Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date / Clerk Nurse	SINGLE ACTIONS (b)(6)-2 all	Date to be Done	Time to be Done	Time Done	Initials
17 [redacted]	Admit ICU #1, surgery stable				
17 [redacted]	CBC, Chem 8 this PM	17 AUG	1800		
17 [redacted]	Pt to OR today for toe Amputation				
17 [redacted]	Resume prep Orders/meds				
17 [redacted]	D/C Foley	17 Aug		[redacted]	[redacted] (b)(6)-2
18 [redacted]	D/C to EPW camp tomorrow	18 Aug			
18 [redacted]	Rx on chart	18 Aug			
18 [redacted]	Δ dressings + remove packing prior to d/c	18 Aug			
18 [redacted]	Transfer to ICU #2				

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (~~DIET~~ 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 16 17 18 19
17	(b)(6)-2 [redacted]	NS@125cc/HR	05	X [redacted] > HL'd 18Aug03
			17	[redacted]
	(b)(6)-2			
17	[redacted]	Ancef 1gm IVPB @ 8a	06	[redacted]
			14	[redacted]
			22	[redacted]
				D/C [redacted] (b)(6)-2 19Aug03
17	[redacted]	HL	05	[redacted]
	(b)(6)-2		13	
			21	
				(b)(6)-2

ALLERGIES: ☐ YES ☒ NO NKDA

PRIMARY DIAGNOSIS: shrapnel wounds / partial tib amp

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

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17442

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	
	-----	Resume preop orders/meds					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED												
17 -----	[redacted] (b)(6)-2	MSO4 2mg q10 IV PRN q PAIN	D/T	17Aug 0437	17Aug 0830	17Aug 1330	17Aug 1912	18Aug 0330	18Aug 0553	18Aug 0440					
----- -----			D/I	2	2mg	2mg	2	2mg	2mg	2mg	(b)(6)-2			all	
17 -----	[redacted] (b)(6)-2	Phenergan 25mg IV q6° prn nausea	D/T												
----- -----			D/I												
18- -----	[redacted] (b)(6)-2	Tylenol 650mg PO q4-6° prn-pain	18Aug 1430 0552-5 PO BOD												
18- -----	[redacted] (b)(6)-2	Percocet 1-2 tabs PO q4-18 prn-severe pain (b)(6)-2	21/15 18Aug 0440 PO [redacted]	[redacted]	(b)(6)-2										
----- -----															

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: 17 AUG 05
Time In: 1055
Allergies: NKDA
Pre-op V/S: 03/95/104
Procedures: R/C Amputation (L) TKC, repair facial/AC

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 15-1000 Colloid —
OR Output: UOP 100 EBL Min
Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	1055	1130	1155
SaO2	94	94	93
FiO2			
Methods	RA	RA	RA
240			
220			
200			
180			
160			
140		V	
120	V		
100			
80			
60	^	^	^
40			
20			
RR	18	16	20
T	98	98	
Time			
Pain (0-10)			
LOS			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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.	12	12	12

Codes

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

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

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

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

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] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC:

DATE: 17 Aug 2005

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

[redacted]

(b)(6)-4

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

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

USAPPC V2.00

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

NEUROVASCULAR

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

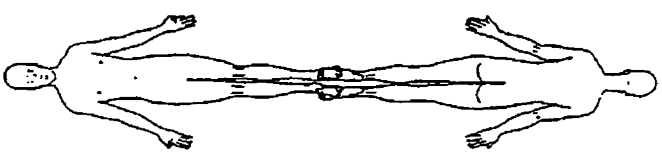
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1103
pt arrived from OR on litter sleepy but
arousable BS clear to auscultation Bowel
sounds present + foley to gravity draining clear
yellow urine able to move all extremities
adequately responds to commands multiple wounds
on legs + arm lacerations sutured on face
pulse adequate pedal pulses in bilateral
toes occlusive dressing on bilateral feet from
toes to ankles occlusive dsg on R thigh
sutured laceration to face open to air
serous sanguinous drainage small amount with [redacted] (b)(6)-2
on dressings on bilateral feet @ toes ~~foley~~
18 gauge peripheral IV in L arm infusing NS
[redacted] (b)(6)-2

Discharge Criteria:
Date: 17Ag0 **Time:** 1134 **PARS:** 12
BP: 130/59 **T:** 98 **HR:** 103 **RR:** 14 **Sa02:**
Pain Level at D/C (0-10):
Intake: 150 **Output:**
Additional Data:
Transferred To: ICW-1
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP 8-3
Charge Nurse Signature: [redacted] (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ		UNK - EPW.	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	24Y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	0130	(b)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW1	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 (YYMMDD)
05		030818

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030817

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

FOR LOCAL USE

Dx. - Shrapnel Wounds / partial Toe Amputation.

Dx	Proc	T - INS
8910	8411	1449
8930	8659	
8411		
E923		

ADMITTING OFFICER (Signature, as re[quired]) [redacted] (b)(6)-2

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

DA FORM 2005 MAR [illegible]

MEDCOM - 17446

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	UNK	UNK	UNK	—	—	N

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	—	ICU2

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	0130	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	17 Aug 03

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

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

Shrapnel (R) thigh, (R) Knee

890.0
891.0
879.2
875.0
E991.9

DX
8900
8910
E9911.9 I 599 T 9

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

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

SIGNATURE OF [redacted]AL OFFICER (b)(6)-2 (b)(6)-3 [redacted] (b)(6)-2

A FORM 3647, MAY 79 EDITION OF 1 [redacted] USAPPC V1.10

MEDCOM - 17447

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

EPW ♂ hit by mortar rd.

PMH: unknown
SurgHx unknown
Meds: Ø
Allergies NKDA

PHYSICAL EXAMINATION

HEENT: WNL
Chest: CTA
CVR: S1S2
Ext: 2 – 1.0 cm holes lateral [illegible] thigh, 1/2 cm medial thigh [illegible] knee effusion, 2+ DP/PT
ABD: soft [illegible]

XR Ø fx [illegible]

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

Ⓐ Soft tissue wound
Ⓟ Local wound care, [illegible], oral ABx, d/c

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	8/17/03		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
(b)(6)-2		

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-108

[redacted]
(b)(6)-4

MEDCOM - 17448

AUTHORIZED FOR LOCAL REPRODUCTION

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

17 Aug — D/C Summary

- EFW S/P multiple fragment (R) leg
chest / ABD

Overnight NO issues.

Small wounds chest ABD 5 pain.

(R) Leg 2×2 cm tissue defect. No bleeding this Am.

(A) tissue fragments.

(R) wound clean D/C to EFW Camp Aby Keflex / pain control.

[redacted] (b)(6)-2 / [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
USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17AUG03 0334	Pt arrived from EMT via litter @ 0230. VSS, temp 99.1°. A+OX3. lung sound clear bilaterally apex to base. RR equal + unlabored c no use of accessory muscles noted. 96% RA. Radial + Pedal pulses strong & equal to palpation bilaterally. HR 95, RRR. Cap Refill <3sec to all extremities. PERRLA. Mucous membranes moist. Pt to be on Reg diet for breakfast. BS active x 4 Quadrants. Non-distended, non-tender to palpation. Ø void since admission. ØBM. Bath given. Dressing applied to larger 2dime sized wounds to Ⓡ hip + 5mm wound to Ⓡ upper knee. Pt has multiple small wounds to Ⓡ upper leg + Ⓡ chest + abdomen. Ø c/o pain except when bathing or with movement of Ⓡ leg. ROM to BUE & LLE complete. ROM to RLE complete, but weak d/t pain. Pt has IV to Ⓛ ac c LR @ 100cc/hr with no signs of redness or infiltration noted. BUE restrained d/t EPW status, Will continue to monitor for A's – SPC [redacted] (b)(6)-2 MDM
17 aug 03 0800	Initial assessment: pt awake, oriented c unable to communicate due to language barrier. Pt able to follow simple commands. pupils 2mm. - slow to react to light. Moves all extremities. Both wrists restrained c Keep pt status c EPW. Guard @ bedside. Offered breakfast but refused. Skin warm and dry. No resp. distress noted. RR: 12 per minute

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]INED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR (b)(6)-2 Court

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 - 17450

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 0800	Lungs: CTA bilaterally, Ø wheeze or cough. Heart $S_1 S_2$ Ø murmurs. Ø peripheral edema. Capillary refill < 2 sec. Good skin turgor. Good muscle strength. peripheral pulses strong and equal x4. @ 37. abd. flat. non-tender. Ø N/V. active bowel sounds x4 quad. Voids per urinal. Ⓡ thigh drsg dry & intact Ⓛ antecubital IV site free of infiltration or signs of infection. LR @ TKO. pt condition stable. —— [redacted] MAJ AN (b)(6)-2
17 Aug 03	When asked whether he had any pain, pt pointed to Ⓡ thigh. MSO4 3mg IVP given for pain. will assess for effectiveness of pain med. —— [redacted] MAJ AN (b)(6)-2
	17 Aug 03 P/C Surg. No issues o/night. X-ray = Ø Fx. RTD Sfw [illegible] [illegible] [redacted] (b)(6)-2

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

MEDCOM - 17451

ACLU-RDI 1642 p.11

DOD-031040

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER [redacted] (b)(2)-2
		RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL
STREET ADDRESS			DATE *(Day, Month, Year)* 16 Aug 03 / TIME 0001
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Ambu

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		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT: Shrapnel (R) leg Chest

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME	0001				
☐ URGENT		BP	133/73				
	INITIALS	PULSE	89				
☐ NON-URGENT		RESP	16				
		TEMP					
		WT					

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:	Lytes &	ACUTE ABDOMEN		LS SPINE
BLOOD C&S X					SINUS		HEAD CT
					ANKLE R/L		☑ R Knee
							☑ R Hip

ORDERS

☑ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
001	Tetnus .5mg IM				
001	Ancef 1g				
002	NS KVO 4 50ml				

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted] (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

NSN 7540-01-075-3786

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	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT			U/A DIP		745	EKG INTERPRETATION	
PT			U/A MICRO				
APTT	BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

DIAGNOSIS

Shrapnel wounds to thigh/knee

PROVIDER SIGNATURE AND STAMP

[redacted]

(b)(6)-2

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 - 17453

ACLU-RDI 1642 p.13

DOD-031042

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR AUG DAY: 17 18 19

~~19~~ 2003 HOUR: 20 30

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 20 — 96%

BLOOD PRESSURE: 130/72

Record special data only when so ordered

HEIGHT: WEIGHT →

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

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17454

Ward/Section: ICU 2	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
17/08/03 03:03
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	114	73-118	MG/DL
BUN	33*	7-22	MG/DL
CRE	1.9*	0.6-1.2	MG/DL
CK	833*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	3.2*	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.5 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: 17 Aug 03	LAB ID NO.:

(b)(6)-4

[redacted]

				Patient Limits
WBC	16.1 H	x10^3/uL	4.5	10.5
RBC	4.82	x10^6/uL	4.00	6.00
HGB	14.5	g/dL	11.0	15.0
HCT	41.1	%	35.0	60.0
MCV	84.5	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	35.5 L	g/dL	32.0	37.0
PLT	278.	x10^3/uL	150.	450.
LYM%	9.9 eL	%	20.5	51.1
LYM#	1.6	x10^3/uL	1.2	3.4

(b)(6)-4

[redacted]

10-16-07
09:25

				Patient Limits
WBC	16.1 H	x10^3/uL	4.5	10.5
RBC	4.82	x10^6/uL	4.00	6.00
HGB	14.5	g/dL	11.0	15.0
HCT	41.1	%	35.0	60.0
MCV	84.5	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	35.5 L	g/dL	32.0	37.0
PLT	278.	x10^3/uL	150.	450.
LYM%	9.9 eL	%	20.5	51.1
LYM#	1.6	x10^3/uL	1.2	3.4

518–124

NSN 7540–00–634–4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

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

- [X] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 17 Jul 03

DATE AND HOUR REQUIRED: on call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted] (b)(6)-2

DATE VERIFIED: 17 Aug 03

TIME VERIFIED: 0145

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DONOR	RECIPIENT
ABO	ABO
Rh	Rh

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML | TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED | TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

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

[redacted]

(b)(6)-4

SEX: M | WARD: ENT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 17457

Medical Record Copy

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: 17 Aug 03 TIME OF ORDER: 0130 HOURS

LIST OF ORDERS NOTED AND SIGN

- Admit to ~~General~~ Surgery Orthopedics ICU #2
- Dx: Shrapnel (R) thigh / (R) knee
- Condition: stable
- V/S: per routine
- All: NKDA.
- Meds: 1 gm ANCEF IV Q6°
- 2-4mg MSO4 IV Q4° prn pain.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- 650 mg Tylenol po Q4 prn fever
- Diet: NPO until reevaluate
- Activity as tolerated
- ~~Meds~~
- Plan: as per orthopedics

NURSING UNIT | ROOM NO. | BED NO.

Noted CPT ... [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 8/17/03 TIME OF ORDER: 0230 HOURS

- Bath Patient
- Clean wound (R) thigh & knee Apply dry dressing
- Regular Diet

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER: 17 Aug TIME OF ORDER HOURS

D/C EPW Camp

[redacted] / [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 78 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo 08 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20
17AUG	[redacted] (b)(6)-2	Vitals per routine	06				
			18				
[redacted]							
17AUG	[redacted] (b)(6)-2	Activity as tolerated	18				
			18				
17AUG03	[redacted] (b)(6)-2	Regular Diet	06				
			12				
			18				

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel (R) thigh (R) Knee

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo August Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
17 AUG	[redacted]	Admit to Surgery ICU/Trauma	17AUG03	NOW	0230	[redacted]	(b)(6)-2
17 AUG	(b)(6)-2 [redacted]	Condition stable	17AUG03	NOW	0230	[redacted]	(b)(6)-2
17 AUG	(b)(6)-2 [redacted]	Plan as per ortho pt	17AUG03				
	(b)(6)-2 -----	Bathe patient	17AUG03	NOW	0310	[redacted]	(b)(6)-2
	-----	Clean wound ® thigh + knee, apply	17AUG 03	NOW	0310	[redacted]	(b)(6)-2
	-----	dry dressing					

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17
17AUG	[redacted]	1 Gm Ancef IV q 6 0	06	0800
	(b)(6)-2		12	[redacted] (b)(6)-2
			18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

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

	-----	[redacted]				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
17 Aug 06	[redacted]	2-4mg MSO4	17 Aug 06 [redacted] (b)(6)-2
-----	(b)(6)-2	IV q 4° prn	0830 [redacted] (b)(6)-2
-----	-----	pain	
17 Aug 06	[redacted]	650mg Tylenol	
-----	(b)(6)-2	p.o q 4° prn	
-----	-----	Fever	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE			5. SEX	
9	10	11	12	13	14	15		16	17		18	
[redacted]							EPW #[redacted] (b)(6)-4			E1 EPW	M	

b)(6)-4

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC		RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	BACKGROUND	
Z	Z	Z	Z	Z	Z	Z	Z	Z	Z	Z	X	9		UNK

10. LENGTH OF SERVICE			ETS	11. FMP			12. SOCIAL SECURITY NUMBER									
32	33	34		35	36		37	38	39	40	41	42	43	44	45	
Z	Z	Z	—	~~4~~ 9	[redacted] (b)(6)-2		[redacted]									

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS		HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
—	46		0130	—
	Z			

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
—			K	7	8	Z	Z	Z	Z	Z				

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	NO
									1		N

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU 2	UNK
Ø		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2		UNK

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
~~5~~	Ø							Ø	3	Ø	8	1	7

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							Ø	3	Ø	8	1	7

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

Shrapnel ® Thigh, ® Knee

DX	INJURY	Trauma
8900	599	9
[redacted] (b)(6)-2 8910		
E9919		

ADMITTING OFFICER (Signature, as required)	CLERK
[redacted] (b)(6)-2	[redacted] (b)(6)-2

DA FORM 3888, MAR 80

MEDCOM - 17463

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	unk	X	unk	N/A	N/A	No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
90 70	[redacted] (b)(6)-4	N/A	

15. FLYING STATUS	16. RATING/ OSG	17. DEPT. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78	N/A		N/A

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From EMT	2359	AA14

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
Unk	41 56	16 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	Unk	16 Aug 03	

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

Shrapnel to Head

Dx 8737
E9917

Trauma
9

Inj
599

Blood
N

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDDP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDDP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
	For [redacted] (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 17464

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	[redacted]	(b)(6)-4 EPW [redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	ZZZ	X	9	Unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2359	N/A (b)(6)-4

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 [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
C		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	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
41		030816

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AADA		030816

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

FOR LOCAL USE

Dx: Shrapnel to Head

ADMITTING OFFICER (Signature, as required)

[redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2 [redacted] (b)(6)-2 [redacted] SPC, 91618

DA FORM 2085, MAR 80

MEDCOM - 17465

INPATIENT TREATMENT RECORD COVER

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	44	—	—	—	—	DO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4 [redacted]	—	ICU2

15. FLYING STATUS	16. [illegible] DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K-78	—	—	NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0149	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	21	23Aug03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	17Aug03	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

MVA

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/p neck exploration, RUE

874.8
884.1
882.0
823.90
E991.2

79.66
86.28
83.14
93.54

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF RAD OR MEDICAL RECORDS
Dr [redacted] (b)(6)-2	for [redacted] (b)(6)-2

DA FORM 3647, MAY 79 — EDITION OF 1 AUG 78 IS OBSOLETE — MEDCOM - 17466 — USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

44 yo male Iraqi [illegible] ATC
40 (R) groin pain. Denies abd pain.

Illness ∅
Meds ∅ [illegible] ∅
PMHx ∅

PHYSICAL EXAMINATION

117/78 81
Mild distress
HEENT: OP clear.
Neck: small penetrating wd
Chest: CTA
Abd: soft NT. FAST ⊖
Ext: Lt deltoid x4
(R) LEx wound A/B joint, small lac

VA

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

At [illegible] ward (L) Arm
(R) neck [illegible]

p/ OR (R) LEx debridement
wound exploration

130 | 104 | 12 < 142
4.2 | 21 | 1.6

19 > 12.8 / 40.1 < 217

(b)(6)-2 [redacted]

DATE 8/16

IDENTIFICATION NO.

ORGANIZATION

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

REGISTER NO.

WARD NO.

[redacted]
(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
19Aug03 1730	Pt admitted from ICU3 in stable condition. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR on mon, abd soft, non-tender, bowel sounds active x4 quads. Dsg to (R) side of neck CDI. (R) arm dsg CDI. Multiple shrapnel wounds to upper body torso. Casts from (R) groin to (R) toes. Strong pulses and brisk cap refill to bilat LE. IV to (L) AC. ∅ complaints [redacted] (b)(6)-2
2230	Care assumed @2100. VSS, patient is sleeping awoken by verbal stimuli, no c/o pain, lungs CTA, A&Ox4, Dsg's on (L) index finger, (R) arm, right side of neck, and cast on (R) leg all CDI. (R) foot c slight edema, pt able to wiggle toes and has (+) sensation. HL flushes well, pt on IV/PO ABX. Pt has various flesh wounds from the shrapnel over his chest and upper extremities. Nb complaints at this time, will continue to monitor [redacted] (b)(6)-2 q1hr c
20Aug03 0800	Pt. awake & alert sitting up in bed. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. HL in (L) AC c s/s of infection. VSS. Staples to (R) clavicle intact, site c s/s of infection. Dsg to (R) upper extremity CDI, (R) hand slightly swollen, radial pulse palpable, cap refill <3sec (+)

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. ICU3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

[redacted]
(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
8/23/03	D/C Note. EPW Male sustained open (R) TIBIA Fracture and soft Tissue lacerations to Right arm on 16 Aug 03. Wounds are closed. Fracture is stable. Long leg Cast is applied. Pt should return in cast 6-12 weeks. Follow up XRays should be obtained in Six weeks. Sutures to be removed in one week from arm [redacted] (b)(6)-2 By [redacted] me (b)(6)-2

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | REGISTER NO. | WARD NO.

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

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

MEDCOM - 17469

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2

FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
17Aug03(1700)	cont. — Pt slept most of afternoon. Still denies wanting anything for pain. Sensation intact — [redacted] 1LT/AN
	(b)(6)-2
18Aug03(0630)	Received report from CPT [redacted] (b)(6)-2 and assumed care of pt @ 0615. See DA Form 4700 for assessment data. Pt says has little pain. > c̄ movement. Resting in bed c̄ Ⓛ ankle + Ⓡ wrist restrained. Ⓡ leg elevated on blanket. — [redacted] (b)(6)-2 1LT/AN
18Aug03(1710)	Pt did well throughout shift. VSS. Needed pain meds x1. IV Abx given. Ⓡ leg kept elevated on blanket. Very minimal drainage on Ⓡ hand bandage. SL still flushes well. Foley in place. Pt ate breakfast + lunch independently. [redacted] 1LT/AN
	(b)(6)-2
13Aug03	Brief op note
	Pre Op Dx: Ⓡ TBI A-FX, open wound Ⓡ UE, Ⓛ IF
	Post Op Dx: Same
	Procedure: I+D Ⓡ leg Ⓛ IF, Ⓡ arm, exploration of LLC Ⓡ leg, DPC Ⓛ leg, Ⓛ IF, Ⓡ UE
	Surgeon: [illegible]
	Anesthesia: General mask
	EBL: [illegible]
	Fluids: 300cc
	Cx: ∅
	Post Op Plan: Up ad lib, [illegible]

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

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03	[illegible] Op Note
	Pre Dx - (R) supraclavicular wound
	Post Op Dx - SAA
	Procedure - (R) supraclavicular neck explore
	Surg [illegible]
	Asst [illegible]
	Anes GET
	Findings frag lodged in clavicle, no surgery [illegible]
	[illegible]
	Complications Ø
	[redacted] (b)(6)-2
17 AUG 03	Ortho Op Note
0525	Pre Op Dx
	(1) Open grade II (R) tibia fracture
	(2) Fragment wounds (R) arm
	(3) Open (L) IF PIPJ wound
	Post Op Dx - Same
	Procedure: (1) I+D (R) tibia fx, apply splint
	(2) I+D (R) arm wounds

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

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

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

(3) I+D (C) IF PIRS.
Surgeon [redacted] (b)(6)-2

Findings: Soft tissue wounds only in (R) arm, no bony involvement. Stream fragments seen on distal side. (R) tibia I+D's, fracture stable. (C) IF small puncture wound, into PIRS. I+D done.

PLAN: Report I+D in 48 hours, with Plaster in long leg cast for tibia fracture. Wet dressing (2) IF expandable, extension brace to be used as well.

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

17AUG03 @0610 pt returned from OR @ 0555 pt VSS see recovery Flowsheet for details pt dressing CDI will report to oncoming shift — [redacted] (b)(6)-2 RPC 94th

17Aug03@1700 Finished recovering pt @ 0705. Had received report on pt @ 0620. Pt states that he has little pain but not enough for medicine. See DA Form 4700 for assessment data. Pt slept most of the morning. Around 1030 gave pt @ bath (sponge). Pt was c/o some pain during that so gave 4mg MSO4/IVP. Tolerated it well @ leg elevated on blanket. Sensation intact. Pt ate lunch independently

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.01

NSN 7540-01-634-4176

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Aug 03 0800	sensation, full ROM of digits, wrist & elbow. PSG to (D) forefinger CDL. Cast to (R) UE intact, full ROM of digits, <3sec cap. refill, (+) sensation. Multiple shrapnel wounds to chest & UE, wounds ∅ drainage or s/s of infection. Pt. ∅ complaints @ this time. Will continue to monitor. [redacted] (b)(6)-2 RN/A
20 Aug 03	Orders Shift (R) LLC intact, pain well controlled. Drsg (R) UE intact. Drsg ∅ in AM. Needs crutch training. [redacted] (b)(6)-2
20 Aug 03 1330	Pt awake and alert. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4. Quads. Incision to (R) clavicular area c. T. Sutures intact, open to air, ∅ s/s infection. (R) arm T dsg CDI. Cast to (R) leg from groin to toes. Able to move (R) toes, strong pulses and brisk cap refill to bilat LE. ∅ complaints [redacted] (b)(6)-2
20 Aug 03 0130	Care assumed @ 2100. VSS, AOX3, ∅ pain. Given for pain @ 2100. Lungs rook CTA, bowel sounds active x4 quads.

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.)*

FE/PW [redacted] (b)(6)-4

REGISTER NO. | WARD NO. ICW2

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 - 17473

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Cast on ⓛ leg CDI, ⊕ cap refill and sensation in toes. Dsg on rue CDI, pulse ⊕, cap refill and sensation ⊕. ⓡ hand slightly edematous. Dsg on index finger of ⓡ hand CDI. ⓛ hand with staples CTA CDI, skin around wanden neck pink, nn painful to tech. Various shrapnel sites over chest s/s infection. Continue to monitor. [redacted] (b)(6)-2 9 MMCO
21 Aug 03 0630	Pt sleeping, easily arousable to verbal stimuli. Lungs CTA bilat, ⊘ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Incision to ⓡ clavicular area CDI, ⊘ s/s infection. Staples open to air. Dsg to ⓡ arm CDI. Swelling noted to ⓡ hand, ⊘ c/o pain, pt instructed to elevate hand. Mult. shrapnel wounds to torso, dried and healing. Cast to ⓡ leg from groin to toes intact. Strong pedal pulses and brisk cap refill to bilat LE. [redacted] (b)(6)-2 MMCO
21 AUG 03	(1650) Pt admitted to unit via litter in stable condition. Pt A/O x 3. Lungs CTA ⓑ. ⊕ DS x 4 quads. VSS. ⓐ in ⓞ ac dkd d/t infiltration. Dsg on ⓡ arm CDI. Sutures on ⓡ arm intact. Upper ⓡ arm incision packed c iodoform dsg. Sero-sang drainage c pus expelled from lower end of incision prior to packing. ⊘ c/o pain @ this time. Will continue to monitor [redacted] (b)(6)-2 MMCO
21 AUG 03 2221	VSS. AO. Denies pain @ this time. Dsg intact to ⓡ arm. ⓡ cast intact. ⊕ pulses. Staples to ⓡ wrist CDI. Telemetry PD well. Unit to monitor. [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

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)*
25 Aug 03 1100	Received pt resting in bed in stable condition. VSS, (B)LE cast in place. No exceptions to assessment WNL. Pt tol po and drinking. Pt waiting for return to CPW c̄ MP today. No other remarkable findings. Will cont to monitor pt [redacted] (b)(6)-2
25 AUG 03	PT NOTE
	HX: CRUTCH TRAINING ! AMBUL ASST.
	T/M: (B) UE ! (L) LE GMM ~ 5/5. PNT DEMONSTRATED (I) 3PT NWB GAIT TO INCLUDE
	STAIR. MINIMAL ASSIST REQ'D NEGOTIATING STAIR AT LATRINE. PNT AMBUL ~ 200' PNT
	DENY DIZZINESS, NAUSEA, OR EXCESSIVE FATIGUE.
	DX: CRUT TRAINING. AMBUL.
	I: SAME
	G: AMBULATE PNT ~ 500' BID X 2WKS.
	(b)(6)-2
	SPC [redacted]
	91W10 N9 PT TECH

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 - 17475

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FAC [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

SEX: M

AGE: 44

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			

ARRIVAL

DATE *(Day, Month, Year)*: 17/08/03 | TIME: 0010

TRANSPORTATION TO FACILITY: Medevac

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Shrapnel - extremities, (B) Abd

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0010

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

VITAL SIGNS

TIME	0010	0030	0045	1240		
BP		119/70	121/69	106/66		
PULSE	86	80	78	83		
RESP			16	14		
TEMP						
WT	0299.1.		98.1.	98.1.		

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0030	5cc Tetanus	[redacted]	(b)(6)-2		
0035	1gm Ancef		(b)(6)-2		
0040	10mg Morphine		(b)(6)-2		

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 ☐ 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

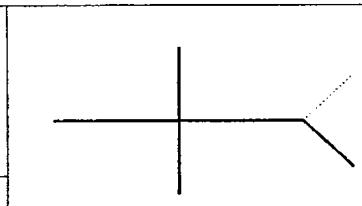
STANDARD FORM 558 (REV. 9-98)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 17476

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL GSW to r forearm Good PMS distal ↓ ROM GSW to r leg Tib/Fib Good PMS - able to move left leg - shrapnel wounds noted to chest + neck HRRR. Lungs CTAB

Ø surg
⊕ tobacco

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted]
(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23AUG03	0930		Assumed care of pt @ 0700 per report from night shift. Pt alert, speaking freely. ϕ C/O pain. Cast on RLE intact. Toes warm to touch. Pt able to move all toes. Staples to (R) side of neck CDI. Sutures to (R) upper and lower arm CDI. Dsg d/d to sutures on (R) upper arm. Shrapnel wounds noted on chest dry and intact. AM care done this am by pt. VSS. RLE elevated on [redacted] (b)(6)-2 pillow and blanket. 2-point restraints in [redacted] (b)(6)-2 place. Monitoring. — [redacted] (b)(6)-2 RN
23Aug03	2100	=	VSS, A+O x3, ϕ C/O pain, cast to (R) LE and neurovascularly WNL, lacerations to area above (R) AC & C sutures → Dsg Δ'd. and lac to (R) FA C sutures open to air. Wound to (R) clavicular area C Staples open to air → ϕ erythema or irritation, Shrapnel wounds scattered over abdominal area. No other remarkable assessment findings (R) LE elevated on blanket rolled [redacted] (b)(6)-2 RN Will continue to monitor.
23 Aug03	2230	:	pt. OOB and ambulating in hallway NWB C crutches. [redacted] (b)(6)-2 RN (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

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 - 17478

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03	0850		Pt received sleeping, awoke spontaneously alert, lungs CTA bilat, S1 S2 noted ± Ⓟ peripheral pulses bilat UE's & Ⓠ LE's, Ⓠ LE ± full length cast & pt ± sensation & warmth to his toes, Ⓟ bowel sounds in all quads, tolerated PO fluid & meal well. Sutures to U & L Ⓡ arm intact ± s/s of infx, staples Ⓡ clavicle ± s/s of infx, multiple scabed over shrapnel wounds throughout torso, sutures Ⓠ index finger intact & ± s/s of infx. Pt to A/E to EPW camp today, cont. to monitor. (b)(6)-2 [redacted] SW
24 Aug 03	1830		VSS, 1 to 1, Ø c/o pain, cast to Ⓡ LE, ambulates QOB NWB ± crutches well, Ⓡ LE elevated. Wounds to Ⓡ LE ± sutures approximated. Wound to Ⓡ clavicular area ± sutures approximated. No other remarkable assessment findings. Pending D/C back to EPW camp. [redacted] SW (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22AUG03	1115		Assumed care of pt @ 0700 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Staples to Ⓡ side of neck CDI. Sutures on Ⓡ arm intact. Bottom of incision on Ⓡ upper arm packed c Iodoform dsg. Small amount of drainage on old dsg. New dsg applied to sutures on Ⓡ upper arm. Shrapnel wounds noted on chest Ø S/Sx infection on any wound sites. Ⓡ leg in cast intact, elevated on pillow and blanket. Voiding s difficulty. 2 point restraints in place. Pt able to move toes on Ⓡ foot. Cap refill <2secs. Pt resting quietly @ this time. Will continue to monitor. — [redacted] (b)(6)-2
22 Aug 03	2030		VSS, A+Ox3, communicates in Arabic native language, Ø c/o pain, cast to Ⓡ LE → neurovascular √'s WNL (Ⓐsensation/Ⓜmovement wiggles toes well, CRT<3secs in toes, can fit two fingers under cast @ Ⓟthigh, Ⓞ edema), wound to Ⓡ clavicular area c Staples COI, wound to Ⓡ LE → dsg reinforced, wound to Ⓡ LE (Ⓟ FA) c Sutures approximated, Ø IV access, PO antibiotics, Crutches for NWB exercise, Continue IS @ BS. Will continue to Monitor — [redacted] (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BA(

MEDCOM - 17480

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 44 HEIGHT: } unknown WEIGHT: }	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): unknown 3. PREVIOUS SURGERY [ ] NO [X] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: ? Implants: ? Medications: ?
Jewelry removed: yes/no Family waiting: yes/no

Emergency case s/p blast injury - multiple shrapnel wounds.

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted]
(b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION √ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. √ Potential impairment of mobility due to sedation; pain; injury E.2. √ Potential discomfort due to injury; pain	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. √ Disminished visual perception due to being injury; sedation; F.2. √ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. o Address pt. from either side. ø Validate pt.'s understanding of verbal communications. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

(b)(6)-2 [redacted] RN 17 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title (b)(6)-2 [redacted] RN	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and [redacted] RN (b)(6)-2
DATE: 17 Aug 03 TIME: 0340	DATE: 17 Aug 03 TIME:

REVERSE OF DA FORM 5179, JUN 91 USAPA V1 01

MEDICAL RECORD — **INTRAOPER[illegible]E DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesth.

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 1420

4. PATIENT IN ROOM TIME 1420 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

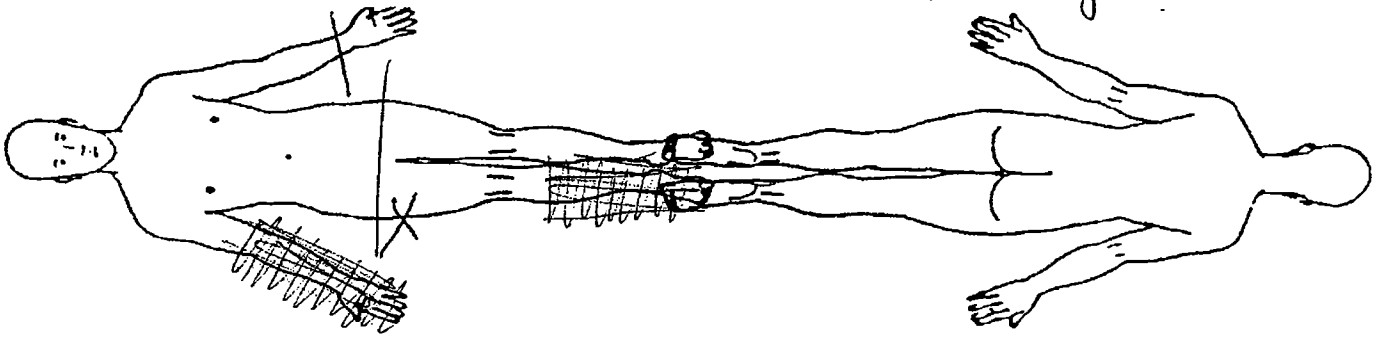
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine prep BY WHOM: (b)(6)-2
SITE: ~~Lt~~ Rt. arm & leg BY WHOM: LTC [redacted]
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS		C = Correct I = Incorrect Initial Other	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No	V	C	C	PFC [redacted]	LTC [redacted]
Needle Sharp	☒ Yes ☐ No	V			"	"
Instrument	☐ Yes ☒ No	/	/	/	/	/
Other	☐ Yes ☒ No	/	/	/	/	/

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

[redacted]
(b)(6)-4

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

☒ ESU NO: Valleylab Force 2
GROUND PAD: BRAND Polyhesive
LOT NO: 68036

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES D[illegible] MEDCOM - 17483 [illegible]S OBSOLE[illegible] USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl -

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION (Specify)
Kerlix fluffs + rolls 2x2 - Lt finger
Webril +
Long leg cast - Rt. leg

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] (b)(6)-2 Anesthesia: Maj. [redacted] (b)(6)-2 Anesthesia Type: & Mask/IV sedation

Bovie Pad site intact pre-op clear post-op clear Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op NA: post-op NA

20. OPERATION(S) PERFORMED
I + D (R) arm + Rt. ↓ leg; I + D (Lt) trigger finger

21. PATIENT TRANSFERRED TO ICU-3 TIME 1600 METHOD via Gurney

22. RECI[redacted] LTC, AN

R[redacted] FORM 3179-1, OCT (b)(6)-2 MEDCOM - 17484 USAPA V1.01

MEDICAL RECORD — **INTRAOPE** — **DOCUMENT**

For use of this form, see AR 40-68, the pr . 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 LT [redacted]

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0345

4. PATIENT IN ROOM TIME 0345 (b)(6)-2 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

Emergency case s/p blast injury - multiple shrapnel wounds

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

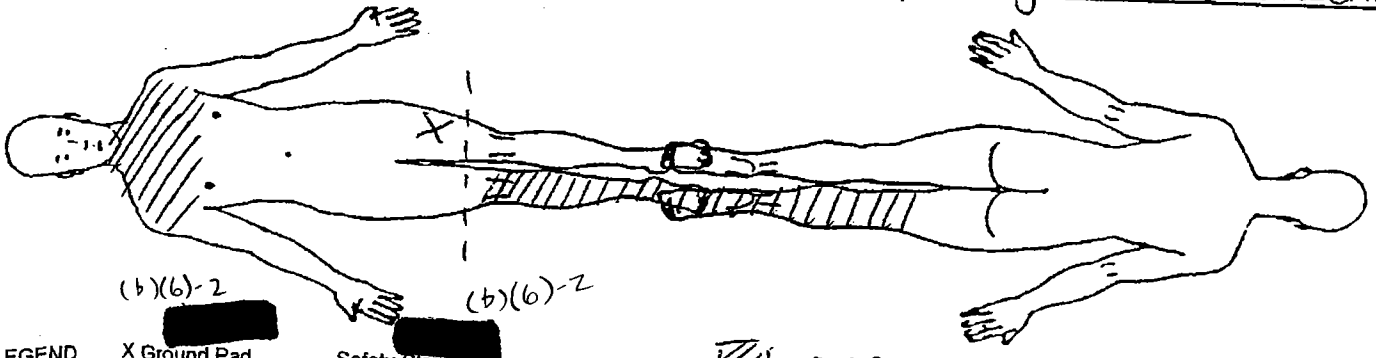
HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted] (b)(6)-2
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR Right leg ☐ CLIP

COMMENTS: No nicks or cuts

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Right Arm, Leg BY WHOM: 1LT [redacted] (b)(6)-2
SITE: Left hand upper chest/neck BY WHOM: CPT [redacted] (b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SPC [redacted] (b)(6)-2
1LT [redacted] (b)(6)-2

C = Correct I = Incorrect

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

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

CIRCULATOR (b)(6)-2 1LT [redacted]

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

[redacted]

(b)(6)-4

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

☒ ESU NO: #3 Cut 30 Coag 30
GROUND PAD: BRAND VL PEM Polymer Pad
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA F MEDCOM - 17485 S OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* fluffs. kerlix. ACE 4x8 on neck wound

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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

(b)(6)-2 DA5179 initiated

20. OPERATION(S) PERFORMED I&D / ~~fasciotomy~~ Right leg
Neck exploration

21. PATIENT TRANSFERRED TO ICU2 TIME See DA7359 METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT MEDCOM - 17486 USAPA V1.01

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 25 Aug

19 | HOUR: 0800

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD — Bp 96/66

BLOOD PRESSURE — P 89; T 98.1; pL 160

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3

POST-OP DAY

MONTH-YEAR: Aug 2003 | DAY: 19 20 21 22AUG03 23AUG03 24 Aug | HOUR: 0800 2100 0800 1800

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° / 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 →

O_2 sat

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. ICU 2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17488

Ward/Section: ICW2	REQ. TESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 21 Aug 03	TIME: 0800
		SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	/	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 21 Aug 03	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 17 Aug 05	TIME 0130	SSN/PSEUDO SSN: —

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Yes	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Yes	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Yes	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.015	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Small	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	5.0	N/A	Micro Parasites		
Segs		Mono	Prot	~~Trace~~ Negative	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Yes	Negative	Other		
Atyp		Imm	Leuk	—	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

CSF		
Cell Count		
Directigen		Negative

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

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

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 17 Aug	TIME 0004	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		26-8
ALT		10-4
AMY		14-9
AST		11-3
TBIL		0.2-1.
BUN		7-22
CA^{++}		8.0-1(
CHOL		100-2(
CRE		0.6-1.
GLU		73-11
TP		6.4-8.1

(Piccolo) Metlyte 8

TEST	RESULT	R RA
GLU		73-118
BUN		7-22 m
CRE		0.6-1.2
CK		39-380 30-190
NA^+		128-14
K^+		3.3-4.7
CL^-		98-108
tCO_2		18-33 m

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
17/08/03 01:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	142*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	302	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	104	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: (b)(6)-2 [redacted]	DATE: 17 Aug 03	LAB ID NO.:

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

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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	16.0	9.8-13.6 secs
APTT	28.9	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY [redacted] (b)(6)-2	**DATE:** 17 Aug	**LAB ID NO.:**

Ward/Section: ICU 3	REQUESTING PHYSICIAN: Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted] (b)(6)-4	DATE 17Aug03	TIME 0805	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 8-17-03	**LAB ID NO.:**

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
GI		
BI		
CA		
CR		
NA		
K+		
CL		
tCC		
TI		
ALI		
ALI		
ALT		
AM		
AST		
TBI		
GGT		
TP		
TE		
NA+		
K+		
CL-		
tCO_2		

======= PICCOLO =======
17/08/03 08:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	116	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	697*	39-380	U/L
NA+	132	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	21	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
17/08/03 08:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	50	26-84	U/L
ALT	17	10-47	U/L
AMY	16	14-97	U/L
AST	28	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.3	8.0-10.3	MG/DL
CHOL	108	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.7*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Tobacco

MEDICAL RECORD - ANESTHES'

...f this form, see AR 40-66; the proponent age... ...ie OTSG

NKDA

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

DRUG (Units)										
Versed (mg)	2-1		Propofol (mg)			30				
Fentanyl (mcg)	100	150			50	50	25			
Lidocaine (mg)	100									
Ketamine (mg)	80									
Sux (mg)	100									
VCIS (I)		5		5						
VOLAT AGENT Iso % del		1.5	1.0	1.2	1.2	1.2	1.5	X	1.5	1.0 X
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	10	2	2	2	2	2	2	2	2	2

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

FLUIDS

LINE site 18G-R AC ☒ Warmed	NS	500						500		
18G-L HD ☒ Warmed	LR #1							1000		
☐ Warmed										
☐ Warmed										

LOSSES

EST BLOOD LOSS		5				50				
URINE -		500								

TOTALS	TOTAL EBL
3/30	<100
375	
100	TOTAL URINE
80	550
100	
10	

FLUIDS SUMMARY

CRYSTALLOID- 1500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment 18G PIV (L) hand
(2) Room, monitor O2 induced eyelids taped + DO placed
(3) I+D (R) tibia + Neck exploration started
(4) Reversed Neostigmine 5mg + Glycopyrrolate 0.8mg
(5) Extubated ETCO2 c50; TV 700ml RR 28 + L30

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 40

INITIAL DATA:

BP- 106/66

HR- 83

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (b)(6)-2 ANES- X-X PROC- ⊙-Ø

TIME- 0380

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) ╪ | TOURNIQUET T—T

TIME → 0330 · 0400 · 30 · 0500 · 30 · 0600

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	—	820	830	860	860	870	810	240	360
f - breaths/min	—	10	8	7	7	7	7	18	14
Peak inf pres / PEEP	—	25	23	23	23	24	23		—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S/A	S

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	+	35	31	32	33	33	33	48	48
BP/oth — FIO2 (Frac or %)	6.75	0.75	0.75	0.75	0.76	0.75	0.77	0.79	0.79
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	SR	~	SR	~SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site	available				34	34	34	34	34
N-M Block (T/4)	—	4/4	—	4/4	0/4	0/4			Suct Ready
BS									
Warming blkt	x1 blanket →								
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) Head 45° (3) (4) (5)

RECOVERY AT 0545

PACU (ICU) 3 (Specify)

OTHER 97.9

CONDITION: Stable

RESP- 18 SpO2- 99

BP- 137/72 HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0315	0340	0554
PROC	Ready	Begin	End
	0350	0410	0535

PROCEDURES and CPT Codes: I+D (R) arm + I+D (R) tibia & cast
Zone I neck exploration I+D (L) finger

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* RSI c cricoid
G-ETA

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

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DL x1 MAC 4 Grade I view 8.0 styletted 24cm @ lips
10ml air cuff; + BBS; Sust ETCO2

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

ANESTHETISTS: [redacted] MAJ/CRNA

PROCEDURE LOCATION: 2

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — ME[redacted] COPY [illegible] PATIENT'S MEDICAL RECORD — USAPA V1.00

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

17 Aug 13.5 / 35.2 (197 Tobacco IVPB Ancef

MEDICAL RECORD - ANESTHESI

...e of this form, see AR 40-66; the proponent ager... ...ne UTSG

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)							TOTALS
Versed (mg)	3						3
MsO4 (mg)	5 ~ 5 ~ 3 ~ 4						17
Ketamine (mg)	<50>						50
Glycopyrrolate (mg)		0.2					0.2
Propofol (mg)			20				20
( )							

TOTAL EBL: <50

TOTAL URINE: 100

VOLAT AGENT: Iso							
% del	~ 2.0	~ 2.0	- 2.0	~ 1.8	1.5	X	
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	10 ~ 2	~ 2	2	~ 2	2	10	

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

FLUIDS SUMMARY
CRYSTALLOID- 300
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site 18G (L) A [X] Warmed — LR #1 ——— 200
[ ] Warmed
[ ] Warmed
[ ] Warmed

LOSSES

EST BLOOD LOSS
URINE - 100

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

BODY WEIGHT: 80 KG

HEMATOCRIT: 35.2

INITIAL DATA: BP- 122/70 HR- 85

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? [redacted] (b)(6)-2 TIME- 1400

TIME: 1415 · 1500 · 30 · 1600 · 30 · 1700

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

Grid annotation: Rfid foley

VT - ml	450	390	420	440	430	560-600	
f - breaths/min	18	18	10	13	11	12	
Peak inf pres / PEEP	—	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S ~	C ~	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		35	33	36	40	43	48
✓ BP/oth	✓ FIO2 (Frac or %)	0.65	0.65	0.65	0.60	0.64	0.63	0.63
ART line	✓ SpO2 (%) 93	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR ——→			SR	SR	SR	SR
Gas analyzer	✓ TEMP-site available ——→							
	✓ N-M Block (T/4)							
	BS	+	~	+	+	+	+	
✓ Warming blkt	x1 wool blanket ——→							
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS ① ② ③ ④; Position — Turned 45°

REMARKS

Code drugs with numbers, events with letters

① Pre-op agree c 1st pre-op. Lungs CTA(?) RRR (?) 18G (L) AC patent
② Room, monitors, O2. Induced, eyelids taped
③ SV TV 74ml/kg foley D/c'd per Dr. [redacted] (b)(6)-2 to litter, to ICU-3 Pt removed OA + NP tube
④ Report to RN O2 SF MC SaO2 97% to 98%

RECOVERY AT: 1600

PACU (ICU 3) (Specify) T-982

OTHER

CONDITION: Stable, sedated, arousable

RESP- SpO2- BP- 132/71 HR- 94

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1410	1420	1610
	Ready	Begin	End
PROC	1430	1450	1555

PROCEDURES and CPT Codes: I & D multiple shrapnel wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — 40 OA to RL OA 90mm, NP tube 34FR + BBS; sust ETCO2

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

[redacted] (b)(6)-4

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

PROCEDURE LOCATION: 1

DATE: 19 Aug 03

[redacted] CRNA / MAJ

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 17496 (b)(6)-2 PATIENT'S MEDICAL RECORD USAPA V1.00

PRE-ANESTHETIC ASSESS AND PLAN OF CARE

AGE: 44 Days Mos (Yrs) GENDER: (X) Male ( ) Female ALLERGIES: NKDA

PS: 1 (2) 3 4 5 (E)
WT: 80 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: Neck Exploration (R) elbow I+D; (R) leg (tibia) Ex Fix
SURGICAL SERVICE: Ortho / General Surgery
NPO SINCE: Full Stomach

PREOP DX / MECHANISM OF INJURY: Mortar Shrapnel Wounds to Right Elbow, (R) leg-tibia and right neck

HABITS:

Tobacco: yes
EtOH: No
Drugs: No

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Received Ancef 1g in ED
( ) tetanus .5cc
( ) morphine 10mg
( )
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

130	104	12	142
4.2	21	1.6	

19	12	217
	40	

Other: PT 16.0
PTT 28.9

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	7
Angina	N	Y	7
MI	N	Y	1
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	7
COPD	N	Y	1
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	7
Gastrointestinal:			
Hepatitis	N	Y	1
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	7
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	7
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	7
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	7
Other	N	Y	
Other Problems:	N	Y	1
Familial Hx 7,	N	Y	1

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

BP: 106/66 HR: 83 RR: 14 T: ____

Pain (0/10 Scale): ____

Airway Exam:
Dentition ok
Trachea midline
TMJ/C-spine Full Rom
Oropharynx MP II TMD 3 FB

Chest:
Lungs Vesicular BS (B)
Heart S1, S2

IV Access: 16g (L) AC

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: (Intubation) / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

Signed: (b)(6)-2 MD ( ) Sedated/nonresponsive/minor patient with no family or guardian present.
Date: 17 AUG 03 Time: 0245

PATI[redacted]

[redacted] ICU #3

(b)(6)-4

Nursing Unit: ICU 3

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

NURSING UNIT: 1CW#1 | ROOM NO. | BED NO.

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 0930 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Transfer to ICW 2 [redacted] (b)(6)-2
(2) Dx: s/p neck exploration, RUE wound
(3) Condition stable
(4) VS q shift
(5) Act: BSC
(6) NKDA
(7) Diet ~~regular~~ NPO for OR today

DATE OF ORDER | TIME OF ORDER ______ HOURS

(8) CWF - [illegible]
(9) Ancef 1gm IV q 8°
(10) Percocet [illegible] po q 4°

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

(b)(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19 AUG 03 | TIME OF ORDER ______ HOURS

✓ ICW-2
✓- Stable
✓- routine vitals
✓- OOB c crutches, NWB (R) LE
✓- PT for gait training
✓- Dressing Δ 48°
✓- Regular Diet

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

✓ - Clindamycin 300 mg po q 8°
✓ - Heplock IV
✓ - T#3 [illegible] po q 4° prn pain
✓ - MSO4 2-3 IVP q 1° prn breakthrough
✓ - Ambien [illegible] po QHS
✓ - Phenergan 25 mg IV q 6° prn nausea
- I.S. at bedside, instruct use

NURSING UNIT: 2FVS | ROOM NO.: 2030 | BED NO.

19 Aug 03 [redacted] (b)(6)-2 [redacted]

DA FORM 4256, 1 APR 79 | REPLACES EDITION [redacted] WHICH MAY BE USED. (b)(6)-2

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

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

MEDCOM - 17498

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)-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | DATE TIME ORDER NOTED AND SIGNED

17 Aug 03 0149 HOURS

Admit to ICU 3

Dx: neck/arm/abd shrapnel wounds

Condition Serious

IVF LR @ 125 cc/hr

NPO

Ancef 2 gm IVPB q 8°

MSO4 2-6 mg IVP q 2° PRN pain

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

Foley to gravity drainage

VS q 1 hr

Continuous Pulse oximetry

O2 NC 2L titrate to keep O2 sat 94%

Phenergan 12.5 mg IVP q 6° PRN nausea

pre-op

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

NICDA

HOURS

[redacted] (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug 03 | TIME OF ORDER: ______ HOURS | LIST TIME ORDER NOTED AND SIGN

1) To ICU 3
2) Dx S/P [illegible] RUE, RLE [illegible] Neck exploration
3) Cardiac [illegible]
4) Vitals Q1° X6 then Q4° [illegible]
Neurovascular Check
5) Activity Bedrest

DATE OF ORDER | TIME OF ORDER

6) Diet advance as tolerated
7) IV LR at 125cc/h
heplock when taking PO
well
8) I's & O's
9) Incentive Spirometry 5X Q1° While Awake

DATE OF ORDER | TIME OF ORDER ______ HOURS

10) MEDS
MSO4 2-8mg IV Q1-2° prn
* Zofran 4mg IV Q6° prn [illegible]
Ancef 1gm IV Q8°
11) labs CBC, Chemistry [illegible] in AM
[illegible] in AM
12) Call MD T > 101.5, SBP > 180

DATE OF ORDER | TIME OF ORDER

< 90, UOP < 30cc/h ______ HOURS
13) Foley to gravity

[redacted]

(b)(6)-2

part of [illegible] [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

24 hr CC Done 18 Aug 03 @ 0030 hrs [redacted] CPT [illegible] / AW

(b)(6)-2

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

MEDCOM - 17500

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	8/22/03	1400 HOURS	
	① PT for crutch training today		
	[redacted] (b)(6)-2		
NURSING UNIT: [illegible] ROOM NO.: [illegible] BED NO.: 155			
PATIENT IDE [redacted] (b)(6)-2	DATE OF ORDER 8/23/03	TIME OF ORDER 0700 HOURS	
# [redacted] (b)(6)-4	D/C to EPW Camp today		
	[redacted] (b)(6)-2		
NURSING UNIT: ICU #1 ROOM NO.: [redacted] (b)(6)-2 BED NO.: 3800			
PATIENT IDENTIFICATION [redacted] (b)(6)-2	DATE OF ORDE [redacted] (b)(6)-2	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.	
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.	

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

MEDCOM - 17501

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. 08

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19 20 21 22 23 24 25
19 Aug	[redacted] (b)(6)-2	Clindamycin 300mg PO q8°	8 / 16 / 24	[redacted]
19 Aug	[redacted] (b)(6)-2	IV-heplock	05 / 13 / 21	[redacted] dc 21 AUG 08
19 Aug	[redacted] (b)(6)-2	Ambien 10mg po QHS	22	[redacted] all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO — unk

PRIMARY DIAGNOSIS: S/P neck exploration, RUE

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 - 17502

PRN meds

Tylenol #3 ii po q4° prn pain	ii po 2145 20 Aug [redacted] 21 Aug 0015 ii po [redacted] (b)(6)-2
MSO4 2mg IVP q1° prn break-through pain	(b)(6)-2
Phenergan 25mg IV q6° prn nausea	

MEDCOM - 17503

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 19 20 21 22 23 24 25 26 27
19 Aug	[redacted]	VS routine	05	[redacted]
			13	
			21	
19 Aug	[redacted]	Ltr crutches, NWB RLE	09	[redacted]
			13	
			21	
19 Aug	[redacted]	PT for gaiting SE	10	[redacted]
19 Aug	[redacted]	Regular diet	06	[redacted]
			12	
			17	
19 Aug	[redacted]	T Sat bedside	05	[redacted]
			13	
			21	

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P neck exploration

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Aug	(b)(6)-2	Admit to ICU 2	19Aug		1730	(b)(6)-2
19Aug	(b)(6)-2	D5 @ 45°	21Aug 08			(b)(6)-2
22Aug	(b)(6)-2	PT for crutch training today	22 Aug			(b)(6)-2
23 Aug	(b)(6)-2	D/C to EPW Camp today	23 Aug			

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

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL [illegible] A

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

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

OTSG APPROVED (Date)

Date: 17 Aug 07
Time In: 0555
Allergies: NKDA
Pre-op V/S: _____
Procedures: _____

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 Colloid _____
OR Output: UOP _____ EBL _____
Meds/Times: see OR Flowsheet

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	0545	0605	0610	0625	0640	0700	0805
SaO2				100	100	94	
FiO2				[redacted]	RL		
Methods				NRB	NRB	NC	
240							
220							
200							
180							
160							
140	V						
		V		V	V	V	
120			V				
100							
80	•	•	•			•	
	^	^	^	•	•	^	
60				^	^		
40							
20							
SPO2	98	100	100	100			
RR	25	15	22	16	16	15	
T	98.9	98.4	98.9	98.6	98.4	98.3	
Time	0640						
Pain (0-10)	NC						
LOS							

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
0705	LR	500	0930	[redacted]	200
				(b)(6)-2	

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

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

[redacted] EPW

(b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0555	7	see flowsheet				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	[redacted]	limited			≤3	warm	NFR
15'							
30'	[redacted]	limited	+	P	<3sec	warm	P
45'	[redacted]	limited	+	P	<3sec	warm	P
60'	[redacted]	limited	+	P	<3sec	warm	P
90'							
D/C	[redacted]	limited	+	P	<3sec	warm	P

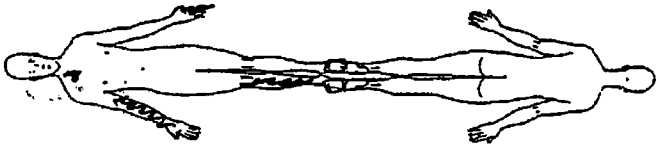
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'	[illegible]	[illegible]	[illegible]
60'	no Δ	no Δ	no Δ
D/C	no Δ	no Δ	no Δ



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0700	foley	clear/yellow	225

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0630	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

See progress note
0700 - Received report on pt @ 0625. Pt laying in bed w eyes closed & non-rebreather on. YSS. Arouses easily. Asked pt if he had pain and shook head - no. Neurovascular checks good. Able to feet move all extremities, cap refill <3sec all extremities, and sensation intact. Foley in place. IVF infusing. (b)(6)-2 [redacted] RN
0705 - Pt stable. Will be staying on unit. See DA Form 4700 for further data. [redacted] RN (b)(6)-2

Discharge Criteria:
Date: 17Aug03 **Time:** 0705 **PARS:** 10
BP: 128/75 **T:** 99.1 **HR:** 83 **RR:** 15 **Sa02:** 94%
Pain Level at D/C (0-10):
Intake: 200 **Output:** 225
Additional Data:
Transferred To: stay on unit
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room [redacted] 3 (b)(6)-2
Charge Nurse Signature: [redacted] RN

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

Date: 19 Aug 03
Time In: 1615
Allergies: NKDA
Pre-op V/S: 122/100 85
Procedures: I+D Graft RLE

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
80kg
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 100cc EBL 750cc
Meds/Times: 1g Ancef 3g versed 50g Ketam

Drains: Hemovac, NG, JP, T-tube, Foley D/C'd, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	1615	1800	
SaO2	98		
FiO2	NC		
Methods	RA		
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
RR	14	16	
T	98	98	
Time			
Pain (0-10)			
LOS			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE

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

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

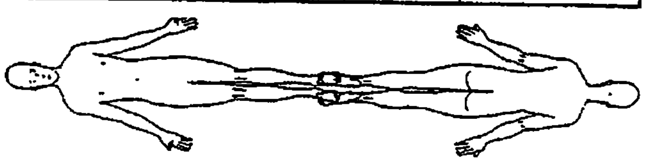
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1615
pt admitted to unit via litter. Sleepy but arousable. full leg cast on (R) leg cap refill < 3 sec pulse ox on (R) toe c̄ sat of 96 correlating c̄ finger pulse waveform present Pt on face mask @ 10 L. Pt able to move toes bilaterally on command. Occlusive dsg to (R) neck on clavicle. Occlusive dsg to (R) arm occlusive dsg on 2nd digit of 2nd finger on (R) hand. multiple wound on arms and torso open to air + healing
1700 condition stable for discharge from RR

Discharge Criteria:
Date: 19 Aug 03 Time: 1717 PARS: 10
BP: 136/78 T: 98 HR: 94 RR: 16 SaO2: 95
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICW 2
Report Given To: ICW 2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3[redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

P AL RECORD-SUPPLEMENTAL MEDICA 'A

For use of th... ..n, see AR 40-66; the proponent agency is the Office of ... ...geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0930 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	
	Sensorium	expresses needs appropriately	
	LOC / GCS	Ø c/o pain	
		MAE, able to move (R) toes	
CARDIAC	Cardiac Rhythm	S1S2 NSR Ø ectopy	
	PRI: / QRS:	+2 pulses x 4 ext	
	Pulse Strength		
	Cap Refil / JVD	Ø edema noted x on	
	Edema	shrapnel wounds	
	Chest Pain		
RESP	Respiratory Pattern	CTA bilaterally	
	Breath Sounds	even unlabored breathing	
	Secretions		
	Cough		
SKIN	Color	dressing on (R) neck CDI	
	Integrity	(R) hand dressing CDI	
	Backside	(R) leg dressing CDI	
		multiple shrapnel wounds throughout body	
IV	Access Devices	(R) AC PIV	
	Location	(R) hand PIV	
	Condition		
GI	Abdomen	+ BS x 4 quad	
	Bowel Sounds	soft, NT, ND	
	Stoma/Ostomy		
GU	Device	foley to gravity	
	Color / Clarity	dark yellow	

(Continue on reverse)

P[redacted]e & Title) [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted] (b)(2)-2

DATE: 19 Aug 03

PA[redacted]NTIFICATION *(For typed or written entries give: Name — last, first,* [redacted] *grade; date; hospital or medical facility)*

[redacted]

(b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17510

ACLU-RDI 1642 p.70

DOD-031099

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 19 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	122						99																			
NBP	70						52																			
TEMP	99						98.9																			
HR	85						94																			
RR	18						20																			
SaO2	97						96																			
FiO2	RA						RA																			
Source																										
MAP																										

NTAKE	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	Total
PB																										
T																										
PO		240																								
Total																										

TPUT	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					300																					
N																										
STOOL																										
DRAIN																										
Total																										

F ORD-SUPPLEMENTAL MEDICA TA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0620 Initals: [redacted] (b)(6)-2	Time: 1900 Initals [redacted] (b)(6)-2
NEURO	Pupils	Perrel 3mm, Alert. Moves all extremities	PERRLA
	Sensorium	Sensation intact. No problems swallowing	Intact.
	LOC / GCS	@leg in hard splint. @arm splinted. c limited rom. Little pain. c mvmt.	Awake; alert. GCS 15
CARDIAC	Cardiac Rhythm	Regular S1S2. Ø murmur. Radial pulses 3+ @ Pedal 3+. Cap refill <3sec all extremities. Trace edema @ foot.	NSR
	PRI: / QRS:		Ø
	Pulse Strength	Ø CP, Ø JVD	normal pulses — @2 Unable to assess RLE pulse. RUE c RLE warm to touch. Cap refill <2sec.
	Cap Refil / JVD		
	Edema		
	Chest Pain	@arm restrained (unsplinted) & @ankle restrained c verbal, CEPW)	full sensation
RESP	Respiratory Pattern	Regular, even, unlabored. Clear	normal on RA
	Breath Sounds	all lung fields c bases. Strong	LCTA (B)
	Secretions	cough. Able to clear secretions.	Ø
	Cough		Ø
SKIN	Color	WNL. Warm, dry. Shrapnel wounds	NFR
	Integrity	to chest. Dressed/clean. Bandage to @ supra-	Shrapnel lesions to ant. chest.
	Backside	clavicular area & @ pointer finger. Pam splint	intact c scratch marks
		@ leg splinted.	due to pruritus.
IV	Access Devices	@ wrist 18g SL. @ AC 18g SL. Ø s/s	@ wrist; @ ac PIV's 18G
	Location	of infection dressing intact.	↓
	Condition	flush c resistance	C, D, I
GI	Abdomen	Soft, non-distended. ABS x4.	soft nontender
	Bowel Sounds	Ø BM. Tender RUQ. Nontender	BS present x 4
	Stoma/Ostomy	LLQ, LQ, RLQ	Ø
GU	Device	Foley to DD. Clear yellow urine	Foley to gravity.
	Color / Clarity	Secured to leg. Ø drainage c insertion	Clear yellow adequate
		site	output

(Continue on reverse)

PRE[redacted]nature & Title) [redacted]LUT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted] (b)(2)-2

DATE: 18Aug03

PATIENT'S IDENTIFICATION *(For 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 - 17512

ICU3

Patients Name: EPW [redacted] (b)(6)-4 Date: 18 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	121/60					114/70				120/66								100/70				112/68				
TEMP	98.8					98.7				99.7								99.8				98.6				
HR	84					72				90								78				70				
RR	14					16				15								16				16				
SaO2	95					98%				95%								98%				94				
FiO2	0																					0				
S[illegible]e	RA					RA				RA								RA				RA				
I						89				88																

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	Tot
IVF																										
IVPB			50								50	100														
NGT																										
F		120					240					300														
[illegible]otal																										

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	Total
URINE	225					350						550	1125					200				[redacted]		150		350
N[illegible]																							(b)(6)-2			
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17513

DOD-031102

ACLU-RDI 1642 p.73

...CORD-SUPPLEMENTAL MEDICA

For use of t... ...n, see AR 40-66; the proponent agency is the Office of T... ...geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0900 Initals [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
NEURO	Pupils	3mm, PERRL. Alert. Obeys	Perrla A+O x3. Obeys
	Sensorium	commands. Speaks little English.	commands. Sensorium
	LOC / GCS	Sensation intact all extremities. Swallows	intact.
		difficulty. @arm, @leg in splints.	GCS 15
CARDIAC	Cardiac Rhythm	SR ectopy. S1 S2. Pulses 3+ @radial,	NSR S1 S2
	PRI: / QRS:	@radial, @pedal). Caprefill <3 sec all	ø
	Pulse Strength	extremities. ø JVD. Trace edema	normal pulse (2)
	Cap Refil / JVD	@leg & arm 2° around shrapnel	<3 all extremities
	Edema	wounds. ø CP.	mild c/i/w/d extremities
	Chest Pain		ø
RESP	Respiratory Pattern	Regular, even, unlabored.	normal on RA
	Breath Sounds	Clear all lung fields. PA sats	CTA (B)
	Secretions	>94%. ø cough	ø
	Cough		ø
SKIN	Color	WNL, splint & ace wrap to @arm/leg.	WFL
	Integrity	bandage & drainage to @supraclavicular	wounds to (R) UE & (R) LE
	Backside	area. bandage to @ pointe finger & drainage	intact.
		minimal. Small shrapnel wounds to	
IV	Access Devices	chest & ecchymosis. 18g to @wrist	(L) wrist 18 G, (L) AC 18 G
	Location	infusing LR KVO. 18g to @AC infusing @	↓
	Condition	125cc/hr. Both & s/s of infection. Dressing	C, D, I.
		intact.	
GI	Abdomen	Soft, nontender ABS x4. No BM	Soft nontender
	Bowel Sounds	this AM. Hasn't eaten since	@ x4 quadrants
	Stoma/Ostomy	surgery.	ø
GU	Device	Foley to DO clear yellow urine	
	Color / Clarity	tube secured to leg.	

(Continue on reverse)

PREPARED [redacted] (b)(6)-2 DEPARTMENT/SERVICE/CLINIC ICU3 [redacted] DATE 17 May 03

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

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

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17514

ICU Flowsheet Patient Name: Date: 08 / 17 / 2003

Vital 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									98.8	98.7	99.1			99.6	99.3	99.4					99.9			99.2		
Pulse									80	78	82			82	78	71					78			76		
B/P A-Line																										
MAP									88	97	91			85	82	99								87		
B/P Cuff									114/70	130/71	119/73			113/68	110/64	122/83				1	129/66			114/63		
Respirations									14	16	14			16	12	13					13			14		
Sa02									95%	96%	97%			97%	97%	96%					95% RA			95% RA		

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
									125	75	125	125		125	125	125										
B										50																
intake										20				240												
t. IN							1500																			
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									325	125/450	125/575	275/850		175/1025	100/1125									750		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

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

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 17515

MEDI
his fo

.ECORD-SUPPLEMENTAL MEDICA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0300 Initals [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	A&O x3	
	LOC / GCS	pt follows commands purposeful movement	
CARDIAC	Cardiac Rhythm	HR-72 BP- 112/63	
	PRI: / QRS:		
	Pulse Strength	Pulse present & strong x4	
	Cap Refil / JVD	Cap Refill ≤3 sec Ø JVD	
	Edema	Swelling to shrapnel sites	
	Chest Pain	Ø chest pain Pt Denies	
RESP	Respiratory Pattern	Regular RR-22 SpO_2 95% RA	
	Breath Sounds	CTA (B)	
	Secretions	Ø Secretions Ø cough	
	Cough		
SKIN	Color	Normal for Race	
	Integrity	shrapnel wounds throughout body	
	Backside	No breakdown	
IV	Access Devices	IV in (R) AC NS @ ~~125~~ cc/hr	
	Location	LV in (L) wrist LR @ TKO	
	Condition	both patent & infection/infiltration	
GI	Abdomen	Soft Flat nontender nondistended	
	Bowel Sounds	Bowel sound normoactive x4	
	Stoma/Ostomy	Ø ostomy Ø Stoma	
GU	Device	Foley to gravity	
	Color / Clarity	clear yellow no sediment	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU3, [redacted]

DATE
07 Aug 03

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

[redacted] EPW

(b)(6)-4

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17516

ICU3

Patients Name: EPW [redacted] (b)(6)-4 Date: 17 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																							112/63			
TEMP																										
HR																							83			
RR																							19			
SaO2																							96%			
FiO2																										
S[redacted]e																							RA			
I[redacted]																							82			

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	To
IVF																							125			
IVPB																										
NGT																										
F[redacted]																										
[redacted]tal																										

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	Total
URINE																							450			
NGT																										
STOOL																										
DRAIN																										
Total																										

(1500) IVF @ 125 cc/hr

PT to OR

PT to OR

PT to OR

MEDCOM - 17517

ACLU-RDI 1642 p.77

DOD-031106

ADMISSION AND CODING INFORMATION

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

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

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0149	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
	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 (YYMMDD)
05		030823

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030817

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

FOR LOCAL USE

DX: s/p neck exploration, RUE

Dx: 82390
8749
8821
E9919

Pr: 7966
8345

Inj Trauma
443 1

ADMITTING OFFICER (Signature, and Grade)	SIGNATURE OF ADMITTING CLERK
[redacted] (b)(6)-2	[redacted] (b)(6)-2

DA FORM 2985 [redacted]

MEDCOM - 17518

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

PATIENT'S IDENTIFICATION	DATE OF DISCHARGE	TIME OF DISCHARGE
#[redacted] (b)(6)-4	25 Aug 03	1350

SIGNATURE OF WARD OFFICER: [redacted] (b)(6)-2

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE 25 Aug 03

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

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 8-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

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
(b)(6)-4 [redacted]	EPW [redacted] (b)(6)-4		N/A	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	35y	Z	unk	N/A	N/A	NO
11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99 20.	(b)(6)-4 [redacted]	N/A	14 12
15. FLYING STATUS	16. RATING/ OSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78 ~~K79~~	N/A		WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0215	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	50	30 Aug 03

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

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

S/P I&D (R) leg + (L) FA

Trauma: 1

Inj: 449

Dx: 87352
87330
87359
E9919

PR: 2181
8659

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	14	14

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	14	14

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER
[redacted] (b)(6)-2	For [redacted] (b)(6)-2

DA FORM 3647, MAY 79 (b)(6)-2

MEDCOM - 17520

USAPPC V1 10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] S/P [illegible]

[illegible]

[illegible]

PHYSICAL EXAMINATION

[illegible]

(1) [illegible]

(2) [illegible]

[illegible]

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

(b)(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	[illegible]		

PATIENT'S IDENTIFICATION [redacted] written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-108

[redacted]

(b)(6)-4

MEDCOM - 17521

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

17 AUG 03 @ 0154

OMFS Brief OP NOTE

Pre OP dx: facial lacs S/P mortar round attack

Post op dx: Same

Procedure: Closure of facial lacs

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

Findings: multiple shrapnel wounds c Right nasal laceration, left temporal + left frontal lac.

Anesth: GETA

Cond: Stable

and remained under general anesth for completion of Ortho SL.

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

OMFS

17 AUG 03 0218

Ortho Op Note

Pre Op Dx (1) Multiple fragment wounds

~~Post Op~~ (2) (R) leg compartment syndrome

(3) (L) volar forearm compartment syndrome

Post Op dx - same

Procedure: (1) I+D of wounds

(2) (R) leg 4 compartment fasciotomy with

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

MEDCOM - 17522

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ligation of popliteal vein.
	(3) (L) volar forearm fasciotomy
	Surgeon: [redacted] (b)(6)-2
	EBL - 300 FLUIDS - 2000 crystalloid
	Findings - Popliteal vein injury, ligated. 4 compartment fasciotomy with good results. Volar forearm fasciotomy with good results
	PLANS: DPC in 48 hours.
	[redacted] (b)(6)-2
	Brief Operative
FEB 03	Pre-Op Dx: open wound (R) leg, (L) forearm, post fasciotomy, (L) thigh abscess
	Post-Op Dx: same
	Procedure: I&D & DPC (R) leg (L) forearm, (L) thigh
	Surgeon: Oliveira
	Assist: [redacted]
	Anes: general
	Cx: 4
	Path: [redacted] (b)(6)-2
	1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17AUG03 0230	pt arrived to ICU2 for Recovery. monitors Applied. S/P I+D of (L) forearm wound, +(R) lower extremity. Neuro - A+O. (R) p.p.l. 2mm reactive c scleral edema (L) eye pupil 2mm reactive, CV capillary refill <3sec x 4 distal extremities S1 S2 present. Resp 18 on RA c sats 96% Lungs clear in uppers diminished in bases GI: BS(+) 4quads. GU: Foley to gravity c QS clear yellow urine. Lines 2 PIV's upper (R) extremity. VSS. [redacted] (6)(6)-2

	0253	0238	0248	0258	0315	0330	0400
HR	118	99	87	98	68	64	61
B/P	115/76	125/72	129/62	122/80	103/58	100/56	
RR	18	16	18	21	20	20	21
SATS	100	99	96	99	97	96	97
MODE	FM	FM	RA	RA	RA	RA	RA
Temp	95.6		97.6				97.8
UOP		50/50					200/250

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17AUG03	DATE [illegible] INITIALS [redacted] (b)(6)-2
0600	[illegible]
	DATE 17AUG03 INITIALS [redacted] (b)(6)-2
	pt Alert. VSS. MAE. follows simple commands. pupils 3mm brisk. (R) eye echymosis to lid and sclera edema. CV: S1 S2 present 2+ pulses x4 quads. ø edema noted. capillary refill <3sec x4 distal extremities. Resp: even & unlabored. O2 SATS 96-98% RR 18-22. Lungs CTA. GI: BS (A) x4 quads tol clear liquids. ø emesis this shift. GU: Foley to gravity draining QS clear yellow urine. Lines: (R) forearm flushes well. ø S/S infection. Integ: warm & dry dsg's to (L) arm & (R) Leg. will continue to monitor.
	[redacted] (b)(6)-2 CPT/AN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
[illegible]	[redacted]		
SPONSOR'S NAME	SSN/ID (b)(6)-2	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

1

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*																
	05	06	07	08	09	10	11	12	13	14	15	16	17	18	→19	20	21	22
B/P	97/[illegible]	100/60	109/58	111/60	114/64	127/71	114/64	110/54	116/54	112/53	115/62	107/55	118/56	110/62		115/60		117/57
HR	71	67	57	56	63	63	76	94	92	94	92	96	92	92		76		81
RR	18	18	18	19	16	17	18	20	17	20	16	18	19	14		19		20
SAT	99	99	97	96	98	98	99	100	95	96	95	96	97	94		98		98
O_2																		
MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA		RA
Temp	98.8									100						99.2		
IN's																		
100				sips					sips				240			sips		sips
OUTs																		
Foley						600		300		350		150		150		250		300

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-800/50618

MEDCOM - 17526

ACLU-RDI 1642 p.86

DOD-031115

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
17 Aug 03	0600 See ICU-2 flowsheet for initial assessment. (b)(6)-2 [redacted] RN
	0640 Cleansed body of old dried blood. [redacted]
	(b)(6)-2
	0800 2mg MSO4 given IVP. c/o pain [redacted]
	(b)(6)-2
	1030 VSS, afebrile (b)(6)-2 [redacted] RN
	1530 [illegible] [illegible] to foot @ R leg c/o pain. ACE wrap removed. (b)(6)-2
	replaced again c less tension [redacted] RN
	1600 Cl. liquid diet, tolerated well [redacted] RN
	(b)(6)-2

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

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

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

(b)(6)-4

[redacted]

17 Aug 03

PROGRESS NOTES
Medical Record

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

MEDCOM - 17527

DATE	NOTES
13AUG03	or 040 staff Wounds clean well Cleaned DPC tomorrow (b)(6)-2 [redacted]
24AUG03 0959	Ortho Op Note Pre-Op Dx - Compartment Syndrome (R) leg Post-Op Dx - Same Procedure - DPC (R) leg, debridement wounds Surgeon - [redacted] (b)(6)-2 Anesthesia - General Findings - Medial incision closed without difficulty. Lateral incision closed with additional sutures. Plan - Wound care. [redacted] (b)(6)-2

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Aug03	[illegible] assumed care, [illegible] at [illegible]
	see TW-2 flowsheet for initial
	assessment (b)(6)-2 [redacted]
	0830 Update given to Dr. [redacted] (b)(6)-2
	orders received (b)(6)-2 [redacted]
	1050 MSO4 5mg IVP given c/o
	(R) leg pain. (b)(6)-2
	1340 Dr. [redacted] @ bedside,
	speaks c pt about I&D tomorrow; NPO p MN (b)(6)-2 [redacted]
2020	A+O, follows commands. $S_1 S_2$ Ø murmur, (R) hand +
	(L) foot cap refill < 3 sec, MAE, pulses 2+ (R) UE + (L) LE
	PIV (R) hand patent Ø S/S$_x$ infection. LSCTA resp reg
	unlabored. VSS. (+) BS x4 quads Foley drng cl yellow
	sufficient amts. Tylenol for c/o headache given c good
	effect. Dsg to (L) arm CDI. (R) LE elevated c dsg
	noted to have mod amt serosanguinous drng.
	Will monitor. (b)(6)-2 [redacted] 1LTAN
19AUG03	Pt sleeping - VSS. Plan for I+D of (R) LE in AM
0400	NPO since midnight. Will monitor. [redacted] 1LTAN (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 - 17529

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-Aug-03	Pt recovered, had I+D of (L) upper extremity and (R) LE.
1015	Pt Alert verbal c translator, Resp even non-labored.
	Lungs CTA (B), ⊕ cough ∅ secretions, Pulses LUE + RUE +2
	RUE + LLE +3, NSR s ectopy, saline lock in (L) hand. ABD-NT, ND
	BS x4, Foley d/c'd, had 100 cc clear yellow urine. Remaining
	Dressings to (L) shoulder (L) thigh and LUE + LLE C/D/I.
	(R) LE ↑. Will monitor. VS 122/71-87-14-98.4-95% SpO2 on RA.
	[redacted] SSG [illegible]
	(b)(6)-2
19 Aug 03	Assumed care @ 1030. pt awake lying in supine
	position. Does not speak English but able to
	follow commands. Requested something
	for headache 30 minutes ago and medicated
	by SSG [redacted]. HOB ↑ 45°. See initial assessment
	on DAF 4700. Encouraged to use incentive
	spirometry. Able to raise all three balls and
	hold for 1 min x10 times. Brushed teeth.
	No signs of distress or agitation noted.
	(R) leg drsg dry & intact. ↑ edema to (R) foot
	warm to touch compared to (L) foot. Tender to
	light palpation. [redacted] [illegible]
19 Aug 03	(b)(6)-2
11 30	Complete bath given. OOB to chair. Pt
	able to stand c (L) ~~foot~~ leg. [redacted] tolerance. cont

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP
		[redacted]

(b)(6)-2

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

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)
19 Aug 03	sitting in a chair. Bacitracin applied to (R) nose d/t to canker sore. no sign of infection noted @ this time. no resp distress noted. Breathing unlabored. RR 14 SaO2 100%
1345	on RA. pt requesting to get back into bed. pt able to brace and support self back into a bed. no other c/o noted [redacted] (b)(6)-2
1600	Flushed (R) hand heplock. Ancef ÷ gm IVPB infusing over 30'. Pt c/o (R) foot & swelling. T (R) leg to L swelling. no other discomfort. pt resting quietly. Lungs remain CTA bilaterally. SaO2 100% [redacted] (b)(6)-2 MHSq
1720	ordered to transfer pt ICU 2. pt to be transferred via litter to ICU2. VS HR 104, BP 105/55, RR 14 SaO2 97% [redacted] MHSq RN
1730	Admitted from ICU2 in stable condition. Lung CTA bilat, Ø resp distress. NSR. Abd soft non-tender, bowel sounds active x 4 Quads. Drsg to (L) Arm & (R) leg CDI. Ø Complaints [redacted] (b)(6)-2 10/RN
19 Aug 2312	Care assumed @ 2100. VSS, AOx3, ~~0/11~~ T3 given for pain @ 2200. Lung sounds CTA, pulses (+), bs (+) Pt c dsg on lle CDI, (+) pulse and ability to wiggle fingers on rle. Dsg on Rle CDI, (+) pulse and able to wiggle toes, R foot & has edema. PA on IV ABX, HL flushes well. Will continue to monitor. [redacted] (b)(6)-2 RN/C

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)*
20 Aug 03 0040	Pt. awake & alert c HEB @ 75°. HR Regular, Lung sands clear bilat, bowel sounds (+) x 4 quads. VSS. IVL in (R) hand & S/S of infection. Ace wrap to (R) calf CDI, pedal pulse palpable, (+) sensation, full ROM in digits, limited ROM in ankle, <3sec cap refill. Ace wrap to (L) FA CDI, cap refill <3sec full ROM of digits, limited ROM of wrist, (+) sensation. DSG to (L) shoulder CDI. 3 sutures to bridge of nose intact, site c S/S of infection. Pt. c complaints @ this time. Will continue to monitor. [redacted] (b)(6)-2
8/20/03	Staff cmnt Stay clear Begin wet to dry tomorrow [redacted] (b)(6)-2
20 aug 03 1330	Pt awake and alert. Lungs CTA bilat, no resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Dsgs to (L) arm and (R) leg CDI. Strong pulses and brisk cap refill x 4 extremities. Pt c complaint of n/a, given Tyl [redacted] (b)(6)-2 IVF
2315	Care assumed @ 2100. VSS, AOx3, c/o slight pain in RLE, on medicine regimen. Lung sounds CTA,

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

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

REGISTER NO.

WARD NO. ICU2

CPL# [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 - 17532

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	pulses (+) x4, bs active x4 quadrants. Dsg on (R) CDI, (+) pulse and sensation in (R) foot. Dsg on (L) FA CDI, pt able to wiggle fingers and has (+) pulse. Dsg on (L) thigh CDI. No complaints at this time, will continue to monitor. (b)(6)-2 [redacted]
21 Aug 03 0740	assumed care @ 0600 - VSS - no c/o pain @ this time - dsg intact on (L) FA & (R) calf - neurov's WNL in (L) hand & (R) foot, (+) movement, (+) sensation - SL patent in (R) AC - [redacted] (b)(6)-2
21 Aug 03 1500	Received pt via litter from A/E. Pt alert + oriented. Dsg to (L) FA, (L) [illegible]. (R) lower leg [illegible] [redacted]
21 Aug 03 0200	Assumed care @ 1900; All VSS, pt A&O, NVV WNL (+) movement & sensation; drsg to (L) FA & (R) LE CDI p drng; S1S2, (+) pulses x4, LS CTA (B) equal & unlabored; (+) BS x4, abd soft non-tender, pt voiding QS, clear yellow urine via urinal; Ø c/o pain/discomfort @ this time; cont to monitor [redacted] (b)(6)-2
21 Aug 03 @ 1000	A+O. VSS. Restraints removed & reapplied to (R) arm & (L) foot. Neurovasc ✓ WNL to all extremities. Lungs clear. BS (+) x 4 quadrants. Abd soft nondistend. Voiding clear yellow urine. Tolerating regular diet. Sutures intact to (L) FA incision. Ø drainage noted. 0.5cm opening midline of incision packing removed & replaced. Scant amt of drainage on old packing. (L) thigh incision c staples intact with 0.5cm opening midline incision. (R) lower leg with mango [illegible] in place & edges aligned with staples intact around edges. (L) [illegible] 0.5 cm wound cleaned c NS & redressed. All dsg [illegible]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

[redacted]

(b)(6)-2

MEDCOM - 17533

ACLU-RDI 1642 p.93

DOD-031122

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22Aug03		2100	Assumed care @ 1900; All VSS; pt A&O X3, NV ✓ WNL to all extremities, ⊕ movements/sensation; S, S2, ⊕ pulses x4 ☐ bris K cap Ref; LS CTA ⊕; ⊕ BS X4, abd soft non-tender, pt voiding QS, clear yellow urine via urinal; All dsgs CDI ⊖ for drug; sutures to frontal & ⓛ parietal region removed, along ☐ sutures along the bridge of nose ⊖ complication; ⊖ c/o pain or discomfort @ this time; Cont monitor (b)(6)-2 [redacted]
		2300	I concur ☐ above assessment. [redacted] CP
23 Aug	1000		Dr [redacted] (b)(6)-2 changed drsg to ⓛ lower arm and ⓡ lower leg. Drsg changed to ⓛ thigh and ⓛ shoulder. Tylenol 650 mg given for HA. Continues PO clindamycin and bacitracin well. Restraints removed and reapplied. Will check restraints frequently. Will continue to monitor [redacted] (b)(6)-2 CTR
23Aug03		2010	Assumed care @ 1900; All VSS; ⊕ movements & sensation, pt neurologically intact; S, S2, LS CTA ⊕; ⊕ BS X4, pt voiding QS, clear yellow urine via urinal; all dsgs CDI, ⊖ for drug; ☐ percs given for pain ☐ good relief; cont monitor [redacted] (b)(6)-2
23Aug03		2050	Restraints to ⓡ UE & ⓛ LE in place & compl; cotton/bris K cap Ref to all extremities; Cont monitor [redacted] (b)(6)-2
		2300	I concur above assessment. [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

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 - 17534

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24Aug03	1050		Return from PACU via litter VSS A&O. (R) FA IV patent & intact infusing LR @ 125cc/hr. Drsg to (R) (R) lower leg dry & intact. Lungs clear BS (+) x4 Restraints reapplied. Will check restraints frequently. Peripheral pulses palpable. Drsg to (L) FA / (L) thigh changed as ordered - also (L) shoulder. Will continue to monitor [redacted] 2LT AN (b)(6)-2
24Aug03		1930	Assumed care @ 1800; All VSS, pt A&Ox3, NV✓WNL (+) movement & sensation in all extremities; S, Sz, (+) pulses x4 ē brisk cap ref; LS CTA (B); (+) BSx4; SL patent & intact; all dsgs CDI s̄ drng; Restraints intact s̄ complication, brisk cap ref in those extremities; cont to monitor [redacted] (b)(6)-2
25Aug03	1100		Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ II Perc this am for pain c̄ good relief. Wet → dry drsgs on (L)UE and (R)LE Δd this am. Drsgs on (L) thigh and shoulder also Δd. All wound sites s̄ S/Sx infection. Pt moves all extremities well. Cap refill <2 secs. Voiding s̄ difficulty. Tol reg diet well. 2 point restraints in place. Will cont to monitor [redacted] (b)(6)-2
25Aug03		1900	Assumed care @ 1800; VSS, NV✓intact, (+) movement & sensation, in all extremities, dsg CDI s̄ drainage; ∅ S/Sx infection, Tol Reg diet, voiding QS s̄ difficulty; 2 point restraints intact brisk cap ref; cont to monitor [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20

STANDA[redacted]EV. 7-91) BACK (b)(6)-2

MEDCOM - 17535

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 Aug 03 0830	Pt received awake, alert, $S_1 S_2$ noted ± peripheral pulses ®, lungs CTA bilat, (A) bowel sounds, pt voiding QS. Dsg Δ to © shoulder, © FA, © thigh, © LE all 3, 3/5 intx. will cont. to monitor. [redacted] (b)(6)-2
28 Aug 03 1900	Pt received Awake and Alert in [redacted] bed. PERRLA. S_1, S_2 Present HRRR. ®2 Peripheral pulses Lungs Sand CTA through out. ®RS x4 quads. Dsg © Shoulder © FA © thigh © LE CDI. C/O small pain will continue to monitor. (b)(6)-2
29 Aug 03	Rec'd report on pt, c/o generalize pain, pt given Ti percocet @ 1110. Incis CTA BS (+) All dsg Δ ± minimal drainage. Dsg to © shoulder changed taken off and area cover. Pt tolerated reg meal for breakfast. H/L in ® forearm. West Restraint taken off for ATHcare. ⊖ skin breakdown. Will continue to monitor [redacted] (b)(6)-2
1500	Pt has med form BM pt used BSC. [redacted] (b)(6)-2
1535	Pt medicated per MD order ± Ti percocet for pain in ® leg. Monitor. [redacted] (b)(6)-2 9/WMA
29 Aug 03 1980	= VSS, A+O x3 C/O pain @ present, Dsg to © UE Δ'd ⇒ CDI. Dsg to ® LE CDI, neurovascularly WNL to ® LE ⇒ ® sensation, 2+ pedal pulse, 2+ edema to ® foot. Dsg CDI to © thigh. Continuing PO Clindamycin. ⊖ other remarkable assessment findings. Tolerates PO, good UOP. [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)

REGISTER NO

WARD NO. (b)(6)-2

PROGRESS NOTES
Medical Record

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

DATE

25AUG03 (1120) Assumed care of pt [redacted] shift. A&O, speaking some English. VSS. medicated c IV Percs this am for pain c good relief. Wet + dry dsgs &d on @UE and shoulder, @LE, [redacted] and @thigh. All sutures and staples intact. Φ S/Sx infection @ wound sites. SL in @ forearm flushes well c S/Sx infection/infiltration. Voiding c difficulty. Tol. reg. diet well. 2 point restraints in place. Am care done by pt this am. Will cont. to monitor. [redacted] WDAW (b)(6)-2

26 Aug03 @ 2000 Assumed care @ 1800; A&O x 3; pt A&O, Φ c/o pain or discomfort @ this time; All dsg CDI, Φ drainage noted; S1S2, LS CTA B; BS x 4, abd soft, pt voiding QS, clear, yellow urine c difficulty; HL in R FA intact, freely flushing c S/Sx infection; pt Tol Reg diet well; 2 point restraints intact, cap refill brisk; cont to monitor. [redacted] (b)(6)-2

27 AUG03 (1420) Assumed care of pt @ 0600 c report from night shift. A&O x 4, speaking Arabic. VSS. Pain controlled c Percs. Dsgs to @LE, @UE, @ thigh and shoulder &d this am. Φ S/Sx infection @ wound sites. SL in @ forearm flushes well c S/Sx infection/infiltration. A&O x 4 voiding c 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 check. Will cont to monitor. [redacted] WDAW (b)(6)-2

28 AUG03 0010 VSS. AO. DSG's CDI. to chest, @ arm and @ leg. Provided 2 percocets for pain. @ pulses to 4 UEs BLE. Resting comfortably in bed. [redacted]

[redacted] (b)(6)-4

(b)(6)-2

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 AUG 03 0800	VSS. Alert & Oriented. Drsg to (R) lower leg incisions. (R) lower leg incisions c [redacted (b)(6)-2] sutures intact & drainage noted edges approximated. (L) FA & (L) thigh incisions c staples intact & drainage noted. (L) FA incision with edges approximated packed 1.5cm opening adjacent to incision. (L) thigh incision edges well approximated except 1cm opening midway incision packed EW → Dry packing. Opening pinker. Pt ambulate c crutches to BR under supervision. (R) FA IV D/Ced diffficult to flush. Pt equate transport to EPW camp. [redacted (b)(6)-2] Antibiotic del to Keflex 250mg PO QID X 10 days. Will continue to monitor [redacted (b)(6)-2] 2LT R.
30 AUG 03 1240	D/C to EPW camp. MP [redacted (b)(6)-2] located. [redacted (b)(6)-2] 2LT HC

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 - 17538

NSN 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, Month, Year): 17 AUG 03 | TIME: 0015

TRANSPORTATION TO FACILITY

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		
34	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 INTITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: (R) leg injury (L) forearm

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 0030

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

VITAL SIGNS

TIME	0030				
BP	123/69				
PULSE	88				
RESP					
TEMP	97.8				
~~WT~~	160				

LAB ORDERS

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

X-RAY ORDERS

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

☒ PULSE OX

ORDERS

☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0030	Ancef 1gm IV	[redacted]	(b)(6)-2		
0030	Tetanus				
0030	Morphine 5mg	[redacted]	(b)(6)-2		
0045	Morphine 5mg	[redacted]	(b)(6)-2		

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted]

(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

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 34
HEIGHT: } unknown
WEIGHT: }

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): unknown

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

4. PROPOSED SURGICAL PROCEDURE: s/p multiple GSW / Blast injury
Emergency case

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed (yes) no Family waiting: yes (no) unknown

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	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.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	ø PT. will be able to breathe without difficulty during immediate intra-operative 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 integuity due to bovie pad; position; fluid shift	ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. MEDCOM - 17540 USAPA V1 01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communications. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

(b)(6)-2 [redacted] 117/AN 17 Aug03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and
[redacted] 117/AN	[redacted] 119/N
DATE: 17 Aug03 TIME: 0055 (b)(6)-2	DATE: 17 Aug03 TIME: (b)(6)-2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAO[illegible] TI[illegible] OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] (b)(6)-2

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0058

4. PATIENT IN ROOM TIME 0058 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Emergency case s/p blast injury

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

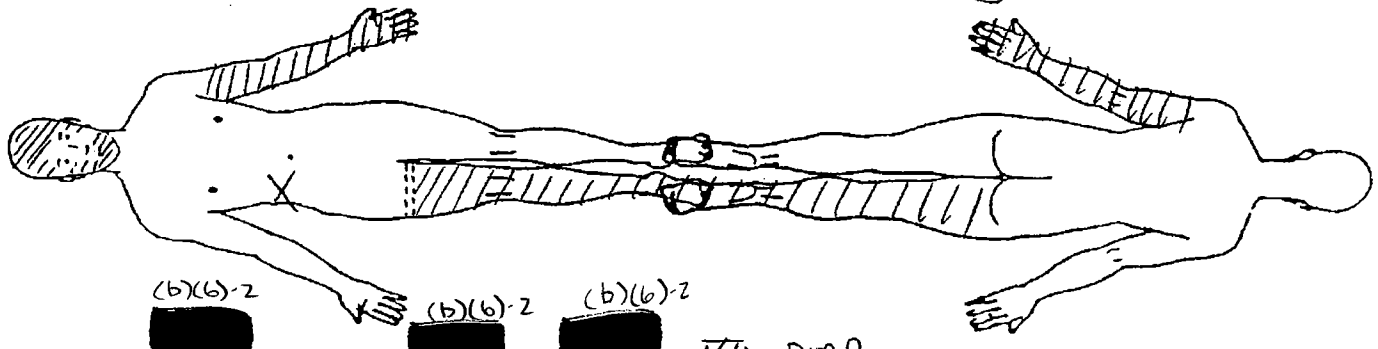
COMMENTS: Normal anatomic body alignment maintained

(b)(6)-2 8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: (R) leg & (L) FA No nicks or cuts

PREP SOLUTION (Specify) Betadine/Betadine
SITE: LFA & Right Leg BY WHOM: 1LT [redacted] (b)(6)-2
SITE: Chin & forehead BY WHOM: Dr. [redacted] (b)(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ===Tourniquet ▽/△ - prep

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

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

C = Correct I = Incorrect

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

CIRCULATOR (b)(6)-2 1LT [redacted]

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

[redacted]
(b)(6)-4

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

☒ ESU NO: #3 Cut: 30 Coag: 30
GROUND PAD: BRAND 68936
LOT NO: EXP 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — MEDCOM - 17542 — REPLACES DA [illegible] (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint LOT EXP AT DOD 10/05	Q.S.	intra-op	Topical application	MFR: [redacted] (b)(6)-2	Dr. [redacted] (b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

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

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)*

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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

Foley cath placed in EMT

DA 5179 Initiated

20. OPERATION(S) PERFORMED Fasciotomy Right leg and LFA, I&D of wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	0225	Litter

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

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

MEDCOM - 17543

MEDICAL RECORD — **INTRAO… TI…OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM TIME 0730 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

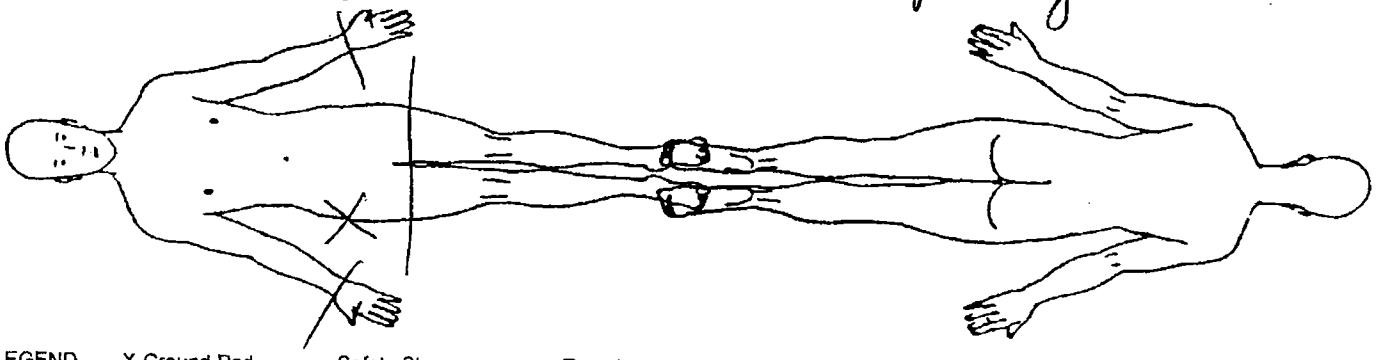
COMMENTS: Body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol
SITE: Lt arm BY WHOM:
SITE: Rt. ↓ leg BY WHOM: LTC [redacted] (b)(6)-2
COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted]
(b)(6)-4

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

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES DA [illegible] MEDCOM - 17544 IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr. [redacted] (b)(6)-2 Anesthesia: Maj. [redacted] (b)(6)-2 Anesthesia Type: GETA

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

Tourniquet Site intact pre-op NA: post-op NA

20. OPERATION(S) PERFORMED

I+D open wounds (R) ↓ leg + (Lt) arm + (Lt.) thigh wound plus DPPC

21. PATIENT TRANSFERRED TO ICU 2 TIME 0855 METHOD via gurney

22. REGISTER[redacted]GNATURE: LTC, AN

REVERSE OF DA FORM 5179-1, OCT (b)(6)-2

USAPA V1.01

MEDCOM - 17545

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

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

3. DATE 24 Aug 03 TIME PATIENT ARRIVED IN SUITE 0845

4. PATIENT IN ROOM TIME 0845 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted] (b)(6)-2	RELIEF CIRCULATOR	MAJ [redacted] (0930 - End) (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify)

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

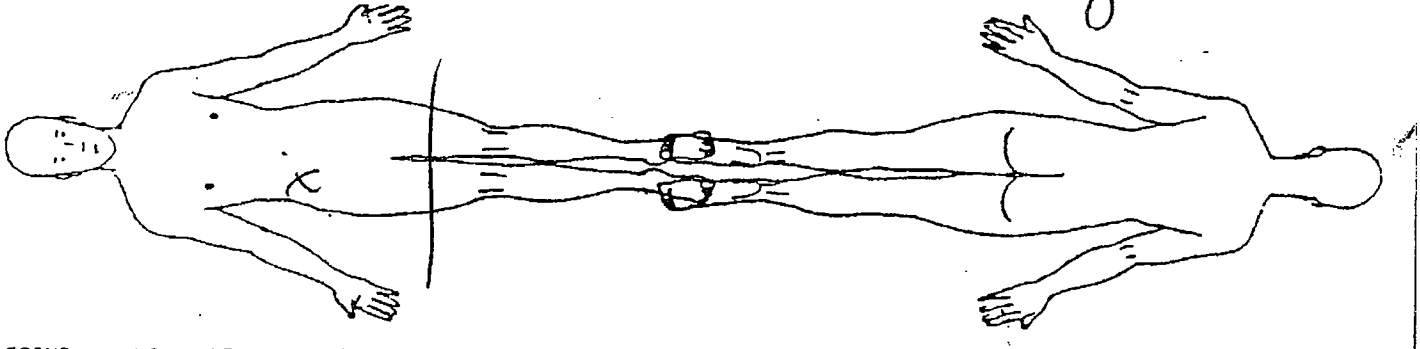
COMMENTS: Body maintained in correct alignment

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine soap/sol
SITE: (R) leg
SITE:
BY WHOM: LTC [redacted] (b)(6)-2
BY WHOM:
COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted]
(b)(6)-4

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

☒ ESU NO: Valleylab Force 40 mL
GROUND PAD: BRAND Polyhesive REM II
LOT NO: 69671

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO: (Bovie ESU not used)

MEDCOM - 17546

13. PROSTHESIS, IMPLANTS ☐ YES [illegible] IF YES NAME; ID NUMBER; M[illegible] ER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT [illegible] ANESTHESIA) YES ☒ NO ☐

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix roll

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] (b)(6)-2
Anesth: Cpt. [redacted], CRNA
(b)(6)-2

20. OPERATION(S) PERFORMED
Delayed Primary Closure of Fasciotomy @ R leg

21. PATIENT TRANSFERRED TO ICU TIME 1000 METHOD via Gurney

[redacted], LTC, [illegible] MEDCOM - 17547

REVERSE OF DA FORM 5179-1, OCT 8[illegible] USAPA V1.01

(b)(6)-2

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19

DAY

HOUR

PULSE (O)

TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU2

BPW [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 - 17548

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

(b)(6) -4

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

MEDCOM - 17549

ICU1

Patients Name: [redacted] (6X6)-4 Date: 8 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																			120/66						110/66	
TEMP																			98						98.3	
HR						80				94									80						82	
RR						20				16									18						18	
SaO2						99				95									97						100	
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	T
IVF																										
IVPB			50								50		100							50						
NGT																										
P																										
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	Total
U[illegible]			800				100				100		1300						800						500	
NGT																										
STOOL																										
DRAIN																										
Total													1300													

MEDCOM - 17550

DOD-031139

ACLU-RDI 1642 p.110

ICU1

Patients Name: [redacted] (b)(6)-4 Date: 19-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	119/60	119/59			130/78	112/60			108/60		102/60															
TEMP	99°	98°			98.4	98.4																				
HR	78	79			92	89			98		104															
RR	20	21			16	14			14		12															
SaO2	100	100			95	98			96		97															
FiO2	~~RA~~																									
Source	RA	RA			RA	RA			RA		RA															
MAP	83	79			90	78			78		95															

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	T
IVF	~~0~~	0	0		0																					
IVPB	~~0~~	0			0						50															
NGT	~~0~~	0	50		0																					
PO	~~100~~																									
PO	~~100~~	NPO	0		~~50~~	170			100																	
tal																										

PUT	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	Total
E	200	300			100																					
NGT																										
STOOL			150																							
DRAIN																										
Total	200	300			~~150~~																					

MEDCOM - 17551

DOD-031140

ACLU-RDI 1642 p.111

Ward/Section:	REQUESTING PHYSICIAN: (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE: 10AUG 0830	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)

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

~~MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED~~

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	17.3	9.8-13.6 secs
APTT	26.2	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY [redacted] (b)(6)-2 | **DATE:** 17 AUG | **LAB ID NO.:**

Ward/Section:	REQUE [redacted] (b)(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] (b)(6)-4		DATE 17 Aug 03	TIME 0030	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/
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. RANG.
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
17/08/03 01:29
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.1*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	18	10-47	U/L
AMY	29	14-97	U/L
AST	21	11-38	U/L
TBIL	0.3	0.2-1.6	MG/DL
BUN	13	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	♦♦♦	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	150*	73-118	MG/DL
TP	5.7*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
17/08/03 01:28
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	146*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	257	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 17 Aug 03	**LAB ID NO.:**

Ward/Section: ICU #2	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EDW [redacted] (b)(6)-4	DATE 17AUG03	TIME 0800	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

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

(b)(6)-2

Ward/Section: FCU3 | REQUESTING PHYSICIAN: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

(b)(6)-4 LAST, [redacted] (b)(6)-4 | DATE: 17AUG | TIME: 1400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
Sed Rate		
Other		

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | **DATE:** 17AUG13 | **LAB ID NO.:**

Jolacco

MEDICAL RECORD - ANESTH

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

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)							TOTALS
Fentanyl (mg)	50-50	100	50-150	-50			450
Lidocaine (mg)	50						50
Propofol (mg)	170-30			70			270
Sux (mg)	80						80
VCB (mg)	5		2				7

VOLAT AGENT	Iso % del	1.5 ~1.5	1.0	1.0	1.0	1.5	X
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	10	2	2	2	2	2	10

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

TOTAL EBL: 500

TOTAL URINE: 350

FLUIDS SUMMARY
CRYSTALLOID- 2000 [redacted]
COLLOID- Ø (b)(6)-2
BLOOD- Ø

FLUIDS

LINE site #1 PIV (R) A ☑ Warmed — #1 ——— 800 — 1000

#2 PIV (R) A ☑ Warmed — #2 ——— 600 — 1000

☐ Warmed

☐ Warmed

L 2 SMT

LOSSES

EST BLOOD LOSS — 500 — 500

URINE - 300 — 350

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

BODY WEIGHT: 84 (KG) LB

HEMATOCRIT: 36.5

INITIAL DATA:
BP- 103/60
HR- 91

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE [redacted]
TIME- 0000

TIME: 0045 · 0100 · 30 · 0200 · 30 · 0300

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; (b)(6)-2; ANES- X-X; PROC- ⊙-Ø

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

VENTIL

VT - ml	—	620	620	620	640	660	400
f - breaths/min	—	10	10	10	7	6	16
Peak inf pres / PEEP	—	24	24	24	24	23	—
MODE - S(pon), A(ssist), C(on)	S/C	C	C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	—	40	40	32	33	35	40
BP/oth	FIO2 (Frac or %)	0.78	0.78	0.78	0.78	0.78	0.78	0.78
ART line	SpO2 (%)	100	95	100	100	100	100	100
Steth- PC/ES	ECG	SR ———				SR	SR	SR
Gas analyzer	TEMP-site	available ———						
	N-M Block (T/4)		0/4			4/4	4/4	
BS								
✓ Warming blkt	x1 blanket ———							
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0—1

REMARKS
Code drugs with numbers, events with letters
(1) Pre-oxed.
(2) Room, mon. O2 Induced eyelids taped
(3) OG soft bite block
(4) Reversed OP suctioned Neostigmine 5 + Glycopyrrolate 0.8 mg IV Extubated. S complications To ICU-2 Report given

RECOVERY AT 0225
PACU ICU 2 (Specify)
OTHER —
CONDITION: Stable, arou...
RESP- 20 SpO2- 97-...
BP- 115/78 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0045	0055	0235

	Ready	Begin	End
PROC	0100	0118	0210

PROCEDURES and CPT Codes: I+D & Sutures scalp wounds
Fasciotomy (R) LE, I+D (L) arm

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA (b)(6)-2
RSI T Cric

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

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments [redacted] (b)(6)-2
DL x 2 CRT [redacted] DL x 1 Miller 3 Dr...
Grade I 8.0 styletted 24 @ lips + BBS, sust ETCO2

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

ANESTHETISTS: [redacted] (b)(6)-2 CRNA/MAJ

PROCEDURE LOCATION: 2

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 17556

(b)(6)-2

COPY 1 [redacted] ENT'S MEDICAL RECORD

USAPA V1.00

ACLU-RDI 1642 p.116

DOD-031145

17Aug 1500(h) 9.0 / 26.8 < 335   Meds - Ancef ī 1gm IVPB q8° ~ Mortar Round to EPW camp

MEDICAL RECORD - ANESTH[ESIA]

Tobacco   SSCAL 8-16-03   NKDA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)							TOTALS
Versed (mg)	2						2
Fentanyl (mcg)	50	50	50	50	50		250
Lidocaine (mg)	100						100
Propofol (mg)	200						200
MSO4 (mg)			3		2	1	6
Robinul (mg)			0.2				
VOLAT AGENT Iso % del	2.5	2.0	1.5	1.5	1.5		
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	10	2	2	2	2		

TOTAL EBL: <50

TOTAL URINE: 150

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

FLUIDS

LINE site (R) PIV / AP — Warmed — LR → #1
Warmed
Warmed
Ancef — Warmed — 1g IVPB →

FLUIDS SUMMARY
CRYSTALLOID- 500 LR
COLLOID- Ø
BLOOD- Ø

LOSSES

EST BLOOD LOSS
URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 84 (KG) LB

HEMATOCRIT: 26.8

INITIAL DATA: BP- 119/59 SaO2 100% HR- 79

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? [redacted]

TIME- 0700

TIME → 0730 , 0800 , 30 , 0900

SYMBOLS: BP by cuff V Λ; Heart rate; Resp rate ●; BR (transduced); TOURNIQUET T—T; (b)(6)-2 ANES- X-X; PROC- ⊙-Ø

220 200 180 160 140 120 100 80 60 40 20

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment agree ī previous pre-op. Lungs CTA (B) =, ↑R RR (-)
(2) Room, monitors O2 Induced eyes taped
(3) Attempted PIV access PIV in (R) hand patent Continue to use
(4) To litter to ICU-2 Report given

VENTIL

VT - ml	+	250	370	390	390	830
f - breaths/min	—	23	16	15	14	15
Peak inf pres / PEEP	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	+	32	35	35	33	30
✓BP/oth	✓FIO2 (Frac or %)	0.65	0.65	0.66	0.65	0.65	0.65
ART line	✓SpO2 (%)	100	99	99	100	100	100
Steth- PC/ES	✓ECG	SR →		SR	SR	SR	SR
Gas analyzer	✓TEMP-site	available →					
	N-M Block (T/4)						
	BS	+					
✓Warming blkt	✓1 wool blanket →						
Conv warmer							

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

RECOVERY AT 0859
PACU (ICU 2) (Specify)
OTHER T-97.5
CONDITION: Stable awake
RESP- 2 SpO2- 100
BP- 139/71 HR- 130

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0720	0730	0910
	Ready	Begin	End
PROC	0740	0750	0850

PROCEDURES and CPT Codes: I+D (R) Lower leg / I+D (L) arm

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GMA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
LMA #4 not seated removed. Mask ī OA #90mm + 34 FR NP tube; + BB'S + Sust ETCO2

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

PROCEDURE LOCATION: 7

[redacted] CRNA/MA

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998   MEDCOM - 1755   COPY 1 - PATIENT'S MEDICAL RECORD   USAPA V1.00

(b)(6)-2

34 y/o M NKDA

ASA II

MEDICAL RECORD - ANESTHE

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML; "1" = CONSTANT INFUSION

DRUG	(Units)	
Versed	(mg)	2
Fentanyl	(mcg)	250
Lidocaine	(mg)	100
propofol	(mg)	150
MSO4	(mg)	
	( )	
VOLAT AGENT 1.5	% del / % e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	5/2/1/1/1/1/1/1/1.5

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (2) (3)

FLUIDS

LINE site: 18g (1) AntCub — Warmed — LR — 700 — 200 LR

Warmed

Warmed

Warmed

LOSSES: EST BLOOD LOSS; URINE

TOTALS	TOTAL EBL
2/0	
250/0	min.
100	TOTAL URINE
150	
10/0	-0

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) PT ID (0820) PreOp Hx done PT prep complete ID ✓, NPO ✓, Allergies med ✓, NKDA

(2) RM, O2, monitors

(3) induction

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 KG / LB

HEMATOCRIT: 29

INITIAL DATA: BP- 120/70; HR- 74

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME-

TIME → 0845 X 0915 0930 X 1000 X 1030 X 1100 X 1130

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	380	300	370	390	330	
f - breaths/min	15	9	10	10	14	
Peak inf pres / PEEP	/	/	/	/	/	
MODE - S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	41	44	45	45	42
BP/oth	✓ FIO2 (Frac or %)	.74	.74	.74	.74	.77
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site	Axill				
	✓ N-M Block (T/4)	Axill				
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0 ✓ → 7

RECOVERY AT 1000

PACU ICU (Specify)

OTHER

CONDITION: Stable

RESP- 10 SpO2- 90

BP- 154/81 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0845	1010
PROC	Ready	Begin	End
	0857	0908	0956

PROCEDURES and CPT Codes: DPL

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

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

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Nasal airway 34 F + pt SV.

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

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PROCEDURE LOCATION: 2-1

DATE: 24 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 17558 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

PRE-ANESTHETIC ASSES N ID PLAN OF CARE

AGE: 34 Days Mos Yrs

GENDER: ( ) Male ( ) Female

ALLERGIES: NKDA

P S: 1 (2) 3 4 5 (E)

WT: 83 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: (R) leg compartment syndrome

SURGICAL SERVICE: I&D multiple GSWs

NPO SINCE: Ortho

PREOP DX / MECHANISM OF INJURY: GSW

HABITS:

Tobacco: Cigars

EtOH: Beer ~ 4/day

Drugs: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ø
( )
( )
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ________Hrs

LABORATORY STUDIES:

130 | 105 | 13 < 150
3.5 | ~~25~~ 19 | 1.3

18.5 > 12 / 36.5 < 437

Other: PT - 17.3
PTT 26.2

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	Unknown
Angina	N	Y	
MI	N	Y	Denies
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

BP: 103/60 HR: 91 RR: 20 T: ____

Pain (0/10 Scale): 10

Airway Exam:
Dentition intact
Trachea midline
TMJ/C-spine
Oropharynx MP difficult to assess

Chest:
Lungs
Heart

IV Access: x 2 PIV (R) A

Ulnar Filling:

Back:

Other:

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ________ (✓) General: (Intubation) / Mask-LMA Notes: ________

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

(b)(6)-2

Signed [redacted] CRNA/MAJ Date: ________ Time: ________

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

PATIENT IDENTIFICATION:

[redacted]
(b)(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ________ Date: ________ Time: ________

Nursing Unit: ________

MEDCOM - 17559
28 COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

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 (HOURS) | LIST TIME ORDER NOTED AND SIGN

17 AUG 03 0215

1. TO ICU
2. S/P I+D (R) LEG, (L) ARM WITH DEBRIDEMENTS
3. CONTIN FOLEY
4. VS MONITOR
5. NPO MIDST

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

6. REGULAR DIET
7. FOLEY TO GRAVITY
8. IV - 2L AT 125 cc/HR NSS LOCK WHEN TAKEN PO WHEN
9. TYLENOL 650 mg PO Q 4 HRS PRN
10. PERCOCET 1-2 PO Q 4-6 HRS PRN
11. MSO4 - 2-6 mg IVP Q 2 HRS PRN
12. ANCEF 1 GRAM IVPB Q 8 HRS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

13. CBC AT 0800 [redacted] (b)(6)-2

19 AUG 03 0800

- Routine vitals
- Update LD
- Heplock IV
- D/C Foley
- Regular Diet
- T#3 Tylenol #3 PO q 4 hrs prn pain

19-Aug-03 0800 [redacted] (b)(6)-2 966 Glucose

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

- MSO4 2 mg IV q 1 hr PRN breakthrough pain
- Phenergan 25 mg IV q 6 hrs PRN nausea
- Chemotherapy 300 mg PO q 8 hrs [redacted] (b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—403-924

"USE BALL POINT" "IN 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

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

① General IDay IV q 2 Max dose 20mg IV PRN for post-op Shivering

[redacted] (b)(6)-2 19 Aug 03 1000

NURSING UNIT | ROOM NO. | BED NO.

[redacted] (b)(6)-2 CRNA/MA (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
19 Aug 03	1750 HOURS

① Transfer to ICU 2
② Cont current orders

NURSING UNIT | ROOM NO. | BED NO.

24 V/S 2315 19 Aug 03 [redacted] (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
8/20/03	1400 HOURS

① Start wet to dry dsg's in AM
② D/C Ancef

[redacted] (b)(6)-2 noted 20 Aug 03 1415 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 V/S 2300 20 Aug 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
8/23/03	0900 HOURS

NPO p MN

[redacted] (b)(6)-4 [redacted] (b)(6)-2 ready 8/23/03 0915

NURSING UNIT | ROOM NO. | BED NO.

ICU #1 24 V/S 2300 23 Aug [redacted] (b)(6)-2

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 POINT" MEDCOM - 17561 "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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 Noted 24 AUG 03 1024 [redacted] (b)(6)-2				24 AUG 03	1000 HOURS	
			1	REGULAR PHYSICIANS ORDERS		
			2	REGULAR DIET		
			3	IV - LR AT 125 cc/HR. HEP LOCK WHEN NOT IN USE PER POLICY		
			4	DAILY DRESSING CHANGES		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER [redacted] (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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] (6)(6)-4				30 AUG 83	0716 HOURS	
			(1)	DISCHARGE TO EPW CAMP TODAY.		
			(2)	KEFLEX 250mg P.O. Q 6H X 10 DAYS		
			(3)	CRUTCHES, WEIGHT BEAR AS TOLERATED		
NURSING UNIT	ROOM NO. (6)(6)-2	BED NO.	(4)	TYLENOL 650mg P.O. Q 4HRS PRN		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER [redacted]	(6)(6)-2
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

Noted 30 AUG 0930

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

MEDCOM - 17563

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 19 20 21 22 23 24 25 26 27 28 29 30
Copied	[redacted] (b)(6)-2	VS routine	07 / 13 / 19	[redacted]
Copied	[redacted] (b)(6)-2	OOB up ad lib	07 / 13 / 19	[redacted]
Copied	[redacted] (b)(6)-2	Reg diet	06 / 12 / 17	[redacted]
		Foley to gravity	05 / 13 / 21	[redacted] } d/c'd [redacted]
20 Aug	[redacted] (b)(6)-2	Start W->d sg D's to start in am 21 Aug	08	[redacted]
30 Aug 03	[redacted] (b)(6)-2	crutches, wt bearing as tol	06 / 18	[redacted]

(b)(6)-2 all

ALLERGIES: YES NO — UNK

PRIMARY DIAGNOSIS: s/p GSW R leg & L FA

ADDITIONAL PAGES IN USE: YES NO

PAGE NO: ____

PATIENT IDENTIFICATION: [redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 72 MAY BE USED. — USAPA V1.00

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo [illegible] Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 Aug	[redacted]	Admit to ICU	24 Aug		1730	[redacted] (6)(6)-2
23 Aug	[redacted]	NPO p MN	23 Aug		[redacted] (6)(6)-2	
24 Aug	[redacted]	Resume Previous Orders	24 Aug	Today	done	[redacted] (6)(6)-2
30 Aug 03	[redacted]	D/C to EPW camp today				
	(6)(6)-2					

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

USAPA V1.00

PRN meds

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.

M 08 Y 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
17Aug	[redacted] (b)(6)-2	Tylenol 650 mg PO Q4 hrs prn		
17Aug	[redacted] (b)(6)-2	Percocet 1-2 PO Q4-6 hrs prn		
17Aug	[redacted] (b)(6)-2	MSO4 2-6 mg IVP Q2 Hrs prn		
17Aug	[redacted] (b)(6)-2	T3 PO q4hrs prn pain		
17AUG03	[redacted] (b)(6)-2	Percocet 1-2 po q4-6 prn		
		One Time Meds		

(b)(6)-2 (all)

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S78 IED (R) leg (L) FA

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

PATIENT IDENTIFICATION

RPW [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

CLINICAL RECORD

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

Mo. 8 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19 20 21 22 23 24 25 26 27 28 29 30 31 Sept 1
Copied	[redacted]	IV LR @ 125cc/hr	05	
	(6)(6)-2	HL when tol PO	13	
			21	
Copied	[redacted]	Ancef 1 gram IVPB	08	[redacted] D/C
	(6)(6)-2	98°	16	[redacted] 20 Aug 03 1400
			24	
Copied	[redacted]	Heplocke IV	05	[redacted] D/C
	(6)(6)-2		13	
			21	
Copied	[redacted]	Clindamycin	08	[redacted]
	(6)(6)-2	300mg PO q8°	16	[redacted] D/C
			24	
24 Aug 03	[redacted]	IV LR @ 125 cc/hr	07	[redacted] D/C'd
	(6)(6)-2	Heplock when	19	
		Tolerating PO well		
30 Aug 03	[redacted]	Keflex 250mg PO	06	
	(6)(6)-2	QID x 10 days	12	
			18	
			24	

(6)(6)-2 all

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: unk GSW 1st D & leg & L PA

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

MEDCOM - 17567

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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

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

OTSG APPROVED (Date)

Date: 19-Aug-03
Time In: 0900
Allergies:
Pre-op V/S: 119/69 / 74
Procedures: I+D RUE & LUE

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid LR 500 Colloid
OR Output: UOP 150 EBL 50 cc
Meds/Times: 150 mg Fent · 5 mg MSO4

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

Pre Op Meds

History

Time	0900	0905	0910	0915	0930	0945	1000	1015	1100
SaO2	100%	100%	94%	94%	100%	99%	96%		
FiO2	RA	RA	RA	RA	RA	RA	RA		
Methods					FM				
240									
220									
200									
180									
160									
140				V					
120	V	V	V		V	V	V		
100	0	0		0		0			
80	1	1	1	1	0	0	1		
60					1	1			
40									
20									
RR	16	16	22	12	14	13	14		
T	98.6	98.8	99.1	98.8	98.4	98.4	98.4		
Time	0900	0945							
Pain (0-10)	6	7							
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	2	V/S X = A-line BP ° = Cuff BP ~ = Pulse
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	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10	

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)

PREPA[redacted] SSG Travis

(6)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU-2

DATE: 19-Aug-03

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

FF [redacted]

(6)(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LUE/RLE	+	+	+	B	W	
15'	"	+	+	+	B	W	
30'	"	+	+	+	B	W	
45'	"	+	+	+	B	W	
60'	"	+	+	+	B	W	
90'							
D/C	"				B		

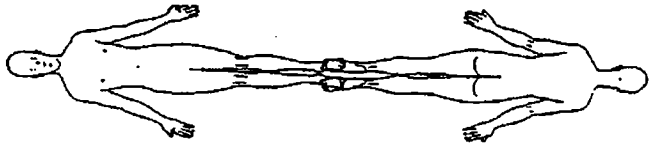
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LUE & RLE	Gauze	Ø
30'	"	"	Ø
60'	"	"	Ø
D/C	"	"	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	Foley	Clear/yellow	100

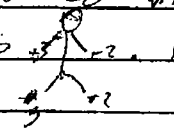
CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt is A&O x 4 c LUE & RLE. Pt made follow simple commands has symmetrical sensation x 4 extremities. Bandages c/d/I. Dressings c/d/I.



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

MEDICAL RECORD-SUPPLEMENTAL MEDI L DATA

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

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

OTSG APPROVED *(Date)*

Date: 24 Aug 07 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block Hair

Time In: 1000

Allergies: NKDA OR Intake: Crystalloid LLR Colloid

Pre-op V/S: 120/70 18 74 OR Output: UOP EBL minim

Procedures: DPC Meds/Times: Ancef 1gm 0900

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

Airway: (Nasal), Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1000	1005	1010	1015	1030	1040
SaO2	97	100	96	94	95	96
FiO2	28	24	24	24	24	FT
Methods	MXC	NC	NC	NC		
240						
220						
200						
180						
160	✓					
140			✓	✓		
		✓		✓	✓	
120						
100						
80	^	^	^	^	^	^
60						
40						
20						
RR	10	15	17	10	15	14
T	98			97.0		
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	1	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	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

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)

PREPA[redacted] (b)(6)-2 ILT /AN

DEPARTMENT/SERVICE/CLINIC

DATE

PATI[redacted] written entries give: Name – last, first, i[redacted] ical facility)

[redacted]

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

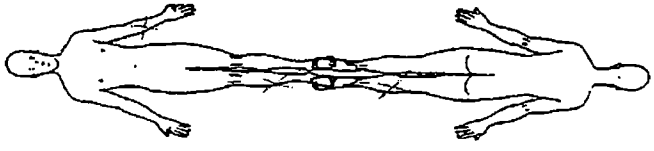
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) forearm	CDI	
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt. arrived to PACU @ 1000. via stretcher, drowsable, responds to stimuli. O2 sat 90% RA. placed NC @ 95%. lungs CTA. nasal trumpets (R) nare. NSR & echopy dressings to (R) forearm & (R) leg CDI. +2 pulses x4. peripheral capillary refill <3sec. Skin warm & dry (+)BS. LR KVO to (R) forearm will continue to monitor. [redacted] LT AW (b)(6)-2

Discharge Criteria:
Date: 13 Aug 10 **Time:** 1045 **PARS:**
BP: 133/81 **T:** 97.3 **HR:** 97 **RR:** 15 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: DCWI
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: LT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RD-SUPPLEMENTAL MEDICAL DA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0630 Initals: [redacted](6)(6)-2	Time: Initals:
NEURO	Pupils	3mm, brisk, PERRLA	
	Sensorium	Alert, follows simple instructions	
	LOC / GCS	Denies pain	
CARDIAC	Cardiac Rhythm	NSR 5 cath'd, rate 70's-80's	
	PRI: / QRS:	Pulses - RUE inaudible but exp not'd	
	Pulse Strength	+3 peds, RUE + LUE +2 radials, @ LE o/l	
	Cap Refil / JVD	Saline lock in (R) hand	
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	Regular, even + nonlabored	
	Breath Sounds	CTA (B)	
	Secretions	O	
	Cough	non-productive	
SKIN	Color	normal for race	
	Integrity	wd's LUE, RLE, (L) shoulder, (R) thigh	
	Backside	NO wx or DCAP-BTS	
IV	Access Devices	(R) hand saline lock	
	Location	CVAI	
	Condition		
GI	Abdomen	BS x4, NT, ND	
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device	Foley	
	Color / Clarity	clear/yellow	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC [redacted](6)(2)-2

DATE

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

[redacted]
(6)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17572

MED. ... RD-SUPPLEMENTAL MEDICAL ...

For use of this form, see A... -66; the proponent agency is the Office of The Surgeo... ...eral.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	Pupils RR, pt moves	
	Sensorium	translator @ bedside	
	LOC / GCS	c/o pain @ lower	
		leg	
CARDIAC	Cardiac Rhythm	SR HR 80's, Ø	
	PRI: / QRS:	ectopy beats noted	
	Pulse Strength	[illegible] ace wrap dry	
	Cap Refil / JVD	Ø pulse c sensation	
	Edema	Ø lower leg [illegible]	
	Chest Pain	[illegible] Ø pulse	
		[illegible] to move	
RESP	Respiratory Pattern	RR [illegible] unlabored	
	Breath Sounds	[illegible]	
	Secretions	SpO2 @ 95% RA	
	Cough	[illegible] cough [illegible]	
		[illegible] [redacted]	(b)(6)-2
SKIN	Color	[illegible] pale	
	Integrity	[illegible]	
	Backside	[illegible]	
		[illegible]	
IV	Access Devices		
	Location	→	
	Condition	→	
GI	Abdomen	Abd soft [illegible]	
	Bowel Sounds	[illegible]	
	Stoma/Ostomy	[illegible] yellow [illegible]	
		[illegible]	
GU	Device	[illegible]	
	Color / Clarity	HR 80's	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU3 [redacted]

DATE

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17573

IC RECORD-SUPPLEMENTAL MEL .L B. A

For use of . . rorm, 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 08MAR8

		INITIAL SHIFT ASSESSMENT			
		Time:	Initals:	Time:	Initals:
N E U R O	Pupils				
	Sensorium				
	LOC / GCS				
C A R D I A C	Cardiac Rhythm				
	PRI: / QRS:				
	Pulse Strength				
	Cap Refil / JVD				
	Edema				
	Chest Pain				
R E S P	Respiratory Pattern				
	Breath Sounds				
	Secretions				
	Cough				
S K I N	Color				
	Integrity				
	Backside				
I V	Access Devices				
	Location				
	Condition				
G I	Abdomen				
	Bowel Sounds				
	Stoma/Ostomy				
G U	Device				
	Color / Clarity				

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (6)(2)-2
ICU3, [redacted]

DATE

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17574

ICU1

Patients Name: EPW [redacted] (6)(6)-4 Date: 18 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																				115/71		114/68		115/69		
NBP																										
TEMP																				98.8		98.6		98.8		
HR																				80		76		76		
RR																				18		20		20		
SaO2																				98		99		97		
FiO2																				RA		RA		RA		
[illegible]																										
M[illegible]																										

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	To
IVF																										
IVPB																				50						
NGT																										
PO [illegible]																										
[illegible]otal																										

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	Total
URINE																				300		300		400		
NGT																										
STOOL																										
DRAIN																										
Total																										

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A 1 1 D 1 (positions 1–6)

2. MTF LOCATION (State or Country Code.): I Z (positions 7–8)

3. REGISTER NUMBER (9–15): [redacted] (b)(6)-4

NAME (Last, First, Middle Initial): EPW [redacted] (b)(6)-4

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26):

7. AGE AT ADMISSION (27–29): 3 4 y

8. RACE (30): Z

9. ETHNIC BACKGROUND (31): 9

RELIGION: unk

10. LENGTH OF SERVICE (32–34):

ETS: N/A

11. FMP (35–36): ~~9 9~~ 20

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS (46): u

HOUR OF ADMISSION: 0215

BRANCH / CORPS: N/A (b)(6)-4

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): ~~K 7 9~~ K78

16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):

18. MOS (64–70):

19. TRAUMA (71):

PREV. ADMISSION: YEAR: NO [X]

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74): 5 0

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 0 3 0 8 3 0

24. CLINIC SVC - ADMITTING (87–90): A E A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 0 3 0 8 1 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

Dx: S/P I+D (R) leg + (L) FA

Dx [illegible] Px 2181 [illegible] Trauma 1 [illegible]

87329

[illegible]

ADMITTING OFFICER (Signature, [redacted] (b)(6)-2

[redacted] Dr. [redacted]

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

[redacted] , SPC, 9/6[illegible]

(b)(6)-2

DA FORM 2985, MAR 90

MEDCOM - 17576

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4 [redacted]

2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
UNK - NAME	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	24y	X	MUSLIM			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
9920	(b)(6)-4 [redacted]	[redacted] (b)(6)-4	ICU 2

15. FLYING STATUS	16. FLYING DSG	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	0200	Gen Surg.

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	D/C TO CAMP	31 AUG 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		17 ~~12~~ AUG 2003	

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: ① Shrapnel Wnds
② S/P Ex-Lap S-B repair

Dx: 868.19
959.8
E991.9

Px: 46.73
87.79
99.04

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	19	19

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	19	19

SIGNATURE OF ATTENDING MEDICAL OFFICER

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

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

DA FORM 3[redacted]

USAPPC V1.10

MEDCOM - 17577

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

20's yo ~~w~~ Iraqi male sustained shrapnel
from Blast injury c/o abd distension and pain

All Ø PMH Asthma PSH Ø Tob Ø

PHYSICAL EXAMINATION

NC AT TM clr OP clr
Neck ⊖ wound ⊖ Pain ⊝ CRON
Chest – small SQ Puncture @ Ⓡ Supra clav fossa
CBM
Back ⊖ injury
Car RRR ⊖ ⊖ ⊖
Abd

⊕ tend ⊕ FAST
⊕ Peritoneal sx
entrance wound

GU hypospadius
Rectal not done ⊖
ext occ shrapnel
pepper
cxr ⊖ ptx or effusion
Art Neck Lat fragment

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

A/P ① Acute Abd ⊕ FAST → OR
Other insignificant shrapnel injury → Bandage

(b)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN [redacted]

DATE	IDENTIFICATION NO.	ORGANIZATION
17 Aug 03		

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

REGISTER NO.	WARD NO.

EPW [redacted]

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0400	VS as follows: T 96 (A) P 113 R 18 BP 125/7 [redacted] (b)(6)-2
	O2 sats 94% RA (b)(6)-2 [redacted] CPT AN
0445	Nursing Note: Pt. is Alert. Arrived from [redacted]
	surgery earlier. Assumed care of pt.
	at this time.
06	VS as follows: T: 99 P: 118 R: 20 BP: 108/68
	Lungs clear. Ex lap drsg c minimal drainage.
	Drsg to (R) groin area D&I. Bandaide to
	(L) thigh. Foley to gravity clear & yellow
	urine. Abd is distended. cap refill <
	3 secs x4 extremities. pulses palpable
7 Aug 03	x4 extremities.
	CPT [redacted] (b)(6)-2
0600	PT A+O x3 VS 100/72 P 120 R 18 SaO2 98% RA T 99.4
	color good pulses weak ~~peri~~ peripheraly.
	LS CTA ABD DTN around mid Drg site. ABD
	Drg (+) bloody drainage to gauze & tape. from
	xyphoid to 2" above syphis pubis. (-) BS (+) TTP
	NV1 morn H+H 9/26 MD notified instructed
	wait 2hrs retake H+H. IV (L) FA 18G patent @
	150cc/hr LR. Heplock (R) FA patent. Foley to gravity
	drg clear yellow urine will cont to monitor
	SGT [redacted] 91WM6 -
	(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.)

EP W [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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 AUG 03	OP Note
0200	Indication Penetrating Abd wound with Abd pain and (+) FAST
	Procedure ex LAP, small bowel Repair
	Surgeons - [redacted] (b)(6)-2 [redacted] (b)(6)-2
	Anesth GEN
	1000 Hespan EBL 400
	3000 LR 40 275
	Findings (1) Hemoperitoneum
	(2) Post Recess hemotoma Not Bleeding
	(3) Single through & through SB enterotomy @ Distal Ileum repaired
	(4) (-) Iliac vessels & Ureter explored
	5 injury.
	Comp None
	to ICU in good cond
	[redacted] (b)(6)-2 [redacted] (b)(6)-2

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

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

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

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

MEDCOM - 17580

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17aug03 0745	pt awake. Yo abdominal pain. pt does not speak English but able to use body gestures. MSO4 5mg IVP given, Monitor for pain relief. [redacted] (b)(6)-2 Morton
0830	CBC results HCT 26.1 Hgb 8.4. Dr. [redacted] (b)(6)-2 aware. Order to transfuse 2 PRBC.
0940.	Hang 1 PRBC, unit # W001303, (2) antecubital sites patent. Blood transf. purged w NS. VS Temp 99.4 pulse 130 BP 104/56 RR 22 Monitor for reaction closely. VS monitor closely. Blood to be infused over 4°.
0945	98/52. Pulse 130. SaO2 96% LR on hold until Blood completion T 99
0950	100/56 p 135 SaO2 96% T 98.8 SGT [redacted] 91WM6 (b)(6)-2
0955	98/54 p 135 SaO2 96% T 98.8 SGT [redacted] 91WM6 (b)(6)-2
1000	100/52 p 124 SaO2 97% T 99.4 SGT [redacted] 91WM6 (b)(6)-2
1005	96/50 p 126 SaO2 96% T 99.5 SGT [redacted] 91WM6 (b)(6)-2
1010	98/50 p 128 SaO2 96% T 99.2 SGT [redacted] 91WM6 (b)(6)-2
1015	96/54 p 120 SaO2 96% T 99.9 SGT [redacted] 91WM6 (b)(6)-2
1030	96/54 p 113 SaO2 97% T 100.0 SGT [redacted] 91WM6 (b)(6)-2
1045	94/52 p 114 SaO2 96% T 100.1 - Infusion complete
1055	Rx. start PRBC W001303 010745 exp. 21Aug03 (b)(6)-2 B pos. VS 98/58 p 112 T 100.1 R 24 [redacted] 91WM6
1100	96/52 p 110 T 100.1 SaO2 96% SGT [redacted] 91WM6 (b)(6)-2
1105	100/60 p 106 T 99.8 SaO2 96% SGT [redacted] 91WM6 (b)(6)-2
1110	102/58 p 108 T 100 SaO2 96% SGT [redacted] 91WM6 (b)(6)-2
1115	100/56 p 106 T 99.6 SaO2 96% SGT [redacted] 91WM6 (b)(6)-2
1120	102/62 p 106 T 100' SaO2 96% SGT [redacted] 91WM6 (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50818

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 0935	100/60 P 107 T 100.2 SaO2 96
1145	108/58 P 110 T 100.1 SaO2 96
1205	Infusion complete VS 108/62 P 108 R 22 T 100.2 SaO2 97% RA [redacted] (b)(6)-2 Urine output 30cc MD notified - give 1000cc LR bolus per MD order SG [redacted] 9 IVMM (b)(6)-2
1345	Bolus Complete - urine Output 60cc ABD T DN ↑ tenderness to touch (b)(6)-2 Dr notified & new orders SG [redacted] 9 IVMM,
1400	pt c/o abd pain when touched MS04 given per MD suggestion 5mg IVP SG [redacted] 9 IVMM (b)(6)-2
18 Aug 03 0700	c/o ABD pain [redacted] (b)(6)-2 given @ incision site Dry midline CDI. given MS04 4mg by CPT [redacted] (b)(6)-2 NAD NOted to be (R) nare D/S patent drg cloudy water Secretion will cont to monitor for effect [redacted] (b)(6)-2
1845	Pt A+O, VSS, S1S2 murmur 2+ pulses all extrem. LSCTA, resp reg unlabored, abd. soft, slightly distended, NGT to LIS drng green fluid small amts. Given 5mg MS04 IVP for pain c good effect. ↓BS x 4 quads. Foley drng clr yellow urine sufficient amts.

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.

#1 [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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 AUG 03	~~Surgery~~ POD #1 ex lap - Repair of small bowel c/o Abd discomfort & nausea NGT in place VS T 99.1 HR 96 98-110 97% RA Chest CTA Abd mod distended TTP but improved hypoactive but present BS 40 60-100 c/hr CMS 9.1 / 28 / 186 A/P Doing well cont current plan [redacted] (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1845 (cont.)	Abd dsg CDI. Will monitor. [redacted] (b)(6)-2 ICTAN
19Aug03 0400	Pt resting. VSS. New 18G PIV started @ wrist labs sent. medicated c 5mg MSO4 for c/o pain to (R) flank IL. Will monitor. [redacted] (b)(6)-2 ICTAN
19 Aug 03 0600	Received report from outgoing shift. Pt rests c eyes closed easily aroused A+Ox3 perla EOMI VS 142/84 P 108 R 14 even unlabored CS-CTA T 98.4 SaO_2 99% 2L O_2. color good cap refil brisk Dsg midline abd CDI BS hypoactive (+) BM noted ↓ from yesterday NBO tenderness ↓ from yesterday. Grip strengths equal NVI moves all 4 extremities foley patent draining clear yellow urine. NG to LIS drg green secretions will cont to monitor SOS [redacted] (b)(6)-2 9/MMS
19Aug03	0900 OOB X 1½ hrs AM Care given Pt washed teeth brushed lotion applied tolerated well NAD (Pt @ bedside chair for duration. SOS [redacted] (b)(6)-2 9/MMS
19Aug03	0916 Ambulated from chair to bed c/o ABD Pain given MSO4 3mg by CRT [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

[redacted] (b)(6)-2

MEDCOM - 17584

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03 Cont.	tolerated well NAD SGT [redacted] 9MMG (b)(6)-2
19Aug03	No Bowel [illegible] NL [illegible]
	[illegible]
	[redacted] NL (b)(6)-2
	[redacted] (b)(6)-2
19Aug03	1600 OOB to chair tolerated well NAD SGT WAL (b)(6)-2
19Aug03	1730 in bed from chair tolerated well NAD SaO2 96% RA SGT [redacted] (b)(6)-2
20AUG	Surg
	Pt AFOS VSS HR 102 Emesis this AM
	[illegible]
	[illegible] mild [illegible]
	ABD: SOFT. NT, ⊕ Distension [redacted] (b)(6)-2
	RP: [illegible]
	Plan NPO
	NG to Suction
	ICUs & CXR [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-800/50618

MEDCOM - 17585

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Aug 03	Progress Note
	POD #4 s/p Shrapnel injury to abd requiring ex lap
	c̄ drainage of rectus hematoma + SB enterotomy
	repair.
	Pt c/o nausea, abd pain, ∅ BM since
	prior to mortar attack = 9 days.
	Some improvement c̄ Dulcolax last night
	CBC yesterday nl
	afebrile
	AAS c/w excessive bowel gas/ileus. (gas throughout
	colon)
	PE: distended nontender
	tender to palpation
	∅ rebound
	NG in place
	Imp: Ileus(?) vs pain 2nd rectus hematoma
	Plan cont NG suction
	cont observation
	√ CBC in AM [redacted] [illegible]
	(b)(6)-2

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

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

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

[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 - 17586

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG03 AnEst IUF	Surgery POD #6 - enterotomy / Abd wall / pelvic hematoma Minimal complaint ⊖N/V ⊕ Flatus Tm 100.5 110 150/80 NG output 500 ⊙ S4PL PE: wound C/D staples in place Abd - mod distended, min TTP., ⊕BS 12.7 / 30.7 / 393 138 / 3.6 98 / 20 14 / 96 / 1.2 A/P POD#6 ex lap c̄ hematoma. prolonged ileus. Now c̄ ↑WBC and low grade temp would CT to R/O Abscess. but will ✓ CXR. today. [redacted] (b)(6)-2 [redacted] (b)(6)-2
23Aug03 2330	Pt awake and alert. NGT to Ⓡ nare intact, draining dark green fluid. Lungs CTA bilat Ø resp distress. NSR. Abd soft, non-tender, bowel sounds ~~active~~ error [redacted] (b)(6)-2 ~~4 quads~~ hypoactive x4 quads. Pt c̄ c/o dry throat & cough, given sips of water. Abd incision CDI, staples open to air. Low grade fever noted, incentive spirometer encouraged. (b)(6)-2 [redacted] RN
24Aug03 0045	280cc orange urine emptied from foley. U/O @ 150 cc/hr. Ø sediment noted to urine (b)(6)-2 [redacted] RN
0530	350cc dark green fld to NGT suction. Ø complaints at this time. (b)(6)-2 [redacted] RN

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

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

BLWL

MEDCOM - 17587

ACLU-RDI 1642 p.147

DOD-031176

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 Aug 03	1245 - Pt alert & oriented OOB to chair. Ambulated c assistance x1. Lungs CTA, HR reg, BS hypoactive. Belly distended & soft. Staples to abd incision intact, ∅ S/S of infx. NG intact to L intermittent drainage green stomach fluid. IV to ⓛ arm patent. Voicing ∅ complaints. Wilcat to [redacted] (b)(6)-2
24AUG03	Surgery. No complaint ⓒ Flatus ⊖N/V VSS RR 72 Abd mod Distended soft ↓ Abd Tenderness hypoactive BS. (13.1) <556 140/102/16 9D 37.8 4.2 21 1.4 A/P Post-op ileus cont current Rx would obtain CT when Available [redacted] (b)(6)-2 (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.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

24 Aug 03 1900: Assumed care @ 1400, T-99.0°F P-74 R-16 BP-137/81 SpO2-96% HR-regular. Lung sounds clear bilat, Abd slightly distended, tender, BS hypoactive Staples to midline abd.- intact. NG suction draining green @ intermitent setting. Foley d/c'd. Ambulating q 4°z NG clamped. MSO4 to control abd pain. Will continue to monitor. [redacted] (b)(6)-2

25 Aug 03 assumed care @ 2200 - staples intact on abd
0100 incision, no drainage noted, abd soft, non-tender on palpation, only one BS heard in lower R quad - LR @ 150 cc/hr infusing into L PA, site patent - NGT to LIS, small amount of greenish output - lungs clear throughout x inspiratory wheezes noted in L upper lobe [redacted] (b)(6)-2 Chief RN

25 Aug 03 Pt. had 400cc NGT output dark green - this shift -
0500 voided 300cc spontaneously in urinal - [redacted] (b)(6)-2

1400 T-96.8 BP 130/62 R-16 P-62 [redacted] (b)(6)-2

25 Aug 03 - 950 cc of green chunky fluid removed from NG collection container. Pt. c/o
1200 complaints @ this time. VSS. HR Regular, Lung sands clear bilat, bowel sounds hypoactive x 4 quads. Vertical midabdominal incision well approximated, staples intact. IV LR @ 150 cc in L wrist infusing well c s/s of infection or infiltration. NG tube in place to int. suction 20 sec on 20 sec off. All other assessment findings WNL. Will continue to monitor [redacted] SGT (b)(6)-2

25 Aug 03 1633: Assumed care @ 1400, T-98.7°F P-80 R-16 BP 143/78 SpO_2 95%, HR-reg. Lung sounds clear bilat. BS-hypoactive x4: Midline abd. incision intact, 4R infusing @ 150cc in L wrist. Ambulated x2. NG to LIS. No c/o pain or discomfort @ this time. [redacted] 2LT (b)(6)-2

25 AUG 03 2200 PT VS P-81, BP-140/82, T-98.5, R-18, SpO2-93- [redacted] PVT (b)(6)-2

0745 [illegible] very weak attempt - IV patent, LRC 150cc/hr - BBS heard x 4 quads - lungs CTA (B) - staples intact on abdomen, ⊘ drainage from incision - c/o abd pain and wanting medicine to sleep, medicated for pain, will monitor results - NGT to LIS c (b)(6)-2 moderate amount of drainage, green bile - [redacted] clear

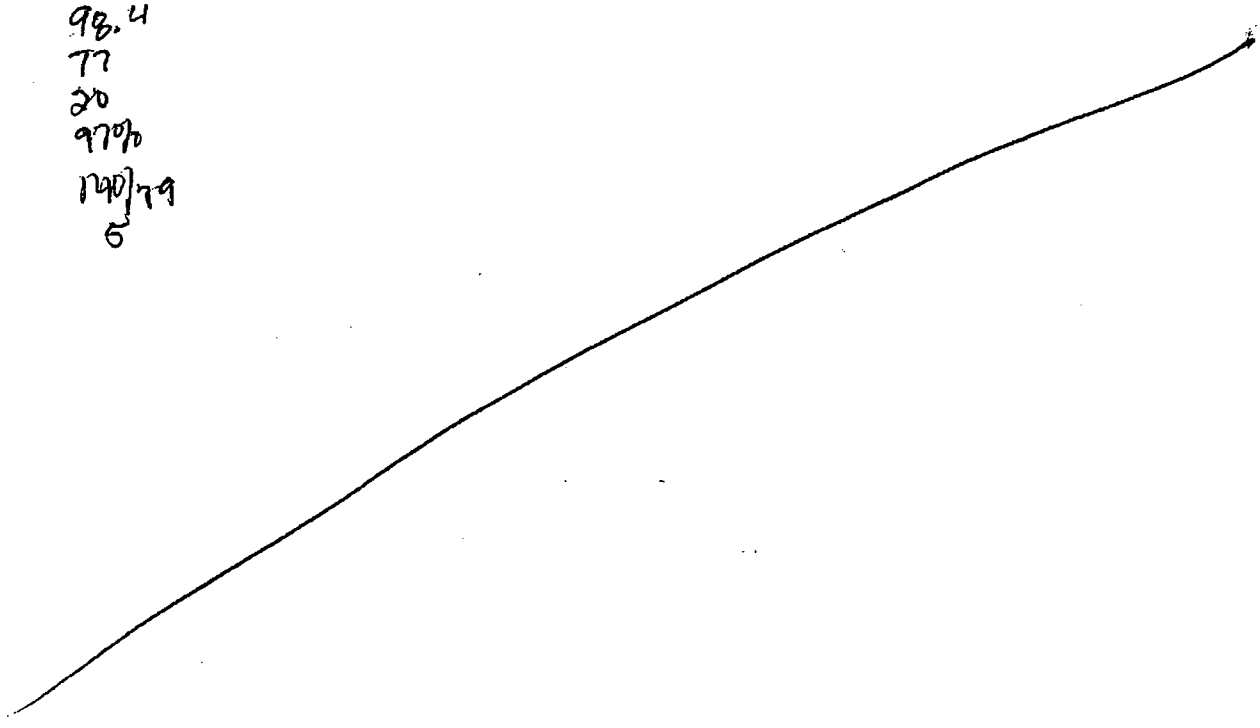
26 Aug 03 400cc dk green bile c mucous NGT output - pt. slept (b)(6)-2
0500 throughout night c further c/o pain - [redacted] cPRN

26 Aug 03 Pt vitals BP 146/76 P 54 T 98.4 R 16 SpO2 94 SPC [redacted] 9mm
0522 (b)(6)-2

26 Aug 03 1112 - Pt A+O x 3 OOB ambulating x 1. Sitting in chair. VSS, lungs CTA, BS ⊕ in lower quadrants. NG intact to LIS c green bile noted. IV to (D) arm → patent. Staples intact to abd incision, ⊘ S/S of infx. Voicing ⊘ complaints. Will cont to monitor [redacted]
(b)(6)-2

26 Aug 03 1510: Assumed care @ 1400. Awake & alert. T-98.8°F P-84 R-16 BP-154/82. SpO2-99% on RA. HR-reg. Lung sounds clear, BS X⊕. Midline incision staples intact, NO S/S of infection, NG to LIS draining Dark green bile, Ambulates ward c I assist. Will continue to monitor, [redacted]
(b)(6)-2

2200 ~~total~~
98.4
77
20
97%
140/79
6



PROGRESS NOTES

DATE

26AUG03 Surgery

No complaint

VSS Afeb NG 900 over 12hrs

abd: mod distended, soft, nontender Normal Bowel sounds today.

12.4 / 34 / 546

A/p ↑ Bowel Activity today.

will ↓ to clears if BS present tomorrow

[redacted] (b)(6)-2

[redacted] (b)(6)-2

26Aug03 assumed care @ 2200 - VSS - no c/o pain 2355 during assessment, pt. sleeping @ present - lungs CTA (B) - BS hypoactive, NGT to LIS 400cc green bile output from 1400 - 2200 - staples intact on abd incision, no drainage noted - IV patent in (L) FA, 2RC 150cc/hr, site [redacted] (b)(6)-2 ~~patent~~ S/S infection - abd soft, nontender, slightly distended [redacted] (b)(6)-2 CPM

27Aug03 NGT output 400cc dk. green bile 2200-0430-0445 c/o abd pain when awoken for VS, given 650mg tylenol PO -

ECWZ

EPW

[redacted] (b)(6)-4

27Aug abd slightly distended, nontender, soft, (b)(6)-2
cont. hypoactive BS in upper quad [redacted]

(b)(6)-2

27AUG030400 P 67, BR 93, BP 147/86, T 93.4 —— SPC [redacted] 41W

27AugO3 A. transfered to ICU1 [redacted]
1015

(b)(6)-2

(b)(6)-4

T-MN/A [redacted]

MEDCOM - 17592

PROGRESS NOTES

DATE	
27 Aug 03	Surgery PT STABLE AFOS LUNGS: CTA CAR: RRR ABD: SOFT, STILL DISTENDED (+) BS Ø BM NG 40 LAST SHIFT Rx: Bloss Plan: cont CURRENT MANAGEMENT [redacted] (b)(6)-2
27 Aug @2100	Pt alox3, VSS, pulse: slightly tachy, HRRR, (+) BS x4, abd: slightly distended. c/o pain. demerol 20mg given c some relief. NGT intact c intermittent suction. s/p ex-lap. IVF LR@150 infusing c s/sx of infection/infiltration. will cont to monitor [redacted] (b)(6)-2 9 Bloom-SPC
27 Aug 2200	Ø BM yet. voiding often, cont [redacted] (b)(6)-2
28 Aug 03 @0505	1000cc from NGT suction, coffee ground colored. Demerol 25mg for pain will cont to monitor [redacted] (b)(6)-2 BBloom
28 Aug 03	Surgery PT STABLE AFOS LUNGS: CTA B CARDIAC ABD: SOFT, (+) BS Ø BM NG 1000 overnight Loss Rx: Bloss Plan: cont CURRENT MANAGEMENT [redacted] (b)(6)-2

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

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 AUG 1000	VSS A&O per interpeter. NG to intermitted LWS suction. NG draining dark green fluid. IV @ FA patent & intact IVF Bag D5 1/2 NS @ 20 ml/hr @ 125 cc/hr. @ swelling or pain noted. DOB circulated to BR Passed Gas @ BM Am Care done. NG to be changed to Maalox as ordered. Abd soft non distended. BS (+) X 4 quadrants. Restraints removed and reapplied. Will check restraints & Circulation of extremities. (b)(6)-2 2CT
28 AUG 1700	Duty Md. Rounds Dr [redacted] pulled NG. & ordered clear liquid diet. Tolerated clear liquids. Ambulated to BR had small BM. Midline Abdominal suture intact with edges to incision well approximated @ drainage, redness or swelling noted from incision [redacted] (b)(6)-2 2CT
29 AUG 03	VSS. (+) pulses. BS & hyperactive. Reported to have small BM on prior shift. Ex-lap & staples OTA & DRY. Tolerating PO sips of water & clear diet well. Instructed to use IS and ambulate frequently and return demonstrate. [redacted] (b)(6)-2 RN

(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.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

29AUG03 (0940) Assumed care of pt @ 0000 w/ report from night shift. Pt alert, speaking Arabic. VSS. ϕc/o pain @ this time. Lungs CTA(B). BS hypoactive x4 quads. Staples to abd midline CDI - open to air. IVF NS c 20KCl infusing via dial-a-flow into (R) forearm. S/Sx infection/infiltration @ site. KUB done this am. Pt tol. clear liquids well. Voiding c difficulty. ϕBM so far this shift. 2-point restraints in place. - ϕ S/Sx complications c skin breakdown / circulation. Will continue to monitor.

[redacted] (b)(6)-2

(1420) Pt ↑ to amb in hallway c difficulty. Pt had large loose BM this pm. Pt states (+) relief of abd pain. Will monitor.

[redacted] (b)(6)-2

(b)(6)-2

29AUG03 Surgery
STAB LOP ABD
LUNGS: CTA
CVS: RRR
ABD: SOFT, NT, ND, BS (+)
EXT: Pedal pulses
PLAN: Clear liquids

KUB: improved

[redacted] (b)(6)-2

29AUG03 1940 Pt resting in bed, AtOx3, VSS, c/o pain, medicated c 2 percs, LS CTA(B), (+)BS x4, S1 S2 present, skin warm dry, staples to abd midline CDI open to air, ϕ S/Sx of infex, IV (R) FA patent infusing NS c 20KCl via dial →

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

EPW

[redacted] (b)(6)-4

MEDICAL RECORD	PROGRESS NOTES

DATE	
	a- flow, proper circulation and skin integrity on (b)(6)-2
Cont.	pts. of restraint. [redacted] (b)(6)-2 91WM6 [redacted] 91WM6
2150	Pt had a BM hard + formed [redacted] (b)(6)-2
	[redacted] (b)(6)-2
30 Aug	Surgery
	Pt states abd
	Lungs: CTA
	CV: RRR
	ABD: soft, NT, ND +BS
	Inc: heal well
	Plan: Advance diet [redacted]
	(b)(6)-2
30AUG03	(1410) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. Pain controlled c̄ Percs. VSS. Steri strips to midline abd incision CDI. Staples removed by MD today. Pt adv to reg diet for lunch. Tol. well. New IV started in Ⓡ forearm. IVF infusing s̄ s/sx infiltration. IV in Ⓛ arm d/cd d/t infiltration. AM care done by pt. voiding s̄ difficulty. ⊕bs x4 quads. 2 point restraints in place - Ø s/sx complications c̄ skin breakdown/circulation. Will cont. to monitor [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)*

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 17596

MEDICAL RECORD	PROGRESS NOTES
DATE	

30AUG03 2145 Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, steristrips on midline abd incision CDI, pt OOB ambulated around the ward, c/o mild pain, IV (R) FA patent infusing D5½ NS ⊂ 20 mEq KC @ 125 cc/hr, proper circulation and skin integrity on pts of restraint: [redacted] (b)(6)-2 GIWM6 (b)(6)-2

31AUG03 0600 Received pt resting in bed, VSS. A+Ox3. ~~Staples~~ midline abd steri strips CDI & drainage noted. IV patent & intact @ Rt, Hl. Amb to BR x2. Pt c/o gas pain abd slightly distended, but soft. Broke out in sweat during first attempt c BR. Dr [redacted] (b)(6)-2 ordered Dulcolax Suppository x1 for stimulation of bowel. placed. Pt amb to BR for 2nd time w/ successful BM. No other remarkable assessment findings will cont to monitor pts. [redacted] (b)(6)-2

1400 D/C to CPW comp in stable condition [redacted] (b)(6)-2 [redacted] (b)(6)-2 Avoid of gas pain complaint

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)	REGISTER NO.	WARD NO.
(b)(6)-4 [redacted] (b)(6)-2 # [redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

NSN 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, Month, Year) 17 Aug 06 | TIME 0000

TRANSPORTATION TO FACILITY

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 NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN (Date) earlier today
IS THIS AN INJURY?	✓		WHERE Ein Gay
INJURY/SAFETY FORMS			
HOW Mortar Round			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT Abd pain hx - asthma

CATEGORY OF TREATMENT

☒ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME 0001

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

VITAL SIGNS

TIME	0002				
BP	141/92				
PULSE	75				
RESP	18				
TEMP	99.9(O)				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 94%

☒ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0010	1gm Ancef IM		(b)(6)-2		
0010	0.5cc Tetanus IM		(b)(6)-2		
0025	5mg Morphine IV		(b)(6)-2		

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 ☐ 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)*

A [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

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
20 Aug 03		12:30	Pt OOB to chair x 90min. Had 1 episode of emesis while up in chair. After emesis Ø c/o Nausea. CXR & KUB done this am. Will continue to monitor pt. [redacted] LN
			(b)(6)-2
20 AUG 03			Transfer Summary
			20 1SL y.o. EPW struck by Shrapnel during mortar attack 16 AUG 03
			Had Xlap with finding of hemoperitoneum (R) rectus sheath hematoma, single through/through enterotomy to distal ileum which was primarily repaired.
			Postop pt has had persistent ileus attempt at removal of NG unsuccessful on POD#2 NG replaced. Currently 5 bowel sounds. Single episode emesis today
			Diag 1) S/P Exlap for Shrapnel Injury to small bowel
			2) Postop Ileus
			Plan Transfer 21CSH.
			NG, IVF.
			Awaiting Bowel [redacted]

(Continue o[redacted]se side)

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

REGIS[redacted]

WARD NO.

[redacted]

(b)(6)-4

(b)(6)-2

MEDCOM - 17599

NURSING NOTES
Medical Record

STANDARD FORM 510 (Rev. 7-91)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
~~17:00~~			Pt ambulated length of ward x 2.
20Aug03		17:00	UOP sufficient. Ng tube to low intermittent
			suction. Minimal drainage through the day. (b)(6)-2
			Will continue to mon. for pt. [redacted]
20 Aug 03		2030	[illegible] pt from ICU #2 [illegible]
			[illegible], Pt c BM x [illegible] of
			stool. (b)(6)-2 [redacted]
20 Aug 03		2300	Pt c C/O Pain [illegible] 2mg MSO4 [illegible] Pt
			[illegible] c eyes closed [illegible] (b)(6)-2 [redacted]
		0100	Pt c C/O Pain given 2mg MSO4. Pt c emesis [illegible]
			[illegible] notified Pt given 12.5mg [illegible]
			IVP (b)(6)-2 [redacted]
21Aug03	0800		Rest c eyes closed. easily
			aroused VS - 146/92 P101. R18 SaO2 96% RA NV
			A+O X3 NAD LS CTA, even unlabored diminished
			@ bases abd ⊕ D[illegible] ⊕ TTP around wound
			site midline staples intact ⊖ d[illegible] ⊖ [illegible]
			noted. NG-LIS
21aug03	2245		VSS, A+O, pt receiving IV Phenergan &
			Reglan around the clock for N/V. Pt.
			had x1 episode of emesis light green ~50
			cc fluid. NGT to LWS intermittent
			suctioning dark green fluid. Staples to
			midline abdomen CDI. Foley to gravity
			draining clear yellow urine. IV to (R) AC
			running LR @ 150cc/. No other remarks

STANDARD FORM 510 (REV. 7-91)

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

MEDCOM - 17600

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			Continued 21 Aug 03 2245- assessment finding- Pt does not appear to be in any pain @ this time. A&Ox4. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03	0040		1300 cc total from NG dark green fluid (b)(6)-2 [redacted]
20 Aug 03	0120	99.1	NG tube with drain 6 inches per MD order & re-taped. HR Regular, lungs sounds clear bilat bowel sounds x 4 quads. IV in RAC s/s of infection or infiltration infusing well @ 150cc/hr. Staples to ventral mid-abdominal incision intact, sts s/s infection. Foley draining clear yellow urine. NG tube draining moderate amts of milky green fluid. VSS. Pt c/o complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug	0738	155	RTVS BP 158/81, HR 100, T 99.2, RR 18, SpO2 95% on [redacted] (b)(6)-2
20 Aug	1000		BM x1 (b)(6)-2 [redacted]
	1525	1700	Pt. c/o temp of 100.8, Tylenol 650mg PR given. (b)(6)-2 [redacted]
	1580		125cc dumpy green fluid emptied from NG suction. (b)(6)-2 [redacted]
22 Aug 03	1925		Assumed care @ 1700, HR: 112 BP 155/88 T-100.5°F Sleeping. NG to low intermittent suction c dark green drainage. Lung sounds clear bilat. Audible heart murmur. LR @ 150 cc/hr infusing in RFA. No signs of pain @ this time. Foley patent. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03		2312	NG output recorded - 800 cc (b)(6)-2 [redacted]
23 Aug 03	0415	0	Late entry for 1700 22 Aug 03: T-100.5°F P-112 R-24 BP - 155/88 SpO2 95% (b)(6)-2 [redacted]
23 Aug 03	0500		NG output - 500 cc (b)(6)-2 [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

NSN 7540-00-634-4123

510-112

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated (b)(6)-2
23 Aug	0730		PTNS. BP 133/84, HR 103, T 99.4, RR 20, SPO2 95% [redacted] 9m
	1200		Pt alert & oriented. OOB x2 ambulating. Had CXR done. VSS, lungs CTA, HR Reg; BS+, Pulses +2 x4. Staples intact to abd, no S/S of infx. Foley intact draining orange urine. NG tube to ↓ intermittent draining green gastric juices. IV patent to [redacted] forearm. Voicing & complaints (b)(6)-2 will cont to monitor. [redacted] 2 Aug
	1730	1600	Pt. c/o ABD pain. 5mg MSO4 given c good results. [redacted] (b)(6)-2 JPW
		1736	Pt. care assumed @1500. VSS. HR Reg, lungs CTA. BS hypoactive BVRQ, active BFQ. NC ABD incision c staples OTA c S/S infection. ABD firm, mod. distended. NG patent, draining green thn liquid. Foley ⇒ gravity draining orange colored urine c sediment. will cont to monitor. [redacted] (b)(6)-2 JPW
		2215	1375cc orange clear urine per Foley, 875 cc green, black, mucoid drainage per NG. 1800cc NG output on day shift per LT.
			(b)(6)-2 [redacted] (b)(6)-2 [redacted] JPW

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 17602

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 Wheeled litter BY Anesthesia/Surgeon

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

3. DATE 17AUG03 TIME PATIENT ARRIVED IN SUITE 0025

4. PATIENT IN ROOM TIME 0025 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Prone padded OR Bed, Head on foamdoughnut, Bilateral Arms extended to sides <90° in CAP secured to padded armboards with Safety straps. Correct Body Alignment maintained. - Folded towels under heels

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

COMMENTS:

8. SKIN PREPARATION

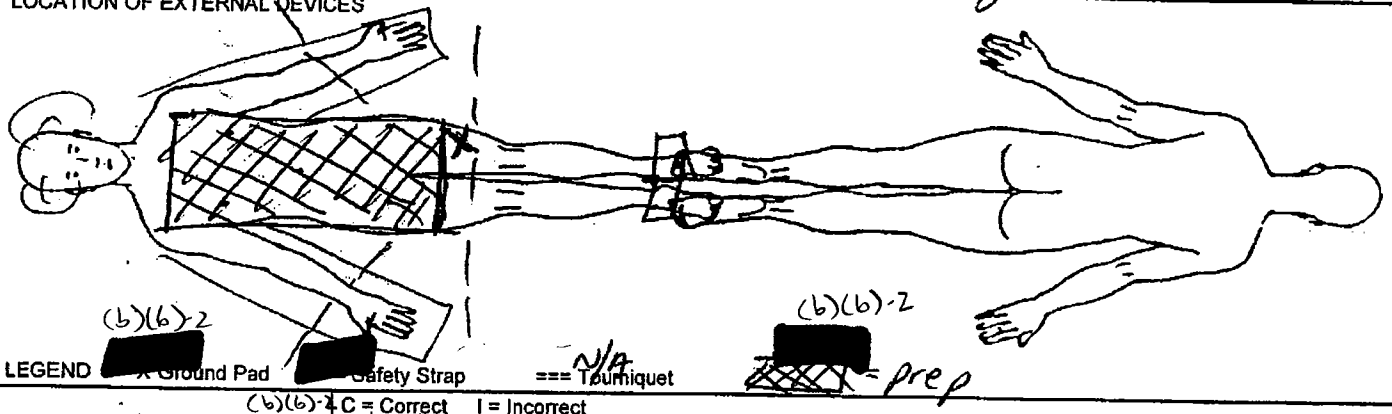
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR by Dr [redacted] (b)(6)-2 ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Beta/Beta
SITE: Chest/Abdomen BY WHOM: CPT [redacted] (b)(6)-2
SITE: +Groin as below BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



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

(b)(6)-2 C = Correct I = Incorrect

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

SCRUB (b)(6)-2 SPC [redacted] " "

CIRCULATOR (b)(6)-2 CPT [redacted] " "

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

[redacted] (b)(6)-4

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

☒ ESU NO: 4 - SN- F0E 000411
GROUND PAD: BRAND REM Polyhesive II Valleylab
LOT NO: 68936 / 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 17603

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING RO[redacted] IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 4x8 plain sponges. Silk tape.

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. foley 16F	2.	3.
SITE	1. Urinary Bladder by Dr [redacted] (b)(6)-2		3.

19. ADDITIONAL INFORMATION
WC IV
Surgeons: Dr [redacted] (b)(6)-2
Dr [redacted] (b)(6)-2
Anesthesia: CPT [redacted] (b)(6)-2 CRNA Anesthesia Type: GEN/Endo.

Bovie Pad site intact pre-op CT ; post-op CT Bovie Settings: Coag/Cut 30/30 Blend 1
Tourniquet Site intact pre-op N/A post-op

Form DA 5179 not completed DT lang barrier + Emergent Status

20. OPERATION(S) PERFORMED
Exploratory Laparotomy & Bowel Repair

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	0220	Wheeled litter

22. RE[redacted] (b)(6)-7

MEDCOM - 17604 USAPA V1.01

REVERSE OF DA FORM 3953-1, OCT 87

ACLU-RDI 1642 p.164

DOD-031193

ICU1

Patients Name: EPW (b)(6)-4 VS 4 Date: 20-21 AUGUST 2003

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	140/				130/				139/							142/	142/									
NBP	/84				/86				/82							80	80									
TEMP	98.3				98.6				98.9								98.9									
R	102				98				108							102	106									
	16				18				18							16	16									
O2	98				97				98							98	98									
IO2																RA										
ource	RA				RA				RA							RA	RA									
MAP																RA										

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	Total
IVF	150	150	50	150	150	150	150	150	150	150	150	150		150	150	150										
IVPB			100																							
NGT																										
PO																										
Total	150	300	450	600	750	900	1050	1200	1350	1500	1650	1800		1950	2100	2250										

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	Total
URINE		300																								
NGT																										
STOOL																										
DRAIN																										
at stable: "... 4 days since last BM..."																										
Total		300							1600										700 1700							

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (•)

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

EPW [redacted]

(b)(6)-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY | POST- DAY | MONTH-YEAR | DAY | 19 | HOUR

27 Aug	28 Aug
0900	0700

29 AUG 03 | 30 AUG 03 | 31 AUG 03

19	0800

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

134/88	P 58 T 97.7	123/71	96	P 70 T 97.1	121/72	168	97.8	126/73	120/72	80	98.3	134/83	85	97.8

HEIGHT: | WEIGHT →

SPO2

96	90	95%	96%	96%	96%	(on)	98%	97%

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU #1

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

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 16 Mar	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
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	23.3	9.8-13.6 secs
APTT	28.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

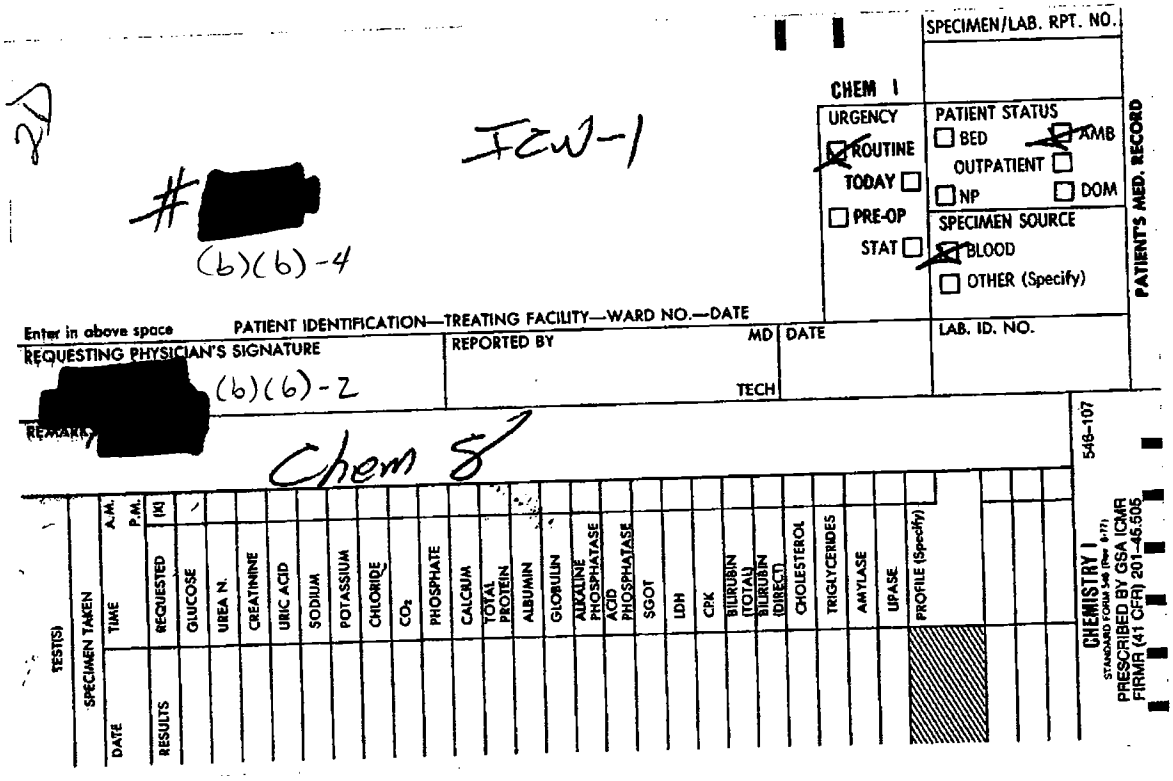
REMARKS:

REPORTED BY: (b)(6)-2 [redacted]

DATE: 17 Mar 03

LAB ID NO.:

MEDCOM - 17608



2D

ICW-1

[redacted]

(b)(6)-4

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE

LAB. ID. NO.

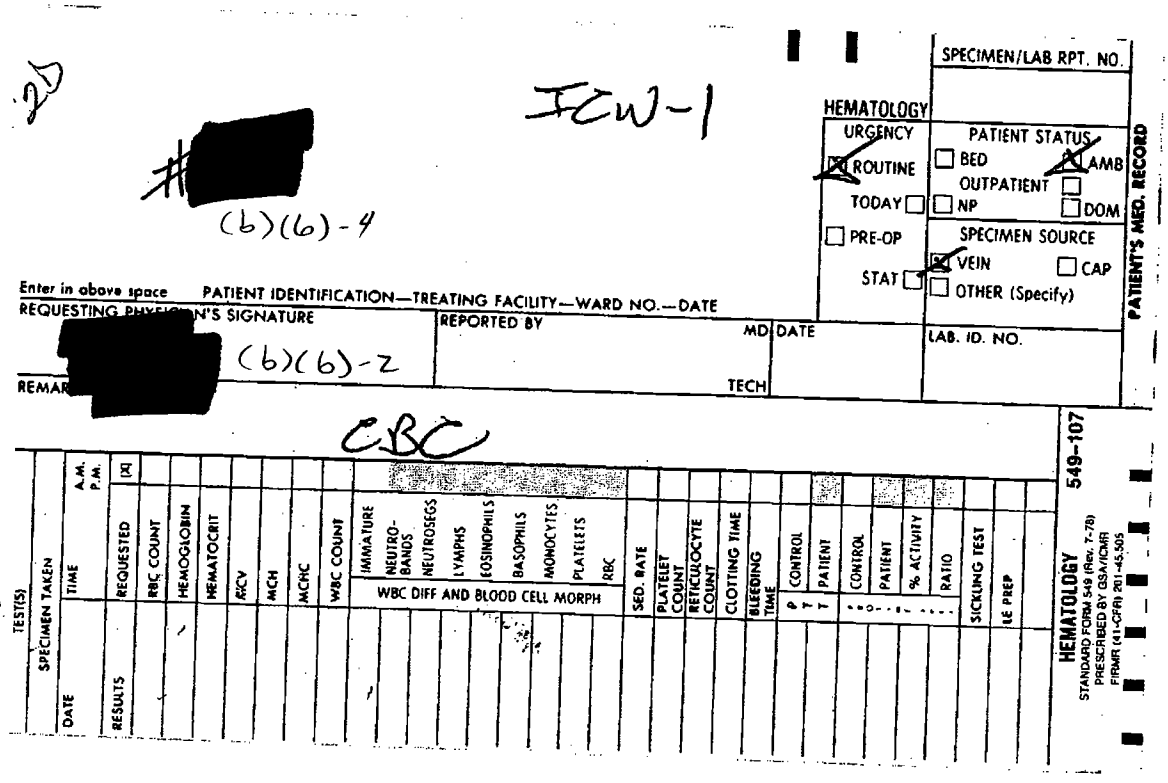
REMARKS

Chem 8

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
			[X]	
GLUCOSE				
UREA N.				
CREATININE				
URIC ACID				
SODIUM				
POTASSIUM				
CHLORIDE				
CO_2				
PHOSPHATE				
CALCIUM				
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				

548-107

CHEMISTRY 1
STANDARD FORM 548 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505



20

ICW-1

[redacted]

(b)(6)-4

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: [X] ROUTINE

PATIENT STATUS: [ ] BED [X] AMB [ ] OUTPATIENT [ ] NP [ ] DOM

TODAY [ ]

[ ] PRE-OP

STAT [ ]

SPECIMEN SOURCE: [X] VEIN [ ] CAP [ ] OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE

LAB. ID. NO.

REMARKS

CBC

TEST(S)	A.M. P.M.	REQUESTED [X]	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	RICV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
SPECIMEN TAKEN	TIME																							P T T							
DATE																															
RESULTS																															

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FPMR (41-CFR) 201-45.505

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

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
17/08/03 00:32
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	142*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

ST	RESULT	REF. RANGE
		3.5-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

T	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

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

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4 [redacted]		DATE 17 Aug	TIME 0840	SSN/PSEUDO SSN:

0800

before trans
17 Aug

(b)(6)-4 [redacted]

Urinalysis				Misc. Serology		
	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	Color		N/A	RPR		Negative
	App		N/A	Mono		Negative
	Glu		Negative	**Microbiology**		
	Bili		Negative	Source		
	Ket		Negative	Gram Stain		
	SG		N/A	Occ Bld		Negative
	Bld		Negative	H. pylori		Negative
	pH		N/A	Micro Parasites		
	Prot		Negative	Malaria		
	Urob		0.2-1.0	O & P		
	Nit		Negative	Other		
	Leuk		Negative	**Microscopic Urinalysis**		
	HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**		**Blood Bank**
Sed Rate			Cell Count		**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**
Other			Directigen	Negative	ABO/Rh

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

Ward/Section: ICU 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: 17 Aug	TIME: 0230	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
		x 10^9
		g/dl (M) g/dl (F)
		% (M) % (F)
		fl (M) fl (F)
		0 x 10^3 ed
		1.1%

ferential

		% (M) % (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 SE 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] **DATE:** 17 Aug 03 **LAB ID NO.:**

Ward/Section: ICU A	REQUESTING PHYSICIAN: [redacted] (6)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (6)(6)-4	DATE: 17 Aug	TIME: 1600
		SSN/PSEUDO SSN:

(Hematology) CBC

17 Aug 1000

(6)(6)-2 [redacted]

TEST	RESULT	REF. RANGE
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:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 17 Aug	TIME: 0428	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
17/08/03 05:20
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.4*	3.3-5.5	G/DL
ALP	50	26-84	U/L
ALT	17	10-47	U/L
AMY	66	14-97	U/L
AST	23	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	15	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	76*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	161*	73-118	MG/DL
TP	4.3*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
tCO		
TE		
ALI		
ALI		
AL		
AM		
AS		
TBI		
GG		
TP		
T		
TI		
NA		
K		
CL		
tCC		

---
i-STAT E88+
Pt: [redacted] (b)(6)-4
Pt Name:_____

Glu_____159 mg/dL
BUN_____18 mg/dL
Na_____142 mmol/L
K_____3.6 mmol/L
Cl_____107 mmol/L
TCO2_____26 mmol/L
AnGap_____13 mmol/L
Hct_____26 %PCV
Hb*_____9 g/dL
*via Hct
pH_____7.260
PCO2_____54.9 mmHg
HCO3_____25 mmol/L
BEecf_____-2 mmol/L

Sample Type_:
17AUG03 05:12
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: JAM5046A
CLEW A93

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17 AUG	LAB ID NO.:

Ward/Section: ICU #2	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: EPW [redacted] (b)(6)-4	DATE: 17 Aug 03	TIME: 0400
SSN/PSEUDO SSN:		

(Hematology) CBC

TEST	RESULT	REF. RANGE
(b)(6)-4 [redacted]		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] **DATE:** 17 Aug 03 **LAB ID NO.:**

Ward/Section: 12W2	REQUESTING PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 18 Aug	TIME: 1900	SSN/PSEUDO SSN:

18 Aug

(b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
Hematocrit		37-47 % (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | DATE: 8-8-03 | LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICIAN: DR [redacted] (6)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (6)(6)-4	DATE: 19 AUG 03	TIME: 0400
		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
Abs	Imm	
RBC		
MCV		80.1-95.0
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
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
[illegible]		Negative
[illegible]		Negative

Microscopic Urinalysis

Blood Bank

MUST [illegible] WITH EVE[illegible] STED

ABO/[illegible]

Blood Bank Unit Crossm[illegible]
(MUST SUBMIT SF 518 WITH EVE[illegible] REQUESTED

UNIT	TYPE	CRO[illegible]

REMARKS:

REPORTED BY: (6)(6)-2 [redacted] DATE: 19 Aug 03 LAB ID NO.:

(b)(6)-2

Ward/Section: IC 42	REQUESTING PHYSICIAN: Dr [redacted] / (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20AUG03	TIME: 0400
		SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
[redacted]		
[redacted]		
[redacted]		
[redacted]		
Pl[redacted]		
Ly[redacted]		
[redacted]		
Seg[redacted]		
Ban[redacted]		
Lymph		
Atyp	Imm	
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward/Section: ICU 2	REQUESTING PHYSICIAN: Dr. [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 AUG 03	TIME: 2100
		SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

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

======= PICCOLO =======
20/08/03 21:15
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	103	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	302	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

Na 136

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20AUG23	TIME:	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
Se		
Ba		
Ly		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 20Aug23	LAB ID NO.:

Ward/Section: ICW#1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
#[redacted] (6)(6)-4	22AUG03	0500	[redacted] (6)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.8	4.8-10.8 x 10^3
RBC	3.06	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	90.8	80-94 fl (M) 81-99 fl (F)
Plt	526	130-500 x 10^3 verified
Lymph %	13.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW#1 | REQUESTING PHYSICIAN:

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

LAST, FIRST, MI. [redacted] (6)(6)-4 | DATE 22AUG05 | TIME 0502 | SSN/PSEUDO # [redacted] (6)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	88	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	164	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	99	98-108 mmol/l
tCO_2	19	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

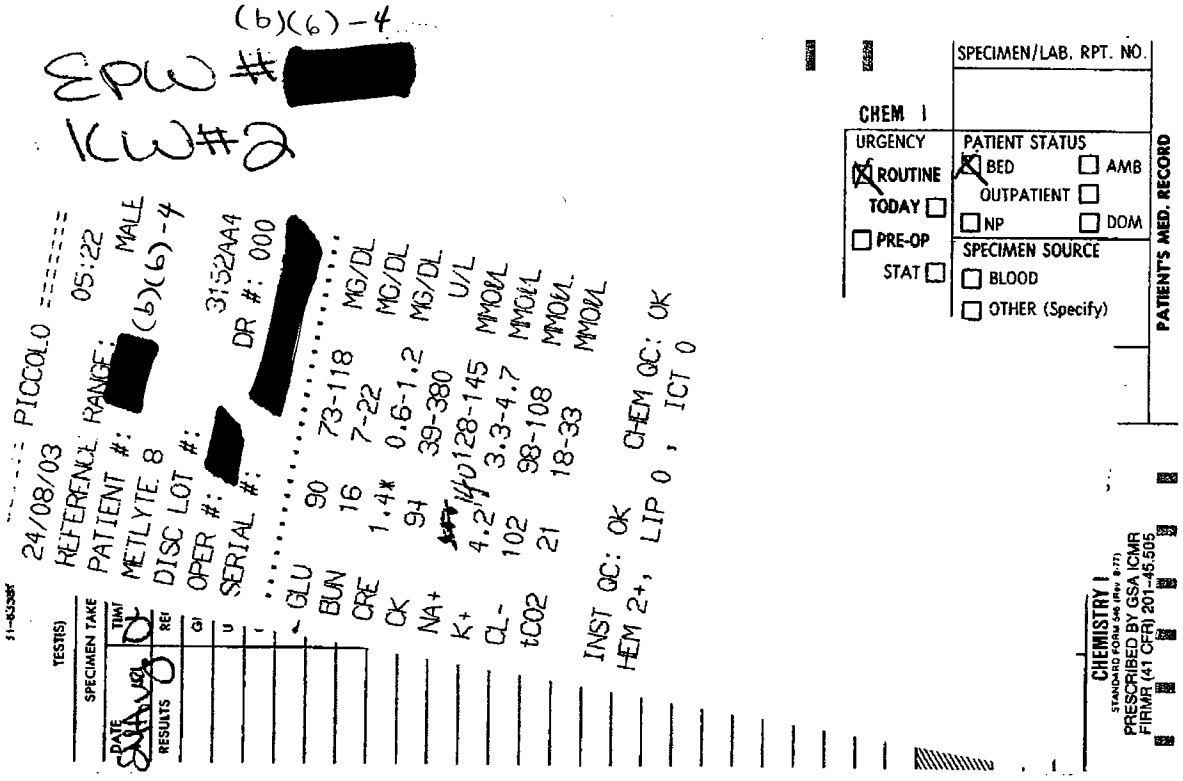
REMARKS:

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

(b)(6)-4

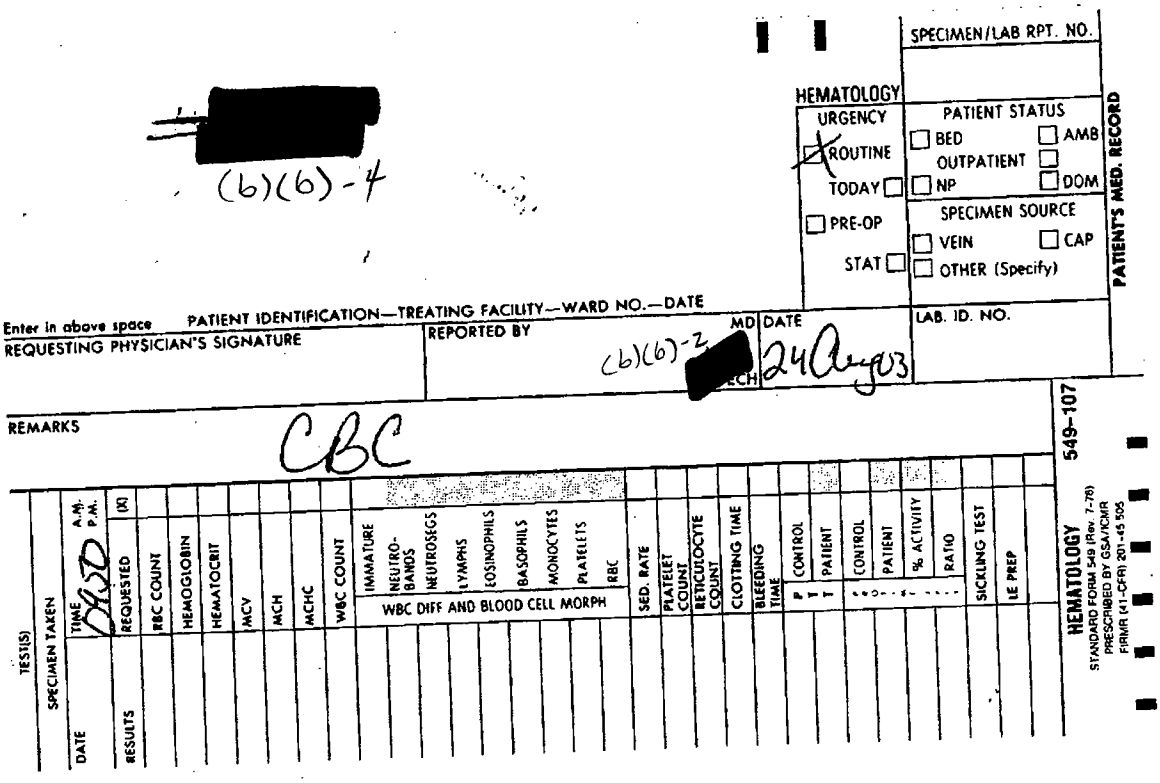
EPW # [redacted]

KCW#2



[redacted]

(b)(6)-4



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

ICW2

23 Aug

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY: ☐ ROUTINE ☐ TODAY ☒ ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY ICW2 MD TECH | DATE 23 Aug | LAB. ID. NO. EPW [redacted] (b)(6)-4

REMARKS Chem 7

546-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)
	RESULTS																										

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

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

ICW2

HEMATOLOGY

URGENCY: ☒ ROUTINE ☐ TODAY ☐ ☐ PRE-OP ☐ STAT ☒

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

SPECIMEN/LAB RPT. NO.

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2 | REPORTED BY | MD TECH | DATE 25 Aug 03 | LAB. ID. NO.

REMARKS CBC

549-107

TEST(S)	SPECIMEN TAKEN DATE 25 Aug 03	TIME 0405 A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEURO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	RESULTS																														

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

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

CHEM 1

SPECIMEN/LAB. RPT. NO.

URGENCY: [X] ROUTINE; TODAY [ ]; PRE-OP [ ]; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] BLOOD; [X] OTHER (Specify) ICU2

PATIENT'S MED. RECORD

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

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

REPORTED BY — MD — DATE 25Aug03 — TECH

LAB. ID. NO.

REMARKS

Chem 7

TEST(S)	SPECIMEN TAKEN: TIME	P.M. (X)	REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)
RESULTS	DATE 25Aug03 0405																											

546-107

CHEMISTRY I
STANDARD FORM 66 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

---

i-STAT E

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

Pt Name:_____

Glu_____87 mg/dL

BUN_____21 mg/dL

Na_____141 mmol/L

K_____3.7 mmol/L

Cl_____105 mmol/L

TCO2_____26 mmol/L

AnGap_____13 mmol/L

Hct_____34 %PCV

Hb*_____12 g/dL

*via Hct

PH_____7.374

PCO2_____45.7 mmHg

HCO3_____27 mmol/L

BEecf_____1 mmol/L

Sample Type_:

25AUG03 04:16

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A

---

i-STAT CREA

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

Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:

25AUG03 04:13

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID [redacted] (b)(6)-4 08-24-03
WB 02:15

				Patient Limits	
WBC	13.1	*H	x10^3/uL	4.5	10.5
RBC	4.17		x10^6/uL	4.00	6.00
Hgb	11.8		g/dL	11.0	18.0
Hct	37.8		%	35.0	60.0
MCV	90.5		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	356.	H	x10^3/uL	150.	450.
LY%	13.2	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

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

ICW2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ROUTINE ☒ | TODAY ☐ | PRE-OP ☐ | STAT ☐

PATIENT STATUS: ☐ RED ☐ AMB | OUTPATIENT ☐ | ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ VEIN ☐ CAP | ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

[redacted] (b)(6)-2 | REPORTED BY | MD | DATE | TECH 26 Aug 03 | LAB. ID. NO.

REMARKS

CBC

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN: DATE	TIME (A.M. / P.M.)	RESULTS
	23 Aug 03	0433	

REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE | NEUTRO-BANDS | NEUTROSEGS | LYMPHS | EOSINOPHILS | BASOPHILS | MONOCYTES | PLATELETS | RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
P T T: CONTROL | PATIENT
CONTROL | PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP

PICCOLO
23/08/03 05:13
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	96	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	95	39-380	U/L
NA+	~~137~~ 138	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	20	18-33	MMOL

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

ID: [redacted] (b)(6)-4 08-25-03 21:13
WB

				Patient Limits	
WBC	12.9 H	x10^3/uL		4.5	10.5
RBC	3.86 L	x10^6/uL		4.00	6.00
Hgb	10.8 L	g/dL		11.0	18.0
Hct	34.4 L	%		35.0	60.0
MCV	89.2	fL		80.0	99.9
MCH	28.0	pg		27.0	31.0
MCHC	31.4 L	g/dL		33.0	37.0
Plt	548. H	x10^3/uL		150.	450.
LY%	18.8	*L	%	20.5	51.1
LY#	2.4	*	x10^3/uL	1.2	3.4

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

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

ICW2

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

[redacted] (b)(6)-2

REPORTED BY MD TECH

DATE 26Aug03

LAB. ID. NO.

REMARKS chem7

546-107

CHEMISTRY 1
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN: DATE	TIME A.M. / P.M.	RESULTS
REQUESTED	26 Aug03	0433	
GLUCOSE			
UREA N.			
CREATININE			
URIC ACID			
SODIUM			
POTASSIUM			
CHLORIDE			
CO_2			
PHOSPHATE			
CALCIUM			
TOTAL PROTEIN			
ALBUMIN			
GLOBULIN			
ALKALINE PHOSPHATASE			
ACID PHOSPHATASE			
SGOT			
LDH			
CPK			
BILIRUBIN (TOTAL)			
BILIRUBIN (DIRECT)			
CHOLESTEROL			
TRIGLYCERIDES			
AMYLASE			
LIPASE			
PROFILE (Specify)			

==(b)(6)= PICCOLO =======

26/08/03 05:19

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	60	39-380	U/L
NA+	136	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

EPW [redacted]

(b)(6)-4

ICWZ

SPECIMEN/LAB. RPT. NO.

CHEM I

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

[redacted] (b)(6)-2

TESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE

TECH 27Aug03

LAB. ID. NO.

REMARKS

Chem 7

TEST(S)	SPECIMEN TAKEN DATE	SPECIMEN TAKEN TIME A.M. P.M.	(X) REQUESTED	RESULTS
GLUCOSE				
UREA N.				
CREATININE				
URIC ACID				
SODIUM				
POTASSIUM				
CHLORIDE				
CO_2				
PHOSPHATE				
CALCIUM				
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				

546-107

CHEMISTRY I

STANDARD FORM 546 (Rev. 9-77)
PRESCRIBED BY GSA (ICMR
FIRMR (41 CFR) 201-45.505

(b)(6)-4

ID: [redacted]

AGE

26-Aug-03
20:12

				Patient Limits
WBC	13.9	H	x10^3/uL	4.5 10.5
RBC	3.59	L	x10^6/uL	4.00 6.00
Hgb	9.9	L	g/dL	11.0 16.0
Hct	32.4	L	%	35.0 60.0
MCV	90.3		fL	80.0 99.9
MCH	27.7		pg	27.0 31.0
MCHC	30.6	L	g/dL	33.0 37.0
Plt	582.	H	x10^3/uL	150. 450.
LY%	17.9	aL	%	20.5 51.1
LY#	2.5	*	x10^3/uL	1.2 3.4

i-STAT EC8+

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

Pt Name:_____

Glu_____79 mg/dL

BUN_____21 mg/dL

Na_____141 mmol/L

K_____3.9 mmol/L

Cl_____104 mmol/L

TCO2_____30 mmol/L

AnGap_____13 mmol/L

Hct_____32 %PCV

Hb*_____11 g/dL

*via Hct

PH_____7.360

PCO2_____49.6 mmHg

HCO3_____28 mmol/L

BEecf_____3 mmol/L

Sample Type_:

27AUG03 04:10

(b)(6)-4

EPW [redacted]

ICW2

HEMATOLOGY

URGENCY: ☐ ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

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

REPORTED BY

MD DATE 23 Aug 03

TECH

LAB. ID. NO.

REMARKS CBC

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

TEST(S) | SPECIMEN TAKEN: DATE, TIME, A.M./P.M. | RESULTS: REQUESTED (X), RBC COUNT, HEMOGLOBIN, HEMATOCRIT, MCV, MCH, MCHC, WBC COUNT, WBC DIFF AND BLOOD CELL MORPH (IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC), SED. RATE, PLATELET COUNT, RETICULOCYTE COUNT, CLOTTING TIME, BLEEDING TIME, PTT (CONTROL, PATIENT), PT (CONTROL, PATIENT, % ACTIVITY, RATIO), SICKLING TEST, LE PREP

ID: [redacted] 08-22-03

WB (b)(6)-4 20:43

				Patient Limits	
WBC	12.7	H	x10^3/uL	4.5	10.5
RBC	3.39	L	x10^6/uL	4.00	6.00
Hgb	9.8	L	g/dL	11.0	18.0
Hct	30.7	L	%	35.0	60.0
MCV	90.7		fL	80.0	99.9
MCH	28.9		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	393.		x10^3/uL	150.	450.
LY%	11.3	*	%	20.5	51.1
LY#	1.4	*	x10^3/uL	1.2	3.4

(b)(6)-4

EPW [redacted]

ICW2

23 Aug

HEMATOLOGY

URGENCY: ☐ ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE

TECH

LAB. ID. NO. EPW [redacted] (b)(6)-4

REMARKS CBC ICW2 EPW

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

TEST(S) | SPECIMEN TAKEN: DATE 23 Aug, TIME 0400, A.M./P.M. | RESULTS: REQUESTED (X), RBC COUNT, HEMOGLOBIN, HEMATOCRIT, MCV, MCH, MCHC, WBC COUNT, WBC DIFF AND BLOOD CELL MORPH (IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC), SED. RATE, PLATELET COUNT, RETICULOCYTE COUNT, CLOTTING TIME, BLEEDING TIME, PTT (CONTROL, PATIENT), PT (CONTROL, PATIENT, % ACTIVITY, RATIO), SICKLING TEST, LE PREP

Ward/Section: ICU#1 | REQU[redacted] (b)(6)-2 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. | DATE | TIME | SSN/PSEUDO SSN:

#[redacted] (b)(6)-4 28AUG0500 #[redacted] epw (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		

(Hematology) Ma

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		

Urinalysis

TEST	RESULT	REF
		N/A
		N/A
		Negat
		Negat
		Negat
		N/A
		Negati
		N/A
		Negati
		0.2-1.(
		Negati
		Negati
		Negati

(b)(6)-4

[redacted]

06-27-03
20:42
Patient
Lower

WBC	11.9 H	x10^3/uL	4.5 10.5
RBC	3.36 L	x10^6/uL	4.00 6.00
Hgb	9.4 L	g/dL	11.0 18.0
Hct	30.2 L	%	35.0 60.0
MCV	89.9	fL	80.0 99.0
MCH	28.1	pg	27.0 31.0
MCHC	31.2 L	g/dL	32.0 37.0
Plt	367 H	x10^3/uL	150. 450.
Lym	17 L	%	20.0 51.0
Lym	2.1 L	x10^3/uL	1.2 3.4

PICCOLO

28/08/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	49	39-380	U/L
NA+	137	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	102	98-108	MMOL
tCO2	23	18-33	MMOL

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

Misc. Serology

RANGE

Spun Hematocrit		
Sed Rate		
Other		

Cell Count		
Directigen		Ne

Coagulation Studies

Bloo (MUST SUBMIT SI

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

REMARKS:

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

CBC & chem 7

MEDCOM - 17631

Ward/Section: ICW4	REQU[redacted] (b)(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EDW # [redacted] (b)(6)-4	DATE 28 AUG	TIME 0500	SSN/PSEUDO SSN: # [redacted] (b)(6)-4

i-STAT

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

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:	**DATE:**	**LAB ID NO.:**

CBC & Chem 7

(b)(6)-4

[redacted] PICCOLO [redacted]
29/08/03 05:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....136.....

GLU	[redacted]	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	42	39-380	U/L
NA+	121*	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

[redacted] (b)(6)-4

[redacted]

WBC	10.2		x10^3/uL	4.5	10.5
RBC	3.74	L	x10^6/uL	4.00	5.50
HGB	10.5	L	g/dL	11.0	16.5
HCT	33.6	L	%	35.0	50.0
MCV	97.8		fL	80.0	99.0
MCH	28.0		pg	27.0	31.0
MCHC	31.2	L	g/dL	33.4	37.0
PLT	552.	H	x10^3/uL	150.	450.
LY%	20.0		%	20.5	51.1
LYM	2.0	*	x10^3/uL	1.2	5.4

Ward/Section: ICU #1

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

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

DATE: 30AUG

TIME: 0530

SSN/PSEUDO SSN: [redacted] (b)(6)-4

MISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

```
=======_PICCOLO =======
30/08/03            05:40
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #:        3151AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted]
.....................
GLU    98    73-118    MG/DL
BUN     8    7-22      MG/DL
CRE   1.2    0.6-1.2   MG/DL
CK     40    39-380      U/L
NA+   128    128-145   MMOL
K+    3.9    3.3-4.7   MMOL
CL-   97*    98-108    MMOL
tCO2   23    18-33     MMOL

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

RANGE
6 mmol/L
mmol/L
mmol/L
45
mmHg (art) mmHg (ven)
mmHg (art) en)
mmol/L (art) mmol/L (ven)
mmol/l. (art) mmol/L (ven)
%
(+3)
l/L
mmol/L
1.32 mmol/L
mg/dl
05 mg/dl
1.5 mg/dl
51% PCV
17 g/dl
y
F. RANGE

(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		3.5-5.5 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
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

	DATE:	LAB ID NO.:

ICU 2

MEDICAL RECORD - ANESTHESI...

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

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

DRUG (Units)	Doses	TOTALS
Versed (mg)	2.5	2.5
Fentanyl (mcg)	50 100 50	200
Ketamine (mg)	70	7
Sux (mg)	120	120
Vec (mg)	10	10
MSO4 (mg)		7
VOLAT AGENT Iso % del / % e.t.	1.6 - 1.7 - 1.0 - 1.5 - 1.5 - 0.8 X	
AIR L/Min		
N2O L/Min		
O2 L/Min	10 - 2 - 2 - 2 - 2 - 2 - 2 - 10	

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

TOTAL EBL: 400

TOTAL URINE: 275

FLUIDS - SUMMARY
CRYSTALLOID- 3200 cc
COLLOID- 1000
BLOOD- Ø

FLUIDS — LINE site
- 18 (R) Arm ☐ Warmed — LR 800 → 2600 cc — X LR, X Hespan
- 18 (L) Arm ☐ Warmed — LR — X LR, X Hespan
- 18 (L) Brachial ☐ Warmed — LR
- ☐ Warmed

LOSSES
EST BLOOD LOSS
URINE - Foley 300 / 200 — 700/400 — 25/275

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

BODY WEIGHT: 80 KG

HEMATOCRIT: 14/45

INITIAL DATA: BP- 141/92; HR- 79

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCED [redacted] TIME- 2330

TIME → 0015 0030 45 0100 15 30 45 0200 15 30

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

(b)(6)-2

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

VENTIL

VT - ml	–	830	800	790	720	750	720	500
f - breaths/min	24	8	8	8	8	9	9	12
Peak inf pres / PEEP	–	23	23	27	24	20	23	–
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S
ET CO2 (torr)	(+)	33	30	30	31	31	31	35
FIO2 (Frac or %)	.71	.71	.72	.72	.72	.72	.72	.72
SpO2 (%)	100	100	100	100	100	100	100	100
ECG	SR	ST	SR	SR	SR	SR	SR	SR
TEMP-site Nasal		36.3	36.0	35.8	35.6	35.4	35.3	
N-M Block (T/4)		0/4 1/4		0/4	0/4	0/4	1/4	1/4

X BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer; Y ET CO2; Y FIO2; Y SpO2; X ECG; Y TEMP-site

Warming blkt
Conv warmer

ST @ 50

EVENTS Position → on ——— on → →

(Code drugs) with letters & symbols, (enter) in REMARKS

REMARKS — Code drugs with numbers, events with letters

0015 Arrived Fwd, To OR via litter.
0025 In room, (+) monitors (+) O2, Smooth IV induction, Eyes taped, 3rd IV started, pt padded, arms < 90°, OG placed, stomach sxn,
0047 Procedure started, Lab results received, HCT 45 HB 14 Reported to Surg.
0130 2 gm Ancef IV
0206 Reversed c̄ 5 mg Neostigmine (+) 0.9 mg Robinul.
0210 Pt SXN x 2, Extubated c̄ HL > 5 sec. 5 dyspnea. To ICU 2 in stable condition, Report to Anes.

RECOVERY AT 0215
PACU (ICU) 2 (Specify)
OTHER
CONDITION: Stable
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start 0015	Room 0025	End 0220
PROC	Ready 0035	Begin 0047	End 0207

(PRO)CEDURES and CPT Codes: Ex Lap

(PATI)ENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade technique, comments*
RSI c̄ Cricoid pressure, DL x 1 eff (?) c̄ MAC 4 #8 ETT, (+) BBS (+) ETCO2, secured @ 22 cm teeth, soft bite block placed, Grade I view

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

ANESTH(ESIA): [redacted] (b)(6)-2 CPT CRNA

PROCEDURE LOCATION: OR 1

DATE: 17 Aug 03

PAGE 1 OF 1

(DA F)ORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDCOM - 17635

ACLU-RDI 1642 p.195

DOD-031224

AND PLAN OF CARE

AGE: 24 Days Mos (Yrs) GENDER: (X) Male ( ) Female

ALLERGIES: NKDA

P S: 1 (2) 3 4 5 (E!)

WT: 80 (Kg/Lb) HT: ____ In.

PROPOSED PROCEDURE: Ex lap

SURGICAL SERVICE: Gen

NPO SINCE: ____

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury (Shrapnel wounds)

HABITS:

Tobacco: X

EtOH: X

Drugs: X

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) ____

( ) ____

( ) ____

( ) ____

( ) ____

( ) ____

PREMEDICATIONS:

None / Yes @ ____ Hrs

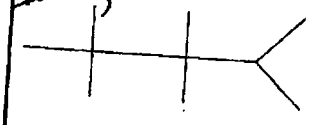
____

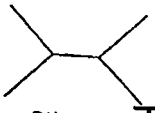
____

____

LABORATORY STUDIES:

Pending





Other: T&C x 4 units

____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	(Y)	Asthma Hx
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	Foley
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY

X

PHYSICAL EXAMINATION

BP: 141/92 HR: 79 RR: ____ T: 96 %RA

Pain (0/10 Scale): ____

Airway Exam:

Dentition ____

Trachea 3FB

TMJ/C-spine ____

Oropharynx MP II

Chest:

Lungs 18g (L) AC

Heart CTA

IV Access: IVs x 2 18s

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with pat[redacted]r legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] (b)(6)-2 CRNA CVT Date: 17 Aug 03 Time: 0005

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: EMT

28TH COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

MEDCOM - 17636

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify)

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 17 Aug 03

DATE AND HOUR REQUIRED:

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

IF PATIENT IS FEMALE, IS THERE HISTORY OF: N/A

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: EX LAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: SGT [redacted] (b)(6)-2

DATE VERIFIED: 17 Aug 03

TIME VERIFIED: 0024

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

SECTION II – PRE-TRANSFUSION TESTING

TRANSFUSION NO.

PATIENT NO.

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 21 Aug 03

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

DATE: 17 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISS[redacted] (b)(6)-2

AT (Hour): 0930

ON (Date): 17 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): SGT [redacted] (b)(6)-2 91WM6

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

TEMP. 100.1 PULSE 112 BP 98/60

TYPE OF TRANSFUSION: 1 Aug 03

TIME STARTED: 1055

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME COMPLETED: 1205

DATE COMPLETED: 17 Aug 03

INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and IV solutions to the Blood Bank.

DESCRIPTION: 104/56 P 108 T 100.2
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] 91WM6 (b)(6)-2

SEX

WARD

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

MEDICAL RECORD COPY

MEDCOM - 17637

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify)

VOLUME REQUESTED (If applicable): 1 UNIT ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 17AUG03

DATE AND HOUR REQUIRED:

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR [redacted] PROCEDURE: EX LAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: SGT [redacted] (b)(6)-2

DATE VERIFIED: 17AUG03

TIME VERIFIED: 0024

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO. (b)(6)-4 [redacted]

SECTION II – PRE-TRANSFUSION TESTING

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	COMP

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 17 Aug 03

REMARKS: EXP 21 Aug 03

SECTION III – RECORD OF TRANSFUSION

INSPECTED AND [redacted] PRE-TRANSFUSION (b)(6)-2

AMOUNT GIVEN: 350 ML

POST-TRANSFUSION DATA
TIME: 1045 DATE COMPLETED: 17AUG03 INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION: 94/52 P114 SaO2 96 T100.1

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] (b)(6)-2 91 WMD

SEX: M

WARD: ECU 2

AT (Hour): 0431

ON (Date): 17 Aug 03

IDENTIFICATION:

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

VERIFIER (Signature): SGT [redacted] (b)(6)-2 91 WMD

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

TEMP. 99.4 PULSE 130 BP 104/60 RR 22

DATE OF TRANSFUSION: AUG 03

TIME STARTED: 1340

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: Last, first, middle; rank/[illegible] hospital number and name of facility.)

[redacted] (b)(6)-4

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

MEDICAL RECORD COPY

MEDCOM - 17638

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: 17 Aug 03 TIME OF ORDER: ____ HOURS

LIST TIME ORDER NOTED AND INITIALS

① Admit ICW 2
S/P Ex Lap SB Repair
Cond stable
Vitals Q2° c SAT I/O
All NKDA
Act OOB TID
Foley to gravity

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

NPO
IVF LR @150cc/hr
Meds
MSO4 2-10mg IV Q2° PRN Pain
Ancef 1gm IV Q8°
Tylenol 650mg PO Q6° PRN Fever

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

CBC, Chem 8, Chem 12 in AM

(b)(6)-2 [redacted]

(b)(6)-2

Noted 17 Aug 03 @ 2030hrs [redacted] (b)(6)-2 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 AUG 03 TIME OF ORDER: 1845 HOURS

① VS Q6°
V.O. Dr [redacted] / [redacted] ILTAN
(b)(6)-2 (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

17AUG03 0720

1. 5 ips of Water
2. ~~IV~~ CBC @ 0830

(b)(6)-2

[redacted]

(b)(6)-2

noted 17 Aug 0830

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

17AUG03 0900

1. TY 24 PRN ~~QN~~ NLT 2hrs

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

17AUG03 1410

1. CBC @ 1530

(b)(6)-2

[redacted]

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

18AUG03 ~~1515~~ 0650

1. CBC Now and QAM
2.

(b)(6)-2

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

19 Aug 03 1700

1. Transfer to ICU 2
2. Cont Current Orders

[redacted]

(b)(6)-2

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

22Aug03 2315

DC Roslin and Phenergan V.O. from Dr. [redacted]

(b)(6)-2