CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

VO Dr. [redacted] /s/ [redacted]

Phenergan 12.5 mg IVPush now b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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: 20 ... 03

TIME OF ORDER: ____ HOURS

LIST TIME ORDER NOTED AND SIGN

✓ 1- CXR ʒ done

✓ 2- KUB ʒ done

3- CBC & Chem 7 in AM

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: ...

TIME OF ORDER: ____ HOURS

Mach [redacted]

b(2)-2

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 Aug 03

TIME OF ORDER: 2045 HO[redacted]

— Send CBC, chem 8

— flat plate, upright abdomen & KUB

— Dulcolax supp. 1 [redacted] repeat in [redacted]

b(6)-2

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER

T[redacted]

____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256

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

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

"USE B... POINT PEN - PRESS FIRMLY / NO CARBON PAPER REQ... ED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

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

DATE OF ORDER: 21 Aug 03 | TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

1 - Reglan 10 mg IVPB q 4°
2 - Ambulate q 4°
3 - KUB in AM
4 - call for UO < 30cc/hr
HR > 120 SBP < 90 [redacted]
O2 SAT < 90% RA [redacted]
5 - CBC / Chem 7 q AM [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 21 Aug 03 | TIME OF ORDER: b(6)-2 HOURS

1 - Phenergan 25 mg IVPB q 6° [redacted]

1800

NURSING UNIT | ROOM NO. | BED NO.

2200 21 Aug 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Aug 03 | TIME OF ORDER: 2300 HOURS

DC Reglan and Phenergan
V.O. from Dr [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

24° ✓ 23 Aug 03 0400 [redacted]

PATIENT IDENTIFICATION

EPW b(6)-4

[redacted]

38

NURSING UNIT: CW2 | ROOM NO.: 5 | BED NO.: C

DATE OF ORDER: 23 AUG 03 | TIME OF ORDER: 0700 HOURS

1. OOB to chair AT TTD c Ambulation
2. ~~DC Foley PT to void by~~
2. incentive spirometry
3. KUB this AM and CXR PA/LAT [redacted]
4. CBC Normal [redacted]

23 Aug 1000

[redacted]

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

24 ✓ 23 Aug 0030 [redacted]

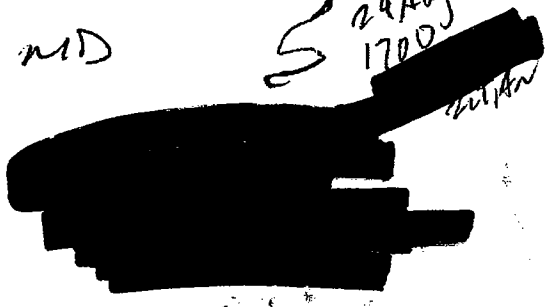
☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

b(6)-2

MEDCOM - 17643

8/24/03 ① D/c Foley pt to void w/~ 6 hrs. or call MD

Noted 24Aug03 1700



b(6)-2

ACLU-RDI 1643 p.4

DOD-031233

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

DATE OF ORDER 25Aug03 TIME OF ORDER 2230 HOURS

LIST TIME ORDER NOTED AND SIGN

Maalox 30cc PO x1 Now [redacted]

V.O. from Dr [redacted]

[redacted]

b(6)-2

NURSING UNIT ICW2 ROOM NO. 5 BED NO. C

2[illegible] 26Aug03 0045 [redacted]

PATIENT IDENTIFICATION

Noted 26Aug03 [redacted] b(6)-2

DATE OF ORDER 26AUG03 TIME OF ORDER 1700 HOURS

① D/C Ancef

b(6)-2

[redacted]

NURSING UNIT ICWZ ROOM NO. 5 BED NO. C

2[illegible] 0001 27Aug03 [redacted]

PATIENT IDENTIFICATION

EPW

[redacted]

DATE OF ORDER 27AUG03 HOURS

1- Demerol 25mg q[illegible] PRN PAIN

2- Cont A.M. LABS

3. DC MSO4

4. Percocet [illegible] po q4-6°

[redacted]

b(6)-2

NURSING UNIT ICWZ ROOM NO. 5 BED NO. C

PATIENT IDENTIFICATION

EPW

[redacted]

27 1623 b(6)-4

b(6)-4

DATE OF ORDER 27AUG03 TIME OF ORDER 1623 HOURS

Carafate 1gm [illegible] Q6°

Zantac 50mg IV Q8°

CBC, Chem [illegible] AM

Maalox [illegible] NG 30cc Q6°

Clamp [illegible]

[redacted]

NURSING UNIT ICW2 ROOM NO. 5 BED NO. C

[illegible] 28AUG03 [redacted]

REPLACES EDITION OF [illegible] JUL [illegible] MAY BE [illegible]

b(6)-2

DA FORM 4256 1 APR 79

MEDCOM - 17645

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
Noted 28AUG03 0900 [redacted] b(6)-2

DATE OF ORDER: 28 Aug 03 TIME OF ORDER: ______ HOURS

1- change fluid to D5 1/2NS c 20 KCL @ 125cc/hr

2- UA + Chem 7 qd

3- KUB in AM

[redacted]

NURSING UNIT: ICW 1 | ROOM NO. | BED NO.

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION
Noted 28 Au 1520 b(6)-2 [redacted]

DATE OF ORDER: 8/28 TIME OF ORDER: 1620 HOURS

① clear [illegible]

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[illegible] [redacted] /AN 28Aug03 2035

PATIENT IDENTIFICATION
b(6)-2 Noted [redacted] 30AUG03 [illegible]

DATE OF ORDER: 30AUG03 TIME OF ORDER: [redacted]

1- Reg. Diet

[redacted]

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

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

DATE OF ORDER: 8/30 TIME OF ORDER: ______ HOURS

① D/C IV zantac ✓

② D/C Maalox ✓

③ D/C IVF ✓

④ D/C Amlodipine ✓

[redacted] b(6)-2

NURSING UNIT: 3?0 | ROOM NO.: MOD | BED NO.: 3 Bay [redacted]

DA FORM 1 APR 79 **4256** REPLACES EDITION [redacted] WHICH MAY BE USED.

MEDCOM - 17646

ACLU-RDI 1643 p.6

DOD-031235

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED & SIG
	8/31	1700 HOURS	
①	D/C to EPW camp today		
②	NO meds recalled	b(6)-2	

[redacted]

8/31/03 1515

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

b(6)-2

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. Y Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
17 Aug 03	[redacted]	Vitals q2hr c sym + TIO
17 Aug 03	[redacted]	Act. OOB TID
17 Aug 03	[redacted]	Foley to gravity
17 Aug	[redacted]	pt may have sips of water
18 Aug	[redacted]	CBC q am chem 7
18 Aug	[redacted]	VS q 8°
21	[redacted]	Amb q 4°
23 Aug	[redacted]	OOB to chair TID & ambulation
23 Aug	[redacted]	Incentive Spirometry
18 Aug	[redacted]	Clean lip dent

HR | DATE COMPLETED

16 17 18 19 20 21 22 23 24 25 26 27 28 29

[redacted] D/C 18 Aug 03

[redacted] D/C 24 Aug 03

[redacted]

b(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

s/p ex lap SB repair cond. stable

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 EDI MEDCOM - 17648

BLD-2 AH

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 Aug 03	[redacted]	Admit ICU 2	17 Aug 03	0230	0230	[redacted]
17 Aug 03	[redacted]	CBC, Chem 8, Chem 12 in am	17 Aug 03	0400	done	
17 Aug	[redacted]	CBC @ 0830	17 Aug	0830		
20 Aug	[redacted]	CBC and Chem 7 in am	21 Aug	0600		
20 Aug	[redacted]	CBC Chem 8	One	Dose	[redacted]	[redacted]
20 Aug	[redacted]	Abd x-ray	Done	Done	2120	[redacted]
21	[redacted]	CBC/chem 7 in AM	Done	done		
21	[redacted]	Kub in am	Done	done		
24	[redacted]	D/C Foley Pt to void x 8 hrs or call MD	24 Aug	1645	1645	[redacted]
25 Aug	[redacted]	CBC & Chem 7	25 Aug	IN AM		[redacted]
28 Aug	[redacted]	KUB in AM				
31 Aug	[redacted]	D/C to EW camp today (No meds needed)	31 Aug			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
		call MD no < 32 ax	
		HR > 120 SBP < 90	
		RR > 30 O2	
		Sat < 90%	

USAPA V1.00

b(6)-2 AM

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

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

Mo. Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	1
18	[redacted]	CBC, Chem 7 QAM	05	[redacted]		DLC 8/30
8	[redacted]	VS Q6°	6			
			18			
18	[redacted]	AMB QA°, OOBTC TID	6			
			18			
18	[redacted]	Incentive Spirometry	6			
			18			
18	[redacted]	Clear liquid diet	6			
			18			DLC
30 AUG 03	[redacted]	Reg diet	06	[redacted]		
			18			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: ex-lap i SBrepair

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

M 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	[redacted]	PT D/C to EPW camp today; no meds needed b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
17	[redacted]	Call MD for UO<30cc/hr HR>120, SBP<90, RR>30, O2Sats<90% b(6)-2	

USAPA V1.00

b(6)-2

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)** | Mo. 8 Yr. 03

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16 17 18 19 20 21 22 23 24 25 26 27 28 29
17 Aug 03	[redacted]	IVF LR @ 150 cc/hr	06	[redacted]
			18	
17 Aug 03	[redacted]	ancef 1 GM IV	00	
		q8h	08	
			16	
21	[redacted]	Reglan 10 mg q 4°	02	X X X X X [redacted]
		10 mg	06	
			10	
			14	
			18	
			22	RD
21	[redacted]	Phenergan 25 mg IVPB	6	X X X X X
		q6°	12	X X X X X
			18	X X X X X
			24	X X X X X RD
17	[redacted]	Ancef 1 GM IV	02	[redacted]
		Q8h	14	
			22	

Dcd 22 Aug 03 2315

Dcd 26 Aug 03 1850

5(6)-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: SP Ex lap SB repair cond. stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

EDW # [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 17652

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 8 Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20 Aug 03	[redacted]	Dcc: Dor— Bisacodyl →	20 Aug 2045	2045	2045	[redacted]
20 Aug	[redacted]	Repeat in 2° →	20 Aug	2400	(H)	
21 Aug	[redacted]	Phenergan 12.5 mg IVP x 1	21 Aug	0520	0520	[redacted]
23 Aug	[redacted]	KUB & CXR PA & Lat this Am	23 Aug	—	done	[redacted]
25 Aug	[redacted]	Maalox 30 cc PO x1 NOW	25 Aug	1030	1030	[redacted]

b(6)-2 Am

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
17 Aug 03	[redacted]	MSO4 2-10 mg IV q1hr PRN pain	17 Aug 0745 5mg IV [illegible]; 17 Aug [illegible] [redacted]; 17 Aug [illegible]; 18 Aug 5mg IVP 0400 [redacted]; 18 Aug 5mg IVP 0700; 18 Aug 3mg IVP 1000; 18 Aug 3mg IVP 1340; 18 Aug 5mg IV 1700; 18 Aug 5mg 1920; 18 Aug 5mg 2330; 19 Aug 5mg 0400; 19 Aug 03 3mg 0910 Cont [redacted]
17 Aug 03	[redacted]	Tylenol 650 mg PO q6h PRN pain	0430 27 Aug BLS
19 Aug	[redacted]	MSO4 2-10 mg IV q 1 hr PRN PAIN	19 Aug 1205 5mg IVP; 19 Aug 1330 3mg IVP; 19 Aug 1600 3mg IVP; 19 Aug 03 2040 3mg IVP; 19 Aug 2110 3mg; 19 Aug 2315 3mg; 20 Aug 0015 5mg; 20 Aug 0040 5mg; 20 Aug [illegible]; 20 Aug [illegible]; 20 Aug [illegible]; 22 Aug [illegible]; 23 Aug 0500 5mg IVP; 23 Aug 1531 5mg; 23 Aug 2145 5mg [redacted]
		phenergan 25 mg IVP q6°	NKA [illegible] 1820 [illegible] → D/C order rewritten [redacted]
19 Aug	[redacted]	MSO4 2-10 mg IV q1° PRN pain	24 Aug 0810 5mg; 24 Aug 1650 5mg [redacted]; 25 Aug 0200 5mg [illegible]; 26 Aug 03 0100 5mg BLS IVP ⊕; 27 Aug 03 0130 5mg IV BLS ⊕

USAPA V1.00

MEDCOM - 17653

b(6)-2 AH

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: 27	28	29	30	31	1	2	3	4	5	6	7	8	9
17 Aug	[redacted]	~~IVF LR @ 150/hr~~	06 18	~~Continue~~													
21 Aug	[redacted]	~~IVF LR @ 150cc/hr~~	N 06 18	[redacted]	Δ'd 28 Aug 03												
22 Aug	[redacted]	~~Carafate 1gm slurry Q 6°~~		Not available													
27 Aug	[redacted]	Zantac 50mg IV Q 8°	08 16 24	[redacted]	D/C @ 1130												
27 Aug	[redacted]	Maalox down NG 30cc Q 6hr Clamp for 1hr	06 12 18 24	0 / N / [redacted]	Δ NG D/C'd 28 Aug 03 D/C												
28 Aug	[redacted]	Δ IVF to D5 1/2 NS c 20 meq KCl/L @ 125cc/hr	06 18 X	[redacted]	D/C @ 1130												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Exp Lap SB repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 17654

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
31	[redacted]	Ducolax suppository x1 now	31	0900		[redacted]

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
27 Aug	[redacted]	Demerol 25 mg	27AUG 2040 25mg	28 0440 25mg												
		Q1° PRN pain	[redacted]													
28 Aug	[redacted]	Percocet ii q4-6° prn Pain	28AUG 2300	29AUG 1420	29AUG 1930	30AUG 0810	30AUG 1335	30AUG 1755	30AUG 2345							
			ii	ii	ii	ii	ii	ii	ii							
			[redacted]													
		b(6)-2 A11														

USAPA V1.00

MEDCOM - 17655

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 03
Time In: 0230
Allergies: NKDA
Pre-op V/S: 41 192/79
Procedures: Ex lap SB repair
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3200 Colloid 1000
OR Output: UOP 275 EBL 400
Meds/Times: see DA 7889

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds: 0

History: cysthmen

Time	0230	0245	0300	0315	0330	0345
SaO2	98	100	100	100	100	98
FiO2	10	10	10	06	02	
Methods	RA	NC	NC	NC	NC	
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	28	28	20	16	16	
T	96					
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
PACU	NS	1000cc	Lasso	SK	1000 cc

X-rays: | Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

b(6)-2 [redacted] 0900 HN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: 124 #3 | DATE: 17 Aug 03

PATIENT IDENTIFICATION (For typed or written entries: 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

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

ACLU-RDI 1643 p.16

DOD-031245

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0230	10	MSO4 5mg	IV	10	I	
0235	10	MSO4 5M	IV	10	I	
0240	10	MSO4 5M	IV	10	I	
0245	10	MSO4 5M	IV	cefep	E	

NEUROVASCULAR

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

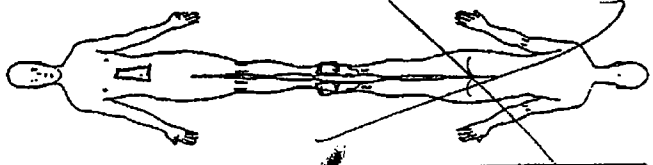
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ABD	Gauze	-0-
30'	ABD	Gauze	sm. amt
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
PACU	Urine	Yellow	350

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0230	Stach	no	no
0320	Stach	no	no

WAMC OP 173-E

NURSING NOTES

0230 Pt received from OR via gurney; accompanied by OR staff. O2 via NRB 10LPM placed for sats 88%. Pt moaning & holding on to abd. Sterile dressing clean dry & intact. Monitors placed - see vitals. Will continue to monitor - [redacted] opt
0330 - Pt sleeping comfortably - VSS. No issues at this time - Pt meets PACU discharge criteria. Pt to remain in ICU 2 - [redacted] opt/A

b(6)-2 A4

Discharge Criteria:
Date: [illegible] Time: 0330 PARS: 9
BP: 146/83 T: HR: 106 RR: 12 Sa02: 98
Pain Level at D/C (0-10):
Intake: 12 Output: 350
Additional Data: -0-
Transferred To: Remained in ICU 2
Report Given To: [redacted] opt
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] opt/A

b(6)-2

ACLU-RDI 1643 p.17

DOD-031246

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
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

		INITIAL SHIFT ASSESSMENT		
		Time: 1900 Initals: [redacted] b(6)-2	Time:	Initals:
NEURO	Pupils	3mm brisk PERRL		
	Sensorium	A+O interacts c staff using sign language and other pt.		
	LOC / GCS			
CARDIAC	Cardiac Rhythm	ST 100's S1 S2 present		
	PRI: / QRS:			
	Pulse Strength	2+ x4 distal extremities		
	Cap Refil / JVD	<3sec x4 extremities		
	Edema	Ø edema noted		
	Chest Pain	denies @this time		
RESP	Respiratory Pattern	even + unlabored		
	Breath Sounds	clear in uppers and diminished in bases Ø secretions noted		
	Secretions	Ø cough		
	Cough	SATS 95-98% on RA		
SKIN	Color	warm + dry		
	Integrity	dsg to midline abdomen CDI		
	Backside	(R) Lower abdomen bloody drainage noted. small puncture wound		
IV	Access Devices	(L) Forearm Hep L		
	Location			
	Condition	flushes well Ø s/s of infection		
GI	Abdomen	distended in pain		
	Bowel Sounds	(+)x4 quads hypoactive		
	Stoma/Ostomy	MD called @ change of shift. NGT placed to LIS		
GU	Device	Foley to gravity		
	Color / Clarity	Yellow urine		
		QS		

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU3, [redacted] (6)2-2

(Continue on reverse)

DATE

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

A FORM 4700, MAY 78

MEDCOM - 17658

USAPPC V2.00

ICU1

Patients Name: [redacted]

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							94		101		118			120		118		139		140		136		138		
NBP	108/72		110/72		104/56		152		80		66			78		69		83		81		78		79		
TEMP	99.4		99		99.4		100.1		100.2		100.1			99.8		98.8		98.4		98.8		97.8		98.8		
HR	120		128		130		114		116		126			122		123		101		100		103		106		
RR	18		22		24		22		24		22			24		22		20		18		16		20		
SaO2	98		97		99%		96		97		96			97		96		96		95		96		95		
FiO2	0		RA		RA		RA		RA		RA			RA		RA		RA		RA		RA		RA		
Source																										

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 LR	150	150	150	150	HAD	150	150	1150	150	150	150			200						50						
IVPB																										
NGT																										
Blood				350		375										x2										
Cmesis					X1 episode Bilious Blood																					
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	Tot
URINE		110	80	60	40	40	30	50	45	50	60	80		110		250		150		200		150		150		
NGT																350								200		
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17659

ACLU-RDI 1643 p.19

DOD-031248

MED[illegible] RECORD-SUPPLEMENTAL MEDICAL

For use of this for[illegible] 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

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0600 Inital[redacted]	Time: Initals:
N E U R O			
	Pupils	3mm brisk perrla consl NV1	
	Sensorium	A+OX3 interactive	
	LOC / GCS	Communicates by sign, Interpeter & other pts	
C A R D I A C	Cardiac Rhythm	ST 100's	
	PRI: / QRS:		
	Pulse Strength	2+ X 4 extremities	
	Cap Refil / JVD	< 2 sec X 4 extremities	
	Edema	⊖ edema	
	Chest Pain	denies CP	
R E S P	Respiratory Pattern	even unlabored	
	Breath Sounds	CTA bilat diminished lower lobes	
	Secretions	⊖ nasal secretions	
	Cough	⊖ cough R-18 SaO2 96% RA	
S K I N	Color	pink warm dry	
	Integrity	dig midline abd CDI	
	Backside	⊖ lower abd bloody dsg noted ⊖ sm puncture wound Dsg D'ed	
I V	Access Devices	⊖ FA 18g LR runs 150cc/hr	
	~~Location~~	patent flushes well ⊖	
	Condition	S+S inf rate or infx	
G I	Abdomen	⊕ DTN noted tender	
	Bowel Sounds	BS hyperactive x 4 ⊖ rigidity	
	Stoma/Ostomy	NGT ⊖ nare patent to LIS drainage cloudy watery	
G U	Device	Foley to gravity yellow	
	Color / Clarity	urine ⊖ noted sediment ⊖ odor	

(Continue on reverse)

PREPARED BY
SGT [redacted] 11NOV06 b(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU [redacted] (b)(2)-2

DATE
18 Aug 03

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

EPW # [redacted] b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17660

ICU1

Patients Name: EPW [redacted] 3

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	135		132/70		127/89		117/76		109/77			135/64							147/80						144/63	
NBP	79		98		99		96		98			100							100						98	
TEMP	98.8		98.8		99.4		99.6		99.8			100.2							101.2						101.2	
HR	100		98		125		114		118			130							123						120	
RR	18		20		20		18		20			22							20						20	
SaO2	96		96		96		97		97			97							97						95	
FiO2	RA		RA		RA		RA		RA			RA							2L						2L	
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	Total
IVF	150	150	150	150	150	150	150	150	100	50	150	150		150	150	150	150	150	150	150	150	150	150	150	150	
IVPB			350									50								50	-					
NGT	[redacted]	[redacted]																								
J																										
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
URINE	40		200		150		125		110		150								500						550	
NGT	30		5		10		15		120		10														400	
STOOL	0		0		0		0		0		0															
DRAIN																										
Total	-																									

MEDCOM - 17661

DOD-031250

ACLU-RDI 1643 p.21

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

19 Aug 03

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)

QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 2020 Initals [redacted]
N			
E	Pupils		MOTB
U	Sensorium	Sil [redacted]	3mm Reactive
R	LOC / GCS		follows commands
O			
C	Cardiac Rhythm		
A	PRI: / QRS:		5.52 NSR
R	Pulse Strength		
D	Cap Refil / JVD		+2 x4 extremities
I	Edema		Ø
A	Chest Pain		Ø
C			
R	Respiratory Pattern		unilaterally equal
E	Breath Sounds		CTA
S	Secretions		
P	Cough		
S	Color		
K	Integrity		WNL for race
I	Backside		intact
N			intact
	Access Devices		
I	Location		@ wrist
V	Condition		CDI
	Abdomen		
G	Bowel Sounds		Distended & tender
I	Stoma/Ostomy		+ x4 quads
			Ø
G	Device		
U	Color / Clarity		via foley

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE

ICU3, [redacted]

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

MEDCOM - 17662

USAPPC V2.00

ACLU-RDI 1643 p.22

DOD-031251

ICU1

Patients Name: EPW # [redacted]

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	142/84						140/86							142/86						112/82						
TEMP	98.4						99.2							97.8						99						
	108						110							112						112						
RR	14						16							22						22						
SaO2	99						99							96						95						
FIO2	2L						2L							2L						2L						
Source	NC						NC																			

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 LR	150	150	150	150	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	150	150	150	150	
			50								50									50						
IVPB																										
NGT	[redacted]																									
																				200	300	150	150	150	150	
											200									2700	3,000					3,600
Sub Total			200																							

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	To
URINE	120						550							490												
NGT	10						250							35												
STOOL	0						0							0												
DRAIN																										
																									700	
Total																										

MEDCOM - 17663

DOD-031252

ACLU-RDI 1643 p.23

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A I 1 D 1 [redacted]
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): UNK- NAME
4. PAY GRADE: EPW
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): [redacted]
7. AGE AT ADMISSION: 24Y
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION: MUSLIM
10. LENGTH OF SERVICE: Z
ETS: UNK
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 0200
BRANCH / CORPS: b(2)-4
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: Z
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 1
PREV. ADMISSION: YEAR [ ] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0
WARD: ICU2
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 05
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 030831
24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 030817
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

DX: (1) Shrapnel Wounds
(2) S/P Ex-lap. S-B repair

Trauma 9 Injury 549

Dx 868.19, 959.8, E991.9
Px 46.73, 87.79, 99.04

b(6)-2

ADMITTING OFFICER (Sign): [redacted]
SIGNATURE OF ADMITTING: [redacted]
DR. [redacted]

DA FORM 3985 MAR 89

MEDCOM - 17664

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG b(2)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. [illegible]	9. ETS	10. PREVIOUS ADMISSION
M	22	—	—	—	—	NO

11. FMP	12. [redacted]	13. ORGANIZATION	14. WARD
99120		b(2)-4	ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K-78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0649	AEAA

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

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	Unk	24 Aug 03	DR [redacted]

29. [redacted] b(2)-2

30. DATE OF INITIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

mortar Attack

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: Gsw open R frontal depression

Dx: 80359

Px: 0202 Staff Code

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

SIGNATURE OF ATTENDING MEDICAL OFFIC[redacted] b(2)-2 SIGN[redacted]AL RECORDS OFFICER

DR [redacted]

DA FORM 3647, MAY 79 MEDCOM [illegible]665 USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Iraqi EPW involved in ~~Mortar~~ attack 8/16 w/ (L) Frontal fragments penetrating (L) frontal skull. Had been GCS 15 by report of 21st CSH. Taken to OR with debridement local & irrigation and closure of skin. X-rays pre-op (L) frontal depressed skull fragments w/ retained metal (L) frontal lobe.

PHYSICAL EXAMINATION ~~Awakens, Alert & Appropriate although moderately Apathetic~~
(L) Forhead incision ~~[illegible]~~ stapled w/ Brain Extrusion from Defect.

Pupils: OS oval with hippus o/w Briskly Reactive

EOM: normal gaze
Neck: (-) TENDERNESS
Chest: No lesions
Lungs: CTA

Heart: RRR s mum
Abd: (+) BS NT/ND ∅ HSM
Thin Scaphoid.
Ext: ∅ deformity
Back:

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

(1). Pt to OR for GETA w/ (L) frontal wound revision.

[redacted] b(6)-2

[redacted] 8/17/03 | IDENTIFICATION NO. | ORGANIZATION

PA[redacted]IFICATION (*For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility*) | REGISTER NO. | WARD NO. ICU 2

) [redacted]

b(6)-4

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

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03	Summary
1400	22 y.o. ♂ Iraqi arrived c left frontal open
NKDA	skull injury and exposed brain. GCS 15.
PMH/PSH: 0	Few scattered frag wounds to back.
Meds:	C-spine: neg
MSO4	CXR: neg
Anes	Skull: ⊖ frontal skull fx c frags + ?
Dilantin	bone in frontal lobe
	Surgery this AM @ 0200 c debridement
	of necrotic brain, irrigation + skin (only)
	closure c staples.
	Stable post surgery. GCS 15
	AVSS during stay
	Dx: open skull injury
	Tx: trans to [redacted] CSH (b)(2)-2
	[redacted]
	(b)(2)-2 COL, MC
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

IRAQI, [redacted]

(b)(2)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03 0800	Surgery → Pt taken to OR and wound / Brain Skin closed loosely over exposed brain material. → General anesthesia → b(6)-2 [redacted] TC/MC
17 Aug 03 0715	A left for Surgery via Litter and returned @ 0900 MC
17 Aug 03 0900	A+O x 3, PERRLA, Skin W/D to torso, Resp even / unlabored O2 Sat @ 100% on RA. HR regular 84-90 bpm. Lungs CTA. Heart c Dr sg CDI. Neck c Soft collar, Abd Soft / flat and nontender. ↓ B.S. x 4 quads. IV N.S. Δ to LR @ KVO / patent in (L) anticubital c redness or swelling. full rom x 4 ext. Cap refill nail bed <3 sec. able grip c some weakness (R) side. VSS & Resp distress Will monitor for Δ's. HL (R) dorsal arm patent c flush b(6)-2 [redacted] MC/BN
17 Aug 03 0900	Dilantin 100 mg IVPB in fusing via (R) HL well flush & finished VSS remain stable PERRLA will continue to assess [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] NUMBER
	LAST	FIRST	MI	(SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

IRAQI # [redacted]
b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8/17/03	Neurosurg Brief OP Note
1700	Pre-op Dx: ① Frontal open Depressed Skull fx
	Post-op Dx: ① Frontal open depressed Skull fx
	Procedure: ① frontal debridement/Wound Revision
	Cranial plating covering of defect
	Surgeon: TEXT — Finding: Single Scalp layer opened, Necrotic Brain
	Anes/t: GETA — Herniating, depressed ① Frontal skull fx
	EBL: 200cc — Epidural bleeding, Resected Bone/Necrotic Brain Debris
	Count: Correct
	Fluids: 1000 NS 4/0: 900cc
	Drains: ∅
	Compl: ∅

b(6)-2

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.

WARD NO. ICU

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
17Aug03	1734 Received from OR c̄ ? report. pt placed on ICU bed. pt easily arousable to verbal stimuli [illegible] [illegible] [illegible] [illegible]. [illegible] commands [illegible] [illegible] [illegible] [illegible] [illegible] ess [illegible] [illegible] on [illegible] [illegible] [illegible] @ 100%. [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] noted. [illegible] [illegible] [illegible] in place. [illegible] [illegible] [illegible] [illegible] [illegible] with patient. [illegible] [illegible] [illegible] [redacted]
	[illegible]
18AUG03	Neurosurgery POD 1
0642	(S/O) VSSA. b(6)-2
	Closure healthy.
	Neuro normal.
	Tolerating clears.
	(A/P) Doing well s̄ I/D DOSF.
	Advance diet [redacted] tivities.
	Foley at [redacted] b(6)-2
	[redacted] [illegible] 4797

HOSPITAL OR MEDICAL FACILITY	S[redacted]	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN [redacted]	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.

WARD NO. ICU 2

EPW [redacted]

b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Aug03 0800	Pt resting in bed. VSS. Head wound closed with ~~staples~~ sutures open to air. Free of S+S of infection. Pt refuses to eat breakfast. Will continue to monitor throughout shift. SPC [redacted] 9/WM6
1200	VSS. Pt refuses to eat or drink anything. Had interpreter try to help explain why he should eat and he still refused to eat or drink. SPC [redacted]
1700	Pt. rested all day. VSS throughout the shift. Neuro: no changes throughout the shift; Neuro was stable throughout the shift. Drained 100 cc clear yellow urine from foley before D/C'd. Pupils brisk equally reactive. Equal strength bilaterally arms and legs. Follows simple commands. Forehead wound closed c sutures open to air. Ø Drainage. Wound Free of S+S of infection. SPC [redacted] 9/WM6
18Aug03 1930	received pt. from ICW2 ~1800 IR stable condition - IV SL'd in (R) AC, sites S/S infection - pt. ambulated c some assistance - PERRLA, follows simple commands - sutures intact on forehead, sites S/S infection - lungs CTA (B), (+) BS, (+) peripheral pulses x 4 extremities - tol. regular diet [redacted]

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

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

REGISTER NO.

WARD NO. ICW2

#[redacted] EPW

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.19.03 0017.	Pt. care assumed @ 2100. HR Reg, lungs CTA, BS ⊕ x4. Sutures to forehead OTA, CDI. Pt. follows simple commands, tol P.O well. HK intact. Will cont. to monitor — [redacted]
19Aug03	0645 - pt alert & oriented lying in bed. VSS, temp 100.2 gave Tylenol 650 mg. Lungs CTA, HR reg., BS⊕, pulses ⊕ x4. Stitches intact to forehead, ∅ s/s of infx. Will cont. to monitor — [redacted] 2LtAN
19AUG03 0651	Neurosurgery (S/O) Low grade fever overnight. Awake, alert, eating breakfast Above healthy. b(6) - 2A11 No meningismus. (A/P) Stable s̄ Elevation (L) Frontal DSF. Ward care until stable for EPW camp. [redacted] 4157
19Aug03	1?06 - pt [redacted] to chair. AM care given while in chair. Tolerated sitting in chair 30 minutes. Will cont to monitor [redacted] bow
19Aug03 1335	assumed pt care @ 1300. pt awake at alert VSS stitches to forehead intact OTA ∅ s/sx of infection noted. lungs CTA, abd soft, nontender, nondistended BS⊕x4 quads. pulses ⊕x4. ⊕ IV access noted. ∅ complaints voiced @ this time. Will cont to monitor — [redacted] 91WMC —

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 21:48	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D/I. Sutures to frontal lobe intact OTA & apparent S/S infection scant amt ecchymosis to OS periorbital area. LCA@B BS@ x4. ABD soft non-tender. @PP@B. Pt able to tell me his name. @ c/o pain @ this time. Pt transfer from bed to chair S difficulty. Will mon [redacted] /AM
20 Aug 03	1220: Pt alert & oriented OOB to chair S difficulty. A little unstable when transfering from bed to chair. VSS, lungs CTA, BS@, pulses @x4. Sutures intact to forehead. Tylenol given for pain. C/o dizziness. Will cont to monitor [redacted] b(6)-2
20 Aug 03 1340	Assumed pt care @ 1300. pt c/o dizziness while sitting in chair. VSS temp 101.6 given ~~1~~ Tylenol. Sutures to forehead intact @ S/S of infection noted. Both eyes swollen & bruising. Lungs CTA, abd soft BS@ x4. Ext ↑ ext & full ROM @ pulses. @ complaints voiced @ this time. Will cont to monitor [redacted] q1hr/MC
20 Aug 03 21:45	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist/ankle. VS WNL per flow sheet ~~x~~ ↑ temp 100.5° ~~1~~ Tylenol given will retake temp and mon. throughout shift. Skin W/D/I

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 - 17673

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	suture site to frontal lobe well approx. edema noted b/t sutures
	sutures OTA. Ecchymosis noted (B) periorbital. Awake and alert
	LCAB. HRR. S1S2 WNL. BS⊕x4. ⊕PP(B). ∅ c/o's. will cont.
	to mon. [redacted] /AN
21:55	Pt OOB to AMB within unit. c/o dizziness. Amb c assist
	s difficulty. [redacted] /AN b(6)-2
Addendum	Pt. extremely diaphoretic ∴ undersheet saturated. will
	remove blanket and retake temp in 1° [redacted]
0004	Temp ↓ 99.4 [redacted] /AN
21Aug03	assumed care @ 0500 - VSS - no c/o pain @
1030	this time - staples intact on forehead
	incision - slight bruising remains on eyelids
	and below eyes - pt. refused breakfast only
	drinking juice - pt. obeys simple commands,
	very quiet, unable to assess orientation
	@ this time due to pt. not speaking
	english b(6)-2 [redacted]
21Aug 1815	Received pt from Dogwood facility in stable condition. VSS, transferred to bed, restraints
	in place, sutures OTA + intact, ∅ drainage
	noted [redacted] b(6)-2
21Aug03	2130: VSS T ⊕ 100.5, 650mg Tylenol po given, will reevaluate
	(T), wound to (L) side of forehead c sutures approximated
	neurologically WNL, periorbital bruising to both eyes,
	Other assessment findings unremarkable, ∅
	IV access, will continue to monitor [redacted]
22Aug0200	Pt VS BP 124/81, HR 115, RR 24, T 98.3, SPO_2 96% [redacted]
	b(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

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
22 Aug 03	1125		Pt. awake & alert c complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. c IV access. MD in this AM to remove sutures to forehead incision, sutures removed & wound reopened MD now wants dry DSO's to forehead Δd. QD. OD sclera red on (R) side & eye, bruising noted to lids bilat. All other assessment findings WNL. Will continue to monitor. b(6)-2 [redacted]
22 Aug 03		1930	Assumed care @ 1700. Awake + Alert. VSS, Lung sounds clear bilat. Abd soft, nondistended, BS x 4. Dressing to Forehead CD&I. No c/o pain @ this time. Will continue to monitor [redacted]
23 Aug 03	0415		Late entry for 1700 22 Aug 03. T-100.2°F P-74 R-16 BP-104/53 SpO2-98% b(6)-2 [redacted]
23 Aug 03	0723		PVS. BP 109/53, HR 77, T 99.2, RR 16, SpO2 97% [redacted]
	1123		Pt. alert & oriented OOB x1 to chair. Bed AM care in chair. VSS, HR reg, BS @ x4, pulses @ x4. Incision to forehead, open to air, some dried drainage noted. No new drainage this AM. Voicing ø Complaints. Will cont to monitor b(6)-2 [redacted]
		1630	Pt. care assumed @ 1500. Pt. stable c ø complaints HR Reg, lungs CTA, BS @ x4. Incision to Forehead OTA Pt has hematoma to lateral edge of incision about ½ x ½ cc of soft tissue. Will cont. to monitor. b(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICU2

EPW b(6)-4 [redacted]

NURSING NOTES
Medical Record

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

MEDCOM - 17675

ACLU-RDI 1643 p.35

DOD-031264

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8-23		2034	Pt - ambulated length of hallway x2. Gave Pt. 650mg Tylenol for Low Grade Fever [redacted]
23Aug03 2330			Pt awake and alert. PERRLA. Pupils brisk response to light. Incision to (L) forehead CDI, Sutures remove, Hematoma noted to lateral side of incision. Lungs CTA bilat, Ø resp distress. NSR. Abd Soft, non-tender, bowel sounds active x4 quads. Ø complaints [redacted]
24Aug03	0743		PVS: BP 112/61, HR65, T 98.7, RR16, SpO2 99% [redacted]
	1107		BP 85/43, HR69, T 99.0, RR 18, SaO2 98% [redacted]
	WED		BP RETAKEN MANUALLY 100/64 [redacted]
	1302		Pt A+O x3, VSS, Lungs CTA, HR reg, BSO, pulses Ø x4, Incision to forehead Ø drainage noted D/C orders to camp as written [redacted]
		1531	Pt. care assumed @ 1400. Pt c low grade temp of 100.1. Pt. given 650mg Tylenol and assisted c ambulation length of hallway x2. HR Reg, lungs CTA, BSO4. Sutures to forehead CTA, CDI. Pt awaiting transport to EPW camp [redacted]
24 Aug 2200			Pt vital signs taken BP 105/51 P74 R16 T 98.8° SpO2 98 [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS [redacted] b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 17 AUG 03 | TIME: 1545

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
22	AREA CODE	NUMBER	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)*
IS THIS AN INJURY?	Y		WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1545

INITIALS: C

VITAL SIGNS

TIME	1545				
BP	110/48				
PULSE	90				
RESP	22				
TEMP	99.4				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

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)*

EPW [redacted] b(4)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 17677

ACLU-RDI 1643 p.37

DOD-031266

ER case

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: 22 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): mkda 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D Skull fx

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ? see chart
Jewelry removed: yes/no Family waiting: yes/no
wedding Band
ORP → unable to remove

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

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

[redacted]

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

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

[redacted] CPT USN 19 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bone Site: cli

Dsg: cldli

Breathing: extubated

b(6)-2 AM

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT USN

DATE: 17Aug03 TIME: 1625

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT USN

DATE: 17Aug03 TIME: 1730

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

ACLU-RDI 1643 p.39

DOD-031268

MEDICAL RECORD | **INTRAOPERATI\ CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia/Surgeon

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

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 1615

4. PATIENT IN ROOM TIME 1615 NUMBER 2-5

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: proper body alignment maintained, head on foam donut, (L) arm tucked at side, (R) arm extended on padded armboard at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO Dr. Teff
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR
[ ] CLIP

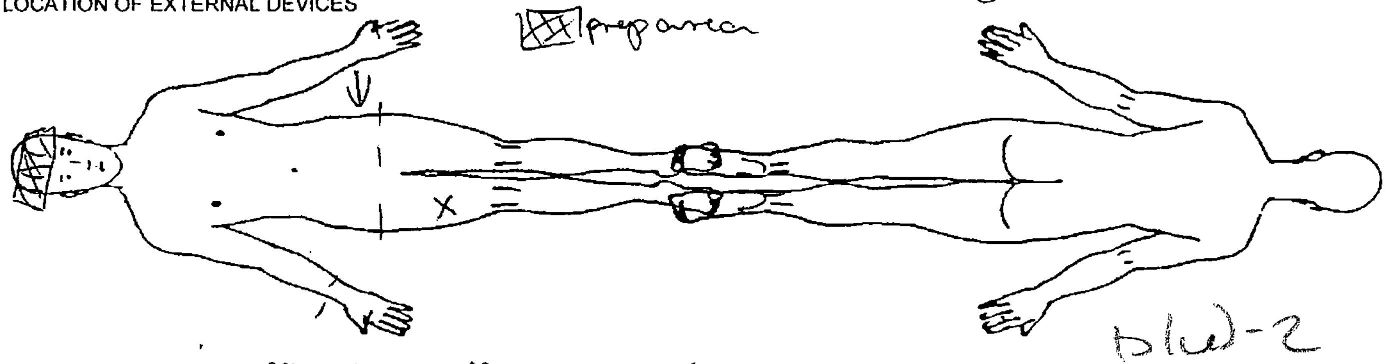
COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Forehead BY WHOM: Dr. [redacted]
SITE: BY WHOM: b(6)-2
see #9

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES

[X] prep area



b(6)-2

LEGEND X Ground Pad SM – Safety Strap SM === Tourniquet NA

C = Correct I = Incorrect Initial: [redacted]

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	C	C	C	[redacted] b(6)-2	[redacted]
Needle Sharp	[X] Yes [ ] No	C	C	C		
Instrument	[ ] Yes [X] No	NA	NA	NA	NA	NA
Other	[ ] Yes [X] 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) [X] YES [ ] NO

[X] ESU NO: VL Force 2 #3 (000417)
GROUND PAD: BRAND VL Rem Polyhesive II
50150 LOT NO: 68936 2005-03
[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:
[X] BIPOLAR NO: VL Force 2 #3
50

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

Biplate Neurosurgical Plating System CMS #05 22201 — Burrhole Cover 81-2054 x1 — 1.5mm Screws size 5 x 3

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Thrombin 5000 u	QS	1510	Topical	[redacted]	Dr. [redacted]
Gelfoam	QS	1510	Topical		Dr.
Avitene (Collagen Hemostat)	QS	1510	Topical		Dr.
					b(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
16 F FIC to bladder - clear, yellow urine return	1510	[redacted]
		b(6)-2

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

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify) 4x8 Tape

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

TYPE/SIZE	1. 16 F FIC	2.	3.
SITE	1. Bladder	2.	3.

19. ADDITIONAL INFORMATION

WC I

Surgeons [redacted] b(6)-2 Anesthesia [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: 50/50 Coag/Cut

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

20. OPERATION(S) PERFORMED

I T D compressed frontal skull fx

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

22. REGISTERED NURSE SIGNATURE [redacted] TIAN

REVERSE [redacted] M 5179 b(6)-2

MEDCOM - 17681 USAPA V1.01

ICU1

Patients Name: EPW #[redacted] 22 y/o

Date: 18-19 AUGUST 2003

66 kg

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	117/60	114/59	117/66	124/68	105/54	108/64	117/69	115/63	107/64	115/61	113/67	114/66														
TEMP	98.4	98.6	98.1	98.5	98.2	98.6	98.4	98.6	99.0	98.9	99.1	99.5														
HR	87	88	94	86	87	88	99	104	93	93	92	100														
RR	14	15	16	15	15	14	16	17	14	13	15	18														
SaO2	94	94	96	95	94	98	96	92	97	93	95	97														
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA														
Source																										
MAP																										
[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	Tota
IVF																										
IVPB																										
NGT																										
Sub Total																										
[illegible]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
URINE		150	100	100	100	125	75	150	150	200																
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17682

DOD-031271

ACLU-RDI 1643 p.42

MEL ECORD-SUPPLEMENTAL MEDICAL

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1800 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	3mm Reactive	
	Sensorium	Moves all extremities	
	LOC / GCS	Alert – Arabic primary language	
		↓ Eyelid	
CARDIAC	Cardiac Rhythm	NSR continuously monitored	
	PRI: / QRS:		
	Pulse Strength	Strong	
	Cap Refil / JVD	↓ JVD < 3 sec cap refill	
	Edema	mild edema and (L) periorbital area	
	Chest Pain	↓ C/O	
RESP	Respiratory Pattern	even regular unlabored	
	Breath Sounds	CTA	
	Secretions	↓	
	Cough	↓ Head injury ↓ encouraged	
SKIN	Color	WFR	
	Integrity	intact	
	Backside	intact	
IV	Access Devices	X2 PIV	
	Location	(R) posterior hand 18G (L) AC 18G	
	Condition	Patent	
		A-line DICP reads	
GI	Abdomen	Soft non-distended	
	Bowel Sounds	XQ quad x4	
	Stoma/Ostomy	↓	
GU	Device	FTC 16 Fr connected to continuous gravity	
	Color / Clarity	Yellow clear	

(Continue on reverse)

PREPARED BY *(Signature & Title)*
[redacted] 91WMH b(6)-2

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

DATE
17 Aug – 18 Aug 13

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, 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

USAPPC V2.00

MEDCOM - 17683

ACLU-RDI 1643 p.43

DOD-031272

ICU1 HOB 45° EPW [redacted] b(6)-4 [redacted] b(6)-4 Dr. [redacted] b(6)-2

Patients Name: # [redacted] ~~Abdul...~~ - 22 y/o Date: 17-18 August 03 65 kg

Transferred from 21st CSH

New PK

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	Keep MAP 70-90																									
NBP	CALL Ho SBP >150											121/61	112/59	112/49	121/63	113/64	113/63	112/65	113/63	119/69	121/69	120/66	120/61	121/66	102/61	
TEMP												99.4 ax			99.2			100.2	98.4			98.7		98.2		
HR												88	86	86	90	95	83	83	96	75	81	72	73	86	92	
RR												12	12	12	12	14	12	12	14	14	14	12	14	11	16	
SaO2												96	100	100	100	100	100	98	98	96	97	96	96	95		
FiO2												RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source																										
MAP			(70-90)									✓		~~88~~	88	83	84	85	82	88	89	86	85	89	79	
[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	Total
IVF	NS @ 125cc/h											125		125	125	125	125	125	125	125	125	125	125	125	125	
IVPB	Ancef 1gm																	50								
~~NGT~~	Diet Regular when fully awake																									
PO.																										
Zantac																		150mg								
Dilantin																		300mg								
H_2O																		30								
Sub Total																		205								
Total												125		250	375	500	626	830	955	1080	1,205	1,330	1455	1580	1705	

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												140		140	140	140	140	[illegible]50	300	350	350	400	—	400	200	
NGT																										
STOOL												ø		ø	ø	ø	ø	ø	ø	ø	ø	ø	ø	ø	ø	
DRAIN																		Took off A-line New DC'd							Mouth care and c/o con gum	
Sub Totals												140	~~140~~	140	140	140	140									
Total												140	(140)	280	420	560	700		1700	2050	2400	3130	4300	4800		5000

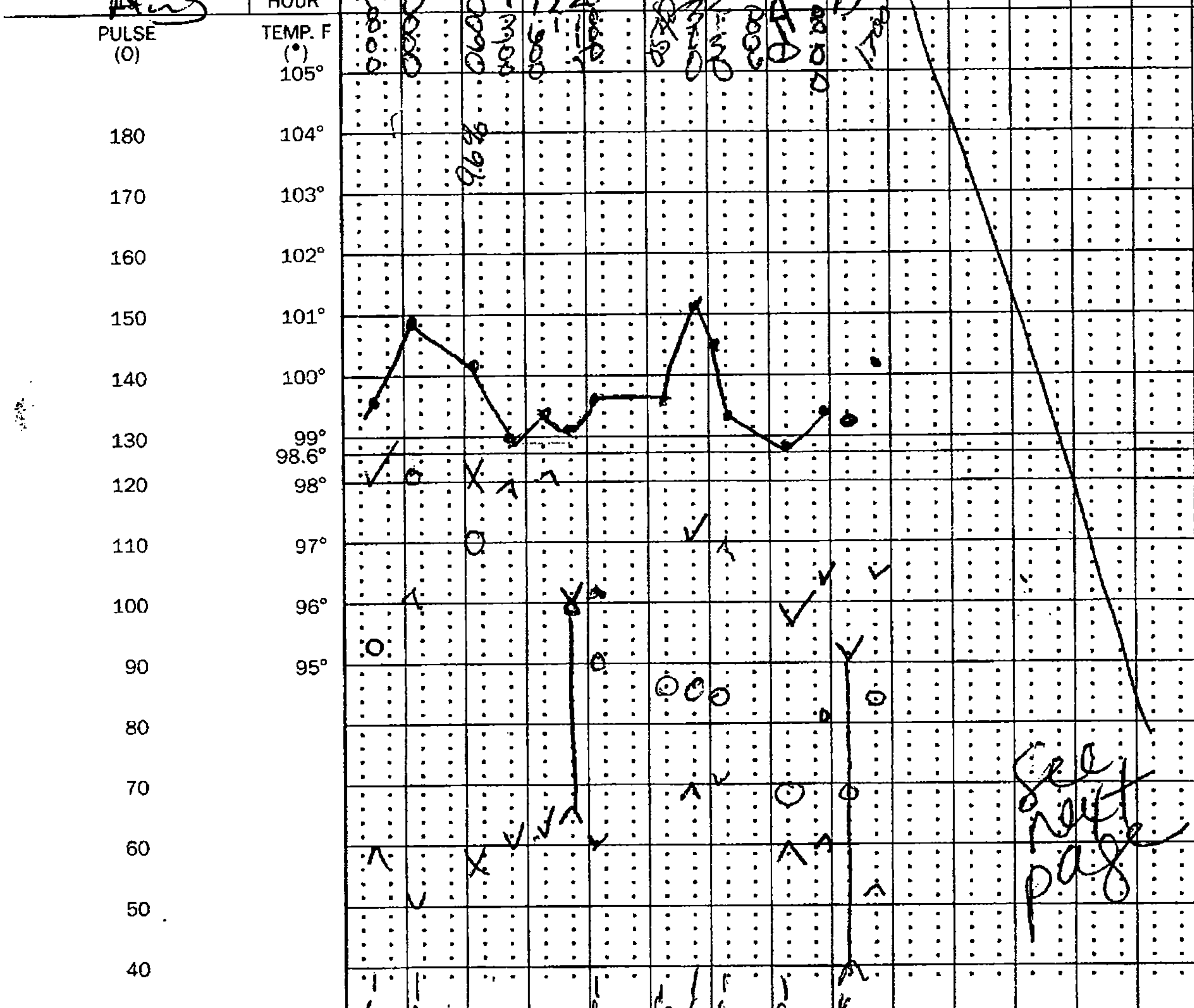
Condition: stable S/P (L) Frontal open Depression - Skull Fx - Revision of wound Dural Closure

MEDCOM - 17684

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	2						
POST- OP DAY	1						
MONTH-YEAR 2003 / DAY	18	19	20	21	22	23	24
HOUR							



RESPIRATION RECORD

Record special data only when so ordered								
BLOOD PRESSURE	120/60		120/60	124/62	118/80	96/60	104/40 104/53	
SpO2		96%		96% 96%	97	97	97% 98% 98%	
HEIGHT: / WEIGHT →						104/62		

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. ICW 2

EPW [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17685

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 19 | DAY | HOUR

21Aug03 22Aug03 23Aug03

2130 0530

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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**

MEDICAL RECORD - ANESTHESIA

For [illegible] this form, see AR 40-66; the proponent agency is [illegible] SG

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

DRUG (Units)							
Fentanyl (mg)	100	50	25/25				
propofol (mg)	100						
Sux (mg)	100						
Vec (mg)	6	1					
( )							
( )							
VOLAT AGENT ~~Iso~~ % del / % e.t.	1.5	1.5	1.2	1.0	1.0 X		
AIR L/Min							
N2O L/Min							
O2 L/Min	6-2	-2	-2	+2	-2	-6	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	(1)(2)	(3)		(4)			

FLUIDS

LINE site 18g RW ☐ Warmed	NS 1000↑	—	600	—	700		
18g LAC ☐ Warmed	LR 600↑	—	300				
☐ Warmed							
☐ Warmed							

LOSSES

EST BLOOD LOSS				200			
URINE				900			

TOTALS

TOTAL EBL	TOTAL URINE
200	900

FLUIDS - SUMMARY

CRYSTALLOID- 1000

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) To room, SOC mons, pre O2.

(2) Smooth IV ind x, intub.

(3) R↔ radial a-line placed

(4) Reversal 3mg neostig & 0.4mg Robinul

(5) Responsive, suctioned & extubated. To ICU stable. Report given

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

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 116/52

HR- 91

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 1610

TIME 16 x 30 x 17 x 30 x 18 x 30

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	730	730	730	730	760	280	
f - breaths/min	10	10	9	9	8	12	
Peak inf pres / PEEP	20	21	21	21	20	—	
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S	

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	32	30	28	28	32	44	
BP/oth	✓FIO2 (Frac or %)	0.9	0.9	0.9	0.9	0.9	0.9	
✓ART line Rt	✓SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	✓ECG	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site							
	N-M Block (T/4)		0/4	2/4	3/4	3/4	4/4	& sust test any
Warming blkt								
Conv warmer								

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

RECOVERY AT

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- SpO2- 100

BP- 121/61 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1610	1615	1740
PROC	Ready	Begin	End
	1620	1630	1725

PROCEDURES and CPT Codes: I&D of Open depressed skull fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA 8.0 ETT 3miller

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped DL x 1 s trauma, ⊕ETCO2, BSEB. Secured 23 m @ teeth.

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

[redacted] b(6)-4 ICN 2

22 yo ♂ EPW b(6)-2

Trf in from [redacted]

SURGEON: [redacted] b(6)-2

ANESTHETISTS: [redacted] MAJ CRNA

[redacted] b(6)-1

PROCEDURE LOCATION: 2

DATE: 8/17/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 17687 — PATIENT'S MEDICAL RECORD — USAPA V1.00

ACLU-RDI 1643 p.47

DOD-031276

PATIENT IDENTIFICATION

EPW # [redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 18AUG03 TIME OF ORDER 0644 HOURS — LIST TIME ORDER NOTED AND

1. D/C Foley. 18Aug03 1700
2. SL IV. 18Aug03 1700
3. up to chair or walk & shift.

[redacted] 4797

b(6)-2

PATIENT IDENTIFICATION

EPW # [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 18AUG03 TIME OF ORDER 1630 HOURS

1. Transfer ICU 2 - Neuro - Teff
2. Dx S/P Craniotomy 17AUG.
3. Condition Good.
4. Vitals q 4°
5. Activity ad-lib.
6. Nursing ad-lib.
   Soft restraints prn.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

7. Diet Regular.
8. IV Saline Lock.
9. meds Percocet 1-2 po q 4° prn severe pain
   Tylenol 325-650 mg po q 4° prn mild pain
   Ranitidine 150 mg po BID
   Dilantin 300 mg po q HS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER b(6)-2 HOURS

10. Lab none.
11. X-ray none

[redacted] 19 pd

[redacted] b(6)-2 4797

[redacted] 24 VS

[redacted] 8/18/03 0838

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 - 363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

#[redacted]

DATE OF ORDER 19AUG03 TIME OF ORDER 0653 HOURS

LIST TIME ORDER NOTED AND SIGN

(+) Up to chair - walk & shift.

19 Aug 03 [redacted]

1797 b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2400 J clon [redacted] PT/AN

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

DATE OF ORDER 24AUG03 TIME OF ORDER 0881 HOURS

(+) Discharge to MP custody.

Noted 8-24-03 0855 mAl/AN

[redacted] 1797 b(6)-1

NURSING UNIT | ROOM NO. | BED NO.

ICW2 | 5 | D 24 V 25 Aug 03 0800 [redacted] BA

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

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.

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

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

MEDCOM - 17689

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER 8/27/03 TIME OF ORDER 1737 HOURS

LIST TIME ORDER NOTED AND SIGN: Noted 19 aug 1833 [redacted] b(6)-2

1. Admit to ICU
2. Dx: S/P (L) frontal open Depressed Skull Fx. Revision of Wound w/ Dural Closure
3. Stable
4. Vitals w/ neuro V's q1° until awake, then q
5. IV ~~D~~ NS ~~w/~~ @ 125cc/hr
6. Foley to gravity
7. MEDS: ~~[illegible]~~ ~~[illegible] mg IVPB BID~~
8. HOB @ 45° until awake, then ad-lib.
9. I/O's.
10. MAP 70-90

Call for SBP > 150

~~CBC, chem 7~~

[redacted] MD b(6)-2

Given to pharma

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 [redacted] b(6)-2 HOURS

1. Diet: Regular when fully awake
2. Meds: Percocet 1-2 po q 4° prn pain.
3. Tylenol 650 mg po q 4° prn mild pain.
4. Ranitidine 150 mg po BID
5. Dilantin 300 mg po q HS
6. D/C Foley at nurse's discretion.
7. D/C Art Line at nurse's discretion.

DATE OF ORDER TIME HOURS

8. Soft Restraints Pr[redacted]
9. Ancef 1 gram IV [redacted] 4797

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

NURSING UNIT | ROOM NO. | BED NO.

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

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

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

Dr's Sheet

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17 18 19 20 21 22 23 24 25 26 27 28 29 30
17aug	[redacted]	Vitals V/S ;	06	[redacted]
		Neuro Q1° until	18	
		awake, Then Q4°		
17aug	[redacted]	Foley to Gravity (16Fr)	06	[redacted] D/C 18 Aug @ 1700 [redacted]
			18	
17aug	[redacted]	HOB 45° until	06	[redacted]
		awake, then ad-lib	18	
17 aug	[redacted]	I & O's	06	[redacted]
			18	
17aug	[redacted]	Keep MAP 70-80	06	[redacted]
		call MO. SBP >150	18	
17aug	[redacted]	Diet: Regular	06	[redacted]
		when fully awake	18	
17aug	[redacted]	Soft Restraints	06	[redacted]
		PRN	18	
17aug	[redacted]	blds-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Condition: Stable

unknown S/P @ Frontal open Depressed Skull Revision of wound & Dural Closure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted]

DLCO-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 aug 03	[redacted]	admit to ICU	17 aug 03	done		[redacted]
17 aug	[redacted]	D/C foley @ nurses discretion	17 aug 03			
17 aug	[redacted]	D/C art line @ nurses discretion	17 aug 03	22:00 17 AUG	22:00 17 AUG	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

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

CLINICAL RECORD

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

Mo. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19 20 21 22 23 24 25
18	[redacted]	Vitals Q4°	04	[redacted]
			08	
			12	
			16	
			20	
			24	
			1	
18	[redacted]	activity-ad lib	05	
			1	
			2	
			1	
18	[redacted]	diet-regular	15	
			13	
			21	
18	[redacted]	OOB to chair QS	09	
			13	
			21	

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P Craniotomy 17 Aug

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

PATIENT IDENTIFICATION: E(W) [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(e)-2 AM

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	transfer to ICU 2 neuro left	18		1800	[redacted]
18	[redacted]	Condition good	noted			
18	[redacted]	labs none / Xrays none	noted			

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

USAPA V1.00

ACLU-RDI 1643 p.54

DOD-031283

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

CLINICAL RECORD

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

Mo. ___ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17 Aug 03	[redacted]	NS @ 125 c/hr	06	[redacted]													
			18	[redacted]													
17 Aug 03	[redacted]	Ranidine 150 mg p.o. BID	10	[redacted]													
	.....		22	[redacted]													
	.....																
17 Aug	[redacted]	Dilaudid 300 mg p.o. QHS	22	[redacted]													
	.....																
	.....																
17 Aug 03	[redacted]	ancef ÷ gm IV Q8° X3	06	[redacted]													
	.....		14	[redacted]													
	.....		22	[redacted]													
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ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS: Candeliar : stable
S/P (L) Frontal Open depression skull FX : Revision of wound : Dural closure

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

PATIENT IDENTIFICATION:
#1 [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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. _____ Yr. 2003
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
1 May 03	[redacted]	Percocett 1-2 P.O. Q4° PRN pain	
.....	.....	DDO-C	
1 May 03	[redacted]	Tylenol 650 mg PO Q4° PRN pain mild	
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

ACLU-RDI 1643 p.56

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

CLINICAL RECORD

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

Mo. 8 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23 24 25
18	[redacted]	SL-Flush QS	05	/ [redacted] / D/C
			13	
			21	
18	[redacted]	Zantac 150mg PO BID	07	/ [redacted]
			17	
18	[redacted]	dilantin 300mg PO qHS	22	/ [redacted]

ALLERGIES: ☐ YES ☐ NO

b(6)-2

PRIMARY DIAGNOSIS: S/P craniotomy 17 Aug

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

ACLU-RDI 1643 p.57

DOD-031286

PRN medications

Percocet 1-2 po q4° prn
severe pain

Tylenol 325mg-650mg PO q4° prn-mild pain	19 Aug 0638 TT BM	20 Aug 0900 TT BM	20 Aug 1340 1 LD	20 Aug 21:4150 TT PO EM	21 Aug 03 2130 650mg RD	22 Aug 1100 650mg PO dt	23 Aug 2000 650mg PO ABS
	8:24 1432 TT ABS						

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

DASG APPROVED (Date)

Date: 17 Aug 08 Time In: 1734

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

Allergies:

OR Intake: Crystalloid 1000 Colloid

Pre-op V/S:

OR Output: UOP 4 EBL 200

Procedures:

Meds/Times:

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

Pre Op Meds

History

Time	
SaO2	
FiO2	
Methods	
240	
220	
200	
180	
160	
140	
120	
100	
80	
60	
40	
20	
RR	
T	
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	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2			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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2			
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2			
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 17 Aug 08

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

[redacted]

b(6) - 2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
Pain Level at D/C (0-10):
Intake: **Output:**
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	022	Z	Z	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0649	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	NO
		9		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU2	unk

[redacted]	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
b(2)-2	unk

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	unk

21. TYPE OF DISPOSITION	TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
SO		030824

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEBA		030918

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

FOR LOCAL USE

Dx: CSW: (L) open frontal depression mortar attack

ADMITTING OFFICER (Signature	ADMITTING CLERK
Dr [redacted] b(6)-2	[redacted] b(6)-2

DA FORM 2985, MAR 8[redacted] USAPPCV1.0

MEDCOM - 17701

INPATIENT TREATMENT RECORD COVER SHEET

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

1.	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
	[redacted]					EPW	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	18y	UNK	UNK	—	—	N	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
99	[redacted]		blue-4			ICU1	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BR	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			1540	ARAA			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION			
UNK			xfer to 28th CSH	20 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

V58.43

GSW @ flank

S/p ex lap liver laceration

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	b(6)-2	[redacted]		

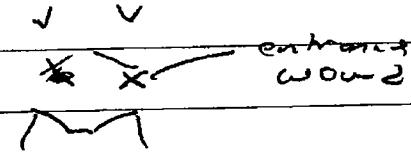
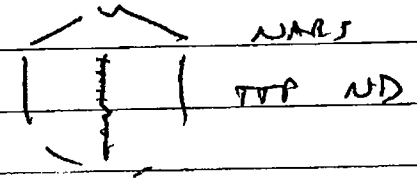
SIGNATURE OF ATTENDING [redacted]

DA FORM 3647 EDITION OF 1 AUG 76 IS O USAPPC V1.10

MEDCOM - 17702

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 AUG 03	History and physical 18 yo male EPW says he was WIA by RPG. to FST where ex Lap performed for Hemoperitoneum. findings @ Rt Lobe Liver Lac. Hemostasis Achieved EBL 200. TP left in Abd. Now Tx for care. NKDA Psm as Above meds PMH ∅ TOB ∅ even NCAT Back  entrance wound Neck NT ∅deformity Chest CBTA ext ∅ccc Abd  NABS TTP ND Ext WNL LABS 14.9 / 244 / 47.6 — 136 / 104 / 7 / 100 / 3.7 / 23 / 0.6 — TP 6.6 Alb 3.4 LFT WNL A/P Liver Lac stable post op. Admit ICU x 24hrs WP Clears.

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) b(6)-1 [redacted] REGISTER NO. WARD NO. ICU

EPW b(6)-1 [redacted]

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

MEDCOM - 17703

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 1715	Received on unit via Stretcher accompanied by FMT staff. A+OX3, speaks English fluently. Pupils 2-3mm & brisk. NSR c HR in 90's. Palpable pulses in all extremities. IV infusing @ 150cc/hr via 18ga in R forearm. Lungs CTA bilaterally c O_2 sats 97-100% on room air. Abdomen c Jrg covering incision. Small amt of drainage noted. JP drain to R lower quad c small amt of serous sanguinous fluid noted. Foley to gravity draining adequate amt of dark yellow urine. Denies discomfort @ present time will continue to monitor — b(6)-2 [redacted] M/m
18 AUG 03 1837	Assumed care of pt @ 1800. Vss, temp 99.9°. A+OX3. lung sounds clear bilaterally, apex to base. RR 20, O_2 Sat 100% RA. HR 88, RRR. Radial + Pedal pulses strong + equal to palpation. Cap Refill <3sec to all extremities. Pt has LR @ 150cc/hr to 18G R ac, site without signs of redness or infiltration. PERRLA. Mucous membranes moist. Clear liquid diet. BS active x4 Quadrants. Non-distended, tender to palpation. Pt has dressing to midline abdomen, small amt of old drainage noted. Pt also has JP drain to RUQ, dressing CDI. Pt has foley to gravity draining concentrated urine [redacted]
2130	ROM to all extremities complete. Will continue to monitor for A's [redacted] Pt c/o pain to abdomen. Given 4mg MSO4 IVP, will monitor for effectiveness + medicate as needed — spc [redacted] b(6)-2

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

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

[redacted] b(6)-1

REGISTER NO.	WARD NO.

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03 0540	Pt received 4mg MSO4 IVP prior to getting up to chair. Pt up to chair c little assist, but lots of encouragement needed. Will continue to monitor. sec [redacted] awmg
19 Aug 03 0700	Pt up to chair ambulated x1. OX3. follow commands. VSS Respirations even and unlabored c BBS CTA Sp02 96-100% RA palpable pulses @ & edema noted. Abd soft, tender to touch active bowel sounds. Midline abdominal incision c dressing CDI. JP drain to bulb suction. IVF LR @ 150/hr IV site s S/S infection. foley cath BSO c clear yellow urine. Denies any distress [redacted]
19 Aug 03 1600	Pt resting in bed. Medicated c Percocet for pain relief & comfort da. Ambulated and up to chair s complications. No distress noted. Will cont to monitor [redacted]
17 19 Aug 03 1715	Pt transfered to ICU2 - No changes in status [redacted]
19 aug 03 1800	Pt admitted from ICU2 in stable condition A&Ox3, alert and ambulatory. Lungs CTA bilat, @ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Midline incision to abd c Staples intact. @ drainage noted, Wound edges well approximated. Dsg to RUQ CDI, @ new drainage noted [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

ACLU-RDI 1643 p.65

DOD-031294

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 -	
	S/P X/lap Doing well tol. diet.
	Will DC JP today
	[redacted] b(6)-2
20AUG03	Progress Note
	Pt stable s/p Ex-lap c̄ liver lac
	VSS Tmax 101
	Lungs: CTA
	Cor: RRR
	ABD: soft, mild TTP ⊕BS
	JP: stable
	Plan clear liquid diet
	Ambulate
	DC Foley

MEDCOM - 17706

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)*
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, no resp distress. NSR. Bowel sounds active x4 quads, abd soft, non-tender. Midline incision to abd CDI, Staples intact, no S/S infection. I.V to LFA KVO @ 150cc/hr. ∅ complaints to [redacted]
20Aug03 2350	Care assumed @ 2100. VSS, AOX3. C/O small amount of pain to abdominal. Lung sounds CTA, pulses ⊕X4, bs present x4 quads, slightly hypoactive. midline abd incision staples CTA CDI, C/O pain upon palpation.
21Aug03 0030	IV to LFA intact pt on IV ABX. To be transferred to [redacted], will continue to monitor [redacted]
2305	Pt slightly tachycardic and hypertensive ∅ C/O pain, will continue to monitor. [redacted]
0030	2 tabs percocet given for pain. [redacted]
0745	assume care @ 0600 - VSS - no C/O pain
21Aug03	this time - ⊕ BS, hypoactive - staples intact on abdomen, no drainage noted from incision - Pt. awaiting transport to [redacted]

b(6)-2

b(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] REGISTER NO. WARD NO. ICU2

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 - 17707

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

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

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 18

MILITARY STATUS

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

ARRIVAL

DATE (Day, Month, Year): 18 Aug | TIME: 1300

TRANSPORTATION TO FACILITY: Medevac

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)
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

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME

INITIALS

VITAL SIGNS — RA 99% | 99% | 96

TIME	1300	1340	1514		
BP	156	166	134		
PULSE	125	133/61	152/86		
RESP	20	18	16		
TEMP	100	100.3	99.3		
WT					

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
URINE C&S	UA MSCC/CATH		CHEM 7 Dr 1 yes	
BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 99 c/o ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1418	30mg Toradol	[redacted]	[redacted]		b(6)-2
1516	12.5 mg Phenagren				
1520	4mg MSO4				

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

ACLU-RDI 1643 p.68

DOD-031297

NSN 7540-01-075-3786

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

Bun 6 Creat 0.6

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 14.9		136	3-7	SUP 02	PH	PO2	RESULTS	
H/H 14.8				PCO2	SAT	OTHER		
PLT		104						
PT				U/A DIP			EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	MICRO At Flank				

PROVIDER HISTORY/PHYSICAL

5) 18 yr old with GSW - abdomen on 17 August - Exploratory lap - (liver laceration), hemoperitoneum

PMH: 0

ALLERGIES: Amoxil
Allergies - NKA
0 PMH allergies

HEAD - Normocephalic
Neck - Supple

Eyes - PERRLA, EOMI
Throat - mucous membranes dry

Lungs - clear
Heart - RRR no MRG
Abd - abdominal dressing - TTP, no B-S
Extremities - no edema : Pulses 2+ DP - 2+

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted]

DIAGNOSIS
1) GSW (Rt) Flank
Laceration Liver Rt lobe
S/P Exploratory

CODES

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

EP2 [redacted]

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 - 17709

-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	2	3	4	5	6		
POST-OP DAY	1	2	3	4	5		
MONTH-YEAR Aug 2003 — DAY	19	20	21	22	23	24	25
HOUR							

PULSE (O): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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)

	19	20	21
RESPIRATION RECORD	20	32 / 30	86
BLOOD PRESSURE	120/80	132/86	140/90, 146/92
SpO2	98%	96%	

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)*

REGISTER NO.

WARD NO. ICW2

[redacted] EPW

b(6)-4

MEDCOM - 17710

VITAL SIGNS RECORDS

Medical Record

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

ACLU-RDI 1643 p.70

DOD-031299

i-STAT 6+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____84 mg/dL
BUN_____7 mg/dL
Na_____134 mmol/L
K_____3.7 mmol/L
Cl_____103 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct

Sample Type_:

19AUG03 04:37

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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i-STAT EC8+

Pt: [redacted] b(6)-2

Pt Name:_____

Glu_____90 mg/dL
BUN_____7 mg/dL
Na_____136 mmol/L
K_____3.7 mmol/L
Cl_____104 mmol/L
TCO2_____23 mmol/L
AnGap_____14 mmol/L
Hct_____46 %PCV
Hb*_____16 g/dL
*via Hct
PH_____7.427
PCO2_____33.2 mmHg
HCO3_____22 mmol/L
BEecf_____-2 mmol/L

Sample Type_:

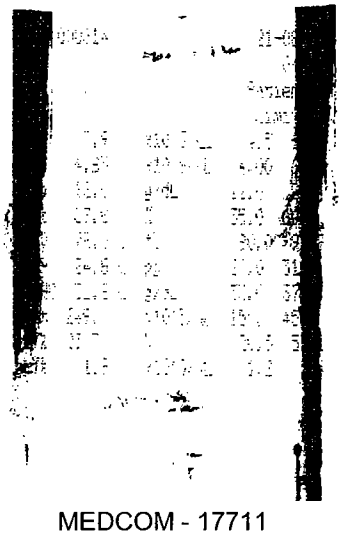
18AUG03 13:12

Oper: [redacted] b(6)-4

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93



b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 18 Aug	TIME 1305
		SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

[redacted]-Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] **DATE:** 18 Aug 03 **LAB ID NO.:**

b(6)-2

MEDCOM - 17712

Ward/Section: EMT	REQUEST[redacted]N: b(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 18 Aug	TIME: 1305	SS[redacted]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

======= PICCOLO =======
18/08/03 13:13
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
...a(6)-4

ALB	3.4	3.3-5.5	G/DL
ALP	81	26-84	U/L
ALT	22	10-47	U/L
AMY	26	14-97	U/L
AST	46*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CHOL	94*	100-200	MG/DL
CRE	0.6	0.6-1.2	MG/DL
GLU	100	73-118	MG/DL
TP	6.6	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
[illegible]N		7-22 mg/dl
[illegible]		8.0-10.3 mg/dl
[illegible]E		0.6-1.2 mg/dl
[illegible]		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
[illegible]B		3.3-5.5 g/dl
[illegible]P		26-84 u/l
[illegible]T		10-47 u/l
[illegible]MY		14-97 u/l
[illegible]ST		11-38 u/l
[illegible]BIL		0.2-1.6 mg/dl
[illegible]GT		5-65 u/l
[illegible]P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
[illegible]A^+		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]L		98-108 mmol/l
[illegible]CO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]	**DATE:** 18 Aug 03	**LAB ID NO.:**

ACLU-RDI 1643 p.73

DOD-031302

b(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICU 2 | REQUESTING PHYSICIAN: DR. [redacted] | DATE: 18JUN23 | TIME: 2107

LAST, FIRST, MI. [redacted] b(6)-2 | 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) Methyte 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.:**

ACLU-RDI 1643 p.74

DOD-031303

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST [redacted], MI. b(6)-4	DATE 18AUG03	TIME 2107
SS[redacted] O SSN: b(6)-4		

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 18 Aug 03 **LAB ID NO.:**

ACLU-RDI 1643 p.75

DOD-031304

b(4)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICU 2 | REQUESTING PHYSICIAN: Dr. [redacted] | DATE: 19AUG03 | TIME: 0412 | SSN/PSEUDO SSN: [redacted] b(4)

LAST, FIRST, MI: [redacted] b(4)-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/d
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/
CHOL		100-200 mg/d
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

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

19/08/03 04:38

REFERENCE RANGE: MALE

PATIENT #: [redacted]

GENERAL CHEMISTRY 12

DISC LOT #: [redacted] 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	3.0*	3.3-5.5	G/DL
ALP	64	26-84	U/L
ALT	39	10-47	U/L
AMY	24	14-97	U/L
AST	44*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	5*	7-22	MG/DL
CA++	8.8	8.0-10.3	MG/DL
CHOL	53*	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	109	73-118	MG/DL
TP	5.0*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

REMARKS:

b(4)-2

REPORTED BY: [redacted]

DATE: 19 Aug 03

LAB ID NO.:

ACLU-RDI 1643 p.76

DOD-031305

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

Ward/Section: ICU 2	REQUESTING [redacted] Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
[redacted] ST, MI.	DATE 19AUG03 TIME 0412	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

REMARKS:

REPORTED BY: [redacted]	DATE: 19 Aug 03	LAB ID NO.:

b(6)-2

ACLU-RDI 1643 p.77

DOD-031306

CBC Chem8 Chem12

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

Ward/Section:	REQUESTING PHYSICIAN:	DATE	TIME	SSN/PSEUDO SSN:
ICU		20Aug	0400	
LAST, FIRST, MI. [redacted] b(6)-4				

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 20 Aug 23

LAB ID NO.:

ACLU-RDI 1643 p.78

DOD-031307

Chem 8 Chem 12

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted] b(6)-4	DATE 20Aug	TIME 0400

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmo				C		8.0-10.3 mg/dl
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. RAI
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
20/08/03 06:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	88	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	932*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

======= PICCOLO =======
20/08/03 05:51
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	66	26-84	U/L
ALT	22	10-47	U/L
AMY	39	14-97	U/L
AST	33	11-38	U/L
~~TBIL~~	~~0.5~~	~~0.2-1.6~~	~~MG/DL~~
BUN	3*	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	115	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	91	73-118	MG/DL
TP	6.0*	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.:
[redacted] b(6)-2		

ACLU-RDI 1643 p.79

DOD-031308

CBC chem8+12

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

LAST, FIRST, MI. [redacted] b(6)-2	DATE 21Aug	TIME 0420	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		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: b(6)-2

REPORTED BY [redacted] **DATE:** 21 Aug 03 **LAB ID NO.:**

ACLU-RDI 1643 p.80

DOD-031309

CBC
metB metB metB

Ward/Section: CW2	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 21 Aug	TIME 0400
		SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 r
K		3.5-4.9 m
Cl		98-109 m
pH		7.31-7.45
PCO2		35-45 mm 41-51 mmH
PO2		80-105 mmk N/A (ven)
TCO2		23-27 mmol/ 24-29 mmol/
HCO3		22-26 mmol/ 23-28 mmol/
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/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. RANGE

======= PICCOLO =======
21/08/03 04:49
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	98	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	432*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.2*	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

b(6)-4
======= PICCOLO =======
21/08/03 04:33
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	57	26-84	U/L
ALT	12	10-47	U/L
AMY	80	14-97	U/L
AST	25	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	3*	7-22	MG/DL
CA++	9.3	8.0-10.3	MG/DL
CHOL	105	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	102	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 21 Aug 3	LAB ID NO.:

ACLU-RDI 1643 p.81

DOD-031310

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: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER: 18Aug03 | TIME OF ORDER: 1540 HOURS | LIST TYPE ORDER (NOTE) AND SIGN

1) Admit to ICU
S/p ex Lap Liver Laceration
cond stable
Vitals Q1° x SAT I/O
All Ø
ACT - OOB to chair
Nurse - IP: to Bulb suction

Noted 18Aug03 [redacted] MD

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Foley to gravity
Diet Clears
IVF LR @ 150 cc/hr
meds
MSO4 2-10 mg IV Q1° PRN pain
Ancef 1gm IV Q8°

Pharmacy done

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

LABS CBC @ 2100
then CBC, Chem 8, Chem 12 Q AM.

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19Aug03 | TIME OF ORDER: 1301 HOURS

Percocet 1-2 PO q 4-6° prn pain
Tylenol 650mg PO q 4-6° prn fever

[redacted] 19Aug03 1400

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	DATE OF ORDER	TIME OF ORDER	LAST TIME ORDER NOTED AND SIGN
[redacted]	19AUG03	HOURS	
NURSING UNIT:	ROOM NO.:	BED NO.:	

1. Codeine 30mg PO bid [redacted] 19Aug03 1505

b(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
E & W b(6)-4 [redacted]	19Aug03	1700 HOURS	
NURSING UNIT: ICU2	ROOM NO.:	BED NO.:	

@ Ventilator Cpx2
@ Central current date

b(6)-2 [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	
E & W b(6)-4 [redacted]	20 AUG 03	
NURSING UNIT: ICU2	ROOM NO.:	BED NO.:

(-) DC Foley

[redacted] noted

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
E & W b(6)-4 [redacted]	8/20/03	(b)(2)-2 HOURS	1240
NURSING UNIT: ICU2	ROOM NO.:	BED NO.:	

Transfer [redacted]

b(6)-2 [redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1980—409-924

"USE BALL POINT" MEDCOM - 17723 "IN PAPER REQUIRED"

b(6)2

CLINICAL RECORD

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

Mo. 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
Oppd	[redacted]	Vitals q4 hrs	05	[redacted]
			13	
			21	
Oppd	[redacted]	Activity - OOB to chair	05	
			13	
			21	
Oppd	[redacted]	Foley to gravity	05	D/C
			13	[redacted] LR @ 125/hr
			21	[redacted] / 200 @ 83
Oppd	[redacted]	CBC, Chem 12, Chem 10 qam	04	[redacted]

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS: S/P exlap liver laceration

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

PATIENT IDENTIFICATION: Epro [redacted] blue-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 - 17724

b(6)-2 A1

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

Mo 8 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28 [redacted]		DC Order (b)(2)-2		clear		[redacted]
20 [redacted]		+cons Ceased [redacted]	29	ASAP		

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

USAPA V1.00

MEDCOM - 17725

b(6)-2 & 4

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.

May 2003

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23
18 Aug	[redacted]	Ancef 1 gm IV Q8°	08	[redacted] Discontinued
			16	
			24	
18 Aug	[redacted]	@ 150cc/hr	06	[redacted] Rewritten See below
			18	
19 Aug	[redacted]	Celace 100mg PO BID	10	[redacted]
			22	
19 Aug	[redacted]	LR @ 150cc/hr	05	[redacted]
			13	
			21	
18 Aug	[redacted]	Ancef 1 gm IV Q8	12	[redacted]
			20	
			04	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: condition = stable S/P ex lap liver laceration

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

PATIENT IDENTIFICATION: [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Aug Yr. 2003

Verify by Initialing		SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
Order Date	Clerk/ Nurse					
18 Aug	[redacted]	Admit to ICU	18 Aug 03		done	[redacted]

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
18 Aug 03	[redacted]	MSO4 2-10 mg IV Q1° PRN fever	18 Aug 03 2336 4mg IVP; 19 Aug 03 0295 4mg IVP; 19 Aug 03 0535 2mg IVP; 19 Aug 03 0625 4mg IVP; [redacted]
19 Aug	[redacted]	Tylenol 650mg PO q 4-6° prn fever	19 Aug 03 1100
19 Aug	[redacted]	Percocet 1 - 2 PO q 4-6° prn pain	19 Aug 03 1400; 19 Aug 03 1930; 20 Aug 03 0200; 21 Aug 03 1430 PO; [redacted]

b(6)-2

b(6)-2

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A I I D I
2. LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): [redacted] b(6)-4
4. PAY GRADE: EPW
5. SEX: M
6. DATE OF BIRTH (YYYYMMDD): 19850101
7. AGE AT ADMISSION: 18
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION: UNK
10. LENGTH OF SERVICE:
ETS:
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 1540
BRANCH / CORPS: b(6)-4
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 1
PREV. ADMISSION: YEAR: NO: X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø
WARD: ICW1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF PRIOR TREATMENT FACILITY: [redacted] b(2)-2
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK
21. TYPE OF DISPOSITION: 50 05
TRANSFERRED TO:
23. DATE OF DISPOSITION (YYYYMMDD): 20030820
24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYYYMMDD): 20030817
27. LOCATION OF OCCURRENCE (Battle Casualty Only): 1 Z
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (YYYYMMDD):

FOR LOCAL USE

GSW (R) flank

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

DA FORM 2985, MAR 2000 MEDCOM [illegible] USAPA 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
[redacted]	[redacted] b(6)-4		N/A	
4. SEX	5. AGE	6. RACE	7. LENGTH OF SVC	8. ETS	10. PREVIOUS ADMISSION
F	62	UNK	N/A	N/A	NO
11. FMP	12. SSN	13. ORGANIZATION		14. WARD
99	[redacted]	UNK N/A		ICU 1
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN K-78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		N/A	N/A		

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM EMT	2130	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	01	20 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	19 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

DX: CLOSED HEAD INJURY
RT TYMPANIC RUPTURE - 872.61

DX: 8505
9981
E9889

Trauma
9
Injury
999

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
b(6)-20	0	0	0	b(6)22	2

SIG [redacted] MD

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

MEDCOM - 17729

[redacted] [redacted] AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Feb 03	Nursing Assessment Continued:
1000	and ® Forehead Ⓣ bruise to ® temporal. Continues
	to be NPO. Lungs CTA Heart NSR abd soft non-
See	tender ē Ⓣ BS X4. MAE. Ⓣ grip both hands.
Flow Sheet	Ⓟ extension of feet Ⓝ dorsi flexion feet. VSS. Temp
for Neuro VS	99°. Mouth dry. IV to Ⓛ wrist patent ē NS @
	100 cc/hr. Continues ē BR. Neuro team visited pt
	this AM. Continue ē Neuro V q°. Ø acute distress
	@ this time. Continue to monitor. [redacted]
1100	Nursing Ø Δ in Neuro status. [redacted]
1200	Neuro V Ø Δ in status / complaints [redacted]
1300	Neuro V ✓S Δ. Back pain improved ē blanket
	roll to spine. [redacted]
1400	neuro V S Δ. Bruises noted to top Ⓛ shoulder. Mild
	Back drainage from posterior Cephalus. Responds
	appropriately to Verbal stimuli. Pt S denies states
	she does not remember being in an explosion
	she was sitting at the end and woke up
	here in the bed ē the above noted Complic
	VSS 163/83 79 20 99°. Continues NPO. [redacted]
1500	Nursing: Ø Δ in Neuro Status. Stable [redacted]
1600	Nursing Ø Δ in neuro Status. C/O pain to IV site Ø S/S of
	Complications.

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

blw-2
A11

ACLU-RDI 1643 p.90

DOD-031319

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Neurosurgery Narrative
8/20/03	62 yo German National married to an Iraqi injured
0900	during bomb blast at UN. Had LOC and initial
	confusion / disorientation upon admission w/ Ruptured
	(R) TM. ? Corneal laceration on OS.
	Currently markedly improved awake alert appropriate
	follows commands briskly no focal deficits no
	drift. SOMI on ?, Dressing over OS.
	A/P: Evac to Germany for CT Head vs. Thin Section CT.
	PMHx significant for prior (L) Suboccipital
	craniotomy.
	[redacted]
	b(6)-2
20Aug03	
1000	Nursing Assessment note: Pt A&O to self, condition
	Responds to verbal stimuli appropriately. Able to voice
	her needs & concerns. dsg to OS which is closed when
	attempted to open clear fluid leaked. Pt is aware.
	States OS feels like something is in it. OD can open
	and see. denies blurry vision unable to maintain OD
	in open position for a period of time. C/o pain to (R) temper

Continued

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME [redacted] LAST | SPONSOR'S ID NUMBER (SSN or Other) MA, AD

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

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.

PROGRESS NOTES
Medical Record

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

[redacted] Progress Note [redacted]
SF Form 509

b(e)-2

20 Aug 03 1700 Neuro Status is improved, [redacted] drg to OS is removed by eye team member. Continues to be unable to use OS. OS Clear c Movement. [redacted]

1800 New orders noted. Neuro V Stable pt ↑ to BSC c assist. Voided x1 large amt amber color. Diet advanced. Pt took 1120 + applesauce 5 diff meeting is resting quietly. Neuro V's Δ to q 4°. [redacted]

21 August 0930 Pt resting in bed. A&Ox3. VSS. LCTA (B). BS x4 hypoactive Pt diet status Δ'd to adv as tolerated ↓ appetite. pt has small cut and bruise to (R) temporal area. Denies HA/N/V/D. Pt states does have some dizziness after she gets up. Pt's (L) eye has been weeping and she states its very painful to open. Pt states she thinks her vision is fine, she just wont open that eye. Pt states (R) eye is fine. Opto does notified and will be in late to evaluate patient. Will continue to monitor & support [redacted]

21 Aug 03 1300 Pt discharged home assisted by family and friends. Erythromycin ointment given to pt for corneal abrasion on (L) eye. Cleared by Neuro. Pt c no questions @ this time [redacted]

b(e)-2

b(e)-4

[redacted]

ACLU-RDI 1643 p.92

DOD-031321

[redacted] [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Neurosurgery Narrative
8/21/03 12:44	62yo m q SIP CHI after UN attack @ Baghdad on 8/19. Pt had LOC awake with mild disorientation no focal neurologic deficits. After 24° had normal speach, mentation and sensorimotor function.
	Pt. noted to have also small corneal abrasion w/o loss acuity's in vision.
	Remainder of exam/C-Spine/CXR were normal no extremity injuries.
	A/P: Plan for D/c to home. F/u with family practioner in 2-3 weeks, Progressively ↑ activity over next 3 week. Regular Diet & Ambulation.

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

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

B(a)-4

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

ACLU-RDI 1643 p.93

DOD-031322

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

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

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 19 Aug 03 | TIME 1942

TRANSPORTATION TO FACILITY medevac

SEX F

AGE 62

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

TIME 1940

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

VITAL SIGNS

TIME	1940				
BP	139/70				
PULSE	71				
RESP	18				
TEMP	97.3				
WT	87kg 192#				

LAB ORDERS

☒ CBC/DIFF ☐ ABG ☒ PT/PTT ☐ BHCG/URINE/BLOOD/QUANT

☒ URINE C&S ☒ UA MSCC/CATH ☒ CHEM: 12 14 45

☐ BLOOD C&S X

X-RAY ORDERS

☐ CXR PA & LAT/PORTABLE ☐ C-SPINE

☐ ACUTE ABDOMEN ☐ LS SPINE

☐ SINUS ☐ HE[redacted]

☐ ANKLE R/L ☐ [redacted]

ORDERS

☒ PULSE OX 95% ☐ [redacted] ☒ MONITOR b(6)-2 ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESPONSE
2000	Tovadol 30mg	[redacted]		

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QU[illegible]ERS/OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 17734

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

5). In volved MVC ejected (German National)

PMH: ?
allergies: ?

GCS - 15

0) Awake, answer Questions
Eye - PERRLA Ear - RT TM - ruptured LT TM - clear
Nose - clear Throat - clear.
Heart - RR ND (IV)
Lungs - clear.
Abd soft, N.T
Extremities - Bruising over Bilateral Shoulders

CXV
~~Bilateral~~ Humerus - Bilateral
Skull.

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
Dr. [redacted]	2015	FCW - ad.	
			PROVIDER SIGNATURE AND STAMP
			[redacted] Blue - 2

DIAGNOSIS

1.) CHI Ruptured TM - RT
2.)
3.)

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted] [redacted]

MEDCOM - 17735

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
19AUG03		2130	Received pt from ER. 62 y/o female closed head injury, RT Tympanic Rupture. Pt is only Alert to person. Answers some questions appropriately, but is not able to tell the year or what happened to her. She has a small wound on left side of hedd. Pt Lungs CTA B, breathing even, unlabored. Card: S.S2, NSR + 2 pulses, <3 sec cap refill. Pt has +BS x 4 qds. Pt states that she needs to urinate but doesn't understand that she has to go on a ped pan. Pt has IV to left arm NS@100cc/hr. Pt VSS. Pt states she has pain when you move her head to the right side. Pt has hx of brain tumor removal. Will continue to do neuro checks q1° (Pupils were perla but could not follow my pen with her eyes)
		2230	I concur [redacted] above assessment. [redacted]
		2230	Neuro checks done. Pt shows improvement. Remembers the year + month. Used BSC — Sgt [redacted] RN
		2330	Neuro checks. Alert to person + time. Able to purposefully move all extremities — Sgt [redacted]
		[redacted]	Neuro check. A+O x 2. Pt left eye watering, notified doctor. Dr thinks she may have a laceration instructed to put a patch over. eye. — Sgt [redacted]

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

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

NURSING NOTES
Medical Record

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

MEDCOM - 17736

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY | HOUR

20 | 20 | 21

0700 | 0600 | 1344 | 0450

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

162/73 | 155/55 | 131/71 | 164/79

76 | 72 | 74

99.1 | 99

HEIGHT: | WEIGHT →

HR | 68

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]

bwtd

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17737

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

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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	14.6	9.8-13.6 secs
APPT	24.4	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: H(6)-2

REPORTED BY: [redacted]	**DATE:** 19 AUG 03	**LAB ID NO.:**

ACLU-RDI 1643 p.98

DOD-031327

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 19 Aug	TIME: 2020

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	*TEST*	*RESULT*	*REF. RANGE*
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	**(Piccolo) Methyte 8**			ALT		10-47 u/l
GLU		70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	*RESULT*	*REF. RANGE*	NA^+		128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I			K^+		3.3-4.7 mmol/l	*TEST*	*RESULT*	*REF. RANGE*
Drug of Abuse			CL^-		98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2		18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

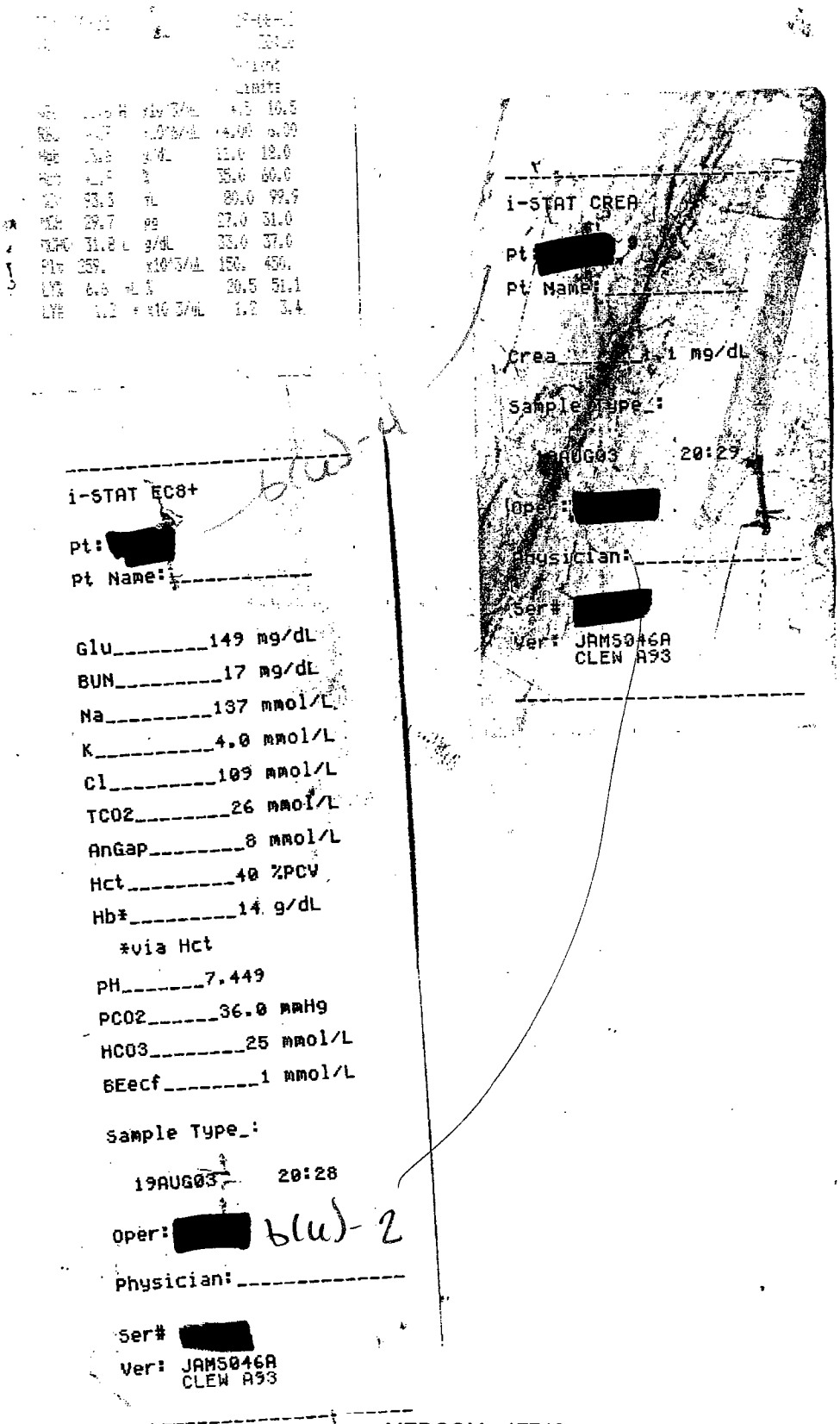
REMARKS:

b(6)-2

REPORTED BY: [redacted]	DATE: 19 AUG03	LAB ID NO.:

ACLU-RDI 1643 p.99

DOD-031328



i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.1 mg/dL

Sample Type_:

19AUG03 20:29

Oper:[redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____149 mg/dL
BUN_____17 mg/dL
Na_____137 mmol/L
K_____4.0 mmol/L
Cl_____109 mmol/L
TCO2_____26 mmol/L
AnGap_____8 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct
pH_____7.449
PCO2_____36.0 mmHg
HCO3_____25 mmol/L
BEecf_____1 mmol/L

Sample Type_:

19AUG03 20:28

Oper: [redacted] b(u)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

b(u)-2

MEDCOM - 17740

[redacted] [redacted]

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

1) Admit ICU
Dx: Closed head injury Rt TM rupture
2) Neuro checks q 1 hour
3) I.V. - Normal Saline at 100cc/hr
4) V.S. q 4 hours
5) NPO
6) Admit : Bedrest

PATIENT IDENTIFICATION [redacted] b(6)-2

DATE OF ORDER | TIME OF ORDER ____ HOURS

7) ~~Urgent~~ Evac
Evac for C-T. - scan

8) Notify Neuro team patient [redacted] admitted b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ICP/0215 20Aug03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

20 Aug 2003 1800 HOURS

1) Advance diet as tolerated
2) D/C q° neuro V's
3) neuro V q 4°; elevate HOB 30°
V/O Dr [redacted] / [redacted]

Noted [redacted] MM pm 20 Aug @ 1801 MM

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

8/20/03 ____ HOURS

1) D/C to home

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. G MEDCOM - 17741 53-710

b(6)-2

CLINICAL RECORD — For use of this form, see AR 40-66; the proponent agency is the Office of The — Mo. ___ Yr. 2005

VERIFY BY INITIALING — INITIAL IN COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	DATE DISPENSED 20
8/19	[redacted]	VS q 4°	05	✓	[redacted]
			17	RN	[redacted]
			/	/	
	[redacted]	Neuro checks q 1°	05	✓	[redacted]
20 Aug	[redacted]	q 4°	17	RN	[redacted]
			/	/	
	[redacted]	IV NS @ 100cc/hr	05	✓	[redacted]
			17	RN	[redacted]
			/	/	
	[redacted]	NPO	05	✓	[redacted]
20 Aug	[redacted]	Advance as tolerated	17	RN	[redacted]
			/	/	
	[redacted]	Act: BR C HOB ↑	05	✓	[redacted]
20 Aug	[redacted]	30°	17	RN	[redacted]

ALLERGIES: ☐ YES ☐ NO — PRIMARY DIAGNOSIS: CHI, (R) TM rupture

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

PATIENT IDENTIFICATION: [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(2)-2

Initialing | (MEDICATIONS) | Mo. | Yr. 2003

Order Date	Clerk/ Nurse	...BLE ORDER, PRE-OPERATIVES	...e to ...ives	Time to be Given	Time Given	Initials
19AUG	[redacted]	Admit ICW 1	19AUG			[redacted]
19AUG	[redacted]	Dx: Closed head injury RT TM Rupture	19AUG			
19AUG	[redacted]	Evac for CT soon				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

USAPA V1.00

ACLU-RDI 1643 p.103

DOD-031332

M[redacted] RECORD-SUPPLEMENTAL MEDIC[redacted]

For use of thi[redacted], see AR 40-66; the proponent agency is the Office o[redacted] Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
INTENSIVE CARE NURSING FLOW SHEET	**QA APPR 08MAR8**

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: 1000 Initals: [redacted]	Time: 1100 Initals: [redacted]
NEURO	Pupils	~~1000~~ OD 3→1 CH Reacts to light does not [illegible] spontaneously	OS Closed not examined
	Sensorium	Eyes closed OS. injured clear fluid ooze c̄ opening. A+O to person/and	OD ⊕ reacts to light 3→1
	LOC / GCS	Response appropriately to stimuli	Ø Δ in LOC & Pain as
		c/o Pain to OS like something is in it. c/o Pain to Jumper & Ⓡ FA 4/10	noted to head + eye
CARDIAC	Cardiac Rhythm	Regular Sinus Rhythm	
	PRI: / QRS:		
	Pulse Strength	MAE + strength x4 ≈ 2+ ⊖ dorsiflexion to LE	⊕ flexion + dorsiflexion to LE possibly due to ineffective communicat
	Cap Refil / JVD	WNL	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Regular	
	Breath Sounds	CTA	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	WNL c̄ regard to ethnicity warm	
	Integrity	dry intact	
	Backside	not checked	
IV	Access Devices	Peripheral IV Ⓛ FA	
	Location		
	Condition		
GI	Abdomen	Soft nontender	
	Bowel Sounds	⊕ active x4	
	Stoma/Ostomy	NA	
GU	Device	Ø	
	Color / Clarity	Ø	

(Continue on reverse)

P[redacted] BY *(Signa*[redacted]	DEPARTMENT/SERVICE/CLINIC b(2)-2	DATE
[redacted] b(6)-2	ICU3, [redacted]	

[redacted]ATIENT'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

USAPPC V2.00

MEDCOM - 17744

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	[redacted]	62Y	4	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2130	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	NO
IZ				☑

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICW 1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
01		030820

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030819

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

FOR LOCAL USE

DX: CLOSED HEAD INJURY
RT TYMPANIC RUPTURE.

b(6)-2

ADMITTING OFFICER (Signature and grade) [redacted] MD

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

DA FORM 2985, MAR 89 MEDCOM - 17745 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	AGE	6. RACE	7. [illegible]	8. [illegible]	ETS	10. PREVIOUS ADMISSION
M	29y	Z	Unk	N/A	N/A	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99 b(6)-2	[redacted]	N/A	1 CM 3

15. FLYING STATUS	16. [illegible] DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K70 9/1	N/A		WIA

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

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

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	Unk	19 Aug 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(6)-2		

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Repair Facial Laceration
Repair Ruptured Globe
Open (L) Humerous Fx
Open (L) Radius Fx

DX; 01352
8712
80151
81250
8731
87330
87210
8749
8702
8832
E993

Rx; 1682
8659
2181
184
0881
0559

Trauma
1
Injury
459

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

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

DA FORM 3647, [redacted] b(6)-2

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 17746

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

Meds [illegible]

NKDA

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

Most [illegible]

b(6)-2

[redacted]

[redacted]	DATE 19 Aug 03	IDENTIFICATION NO.	ORGANIZATION
...ed or written entries give Name last, first, ...; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

[redacted]

MEDCOM - 17747

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19AUG03	Neurosurgery Admit
2037	27 y/o male Iraqi Civilian suffered injuries in blast injury during UN Bombing today. Pt suffered penetrating injuries to his left Face and eye, left shoulder, elbow, and wrist, and right shoulder and hand. He was stabilized at [redacted] and sent to [redacted] b(2)-2
	PMH (-) Allergies
	Takes Voltaren BID
	Exam lacerations (L) Forehead, eye, upper and lower lip, and left cheek. There is a superficial left neck injury preserving the platysmus. There are superficial right anterior shoulder and dorsal hand lacerations, and left elbow & wrist, and left knee.
	Heart RRR.
	Lungs Clear.
	Abdomen benign. FAST Scan negative
	Perineum benign.
	Back nontender. AP/Lat Skull - (L) orbital Fx.
	Neuro intact. Lat C-Spine — negative
	(over)

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)*

Civ II [redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

ACLU-RDI 1643 p.108

DOD-031337

NSN 7540-00-634-4178

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
19 AUG	S: 29 yo ♂
17:20	IV started SCI (R) AC (L) open wrist fracture BP 91/59 (L) open elbow fracture, wrist Temp extensors injured Pulse 83 (L) knee laisoration sensation
17:25	BP: 103/67 in fact all 3 nerves. Pulse: Ultra sound (-) (L) laisoration motion over (L) face ear (L) lip loc. no vision (L) eye Awake alert good on commands GCS - 15
1730	Dr [redacted] 1825 Rectal (-) normal tone pt rolled no injuries identified on back side XRAYS Requested - AP/lat (L) WRIST, (L) ELBOW, (L) Knee
1735	Recid 290♂ from triage - pt involved in explosion at UN. Pt is GCS 15 RTS 12 BP 107/68 P88 RR22 SAO2 99% RA. Pt has large facial laceration & he is able to maintain his airway. He has a large superi- orbital head wound. His (L) arm & wrist are deformed & he has a splint in place. His right arm at 3 o'clock but he can only move his index finger 2nd BP @ 1740 108/66 P88 RR22 — [redacted]

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

[redacted]

b(6)-2

[redacted]

ICU

(b)(2)-2

2

RECORDS MAINTAINED AT: b(6)-2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

MEDCOM - 17749

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1750	Pt remain A&Ox4, GCS15, RTS12, pt require suctioning from blood 2° facial wound but he is able to maintain his airway. Dr [redacted] has seen pt & we are awaiting X-ray at this time. Plan is to continue to monitor pt & maintain airway. SAT 100% RA — [redacted]
1810	X-ray here, pt given 3mg MS SIVP for procedure. BP 91/59 P74 RR20 — [redacted] Lt AN
1825	X-rays completed, (R) radial is strong & palpable, unable to palpate (L) radial due to splint. Pt remains able to move only (L) index finger. — [redacted] Lt AN
1830	Dr [redacted] here, H&H ordered, no Δ in sta[redacted]
1840	Lab here to draw H&H — [redacted]
1845	Ancef 1gm IVPB ↑ — [redacted] Lt AN
1850	BP 94/55 P88 RR22 SAO2 99% RA — [redacted] Lt AN
1855	Lab results HCT 30 Hb 10 — [redacted] Lt AN
1905	Pt to 21CSH. BP 92/50 P88 RR22 SAO2 99% RA, no Δ in status. — [redacted] Lt AN
1906	Ancef 1gm IVPB completed. — [redacted] Lt AN
	b(6)-2 [redacted]
1912	98/76 (R) pulse, (L) too traumatized
	P-103 LS clear (B) Bilat
	SaO_2 - 99% ; 15LPM O_2

[redacted] (b)(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*				
0600 21	Aug 03 Received report from previous nurse, Pt asleep but awakens easily, Pt c/o back pain, positioned for comfort, will monitor b(6)-2 [redacted] cpt/pm				
0715	Anesthesia in for pre-op eval, chart & CRNA to OR, Pt to OR & CRNA @ 0800. [redacted] cpt/pm b(6)-2				
1145	Pt took from OR accompanied by anesthesia in PA sets in the hi 90's; Positioned in bed supine but appropriate, VSS, unable to move (L) thumb but able to move (L) fingers. Dr [redacted] notified ~~him~~ & aware of thumb, ~~no further o~~ Pre op orders renewed, pain meds ordered. [redacted] b(6)-2				
	BP-125/65	RR-20	HR-104	Sats-100%	T-98.3
1150	121/64	~~10~~ 58	103	100	b(6)-2
1155	123/57	10	106	100	
1200	130/64	8	97	100	-98.2
1215	119/59	10	97	100	
1230	123/68	9	103	100	
1245	118/62	8	97	100	-98.5
	Pt more awake, unusant & appropriate, Ø c/o pain since arrival, still unable to move (L) thumb [redacted] cpt b(6)-2				
1830	VSS, hos report from day shift. Pt sleeping in bed c no c/o pain. b(6)-2 [redacted] 9/wound				

(over)

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICU3

[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 - 17751

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Impression / Plan:
	(1) Face/Scalp Lacerations – 1° Closure.
	(2) Orbit / Globe injury – per Ophth.
	(3) Extremity injuries – per Ortho.
	[redacted]
	b(6) - 2
20AUG03	Op Note – Neurosurg
0129	Prep Dx Facial lacerations
	Procedure 1° repair Scalp + Facial lacerations.
	Surgeon [redacted]
	EBL 250
	Findings > 20 lacerations left Face, neck, ear, mouth, nose, and eye. Orbital portion left to ophthalmology. Extremity injuries left to Ortho.
	Complications None.
	[redacted]
	b(6) - 2

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

DEPART./SERVICE | HOSPITAL OR CITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20 Aug 03	27 y/o Iraqi civilian suffered blast injury in UN bombing suffered multiple penetrating facial, forehead deep lacerations. Stabilized @ [redacted] sent here intubated prior to my exam
	V unobtainable exam in OR face wrapped b/c of vigorous arterial bleeding - waited to OR to take down bandages
	EXT very large soft tissue defect over medial canthus forehead, brow, full thickness irreg incisions involving margins of upper & lower lid
	penlight 4L (see above) significant vitreous b/w lids cong inferior subconj heme as cornea large full thickness oblique laceration across central cornea & onto sclera Ac ø view definite, flat uveal tissue non visible between lids iris - ? partial avulsion, ⊙ iris outside wound

(b)(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 see p 2

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

[redacted]

b(6)-4

REGISTER [redacted] | WARD NO.

b(6)-2

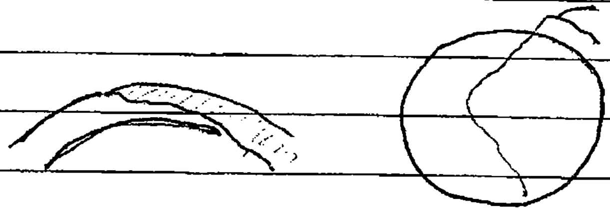
[redacted]GRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
[redacted]scribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LTC

MEDCOM - 17753

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

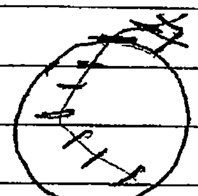
DATE	P.2 NOTES
20 Aug 03	c̄ other uvea extruded.



Imp: ① ruptured globe
c̄ extruded vitreous &
uvea OS
② severe facial lacerations, large soft tissue
medial canthal defect
③ sig lid lacerations OU involving margin
Plan: To OR repair / EUA

Op Note

Preop dx ① ruptured globe c̄ extruded uvea & vitreous cannot
r/o IOFB OS
② severe U&L lid lacerations, large medial canthal
defect c̄ soft tissue / skin loss, lid lacs involve
margin
③ hand lacerations
Postop dx same
Surg [redacted] b(6)-2
Proc repair ruptured globe
repair lid lacerations involving margins upper & lower
medial canthoplasty
repair facial lacerations
repair lid laceration



b(6)-?

Findings ruptured globe extruded vitreous
lens not appreciated flat chamber c̄ heme [redacted]
iris outside wound

MM

STAN[redacted] (1999) BACK
USAPA V1.00

[redacted]
b(6)-4

MEDCOM - 17754

ACLU-RDI 1643 p.114

DOD-031343

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
96.8 - 130	C10 623 Facial trauma 6800 crystaloid 4u PRBC
24 - 132/91	EBL 350 ET @ 23cm Fentanyl 250 Versed 5 mg in the OR.
100% 50%	
FIO_2	
20 Aug 03	Pt received from the OR, agitated post sedation in the
0345	OR. Pt vented, setting TV 700, SIMV 13, PEEP 5, FIO_2 50%
	ET 23 cm @ the lip. Multifacial trauma + stitches noted
	c bloody face. (L) arm appear to be deformed c bulky
	dressing, radial pulse palpable c circulation on the fingers
	< 5 seconds. (R) knee extending to mid calf wrapped c
	ace wrap. Pedal pulse strong c adequate circulation to
	the affected (R) LE (toes). Foley draining amber/yellow urine.
	Refer to OR report also. VS 96.8 - 130 - 24 - 132/91 - 100% sat
	on 50% FIO_2. Pt VS was taken when awaken from sedation.
	[redacted] mg/kg bw)-2
0400	Pt BP/ SBP < 100 after given Fentanyl 250 mg c Versed 5 mg
T 100.1 - 109.	bolus for sedation. Done bolus LR 1 liter, BP returning
35. 97/65	to normal. Pt closely monitored. IV @ 50 cc/hr, Versed 1 mg/hr
MAP: 76	Fentanyl 3 mcg/hr to start + titrate to effect. Pt is calm
	fully sedated. [redacted] mg/kg bw)-2
0500	Pt awaken, follows command. Motion to remove tube (ET), explained
	procedure. Started titrating FIO_2 by 5% q 15 minutes

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] (bl)-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

ACLU-RDI 1643 p.115

DOD-031344

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03	Foley drained 650 cc / amber yellow urine. Continue to
0530	titrate FIO_2 @ 30% sat 100%.
0555	ABG sent to the lab. attached are result. Pt breathing
	over the vent, RR 13 – pt 50 BPM. Follows simple
	command. Motion to take ET out.
20AUG03	Neurosurgery
0708	(S/O) Stable overnight.
	Nurse reports F/C when up from sedation.
	Vitals healthy.
	(A/P) Stable s closure facial lacerations.
	Extubate this am.
	Will work on placement today.
	[redacted] tbl(e)-2
0600	Received report from [redacted] Pt comfortable s vent
	sedation, will plan for extubation s monitor [redacted] cont/pod
0745	Dr [redacted] in for extubation, Versed off since 0700, pt following
	commands, able to lift head up, HOB elevated. ETT suctioned, oral
	cavity suctioned, Pt extubated s incident. placed on NRB. then
	RA in 15 min sats 100%, Pt vomited blood upon extubation but
	had good strong cough. VSS, will continue to monitor [redacted]
(1800)	Received Report from day shift. Pt VSS, c/o
	pain. [redacted] tbl(e)-2 glw, mom b
(2000)	Pt resting in bed VSS, ø c/o pain. Fentanyl effective
	& good effect - will continue to monitor. [redacted] slw, mom
(2200)	Pt's VSS, ø c/o pain noted. [redacted] tbl(e)-2 gwsmd
21AUG03 (0200)	VSS, Pt received 650 mg Tylenol for headache NPO since 2330
	for OR call in AM. [redacted] tbl(e)-2 gwsmd

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

ACLU-RDI 1643 p.116

DOD-031345

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	② large soft tissue defect over medial canthus
	③ lid margin lacerations involving U&L lid
	④ 3 cm hand laceration
	720 facial lac - sutures by neurosurg
	Compl none b(6)-2
	[redacted]
	OpNote [redacted]
21AUG03	PreOp Dx: Open Ⓛ humerus Fx, Open Ⓛ radius [redacted] U/C Fx
	Lacerations, Extensor tendons at wrist
	PostOp Dx: Same
	Procedure: Repeat I&D, Repair ECRL, ECRB, common extensor
	Ⓛ wrist
	Surgeon: Olivero
	EBL: minimal
	Fluids: 1700cc
	Cx: ∅
	PostOp Plan: IV ABX, drsg Δ 48°, Splint in extension, OT
	rehab b(6)-2
	[redacted]

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 17757

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21AUG03	(2100) Pt sleeping in bed. Ø c/o pain. Resting position in bed & ambulates assistance. Pt's [redacted] QS. Will continue to monitor. [redacted] Guzman
22AUG03	(0002) Pt resting in bed, VSS, will continue to monitor Pt. [redacted] Guzman
	(0400) Pt's VSS, sleeping in bed. will continue to monitor. Pt. [redacted] Guzman
	b(6)-2 A11

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

ACLU-RDI 1643 p.118

DOD-031347

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22AUG03	ORDERS
	- TO ICU 2
	- DX: BLAST WOUND
	- CONDITION STABLE
	- VS - ROUTINE
	- BED REST
	- BETADINE TO WOUNDS BID
	- FOLEY TO GRAVITY
	- CLEAR DIET ADVANCE AS TOLERATED
	- IV - LR AT 125cc/HR
	- TYLENOL 650mg P.O. Q 4-HRS PRN
	- PERCOCET 1-2 P.O. Q 4-6 HRS PRN
	- MSO4 2-6mg IVP Q 2HRS PRN
	- ANCEF 1 GRAM IVPB Q 8 HRS PRN
	[redacted] b(6)-2
	- Δ ANCEF TO 1 gm IVPB q8[redacted]
	- BACITRACIN TOPICAL OINTMENT TO FACIAL SUTURES BID
	- ERYTHROMYCIN OPHTH OINTMENT TO SUTURES/LASHES AROUND [redacted]
	LEFT EYE / EYELIDS b(6)-2 [redacted] LTC, MC

Noted [redacted]

RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	SPONSOR'S NAME	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
			[redacted]			

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
24° chart ✓ done	22 Aug 03 @ 2400 [illegible]	

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.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22Aug03 1030	Report given by Air evac. Assumed care of pt ... report given. See ICU Flow sheet. No chart accompanied the pt. New orders recieved by Col. [redacted]
	Will cont. to monitor — b(6)-2 [redacted]
1500	Bacitracin oint applied to wounds / sutures on face, neck & (R) Arm & (R) hand staples. Erythromycin Ophth ointment to sutures / lashes & eyelids [redacted]
1505	Pt chart arrived from [redacted] b(2)-2
1630	T 100.8A Tylenol 650 mg po given. Will monitor [redacted] b(6)-2
1725	T 100.5A Will cont. to monitor [redacted]
1804	T 100.4A Will cont. to monitor [redacted]
1806 (Late entry)	Percocet ii given po for H/A & (R) eye pain — Will monitor — b(6)-2 [redacted]
1908	Resting in bed @ present time — [redacted]
22Aug03 1940	Received pt @ 1900. Pt. resting in bed. Easily arousable. A&Ox3 (R) pupil @ 3mm & reactive. Resp. even, unlabored. SpO2 98% RA. Lungs CTA. NSR 2+ pulses x 3, cap refill brisk x4. Abd. soft, flat (+) BS x4. Foley to gravity c̄ clear, yellow urine. LR @ 125cc/hr infusing into (R) AC s̄ difficulty. Multiple blast injuries to → b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

29 Y10 Iraq Civ

MEDCOM - 17760

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Wrist FA IV s̄ S/S of infection or infiltration noted. LR @ 125 cc/hr via (R) FA. Skin w&d to touch. (L) Arm & hand c̄ cast/Ace bandage CDI. Pt able to move fingers on (L) hand. Cap refill < 3 sec @ (L) fingernail beds. Pt can feel when nurse touches fingers on (L). (L) Knee Ace bandage CDI. Lung sounds clear bil. BS (+) in all 4 quads. (R) radial pulse (+) (L) unable to assess due to cast/Ace bandage on Arm & hand. Pedal pulse (+) bil. Midback area c̄ 4x4 DSG CDI. Will cont. to monitor [redacted]
[redacted] 0700	Foley to gravity c̄ clear yellow urine noted. [redacted]
0730	Bacitracin ointment to facial sutures. Erythromycin oint applied to sutures flanks (L) eye lid. Tylenol 650 mg po given @ 0800 for (L) eye pain. Will cont. to monitor [redacted]
0840	(L) eye oozing yellow drainage. (L) eye [redacted] 4x4. Will cont. to monitor [redacted]
0900	ii Percocet given po for (L) eye pain. Will cont. to monitor [redacted]
1300	MD (Dr. Oliver) D/C'd (L) Arm/hand DSG [redacted] ace wrap. Will cont. to monitor [redacted]

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

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 - 17761

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Aug03	Percocet ii po given for pain (L) Arm. Will cont to [redacted]
1330	Monitor. Family @ bedside. [redacted]
1430	No c/o pain Will Monitor [redacted]
1500	Face (L) side cleaned up due to (L) eye oozing [redacted]
	yellow drainage. Reapplied bacitracin oint. [redacted]
1600	Transfer pt to ICW2 report given to LT [redacted]

b(6)-2 All

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

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

MEDCOM - 17762

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Aug03 1940 cont.	(L)face. Sutures to (L) eye intact. Some serous drainage from (L) eye. (L)UE wrapped c ACE bandage. (R)con. Blast injury to (L)LE, (L) knee wrapped c ACE bandage. Pt. has ϕ c/o @ this time. Will cont. to Monitor. [redacted] LET/kn
23Aug03 0110	Serous drainage noted to be oozing from sutures & eye and (L)side of face. Face wiped c Sterile H2O soaked 4x4. Bacitracin applied to sutures & erythromycin applied to (L)eye @ 2200. Pt. Verbalizes concerns about his appearance. Asked about the swelling in his face but said he did not want to look in a mirror yet. Stated that his face feels like a "piece of leather." Pain controlled c Percocet 1i tabs. Pt. Sleeping at this time. Will cont. to monitor. [redacted] LET/kn
23Aug03 0458	Am care done. Small wound to center of back, skin tear c some blood noted. 4x4 applied to site. 2 lacs to (R) shoulder c staples intact. 1 lac to (R) hand c staples intact. Face cont. to ooze serous fluid.
23Aug03 0500	Pt. c/o facial pain. Medicated c Percocet 2 tabs PO. Tmax through the night 99.8 Ax. IV site (R)AC A'd. Pt c/o site "hurting". ϕ Signs of infiltration. Old site d/c'd c catheter intact. New site placed (R)FA 20g. ϕ other A/s. [redacted] ET/kn
0700 23Aug03	Assumed care of pt @ night shift report given. Pt Alert & Orient x3. (R)eye PERRL @ 2mm, (L) eye sutured shut. Sutures noted to (L) side of head from skull to neck & nose to ear. Open wound on chin approx about 2cm x 2cm red & pink noted. All sutures intact (R) FArm c staples CDI. (R) hand c staples CDI (R)

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

ACLU-RDI 1643 p.123

DOD-031352

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

Recommendations:

- Needs to have facial sutures, including 5-0 Prolene tied over silicone bolsters at medial canthus, and 6-0 silk suture tarsorrhaphy tied over silicone bolsters removed 27-29 August.
- Will require delayed enucleation of ruptured left globe within next 7-10 days. Can be fitted for ocular prosthesis 4-6 weeks after enucleation (Recommend waiting until 1 September before enucleating the left eye to allow eyelid and medial canthal injuries to stabilize).
- Need orthopedics to examine left arm and wrist. Will eventually require physical therapy.

Transfer Medications:

- Bacitracin Topical Ointment to facial sutures BID
- Bacitracin or Erythromycin Ophthalmic Ointment to lashes and eyelid wounds BID

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

[redacted] b(6)-4

MEDCOM - 17764

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	- Keflex 500mg PO QID - Percocet 1-2 PO q4-6h PRN Pain.

[redacted] b(6)-2

[redacted] MD
LTC, MC, US ARMY
COMMANDER
[redacted] SURGICAL TEAM
[redacted] L

b(6) b(2) γ

DIRECTOR, OPHTHALMIC PLASTIC, ORBITAL & RECONSTRUCTIVE SURGERY
DIRECTOR, OCULAR TRAUMA
[redacted] USA

b(6)-2 [redacted]

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

MEDCOM - 17765

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG03	Neurosurgery POD 4
0847	(S) VSA.
	Alert, in good spirits.
	(L) Peripheral Facial palsy.
	Closures healing.
	(A/P) (1) Facial lacerations - healing.
	(2) Facial weakness - possible exploration later.
	(3) (L) arm/leg injuries - per ortho.
	(4) (L) Eye injury - per opthalmo.
	(5) Placement - Contact Family / UM today.

[redacted]

1791

b(6) -2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Doctor's Orders ~~PROGRESS NOTES~~

DATE	NOTES
23AUG03 1406	(1) Transfer ICW 2 ✓ (2) Diagnosis: Facial lacerations, LUE/LLE injuries. ✓ (3) Condition: Good. ✓ (4) V/S c/s: Q-Shift. ✓ (5) Activity: Up ad-lib with assist (6) Nursing: Wcleanse/ bacitracin Facial closures q-Shift. ✓ Δ dressings LUE/LLE q-Shift. (7) Diet: Regular ✓ (8) IV: None (9) Meds: Erythromycin Opht Ointment (4) eye closure q-Shift Tylenol 650 mg po q 4° prn. ✓ Keflex 500 mg po TID x 3 days (10) Labs: None. ✓ (11) X-ray: None.

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

24° Chad ✓ [redacted] Jeff 4797

23 Aug 03 1720

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

DEPART./SERVICE	HOSPITAL / MEDICAL FACILITY	RECORDS MAINTAINED AT

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

C.V. [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24AUG03 0711	(1) Percocet 1-2 PO q 4° prn (2) Elevate LUE on pillow or sling.
24AUG03 0822	(1) Oxygen/backtrack glasses q shift (2) Afrin nasal spray IT each nostril BID x 5 days.

[redacted] 4797 b(6)-2

Noted 24Aug03 [redacted] b(6)-2

[redacted] b(6)-2

noted 24Aug03 [redacted]

24° chart √ [redacted] 25 Aug 0125

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

24 Aug 03
1700

TRANSFER SUMMARY b(6)-4

27yo Iraqi M, [redacted], was working for the UN when the UN Embassy was bombed 19 Aug 03. He was transported to the [redacted] where he was evaluated and found to have open left humerus fracture, open left radius fracture and lacerations with extensive lacerations to extensor tendons left wrist. He also had lacerations to (L) knee. b(2)-2

Extensive lacerations and avulsions to left face to include forehead, eyelids, medial canthus, cheek and lips. Ruptured left globe with no vision OS. He was taken to the OR and underwent washout of (L) arm and leg wounds, Hum Repair ECRL & ECRB and common extensor of left wrist. (L) wrist splinted.

Left globe was explored and found to have large rupture involving length of cornea and onto sclera at 12 o'clock limbus. Extensive extrusion / prolapse of uveal / vitreal tissue. (patient had no light perception vision preoperatively).

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

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

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

[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 9/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.1

ACLU-RDI 1643 p.129

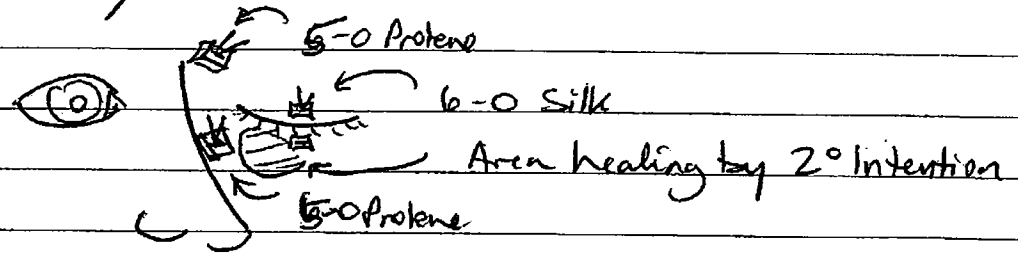
DOD-031358

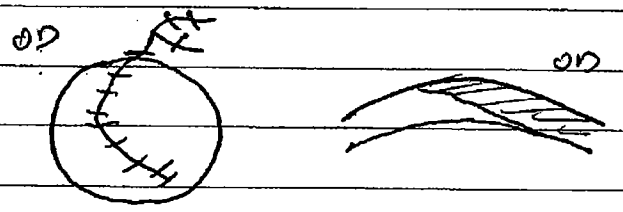
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

No iris details visible due to extensive bleeding into anterior chamber. Globe hopelessly ruptured and not deemed salvageable — however, wounds closed with interrupted and running 8-0 & 9-0 Nylon and plan for delayed enucleation.
Forehead and cheek lacerations repaired.
Upper and Lower transmarginal lacerations repaired with 7-0 and 8-0 Silk. 5-0 Prolene passed through skin and tied over Silicone bolsters to reduce soft tissue and skin defects.
Eyelids closed with suture tarsorrhaphy using 6-0 Silk tied over Silicone bolsters.
A 1cm x 1cm defect remained in medial left lower eyelid. Underlying orbicularis oculi muscle mobilized to close defect and to serve as scaffold for skin re-epithelialization by secondary intention.





Received 4u PRBCs intraop.

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

ACLU-RDI 1643 p.130

DOD-031359

24 Aug 03 2339 - assumed pt care @ 2200. pt has orders for dsng Δ to LUE & LE q Shift. Pt refused to have LUE dsng Δd. Dsng to LUE c splint & ace wrap CDI. RUE c staples to Ⓡ shoulder intact OTA, RAC redden c sm pustules. Ⓡ hand c sutures intact OTA. Pt c/o itching to staple sites. requested something for itching. Spoke c Dr. [redacted] for orders, MD states "its normal to itch, he doesn't need Benadryl." lungs CTA, abd soft BS Ⓟ x4 quads. LE c dsng CDI. RLE c Ⓟ pulse full bom. Will cont to monitor [redacted] 91WM6

0400 V/S 110/64 P 115 R 16 T 97.7 [redacted]

25 Aug 03 0545 - pt c/o HA. given ÷ Tylenol x per prn orders. [redacted] b(6)-2 91WM6

25 Aug 03 0855 Assume pt care @ 0600. Pt Awake A+O x3. Amb c difficulty. VSS. Splint c ace wrap CD+I to RUE, pt states the MD told him to keep splint x 10 days. will clarify. Dsg to RLE Δd stitches intact. C/o itching @ staples on LUE and old IV site, bacitracin applied. ace sutures intact to face, bacitracin applied. HR reg. Lungs CTA. Abd soft. BSx4, no BM since pt has been in hosp. x4 days. Will cont. to monitor. [redacted] 91WM6

1400 Staples removed from Ⓡ hand/shoulder, order for bacitracin to AC area and Ⓡ hand b(6)-2 and shoulder. Ambien ordered for QHS PRN. Do not Δ dsg to ⓇUE. [redacted] 91WM6

25 Aug 03 1522: Assumed care @ 1400. VS @ 1200 = T - 100.2°F P - 97 R-16 BP 119/107 SpO2 - 100%. HR - regular. Lung sounds clear - bilat. Abd soft, nondistended. C/o headache, Tylenol 650mg PO given. Erythromycin oint. to Ⓛ eye, Sutures to Ⓡ side of face & forehead intact. Thick yellow drainage from OS noted. Splint to ⓁUE CD+I. Sm. rash to Ⓡ AC. Wounds to ⓁLE open to air c No s/s of infection. [redacted] b(6)-4 Will continue to monit... [redacted] b(6)-2

25 Aug 03
2350 Pt care assumed @ 2200. Pt resting quietly.
2200 99.9 facial sutures intact OTA c bacitracin applied.
87 OS sutured shut. lungs CTA, BS x4 quads. (R)↑ et ↓.
100% ext c strong (P) pulses. LUE c splint et ace wrap, drsng
24 CDI. LLE OTA ⊖ S/Sx of infection noted, (P) pulse. ⊖
119/73 c/o pain voiced. will cont to monitor [redacted] RN/WMC
26 Aug 03
0400 VS BP 110/70 R 14 T 97.1 P 66 Resp WNL [redacted]

26 Aug 03
0500 pt c/o HA given ii Tylenol per prn orders [redacted] RN/WMC

26 Aug 03
0737 VS T 99.3 P 84 R 20 BP 120/68, pt c/o HA 5/10 Tylenol given @ 0500. pt waiting for AE to Jordan

Nursing discharge Summary.

Pt being transferred to Jordan by A/E
Discharge orders, summary and medications complete.
Pt teaching done c meds. pt understands meds
and wound care. [redacted] RN/WMC

b(6)-2

ACLU-RDI 1643 p.132

DOD-031361

MEDICAL RECORD	PROGRESS NOTES
DATE	

Orthopaedic Summary

26 AUG 03 Mr. [redacted] sustained injuries to his left upper extremity in the U.N. blast incident on the 19th AUG 03. His injuries include

1) Open left distal humerus fracture (non displaced)
2) Open left distal radius fracture
3) Transection of wrist and finger extensor tendons, Extensor radialis brevis, extensor radialis longus, and all common extensor (4th compartment)

1) Himerus fracture is avulsion of bone of lateral aspect of humerus. It is extra-articular and has been debrided with wound closure. Gentle range of motion exercises should commence at one week.
2) Radius fracture was small dorsal lip fracture which was reapproximate with pericostal suture and splinted after debridement. Treatment should mimic that necessary for tendon repair.
3) All tendons have been repaired. If occupational therapy is available, then a pretaal and splint allowing active flexion with resting / passive extension should be initiated. If OT is not available, the wrist and fingers should be splinted in extension followed by Range of motion exercises. (cont)

(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. [redacted] b(2)-2

4) Remove sutures / Staples in one week

[redacted]

PROGRESS NOTES
(2) Medical Record

MAJ MC
CHIEF ORTHOPAEDIC SURGERY SERVICE

[redacted]

b(2)-2

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

ACLU-RDI 1643 p.133

DOD-031362

558-104

7540-01-075-378

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

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

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: CIV [illegible]

CITY | STATE | ZIP CODE

SEX: M

AGE: 29

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

ARRIVAL

DATE (Day, Month, Year): 14 Aug 03 | TIME: @ 1950

TRANSPORTATION TO FACILITY: AM

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2569 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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Trauma

CATEGORY OF TREATMENT

☒ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1937

INITIALS: [redacted]

VITAL SIGNS

TIME	1938	20 20				
BP	107/50	106/49				
PULSE	98	103				
RESP	18	16				
TEMP	Oral					
WT 500	99					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX b(2)-2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1950	MSO4 5mg	[redacted]			
1950	1 NS @ TKO				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

MEDCOM - 17774

[redacted]

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Inmate in explosion today. Care to fwd team & stabilized — (L) knee, (L) eye

O: (L) eye injury - severe
(L) arm injury & neck laceration
Evaluated by Surgical team to x-Ray & Dx [redacted]
and then to OR. Pt stable

(b)(6)-2

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)*

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)

b(6)-4

[redacted]

MEDCOM - 17775

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
231630 Aug 03			NURSING NOTE: Pt transferred to ward via w/c c difficulties. However, upon transfer to bed, pt began to complain that the bed was not soft enough, that his pillow was not soft enough. After explaining that this was the only bed style available and that this would be the bed he would sleep in. Multiple facial lacerations c sutures intact, bandages applied. Airway intact, breathing even and unlabored, LS CTA(B), Abd soft, nontender, c distention. BS(+)x4. Voiding per Foley. AROM to RUE and RLE, Neurovascularly intact to all extremities. RUE splinted c ace wrap, CDI. LLE has ACE c Kerlix, some serosang drng noted. Sticthes to (R) hand are CDI. (L) eye covered c erythromycin ointment. Also has some purulent drng (L) eye seen shut. IV D/C'd intact c Dc order written [redacted] b(6)-2
T=98.8	P=94		
BP=113/54	RR=18		
S_aO_2=97% RA			
23 1800 Aug 03			NURSING NOTE: Foley D/C'd intact. Pt w/d's [redacted]
24 Aug 03	0210		assumed pt care @ 2300. pt awake. VSS. Sutures to (L) side of forehead, cheek, ear & lip intact OTA, DS sutured shut. Lungs CTA, BS(+)x4. R & L EXT c full ROM (+) pulses. LLE c ACE & Kerlix dressing, old drainage noted. LLE c splint & ace wrap. D/C'd pain voiced. will cont to monitor [redacted] 91 WMed b(6)-2
24 Aug 03	0700		Neurosurgery (SO) Stable overnight in ICU. Uncomfortable. Exam Stable. (NP) Injuries (L) Face/arm/leg. Treatment per EMR.

(continued on reverse side)

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

[redacted] b(6)-2

NURSING NOTES
Medical Record

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

MEDCOM - 17776

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03	0729		VS - BP - 107/62 HR 94 Temp 97.8 RR 22 Sat 100% RA VS WNL. A+Ox3. Skin W/D/I. All sutures to scalp intact, sutures to OS intact c white foam padding intact. Face cleansed and Bacitracin re-applied to all sutures. Yellow/white drainage noted c cleansing sutures and OS. OD EOM PERLA WNL. Stales & visual D's. Staples to (R) shoulder intact. Redness noted @ staple insertion sites. Bacitracin applied. Staples to (R) hand intact Bacitracin applied. Splint cast to (L) UE intact. NV √s WNL to digits. LCA (R). HRRS, S_a WNL. BSx4. ABD soft/ non-tender. Appetite excellent. Bacitracin applied to aprasions (R) LE's. ACE wrap dsg to (L) LE CDI (L) LE digits NV √s WNL c/o pain x1 iti Tylenol given. Pt stated @ 0858 Tylenol "provided significant relief" Will cont to mon [redacted] MT/AN
24 Aug 03		1615	Assumed care @ 1400. T-100.7°F P-109 R-16 BP-119/63 SpO_2-100% HR-regular. Lung sounds clear bilat. Abd. soft, nondistended. BS x4. Multiple lac. to face - cleansed and treated c bacitracin. Erythromycin to OS. Thick yellow drainage from OS. Staples to Shoulder intact Staples to (R) hand intact. ACE wrap to (L) leg intact & clean. Splint to (L) arm CDI - sensation present to fingers c good capillary refill. Tylenol 650mg PO given for fever and pain. Will continue to monitor. [redacted]

25AUG2003 – 2133

Discharge Summary, Patient #[redacted] b(6)-4

History: This is a patient who suffered multiple penetrating injuries during the UN bombing on 19AUG2003. These included glass fragments embedded in and causing lacerations to the left face, eye, and neck. He also suffered injuries to his left arm and leg. He presented awake and alert with an admission glascow coma score of 15. Left facial weakness was present on admission. He had no central paresis of his extremities.

Hospital Course: The patient was transferred directly to the operating suite, where repair of his facial lacerations was performed concurrently to irrigation and debridement of his extremity injuries. After facial injuries were repaired, his care was turned over to Dr [redacted] from Ophthalmology. He performed initial repair of the tissue loss in and around the left eye. Postoperatively the patient was left intubated overnight. He was routinely extubated the following morning and has been stable thereafter. Given his options of remaining in Baghdad or being flown to Jordan for his ongoing care, he elected to travel to Jordan. He was released on 26AUG2003.

b(6)-2

Disposition: Sutures may be removed from the face at any time. Eye per Dr [redacted] Extremity injuries per Dr [redacted] Orthopedics. Treating physicians are encouraged to contact me with any questions or concerns.

[redacted] MD b(6)-2

b(6)-2

ACLU-RDI 1643 p.138

DOD-031367

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 29 HEIGHT: 183 cm WEIGHT: 86 kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Closure of Fascial Lacerations / I&D (L) Arm / I&D (L) leg

5. ADDITIONAL INFORMATION:
TOS-D PRO-1500
Epoxy-D

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

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

#[redacted] b(6)-4

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

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

[redacted] 19 Dec 03 DATE

11. POSTOPERATIVE EVALUATION:

Good pt

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Titl
[redacted] b(6)-2	[redacted] b(6)-2
DATE: 19 Dec 03 TIME: 2044	DATE: 19 Dec 03 TIME: 0330

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

ACLU-RDI 1643 p.140

DOD-031369

MEDICAL RECORD — INTRAOPERA OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Orderlies

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 1053

4. PATIENT IN ROOM TIME 1053 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: 29 y/o male awake & cooperative.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
	SGT [redacted] / SPC [redacted]		
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	
	CPT [redacted]		

7. POSITION AND POSITIONAL AIDS (Specify)
At in proper body alignment on Alm board at <90°. Left arm on two Alm boards serving as an Arm table.

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

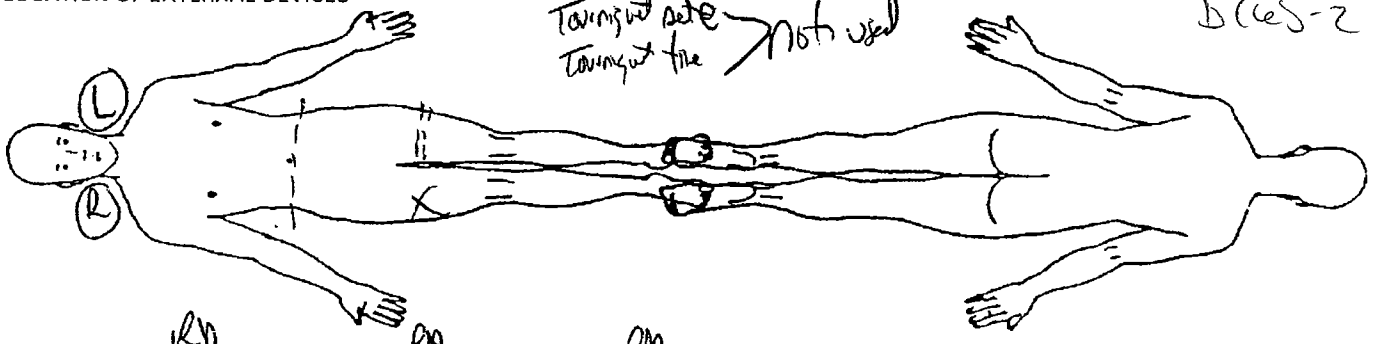
COMMENTS: Tourniquet on left thigh. 10/5 w-drape iodophor tourniquet for prep.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine scrub/paint
SITE: Face, neck, scalp BY WHOM: Dr [redacted]
SITE: left Arm BY WHOM: MAJ [redacted]
site: Left leg By whom: CPT [redacted]
COMMENTS: no pooling noted SPC [redacted] b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (RD) -- Safety Strap (RD) = = = Tourniquet (RD)

C = Correct I = Incorrect b(6)-2

10. COUNTS	Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge ☒ Yes ☐ No		C	C	SSG [redacted]	CPT [redacted]
Needle Sharp ☒ Yes ☐ No				SGT [redacted]	CPT [redacted]
Instrument ☐ Yes ☒ No				SPC [redacted]	CPT [redacted]
Other ☐ Yes ☒ No					

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

[redacted] b(6)-4

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

☒ ESU NO: #3
GROUND PAD: BRAND Valleylab
LOT NO: 69671

☐ 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 V1.00

MEDCOM - 17781

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 ointment	OS	intraop	topical	[redacted]	Dr [redacted]
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

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 ☐

	1.	2.	3.
TYPE/SIZE	3/8" Penrose		
SITE	left leg		

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, DDD, Kerlix, Ace – left [redacted]
Fluffs, kerlix, Ace – left leg

19. ADDITIONAL INFORMATION
Surgeons- Dr [redacted] Dr [redacted] Dr [redacted] Dr [redacted]
Anesthesia- CPT [redacted] / CPT [redacted]
b(6)-2

#8 continued – Applied left eye lid, eyelashes & surrounding tissue betadine paint – CPT [illegible]

20. OPERATION(S) PERFORMED
① Closure of Facial Lacerations ② I&D left Arm ③ I&D Ⓛ leg ④ Ruptured Globe Repair OS
⑤ Repair upper lid & lower lid OS ⑥ I&D Ⓡ hand / shoulder

21. PATIENT TRANSFERRED TO ICU-[illegible]	TIME 0300	METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesthesia

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

3. DATE 21 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

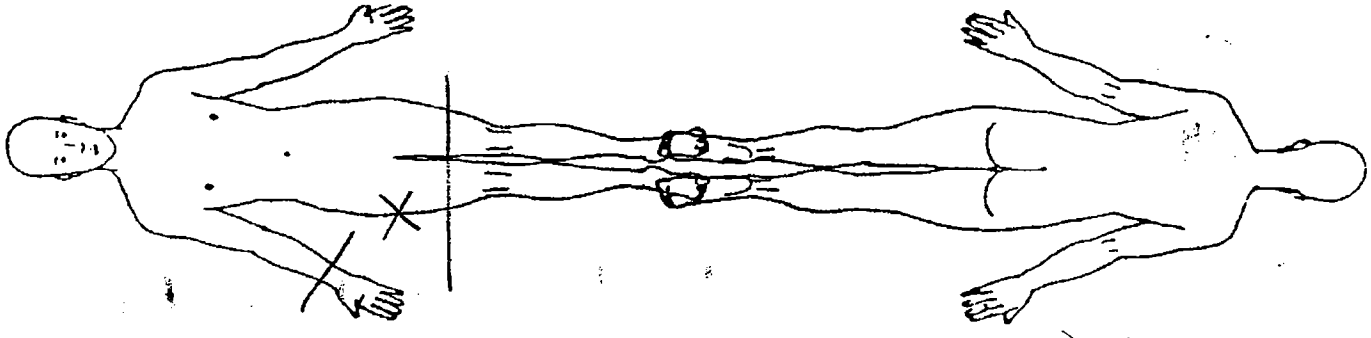
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine soap/sol.
SITE: Lt. arm BY WHOM: LTC [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet b(6)-2

C = Correct I = Incorrect

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

SCRUB	CIRCULATOR
SSG [redacted]	LTC [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: Valleylab Force 2 #3
GROUND PAD: BRAND Polyhesive REM
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES DA FORM [illegible] WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 17783

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]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

	1.	2.	3.
TYPE/SIZE	1. ½" penrose	2.	3.
SITE	1. ~~arm~~ wound Lt arm	2.	3.

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

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
b(6)-2 ICU	1130	via Gurney b(6)-2

22. REGISTERED NURSE SIGNATURE [redacted] LTC, AN [redacted] Maj AA
21 AUG 03

REVERSE OF DA FORM 5179-1, OCT MEDCOM - 17784 USAPA V1.00

ACLU-RDI 1643 p.144

DOD-031373

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August DAY 24

19 2003 HOUR 1400 1500 1600

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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.

Civ [redacted]

b(6)-24

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17785

Ward/Section: EMT	REQUESTING PHYSICIAN: b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: b(6)-4 [redacted]	DATE: 19Aug	TIME: 2000
		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: [redacted] b(6)-2	DATE: 19 Aug 03	LAB ID NO.:

ACLU-RDI 1643 p.146

DOD-031375

i-STAT 6+

Pt: [redacted] b(6)-2

Pt Name:_____

Glu_____183 mg/dL

BUN_____14 mg/dL

Na_____140 mmol/L

K_____4.0 mmol/L

Cl_____109 mmol/L

Hct_____24 %PCV

Hb*_____8 g/dL

*via Hct

Sample Type_:

19AUG03 20:05

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:

19AUG03 20:04

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID: [redacted] 19-AUG-03
20:00

				Patient Limits	
WBC	21.6 H	x10^3/uL		4.5	10.5
RBC	3.25 L	x10^6/uL		4.00	6.00
HGB	9.8 L	g/dL		11.0	18.0
HCT	30.4 L	%		35.0	60.0
MCV	93.5	fL		80.0	99.0
MCH	30.1	pg		27.0	31.0
MCHC	32.2 L	g/dL		33.0	37.0
PLT	289.	x10^3/uL		150.	450.
LY%	11.5	%		20.5	51.1
LY#	2.5	* x10^3/uL		1.2	3.4

29/m 86 Kg NKDA

MEDICAL RECORD - ANESTHES[IA]

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

Voltaren. Ø PSH (-) PMH.

DRUG (Units)													TOTALS
Versed (mg)	2												2
Fentanyl (mcg)	100			50					50				200
Propofol (mg)	100												
Sch (mg)	100												
Nimbex (mg)		10			4		10			10			
Neostigmine (mcg)		150					100						
VOLAT AGENT Iso % del		0.4	0.4	.6	.6	.6	.6	.8	0.8	0.8	.8	.8	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	8	2	2	1	1	1	1	1	1	1	1	1	

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

TOTAL EBL: 350
TOTAL URINE: 800

FLUIDS - SUMMARY
CRYSTALLOID- 6400
COLLOID-
BLOOD- 4 UNITS

FLUIDS

LINE site					
LR 14 ga	☒ Warmed	1000	2400	3000	5200
LR 18 ga	☒ Warmed		500	1500	1600
	☐ Warmed				

LOSSES

EST BLOOD LOSS	100	100/200	100/300	
URINE -	50	50/100	100/200	150/350

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

BODY WEIGHT: 86 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- ___/___ HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Yes TIME- 2358

TIME: 2045 2100 15 30 2145 2200 . 30 . 2300 . 30

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

220 200 180 160 140 120 100 80 60 40 20

REMARKS
Code drugs with numbers, events with letters

2045 PRBC II
[redacted]
2130 PRBC
[redacted]
2205 PRBC
[redacted]
2210 Ca++ 100mg WP.
2220 Ancef 2gm
2230 PRBC
[redacted]

VENTIL

VT - ml		760	700	710	690	710	760	760	730	730	710	760
f - breaths/min		12	8	10	10	10	11	11	11	11	11	12
Peak inf pres / PEEP		18	18	18	17	18	18	18	19	18	18	19
MODE - S(pon), A(ssist), C(on)	S/A/C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		32	39	36	34	34	34	34	34	36	36	34
BP/oth	FiO2 (Frac or %)	72	.75	.63	.62	.62	.61	.61	.62	0.62	.62	.62	.66
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	—	Axil										
	N-M Block (T/4)	4/4	4/4	4/4	0/4	0/4	0/4	0/4	—	0/4			
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position: Off ————>

RECOVERY AT 0325
PACU (ICU) 3 (Specify)
OTHER
CONDITION- Vent 96.8
RESP- 12 SpO2- 99
BP- 140/88 HR- 126

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2030	2000	0330
	Ready	Begin	End
PROC	2100	2110	0315

PROCEDURES and CPT Codes: FACIAL (L) ARM ABDOMINAL

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: PRE-O2 5min 100% FiO2, RSI c cricoid. OVET mac 2 Grade II View 8.0 ETT Placed 23cm @ lips (+)BBS (+)ETC

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

SURGEONS: [redacted] b(6)-4
ANESTH[ETIST]: STA[redacted]

PROCEDURE LOCATION: OR 2
DATE: 19AUG05
PAGE 1 OF 3

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

MEDCOM - 17788

ACLU-RDI 1643 p.148

DOD-031377

MEDICAL RECORD - ANESTHESI

... this form, see AR 40-66; the proponent ager... ...E OTSG

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

DRUG (Units)													
Versed (mg)	1										1	1	
Fentanyl (mcg)		50											
Nimbex (mg)		10				20				10			
Neostigmine (mg)		100					100						
VOLAT AGENT ISO % del	.8	.4	.6	.6	.6	.4	.6	.6	.8	.6	.6	.4	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	1	1	2	3	3	3	3	3	4	4	4	4	

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

FLUIDS

LINE site													
LRM5 ☐ Warmed	320						4000					4800	
LRM5 ☒ Warmed	1500						1700					1600	
☐ Warmed													

LOSSES — EST BLOOD LOSS 350; URINE - 400/700

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 86 KG LB

HEMATOCRIT

INITIAL DATA

BP- /

HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME- 2355

TIME → 2345 24^00 · 30 · 01^00 · 30 · 02^00 · 30

SYMBOLS:

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	750	760	780	810	800	800	740	750	750	800	740	760	
f - breaths/min	12	12	12	12	12	12	12	12	12	12	12	12	
Peak inf pres / PEEP	19	18	18	19	18	18	18	18	18	20	19	19	
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	35	36	34	33	34	34	35	35	35	36	36	36
BP/oth	FIO2 (Frac or %)	68	69	68	68	65	68	69	70	70	65	65	65
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	AVAIL											
	N-M Block (T/4)	0/4	2/4	0/4	0/4	1/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
Warming blkt													
Conv warmer													

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

TOTALS 3 / 50 — TOTAL EBL — TOTAL URINE

FLUIDS SUMMARY

CRYSTALLOID- 1L

COLLOID- 500

BLOOD-

REMARKS *Code drugs with numbers, events with letters*

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHETIC/PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: (D) ARM (L) Fed / Facial trauma / OPerm Closure

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

[redacted] bles-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See pb #1

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

SURGEONS: [redacted]

ANESTHETIST: [redacted] bles-2

PROCEDURE LOCATION: ORZ

DATE: 19AUG03

PAGE 2 OF 3

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

MEDCOM - 17789

MEDICAL RECORD - ANESTHESIA

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)	
Vecuronium (mg)	10
( )	
( )	
( )	
( )	
( )	
VOLAT AGENT Iso % del	.6
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	

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

FLUIDS

LINE site	Warmed	
	☐ Warmed	
LR 14g	☐ Warmed	5000
LR 18g	☐ Warmed	1800
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE -

TOTALS: TOTAL EBL — TOTAL URINE — (see pg 1)

FLUIDS SUMMARY: CRYSTALLOID- COLLOID- BLOOD-

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

0328 to ICU #3 intubated

VSS. ⊕BBS ⊕ETCO2.

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

TIME → 0245 0300 . 30 . 0400 . 30 . 0500 . 30 .

BODY WEIGHT: 86 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- ___ / ___ HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? yes — TIME-

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

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

VENTIL

VT - ml	690
f - breaths/min	12
Peak inf pres / PEEP	19
MODE - S(pon), A(ssist), C(on)	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36
BP/oth	FIO2 (Frac or %)	66
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	ST
Gas analyzer	TEMP-site	Axillary
	N-M Block (T/4)	0/4
Warming blkt		
Conv warmer		

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

RECOVERY AT: PACU ICU ___ (specify) OTHER — CONDITION: RESP- SpO2 BP- HR- (see pg 1)

ANESTHESIA PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: See PG # 2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — See PG #1

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

#[redacted] b(6)-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR

DATE: 19Aug03

PAGE 3 **OF** 3

DA FORM 7389, FEB 1998 — MEDCOM - 17790 [redacted] PATIENT'S MEDICAL RECORD — USAPA V1.00

NKA

MEDICAL RECORD - ANESTHESI[A]

F[or use of th]is form, see AR 40-66; the proponent age[ncy is] the OTSG

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)		09	x	30	x	10	x	30	x	11	x		TOTALS
Versed (mg)	2												2
Propofol (mg)	100												
Zemuron (mg)	50												
Fent (cc.)	2			1	1	1				1	1	1	8
Robinul (mg)				MORPHINE mg				3	3	4			10
Neostigmine (mg)		50/5...											
VOLAT AGENT Sevo % del	X 2-5 - 1	—	1.5 -	1.5	- 1.5	- 1.6	- 1.6	- 1.6	- 1.5	- 1.5	- 1.2 X		
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	6 - 7	—	2 —	2	— 2	— 2	— 2	2	— 2	— 2	— 2 — 4		

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

TOTAL EBL: 100

TOTAL URINE: 500

FLUIDS SUMMARY

CRYSTALLOID- LR 1700

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site RA	☐ Warmed	400 — 500 — 1000 — 1100 — 1200 — 1400
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 86 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 150/... 122/69; HR- 104

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Yes; TIME- 0820

TIME → 0845 09 x 30 x 10 x 30 x 11 x

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

(Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20 — charted BP and heart rate marks)

VENTIL

VT - ml		850	830	880	870	890	950	780	760			420
f - breaths/min		8	8	8	8	8	8	8	6	22	19	17
Peak inf pres / PEEP		23	23	23	23	23	27	23	22			
MODE - S(pon), A(ssist), C(on)	SA	C	C	C	C	C	C	C	C	S	S	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	7	34	33	32	31	30	28	29	32	41	47	49
BP/oth	X FIO2 (Frac or %)	.7	.7	.7	.7	.7	0.7	.7	.7	.7	.7	.7	.7
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site												
	X N-M Block (T/4)	1/c	0	0	4	+TRS ø FADE							
Warming blkt													
Conv warmer													

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

REMARKS

Code drugs with numbers, events with letters

Preop PIV NPO
Emergency Airway
Set-up. OR2
O2, monitors
5min de N2
Propofol, Sevo
SV, OPA, Stable
Robinul, Zem, Fent
DLx1 grd I...
... ease
prep/drape
... split ...
OR suction SV
extubated ...
OH
LUE Tour @ 250
↑ @ 0916
↓ @ 1112
116 min TT.

RECOVERY AT: 1130

PACU (ICU) #3 (Specify)

OTHER

CONDITION: RESP- 14 SpO2- 100% ...; BP- 111/63 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0835	1130

	Ready	Begin	End
PROC	0850	0910	1125

PROCEDURES and CPT Codes: Washout, ~~Flex~~ Tendons (R) ...

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: DLx1, grd I view, 3mAc. 7.0 ETT + ETCO2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: BS = B.

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

[redacted] b(6)-2

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR2

DATE: 21 ... 07

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 17791

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

ACLU-RDI 1643 p.151

DOD-031380

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 (E)
WT: 86 (KG)/LB HT: ____ IN.
ALLERGIES: Ø

PROPOSED PROCEDURE: I&D (L) Humerus Repair Ext Tendon
SURGICAL SERVICE: ORTHO
NPO SINCE: 8 MN

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Fentanyl
( )
( ) Tylenol
( )
( ) Ancef
( )

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A: ____
OTHER: ____
8.1 / 24

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y — Ø Related
CVA N Y
Other N Y

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y — BS CTA
COPD N Y
Other N Y

Renal System:
Acute/Chronic RF N Y — Ø

Gastrointestinal:
Hepatitis N Y — Ø
Hiatal Hernia N Y
PUD/GERD N Y

Endocrine System:
Diabetes N Y — Ø
Steriods N Y
Thyroid N Y

Neurological:
Seizures N Y — Ø
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y

Other Significant Hx:
N Y
N Y

Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
19 Aug Foreign Body Removal of Ruptured Globe
exploratory lap 20 Aug [illegible]

PHYSICAL EXAMINATION
BP 103/67 HR 92 R 14 T ____
Pain Scale 0-10 ____ SaO2 95%
HEENT - Teeth ____ [illegible]
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

Signed: [redacted] Date: 21 Aug 03 Time: 0800 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

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

Patient Identification: (Ward) ICU #3
[redacted] b(6)-4
[redacted]

MEDCOM - 17792

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.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* b(6)-2
[redacted]
DIAGNOSIS OR OPERATION BEFORE
Shrapnel

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

DATE VERIFIED: Set 19 Aug

TIME VERIFIED: 0518

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]
TRANSFUSION NO.
PATIENT NO.

DONOR	RECIPIENT
ABO A	ABO A
Rh pos	Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 2112 ON *(Date)* 19 Aug 03

IDENTIFICATION

I have [redacted] lood Component container label and this form and I find a[redacted] tifying the container with the intended recipient ma[redacted] he recipient is the same person named on this Blood [redacted] sion Form and on the patient identification tag.

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

[redacted] ER (Signature) [redacted]

PRE-TRANSFUSION

TEMP. PULSE 109 BP 101/56

DATE OF TRANSFUSION: 19 Aug

TIME STARTED: 2115

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written e[redacted] NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	DATE COMPLETED	INTERRUPTED
1 UNIT ML	2130	8/19/03	

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
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [ ] [redacted]
- [ ] YES *(Specify)* ____

[redacted] PERSON NOTING ABOVE b(6)-2

SEX	WARD
M	OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 17793

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: 19 Aug 03

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)* b(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: Shrapnel

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. [redacted]

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED: 19 Aug 03 b(6)-2

TIME VERIFIED: 2050

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: A
Rh: Pos

RECIPIENT
ABO: A
Rh: Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b(6)-2 [redacted]

DATE 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 2112 ON *(Date)* 19 Aug 03

IDENTIFICATION

I have [redacted] container label and this form and I find all info[redacted]er with the intended recipient matches item by item. [redacted]ned on this Blood Component Transfusion Form and

[redacted] b(6)-2 AN, CRNA

2[redacted] CRNA

PRE-TRANSFUSION

TEMP. | PULSE 104 | BP 101/56

DATE OF TRANSFUSION 19 AUG 03 | TIME STARTED 2130

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—L[redacted]ade; grade; rank; rate; hospital or medical facility)

[redacted]

b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 2140

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
	124	95/55

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 [redacted]ES *(Equipment, clots, etc.)*
- [ ] YES *(Specify)*

[redacted] ABOVE b(6)-2 [redacted] 4PT, AN, CRNA

SEX: M

WARD: SMT

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 - 17794

Medical Record Copy

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
- [X] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: 19 Aug 03 2110 STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: trauma / facial-arm Lac.

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

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh POS

RECIPIENT: ABO A; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: b(6)-2 [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION

INSPECTED AND [redacted] b(6)-2

AT *(Hour)* 2201 | ON *(Date)* 19 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)* [redacted] CRNA

2nd [redacted] b(6)-2

TRANSFUSION

TEMP. _____ PULSE 129 BP 83/45

DATE OF TRANSFUSION: 19 AUG 03 | TIME STARTED: 2205

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
1 UNIT ML	2224 19 AUG 03	

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

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

[ ] OTHER _____

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

[X] NO [redacted] [ ] YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE: [redacted] b(6)-2 CRNA

SEX: M | WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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
- [X] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: 19 Aug 03 2110 STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: trauma / facial-arm Lac

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

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. b(6)-2

PATIENT NO. [redacted]

DONOR: ABO A, Rh POS

RECIPIENT: ABO A, Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	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 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION

INSPECTED AND [redacted] b(6)-2

AT *(Hour)* [redacted] ON *(Date)* 19 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)* [redacted] ETC CRNA b(6)-2

[redacted] CRNA

TEMP. ____ PULSE 111 BP 111/71

DATE OF TRANSFUSION 19 AUG 03

TIME STARTED 2230

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries, NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	DATE	INTERRUPTED
1 unit ML	2240	19 AUG 03	

REACTION
- [ ] NONE
- [ ] SUSPECTED

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

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

PERSON NOTING ABOVE [redacted] b(6)-2 CRNA

SEX M

WARD OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 17796

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 | TIME OF ORDER | HOURS | LIST TYPE OF ORDER NOTED (AM SICK)

Admit ICU 3
Dx: Repair facial lacs
Repair ruptured globe
Condition fair
Vitals: q1°
Activ. Bed Rest
Nursing: foley in place

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Diet Advance as tolerated
NPO
IV SOLR
Meds: Ancef 1gm q12°

Pred Acetate 1% 1 gtts OS q2°
Ocuflox 1 gtts OS qid
Eryth opth oint to eyelid wounds bid

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Bacitracin to other wounds bid

Meds: ~~Morphine~~
Fentanyl 1-5 µg/kg/hr prn
paid titrate for pain

Vent to be modified by anesth/neurosurg

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

[redacted] OR/ICU

Versed 1-5 mg/hr
titrate for sedation

[redacted] ICU

Vent: TOO, 5 IMV 15, [redacted] ICU
Peep 5, Wean FIO2 for Sat > 95.

[redacted] b(6)-2

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

ACLU-RDI 1643 p.157

DOD-031386

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
II [redacted] b(6)-4		20AUG03	0711 HOURS	
	1.	Hold sedation / Fentanyl @ 0800.		
	2.	Extubate this [redacted]		
		[redacted] b(6)-2		
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		8/20/03	✓ 2300 HOURS	
		- NPO now		
		- on call to OR in AM		
		[redacted] b(6)-2		
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		8/20/03	2330 HOURS	
		tylenol 625 mg po q4°		
		c̄ sip of H_2O		
		[redacted]		b(6)-2
		UTC		
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER HOURS	
		21 AUG03		
		Resume pre-op orders, meds, activity		
		- Regular Diet		b(6)-2
		- Percocet ii po q4° prn [redacted]		
		- MSO4 2mg IV q1° prn [redacted]		
		- Phenergan 25mg IV q6° prn nausea		
		- Ancef 1gm IVPB q8°		
NURSING UNIT / ROOM NO. / BED NO.				

chart ✓ done 21 Aug 1300 [redacted] b(6)-2

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

U.S. GOVERNMENT PRINTING OFFICE: 1986—409-024

"USE BALL POINT PE... APER REQUIRED"

MEDCOM - 17798

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 | BED

DATE OF ORDER 8/24/03 TIME OF ORDER 2045 HOURS

LIST TIME ORDER NOTED AND SIGN

Noted 24 Aug 03 2045 [redacted] b(6)-2

(6) Remove drsg @ home tomorrow evening & leave wounds open to air

PATIENT IDENTIFICATION [redacted] b(6)-4

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER 25 Aug 03 TIME OF ORDER 1309 HOURS

1. LUE - splint to stay on. NWB ✓ dressing Δ-
2. Remove staples (R) shoulder / hand
3. Reaffirm (R) shoulder / hand / antecubital skin ≥ 5 days

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Aug 03 TIME OF ORDER 1320 HOURS

Ambien 10mg PO qhs PRN insomnia ✓

[redacted] b(6)-2 LTC, MC, US Army

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

24° chart ✓ [redacted] 91WM4 24 Aug 03 0720 [redacted]

PATIENT IDENTIFICATION [redacted] b(6)-4

DATE OF ORDER 26 Aug 03 TIME OF ORDER 0643 HOURS

1. Discharge to Today.

[redacted] b(6)-2

Noted 26 Aug 03 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 17799

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

CLINICAL RECORD

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

Mo. 8 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23
20 Aug 03	[redacted]	Vitals q 2°	06	[redacted]			
			18				
			X				
20 Aug	[redacted]	Activity: Bed rest	06	[redacted]			
			18				
			X				
		Nursing:					
20 Aug	[redacted]	Foley in Place	06	[redacted]			
			18				
			X				
20 Aug	[redacted]	Diet as tolerated (Regular)	06	[redacted]			
			18				
21 Aug	[redacted]	Ancef 1g IVPB Q8°	08	[redacted]			
			16				
			24				

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Fair Condition
Repair Facial Laceration,
Repair Ruptured Globe

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(a)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17800

b(6)-2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo _____ Yr 2003	
Order Date / Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20 Aug [redacted]	Admit to ICU 3	20 Aug			
20Aug03 [redacted]	NPO NOW	20 Aug03	2300	2300	
20Aug03 [redacted]	ON CALL to OR in AM	20Aug03	2300	2300	
21 Aug [redacted]	Resume pre-op orders, meds, activities, regular diet	21 Aug	1200	1200	
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				
	.....				

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

USAPA V1.00

ACLU-RDI 1643 p.161

DOD-031390

Green Shift "L" Non-Medical Sheet b(6)-2

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
22Aug	[redacted]	VS routine
23Aug	[redacted]	
22Aug	[redacted]	Bedrest
22Aug	[redacted]	Foley to gravity
23Aug	[redacted]	Clear diet Advance
8/23	[redacted]	as tol. Regular.
8/23	[redacted]	Act. Bd-libc assist.
8/23	[redacted]	Cleanse/Bacitracin + Facial closures q shift
8/24	[redacted]	Include abrasions
25	[redacted]	Include (R) shoulder/hand and AC area
23	[redacted]	D drsgs LUE/LLE q shift
24Aug	[redacted]	Elevate LUE on pillow or sling
24Aug	[redacted]	Error [redacted] Remove dcss;

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

HR	DATE DISPENSED 22	23	24	25	26
06	[redacted]				
14					
22					
06	[redacted]				
14					
22					
06	[redacted]				
14					
22					
06	[redacted]				
14					
22					

Changed 25Aug08 [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blast wounds / Facial lacs, LUE, LLE inj

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 17802

b(6)-2 A-11

(Green Sheet)

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. AUG Yr. 03
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
22Aug - [redacted]	To ICU2	22Aug03	1030	1030	[redacted]
22Aug - [redacted]	Condition Stable	22Aug03	1030	1030	[redacted]
8/23 [redacted]	TX to ICW # 2 ; cond good	8-23	1618	1618	[redacted]
24Aug - [redacted]	Remove dressing @ Knee tomorrow evening	25Aug	2000		
-----	& leave wounds open to air				
25 - [redacted]	LUE - Splint to stay ON - NO DSG Δ	25Aug	1309	Muted	[redacted]
25 - [redacted]	Remove staples (R) hand / shoulder	25Aug	1309	1330	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
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USAPA V1.00

ACLU-RDI 1643 p.163

DOD-031392

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20 21 22 23
20 Aug 03	[redacted]	IV LR 50 cc/hr	00	[redacted]
	.....	b(6)-2	02	
	.....		04	
20 Aug.	[redacted]	Ancef 1 gm q12°	06	[redacted] D/C'd
	.....		10	
	.....		12	
	.....	Pred Acetate 1%	00	[redacted]
	.....	1 gtts OS q2	02	
	.....		04	
	.....		06	
	.....		08	
	.....		10	
	.....		12	
	.....		14	
	.....		16	
	.....		18	
	.....		20	
	.....		22	
	.....		24	
	.....		02	
	.....		04	
	.....		06	
20 Aug	[redacted]	Ocuflox 1 gtts OS	00	[redacted]
	.....	QID	12	
	.....		18	
	.....	b(6)-2	20	
	.....		22	
20 Aug	[redacted]	Erythromycin opth	00	[redacted]
	.....	ointment to eyelid	16	
	.....	wounds BID	12	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: b(6)-2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2 A11

CLINICAL RECORD

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

Mo. 8 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24
20 Aug 03	[redacted]	Bacitracin to other wounds BID	04	[redacted]				
	.....		16					
	.....		X					
	[redacted]	Fentanyl 1-5 u/kg/hr	06					
	.....	prn pain titrate	18					
	.....	for pain	X					
	.....		X					
20 Aug	[redacted]	Versed 1-5 mg/hr	06					
	.....	titrate for sedation	18					
	.....		X					
20 Aug 03	[redacted]	Vent: 700, SIMV 13,						
	.....	Peep 5, Wean FIO2						
	.....	for sat > 95						
	.....							
	.....							
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	.....							
	.....							
	.....							
	.....							
	.....							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Repair Facial Laceration Repair Ruptured Globe.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(2)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	...ERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. 2003
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
.....					
.....					
.....					
.....					
.....					
.....					
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.....					
.....					
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.....					
.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
21 Aug	[redacted]	Percoat 2 tabs	D														
.....		po q 4° prn	T														
.....	.....		I														
21 Aug	[redacted]	MSO4 2mg IV q 1°	D														
.....	.....	prn Breakthrough	T														
.....	.....		I														
21 Aug	[redacted]	Phenergan 25mg	D														
.....	.....	IV q 6° prn nausea	T														
.....	.....		I														
21 Aug	[redacted]	Tylenol 625 mg	D														
.....	.....	po q 4-6° o sig	T														
.....	.....	prn	I														
.....	.....																

USAPA V1.00

ACLU-RDI 1643 p.166

DOD-031395

b(6)-2 A11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22 23 24 25 24
22Aug03	[redacted]	Bacitracin to wounds	10	10a 22Aug03
		BID	22	10p
22Aug03	[redacted]	IV LR @ 125 cc/hr	07	[redacted]
			19	
22Aug03	[redacted]	Ancef 1gm IVPB	06	D/C'd.
		q8°	14	[redacted]
			22	
22Aug03	[redacted]	Erythromycin opth	10	[redacted]
		Ointment to facial	20	
		lacs around (L)	/	D/C'd.
		eye lid BID	/	
22Aug	[redacted]	Bacitracin topical ointment	10	[redacted]
		to facial sutures BID	22	
8-23	[redacted]	Erythromycin Opth.	06	X X [redacted]
		Oint. @ eye closure	14	X X
		shift.	22	
8-23	[redacted]	Keflex 500mg PO TID	08	X X [redacted]
		X5days	16	X X
			24	X X X X X X X
8-24	[redacted]	Afrin Nasal spray 1	10	/ / [redacted] 3 4 5 /
		each nostril BID x	22	/ / /
		5days		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blast Wounds / Facial lacs. LLE/LUE ins.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION: [redacted]

DLW-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

[redacted]

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

MEDCOM - 17807

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**

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
22 Aug 8-23	[redacted]	Tylenol 650 mg po q 4° prn	22 Aug 1630; 23 Aug 0800; 23 Aug 1720; 24 Aug 0710; 24 Aug 1440; 24 Aug 1930; 25 Aug 0535; 25 Aug 1500; 25 Aug 2000; 26 Aug 0800 [redacted]
22 Aug	[redacted]	Percocet 1-2 tabs po q 4-6° prn	[redacted] 22 Aug 2200; 23 Aug 0500; 22 Aug 0900; 23 Aug 1330 [redacted]
22 Aug	[redacted]	MS04 2-6 mg IVP q 2° prn	D/c'd
24 Aug 27 Aug	[redacted]	Percocet 1-2 po q 4° prn	
28 Aug	[redacted]	Ambien 10mg PO qhs PRN insomnia	
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

MEDCOM - 17808

ACLU-RDI 1643 p.168

DOD-031397

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: Initals:
NEURO	Pupils	(R) reactive sluggish ? m[redacted]	
	Sensorium	(D) shut UTA	
	LOC / GCS	follows commands, moves all ext,	
		Versed 4mg fent 50 mcg	
CARDIAC	Cardiac Rhythm	S1 S2 / ST / Ø ectopy	
	PRI: / QRS:	+2 pulses all ext ± LUE (UTA	
	Pulse Strength	2° bulky dressing, cap refill <3sec	
	Cap Refil / JVD	all ext ± LUE 3/4 sec	
	Edema	facial edema,	
	Chest Pain		
RESP	Respiratory Pattern	OTA Intub SIMV-13, TV-700,	
	Breath Sounds	P-5, 30%, PIP-21 22cm@	
	Secretions	teeth #8.0, small amt bloody	
	Cough	secretion from ETT, small amt bloody	
		from yankauer,	
SKIN	Color	wound for vac, multiple sutured	
	Integrity	lacerations (D) face, (R) shoulder	
	Backside	(D) arm fracture, (D) leg lacerations	
		(D) hand lacerations	
IV	Access Devices	(D) (R) hand, (R) AC PIV	
	Location	Ø S/S of infxn	
	Condition		
GI	Abdomen	+ BS x4 quad	
	Bowel Sounds	soft, NT, ND	
	Stoma/Ostomy		
GU	Device	foley, clear, light yellow	
	Color / Clarity		

(Continue on reverse)

PREPAR[redacted] Title) CRT / RN

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

DATE 20 Dec 07

PATIEN[redacted]IFICATION *(For typed or written entries give: Name – last, first, mi[redacted]e; 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

ACLU-RDI 1643 p.169

DOD-031398

ICU3

Patients Name: [redacted] 10/4

Date: 20 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	83/80	101/54	105/60	90/39	111/66	97/60	79/55	102/60	90/57	102/57	105/55	101/63		98/55		117/82		105/58		131/59		123/61		114/68		
NBP																										
TEMP		100.4		100		100.4					100.1					100.3		100.1		100.5		100.0		100.5		
HR	114	114	122	106	107	109	101	100	103	100	91	104		95		97		94		92		95		93		
RR	13	14	21	21	32	29	30	30	28	28	26	24		10		15		14		10		12		14		
SaO2	100	100	100	100	100	100	100	100	100	99	100	100		98		100		100		100		100		98		
FiO2	30	30	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA												
Source	V	V																								
MAP				Q4																						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	50	50	50	50	50	80	50	50	50	80	80	50		50	50	50	50	50	50	50						
IVPB		50														5	5	5								
NGT																										
PO 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
URINE	200	50			100				250	80	50	100		100	150	200	80	200	225	150	150	100	150	200		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17810
DOD-031399
ACLU-RDI 1643 p.170

ICU1

Patients Name: #[redacted] blw-2 Date: 23 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
(hour)	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23
A-Line																									
NBP	97/53	94/55	[illegible]	124/69	140/100	109/61	102/51	[illegible]	104/59	103/50	106/50	102/51		98/56			106/68								
TEMP						99.6		98.4				99.4													
HR	94	85	92	89	81	93	86	92	104	89	99	86		109			94								
RR	12	16	14	17	14	12	15	14	18	14	17	11		24			12								
SaO2	99	97	98	98	97	99	97	99	98	98	100	97		99			96								
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA			RA								
Source																									
MAP	71	70	100	75	77	79	74	81	75	69	69	74		70											

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
(hour)	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
IVF	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125									
IVPB							50																			
NGT																										
PO	240								240																	
Total	365	490	615	740	865	990	1165	1290																		

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		275		350			300			350		400					1000									
NGT																										
STOOL																										
DRAIN																										
Total		275		625			925			1275																

MEDCOM - 17811

ME[illegible] RECORD-SUPPLEMENTAL MEDIC[illegible]

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: 1900 Initals [redacted] b(6)-2
NEURO	Pupils	(L) shut VTA, (R) [redacted] m sluggish	(L) eye closed c̄ sutures, (R) eye
	Sensorium	expresses needs appropriately	3mm, responds to verbal
	LOC / GCS	asleep but awakens easily	stimuli, follows simple
			Commands.
CARDIAC	Cardiac Rhythm	NSR/ST	NSR, S_1 S_2 normal
	PRI: / QRS:	+2 x 3 ext	no ectopy / murmurs
	Pulse Strength	(L) UE: warm, pale, <3sec cap refill	noted.
	Cap Refil / JVD	(+) Color, motion, ↑ sensation	
	Edema	edema on injured areas	
	Chest Pain	facial edema	
RESP	Respiratory Pattern	even and unlabored	RRR, non labored, 100%
	Breath Sounds	98% on RA	O_2 sat on RA.
	Secretions		
	Cough		
SKIN	Color	multiple facial lacerations, (R)	NFR, c̄ lacerations & abrasions
	Integrity	shoulder, (L) hand, (L) leg	to face and body.
	Backside	(L) leg ace wrapped	
		(L) arm ace wrapped	
IV	Access Devices	(R) (R) AC PIV	CR, AC c̄ no s/s of
	Location	Ø S/S of infxn	infection / infiltration.
	Condition		
GI	Abdomen	+ BS x 4 quad	(-) TRO, (+) BS x 4
	Bowel Sounds	flat, ND, NT	Quadr
	Stoma/Ostomy		
GU	Device	foley clear yellow	foley to gravity, QS
	Color / Clarity		Clear / Yellow

(Continue on reverse)

PREP[redacted] & Title) b(6)-2 [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU3 [redacted] b(6)-2

DATE: 21 Aug 03

PAT[redacted]N (For typed or written entries give: Name – last, first[redacted] 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 - 17812

ACLU-RDI 1643 p.173

ICU3

Patients Name: [redacted] 114.5

Date: 21 Aug 83

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	102/57						122/66	114/60	113/60	108/59	110/59	119/55		122/54				118/57		114/55		119/82	123/85			
NBP																										
TEMP	100.2						98.7											98.5		98.0		98.3				
HR	97						106	101	96	102	102	104		105				101		98		110	92			
RR	18						12	10	14	12	11	14		10				15		21		16	20			
SaO2	95						100	100	100	98	99	99		100				99		97		99	99			
FiO2																										
Source	RA						RA	RA	RA	RA	RA	RA														
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
F	50						50	50	50	50	50	50		50	50	50	50	50	50	50	50	50	50	50	50	
PB		100									100															
GT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE							25	125	125	175	200	200		200	150	100	200	200	100	100	200	180	100	150	100	
NGT																										
STOOL				[redacted]																						
DRAIN																										
Total																										

MEDCOM - 17813

DOD-031402

L RECORD-SUPPLEMENTAL MED ΓA

For use o1 . see AR 40-66; the proponent agency is the Offic. .e Surgeon General.

REPORT TITLE	OTSG APPROVED (Date)
INTENSIVE CARE NURSING FLOW SHEET	QA Appr 8 Mar 89

INITIAL SHI[redacted]ESSMENT

		Time: 1030 Initals: [redacted] b(6)	Time: Initals:
NEURO	Pupils	(L) eye ē sutures No orbital. eye	
	Sensorium	sutured closed. (R) eye PERRL @ 2	
	LOC / GCS	mm. Pt Alert & oriented x3 —	
CARDIAC	Cardiac Rhythm	NSR s̄ ectopy noted (L) radial	
	PRI / QRS:	pulse unable to assess due to	
	Pulse Strength	cast (L) Arm & hand. CDI. Pt	
	Cap Refil / JVD	able to move (L) hand fingers	
	Edema	& able to feel sensations ē	
	Chest Pain	fingers. (R) radial pulse (+)	
		Pedal pulses present bil.	
RESP	Respiratory Pattern	= rise & fall of chest bil. R 16	
	Breath Sounds	Clear bil. —	
	Secretions	None @ present time. —	
	Cough	No cough noted. —	
			(cont. 1030)
SKIN	Color	w & d to touch. appropriate for race.	(R) ↑ Arm ē staples CDI (R)
	Integrity	good —	hand ē staples CDI. open
	Backside	Sutures covering (L) face to scalp to	lesion on chin approx 2cm. Wound [redacted]
		chin (L) ear to chin (L) neck CDI.	pink/red in center. —
IV	Access Devices	IV (R) AC s̄ s/s of infection	(L) knee DSG CDI. Mid Back Area
	Location	or infiltration noted. IV KVO	pt has sore area approx @ 5cm b(6)
	Condition	125cc/hr	long by 2cm wide. (R) lateral inner
			calf has sore area ē scab forming
GI	Abdomen	Soft non-distended —	approx @ 3cm wide x 5cm long
	Bowel Sounds	BS (+) in all 4 quads —	edema noted to (L) knee and [redacted]
	Stoma/Ostomy		
GU	Device	Foley to gravity ē clear yellow	
	Color / Clarity	urine to foley bag. —	

(Continue on reverse)

PA[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC b(6)-2
ICU #1, [redacted]

DATE 22 May 03

[redacted] typed or written entries give: Name – last, first, [redacted] hospital or medical facility)

NAME [redacted] RANK: AGE: 29

UNIT: [redacted] b(6)-4 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17814

ACLU-RDI 1643 p.175

MEDCOM - 17815

DOD-031404

D6.2

ICU Flowsheet Patient Name: [redacted] Date: 8/22/2003

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												99 A				100 A	100 A	100 A	100 A	99.6		98.7		
Pulse											92	88	91	91	101	[redacted]	96	94	94	90	85	83	85	81
B/P A-Line																				76			73	
MAP											75	82	72	79	79	73	73	71	80	[redacted]	71	74	[redacted]	B
B/P Cuff											103/59	109/65	106/65	105/55	106/62	103/51	106/54	99/54	101/62	130/57	104/52	108/54	92/54	99/55
Respirations											17	15	16	18	16	12	23	20	25	18	14	17	16	14
Sa02											99	99	99	95	98	[redacted]	99	98	99	98	99	98	99	99
											RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	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
IVF											125	125		125	125	125	125	125	125	125	125	125	125	125	125	
NPB																								50		
PO intake											60				60		60			500				240		
O.R. IN																										
Totals											185	310		435	1020	745	930	1055	1180	1805	1930	2055	2180	2595	2720	2720

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												550		350/900	125/1025		350/1375			800/2175	500/2675		800/3475		350/3825	3350
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

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 [redacted] SIV		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC / BACKGROUND	RELIGION
	29Y	9	Z	Unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1950	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	NO
				X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU3	Unk

[redacted] LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	Unk	Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21 b(6)-2		030826

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AB[redacted]A		030819

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

FOR LOCAL USE

Dx: Repair Facial Lacerations
Repair Globe Rupture
Open (L) Humerous Fx
Open (L) Radius Fx

ADMITTING [redacted] as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b(6)-2	[redacted] SPC 9/8/10

DA FORM [redacted] MEDCOM - 17816 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	[redacted] b(6)-2			N/A	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. ETS	10. PREVIOUS ADMISSION
M	37	UNK	UNK	N/A	NO
11. FMP	12. SSN	13. ORGANIZATION			14. WARD
9920	[redacted]	N/A			ICU3
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K76	N/A		WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION		22. HOURS OF ADMISSION	23. CLINIC SERVICE		
DIRECT FROM EMT		1339	ABDA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION	26. DATE OF DISPOSITION		
UNK		05	26AUG03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION		ADMITTING OFFICER b(6)-2
UNK		UNK	24AUG03		DR [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

DX: MULTIPLE FACIAL AND LEFT UPPER EXTREMITY LACERATIONS.

DX: 8509
2765
3102
9190
924B
E993

Trauma
9
Dying
599

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

SIGNATURE OF ATT [redacted] 4797 PR. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER Faue [redacted]

DA FORM 3[redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

[redacted] b(6)-2

MEDCOM - 17817

MEDICAL RECORD | 1330 | **ABBREVIATED MEDICAL RECORD**

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

37 y/o male UN employee injured in explosion 19AUG03, treated at Italian hospital, then discharged shortly thereafter. Pt returns today with unresponsiveness, headache, photophobia, and anorexia.

PmH None.
All None.
Meds None.

PHYSICAL EXAMINATION

Face/Scalp - repaired lacerations.
Neck/back - non tender.
Chest/Abdomen - benign.
Extremities - multiple abrasions / no crepitance suggesting Fracture.
Neuro - intact
Skin - ↑ turgor / dry mucosae suggesting dehydration.

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

Impression: (1) Mild-moderate concussion / Post-concussive syndrome
(2) Multiple abrasions + contusions.

Plan: (1) IVF / Pain Control.
(2) CXR / (L) humerus X-ray.
(3) CT Scan when suite available.

b(6)-2

PHYS	DATE	IDENTIFICATION NO.	ORGANIZATION
4797	24AUG03		

ON (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

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

[redacted]

ACLU-RDI 1643 p.178

DOD-031407

1441

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 1400 Aug 03	Nursing Note: Pt arrived to ward via litter s difficulty. Pt AAOx3. Airway intact
T=96.8 P=71	breathing even and unlabored, LS CTA⊕. Abd soft nontender s distention. BS⊕x4. Voids —
RR=18 BP=120/64	spontaneously. FROM and neurovascularly intact to all extremities. Abrasions and incisions to
SaO2=100RA	face and CDI. Bacitracin applied. Pt c/o sporadic photosensitivity, headache and dizziness.
	b(6)-2 [redacted]
———	Physician aware.
24 1800 Aug 03	Nursing Note: Neuro check: Pupils equal and reactive to light. ⊖ photosensitivity. ⊖HA.
	⊕ Dizziness while lying in bed. Grips equal Ⓑ. Push-pull ⊕ and strong to ⒷLE. [redacted]
24 2200 Aug 03	Nursing Neuro Note: AAOx3. Pupils equal and reactive to light. ⊕ photosensitivity ⊕ HA.
	⊕ Dizziness while lying in bed. Grips equal ⒷUE. Push-pull ⊕ and strong to ⒷLE [redacted]
2200 24 Aug	25 Aug 03 2330 Pt sleeping, easily b(6)-2
BP 111/61	arousable. PERRLA. Brisk pupillary
P 64	response to light. Pt c/o pain to Ⓛ eye. c/o
T 98.2	slight photophobia. Scattered ecchymotic
R 18	area to face healing. Lungs CTA bilat, ∅
SpO_2 99%	resp distress. NSR. Abd soft, non-tender, bowel
25 Aug 0400	sounds active x4 quads. ∅ c/o dizziness
	+3 strength & coordination to upper and
9/0 110/68 66	lower extremities. Given Percocet 1 tab for
R16 T96.4	n/a b(6)-2 [redacted] MT/RN
	25 Aug 03 0345 Neurovascular check
	grossly intact. PERRLA. Pupils reacting

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

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

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

CIV # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

038

MEDCOM - 17819

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	briskly to light. Bilaterally equal strong upper and lower extremities. Strong pulses and brisk cap refill x4 extremities. Ø b(6)-2 Complaint of pain at this time — [redacted]
25Aug03	1030 - Pt A-Ox3. LSS, afebrile, lungs CTA, HR reg, BS@x4, pulses @ + strong to ↑ & ↓ extremities, PERRLA, skin warm, cap refill < 3 sec. Neurovascular intact. OOBx2 Ambulating to door. Pt states he is slightly dizzy when getting out of bed. Pt slept well throughout night. Stitches intact to face & L arm. Bacitracin applied. Voiding adequately. Tolerated breakfast. Voicing Ø complaints. Will continue to monitor — b(6)-2 [redacted]
	1320 - Pt spiked temp 104.5. MD notified. Motrin given 400 mg. Will have pt to ambulate to b(6)-2 [redacted] Will continue to monitor.
25/1400 Aug 03	NURSING NOTE: Assumed care of pt. AAOx3. Airway intact, breath sounds clear & unlabored, BS, CTA @, Abd soft, nontender, + distention. BS@x4. Voids spontaneously. FROM all extremities/neurovascularly intact to all extremities. Abrasions to face are open to air. MD [redacted] b(6)-2 Will approximate.
2200 25Aug03	PT VS SpO2-98, BP 122/74, T-98.3, R-20, P-86 — [redacted] 9W
2350	Pt awake and alert, visiting with another pt. Sutures removed today, wounds to face CDI, bacitracin applied. Ø C/O pain. PERRLA. Pupils bilat brisk response. Lungs CTA bilat, Ø resp distress. VSR. Abd soft, non-tender, bowel sound

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

038

MEDCOM - 17820

ACLU-RDI 1643 p.180

DOD-031409

PROGRESS NOTES

DATE	
25Aug03 2300 Cont	Active x4 quads. Ambulating Steadily in hallway. Strong pulses and brisk cap refill x4 extremities. Possible D/C to home in am. [redacted] T/AM
26Aug 2400	4/5 B/P 100/70 R/4 P88 R 99.1 NWF 9/w
26Aug03 0900	Pt. VSS. [redacted] mM/AM
8-26-03 0850	Pt D/C to air mac. Meds given.

b(6)-2 A11

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

ACLU-RDI 1643 p.181

DOD-031410

PROGRESS NOTES

DATE

26AUG03 Discharge Summary

[redacted]

b(6)-4 History - 37 y/o right handed male who suffered multiple facial and left upper extremity lacerations in the UN explosion 19AUG03. X-rays of the face, skull, chest, and left arm showed only a left nondisplaced zygoma fracture and a distal humerus soft tissue foreign body consistent with glass fragment. He was initially treated at an Italian hospital and released. He returned 23 AUG03 with dizziness and dehydration.

Hospital Course - Pt was rehydrated with IV fluids and his activities advanced. Despite 36 hours observation, he remained dizzy with upright activities. The UN coordinated transfer to Jordan, so he was released on this date.

Disposition - He will require a CT scan to look at his brain. Sutures are removed. He will need supervised advancement of his activities. He is expected to make a complete recovery.

Medications - Percocet 1-2 po q 3-4 prn.

[redacted]

Neurosurgery

b(6)-2

[redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION

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

DATE OF ORDER 24AUG03 TIME OF ORDER 1537 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICW 2 - Neuro - [redacted]
2. Diagnosis Concussion
3. Condition Good
4. Vitals q 4° c neuro ✓
5. Activity Walk c assist q shift.
6. Nursing may elevate HOB ad-lib.

G UNIT | ROOM NO. | BED NO.

T IDENTIFICATION

DATE OF ORDER ____ TIME OF ORDER ____ HOURS

Cleanse / bacitracin abrasions q shift.

Noted 24Aug03 1400 [redacted] b(6)-2

7. Diet Regular.
8. IV NS @ 150 cc/hr.
9. Meds Tylenol 650 mg po q 4° prn
   Percocet 1-2 po q 4° prn.
   Zofran 4 mg IV q 6° prn.

G UNIT | ROOM NO. | BED NO.

NT IDENTIFICATION

DATE OF ORDER ____ TIME OF ORDER ____ HOURS

10. Lab none.
11. X-rays: CXR / (L) humerus on call.

[redacted]

G UNIT | ROOM NO. | BED NO.

T IDENTIFICATION

Aug03 0315 ... [redacted] chart ✓

DATE OF ORDER 25AUG03 TIME OF ORDER 1307 HOURS

b(6)-2

25Aug 1220 [redacted]

1. D/C IVF
2. Δ VS to [redacted]
3. D/C Neuro ✓
4. May shower ad-lib.

[redacted]

G UNIT | ROOM NO. | BED NO.

[redacted] RN 24° chart ✓

FORM 4256 APR 79 26Aug03 0330 [redacted] REPLACES EDITION OF 1 JUL 77.

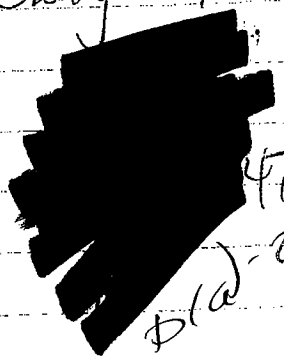
☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-3[redacted]

b(6)-2

Doctors Orders

26 Aug 03
0801

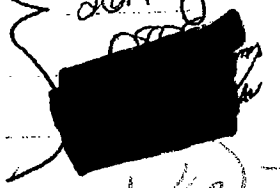
Discharge to Fredn.



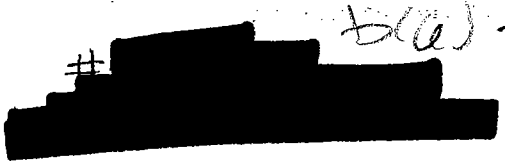
4797

b(6)-2

noted
26 Aug 03
0800



b(6)-2



b(6)-4

Air Evacuation Checklist

Initial when complete

Completed By Physician

✓ Evac Form 3899 completed and sent to PAD.

✓ Category: (R) P U (circle one)

✓ Ambulatory or (Litter) (circle one)

✓ Air Evac Order written in doctor's orders

✓ Prescriptions written for evac.

✓ Narrative Summary Completed

Completed By Nursing

✓ Prescriptions sent to Pharmacy

✓ Medications given to Patient

✓ Nursing Discharge Note written

ACLU-RDI 1643 p.185

DOD-031414