

DAILY MSO4 2 mg IV q 4 hr PRN

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 12 AUG 03 2000

GIVE 4 mg IVP MSO4 NOW

Smoted [redacted]

2000

DAILY

NURSING UNIT | ROOM NO. | BED NO.

24 hr/day [redacted]

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted]

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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	ORDERS	LIST TIME ORDER NOTED AND SIGN
b(6)-4 EPW [redacted] NURSING UNIT / ROOM NO. / BED NO.	DATE OF ORDER: 12AUG TIME OF ORDER: 2205 HOURS Dantan 10mg po q4h prn [redacted] b(6)-2	Noted CPT [redacted] 2205 12AUG
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.	DATE OF ORDER: 13Aug03 TIME OF ORDER: 0945 HOURS Transfer 1 w/ 2 c/o [redacted] 13 Aug 03 1145 Resume all prior [redacted] 2°/done [redacted]	[redacted] aptm b(6)-2
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.	DATE OF ORDER: 16Aug03 1925 HOURS V.O. HL IV Fluids Dr [redacted] 91WM6 [redacted] b(6)-2	[illegible] [redacted] 91WM6 16Aug03 1926
PATIENT IDENTIFICATION b(6)-4 [redacted] NURSING UNIT / ROOM NO. / BED NO.	DATE OF ORDER: 17 Aug 03 TIME OF ORDER: 1300 HOURS - D/C to EPW camp - B2D w→ D Dsg Δ - Keflex 500 mg po Q2D - Flu c 20 mg 10-14 d [redacted] 2°/done [redacted]	noted [redacted] 91WM6 17Aug03 1517

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1986—491-924

"USE BALL POINT PEN—PRESS FIRMLY / NO CARBON PAPER REQUIRED"

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 11 12 13 14 15 16 17 18
11 Aug 03	[redacted]	IVF: NS @ KVO ~~HL~~	05	[redacted]
			06	
11 Aug	[redacted]	Ancef 1 gm IV q 6°	12	DC'd 17 Aug 03
			18	
			24	
11 Aug	[redacted]	Gentamycin 100mg IV q 6°	04	DC'd 17 Aug 03
			10	
			16	
			22	
17 Aug	[redacted]	Keflex 500mg po QID	04	[redacted]
			10	
			16	[redacted]
			22	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft Tissue Wound (L) Lower Leg

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 - 16393

b(6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo.________ Yr.________

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
12 Aug	[redacted]	MSO4 give 4mg @ NAW			[redacted]	
		~~Ambien 10mg PO qHS~~				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED								
11 Aug	[redacted]	Tylenol 650mg PO q6° prn	1700 650mg PO 0815 [illegible]								
11 Aug	[redacted]	Percocet 1-2 PO q4° prn	11 AUG 1900 ii [illegible] [redacted]	11 AUG 2300 ii [illegible]	12 Aug 0700 ii [illegible]	12 Aug 1635 [illegible] [redacted]	12 Aug 2035 ii	13 Aug 0700 ii	13 Aug 0238 i PO	14 Aug i 1935	[illegible] [redacted]
12 Aug	[redacted]	MSO4 2mg IV for dressing change	0830 12 Aug 2mg	[illegible] 2mg 2000	2mg 8/14						
12 Aug	[redacted]	Ambien 10mg PO qHS prn	12 Aug 2010 10mg PO [redacted]	[redacted]	IV 2015 [redacted]						

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

USAPA V1.00

MEDCOM - 16394

ACLU-RDI 1636 p.154

DOD-029783

b(a)-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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18
13 Aug	[redacted]	Vitals: Routine	05	✓					
			13	[redacted]					
			21						
13 Aug	[redacted]	Act: BR	05	✓					
			13						
			21						
13 Aug	[redacted]	Diet: Regular	06	✓					
			12						
			17						
13 Aug	[redacted]	W→D dsg BID 4*4 in 1/2 Strength Dakins solution	08	✓					
			20						

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft tissue wound ⓛ LE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

GW [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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17Aug	[redacted]	D/C to EPW camp*	28 Aug - 07 Sept			
17Aug	[redacted]	F/U c 28th 10-19 days				

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

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. 8 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13
11 Aug	[redacted]	Vitals - routine	05	[redacted]		
			17			
11 Aug	[redacted]	Activity: BR	05			
			17			
11 Aug	[redacted]	Diet: Regular	06	✓		
			11	/		
			17			
11 Aug	[redacted]	W→D drsg BID	05			
		4*4 in ½ strength	17			
		Dakins solution		/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft Tissue Wound (L) lower leg

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

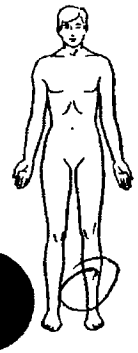
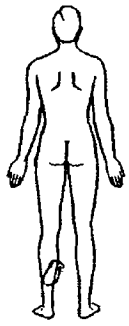
[redacted]

2nd PRIORITY **MODERATE** [redacted]

[redacted]

DECEASED [redacted]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A)  (P) 

[redacted]

TIME	1310
AGE	20 SEX M
LUNGS	clear
PULSE	92
RESP.	~~[illegible]~~ 96
B.P.	120/72
A V P U	

Patient Name (if known)
[redacted] L14145

Notes/Treatment IRAQI has GSW (L) lower Leg for 5 days

To be given to:
TRANSPORTATION OFFICER

T A# G [redacted]

Priority #		2		D
Primary Injury/Illness				
E.M.S. Unit				
Depart Time				
Hospital				

MEDCOM - 16398

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 I I D I	I Z	[redacted]	EPW # [redacted] b(a)-2	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 0 Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
Z Z Z	UNK	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1200	

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 [ ] [X] NO

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 0		0 3 0 8 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B A A		0 3 0 8 1 1

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 - Soft tissue ① LE

TI	DX	PROC
1 450	8910 E9122	8604

[redacted] b(a)-2

ADMITTING OFFICER (Signature as required) [redacted] BDV

SIGNATURE OF CLERK [redacted]

DA FORM 3985 MAR 89

MEDCOM - 16399

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	

4. SEX	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
20 ~~99~~	[redacted]	—	ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
direct from ER		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	11 Aug 03	

29. NAM[redacted] b(2)-2	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED [redacted] DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Cellulitis Dx

891.1
682.6
995.90
E995

Px

88.27 (x2)
99.21
77.17

Trauma 9

Inj 649

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	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]				

SIGNATURE OF ATTENDI[redacted] b(6)-2 [redacted] RDS OFFICER

DA FORM 3[redacted] JSAPPC V1.10

MEDCOM - 16400

9 Aug 03
15 25

1. Transfer to holding
2. Dx Cellulitis
3. Condition Fair \Immediate, delay, minimal, expectant
4. VS Q 15min Q 2° Q 4-6°
   Per Routine
   Call physician if BP >160/90 <90/60
   P >120 <50
   R >25 <10
5. Activity: ___ Bed Rest X Bathroom Privileges ___ Ambulate TID
   ___ With Assistance
6. Nursing:
   ___ Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids X Advance diet as tolerated
   ___ Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR – TKO
   0.9% NS OR LR - @ 500 cc/hr x 2 hrs then 200 cc/hr
9. Allergies
10. Pain Control Acetaminophen + Oxycodone 2 po now
    ___ Morphine Sulfate
    ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
    ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
    ___ c. or 10-30 mg PO q 4° PRN pain
    ___ Tylenol 3 1-2 tabs PO q 4-6° PRN pain
    X Ibuprofen 800 mg TID PRN pain/fever
    ___ Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate ___ on next available transport
    Hold: ___ Till further notice ___ for ___ hours monitor vital signs
12. Meds
    - Rocephin 1gm IVPB qd starting 10/8/03

13. Labs /X-Ray WBC
    X-Ray Lt leg (Tibia/Fibula)

14. PRN Meds:
    a. Benadryl 30 mg Q 4-6° PRN insomnia
    b. MOM or Mylanta PRN for GI
    c. O_2 2 liters per mask for S & S of respiratory difficulty

b(4)-2

Dr [redacted]

[redacted] b(6)-4

EPW

[redacted] b(2)-2

b(2)-2

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

TIME: 1530 SIGN: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature: warm to touch 102.7

Color: Pale / Cyanotic / Jaundiced apparent for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Level: Alert / Lethargic / Unresponsive non-communicative eyes open to stim

Oriented / Disoriented Pupils: 3mm brisk perrla

Extremity Movement: Full / Limited / None (R)LE ↓ pain

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 --- Pedals +2

Capillary Refill: <3 Edema: (R)LE Homan's Sign: (-)

Jugular Venous Distension: (-) Edema:

Heart Sounds: S1 S2

Rhythm: NSR-ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms			[redacted]	
Site			Dorsal	
Saline			LR KVO	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical: even and unlabored

Respirations / No Dyspnea / SOB / Labored / Use of Access Muscles

Breathing Patterns: even and unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor: (-)

Chest Drainage System Gravity: Suction cm:

Air Leak: No Yes --Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway: Size: Type: Position:

Breath Sounds	Anterior Location	Posterior/Lateral Location
Crackles	CBC	CAB
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended on Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intact, Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character (-)

Drains:

GENITOURINARY

Urine: Color: clear straw/amber/cola/burgundy

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 0 SIGNATURE: [redacted] b(6)-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature: WDCM

Color: Pale / Cyanotic / Jaundiced AFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Level: Alert / Lethargic / Unresponsive A+O x 3

Oriented / Disoriented Pupils: 3mm

Extremity Movement: Full / Limited / None (R)LE

CARDIOVASCULAR

Pulses (0 - 4): +2 Radials +2 Pedals +2

Capillary Refill: <3 Seconds +RLE Homan's Sign

Jugular Venous Distension: Edema

Heart Sounds: S1 S2

Rhythm: NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms			[redacted]	
Site			LDorsal	
Saline			LR KVO	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respirations / No Dyspnea / SOB / Labored / Use of Access Muscles

Breathing Patterns: Unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor: (-)

Chest Drainage System Gravity: Suction cm:

Air Leak: NO Yes Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway: Size: Type: Position:

Breath Sounds	Anterior Location	Posterior/Lateral Location
Crackles		
Wheezes	CTA	(B)
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended on Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intact, Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character (-)

Drains:

GENITOURINARY

Urine: Color: Clear Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] b(6)-4

ICU Flowsheet **Patient Name:** **Date: 8 / 4 / 2003**

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature															102.7		102.7		100.9					98.6		
Pulse															113		113			84				77		
B/P [a] A-Line																										
MAP																										
B/P [a] Cuff															99/76		137/76							108/60		
Resepirations															26		26									
SaO02															99		99							96		
mode															RA		99			100				168		
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF:																										
PO Intake															60		60	100				100				
O.RR. IN																										
Totals																										
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly															350		325			1400		2050		650	650	
NG I Tube																								2700	2600	
Drainage #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

C&B [redacted] b(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 03	24 yo ♂ in mild distress due to stab around to bil legs. ∅ n/v or abd cramps
Oral - 103.6 Trectal - 104.4	erythema, swelling, and drainage @ ⓛ leg. @ leg tender ⊕ swelling. Scabs cover both wounds. febrile @ 104.4 Rectal Lungs CTA Heart RRR ABD soft NT ND ∅ organomegaly.
1500	1g tylenol PO
1503	1g Rocephin IV
	Lab: WBC ↑ @ 14,400
	A: 1) Sepsis 2) Infected wounds + cellulitis
	P: IV Rocephin q 8° Patient held
	[redacted] HT SP b(6)-2
1600	500 ml LR (Bag #2)
1642	500 ml LR (Bag #3)
1941	500 mL LR (BAG #4)
	[redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	MAINTAINED AT
2000 hrs 1000ML LR	(Bag #5)		
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
0330 ML LR	Bag #6		

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]		

[redacted] q IW b(6)-4

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

MEDCOM - 16404

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2000	Pt c/o of Slight headache - 10mg Valium. OK per Dr [redacted] 5mg Valium PO. b(6)-7
2227	Continued LR IV 500ml [redacted]
0500	Pt c/o headache - temp taken = 104.2°. 800mg IBP Given
0615	Cleaned wounds on both shins, changed dressings.
10 Apr 03	[illegible]
WBC. 14,400	[illegible]

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

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
			b(6)-2
8-10-03	0930		Dr's [redacted] in to examine pts Wounds cleaned on b/lat lower legs. Wound on (R) leg dressed c Kerlex and Telfa. Pulses palpable b/lat. +1 edema noted in (R) lower leg. (R) leg tender to touch on all of lower leg. (R) leg tender around area of wound. [redacted]
	1330	1330	500cc fluid infused. Another 500cc hung. Pt c/o pain in (R) leg + requests Valium Dr [redacted] informed. He states to use Motrin for pain + advance Valium. b(6)-2 [redacted]
		1430	Pt urinating well still c/o heat + some dizzyness [redacted]
		1809	Changed IV Bag 500ml LR [redacted] b(6)-2

Continue on reverse side

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

b(6)-4 [redacted]

[redacted] b(2)-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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 0900.	Was admitted on 9 Aug 03 for cellulitis Rt Leg — Had I&D wound to both legs Temp 103 at that time. (Rectal 104°) WBC 14,400 Was started on IV Rocephin. Rt leg still quite painful & swollen Temp continues to spike daily despite of IV Rocephin + motrin + Tylenol. Has been in Acute for 5 1/2 Hrs. Transfer to CASH for further evaluation & rehabilitation Routine Ambulatory Dr. [redacted] Maj MC b(4)-4 b(2)-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(2)-2

REGISTER NO. | WARD NO.

[redacted] b(2)-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 - 16407

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.11.03/1500	assumed pt care from [illegible]. At time a/[illegible] pt's VSS [illegible] temp 100.7 → 650mg tylenol, Pt w/no apparent distress @ time of [illegible], CR infusing @ KVO. [illegible] Pt verbalized pain & recvd 2 percocet PO denies N/V @ this time, Pt currently resting quietly in bed. Will cont to monitor [redacted] /CTRN
8-11-03/1800	Rpt recieved, physical assessment completed, Pt c/o pain but recieved pain med 3hr's ago will continue to monitor, Pt set up c̄ Food. [redacted] CPT/RN
8-12-03/0300	Pt c/o Leg pain Percocet II PO given, Pt voided 350 Clear Yellow Urine [redacted] CPT/RN
8-12-03/0500	Pt c/o Headache Tylenol 650 mg Given CPT/RN
8.12/0630	assumed pt care from LT Frazier. Pt resting comfortably in bed & in no apparent distress, LR @ KVO [redacted]
8.12/0700	N a/o cooperative, appropriate c̄ staff [illegible] perrla, brisk. Moves all extrem, hesitant in moving (R) LE d/t pain.
	CV NSR s̄ ectopy, S_1 S_2, +2 radial & pedal pulses bilat. (R) LE red and warm to touch & +2 edema, cap refill <3secs bilat UE & LEs.
	Resp even & unlabored [illegible] breathing, CTA (B), denies SOB, SpO2 97-98% on RA, ∅ cough
	GI hypo BS, denies N/V/D. abdomen soft nontender
	GU Clear straw colored urine uses urinal @ bedside cont....

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

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

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

[redacted]

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

MEDCOM - 16408

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.12/0700	cont... Lines (L) arm PIV patent ¢/D/I, no other issues
	@ this time [redacted]
8.12/0800	VS, 98.5F° SpO2 100%, on RA RR 16 HR 76 BP 129/68 [redacted]
1048	Output @ 0930 - 800cc; output for 1040 - 850 cc.
	intake 240cc. Ø complaints voiced. Will monitor.
	[redacted]
8.12/1400	u/o 700cc intake 900cc [redacted] KT RN
8.12/1600	U/O 950cc intake 1100cc [redacted] KTRN
8.12/1630	Dressing change done, pt premedicated c̄ 2 percocet, iodoform
	packed in (R) LE & reinforced c̄ gauze dressing & ace wrap
	pt tolerated procedure well, pt remains [redacted]le 99°@ 1600
	will cont to monitor [redacted] KTRN
12 Aug 03	Received report from outgoing shift. Pt in bed awake s̄
1800	any complaints. IV LR @ tko (L) forearm. (R) LE dressing
T 99.6	wrapped c̄ ace wrap. Pulses palpable, (R) foot slightly swollen.
1900	Medicated c̄ Percocet II tabs p.o. for c/o pain.
(OW) V: 800	dressing changed to the (R) LE & small cut on the (L) leg
	c̄ iodoform gauze [redacted] /AN
2130	Up to have a bedbath, changed clothing. Had a
(OW) V: 800	snack milk & chips. Medicated for pain. Pt. back
	in bed to rest. T 99.2, VSS [redacted] /AN
2400	Up to void @ bedside. Pain controlled from Percocet
NO V: 800	earlier. (R) LE ↑ on a pillow [redacted] /AN
0130	C/o being hot. Took T 97.5, pt was covered
	c̄ wool blanket including the face. V got closed
	earlier per pt request. Gave cold water.
0300	VS 97.6 - 59 - 20 - 122/62, pt up want snack & milk.
	Otherwise no other complaints [redacted] /AN

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*)
11 Aug 03	Ortho Consult
1430	24 y/o ♂ EPW c reports of "stab wounds"
	BLE ? time ago, now c cellulitis
	RLE c T up to 104. s other c/o.
	∅ PMH/PSH/MEDS/ALL Rocephin IV
	(PE) 99⁵ 92 128/62
14	A · O × III NAD
14.0 / 377 / 43	LLE prox. ant tib ~ 1 cm superficial
	wound, sm. amount pus c ∅ local
	extension ∅ erythema ∅ TTP ∅ ROM
139 / 108 / 5 / 97	NVI throughout
3.9 / 44 / 1.0	RLE erythema mid-calf → ankle
	area ~ 5 cm in center, fluctuant
ESR 81	compartments soft NT, NVI throughout
	∅ pain ankle / knee ROM
	(XR) (—)
	(A) cellulitis c soft-tissue abscess
	(P) I & D, Dsg Δs, Abx
	b(6)-2 [redacted]
	[redacted] MAJ

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]	RECORDS[redacted]
		Ortho	
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	[redacted]

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

REGISTER NO. b(2)-2 WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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MEDCOM - 16410

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)*
19 Apr 03	D/C Summary 24 y/o ♂ admitted 11 Apr for wound infection s/p RUE soft tissue abscess. Abscess I+D, placed on IV Abx x 3 days. Responded well x Δ to po Abx + cont good result Plan BID w → D D/C, Δ until wounds granulated Cipro BID 500 mg until wounds healed [redacted] MAJ b(6)-2

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

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

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 - 16411

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

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

RECORDS MAIN [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS EPW# [redacted] b(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 11 AUG 03 | TIME 1055

TRANSPORTATION TO FACILITY MEDEVAC

SEX M | AGE

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

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT Cellulitis (R) leg

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME 1059

INITIALS [redacted]

VITAL SIGNS

TIME	1057	1550			
BP	129/62				
PULSE	92				
RESP	18	20			
TEMP	99.5	102.1			
WT					

LAB ORDERS

X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	UA MSCC/CATH		X	CHEM: MET B
	BLOOD C&S X			X	SED RATE ESR
					b(6)-3

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L	X	(R) & (L) Tib Fib

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESPONSE
1200	Nafcillin 2gm IV	[redacted]		
11:45	Tetanus booster			
1205	Morphine 2mg IV			
1459	3 Tylenol			

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 ☐ DETERIORATE

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)
USAPA V1.00

MEDCOM - 16412

NSN 7540-01-075-3786

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

TEST RESULTS

WBC 14 | H/H 12.7/43 | PLT 577 | SMAC: 139 | 108 | 277 / 2.9 | 44 | 1.0

ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
SUP 02	PH	PO2	RESULTS ESR: 87	
PCO2	SAT	OTHER		
U/A DIP			EKG INTERPRETATION	
MICRO				

BHCG	ETOH	GLU

PROVIDER HISTORY/PHYSICAL

S: 24yo ♂ c̄ 1 yr old stab wounds bilat lower legs. Developed cellulitis & not improving. Also spiking fevers. Int to R/o deep soft tissue infection vs. osteomyelitis

O: afebrile, non-toxic

(L) ant. prox shin c̄ 2 cm rnd draining wound. ⊖ fluctuance ⊖ tibial tenderness.

(R) lower leg - diffly c̄ ↑ warmth, redness, fluctuant bead of tissue just proximal to ankle ⊖ pain c̄ stretch (passive) of ext. tendons.

X-rays:

(L) tibia - ⊖ fx ⊖ osteo

(R) LE - ⊖ fx ⊖ osteo.

P: Nafcillin 2gm IV now
Tetanus booster
MSSA org

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] b(6)-2

DIAGNOSIS

A: cellulitis (R) LE ... possible osteomyelitis.

CODES

b(2)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 0320	Up awake c/o pain. Medicated c Percocet ii p.o. @ this time. T 97.6 V 55. [redacted] b(6)-7
0500	Slept pain when awaken VS: [redacted] 61-61-20-97.4.
13 Aug 03 0830	Received report on pt around 0615. Pt resting in bed c HOB ↑. No complaints. Pt ate 100% of breakfast independently. See DA Form 4700 for assessment data. Pt stood @ bedside for moment. Stable on feet. No c/o pain c standing. IV abx given. Infusing S. prop lens. Pt cooperative. Dressings in place. [redacted]
13 Aug 2003 @ 1015	Pt given ii percocet @ 0900 for premedication & dressing change. Dressing change to RLE & LLE. RLE wound iodoform packing c 4x4 & ace wrap. LLE iodoform on wound c 4x4 & ace wrap. Slightly painful during dressing change. Pt tolerated well. [redacted]
13 Aug 2003 @ 1115	Pt c/o HA. Only been 2 hrs since last pain meds. Layed pt's head back to help get some sleep. [redacted]
13 Aug 2003 @ 1300	Pt fell asleep for approx an hour. Pt now sitting up in bed eating lunch. Pt will stand @ bedside to urinate. [redacted]
~~13 Aug 2003 @ 161~~	
13 Aug 2003 @ 1615	Pt slept for a while. Had a snack. Has been talking to pt next to him. No change in condition. [redacted]
13 Aug 2003 @ 1900	Pt did well through shift. C/O pain in head & RLE x 2. Pain

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

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

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

b(6)-2 A 11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
cont.	relieved by meds. Pt sitting in bed eating dinner. No Δ throughout shift. b(6)-2 [redacted] RN
8-14/0030	Assumed pt care from LT [redacted], Pt resting quietly in bed or in no apparent distress. LR infusing @ KVO. Pt voided 625cc @ 0600. Pt ate ¾ of breakfast. b(6)-2 [redacted] LT RN
14 AUG 0600 LATE ENTRY	Patient slept throughout night ∅ complaint. Awoke ∁ pain at 0530, given Percocet 2 tabs @ 0545, will monitor pain to (R) leg. Patient resting in bed ∁ HOB ↑. Report given to RN. b(6)-2 [redacted] LT/AN
8-14/1500	Dressing D/C'd to (R) LE, redness & swelling continues to decrease scant with small amount drainage. Pt premedicated ∁ 2 Percocet, pt tolerated dressing well [redacted] RN
1830.	Report received from LT [redacted]. Pt resting in bed quietly. b(6)-7 [redacted]
1950.	Dsg D/C'd to (R) cellulitis wounds. Wounds appear red. Packed ∁ iodoform gauze and rewrapped ∁ ace wrap. [redacted] RN
2240	Percocet 2 tab PO given for pt c/o pain [redacted]
0200	Pt resting in bed ∁ eyes closed. [redacted]
0330.	Pt c/o pain to (R) LE. Percocet 2 tabs PO given [redacted]
8-15/0600	Assumed pt care from LT [redacted] resting quietly in no apparent distress b(6)-2 [redacted] LT RN
8-15/1400	Dressing change to (L) LE removed. (L) LE wound red & slightly swollen, scant purulent drainage noted, rest of wound tightly packed & wound easily cleaned, iodoform packing removed. (L) LE wound slightly taken, iodoform removed no purulent drainage, redness & swelling noted, to Both wounds packed ∁ iodoform & covered ∁ 4x4 & ace wrap. Pt tolerated dressing change well [redacted] LT RN

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

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8-15/1500	Pt rested quietly in bed throughout shift s̄ complications. Pt denied any pain other than during dressing Δ. Pt ate 25% of lunch, denies N/V/D. Ambulated to dirty utility room walk s̄ assist. No other issues noted — [redacted]
15 Aug 03 @ 1835	pt report recieved from Lt [redacted] pt in bed s̄ complaints @ this time will continue to monitor — [redacted]
@0516	pt resting quietly in bed @ this time pt c/o of pain early medicated with percocet no problems since will continue to monitor [redacted]
16 Aug 03 0600	Received report from previous shift. Pt resting c̄ eyes closed. Ø needs expressed @ this time. Drsgs D+I. — [redacted]
0730	Pt ate ≈ 40% breakfast. Ø % pain/discomfort. UO 575cc. Will cont. care. — [redacted]
0845	Premedicated pt c̄ percocet ii tabs for drsg Δ. Will cont. care — [redacted]
0910	Completed drsg Δ. Dried blood and serous fluid noted. Wet to dry drsg c̄ iodoform done to open wound on BLE. Pt tol well. Used spandage to hold drsgs in place. Will cont. care. [redacted]
1240	Pt sitting in bed reading magazine. Ø % pain @ this time. Will cont. care. — [redacted]
1540	Δ'd drsg IV (L) wrist. LR infusing @ 30cc/° [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS [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.

EPW [redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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b(a)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1735	Pt c/o pain (L) LE. Gave percocet # taken WNL cont to assess pain level. [redacted] CHPA
1830	Report recieved from SPC [redacted]. Pt VSS NO changes in condition [redacted] 9WMM6
2145	pt awake VSS, afebrile [redacted] 9WMM6
2400	Drsg Δ done @ this time [redacted] 9WMM6
17 Aug 03 0027	Received report from SPC [redacted] Pt. sitting in bed c distress. Consumed 100% of breakfast. IV access to (R) AC c redness & swelling noted to site. Bandage noted to (R) leg c drainage noted @ present time + pulse to feet & radial. - complaints voiced @ present time. 155; B/P 130/64 RR 12 HR 72 Temp 96.3 SpO2 98% on RA. Will continue to monitor for [redacted] distress.
0850	DBG Δ completed @ present time. Percocet Tab # PO for c/o pain. Will continue to [redacted] monitor.
1034	Resting in bed c eyes closed. - complaints voiced. - distress noted. Will continue to [redacted] Monitor.
1322	Resting c eyes closed Ø distress noted. Will continue to [redacted] monitor.
1412	c/o pain. Percocet Tab # p.o. given for [redacted]
1621	Resting in bed c eyes opened. Ø complaints voiced. Will cont. to monitor. [redacted]

STANDARD FORM 600 (REV. 6-92) BACK

USAPA V2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 @ 1920	pt report recieved @ 1800 from Sgt [redacted] pt sitting quietly in bed c/o problems NO acute signs of distress noted @ present will continue to monitor throughout night [redacted] RN
@2000	VSS → HR- 90 BP- 139/64 RR- 12 SPO2- 97% T- 97.4 no problems noted @ present will continue to monitor [redacted] Tech RN
@2210	pt medicated for pain prior to dressing Δ, dressing Δ complete c/o problems pt sitting up in bed NO signs of acute distress noted @ present will continue to monitor [redacted] RN/Tech
@2340	pt voided 2200cc so far tonight no problem or complaints @ this time will continue to monitor [redacted] RN/Tech
18 Aug 03 1225	VSS, pt c/o abdominal cramps in (R) lower, abdominal quadrant. Pt attempted to have BM c success. ØN/V Pt also c/o pain BLE. Given Percocet 2 tabs PO @ 2000. Voiding c difficulty. LR infusing @ TKO. Ø s/s of infection @ IV site. [redacted] RN/Tech
18 Aug 03 1235	Nursing: Dr. [redacted] notified of abdominal cramps. Pt given 30cc Milk of Magnesia. Will continue to monitor [redacted] RN/Tech
18 Aug 03 1730	Nursing: Dressing Δ completed, small amount of purulent drainage noted from wound on LLE. Wound in tact c Drainage or s/s of infection. Wound packed iodoform gauze. Premedicated c Percocet. Tolerated procedure. [redacted] RN/Tech

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED [redacted] RN/Tech
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.)*

EPW [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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 1830	Report recieved from dayshift. VSS — [redacted]
19 Aug 03 0200	Dsg Δ's done —
0620	Report given to dayshift —
0620	Received report & assumed care of [redacted]. VSS, Pt stable. Pt lying in bed sleeping & appears to be resting comfortably @ this time. Will monitor. [redacted] b(e)-2 A11

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

USAPA V2.0

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Progress [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03	1230 - Pt Alert & oriented transfer from IRaq 3 via ambulatory. Dsg to (R) leg CDI. IV D'Cd Voicing Ø complaints, Will cont to monitor [redacted] b(6)-2 down
1545	Pt alert and oriented. Stable. Discharged to EPW camp t meds, xray and discharge instructions. Ambulatory at time of discharged. Escorted by MP. [redacted] b(6)-2 RE/RN

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

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

EPW [redacted] b(6)-4

[redacted] MEDICAL CARE

Medical Record

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

MEDCOM - 16420

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: [redacted] (ORTHO

FROM: *(Requesting physician or activity)* DR [redacted] maj

DATE OF REQUEST 11 Aug 03

REASON FOR REQUEST *(Complaints and findings)*

Temp spikes to 101 despite IV antibiotics
Persistant cellulitis ~~of~~ following GSW wound.
Please evaluate and advise regarding management.

PROVISIONAL DIAGNOSIS

Rule Out Osteomyelitis ? DVT.

b(6)-2

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted]		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ 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
LOCATION 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(2)-2

[redacted]

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 - 16421

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	9 Aug 03		10 Aug 03						11 Aug 03					
19	HOUR	2000		0500	0800	1400	1700	2115	2330	0530	0830				
PULSE (O) / TEMP. F (●)															
180	105°														
170	104°														
160	103°														
150	102°														
140	101°														
130	100°														
120	99°														
110	98.6° 98°														
100	97°														
90	96°														
80	95°														
70															
60															
50															
40															
RESPIRATION RECORD										20					
BLOOD PRESSURE		120/60		120/60						118/74					
HEIGHT: WEIGHT:															
SpO_2		96		SpO_2 94						97					

TEMP. C

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

(Centigrade Equivalents, for Reference only)

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

EPW

Cellulitis

Ward/Section: EMT [A]

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

CH MIST (Subject to

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

DATE: 11AUG03 TIME: 1115

SSN

(i-STAT)			(Piccolo) Chemistry 1/2			(Piccolo)		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L				GLU		
		mmol/L				BUN		
		mmol/L				CA++		
		45				CRE		
		mmHg (art)				NA+		
		mmHg (ven)				K+		
		mmHg (art)				CL-		
		il)				tCO2		
		mol/L (art)						
		mol/L (ven)				(Piccolo)		
		mol/L (art)				TEST	RESULT	REF. RANGE
		mol/L (ven)				ALB		
						ALP		
		+3)				ALT		
		mmol/L				AMY		
		32 mmol/L				AST		
		g/dl				TBIL		
		mg/dl				GGT		
		mg/dl				TP		
		PCV						
		/dl						

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

11/08/03 11:30

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8 b(6)-4

DISC LOT #: 3151AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	49	39-380	U/L
NA+	♦♦♦	128-145	MMOL
~~K+~~	~~4.6~~	~~3.3-4.7~~	~~MMOL~~
~~CL-~~	~~101~~	~~98-108~~	~~MMOL~~
tCO2	21	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

ID: 0570 11-05-03

NB 11:26

			Patient Limits	
WBC	14.1 H	x10^3/uL	4.5	10.5
RBC	4.47	x10^6/uL	4.00	6.00
Hgb	13.7	g/dL	11.0	18.0
Hct	42.8	%	35.0	60.0
MCV	95.7	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	377.	x10^3/uL	150.	450.
LY%	9.7 L	%	20.5	51.1
LY#	1.4	x10^3/uL	1.2	3.4

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

b(6)-2

REPORTED BY: [redacted] DATE: 11Aug03 LAB ID NO.:

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____97 mg/dL

BUN_____5 mg/dL

Na_____139 mmol/L

K_____3.9 mmol/L

Cl_____108 mmol/L

Hct_____44 %PCV

Hb*_____15 g/dL

*via Hct

Sample Type_:

11AUG03

i-STAT CREA

Pt: 0570

Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:

11AUG03 11:26

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

Ward/Section:	REQUESTING PHYSICIAN: b(a)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(a)-4 [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 10^6
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	81	
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: b(a)-2

REPORTED BY: [redacted] **DATE:** 11 Aug 03 **LAB ID NO.:**

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66; the proponent agency is OTSG

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER: 11 Aug 03 | TIME OF ORDER: 1430 HOURS | LIST TIME ORDER NOTED AND SIGN: 1450

Admit Ortho
Dx cellulitis RLE
vitals routine
Activity BR
Diet regular
IVF KVO
Meds Tylenol 650 mg po q 6 PRN
Percocet 1-2 q 4 PRN
Cipro 400 mg IV BID
BID Dsg Δ BLE c̄ Iodoform gauze

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Chart val 8/12/03 @ 0236 [redacted] CPT/AW

14 Aug 03 1630 — 1635
D/C Δ Cipro to 500 mg po BID

[redacted]

b(6)-4

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° Chart check: [illegible] Maj / AW 2300

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 18 Aug 03 | TIME OF ORDER: 1234 HOURS

Milk of Magnesia 30cc PO x 1
v.o. Dr [redacted]

b(6)-2

[redacted]

1835 18 Aug 03

b(6)-2

1235 18 Aug 03 AW

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-824

"USE BALL POINT PEN—PRESS FIRMLY (NO CARBON PAPER REQUIRED)"

MEDCOM - 16425

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: ICW #2 | ROOM NO.: | BED NO.:

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 0915 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICW 2 [redacted]
2. Dx: cellulitis
3. Cond good
4. VS q shift
5. Act: BSC
6. NKDA
7. Diet: regular
8. IVF: KVO
9. Cefzil 500 PO BID
10. BID dressing D/C (R) LE c iodoform gauze
11. Percocet 1-2 PO q4° PRN
12. XR - (L) HAND R/O Fx [redacted]

b(6)-2

19 Aug 1230

[redacted]

D/C IV [redacted]

b(6)-2

19 Aug All 1230

[redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POI... ...BON PAPER REQUIRED"

MEDCOM - 16426

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 8/9	8/10	8/11
8/9/03	[redacted]	Rocephin 1gm IV q24	1500	[redacted]		
8/9/03	[redacted]	Ibuprofen 800mg po	08	X		
			15			
		b(6) -2 A11	22			

See PRN's

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

[redacted]

EPW 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 - 16427

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
8/9/03	[redacted]	Acetaminophan + Oxycodine 2 PO	8/9/03	1600	1600	DS
8/9/03	[redacted]	VALIUM 5mg PO	8/9/03	2000	2000	[redacted]
8/9/03	[redacted]	IBP 800mg PO	8/10/03	0500	0500	[redacted]
		blw - 2 All				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED															
8/10	[redacted]	Ibuprofin 800mg PO q6-8hr PRN Fever or Pain	8-10 1830 CS	8-10 2130 [redacted]														
8/10	[redacted]	Tylenol 325mg ÷ - II PO q4-6 PRN Fever or Pain	8-10 1330 CS	8-10 1940 [redacted]	8-11 0530 [redacted]													

* U.S.G.P.O.: 1986 - 491-003/43119

MEDCOM - 16428

b(6)-2

CLINICAL RE... | THERAPEUTIC DOCUMENTATION CA... PLAN (NON-MEDICATION) | Mo. ___ Yr. 2003

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11 12 13 14 15 16 17 18 19 20
8-11	[redacted]	Vitals: Routine.	06	[redacted]
			12	
8/11	[redacted]	Activ: BR	06	
			12	
8/11	[redacted]	Diet: Regular	06	
			18	
8-11	[redacted]	BID Dressing Δ BLE	06	
		c Fodiform gauze	18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Cellulitis RLE

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 - 16429

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23
19 Aug	[redacted]	VS QS	05					
			13					
			21					
19 Aug	[redacted]	Act BSC	05					
			13					
			21					
19 Aug	[redacted]	Diet regular	01					
			12					
			17					
19 Aug	[redacted]	DSD to (b)LE c	10					
		iodoform gauze	22					

D/C [redacted] 19 Aug 03

b(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Cellulitis

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

b(a) - 2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Aug [redacted]		Transfer to ICU 2, Cond Stable	____	date		[redacted]
Aug [redacted]		X-Ray @ hand R/O Fx	____	date		[redacted]

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

USAPA V1.00

MEDCOM - 16431

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11 12 13 14 15 16 17 18 19 20
8.11	[redacted]	Cipro 400mg IV BID b(6)-2	10	[redacted]
8.11		IVF KVO	20	
			06	
M Aug 8	[redacted]	ΔCipro to 500mg PO BID b(6)-2	18	
			10	
			22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: RLE Cellulitis

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 - 16432

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18Aug03	[redacted]	Milk of Magnesia 30cc PO x 1	18Aug03		1235	[redacted]

	-----	D(u)-2 All				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
8.11	[redacted]	Percocet 1-2 po q4°	8.11 ii 1510	8.11 ii 1910	8-11 ii 2330	8-12 0300 ii	8.12 1100	8.12 1530	8/12 1900 2 tab	8/12 2300 2	8/13/03 0900 ii	8/13/03 1420 i	8.14 [illegible] ii		8.14 ii 1230	14Aug03 2 tab PO 1240
-----	-----	prn [redacted]														
8.11	[redacted]	Tylenol 650mg po q6°	8.11 ii 1510	8.12 ii [redacted]	8.12 ii	8-15 @ 1100 ii po										
-----	-----	prn														
8-11	[redacted]	Percocet 1-2 PO q4°	15Aug03 0800 PO	15Aug03 0830	16Aug 0845	16 Aug 1226 ii PO	16Aug 1635 ii	16 Aug 1854 ii PO	16Aug 2307 ii PO	17Aug 0544 ii PO	17Aug 1413 i PO	17Aug @2130 ii PO	18Aug 1200 ii			
-----	-----	PRN [redacted]														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

1 blad-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 | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	20	21	22	23	24
19 Aug	[redacted]	Cipro 500mg PO BID	10	[redacted]			D/C		
			22				[redacted] 19 Aug 05		

ALLERGIES: ☐ YES ☒ NO | PRIMARY DIAGNOSIS: Cellulitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW

[redacted]

blad-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 - 16434

PRN Meds

9 mg	PM	Percocet 1-11 PO Q4° PRN	D/C [redacted] 19aug03

...DICAL RECORD-SUPPLEMENTAL MEDIC/
...use of this form, see AR 40-66; the proponent agency is the Office of The... ...n General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: [redacted]	Time: 1830 Initals: [redacted]
NEURO	Pupils	PERRL 3mm, Alert, obeys command	PERRL 3mm Alert, cooperative
	Sensorium	to understanding. Sensation all extremities	Able to move extremities
	LOC / GCS	Ⓡgag reflex, Ⓡgrip >Ⓛgrip moderate	BUE strength equal, BLE strength
		Moves all extremities.	equal but weak
CARDIAC	Cardiac Rhythm	Regular HR, Capillary Refill < 3sec.	SR
	PRI: / QRS:	Radial pulses 3+. Pedal pulses 2+.	
	Pulse Strength	Ⓝreg. JVD. 2+ edema around wounds	Pulses +2 x 4 extremities
	Cap Refill / JVD	Ⓡfoot 2+ edema. Ø C/O CP.	Cap Refill < 3 sec
	Edema		Ø ẽ around wound LE
	Chest Pain		Ø/Denies
RESP	Respiratory Pattern	Regular, even, unlabored	RRR
	Breath Sounds	Clear all lung fields. Ø cough.	CTA Ⓑ
	Secretions	RA sats 98%.	RA
	Cough		
SKIN	Color	WNL ō,x̄ to Ⓡ foot has a red tint	Normal for color x̄ Ⓡ foot
	Integrity	color to it. Skin Dry warm.	ẽ reddened color.
	Backside	Ⓔfoot >Ⓛfoot in warmth. Dressings to	Drsg CDI BLE
		Ⓡmid lower extremity, Ⓡ LE under knee	
IV	Access Devices	18g. SL to KVO ẽ LR to Ⓛ FA.	18g Ⓛ FA, LR @ KVO
	Location	Ø Redness or swelling. Ø pain.	C/I S S/S infection
	Condition	Intact.	intact
GI	Abdomen	Soft, pain x4 quadrants ō palpation.	Soft, Flat, ẽ Pain on palpation
	Bowel Sounds	ABS x4, Ø stool this AM. Eats reg.	BS Ⓝ x 4 quadrants. Reg diet.
	Stoma/Ostomy	diet independently. Adequate PO.	
		Intake	
GU	Device	Urinal @ bedside.	Voiding spontaneously
	Color / Clarity		Clear, Yellow Urine

(Continue on reverse)

PREPARED BY [redacted] LCT/AN b(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU 3 [redacted]

DATE 13 Aug 03

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

[redacted]

b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] b(6)-4 Date: 13 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	123/61		124/59									122/69				120/70										
TEMP	97.4		97.5 (8)									97.9 (8)				97.2										
HR	60		68									77				66										
RR	20		14									16				14										
SaO2	97		98									98				98										
FiO2	RA		RA									RA				RA										
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	20	20	20	—	—	20	20	20	20	20	20	20	200	20	20	20	20	20	20	20	20	20	20	20	20	240
IVPB				100	100								200					100								100
NGT																										
PO		120		240	120	120		360	240	360	360		1920					240								240
Total																										E

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE	250	760		700	625	825	760	525			640	425	5500		550			400			300				800	
NGT																										
STOOL																										
DRAIN																										
Total													5600													2050
																										1450

ƆICAL RECORD-SUPPLEMENTAL MEDIC

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT b(a)-2

		Time: 0630 Initals [redacted]	Time: 1630, Initals: [redacted]
N E U R O	Pupils / Sensorium / LOC / GCS	Perrla 3mm a/o follows commands; appropriate c staff GCS 15 moves all extrem x4 5 direction pc (R) LE d/t pain	PERRLA 3mm. Pt follows simple commands. Pt is responsive to verbal stimuli. Moves extremities x 4.
C A R D I A C	Cardiac Rhythm / PRI: / QRS: / Pulse Strength / Cap Refil / JVD / Edema / Chest Pain	Regular VR S1 S2 +2 radial, +1 pedal (R) LE warm to touch (L) LE cold extrem +1 non pitting edema denies	S1-S2. Regul[redacted] rate, rhythm. (+)2 (B) radial pulses, (+)1 (B) pedal pulse. <2sec cap refill.
R E S P	Respiratory Pattern / Breath Sounds / Secretions / Cough	even unlabored CTA (B) ø ø	Even and unlabored. Rate 12-16/min. Breath sounds clear bilat. No cough noted.
S K I N	Color / Integrity / Backside	appropriate for race see progress notes. no breakdown	Normal for race. Darker skin noted to (R) ankle just below wound.
I V	Access Devices / Location / Condition	(R) wrist PIV (R) wrist 18 G patent	(L) FA 18 PIV. Drsg intact. No redness or drng noted.
G I	Abdomen / Bowel Sounds / Stoma/Ostomy	soft nontender +4 ø	Abd soft and nontender BS x 4. Last BM unknown.
G U	Device / Color / Clarity	ø amber clear	~~Foley~~ Voiding per urinal. Voiding clear yellow urine.

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] LT AN b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 3, [redacted] b(2)-2

DATE 8-14-03

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

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 16438

ICU3

Patients Name: [redacted] b(6)-4

Date: 8-14-03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			124/85												125/85											
TEMP			98°												97											
HR			72												65											
RR			16												17											
SaO2			98												98%											
FiO2																										
Source			RA												RA											
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF																										
IVPB			200																							
NGT																										
PO			450					600																		
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE	625								725						700			550						60		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

		INITIAL SHIFT ASSESSMENT b(6)-2	
N		Time: 0700 Initals: [redacted]	Time: 1900 Initals: [redacted]
E	Pupils	Perrla, 3mm brisk	PERRL brisk
U	Sensorium	c/o follows commands, appropriate	A&O x3
R	LOC / GCS	c staff GCS 15. MAE	pt follows commands ⊕ movement
O		all extremities well c (R)LE d/t pain	to all extremities
C	Cardiac Rhythm	Regular rhythm	NSR HR-53 BP-
A	PRI: / QRS:		
R	Pulse Strength	+2 radial, +1 pedal pulses	⊕2 Radial ⊕2 Pedal
D	Cap Refil / JVD	<3 secs Ø JVD	≤3sec. Ø JVD
I	Edema	+1 non pitting edema (R)LE	+1 RLE
A	Chest Pain	denies	Ø chest Pain @ Present
C			
R	Respiratory Pattern	even unlabored RR 16-18	RR-18 unlabored SpO2 98% on RA
E	Breath Sounds	CTA (B)	CTA (B)
S	Secretions	Ø	Ø secretions
P	Cough	Ø	Ø cough
		SpO2 98-99% @ RA.	
S	Color	appropriate for race.	Normal for Race
K	Integrity	see progress note	wounds to (R)LE
I	Backside	intact no breakdown	no breakdown noted
N			
I	Access Devices	PIV 18G.	IV in (L) Arm TKO
V	Location	(L) Dorsal	
	Condition	patent	patent no s/s of infection/infiltration
G	Abdomen	soft nontender.	soft flat non tender non distended
I	Bowel Sounds	X 4 quads	Normoactive X4
	Stoma/Ostomy	Ø	Ø ostomy O stoma
		denies N/V/D, ate 75% breakfast	
G	Device	urinal @ bedside.	urinal @ bedside
U	Color / Clarity	amber clear QS.	clear yellow
		denies pain while voiding	

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] Nights 1800-0600 b(6)-2

DEPARTMENT/SERVICE/CLINIC b(6)-2
ICU 3, [redacted]

DATE 8.15.03

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

EPW [redacted]

b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 16440

ACLU-RDI 1636 p.200

DOD-029829