II T.
NKA

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)	08	x	30	x	09	x	30	x	10	x	30	x	TOTALS
Versed (mg)	2												2
Fentanyl (cc)	<4>		1						2		1	2	10 cc
lido/propofol (mg)	20/100												
Zemuron (mg)	50		20			10	10	10	Rec				
REGLAN (mg)		10								2			
MSO4 (mg)					5	5							20
VOLAT AGENT FOR % del	x 2	1	.8	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	6	2	2	2	2	2	2	2	2	2	2	2	

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

TOTAL EBL: 100

TOTAL URINE: 300

FLUIDS - SUMMARY
CRYSTALLOID- LR - 2000
COLLOID-
BLOOD-

FLUIDS

LINE site LA 16g ☐ Warmed (300) 500 600 800-1000
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE - Foley per OR Nurse

REMARKS
Code drugs with numbers, events with letters
preop, PIV, V.S.S. to OR cooperative, O_2 monitors stable, IV induction c cricoid, turn 90° ones on pt & preps drapes, local per Surgeon 1% lido c epi ——

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 37.2

INITIAL DATA:
BP- 108/39
HR- 69 97%

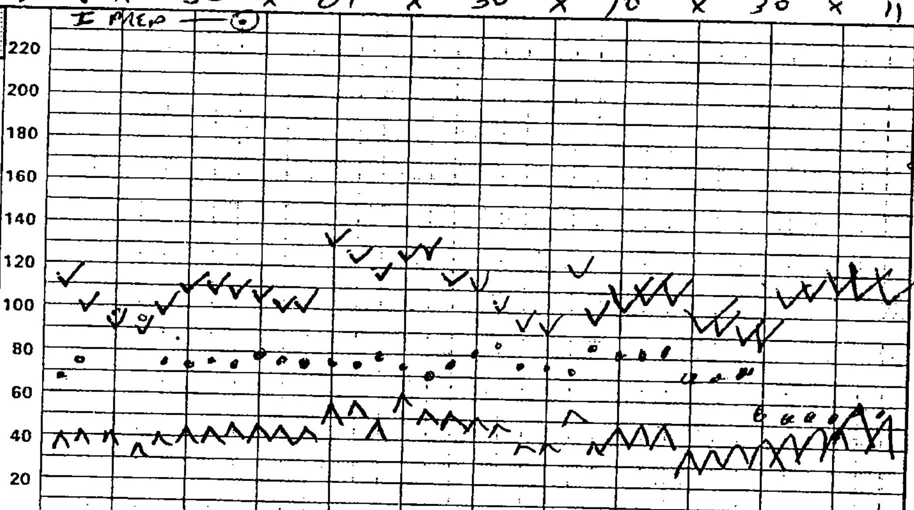
EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE- Yes
TIME- 0740

TIME → 08 x 30 x 09 x 30 x 10 x 30 x 11

I PREP ——⊙

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



VT - ml		680	700	710	690	810	710	830	830	810	810	880
f - breaths/min		8	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP		18	18	19	19	19	16	19	19	19	19	19
MODE - S(pon), A(ssist), C(on)		C	C	C	C	C	C	C	C	C	C	C
Y BP/Auto Cuff — Y ET CO2 (torr)	+	33	33	33	36	37	34	36	34	33	33	33
BP/oth — Y FIO2 (Frac or %)	.8	.7	.7	.7	.7	.7	.7	.7	.7	.73	.73	.73
ART line — Y SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — Y ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — Y TEMP-site Ax		34.4	34.3	35.0	35.5	35.9	35.9	36.0	36	3	36	36
Y N-M Block (T/4)	4	0	1	0	0	0	2	2	0	4	0	—
Warming blkt	BLANKET ——											
Conv warmer												

0926 Throat pack in
1123 throat pack out

RECOVERY AT 1250
(PACU) ICU ______ (Specify)
OTHER
CONDITION: T 35.7
RESP. 12 SpO2 98% 4L NC
BP. 124/61 HR. 101

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0805	1258
	Ready	Begin	End
PROC	0812	0840	1247

Mark with letters & symbols, explain under REMARKS EVENTS Position → arms tucked / padded

PROCEDURES and CPT Codes:
ORIF Lt Zygoma Fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
O_2 x1, 3 MAC, grd I view, 8.0 cTT @ 24, BS = B + ET CO_2, Benzoin tape

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

SURGEON: [redacted]

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

PROCEDURE LOCATION:

DATE: 9/17/03

PAGE 1 OF

NKDA + Smoker
+ sniffing

DA FORM 7389, FEB 1998
ICW2 5C

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 19241

ACLU-RDI 1651 p.1

DOD-032815

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Se[illegible] /Anesthesia)

Age 22 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: OS Retinal Hemorrhage
SURGICAL SERVICE: Ophthal
NPO SINCE: This AM Breakfast

ASA Physical State 1 (2) 3 4 5 E
WT: 76 (KG)/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH: ∅
DRUGS: ∅

CURRENT MEDICATIONS:
() = ordered as premed
()
()
()
()
()
()

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A:
OTHER:
11.3 > 11.9 / 37.2 < 409
CT - Common ZMC fx
small FB in nose
141 | 9 | 27 < 95
K | 109 | 109 (Na Bun Cl Cr)
4.3 CRE

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension (N) Y
- Angina (N) Y
- MI (N) Y
- CVA (N) Y
- Other N Y

Pulmonary System:
- Asthma (N) Y
- Bronchitis/URI (N) Y
- COPD (N) Y
- Other (N) Y

Renal System:
- Acute/Chronic RF (N) Y

Gastrointestinal:
- Hepatitis (N) Y
- Hiatal Hernia (N) Y
- PUD/GERD (N) Y

Endocrine System:
- Diabetes (N) Y
- Steriods (N) Y
- Thyroid (N) Y

Neurological:
- Seizures (N) Y
- Neuropathy (N) Y
- Other (N) Y

Gynecological :
- Pregnancy N Y N/A

Other Significant Hx: (N) Y Legs schrapnel
(N) Y (R) hand wound
Familial HX (N) Y 3rd digit injury

Involved in Car bombing 5 days ago.

ASSESSMENT
PAST SURGICAL/ANESTHETIC
∅

PHYSICAL EXAMINATION
BP 127/54 HR 95 R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MP II MO 2 FB
Nares TMD 3 FBs
CHEST: CTA (B)
CARDIAC: RRR ⊖ (m)
EXTREMITIES: FROM all extremities
IV Access:
Ulnar Filling:
BACK:
OTHER: ~~Jr~~ (X) maxilla + mandible stable
Multiple shrapnel wounds face, (B) periorbital ecchymosis
NPO Since AM

Discussed case c Dr [redacted] ophthalmology pre-op + General Plan for anesthesia acceptable

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

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

b(6)-2
The pati[redacted]erstand and agrees. Questions answered.
Signed: [redacted] CRNA/MAJ Date: 15 Sept Time: 15:35 Hrs

POST-[redacted]SIA EVALUATION AN[redacted]E (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

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

Patient Identification: (Ward)
EP CIV [redacted] b(6)-4 ICW-2

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

1) Chest PA/lat (R)
2) (B) knee and fib-fib
3) (R) forearm views PA/lat and (R) hand

AGE: 22 | SEX: [illegible] | SSN (Sponsor): [redacted]

WARD/CLINIC: ICW IED

REGISTER NO.

PREGNANT: [ ] YES [X] NO

FILM NO. b(6)-2

TELEPHONE/PAGE

REQUESTED BY (Print) [redacted] b(6)-2

DATE REQUESTED 13SEP03

SIGNATURE OF REQUESTOR Karen M. Phillips

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
22 yo Kurdish soldier involved in car bombing - had face sent for OS [illegible] - now doing 3° survey noted to have shrapnel wounds chest, (B) LE / tib fib [illegible] and (R) third digit volar wound - [illegible]; also [illegible] forearm lacs. x [illegible] and able to move digits.

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Chest — 3mm schrapnel in (L) ant chest wall
lungs clear, ⊖ ptx, ⊖ rib fx,

(R) TIB/FIB ⊖ fx - 2-3 mm schrapnel in ant med soft ti[ssue] medial mid soft tis[sue]

(R) knee ⊖ fx 1cm schrapnel ant inf soft tissues of knee prob extra-articular / 2mm piece in region of MCL

(L) knee ⊖ fx - 5mm schrapnel ? in lateral aspect of patella or on surface of lat patella

(R) forearm ⊖ fx - multiple pieces of schrapnel volar soft tissues of forearm + single piece medial elbow soft tissues but not w/in joint. [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 19243

ACLU-RDI 1651 p.3

DOD-032817

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
CT FACE
Axial & coronal
views 3mm cuts ?

AGE	SEX	SSN	WARD/CLINIC	REGISTER NO.
22	M	# [redacted]	ICW2	

b(6)-4

FILM NO.

PREGNANT: ☐ YES ☒ NO

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

TELEPHONE/PAGE NO.

DATE REQUESTED: 15 Sep 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
Left ZMC Fx
if c/n get coronal view then get 1.5mm axial cuts c̄ coronal reconstruction [redacted]

b(6)-7

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Mont*[redacted]

RADIOLOGIC REPORT

1) Numerous Metallic fragments : (R) intraorbital including → (L) intraglobular nasal bone.

2) ZMC fx. { Commin (L) max fx involving orbital flr and lateral wall (No evid of muscle entrapment) although displaced at least 5mm
(+) obliquen (L) zygomatic fx anteriorly

3) (L) maxillary hematoma.

4) (L) facial swelling

b(6)-2
[redacted]

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
[redacted]
Civ # [redacted]
b(6)-4

LOCATION OF [redacted]

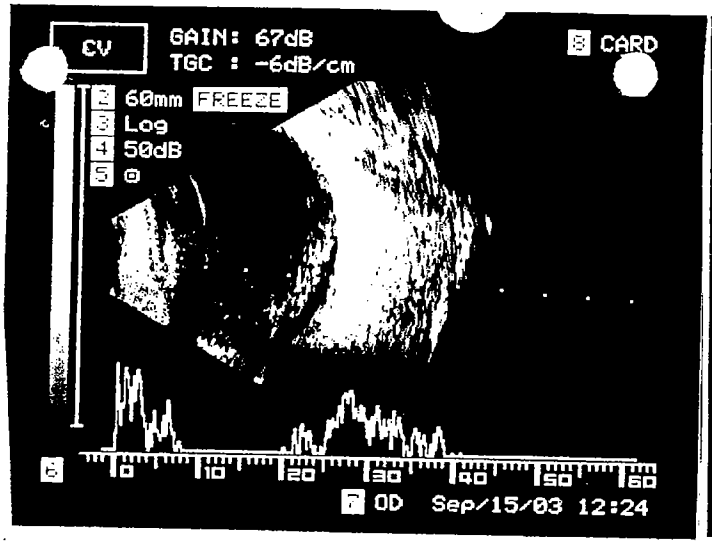
LOCATION OF RADIOLOGIC FACILITY

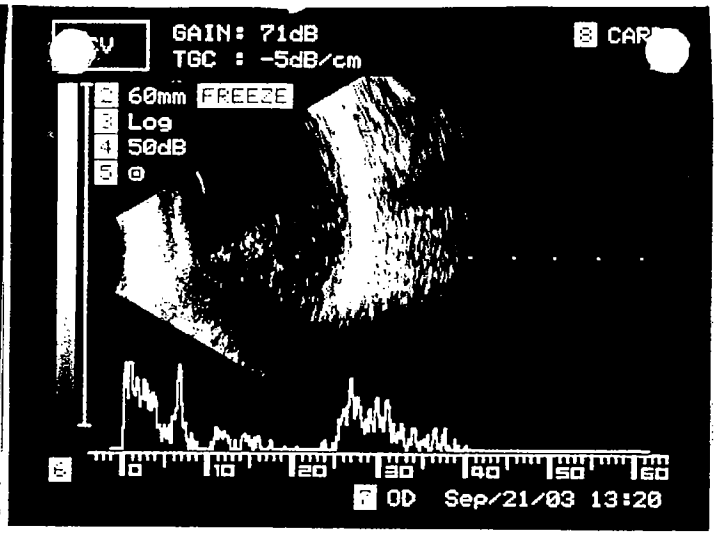
SIGNATURE

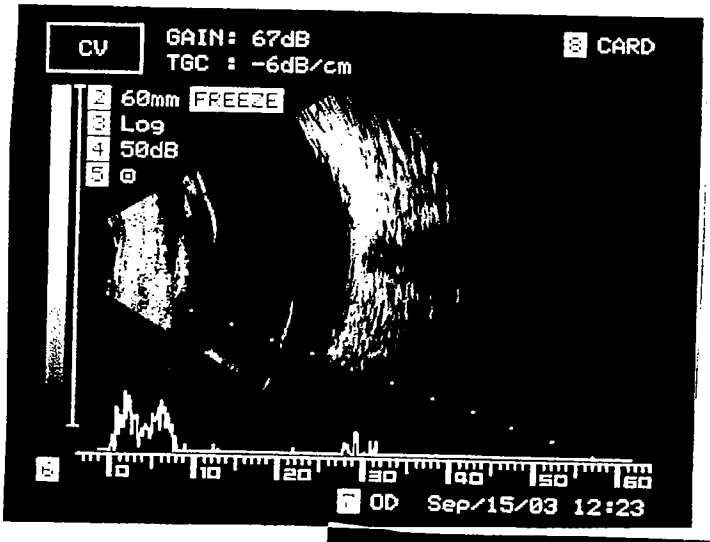
RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

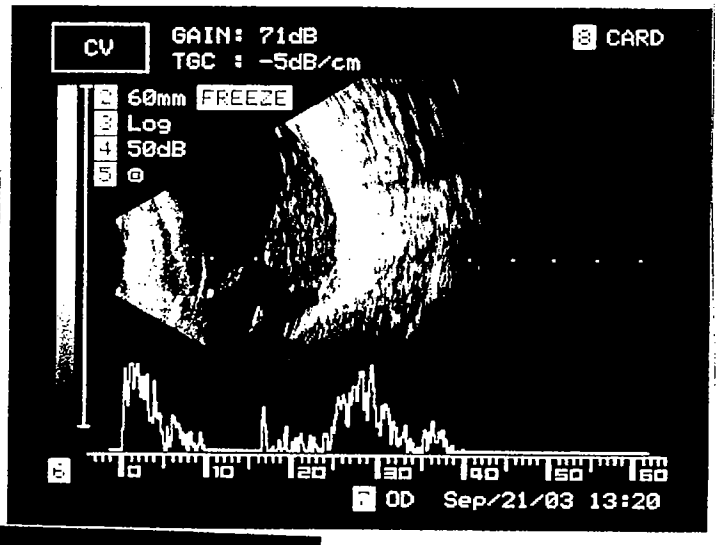
STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

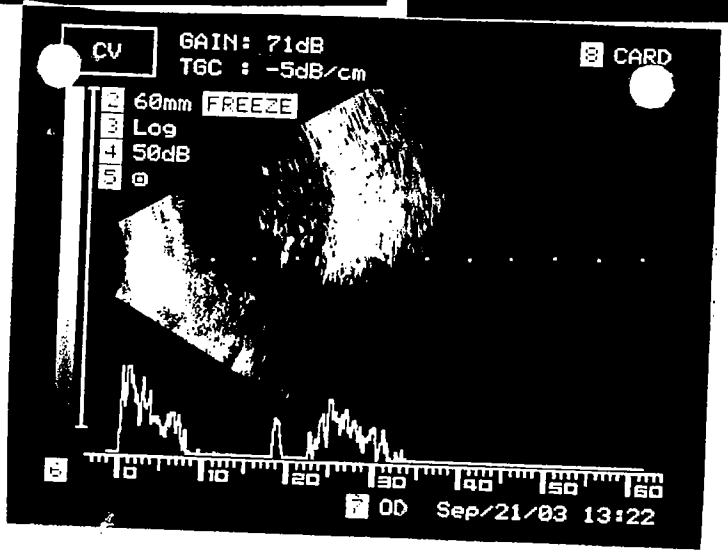
MEDCOM - 19244











#[redacted]

blw-4

[redacted]

MEDCOM - 19245

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: ICW2 | ROOM NO.: 5 | BED NO.: C

DATE OF ORDER: 15 Sept 03 | TIME OF ORDER: 2020 HOURS | LIST TIME ORDER NOTED AND SIGN: [redacted]

Phenergan 12.5-25mg IV q6hrs prn nausea/vomiting

V.O. Dr [redacted]

[redacted]

b(6)-2

b(6)-2

[redacted] 1LT/AN 16Sept03 0300

PATIENT IDENTIFICATION

CIV

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: 5 | BED NO.: C

DATE OF ORDER: 9/16/03 | TIME OF ORDER: 0701 HOURS

Start drops 0900 this am

Homatropine 5% T gtts OS tid

Pred Acetate 1% T gtts OS q2° while awake

Ocuflox T gtts OS qid

[redacted]

b(6)-2

Noted 9/16/03 0725 [redacted]

PATIENT IDENTIFICATION

CIV b(6)-4

[redacted] b(6)-2

NURSING UNIT: ICW2 | ROOM NO.: 5 | BED NO.: C

DATE OF ORDER: 15 Sep 03 | TIME OF ORDER: @1401 HOURS

1. NPO p̄ MN
2. @MN start NS @125cc/hr
3. OKAY TO SHOWER TODAY
4. VOID ON CALL TO OR IN AM

b(6)-2 [redacted]

1LT/AN 9.16.03 1426

24° [redacted] 1LT/AN 17Sept03 0005

PATIENT IDENTIFICATION

CIV b(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: 5 | BED NO.: C

DATE OF ORDER: [redacted] OF ORDER: HOURS

[redacted] q day.

Z [redacted]

b(6)-2

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

MEDCOM - 19246

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-2

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER: 15 Sep 03 — TIME OF ORDER: @ 1228 HOURS — LIST TIME ORDER NOTED AND SIGN

b(6)-2

1. Admit to ICW2 - Dr [redacted]
2. DX: (L) 2MC FX + OS retinal Hemorrhage
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib

PATIENT IDENTIFICATION

CIV b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	[redacted]

DATE OF ORDER — TIME OF ORDER — HOURS

7. Nurs: HOB ↑ 30°-45°
   Clean facial wounds +
   Place Bacitracin
8. Diet: ~~Soft diet~~
   NPO ~~p MN for SX~~
9. IV: NS @ 125cc/hr @ MN
   HLIV now
10. Meds: Ancef 1gm IV q 8°

[redacted] b(6)-2

PATIENT IDENTIFICATION

CIV

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER — TIME OF ORDER — HOURS

Percocet 1-2 tab PO q4° pm Pain
MSO4 2-4mg IV q1° pm severe pain

b(6)-2

[redacted]

MAJ/DC

0900 9/16 In Am: Pred Acetate 1% i gtts OS q2°
Ciloxin i gtts OS qid

[redacted] b(6)-2

PATIENT IDENTIFICATION

CIV

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER: 9/15/03 — TIME OF ORDER: 1920 HOURS

15 Sep 03 2214

Post-op SAA
soft diet, adv as tolerated.

[redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER: 17 Sep 03 @ TIME OF ORDER: 1256 HOURS

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

1. Admit to PACU then ICW 2 Dr [redacted]
2. Dx: S/P ORIF of Left 2MC fracture closure of laceration
3. Cond: Stable

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] b(6)-2

4. Vitals Per routine
5. Aller: NKDA
6. Activ: Ad lib
7. Nurs: D/C Foley HOB ↑ 30°
8. Diet: Clears then regular diet as tolerated

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

9. IV: HLIV
10. meds: MSO4 2-4 mg IV q1° prn severe pain
    given @ 1911 - Phenergan 12.5 mg IV q4° prn N/V
    Ancef 1gm IV q8°
    Percocet 1-2 tab po q4° prn pain
    Homatropine 5% i gtts OS TID
    Pred Azetale 1% i gtts OS q2°
    b(6)-2 [redacted]
    aloxin i gtts OS QID
    Bacitracin to wounds BID Face + left ear

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

11. PA + lateral Face films

[redacted]

b(6)-2

MAJ/DC b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° Chart [redacted] 91WMG 18 Sept03 0115 [redacted] LT/AN 18Sep03 0300

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

U.S. GOVERNMENT PRINTING OFFICE: 2001-478-200

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

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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
Civ [redacted] b(6)-4		9/18/03 — 1330 HOURS	
	①	Prednisone 60mg po q day	[redacted] b(6)-2
	②	Zantac 150mg po bid	9/18/03
		[redacted]	
		b(6)-2	
NURSING UNIT: ICW2 / ROOM NO.: 5 / BED NO.: C		24° Chart [redacted] 91WM6 19Sept03 0450	0500 19Sep03 [redacted]
PATIENT IDENTIFICATION		9/19/03 — 1130 HOURS	
	①	Ambien 10mg po qhs prn insomnia	[redacted]
		[redacted]	noted 9/19/03 1220
		b(6)-2	[redacted]
NURSING UNIT / ROOM NO. / BED NO.		24° Chart check 20Sep03 0330 [redacted] LT/AN	
PATIENT IDENTIFICATION		24Sep03 @ 0900 HOURS	
	①	D/C ancef	
		[redacted]	Noted 24Sep03 0915
		b(6)-2	[redacted]
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		24 Sep 1200 HOURS	
	①	CXR + (R) shoulder XR - pain	
		[redacted]	Noted [redacted] 24 Sep 03 1300
NURSING UNIT / ROOM NO. / BED NO.		b(6)-2	[redacted]

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

MEDCOM - 19249

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: C[redacted] b(6)-4

DATE OF ORDER: 9/24/03 TIME OF ORDER: 1200 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Cipro 500mg po bid [redacted] [illegible] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted 24SEP03 1735 [redacted] b(6)-2

DATE OF ORDER: 9/24/03 TIME OF ORDER: 1700 HOURS

(2) Decrease Pred to 30mg po qDay x4days then 15mg po qDay x 4days then 10mg po qD x 4 days then d/c [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 9/24/03 TIME OF ORDER: 1700 HOURS

(1) Clindamycin 600mg IV q8° x 72 hours

(2) Continue Ancef 1gm IV q8° b(6)-2

[redacted] [illegible]

NURSING UNIT | ROOM NO. | BED NO.

25 Sep 03 0255 [redacted] 24° chart ✓

PATIENT IDENTIFICATION b(6)-4 b(6)-2

[redacted]

DATE OF ORDER: 25 Sep 03 TIME OF ORDER: @ 0830 HOURS b(6)-2

(1) Percocet 1-2 tab po q 4-6° prn pain [redacted]

[illegible] 25 Sep 03 0845

NURSING UNIT: KW2 ROOM NO.: 7A BED NO.: b(6)-2 b(6)-2

24° chart ✓ [redacted] q [illegible] 26 Sept 0130 24 [redacted] [illegible] 26 Sep 03 0400

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

U.S. GOVERNMENT ...

MEDCOM - 19250

CLINICAL RECORD - DOCTOR'S ORDERS

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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

CIU [redacted] b(6)-4

DATE OF ORDER: 28 Sept

TIME OF ORDER: 2140 HOURS

LIST TIME ORDER NOTED AND [redacted]

DC IV

DC Ancef

V.O. Dr [redacted]

[redacted]

NURSING UNIT: ICW#2

ROOM NO. / BED NO.: 29Sep03 0030 [redacted] 1LT/AN 24° chart ✓ b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 9/29/03

TIME OF ORDER: 0908 HOURS

(1) Maintain Pred c 30mg po qD per Iraqi V-R surgeon.

Continue Cipro 500 bid.

[redacted]

Done & noted. 9-29-03 0930

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 2001-478-200

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

MEDCOM - 19251

b(6)-2 ANN

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27
15	[redacted]	Vitals per routine	D	/	[redacted]											
17			E													
			N													
15	[redacted]	Activity ad lib	D	/	[redacted]											
17			E													
			N													
15	[redacted]	HOB ↑ 30-45	D	/	[redacted]											
17			E													
			N													
15	[redacted]	Clean facial wounds & place backtrack	D	/	[redacted]											
			E	W												
			N													
15	[redacted]	Soft diet, advance as tolerated	06	/	[redacted]											
			11	/	[redacted]											
17	[redacted]	DIET:- CLEAR THEN REGULAR AS TOLERATED	D	—	[redacted]											
			E	—												
			N	—												
17	[redacted]	DIC FOLEY	D	—	[redacted]											
17	[redacted]	BACITRACIN TO FACIAL WOUNDS & LEFT EAR-	D	/	/	[redacted]										
			E	/	/											
			N	/	/											

SEE BELOW

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	① 2MC Fx + OS retinal hemorrhage	PAGE NO:

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15	[redacted]	Admit ZCU 2 (Perkins): condition stable				[redacted]
16	[redacted]	NPO @ MN	9-17	0001	done	[redacted]
16	[redacted]	OK to shower today	9-16	noted		[redacted]
16	[redacted]	Void on-call to Ortho AM	9-17	AM	done	[redacted]
17SEP	[redacted]	PA + LAT Face films				[redacted]
24 SEP	[redacted]	CHEST X-RAY	24 SEP	1 LN	done	[redacted]
24 SEP	[redacted]	@ SHOULDER X-RAY	24 SEP	1 LN.	done	[redacted]

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

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 28 29
Copied	[redacted]	Vitals per routine	D	[redacted]
			E	
			N	
Copied	[redacted]	Activity ad lib	D	[redacted]
			E	
			N	
Copied	[redacted]	HOB ↑ 30-45°	D	[redacted]
			E	
			N	
Copied	[redacted]	Clean facial wound	D	[redacted]
		& place bacitracin	E	
		to face & Ear	N	
Copied	[redacted]	Diet: Regular	D	[redacted]
			12	
			17	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Retinal Hemorrhage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

Kurdish Soldier

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 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. 09 Yr. 07

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17 18 19 20 21 22 23 24
15	[redacted]	NSO 125 cc/hr @ MN	D	[redacted]
		HL Now	E	[redacted]
15	[redacted]	Amox 1 gm IV q 8hs	08	[redacted]
17			16	
			24	
15	[redacted]	Pred Acetate 12 1 gtts	02	[redacted]
16		OS q 2°, Start in AM	04	
17	[redacted]	while awake	06	
			08	
			10	
			12	
			14	
			16	
			18	
			20	
			22	
			24	
15	[redacted]	Ciloxan 1 gtts OS qid	06	[redacted]
16		Start in AM	12	
17			18	
			24	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) ZMC fx + OS retinal hemorrhage

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

PATIENT IDENTIFICATION:
C[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. 09 Yr. 83

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
15 / 17	[redacted]	Percocet i-ii PO, 4° prn pain	15Sep 2245 ii PO; 16Sep 0045 ii PO; 9-16 1600 ii; 16Sep 0045 ii PO; 17Sep 1635 ii; 17Sep 1915 ii; 17Sep 2210; 18Sep 2030 ii PO; 19Sep 0030 ii PO; 19Sep 0910 ii PO; 19Sep 0235 ii PO; 19Sep 1800 ii PO; 20Sep 0400 ii; 21Sep 0445 ii PO; [redacted]
15 / 17	[redacted]	MSO4 2-4mg IV q1° prn pain (severe)	15Sep 2245 4mg BNS IVP; 16Sep 0700 4mg IV; 16Sep 4mg 1950; 17Sep 4mg 1600; 17Sep 1915 4mg; 18Sep 0030 4mg; 18Sep 0230 4mg; 18Sep 1350 4mg; 18Sep 9:30 2mg; [redacted] D/C
15 / 17	[redacted]	Phenergan 12.5-25mg IV q6hrs prn nausea/vomiting	15Sep 25mg 2245 BNS IVP; 16Sep 0705 25mg IV; see below
		PHENERGAN 12.5MG IV Q 4° PRN NAUSEA/VOM	18Sep 1045; 12.5MG [illegible]
Copied	[redacted]	Percocet i-ii PO q4° prn pain	23Sep 0200 ii; 9-23 1600 ii; 9-24 0400 ii; 24 1600 ii PO; 25Sep 0045 ii; 25Sep 0805; [redacted] D/C

MEDCOM - 19256

USAPA V1.00

ACLU-RDI 1651 p.16

DOD-032830

b(c)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 03

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
16Sep	[redacted]	Homatropine 5% 1gtts	08	[redacted]
17Sep		OS TID	16	
			22	
17Sep	[redacted]	[redacted]	D →	[redacted]
			E →	
			N →	
18Sep	[redacted]	PREDNISONE 60 MG	18	[redacted] X'd 24SEP03
		PO A DAY.		
18Sep	[redacted]	ZANTAC 150ML PO	08	[redacted]
		BID	20	
24SEP	[redacted]	Cipro 500mg PO BID	10	[redacted]
29Sep		Continue cipro	20	
24SEP	[redacted]	↓ Pred to 30mg PO q day x4 days then 15mg PO q day x4 days then 10mg PO q d x4 days, then DC	18	[redacted]
24SEP	[redacted]	Clindamycin 600mg IV q 8° x72 hours.	06 14 22	[redacted]

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Retinal hemorrhage

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

PATIENT IDENTIFICATION: Civ [redacted] b(a)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 9 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
16 Sept	[redacted]	@ MN, start NS @ 125 cc/hr.	9-17	0001	0002	[redacted]
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY														
			INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15 Sep	[redacted]	Ambien 10mg po	9-20 2200	9-21 2100	22 Sep 2220	23 Sep 2300	25 Sept	26 Sep 2200	28 Sep 0005	28 Sept						
		q hs prn insomnia	ī PO	ī PO	ī PO [redacted]	ī	2230 ī PO	PO	[redacted]	2145						
25 Sep	[redacted]	~~PERCOCET 1-2 TAB~~	Rewritten on other sheet													
		~~PO Q4-6° PRN PAIN~~														

MEDCOM - 19258

USAPA V1.00

ACLU-RDI 1651 p.18

DOD-032832

b(6)-2 A II

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 25	26	27	28	29	30
17 Sep	[redacted]	Pred Acetate 1% 1 gtts OS Q2° While Awake	D	[redacted]					
			E						
			N						
13 Sep	[redacted]	Ciloxin 1 gtt OS QID	06	[redacted]					
			12						
			18						
			24						
24 Sep	[redacted]	Ancef 1 gm IV Q8	08	—		[redacted]	DC'd 28 Sep 03 [redacted]		
			16	—					
			24	—					
29 Sep	[redacted]	Prednisone ~~30mg~~ 20mg po QD	18	←					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
RETINAL BLEED, MAXILLA FX, SCRAPNEL (R) KNEE

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

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

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._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25	-----					

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
25Sep 28Sep	[redacted]	Percocet I-II PO	25Sep 1215 ii PO	26Sep 1530 ii PO	27Sep 1130 ii PO	28Sep 0005 ii	28 Sep 0946 ii	28 Sept 2050 ii	29Sept 0936 ii PO							
-----	-----	Q4-6 PRN	[redacted]													
17Sep	[redacted]	Phenergan 12.5 mg														
-----	-----	IVP Q4 PRN n/v														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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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** 22yo

DTSG APPROVED *(Date)*

Date: 15 Sep 03
Time In: 1915
Allergies: NKDA
Pre-op V/S: 122/54, 95
Procedures: Globe repair (L)

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1400 Colloid 0
OR Output: UOP 0 EBL min
Meds/Times: Versed, Fent

76kg.
37.2/

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

Pre Op Meds Fent 4mg Versed 2mg. History

Time	1915	1922	2215	2245
SaO2	97	97	96	97
FiO2	RA	RA	RA	
Methods				
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80				
60				
40				
20				
RR	16	14	16	22
T	99	9		
Time				
Pain (0-10)	NA	NA		
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1950	LR	1000	PIV	[redacted]	[redacted]

X-rays: Labs:

Post-Anesthesia Recovery score

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

(Continue on reverse)

PREPARING [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Sep 03

PATIENT'S IDENTIFICATION *(Give: Name — last, first, middle; grade; date; hosp* [redacted] b(6)-4

C-1V [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
		None				

NURSING NOTES

1920: pt remains in litter; SaO2 [illegible]% RA; ∅ airway concerns; pt sleeping but arousable; tolerates repositioning; bulky dsg to (L) eye ∅ s/s of hemorrhage; PIV x2 patent; report received from CRNA; [redacted] [illegible] medications [illegible].

1950: report given to [redacted] RN; pt to be transferred to ICW 2 [redacted]

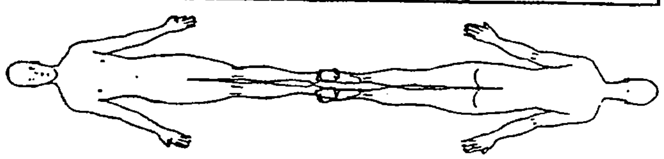
b(6)-2

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	OS	bulky	∅
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1950	∅	∅	∅

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1920	SR	∅	∅

Discharge Criteria:
Date: 5 Sep Time: 1950 PARS: 10
BP: 122/44 T: 99.? HR: 106 RR: 16 Sa02: 95 RA
Pain Level at D/C (0-10): UTA
Intake: 100 Output: ∅
Additional Data: ∅
Transferred To: ICW 2
Report Given To: [redacted] ICW 2
Transferred Via [redacted] Gurney Ambulance
Transferred [redacted]
Cleared IAW R[redacted] Ro[redacted]
Charge Nurse Signature: [redacted]

b(6)-2

WAMC OP 173-E

2000 ??
10cc Fent
10mg Versed
10 Reglan
800 Ancef

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

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

Date: 17 Sep 03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1250
Allergies: NKDA OR Intake: Crystalloid 2000cc Colloid
Pre-op V/S: 108/89 HR 69 OR Output: UOP 300 EBL 100
Procedures: ORIF Ⓛ Zygoma Fx Meds/Times:

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

Pre Op Meds History

Time	1250	1300	1310	1320	1330
SaO2	98	97	98	97	99
FIO2	RA	RA	RA	RA	RA
Methods					
RR	10	12	15	19	14
T	99	99.4		99.1	

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

Time [redacted]
Pain
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	1	1	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2	V/S X = A-line BP ˇ = Cuff BP • = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	
~~Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse~~	2	2	2	LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	08	09	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)

b(6)-2 PRE[redacted] ILT/AW

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 17 Sep 03

PATI[redacted] *...en entries give: Name — last, first, m... ...cility)*

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

NURSING NOTES

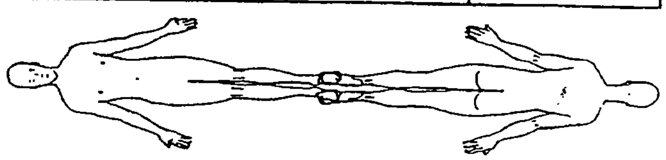
Pt arrived to PACU @ 1250
wakes up to voice, open eyes.
VSS. afebrile. (R) arm dressing C/D/I
face lacerations intact c̄ no drainage.
(L) ya PIV c̄ 125cc/hr [redacted] b(6)-2

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	(R) arm		CDI
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1340	Foley	Yellow	225

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1330	NSR	Ø	Ø

WAMC OP 173-E

Discharge Criteria:
Date: 12/8/03 **Time:** 1330 **PARS:**
BP: 122/56 **T:** 99.1 **HR:** 89 **RR:** 14 **Sa02:** 98
Pain Level at D/C (0-10): Ø
Intake: Ø **Output:** 225
Additional Data:
Transferred To: ICW 2 [redacted]
Report Given To: SGT
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Reco[redacted]
Charge Nurse Signature: [redacted] RN

b(6)-2

MEDCOM - 19264

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
A11D7	IE	b(6)-4	CIV	M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]	UNK	22Y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
Kurdish Army	U	1228	— b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K76	—

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
Ø5		030929

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
ABEA		030915

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 ~~Retinal Hemorrhage~~ Ruptured Globe OS

② Endophthalmitis OS

③ Zmc Fracture (L)

④ Multiple Facial Lacerations

b(6)-4

ADMITTING OFFICER (Signature, as required) [redacted]

SIGNATURE OF ADMITTING [redacted]

DA [redacted] 3985

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER	2. NAME (Last, First, MI)				3. GRADE	ADMISSION REMARKS
[redacted]	[redacted] EPW				NA	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	28	UNK	UNK	NA	NA	NO
11. EMP 20 99	12. SSN [redacted]			13. ORGANIZATION NA b(6)-4		14. WARD ICU2
15. FLYING STATUS	16. DSG	17. DEPT./ BEN NA KNO		18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE NBI
NA						

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	10/14/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	9/18/03	Dr. [redacted]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: BILAT TIB/FIB FX

79.66
83.14
78.17
84.15
86.04
84.3
78 51
86.69

823.92
E993

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	27	27

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	27	27

[redacted] DICAL OFFICER

Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

[redacted]

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

b(6)-2

MEDICAL RECORD | 18 Sep 1000 | **ABBREVIATED MEDICAL RECORD**

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

28 y/o c̄ injury this am ? mechanism ? IED or GSW, arrived EMT by Medicine ~0930

: Meds ō All ō PMH?

PE 112/50 88 R 16-20 100% sat on rebreather

PHYSICAL EXAMINATION

PERRL

(R) TM nl (L) wax

neck - ō step off or notable tenderness

chest clear bil ō (R) abd - nonspecific, ō widens pain, FAST (-)

pelvis stable

rectal - good tone, ō mass, prostate nl

extr - UE OK, moves all

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

RLE - open fx, exposed tendons distal (R) tibia/fib

LLE - midshaft fx ? entry (L) medial midfoot, large exit lat LLE (DP+PT (+) by Doppler, palpable PT on (L)

A - bil tib/fib fx P - ortho for (R) BKA
(L) ex fix

b(6)-?

SIGN[redacted] | DATE 18 Sep | IDENTIFICATION NO. | ORGANIZATION

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

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18 Sep 03	Pt admitted @ 1620 S/P (B) BKA (R) ... / TIB FIB FX.
1800	Both LE c̄ Ace wraps - intact - elevated. Pt has
	awakened spontaneously since admission, but never
	completely awakened to move about restlessly.
	Pt did awaken to check his (B) LE to see if
	they "were there" and gave a "thumbs up" for
	okay. Then went back to sleep. 1 u PRBC infused
	over 1 hr. w/o complications. C-collar continues
	to be in place - though no orders for Cat Scan
	or X-Ray to be done OR any precautionary
	measurements. ~~Pt able to~~ Pt c̄ full sensation
	(appears) to LLE + trace edema. Cap Refill difficult
	to assess d/t thickened toe nails and discolored
	feet. VSS. Report to be given to oncoming
	shift. Pt still sleeping c̄ SPO2 - 98% on RA.
	POC: IV ABX, monitor H/H, review X-Ray and
	pain mgmt. ——— b(6)-2 CPT [redacted]
18 Sep 03	Received report from CPT [redacted]. Pt. resting quietly
1815	in bed c̄ HOB ~~...~~ elevated. Stiff neck brace on.
	18 G IV to (R) AC infusing LR @ 150 cc / HR. 18
	G to (L) AC, SL, flushed @ this time. ⊖ s/s of

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. 1012

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sep. 03	erythema, ⊖ irritation to either site. 16 F foley to
1815	gravity draining clear yellow urine. Ⓐ & Ⓑ BKA,
	knee is elevated & wrapped in kerlix and ace wraps. ⊖
	drainage noted @ this time. Ⓐ external fixator to ⒶLE,
	wrapped in ACE wrap ∈ a small amount of drainage
	noted. Cap refill to ⒶLE <3 sec, toes are cool to
	touch. Pedal pulse present to ⒶLE. ——— SPC [redacted]
1850	CBC drawn and brought to lab @ this tim SPC [redacted]
2010	ii Percocets given PO for 6/10 pain to ⒶLE.
	Neck brace removed by Dr. Bragmen at this tim.
	Pt. drank 240 cc's H_2O @ this tim. ⊖ 6/10 nausea /
	stomach pain. ——— SPC [redacted]
2045	Interpreter came and spoke to pt., explained injuries,
	pt. has no questions @ this tim ——— SPC [redacted]
2300	Pt. resting quietly in bed. Easily awaken, ⊖ 6/10 pain /
	discomfort @ this tim ——— SPC [redacted]
0100	Pt. easily awaken ⊖ 6/10 pain / discomfort @ this tim SPC [redacted]
0400	Blood drawn @ this tim @ 6/10 pain / discomfort @
	this tim ——— SPC [redacted]
0445	Dr. [redacted] notified of pts H&H, orders written for
	2U PRBC ——— SPC [redacted]
~~0535~~	121/74 95% 27 124 102° SPC [redacted]
~~0549~~ 0702	128/71 95% 25 126 102° SPC [redacted]
0545	124/73 94% 25 127 102° SPC [redacted]
0600	126 172 95% 23 134 102° SPC [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/18/03	Brief Op Note
	Pre Op Dx: Gd III C open (R) TIBIA Fx, Gd III B (L) open TIB/FIB Fx
	Post Op Dx: Same
	Procedure: I&D (L) TIB/FIB Fx, FASCiotomies, external
	fixation (L) TIBIA
	Amputation (R) LE (BKA) open
	Surgeons: [redacted] b(6)-2
	EBL: 500cc
	Fluids: 3u PRBC
	3000 LR
	Uout: 500cc
	Findings: - Grossly contaminated open (R) distal tibia fx c̄ extensive
	bone loss + N/V compromise
	- Open (L) TIB/FIB Fx c̄ marked blast effect, tight
	compartments, w soft tissue stripping
	Cx: Ø
	Post Op Plan: Repeat I&D 48°, revision amputation (R) leg,
	exchange rod (L) TIBIA later w ABx
	[redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 19270

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9/20/03	Brief Op Note
	PreOpDx: Open (R) BKA
	(L) open tib/fib fx ̄p Exfix
	PostOpDx: Same
	Procedure: Revision (R) BKA flap
	Closure Medial fasciotomy (L) leg
	Repeat I+D
	Surgeons: [redacted] / [redacted]
	Anesthesia: GETA
	EBL: 50
	Fluids: 500cc
	Findings: (R) stump ̄c minimal fascial purulence
	Cx: ∅
	PostOpPlan: IV ABX, repeat I+D, exchange nails
	[redacted]
	b(6)-2

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

MEDCOM - 19271

ACLU-RDI 1651 p.31

DOD-032845

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Pseptos 1330	Throughout the day pt has been stable - resting in bed c HOB 30-45°. LE elevated on pillows c Chux underneath. Chux D'ed x2 since 0600. Foul smelling odor from blood coming from RLE & LLE. Dr. [redacted] notified. Both drsngs saturated on bottom of ACE wraps. + pulse (DP) to LLE c popliteal/femoral @ on RLE. MSO4 3-5mg Q2-3° for breakthrough pain and percocet tabs (1/1) Q4° for pn management. Results from pn meds c pt acknowledging a ↓ in pain and him sleeping mostly. Pt able to move BLE. VSS. 2u PRBC infused this am - awaiting post H/H results. 40-200cc's - clear-amber urine. Intaking 30-50% of each meal. MIVF @ 150cc/hr IV ABX per schedule b(6)-2 - CPT [redacted]
1830	Chux D'd TOWEL DRESSING REINFORCED c 6 ABD PADS AND 2 KERLIX WRAPS. DR. [redacted] b(6)-2 NOTIFIED OF MALODOROUS SMELL COMING FROM LLE. RLE Chux D'D AND STUMP ELEVATED. WILL CONTINUE TO MONITOR. [redacted] b(6)-2 T/
2300	BLE Chux D'D FOR 2ND [redacted] RLE. (RLE SATURATED THROUGH DRSG REINFORCEMENTS PULSE 2+ CAP REFILL BRISK. PT ABLE TO WIGGLE TOES. BURN PAD PLACED UNDER LEG TO SOAK UP SATURATION FROM LEG. (RLE Chux REMOVED AND BURN PAD PLACED UNDER STUMP. AND ELEVATED. WILL CONTINUE TO MONITOR. [redacted] b(6)-2 cont
2330	MEDICATED c [redacted] PERCOCET FOR PAIN. WILL CONTINUE TO MONITOR [redacted] b(6)-2

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

EPW b(6)-4 # [redacted]

MEDCOM - 19272

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19Sept03 0045	Received pt from SPC [redacted] @ 0000 - resting in bed HOB 45° c LE ↑. Pt receiving 1 unit PRBC and flevrush c last temp @ 102.3 @. Pt
# 4/30/1962 Exp 19/9/03	able to use ICS to obtain 3 "breaths" up x10 times. At 0000 the blood VS were @ q 15min and are as follows:
[redacted]	0000 131 124/72 24 92% RA
	0015 133 125/67 23 89 RA
	0030 126 121/66 19 92 RA
	0045 123 109/70 19 92 RA 101.6 @
	0100 120 122/66 22 94 2LNC 101.3
	0130 106 123/70 17 98 2LNC 98.3
	~~0000~~ End 1st u PRBC ——— CPT [redacted] b(6)-2
0755	↑ 2nd u PRBC - Pt AOX3 - eating breakfast
# [redacted]	0755 117 118/81 19 100% 2LNC 99.4
	0800 107 121/75 22 99% 2LNC
Exp 25Sept03	0805 106 119/68 19 100% 2LNC
	0820 106 131/61 24 100% 2LPC 100.3
	~~0830~~ 102 124/68 19 100% 2LNC
	0845 102 119/72 18 100% 2LNC 100 4@END
	——— GO TO PACU [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~20 SEP 03~~ 0000	PT TAKEN OFF O2 VIA NC 2L. WILL MONITOR. b(6)-2 [redacted]
0030	PT MAINTAINING SpO2 @ > 98% ON RA. WILL CONTINUE TO MONITOR. [redacted] b(6)-2
20 SEP 03 (0645)	Assumed care of [redacted] receiving S-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Currently resting comfortably. 5 % discomfort. b(6)-2 [redacted] PT/AN
20sep03	Surgery POD #2
	No events overnight
	VS: HR 90's - 100's TM 101.7 BP 120-150/60's
	UO- 100-250 cc/hr
	chest CBM
	ctr RRR + PP
	Abd ND NT NABS
	ext - dressing saturated with foul smelling sero sanguinous drainage
	LABS 8.2 27 106
	A/P s/p (R) BKA (L) exfix fasciotomy. to OR today for re washout 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.	

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sep03 (1250hrs)	Patient c/o (L) LE pain. 2+ pulse/doppler. Wiggles toes c minimal limitations; brisk capillary refill unchanged. Continues c copious serosanguinous, foul-smelling d/c. Given 2 Darvocet tabs c water for pain —— Will monitor for effectiveness. —— [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 19275

ACLU-RDI 1651 p.35

DOD-032849

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Sep 03 1845	Received report from CPT [redacted] b(6)-2 on pt. who is resting in bed quietly, HOB @ 45°, pt. easily awoken, understands basic commands and gestures despite language barrier. Assessment completed on DA Form 4700, will continue to monitor — SPC [redacted] b(6)-2
2000	Pt. given 650 mg Tylenol per Dr's. orders for Ax. temp of 101', incentive spirometer use also encouraged. Will continue to monitor. — SPC [redacted]
2100	Pt. c/o pain to @ LE Ti Percocets given @ this time — SPC [redacted] b(6)-2
2300	Pts. temp has dropped down to 99.0 c/o pain or discomfort @ this time. Asked to have HOB lowered. SPC [redacted]
0100	Pt. resting quietly in bed easily awoken. Will continue to monitor — SPC [redacted] b(6)-2
0300	Pt. resting quietly. c/o minor pain to @ LE 0 pain meds given @ this time — SPC [redacted]
0340	Blood drawn for pt. CBC + bright to lab — SPC [redacted]
0458	Pt. given bed bath @ this time. @ additional b(6)-2 DRNG noted to @ LE DRSG & DRNG noted to @ LE. Will continue to monitor — SPC [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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 SEP 03 (0630hrs)	Assumed care of patient p̄ receiving Δ-of-shift report @ 0600hrs. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial assessment information. Pt. currently resting quietly in bed s̄ noted distress/discomfort. Will continue c̄ present plan of care. [redacted]
21 Sept 03 1050	- Assumed care of PT. PT temp was 102.3 Ax. Encourage incentive use. Give Ti Tylenol 325mg PO. Will cont to monitor, for Δ's. [redacted]
21 Sept 03 1130	- PT's temp 100.7, will cont to monitor PT. [redacted]
21 Sept 03 1415	- PT transferred to ICW1 as per MD order. [redacted]

b(6)-2 All

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

MEDCOM - 19277

ACLU-RDI 1651 p.37

DOD-032851

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	(cont) wrap; sm amt of drainage noted to posterior aspect of affected leg; dsgs to bilat feet, wrapped c Kerlix, CDI ⊖ drainage; PIV patent & infusing LR @ 125 s s/sx infection/infiltration; restraints in place, ⊕ circulation, ⊖ skin break ↓, cont to monitor b(6)-2 [redacted]
23SEP03	(1510) Assumed care of pt Ⓛ [illegible] p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Drsg to back of Ⓡ thigh Δd. large amount brown/green drainage noted on old drsg. Small amount of bleeding noted in wound. Pin care done on ex fix. Pt able to move RLE. cap refill <3secs. ⊕ pedal pulses equal bilat. Drsgs to bilat feet Δd - Silvadene applied to wounds and wrapped c Kerlex. Pt OOB to chair - tol. well. Tol. reg diet well. Voiding s difficulty. 2-point restraints in place s S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] 47AD
	(1645) Drsg to Ⓡ thigh Δd d/t large amount of drainage on old drsg. RLE elevated on blanket. IVFs SLd in IV in Ⓛ forearm. Ø S/Sx infiltration/ infection monitoring. b(6)-2 [redacted] [illegible]
23sep03 @ 1950	Assumed care @ 1800; VSS, pt A&Ox3, [redacted] b(6)-2 CMS to all extremities, NV intact, pain controlled b(6)-2 c percs; Ex-fix in place, ~~wrapped c Kerlix s drainage~~ c sm amt [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. ICW #1

PROGRESS NOTES
Medical Record

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

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

drainage coming [redacted] seeping through old dsg on posterior aspect of R wrist; Dsg Δd, SM amt of bleeding occured in wound; Kerlix packed in wound still intact; pin care completed- minimal drainage; pt refused Dsg Δ to b/l at feet, stated he only wants it Δd once today; ⊕BSx4, pt voiding ⊖S, dark yellow urine ⊖ difficulty; pt ↑ OOBTC - Tol well; NPO p MN d/t surgery tomorrow; restraints in place, ⊕ circulation, ⊖ skin breakdown will cont to monitor. b(6)-2 [redacted]

24SEP03 (1305) Assumed care of pt @ bedside p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c MSO4. 18g IV started in ® forearm. IVF infusing @ TKO ⊖ S/Sx infiltration. SL in © forearm dlcd d/t infiltration - catheter intact. Pt remains NPO for surgery. Drsg to ® thigh Δd this am. Large amount green/brown drainage noted on old drsg. Small amount of bleeding noted in wound. Packing in place. Drsgs to pins and b/l at feet CDI. Pt voiding ⊖ difficulty. 1 point restraint in place. ⊖ S/Sx complications. Will continue to monitor. [redacted] (WAW)

(1440) Pt tx to OR via gurney. b(6)-2 [redacted] (WAW)

(1700) Pt tx to unit from ICU #3 p recovery in stable cond. Pt tx to bed ⊖ difficulty. VSS. Pt medicated c MSO4 for pain c good relief. Drsgs CDI. Will continue to monitor. [redacted] (WAW)

24Sep03 @ 2345 - assumed care of pt @ 1800. VSS. Speaking arabic, alert, Co pain to ® thigh. Percocet given c good relief noted. LS CTA, ⊕ BS x 4 quads, ⊕ post op void of 600cc dark urine. ® thigh drsg Δd and pin care completed. ⊕ CMS to RLE. (BID) feet drsgs Δd - (CONT)

STAND [redacted]

b(6)-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24SEP03 (P) 2345	(CONT) silvadene applied to burns. (R) FA IV c̄ LR @ TKO for abx s̄ s/sx of infiltration. 2pt restraints on c̄ ⊖ signs of skin or circulation compromise. Plan: monitor drainage from (R) thigh drsg, cont IV abx as ordered, monitor pain control. b(6)-2 [redacted]
25Sept03	1205 - VSS - A+O assessment completed. PERRLA, LS - CTA (B). Resp even unlabored, BS x4 abd distended. voiding per urinal c̄ dark yellow urine. IV heplock (R) FA CDI Drsng Δ to (B) feet. silvadene applied. Drsng Δ to (L) femur c̄ Brownish/greenish discharge on drsng. new drsng applied. Pin care completed. Pt. tolerated breakfast well. will cont to monitor pt. [redacted]
25SEP03 2236	VSS. AO. Sensation ⊕ to RLE. ⊕ pulses BLE palpable to RLE. Pin care and outer DSG changed to wound. [illegible] odor present c̄ light green purulent drainage noted. Tolerated well. ∆'d DSG and debrided wounds to both feet. Tolerated well. b(6)-2 [redacted] b(6)-2

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b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26SEP03	(0845) Assumed care of pt @ 0800 c report from night shift. Pt alert, speaking Arabic. VSS. @ c/o pain @ this time. Pt NPO for surgery today. LR started @ 125cc/hr. into IV in @ forearm. @ S/Sx infiltration/infection. Pt amb to chair this am - tol. well. Pt voiding c difficulty. Ex fix in place @ pedal pulse on @ foot. Drsg to @ thigh c mod amount brown drainage noted. Drsgs to feet CDI. Pt to surgery @ 0850 via gurney. Tx to gurney c difficulty. [redacted] MAJ (1440) Pt returned from OR, in stable cond. Tx to bed c difficulty. IV in @ forearm dlcd d/t infiltration. 18g IV started in @ forearm. IVF infusing c S/Sx infiltration. Drsgs to feet d. Silvadene applied to burns. Drsg to @ thigh reinforced c abd pad and kerlex. Pt able to move RLE. @ pedal pulse. Cap refill <3secs. @ void. 2 point restraints in place c S/Sx complications. Will cont. to monitor. [redacted] MAJ
27sep03@	Assumed care @ 1800; All VSS; pt A&Ox3, @ CMS, [redacted] brisk cap ref, @ pulses x4, NV intact throughout; pain controlled c percs; (R) LE ↑ on 2 blankets; b/lat dsgs to feet d c silvadene applied, @ S/Sx infection; dsg to (R) thigh CDI, Ex fix in place; Dr [redacted] gave V.O. not to d dsg to (R) thigh @ drainage thins for; PIV patent & infusing LR @ 125 cc/hr c S/S infection/infiltration restraints in place, @ circulation, @ skin breakdown; cont to monitor [redacted]
27SEP03	(1500) Assumed care of pt @ 0800 c report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Ex fix in place on RLE. Pt able to move RLE. @ pedal pulses equal bilat. Cap refill <3secs. Pin care

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b(6)-2 All

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 03 0800	[redacted] Pt Alert ē oriented. Lungs CTA(B). Resp even ē unlabored. Abd soft nontender. ē (+) BS X4 quads. (R) stump ē acewrap C/D/I. Good ROM. LLE ē fixator intact. Pin care ē drsg Δ wet to dry completed. Sutures intact. Small amount serosanguinous drainage from shin wound. lateral calf wound beefy red. Strong pedal pulse. Brisk capillary refill. Medicated ē Percocet 2 (two) tabs PO per pain during drsg Δ. Currently tolerating breakfast well. Will continue to monitor. RUE heplock patent. BLE elevated [redacted]
25 Sep 03 1220	Sleep. Levoquin 500mg IVPB [redacted]
25 Sep 03 1445	Medicated ē percocet two tabs p.o. for c/o pain. Doing ROM ē (R) stump. Will continue monitoring. [redacted]
25Sep03@2115	Assumed care @1800; All VSS, pt A&Ox3 speaking arabic; (+) CMS through brisk cap ref; (+) pulses x4; NV intact; pt OOBTC s̄ difficulty; (R) stump dsg CDI; pin care to (L) LE completed ē 1/2 sterile H2O, 1/2 peroxide; W→D dsg Δ to (L) calf wrapped ē Kerlix & Ace wrap; (+) drainage, sutures intact; wound beefy red (-) S/Sx infection; pain controlled ē percs; HL patent s̄ s/s infection; LEs ↑; restraint in place; (+) circulation (-) skin breakdown; ROM completed, pt TOL well, cont to monitor [redacted]

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[redacted] b(6)-4

ACLU-RDI 1651 p.42

DOD-032856

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 Sept 03 0800	Alert & oriented. (L) AC IV dislodged; IV D/c'ed and restarted to (R) FA x1 attempt c̄ 18g 1¼" catheter. IV saline lock. Ace wrap intact and dry to (R) leg stump. External fix intact to (L) leg. Pedal pulses palpable to (L) LE. Will continue plan of care. b(6)-2 [redacted]
23SEP03 2219	VSS. (+) pulses to R&LLE extremity. (+)1 pulse palpable to LLE. CNS intact. OOB to BR x1 s̄ difficulty & crutch walked. Voiding light yellow urine s̄ difficulty, quantity sufficient. IV saline locked. [redacted] b(6)-2
24 Sept 0900	VSS Alert & oriented (R) FA saline lock patent s̄ ~~...~~ intact and flushes without difficulty. Ace wrap drsg to (R) stump dry & intact. Ace wrap drsg to (L) LE c̄ external fix dry & intact. Pedal pulse palpable to (L) LE. Voided clear amber urine quantity sufficient. Will continue care as planned b(6)-2 [redacted]
24SEP03 2234	VSS, AO. (+) pulse to LLE. VFix in place & intact. c/o severe pain and provided 75 mg Demerol. DSG's intact to (R) BKA and (L) VFix. All other systems WNL. [redacted] b(6)-2

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b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03	0830 Medicated c̄ Percocet two tabs p.o. for c/o pain to B LE. Tolerating breakfast well. Will continue monitoring. b(6)-2 [redacted]
26 Sept 03	Assume care of PT. A+Ox3, VSS. Has a distal pulse in left leg. Maintains a regular diet. Urine is dark brown color aproximately 850cc. Excercises by moving legs while lying in bed. c/o pain
b(6)-2	[redacted] 2 percocets. Administered meds, had to change IV to Ⓛ Arm due to PT [redacted] removing it. Skin irration from restraints is nonexistance. Drs; Δ blood pouring out. Will continue to monitor. SP[redacted]91W
1920	Pt a/o, VSS, LCTAB, HRRR ⊕BSx4, Ⓡ stump c̄ ace wrap CDI. Ⓛ LE ex-fix intact. pin care done. ROM to Ⓡ stump done by pt often. drsg to LLE Δ'd. sero-sang drainage noted. Percocet II tabs given for pain. 2pt restraints on, ⊕ circulation. Will monitor [redacted] 91W M6 SPC
	b(6)-

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#[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sept	VSS pt A&O x3, LCTAB, HRRR ⊕ BS x4 ϕd
	pin care complete, both drsg Δ'd, removed penrose
	drain, wound clean, red with minimal drainage,
	stump healing well sutures intact, skin intact no
	signs of infection noted, pedal pulse present left leg
	pt c/o pain often given perc, pt c/o constipation [redacted]
	~~but~~ no other remarkable findings
	(1745) I concur c̄ above assessment. [redacted]
1950	Pt A10, VSS, C/o pain often but falls asleep
	immediately after complaint. pin care
	done, Ⓛ leg pedal pulse present. Drsg c/o CDI.
	doing ROM often. H2O @ BS, voiding mod. yellow
	urine via urinal. Restraints on. Will monitor
	[redacted]
28 Sept 0745	Received pt resting in bed, VSS, A&Ox3. Ⓛ LE
	ex fix in place, pin care done, w/D drsg Δ'd
	serosang drainage on old drsg ordoo. Medicated
	w/ ii percocets x1 this am. Ⓡ Stump w/
	drsg intact, Tol PO, voids light yellow
	urine. Restraints in place per EPW protocol
	ϕ thumbs / takedown noted. Will cont to
	monitor pt [redacted]
	b(6)-2 All

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ACLU-RDI 1651 p.45

DOD-032859

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(con't)	wrist ē HR. ⊖ redness ⊖ s/sx infection.
	Pt. tolerated drsng changes well.
	Two restraints in place ⊕ circulation
	⊖ skin breakdown. Will cont. to monitor
	Pt [redacted]
~~28Sept03~~	~~1650 – Pt. OOB to BR, ambul~~ ERROR [redacted]
28Sept03	1700 – Pt. c/o stomach pain. Pt. states
	"I haven't had BM x 25 days". abd. [redacted]
	distended, firm. Will cont. to monitor pt [redacted]
28Sep03	Pt A+O x 3, VSS, LS CTA Ⓑ, ⊕ BS x4,
2015	abd soft flat tender to palpation,
	pt c/o ∅ BM in 25 days, requested
	med to assist BM, urinating well in
	urinal, dsg to toes Ⓑ CDI, Ex Fix
	on Ⓡ thigh, dsg ~~DR~~ on pins CDI,
	dsg around knee had moderate amount
	of drnge behind the knee, medicated
	for pain ē ii percs, HL Ⓡ Hand intact,
	proper circulation + ∅ skin break down
	on pts of restraint. [redacted] gw
	[redacted] ew
29Sept	PERRLA, pt awake + oriented x3, WNL, lungs CTA
	respiration ~~even~~ and ~~and~~ unlabored, abd soft
	non distended, BS x4, voiding amber urine per urinal
	drsg changed below knee, pin care completed
	minimal drainage noted swabbed with betadine
	then ~~re-wrap~~ circulation intact ∅ skin breakdown
	restraints x2 in place [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(6)-2 All
27SEP03 (1510)	(cont) done this am. outer drsg to (R) thigh Δd d/t mod amount of drainage on old drsg. Drsgs to feet Δd. Silvadene applied to burned skin. Pt tol drsg Δs well. RLE elevated on ~~pillow~~ [redacted] blanket. SL in (L) arm flushes well s̄ S/Sx infection/infiltration. Tol. reg diet well. voiding s̄ difficulty. 1 point restraint in place s̄ S/Sx complications. will cont. to monitor. [redacted]
27Sep03@2315	Assumed care @1800; All VSS; pt A&Ox3, pain controlled c̄ perc, pt OOBTC x1 for 15 min, Tol well; dsg to feet Δd silvadene applied, wrapped c̄ Kerlix, ⊖ s/sx infection; pin care completed; min drng noted; dsg to (R) thigh Δd, moderate amt of drng noted, RLE ↑; SL in (L) arm infiltrated, IV started in (R) wrist, patent & flushes well, cont c̄ IV abx; restraint in place, ⊕ circulation, ⊖ skin break; cont to monitor, NV intact. [redacted]
28Sep03	0934 - Assumed care of pt. A&Ox3. Assessment completed. Afebrile, Lungs CTA (B), Resp. even unlabored, NSR, S1S2 present. abd soft nontender, BSx4. voiding per urinal. Ext. fix in place to (R) LE. Pin care performed. Drsng changed completed c̄ moderate amount of drainage to drsng. Silvadene applied to (B) feet. Kerlix wrapped around. IV (R)

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b(6)-4

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
28 Sep 03	2045 = VSS, c/o pain to (L) LE - gave ii percocet tabs as ordered, IV HL to (L) arm flushed s̄ difficulty. Dsg to (R) LE stump CDI c̄ Ace wrap, 2+ popliteal pulse, pt. does ROM exercises himself. (R) LE c̄ ex-fix in place, pin care done - no exudate or blood from sites while cleaning, sites look CDI, W→D Dsg to wound on (L) LE Δ'd & W→D to smaller wound to back of (L) leg Δ'd - both CDI, Covered c̄ Kurlex & Ace. Palpable 2+ pedal pulse (L) foot, OOB to BR/chair PRN s̄ difficulty Ø other remarkable findings. POC: Pain Management Infection Control. [redacted] b(6)-2
	Received pt resting in bed, VSS, OOB to BSC, ⊕BM, OOB TC. Medicated x 1 ii percocet for pain. Dsg W→D Δ this afternoon c̄ 1800 5mg MSO4 given for pain prior to dsg Δ. Pin care done. DSG to R stump c/d/i. Pt has full ROM of Bilat extremities c̄ hips + knees. (L) ac

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[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	IV access patent, intact, flushes easily. Pt has ⊕ pedal pulse Ⓛ LE & ⊕ pop. pulse R Ⓡ [redacted]
29 Sep 03 @	2015: VSS, A+Ox3, c/o pain, gave 2 percocet tabs as ordered, pin care done to ex fix, ∅ drainage noted @ insertion sites, DSG to Ⓛ LE CDI - reinforcing prn, 2+ pedal pulse Ⓛ foot, Ⓡ LE stump has DSG c̄ Ace CDI, pt. does ROM exercises. IV H/L to Ⓛ FA flushed + patent, continue to monitor for acute Δ's. Restraint x4, ⊖ skin breakdown [redacted]
30 Sept 03 0800	NPO since MN. Ⓛ for OR today. A+Ox3 Ⓛ FA Saline lock flushed without difficulty. Peripheral pulses palpable. Pin sites on Ⓛ LE external fix. without drainage or crustation. Pt aware of O/C for OR this AM. Will continue plan of care [redacted]
30 Sept 03	0850 Pt transfered to stretcher to O/R - [redacted]
30 Sept 03	1400 Return from PACU via stretcher. Alert oriented. Transfer from stretcher to bed with minimal assist. Lungs clear Bilateral. Ⓛ Pedal pulse palpable. Move toes to Ⓛ foot freely. Capillary refill to Ⓛ toes <3 sec. Ⓛ FA Saline lock: ~~PAIN~~ patent & intact. Ⓛ LE ↑ on ~~[illegible]~~ folded blankets. Uses Incentive Spirometer properly @ 900cc/sec. HOB ↑30° Resting comfortable c̄ eyes closed. Will continue plan of care [redacted]

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b6-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/24/03	OpNote
	PreOpDx : Open (R) BKA
	PostOpDx : ? closure of stump
	Procedure : same
	Surgeon : [redacted]
	Anesthesia : [redacted] b(6)-2 A11
	EBL : min
	Fluids : 600cc
	Cx : ∅
	[redacted]
	OpNote
9/29/03	PreOpDx : Open (L) TIB/FIB Fx ō Ex Fix
	PostOpDx : Same
	Procedure : Removal of Ex Fix, IM nailing of tibia, STSG (L) calf
	Surgeons : [redacted]
	Anesthesia : GETA / MAJ FLORE
	EBL : min
	Fluids : 1600cc
	Findings : Comminuted mid shaft tib/fib fx c̄ lateral granulation bed.
	Cx : ∅

[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sep03 1930	Pt A+Ox3, VSS, IV HL (R) wrist intact ø s/sx of infex, dsg's on toes bilat CDI, Ex Fix (R) thigh in place, RLE elevated c blanket, c/o pain to RLE, medicated c 2 percs, kerlix dsg around R Knee saturated c blood on back of knee, dsg's on pins CDI, abd soft flat non tender, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted]
29Sep03 2100:	I concur c above assessment [redacted]

b(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6Oct03	1150 - Blood drainage went through dressing since 0930. Will cont to monitor pt. [redacted]
1530	- Reinforced dressing to (R) LE due to blood drainage. [redacted]
1535	- Pt. had large BM. [redacted]
6Oct03 1650	Concur c̄ shift assessment. Will continue to monitor throughout shift [redacted] b(6)-2
0000	Pt A&O, VSA, ⊤ Perc given for pain. had BM x1. (R) stump & (L) thigh OTA → (xeroform gauze) (L) calf drsg reinforced. ⊕ pulses to (L) leg. 2pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted]
7OCT 0200	Pt sleeping c̄ ∅ noted distress [redacted] b(6)-2
7Oct@0800	Assume care of pt. Pt in bed c̄ (R) stump elevated. Staples to stump intact. Xeroform on (L) thigh peeling @ edges. Pt has ⊕3 pitting edema in (L) foot. Pulses palpable. Lungs CTA. BS⊕ S/L flushed c̄ 3cc of NS. Lower leg dsg D&I ⊖ c/o pain or discomfort @ present time. Will continue to monitor - [redacted]
1640	Pt medicated c̄ ⊤ percocet per MD order for pain - [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~5OCT03 (1900)~~	~~Pt alert, temp 99, LCTAB, HRRR ⊕BSx4 good, abd. soft, NT, non-distended,~~ (ERROR) [redacted] b(6)-2
5OCT03 (1900)	Pt A/O, VSS, LCTAB, HRRR, ⊕BSx4 Ⓡ thigh incision c̄ sutures OTA, Ⓛ leg calf area ace wrap/Kerlix CDI, Ⓛ thigh c̄ xeroform gauze OTA. leg elevated. Pt does own ROM often. 1 pt restraint on. s̄ compromise to skin/circulation. will monitor. b(6)-2 [redacted] 91WM6.
6OCT03	0957 - VSS - AO - Assumed care of pt. @ 0600. Assessment completed. PERRLA, LS CTA Ⓑ, Resp. even unlabored, BS's present, abd. soft, nontender, BSx4, changed drsng to Ⓛ leg. dressing saturated c̄ blood. Applied Bacitracin to site + wrapped c̄ Kerlex + ace bandage. ⊕ cap refill ROM exercises encouraged, staples intact. pt. c/o ∅ pain @ this time, Voiding per urinal. Will cont. to monitor pt. [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8 OCT 03 1910	Pt Awake. VSS. LS CTA (B). ⊕ BS x4 quads. S1 S2 present. LLE Drsg (Grap Graph site) removed by pt previous shift. L calf area c/[redacted] Drsg. void qs s difficulty. Will contin[redacted] monitor. ——— b(6)-2 [redacted]
09Oct03 [illegible]	Received pt resting in bed, VSS, [illegible] appetite good. (L) LE thigh w/ donor graft site, scab and dried blood noted. bacitracin applied. LLE shin/calf dsg intact w/ serosang drainage noted on calf side. ⊕ BM, am care provided. IV to (L) wrist patent & intact. Will cont to monitor. Restraints per [illegible] protocol, Ø breakdown noted. [redacted] b(6)-2
9 Oct 03 @ 2140	Assumed care @ 1900; All VSS, [redacted] speaking arabic; pt OOB to w/c; dsg to (L) leg CDI s̄ drainage; bacitracin applied to donor site, healing well; PIV to (L) wrist patent s̄ s/sx infection/infiltration; Restraints in place, ⊕ circulation, Ø skin break ↓; cont to monitor b(6)-2 [redacted]
10 Oct 03 0200	Assumed care pt. A+O x3. VSS. LLE skin graft site healing c̄ scab. Calf graft placement dsg CDI Ø bleeding noted. Lungs clear HRRR Active BS. Ø s/s of infection. Remains afebrile. Will cont to monitor ——— b(6)-3 [redacted]

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\# [redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			# [redacted] b(6)-4

DATE	NOTES
7OCT@ 1955	Pt a/o, VSS, LCTAB, ⊕ BSx4, ⓘⓘ percocet given for c/o pain to Ⓛ leg. drsg Δ'd per MD orders, bacitracin applied to skin graft site (Ⓛ calf area) & wrapped c̄ Kerlix. Ⓡ stump sutures removed & steri-strips applied. HL Ⓛ hand flushed - patent. voiding q̄ via urinal. 2 pt restraints on s̄ compromise to skin/circulation. Will monitor ——— b(6)-2 [redacted] 91WM6.
8OCt03	0800 - assumed care of pt @ 0800. VSS - A/O speaking little arabic. LS CTA Ⓑ, Resp. even, unlabored, abd. soft non-tender, BS x4. voiding per urinal - c̄ŷu. Drsng Δ to Ⓛ LE conducted. Bactrocin applied to site + wrapped c̄ Kerlex. min. drainage on old drsng. CDI ⊖ s/sx inf. encouraging pt. to do ROM exercises. Ⓡ stump CDI c̄ steri strips applied. ⊕ edema to Ⓛ foot. elevate leg on pillow. one restraint applied. ⊕ circulation ⊖ skin breakdown. D/C IV to Ⓛ hand ⊕ redness ⊕ swelling. New 18G IV start to Ⓛ wrist. CDI ⊖ s/sx inf. Pt. tolerated well. will cont. to monitor pt. ——— b(6)-2 [redacted]
	(1700) I concur c̄ above assessment. [redacted]

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MEDCOM - 19295

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Oct 03 @ 1945	Assumed care @ 1900; All VSS, pt A&O x3; Ø c/o pain or discomfort @ this time; pt OOB to w/c, TOI well; dsg to (L) LE CDI Ø drainage; pt voiding ∃ difficulty; ⊕ BS x4, ⊕ BM per Bedpan; Restraints in place, ⊕ circulation ⊖ skin breakdown, cont to monitor b(a)-2 [redacted]
11 Oct 03	pt A+O x3, VSS, pt has Ø c/o pain at this time dsg d'd and staples and sutures removed from graft site (L) leg and over the knee cap, both areas skin intact, no drainage or bleeding. bactracin applied to the staple and suture sites skin intact ⊕ circulation, restraints x2 in place. b(a)-2 [redacted] (1525) I concur ∁ above assessment. [redacted] RN
(1910)	VSS, a/o, Ø complaints @ this time. dsg to (L) leg dry & intact, (R) stump OTA ∁ steri-strips, (L) knee incision OTA, Ø S/S/Sx infection, ⊕ circulation 1 pt restraint on 3 compromise to skin/circulation will monitor b(a)-2 [redacted] Alum.
11 Oct 03 1411	Assume care of Pt @ 0600. A+O x3, VSS A dsg on (L) leg, healing nicely. Skin intact around graft site. c/o Ø pain. Restraints x2 in place, no skin irritation. (R) stump shows Ø signs of bleeding, skin intact. will continue to monitor. b(a)-2 [redacted]
(2000)	Pt a/o, VSS, c/o pain to (R) stump. (L) leg graft site OTA ∁ bactracin applied. (R) stump ∁ steri-strips. ⊕ circulation, Ø drainage or bleeding noted. 1 pt restraint on 3 compromise to skin/circulation. will monitor b(a)-2 [redacted] Alum Me

[redacted] b(a)-4

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

MEDCOM - 19296

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13Oct03 1322	Assume care of PT @ 0600. VSS, A+Ox3. Ø c/o pain today. Exercised in wheelchair. (R) stump has no bleeding or signs of infection present. (L) thigh [redacted] graph site was treated with bacitracin. Verbal order from Dr. to let PT (L) leg open for air & restraint on (R) arm, no signs of skin irritation. Will cont. to monitor.
	[redacted] b(6)-2
13OCT03 @2300	assumed care of pt @ 1800. VSS, A&O. (R) leg stump healing well [redacted] (L) LE graft sites & donor sites OTA c̄ bacitracin applied. Pt ↑ W/C in hallway s̄ difficulty. Plan: monitor LE graft/donor sites, monitor pain. D/C pt restraints on s̄ S/Sx skin/circulation compromise. Will monitor, [illegible]. Addendum: poss D/C to hospital tomorrow.
	b(6)-2 [redacted]
14Oct03 0954	Ø Δ in pt's condition. Pt transfer to Iraqi hosp s/c [illegible] intact. Pt D/C c̄ meds. Transferred
	[redacted] 91WM6 b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[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 - 19297

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)
18Sept03 @0930	pt arrived via medevac, ? on accident per interpreter, assuming GSW to (B) LE. (+) doppler pulse on (L), ϕ pulse on (R) per doppler. per ortho surgeon: pt able to move toes (B). Lungs CTA(B), BS@x4, pt is stable, Fastexam(-). pt turned ϕ injuries or deformities noted. C-collar placed, CT scan to head ordered. pt placed on full monitor, O2 NRB @ 10L, VSS. Ortho MD / General Surgeon consulted.
@0940	x-ray portable here. Foley placed c 100cc clear, yellow urine out. pt armed c 18g in (R) AC, 2nd 18G started in (R) bicep c 1st L Lt NS ↑. Ancef 1gm IV Piggy ↑. pt c 500cc NS in. Fentanyl 75mcg IVP given for pain. b(a)-2 [redacted]
@0950	Wounds cleansed ; splen[redacted]ed, waiting for surgery ; CT Scan. [redacted] see 558, sinus tachy. Gentamycin 400mg IVPB ↑ # 1 & PCN 3mu ↑ in ~~arm~~ IV site. Td shot given in (L) deltoid. pt denies allergies per interpreter. No other Δs, will continue to monitor b(a)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted] b(a)-4

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

MEDCOM - 19298

18Sept03

@ 09:1015: x-rays completed, #3 & #4 bags of LR hung @ open wide. pt poor historian per interpreter. Labs redrawn for b(6)-2 & sent.

@ 1055: pt brought to CT Scan c [redacted] escort, on O_2, stable. will continue to monitor [redacted]

b(6)-2

b(6)-4

#[redacted]

NSN 7540-00-634-4175

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Sept 03 09:10	S: Pt has left leg open fracture, right leg broke.
110 BP 118/78 P 114 T RR	O: Lungs bilateral / clear perla - pupils reactive to light good bilateral femoral no distal pulse left leg

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

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: IRAQI
CITY: | STATE: | ZIP CODE:

ARRIVAL
DATE (Day, Month, Year): 18 Sep 03 | TIME: 0930
TRANSPORTATION TO FACILITY: MEDEVAC

SEX: M
AGE: 28

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: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT
DATE LAST VISIT: | 24 HOUR RETURN ☐ YES ☐ NO
TETANUS — DATE LAST SHOT: | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: bilat tib/fib Fx

CATEGORY OF TREATMENT
☐ EMERGENT
☒ URGENT
☐ NON-URGENT
TIME: 0930
INI [redacted] b(6)-2

VITAL SIGNS

TIME	0930	0945	1000	1030		
BP	112/50	119/77	107/77	127/79		
PULSE	114	100	110	101		
RESP.	18	16	16	18		
TEMP	/	101.1 (R)				
~~WT~~	100%	100	100%	100%		

LAB ORDERS
X 1000 CBC/DIFF | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT
URINE C&S | UA MSCC/CATH | X CHEM: Met B 1000
X 1000 BLOOD C&S X
T&C X 2 units PS RRC @ 1000

X-RAY ORDERS
CXR PA & LAT/PORTABLE | C-SPINE
ACUTE ABDOMEN | LS SPINE
SINUS | HEAD CT
ANKLE R/L
X Bilat Tib/Fib KR @ 1015

ORDERS
☒ PULSE OX | ☒ MONITOR | ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	IV NS ‖ bolus	[redacted]	b(6)-2	0946	.5 cc Tetanus
0945	Fentanyl 75 mcg IV			0948	400 mg Ancef IV
0940	Ancef 1gm IV			1015	50 mcg Fentanyl IV
0945	Foley			1050	250 cc NS 3 Mu PCN

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

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

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

[redacted] b(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 19301

ACLU-RDI 1651 p.61

DOD-032875

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP 02	PH	PO2	RESULTS	Xray - comminuted fx b/l tib/fib; Ⓛ fx/lgd
H/H			PCO2	SAT	OTHER		
PLT			U/A DIP			EKG INTERPRETATION	CXR - no acute disease
PT			U/A MICRO				
APTT		BHCG / ETOH / GLU					

PROVIDER HISTORY/PHYSICAL

S: Possible GSW b/l LE's. ? any other injuries.

O: alert c̄ stimuli, GCS = 12

HEENT - ⊝ obvious trauma

Neck - nontender C-spine film (lat) ⊝ fx or subluxation

Lungs - CTAB   Heart - tachy but reg

Extr - b/l open tib fib fx c̄ lg. soft tissue defect Ⓡ medial lower leg,

Pulses absent Ⓡ foot

Ⓛ foot - palpable PT/doppler DP

DP/PT pulses - palpable c̄ doppler (L)

Abd - soft, nontender

FAST exam ⊝ by Dr. [redacted]

P: Ortho consult

Sx consult

CT head.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] b(6)-2

[redacted] b(2)-2

DIAGNOSIS

GSW/b/lat injury LE's

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

MEDCOM - 19302

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21Sep03		1430	Assumed care of PT A&O LSCTA (B). ~~[illegible]~~ S1 S2 present, HRRR. (+)BS x4 quads. (R) BKA Drsg Gauze c̄ seeping serosanguinous Fluid. (L) LE Ex fix. Drsg c̄ Ace wrap CDI. complains of "small" pain. Controlled c̄ percocet. Will continue to monitor. [redacted] Sc 91WM6
21Sep03		1500	I concur c̄ above [redacted]
21Sep03		1502	Pt in 2pt restraint. Circulation skin integrity assessed & WNL [redacted]
21 SEP 03		2117	VSS. AO. Provided 2 percocet for 6/10 pain to BLE. DSG's to R&LLE's CDI. Encouraged use of IS X10 and patient did well. LSCTAB. HRR. BS(+)X4 (+)pulses to LLE. Pins intact. NPO p̄ MN. [redacted]
			Op Note
			Pre Op Dx : Open (R) BKA (L) TIB/FIB Fx
			Post Op Dx : Same
			Procedure : I+D (R) stump (L) leg wound
			Surgeon : Oliverio
			EBL : ∅
			Fluids : 100 cc b(6)-2 All
			T.T. : ∅
			Findings: pus found plan lat + post [illegible]
			Cx : ∅
			[redacted]

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
22Sept03	0630		Pt return from OR via litter. ⊝ s/s of resp distress, pain or discomfort @ present time. Ⓡ leg wrapped c̄ ace bandage. ⊝ drainage noted. Will continue to monitor [redacted] 91WMC
			b(6)-2
	0935		Pt c/o pain given ii percocet per MD orders will reassess [redacted] 91WMC
			b(6)-2
22Sept03	1122		Assume duty of PT after returning from OR. C/O pain given ii percocets. [redacted] ~~Dsg's applied. Minimal walking to and from~~ [redacted] ~~I changed out~~ VSS, A+Ox3. 2 Pt restraint, circulation skin integrity assessed. Linen changed. Little movement of 2x legs. Will continue to monitor. [redacted]
			b(6)-2
22SEP03		2145	assumed care of pt @1800. VSS. A&O speaking Arabic. LSCTA, HRR, ⊕BS, ⊕ post op void. Ⓡ BKA drsg CDI, Ⓛ EX-FIX (TIB) c̄ bulky drsg CDI. Percs for pain, c̄ good relief noted. ⊕ CMS to BLE. Ⓛ FA NC IVFs, Ⓛ FA HL, both s̄ s/sx of infection/infiltration. ~~1~~ 2pt restraint on s̄ s/sx of skin/circulation compromise. Plan: monitor pain control. A&Ox as ordered. [redacted]
			b(6)-2

(Continue on reverse side)

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

[redacted]

b(6)-4

[redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

MEDCOM - 19304

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

M[illegible]CAL RECORD - PATIENT ACTIVITIES F[illegible]VSHEET

For use of this form, see MEDCOM Circular

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sep 03 | PATIENT ACUITY LEVEL: 3 | POST-OP DAY: 1 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1430 To ICU1 From ICU2 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis External Fixator B/P _____ P _____ R _____ T _____

LOC A&O appropriately Neurovascular checks _____

Dressing/cast Gauze to (R) BKA, Drsgs Wrap Ex Fix OLE Tubes _____

Intake (IV, po) RUA 22G Output (EBL, other) FTG Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1430	1914														
BP ARTERIAL LINE																
BP CUFF	130/74	117/66														
TEMPERATURE	99.4	101.0 A														
PULSE	90	103														
RESPIRATORY RATE	17	16														
OXYGEN (L/%)	0	RA														
PULSE OXIMETER	97%	96%														
O2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1914															
PAIN INTENSITY (10 / 5 / 0)	5															
MED ADMINISTERED (Y/N)	Y															
RELIEF ACCEPTABLE (Y/N)	Y															

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW

#[redacted] b(4)-4

DIAGNOSIS: (R) BKA (L) Tib/Fib Fx

DRG: _____ ADMISSION DATE: 18 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): None

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10-14-03	Discharge Summary This Iraqi male had Bilateral open T/B/F/B Fractures secondary to gun ~~shot~~ shot wounds. He has a right Below knee amputation and his left has been stabilized with intramedullary nail. Because of his unstable fracture pattern and (R) BKA, he is unable to bear weight on left leg. He should remain non weight on left leg for additional four weeks. The following six weeks he may begin partial weight bearing on left leg. After that, full weight bearing will be allowed (12 weeks post op). He has small wound posterior left calf which is closing slowly and this should continue to be dressed daily. Continue oral antibiotics until wound is completely closed. Radiographs are not necessary for ten weeks. [redacted] b(6)-2

[redacted] b(6)-4

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 OPER... VIA Wheeled litter BY Anesthesia

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

3. DATE 18SEP03 TIME PATIENT ARRIVED IN SUITE 1130

4. PATIENT IN ROOM TIME 1130 NUMBER 2/2/3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	SPC [redacted] 91D 1230 - 1315 b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR INT.	MAJ [redacted] 66E 1330 - 1400

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, head on foam doughnut. Bilateral Arms extended out to sides < 90° in CAP, secured to padded armboard c safety straps. Bilateral Lower Extremities prepped into sterile field.

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

COMMENTS: Correct Body Alignment Maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR By Dr. [redacted] + Dr [redacted] ☐ CLIP

COMMENTS: no nicks or cuts noted

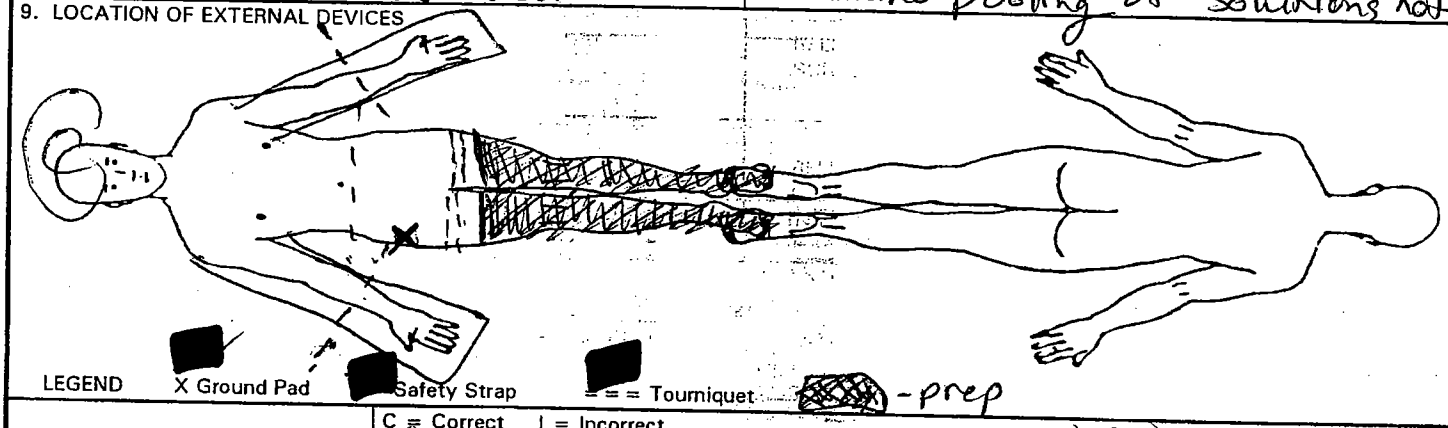
PREP SOLUTION (Specify) Beta/Beta b(6)-2

SITE: RLE BY WHOM: LTC [redacted]

SITE: LLE BY WHOM: CPT [redacted]

COMMENTS: No pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet [redacted] - prep

10. COUNTS

C = Correct I = Incorrect

			Initial Other**	First Closing Count PLE	Final Closing Count
Sponge	☑ Yes	☐ No	C	C	C
Needle Sharp	☑ Yes	☐ No	C	C	C
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

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

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

[redacted] b(6)-4

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

☒ ESU NO: R8B 102395

GROUND PAD: BRAND Valleylab Polyhesive II REI

LOT NO: 68245/2005-02

☐ 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 - 19307

13. PROSTHESIS, IMPLANTS [X] YE — IF YES NAME: ID NUMBER: — URER

Synthes Ex Fix Pins.
294.794 x 4

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] — IF YES, SITE: Flouro via C-arm LLE

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION (Specify)
wet to 0.9% Nacl Kerlex Fluffs) - LLE
Kerlex Roll
ACE wrap
RLE - Kerlex, Fluffs, Lg ABD.
Kerlex Rolls ACE

19. ADDITIONAL INFORMATION
WC-III
Dr [redacted]
Dr [redacted]
Anesthesia - CRNA [redacted] - Gen/Endo
MAS [redacted] relief

Bovie pad site pre-op COI pad site post-op COI Bovie 40/40 Blendl
Tourniquet site RLE pre-op COI post-op COI/LLE pre-op COI post-op COI
TQ time - 19 min

20. OPERATION(S) PERFORMED
Ex Fix Placement C Fasciotomy LLE

21. PATIENT TRANSFERRED TO b(4)-2 ICU2 — TIME — METHOD wheeled litter

22. [redacted] RE CRT/AN

[redacted] 9-1, OCT 87 — MEDCOM - 19308 — USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the ... nt agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPE... G ROOM VIA litter BY Anesthesia	2. PATIENT IDE... D, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 20 Sep 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME 1445 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	Sgt [redacted] (1500-EOC) b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1500-EDC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

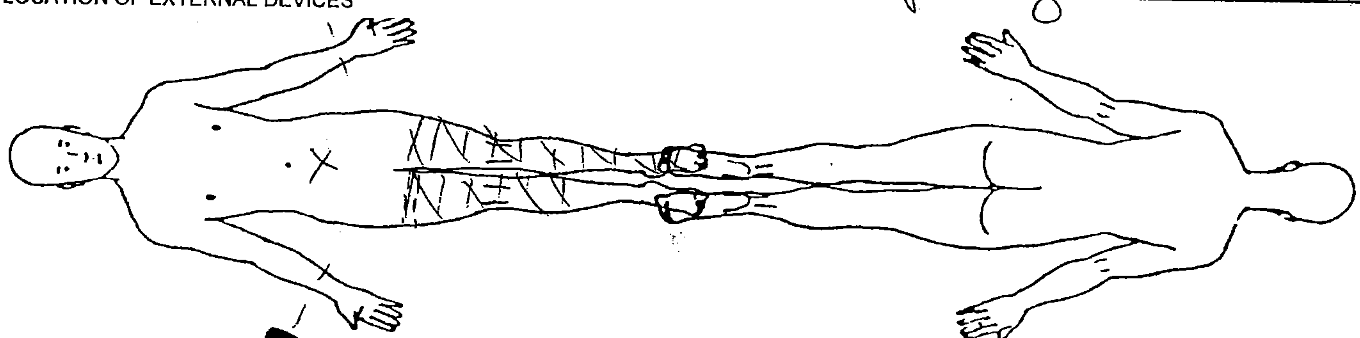
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

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

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* Beta / Beta b(6)-2 SITE: Ⓡ leg to BKA site BY WHOM: [redacted] SITE: Ⓛ leg BY WHOM: [redacted] COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet placed by Dr. [redacted] b(6)-2

C = Correct I = Incorrect

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

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)* #[redacted] b(6)-4 [redacted] b(6)-2 20 Sep 03	12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO ☒ ESU NO: Valleylab Force 40 GROUND PAD: BRAND VL Rem Polyhesive II LOT NO: 68245 2005-02 ☐ ESU NO: GROUND PAD: BRAND LOT NO: ☐ BIPOLAR NO:

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

MEDCOM - 19309

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
none		

PHYSICIAN'S SIGNATURE

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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1in Penrose	2.	3.
SITE	1. (L) lat calf	2.	3.

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

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] (in at 1610) Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op ____ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ✓: post-op ✓
Tourniquet Time: Up 1531 Down 1555

- 5179 on chart, Ø O's noted

20. OPERATION(S) PERFORMED
(R) BKA, stump revision
I+D (L) leg

21. PATIENT TRANSFERRED TO ICU-2 b(6)-2 TIME Col DA7389 METHOD Ter b(6)-2

22. REGISTERED NURSE SIGNATURE [redacted] OTIAN' MEDCOM - 19310 [redacted] CPT/AN

REVERSE OF DA FORM [redacted] USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: stretcher BY: OR staff
2. PATIENT ID VERIFIED BY: [redacted]
3. DATE: 22 Sept 03 TIME PATIENT ARRIVED IN SUITE:
4. PATIENT IN ROOM TIME: 8415 NUMBER: 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 9ID b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 6CE MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

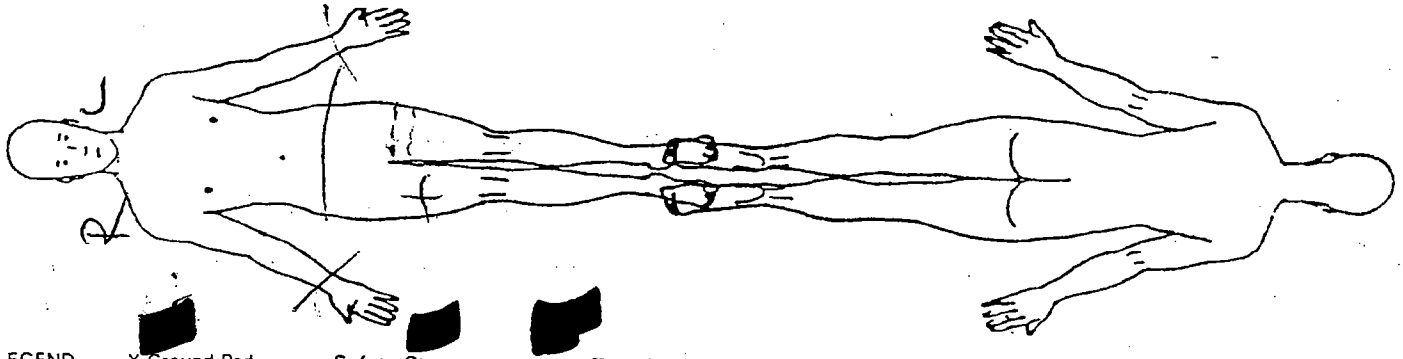
COMMENTS: Pt placed on Padded OR table; arms on padded armboards @ L 90°

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine / Betadine
SITE: (R) LE BY WHOM: [redacted]
SITE: (L) LE
COMMENTS: b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

[redacted]
b(6)-4

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

☑ ESU NO: VL Force 40
GROUND PAD: BRAND VL Reem Poly PT
LOT NO: 70011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19311

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME ① gram stain Ⓡ BKA	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME ② aerobic cx Ⓡ BKA	NAME
CULTURE (C) YES ☑ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix
ace
Abd

19. ADDITIONAL INFORMATION

[redacted] b(6)-2

Foley draining amber urine
Foley d/c'd; tip intact

[illegible]

20. OPERATION(S) PERFORMED

I+D Ⓛ LE Ex Fix I+D Ⓡ BKA

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 0525 METHOD litter

22. [redacted]IGNATURE [redacted] CPT [illegible]

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPE... M — VIA gurney — BY anesthesia

2. PATIENT IL... — RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 30 Sep 03 — TIME PATIENT ARRIVED IN SUITE —

4. PATIENT I... — TIME 1006 b(6)-2 — NUMBER 1-2 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: English Speaker. No translator available.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt supine. Placed on Extable. (L) leg padded c roll on knee holder. Foot held c Steinman pin and Kirschner Traction Bow. (R) BKA on padded foot rest.

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

COMMENTS: (R) arm on padded arm board. (L) arm padded c pelloan.

8. SKIN PREPARATION

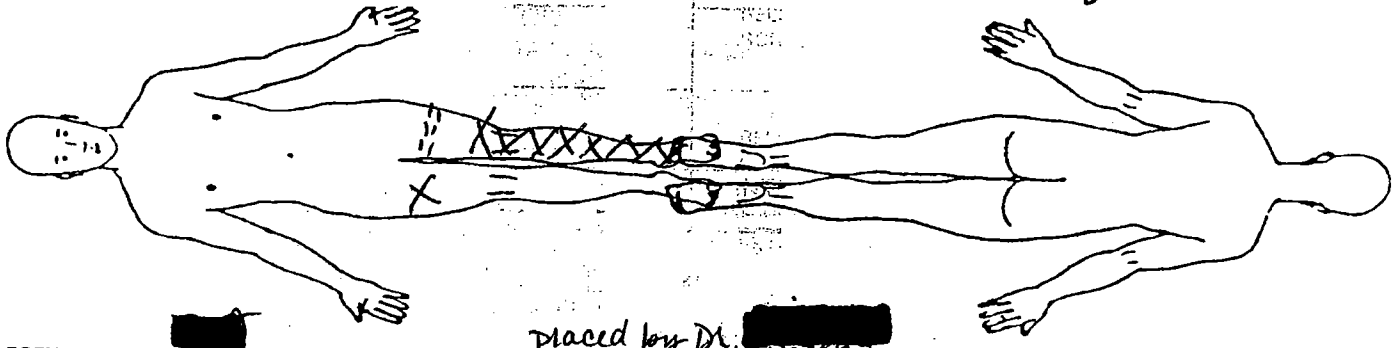
HAIR REMOVAL: ☒ YES ☐ NO — DONE BY: ☒ OR ☐ NURSING UNIT — METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP — DR. Hugate

COMMENTS: no nicks or cuts noted.

PREP SOLUTION (Specify) Beta/Beta — SITE (L) leg. — BY WHOM: CPT [redacted] — SITE: — BY WHOM: b(6)-2

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap = = = Tourniquet placed by Dr. [redacted] XXX-prep.

C = Correct I = Incorrect

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

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

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

EPW # [redacted] b(6)-4

[redacted] b(6)-2

30 Sep 03

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

☒ ESU NO: CUT 30 Valleylab COAG 30 000147

GROUND PAD: BRAND Valleylab E7509

LOT NO: 68244 2005-02

☐ 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 - 19313

13. PROSTHESIS, IMPLANTS ☒ YES — IF YES NAME: ID NUMBER, MANUFACTURER

Synthes 9mm + 10mm IM NAILS
LOAD # 0527203
10 - 315

Synthes IM Instrumen - & Interlocking Screws.
LOAD # 0527202
34, 36, 40

b(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Mineral oil	QS	Intraop	Topical	[redacted]	Dr [redacted]
Bacitracin oint.	QS	Intraop	Topical		Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ — IF YES, SITE: C-ARM (L) Leg

16. LABORATORY SPECIMENS

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

- fluffs
- Kerlix
- webril
- ace wrap
- Splint

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

IM nailing, Removal of EX-Fix (L) leg
(L) TIB/FIB Fx, Skin graft.

21. PATIENT TRANSFERRED TO: PCU3 b(6)-2 — TIME: 1335 — METHOD: gurney

22. REGISTERED [redacted] (OPT/AN)

REVER... DA FORM 5179-1, OCT 87 — MEDCOM - 19314 — USAPA V1.00

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

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

3. DATE 23 Sept 03 TIME PATIENT ARRIVED IN SUITE 2102

4. PATIENT [redacted] b(6)-2 TIME 2102 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

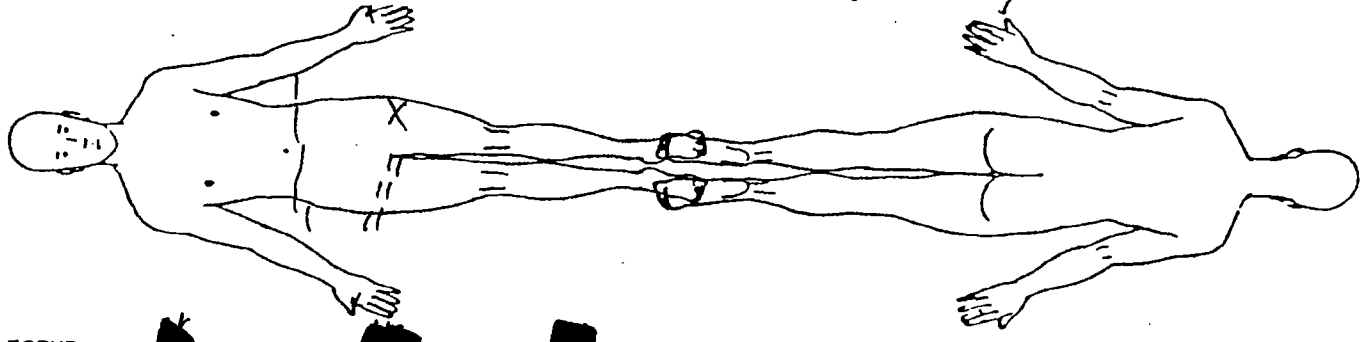
COMMENTS: arms extended on armboards <90° bilaterally b(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta/Beta BY WHOM: maj [redacted]
SITE: Rt stump
SITE: BY WHOM:
COMMENTS: ϕ pooling

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS		C = Correct I = Incorrect Initial: [redacted]		
		Other**	First Closing Count	Final Closing Count
Sponge	☑ Yes ☐ No		C	C
Needle Sharp	☑ Yes ☐ No		C	C
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB [redacted] CIRCULATOR [redacted]

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

[redacted] b(a)-4

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

☒ ESU NO: cut 40/coag 40 Valleylab
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19315

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):

NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

TYPE/SIZE	1. penrose	2.	3.
SITE	1. (L) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
ace wrap
Kerlix
Lg ABD
fluffs

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: b(6)-2 [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 40/40
Tourniquet Site intact pre-op ✓: post-op ✓
Tourniquet Time: Up N/A Down ✓

20. OPERATION(S) PERFORMED

washout and redress (L) V leg; I+D and closure of (R) stump

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 2240 METHOD Litter

22. [redacted] SIGNATURE [redacted] LATAN

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES					
18Sept03	↑ 1u PRBC # W001703002923 / o+ donor					
1620		HR	BP	RR	SaO2	T
	1628	102	115/69	18	96	98.3
	1630	106	118/68	14	97	
	1635	106	126/72	16	96	
	1640	107	102/74	15	100	
	1655	97	115/72	15	97	98.3
	1700	101	117/71	14	98	
	1715	103	114/73	16	97	
	1730	101	123/75	16	99	
	1745	105	124/73	17	98	98.3
	Final	105	124/73	17	98	98.3
	NO difficulties noted during transfusion - CPT [redacted]					

b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (0) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(a)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY | POST- DAY | MONTH-YEAR 19 | DAY | HOUR

PULSE (O) | TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

(P)	92	154/92	142/91	140/88	140/90	138/78	119/66	131/71	132/51	129/69	139/75	140/70
(R)	18	14 98	95	4 106	102		103	84 T	T 98.2		138/63	95
		T 97.8	T 98.4	T 99.7	99.3		99.2	99.8 H	H 84			99.1
		96%	96%	96%	98%			98%	94%			
		RA	RA	RA		93% (RA)	98%			97% RA	96% (RA)	
			97% RA								94% (RA)	96%

HEIGHT: | WEIGHT → 8 lbs 12 oz

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW# [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY | HOUR

PULSE (O) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6)-4

MEDCOM - 19320

ACLU-RDI 1651 p.80

DOD-032894

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (°)

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(e)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19321

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	7 Oct	08 Oct	9 Oct	10 Oct	11 Oct	12 Oct 03	13 Oct 03
19 / HOUR	0700	0[illegible]	0850	0800	0[illegible]		

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 119/55 18; P 107 T 97.7 SpO2 99%; 116/72; 110/60; 99%; 98% RA; 113/69; P 89 T 97.7 SpO2 98%; 112/64; 199%; 18; 122/71; P 74 T 97.5 99%; RA 199%; 19; 116/70; 96/49; P 78 T 97.6 98%; 103/64; 114/62; T 98.1 H 67 99%; 99/59; 76 98.6 98%; 18; 110/80 T 97.7 H 65; 108/68 98% RA

Record special data only when so ordered

~~HEIGHT~~ ~~WEIGHT~~ →

O2
O2 source

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

REGISTER NO.

WARD NO.

#[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19322

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR	DAY
19	HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 18 Sept	TIME 1000	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh	B POS	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs	W634018	OPOS	Comp
APTT		21-34 secs	W825683	"	"
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	DATE: 9-18-03	LAB ID NO.:

b(6)-2

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

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
18/09/03 10:33
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	34	26-84	U/L
ALT	25	10-47	U/L
AMY	15	14-97	U/L
AST	50*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	7.1*	8.0-10.3	MG/DL
CHOL	58*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	149*	73-118	MG/DL
TP	4.8*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
JN		7-22 mg/dl
++		8.0- 0.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+	141	128-145 mmol/l
	5.0	3.3-4.7 mmol/l
	108	98-108 mmol/l
tCO_2	24	18-33 mmol/l

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 5-18-3? **LAB ID NO.:**

b(a)-2 A/H

ID: [redacted]
WB
18-09-03
10:32

				Patient Limits	
WBC	16.0	H	x10^3/uL	4.5	10.5
RBC	3.90	L	x10^6/uL	4.00	6.00
Hgb	7.6	L	g/dL	11.0	18.0
Hct	25.5	L	%	35.0	60.0
MCV	65.4	L	fL	80.0	99.9
MCH	19.6	L	pg	27.0	31.0
MCHC	29.9	L	g/dL	33.0	37.0
Plt	274.		x10^3/uL	150.	450.
LY%	10.5	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB
18-09-03
19:20

				Patient Limits	
WBC	6.7		x10^3/uL	4.5	10.5
RBC	3.41	L	x10^6/uL	4.00	6.00
Hgb	8.2	L	g/dL	11.0	18.0
Hct	25.9	L	%	35.0	60.0
MCV	75.9	L	fL	80.0	99.9
MCH	24.1	L	pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	127.	L	x10^3/uL	150.	450.
LY%	20.0	L	%	20.5	51.1
LY#	1.3		x10^3/uL	1.2	3.4

ID: [redacted]
WB
18-09-03
14:25

				Patient Limits	
WBC	12.5	H	x10^3/uL	4.5	10.5
RBC	3.19	L	x10^6/uL	4.00	6.00
Hgb	7.4	L	g/dL	11.0	18.0
Hct	23.4	L	%	35.0	60.0
MCV	73.5	L	fL	80.0	99.9
MCH	23.2	L	pg	27.0	31.0
MCHC	31.5	L	g/dL	33.0	37.0
Plt	162.	*	x10^3/uL	150.	450.
LY%	9.7	*L	%	20.5	51.1
LY#	1.2	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB
19-09-03
04:08

				Patient Limits	
WBC	5.7		x10^3/uL	4.5	10.5
RBC	3.05	L	x10^6/uL	4.00	6.00
Hgb	7.3	L	g/dL	11.0	18.0
Hct	23.0	L	%	35.0	60.0
MCV	75.5	L	fL	80.0	99.9
MCH	23.9	L	pg	27.0	31.0
MCHC	31.6	L	g/dL	33.0	37.0
Plt	113.	L	x10^3/uL	150.	450.
LY%	12.6	*L	%	20.5	51.1
LY#	0.7	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB
20-09-03
05:04

				Patient Limits	
WBC	8.2		x10^3/uL	4.5	10.5
RBC	3.43	L	x10^6/uL	4.00	6.00
Hgb	8.7	L	g/dL	11.0	18.0
Hct	26.9	L	%	35.0	60.0
MCV	78.5	L	fL	80.0	99.9
MCH	25.4	L	pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	106.	L	x10^3/uL	150.	450.
LY%	17.4	L	%	20.5	51.1
LY#	1.4		x10^3/uL	1.2	3.4

ID: [redacted]
WB
21-09-03
04:24

				Patient Limits	
WBC	7.9		x10^3/uL	4.5	10.5
RBC	2.96	L	x10^6/uL	4.00	6.00
Hgb	7.5	L	g/dL	11.0	18.0
Hct	23.2	L	%	35.0	60.0
MCV	78.5	L	fL	80.0	99.9
MCH	25.4	L	pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	134.	L	x10^3/uL	150.	450.
LY%	14.8	*L	%	20.5	51.1
LY#	1.2	*L	x10^3/uL	1.2	3.4

[redacted] b(2)-2

Microbiology Request Form

Last Name:	Ward:
First Name: [redacted] b(6)-4	Room:
Patient # or SSN: [redacted]	Bed:
	Physician: [redacted]
Collected by: [redacted] b(6)-3	
Date: 22 SEP 03	Source: TISSUE
Time: 0510	Site: R LE BKA
[redacted]	
Received by: [redacted]	Specimen #: [redacted]
Date: 22 SEP 03	
Time: 1200	

Laboratory Results

AEROMONA HYDRO GROUP

Reported	
Date: 24 SEP 03	
Time: 1100	
Tech: IO	
Reviewer: [redacted] b(6)-2	Number of attached sheets:

Microbiology Report

[redacted] b(2)-2

Name:	Specimen:	Status:	**Final**
Patient ID: [redacted] b(6)-4	Source: Wound/Sterile site	Collected:	
Ward/Rm: /	Ward of Iso:	Attd. Phys:	

1 Aeromonas hydrophila group Status: Final

1 Aer hydro group

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	<=4				
ESBL-b Scrn	<=1				
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	<=16	S			
Tetracycline	<=4	S			
Ticar/K Clav (a)	<=16	S			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:	Specimen:	Status:	**Final** b(6)-2
Patient ID: [redacted]	Source: Wound/Sterile site	Collected:	
Ward/Rm: / b(6)-4	Ward of Iso:	Req. Phys: [redacted]	

Printed 9/24/2003 11:14:07 AM

MEDCOM - 19328

Tech: IO

[redacted] b(2)-2

Microbiology Request Form

Last Name: [redacted] b(6)-4
First Name: [redacted]
Patient # or SSN: [redacted]
Collected by: [redacted] b(6)-2
Date: 22 Sep 03
Time: 0510

Ward: ICW-1 6A
Room:
Bed: 6A b(6)-2
Physician: [redacted]

aerobic

Source: Tissue
Site: (R) LE BKA

[redacted]

Received by: [redacted] b(6)-2
Date: 22 Sep 03
Time: 1200

Specimen #: [redacted]

Laboratory Results

Aer hydro group

Reported
Date: 24 Sep 03
Time: 1100
Tech: IO b(6)-2
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 19329

DOD-032903

ACLU-RDI 1651 p.89

Microbiology Report

[redacted] b(2)-2

Name:	Specimen:		Status: **Final**
Patient ID: [redacted] b(6)-4	Source:	Wound/Sterile site	Collected:
Ward/Rm: /	Ward of Iso:		Attd. Phys:

1 Aeromonas hydrophila group Status: Final

1 Aer hydro group

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	<=4				
ESBL-b Scrn	<=1				
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	<=16	S			
Tetracycline	<=4	S			
Ticar/K Clav (a)	<=16	S			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R. b(6)-7

Name:	Specimen:		Status: **Final**
Patient ID: [redacted] b(6)-4	Source:	Wound/Sterile site	Collected:
Ward/Rm:	Ward of Iso:		Req. Phys: [redacted]

Printed 9/24/2003 11:14:07 AM

Tech: IU

b(6)-4

[redacted] OR

Ward/Section:	[redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST MI	DATE 30 Jan 03 TIME 0900	SSN/PEEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	**Microbiology**		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Macroscopic Urinalysis**		
RBC Morph			HCG		Negative			

Spun Hematocrit		42-52%(M) 37-47%(F)	**CSF**			**Blood Bank**
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen		Negative	ABO/Rh

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 01-30-03	LAB ID NO.:

MEDCOM - 19331

MEDICAL RECORD — ANESTHESIA

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

DRUG	Units										
PROPOFOL	(mg)	200									
SUX	(mg)	100									
VECURONIUM	(mg)	5									
FENTANYL	(mcg)	50	100, 50, 50								
MSO4	(mg)		4, 4								
ephedrine	(mg)			10	10	10					
VOLAT. AGENT ISO	% del	1.5	1.5	1.5	1.5	2.0	1.5	1.5	1.5	1.5	1.0 —
	% e.t.										
AIR	L/Min										
N2O	L/Min										
O2	L/Min	3	2	2	2	2	2	2	2	2	2 2 2

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

FLUIDS

LINE site	Warmed		
LR 18g (R)	☐ Warmed	100	800
LR 18g (R)	☐ Warmed	400	800
NS 16g (L)	☐ Warmed	1000	1000

LOSSES — EST BLOOD LOSS: 600; URINE – 200/800

TIME → 1130 • 1200 • 30 • 1300 • 30 • 1400 • 30

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

BODY WEIGHT: 70 (KG) LB

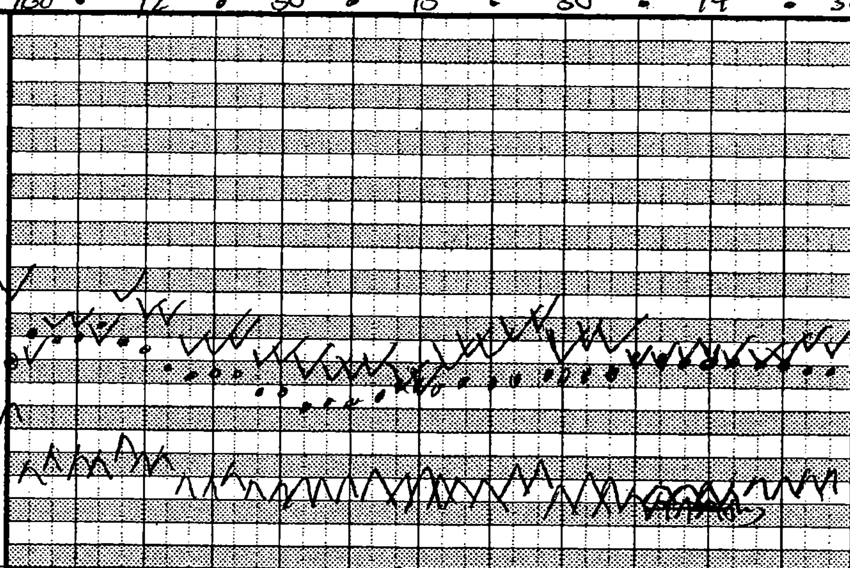
HEMATOCRIT: 7/25

INITIAL DATA: BP – 107/49; HR – 106

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y) TIME – 1110

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



VENTILATION

VT – ml	740	740	740	730	180	370	310	250	280	270	350
f – breaths/min	12	8	8	8	14	18	19	20	19	17	16
Peak inf pres / PEEP	21	19	20	20							
MODE– S(pon), A(ssist), C(on)	S/C	C	C	C	S	SV	SV	SV	SV	SV	SV

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	22	37	38	39	53	48	48	48	49	50	50
BP / oth	FIO2 (Frac or %)	.89	.89	.88	.88	.88	.87	.87	.87	.87	.88	.87
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AXILLARY		34.4 – 36.4			36.3	36.3		36.4 – 36.5		
CO2	N-M Block (T/4)	4/4	0/4	2/4	3/4	4/4	4/4 c sustained tetany					
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — **EVENTS**

Position → Supine — arms < 90° abducted, padded

TOTALS — TOTAL IN: ; TOTAL URINE:

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS– Code drugs with numbers, events with letters

ID PT c BMT. No english speaking.

1144 PRBC # [redacted]

1200 PRBC's # [redacted]

1210 PRBC's [redacted]

TTT = 19 min

RECOVERY AT 1528 — PACU (ICU) 2 (Specify) OTHER

CONDITION: RESP– 12; SpO2– 100%; BP– 117/72; HR– 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1110	1130	1530

	Ready	Begin	End
PROC	1140	1200	1450

PROCEDURES and CPT Codes
(R) BKA (L) Ex-Fix (TIB/FIB Fx)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
PRE-O2 5 min, RSI c cricoid pressure and in-line c-spine stability. DL x1 MAC 2 Grade III view, 8.0 ETT placed, 20 cm @ lips. ⊕ BBS ⊕ ETCO2.

SURGEON [redacted]

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

[redacted]
b(6)-4

[redacted] b(6)-2

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION: OR 2

DATE: 18 SEP 03

PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19332

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

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)		TOTALS	
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " I "=CONSTANT INFUSION		( )			TOTAL EBL: 300
		( )			TOTAL URINE: 500
		( )			
		( )			
		( )			
		( )			
	VOLAT AGENT 150	% del	.6 – .8	FLUIDS – SUMMARY	
		% e.t.		CRYSTALLOID– 3000	
	AIR	L/Min			
	N2O	L/Min		COLLOID–	
	O2	L/Min	2 – 3 ———		
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS				BLOOD– 3 unit	

FLUIDS	LINE site		
	LR 18 (R)	☐ Warmed	
	LR 18 (R)	☐ Warmed	800
	LR 18 (R)	☐ Warmed	500
	NS 18 (L)	☐ Warmed	1000
LOSSES	EST BLOOD LOSS		
	URINE –		

REMARKS–
Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

TIME ➔ 1450 • 1500 • 30 • 1600 • 30 • 1700 • 30

BODY WEIGHT: KG / LB — See PG #1

HEMATOCRIT:

INITIAL DATA: BP– / HR–

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

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

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

VENT				
VT – ml	380	460	560	
f – breaths/min	18	16		
Peak inf pres / PEEP				
MODE– S(pon), A(ssist), C(on)	S	S	S	

MONITORS / ACCESSORIES					
BP/Auto Cuff ✓	ET CO2 (torr)	49	46	46	
BP / oth	FIO2 (Frac or %) ✓	.87	.89	.89	
ART line	SpO2 (%) ✓	100	100	100	
Steth- PC/ES ✓	ECG ✓	SR	SR	SR	
Gas analyzer ✓	TEMP- site	36.6	——		
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT: PACU ICU ___ (Specify) OTHER ___ — See PG #1
CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES			
ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes
(R) BKA (L) Ex-Fix

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — See PG #1

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

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

[redacted]

b(6)-4

SURGEON: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR

DATE: 18SEP03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19333

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

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 **DAYS MOS YRS** **Sex** (✓) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: Ortho
NPO SINCE: _____

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

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:
HB/HCT: 7 / 28
U/A: _____
OTHER: _____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
_____
_____
_____
_____
_____
_____

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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

INFORM[redacted]RSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discu[redacted]al guardian.

b(6)-2 The[redacted]ems to understand and agrees. Questions answered.
Signed[redacted] CRNA Date: 18 SEP 03 Time: 1100 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) _____

#[redacted] b(6)-4

- Ancef
- PCN

28 yo ♂ NKDA

No Δ since Anesthesia pre-op 18 Sept 03

Site / procedure verified

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Fentanyl	(MCG)	250	250
Lidocaine	(MG)	40	
Propofol	(MG)	200	
Sux	(MG)	100	
MSO4	(mg)	3 2 (5)	10
	( )		
VOLAT AGENT 150	% del	1.5–1.5 1.5 1.5 – 1.X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 – 2 – 2 – 2 – 2 – 2 10 – 10	

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

TOTAL EBL: 50
TOTAL URINE: 400

FLUIDS — LINE site (R) [illegible] Warmed — LR — 300 — 200
IVPB PCN — X 3 mg

FLUIDS – SUMMARY
CRYSTALLOID– LR 700
COLLOID– Ø
BLOOD– Ø

LOSSES — EST BLOOD LOSS; URINE – Foley 200

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 25.9

INITIAL DATA: BP – 120/60; HR – 90's

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? (+) TIME – 1445

TIME: 1500 x 30 x (16W) x 30 x 1700

TQ↑ 300mmHg; TQ↑ 2[illegible]min

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES– X-X; PROC–⊙–Ø

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

VENTILATION

VT – ml	710	830	770	700	700	1000
f – breaths/min	10	10	12	5	17	20
Peak Inf pres / PEEP	19	27	25	–	–	–
MODE– S(pon), A(ssist), C(on)	SV CV	CV	CV	A	S	S

MONITORING / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		40	32	33	48	58	55
BP / oth	FiO2 (Frac or %)	.70	.70	.70	.51	.57	.57	.57
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	SR	SR	SR	SR
Gas analyzer CO2	TEMP- site Skin		36	34	36	36	36	36
	N-M Block (T/4)		4/4 ST"					
Warming blkt		Sheet/warm blanket →						
Conv warmer								

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

REMARKS— Code drugs with numbers, events with letters

1445 – Pt to ID – Reg dose chart Ved → IV in place
1500 – On arrive monitors on Induction [redacted]
1515 CPT [redacted] to relieve report received, OG placed stomach [illegible]
1527 Procedure started (R) Leg
1602 Procedure started (L) Leg
1603 Pt awake, extubated P PO SXN ×3, Sdilt To ICU 2 - stable, Report to [redacted]

RECOVERY AT 1650
PACU (ICU) 2 (Specify)
OTHER
CONDITION: Stable
RESP- 20 SpO2- 96 98 R
BP- 145/90 HR- 100

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1445	1500	1653
	Ready	Begin	End
PROC	1520	1527	1635

PROCEDURES and CPT Codes
(B) BKA DeD

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA - #8 Oral ETT #3 Miller → taped 22cm teeth → Eyes taped → OGT LC ⊕ return → Soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — Preoxy → DL ×1 → Gr I view → ETT easily passed atraumatic → teeth OK → BBS/CO2 ×5

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

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

PROCEDURE LOCATION 22
DATE 20 Sept 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 19335

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

NPO ~~x~~ meds @ AGREE w/ PRE . PRE OP

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS / REPEATED DRUGS; SPECIFY UNITS – MG / MCG / ML; "1"=CONSTANT INFUSION)

DRUG	(Unite)	Record	TOTALS
Propofol	(mg)	200	200
Fentanyl	(cc)	2 1 ½ ½ ½	5cc
	( )		
	( )		
	( )		
	( )		
VOLAT AGENT: Forane	% del	2 — 2 — 2 — 1 — X	
	% e.t.		
AIR	L/Min		
N20	L/Min		
O2	L/Min	6 — 2 — 2 — 2 — 6	

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

TOTAL URINE: —

FLUIDS - SUMMARY
CRYSTALLOID– 1000
COLLOID– —
BLOOD– —

FLUIDS
LINE site ☐ Warmed
0.9 NS 20g L FA ☐ Warmed — 1000 → #2 1000
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS; URINE–

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

0410 Id'd, Chart par. NPO ~~x~~ meds. TO OR #2. Mon. pt. O2 Smooth induction, Eyes taped shut.
0520 LMA d/c. TO recovery. Report given. VSS

PHYS STATUS: 1 (2) 3 4 5 E

TIME → 0430 0500

BODY WEIGHT: KG / LB

HEMATOCRIT:

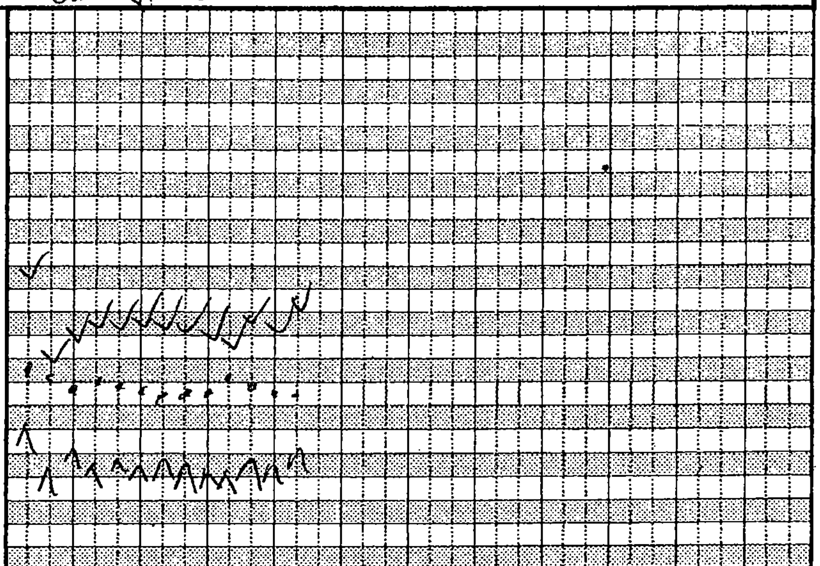
INITIAL DATA: BP – 117/68; HR– 103; T– 100.1

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME– 0410

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

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



VENTS
VT – ml
f – breaths/min
Peak Inf pres / PEEP
MODE– S(pon), A(ssist), C(on): S A A S — S — S — S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	58	60	58	52	45
BP / oth	FIO2 (Frac or %)	.83	.83	.86	.86	.86
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site skin	97	97	97	97	97
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT: (PACU) ICU ____ (Specify); OTHER ____
CONDITION: T- 97.3; RESP- 12; SpO2- 98%; BP- 116/66; HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0410	0415	0530

	Ready	Begin	End
PROC	0426	0447	0522

PROCEDURES and CPT Codes: I&D / washout (L) Leg | R BKA washout

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA w/ LMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
#4.0 LMA ~~x~~ ease (+) ETCO2 (+) BS=BS

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

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

PROCEDURE LOCATION: OR #2
DATE: 2 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19336

ACLU-RDI 1651 p.96

DOD-032910

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)								
MSO4	(mg)	10							
Fent	(mcg)	250							
Phenergan	(mg)	25							
VOLAT AGENT FORANE	% del	2.0	2.0	2.5	2.0	1.0	1.0	1.0	0
	% e.t.								
AIR	L/Min								
N2O	L/Min								
O2	L/Min	3	3	5	3	5	8	8	3 / 8

SINGLE DOSE DRUGS — MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1)(2) … (3)(4)

FLUIDS — LINE site: Rt (R) Hand — NS ———

LOSSES — EST BLOOD LOSS: 60, 40 — URINE —

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP — 126/75; HR — 87

EQUIP CHECK: OK? — (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME — 2105

TIME → 2100 × 2130 × 2200 ∅ 2230 ∅

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

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

VENT

VT — ml	200	380	500	200	430	430	400
f — breaths/min	21	16	12	11	12	16	16
Peak Inf pres / PEEP	/	/	/	/	/	/	/
MODE — S(pon), A(ssist), C(on)	S	S	S	S	S	S	S

MONITORS / ACCESSORIES

BP/Auto Cuff ✓	✓ ET CO2 (torr)	48	58	53	57	57	51	48
BP / oth	✓ FIO2 (Frac or %)	.72	.72	.72	.72	.72	.72	.72
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES ✓	✓ ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer ✓	TEMP- site	Axill						
	✓ N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

TOTALS — TOTAL EBL: 100; TOTAL URINE: 0

FLUIDS - SUMMARY
- CRYSTALLOID — 200 NS
- COLLOID — 0
- BLOOD — 0

REMARKS — *Code drugs with numbers, events with letters*
1. PT ID IN ICW1
2. RM-O2-mon.
3. OOR TO PACU
4. RPT TO SGT [redacted]

RECOVERY AT 2240 — (PACU) ICU ____ (Specify) OTHER ____

CONDITION: RESP — 15; SpO2 — 96; BP — 124/72; HR — 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2048	2102	2248

	Ready	Begin	End
PROC	2106	2125	2238

PROCEDURES and CPT Codes: I+D (R)+(L) LEG

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — GA — MASK

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — #90A inserted — PT maintains SV.

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

[redacted]

b(6)-4

SURGEONS: [redacted] b(6)-2

[redacted] CPT CRNA

PROCEDURE LOCATION: 1

DATE: 24 SEP 03

PAGE 1 OF 1

[redacted] OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 19337

Site/procedure verified

7.9 / 7.5 / 23.2 / 134

21 Sept

VKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	Values
fentanyl	(UG)	250 50/50/50/100
lidocaine	(MG)	40
Propofol	(MG)	150
Succ/Vec	(MG)	100 10
Rocuronium	(UG)	100
MSO4	(mg)	10
VOLAT AGENT 130	% del.	1.5 1.0 1.0 1.0 1.2 1.2 1.2 1.2 1.2 1.0 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2

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

T:S: 2 units

FLUIDS — LINE site 20 G L FA ☐ Warmed — LR —— LR ; ☐ Warmed ; ☐ Warmed ; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE –

TOTALS — TOTAL EBL: — ; TOTAL URINE: —

FLUIDS - SUMMARY
- CRYSTALLOID– LR – 1600
- COLLOID–
- BLOOD– —

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

0930 - Pref. ID
Preop done / chart
Verified. IV in place
1009 – In room –
monitors on –
Induction/intubation
1100 - Lewaquin
8/27 CBC- H/H
6.7 / 8.8 / 27.8 / 387
1250 lunch break - CPT Bentley, CRNA
1245 Ancef [redacted] NRS

Smoker

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 60 (KG) LB

HEMATOCRIT: 23.2

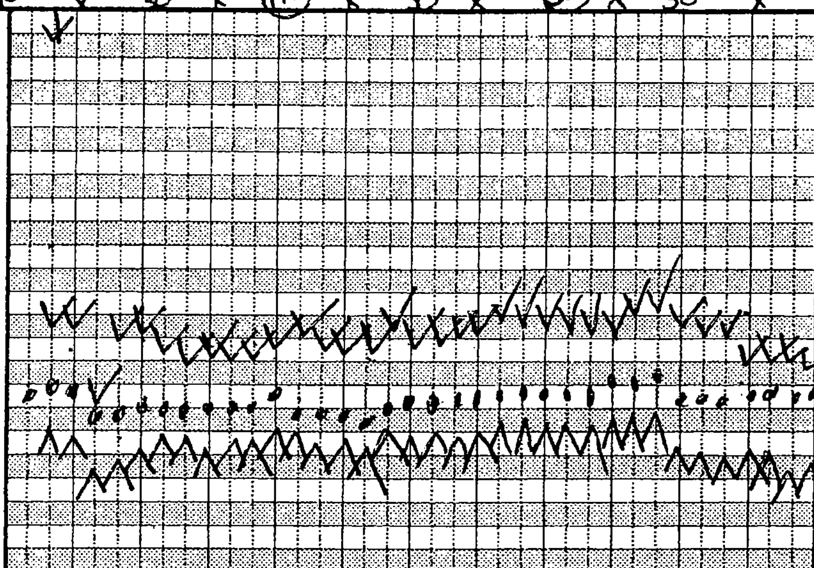
INITIAL DATA: BP – 117/68 ; HR– 80

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? (+) TIME– 0930

TIME ➡ 1000 X 30 X (1100) X 30 X (1200) X 30 X

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



VENTS

VT – ml	620	640	640	640	640	580	660	650	650	700	700
f – breaths/min	9	9	9	9	9	8	8	8	8	8	8
Peak Inf pres / PEEP	26	26	26	26	26	24	26	26	26	26	26
MODE– S(pon), A(ssist), C(on) SV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30	30	30	30	30	34	33	33	33	33	30
BP / oth	FiO2 (Frac or %)	.50	.53	.53	.53	.53	.54	.54	.55	.55	.55	.55
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS	SR	SR	SR
Gas analyzer	TEMP- site	Skin	35	35	35	35	35	35.2			35	
CO2	N-M Block (T/4)	4/4	4/4									

Warming blkt — head wrap / wool blanket / hotline
Conv warmer — Fx table

Mark with letters & symbols, explain under REMARKS — EVENTS; Position → arms < 90° abducted / padded

RECOVERY AT Stable — PACU ICU (Specify); OTHER 98

CONDITION: RESP– 12 ; SpO2– 97% ; BP– 136/82 ; HR– 105

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0930	1009	1340
	Ready	**Begin**	**End**
PROC	1020	1120	1226 / 1310

PROCEDURES and CPT Codes
IM nailing (L) leg + Skin grafts

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA #8 oral ETT taped 22cm teeth. #2 Miller. Eyes taped. OGT to ⊕ return. Soft bite block

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Preoxy – DL x1, gr 1 view. ETT easily passed. BBS+/CO2+. Atraumatic. Teeth OK

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

SURGEONS [redacted] b(6)-2

ANES [redacted]

PROCEDURE LOCATION 2-2

DATE 30 Sept 03

PAGE 1 OF 2

[redacted] b(6)-4

ICW 01

MEDCOM - 19338

[redacted] OP 376 REVISED 1 Jan 99

MEDICAL RECORD — ANESTHESIA

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

DRUG (Unite)	
( )	
( )	
( )	
( )	
( )	
( )	
VOLAT AGENT 150 % del	1.0 X
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	2 — 2 — 8
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	

FLUIDS

LINE site		
1 20 (L)	☐ Warmed	LR —
IA	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE –

TOTALS — TOTAL EBL; TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID– / COLLOID– / BLOOD– see pg 1

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

1339 —
Spont. resp
suctioned →
opened eyes
Extubated
TO PACU VSS

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

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 27.8

INITIAL DATA: BP – 117/68; HR – 80

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? (+)

TIME – 0930

TIME → 1330 x 30 x 1400

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

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

VENT

VT – ml	730	900
f – breaths/min	7	11
Peak Inf pres / PEEP	27	
MODE– S(pon), A(ssist), C(on)	C	S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30	50
BP / oth	FiO2 (Frac or %)	36	158
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	ST	ST
Gas analyzer CO2	TEMP- site SKIN	35	35
	N-M Block (T/4)	4/4	
		5T	
Warming blkt	warm blanket / hot line		
Conv warmer			

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → arm < 90° abducted / padded

RECOVERY AT: PACU ICU ________ (Specify); OTHER ________
CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES			

	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — See pg 1

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

b(6)-2

SURGEON [redacted]
ANESTHESIA [redacted]

PROCEDURE LOCATION 1-2

DATE 30 Sept 03

PAGE 2 OF 2

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

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

MEDCOM - 19339
WAMC OP 376 REVISED 1 Jan 99

ACLU-RDI 1651 p.99

DOD-032913

1a2 Admit

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) one unit ML

REMARKS:

b(6)-4

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 18 Sept 03

DATE AND HOUR REQUIRED 18 Sept 03

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
R. Lt Tib/Fib Fx

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

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

DATE VERIFIED 18 Sept 03

TIME VERIFIED 1000

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

	DONOR	RECIPIENT
ABO	O	B
Rh	pos	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 18 Sep 03

REMARKS: Exp 22 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)
[redacted] b(6)-2

AT (Hour) 1613 ON (Date) 17 Sep 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 (Sig[redacted] b(6)-2
CPT

2nd VERI[redacted]

SGT/CPN

PRE[redacted]

TEMP. 98 PULSE 105 BP 110/65

DATE OF TRANSFUSION 18 Sept 03

TIME STARTED 1622

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1745 18/9/03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.3	106	123/75

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE
CPT[redacted] b(6)-2

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

SEX Male

WARD EMT

[redacted]

b(6)-4

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 - 19340

Medical Record Copy

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)*: one unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 18 Sept 03

DATE AND HOUR REQUIRED: 18 Sept 03

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: Bi LAT. T+b/Fib Fx

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

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

DATE VERIFIED: 18 Sept 03

TIME VERIFIED: 1050

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted] b(6)-2

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO: O	ABO: B
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: 18Sep03

REMARKS: Exp 22 Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: 1806 ON *(Date)*: 18Sep03

IDENTIFICATION

I have [redacted] the Blood Component container label and this form and I find all inform[redacted] the container with the intended recipient matches item by item. Th[redacted]e person named on this Blood Component Transfusion Form and or[redacted]ion tag.

[redacted] b(6)-2 CPT, AM, LPNA

PRE-TRANSFUSION

TEMP. 36.4 | PULSE 81 | BP 96/42

DATE OF TRANSFUSION: 18Sep03

TIME STARTED: 1210

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 UNIT ML

TIME/DATE COMPLETED/INTERRUPTED: 1220 18Sep03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
36.3	82	97/43

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)*

[redacted] Equipment, clots, etc.)

[redacted] VES *(Specify)*

[redacted] RSON NOTING ABOVE b(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last [redacted] rate; hospital or medical facility)

SEX: Male

WARD: 6 MTS

[redacted] b(6)-4

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 - 19341

Medical Record Copy

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)*: one unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 18 Sept 03

DATE AND HOUR REQUIRED: 18 Sept 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Pi Lat + Tib + Fib Rx

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

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

DATE VERIFIED: 18 Sept 03

TIME VERIFIED: 10:00

b(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DONOR	RECIPIENT
ABO O	ABO B
Rh pos	Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

REMARKS: EPR: [redacted] b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)* 1140 (Date) 18 Sep 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]

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

PRE-TRANSFUSION

TEMP. 36.6 | PULSE 85 | BP 117/57

DATE OF TRANSFUSION: 18 Sep 03

TIME STARTED: 1200

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 UNIT ML

TIME/DATE COMPLETED/INTERRUPTED: 1208 18 Sep 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	36.6	82	91/42

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] (Equipment, clots, etc.)

[ ] YES *(Specify)*

PERSON NOTING ABOVE: [redacted] b(6)-2

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

#[redacted] b(6)-4

SEX: M

WARD: OR

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 - 19342

Medical Record Copy

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) ____

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

REQUESTING PHYSICIAN (Print): [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: Bi Lat - Tib/Fib FX

DATE REQUESTED: 18 Sept 03

DATE AND HOUR REQUIRED: 18 Sept 03

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.

VOLUME REQUESTED (If applicable): one unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

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

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED: 18 Sept 03

TIME VERIFIED: 10:00

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

DONOR	RECIPIENT
ABO O	ABO B
Rh POS	Rh POS

REMARKS: C-2[redacted] b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY [redacted] b(6)-2

AT (Hour) 1140 [redacted] ON (Date) 18 Sep 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 reci[redacted]ame person named on this Blood Component Transfusion Form and on th[redacted]ication tag.

[redacted]e) b(6)-2
[redacted]PT, AN, CRNA
[redacted]ignature)
[redacted]

TE[redacted] PULSE 114 BP 87/47 [redacted]

DATE OF TRANSFUSION

TIME STARTED 1144

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 1156 18 Sep 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
36.3	93	108/52

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)

OTH[redacted]ULTIES (Equipment, clots, etc.)
- [ ] YES (Specify)

[redacted]ERSON NOTING ABOVE b(6)-2
[redacted]PT, AN, CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Las[redacted]ade; rank; rate; hospital or medical facility)

SEX M

WARD OR

#[redacted]

b(6)-4

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 - 19343

Medical Record Copy

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)*

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

REQUESTING PHYSICIAN *(Print)* b(6)-2

Dr. [redacted]

DIAGNOSIS OR [redacted] CEDURE

Ⓡ BKA, Ⓛ Tib-Fib Fx ExFix

DATE REQUESTED 19 Sep 03

DATE AND HOUR REQUIRED

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.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* NK

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO. 790

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DONOR: ABO B, Rh neg

RECIPIENT: ABO B, Rh pos

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTE[redacted]

DATE 19 Sept 03

REMARKS: ex 19 Sept 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP[redacted] *(Signature)* b(6)-2

AT *(Hour)* 05[redacted] ON *(Date)* 19 Sept 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] SPC 91W

2nd VERIFIER *(Signature)* b(6)-2 [redacted] LTAN

PRE-TRANSFUSION TEMP. 102.8 PULSE 124 BP 125/71

DATE OF TRANSFUSION 19 Sep 03

TIME STARTED 0535

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 u ML

TIME/DATE COMPLETED/INTERRUPTED 0730 19/9/03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 98.3 PULSE 106 BLOOD PRESSURE 123/70

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

[ ] OTHER *(Specify)*

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

[x] NO [ ] YES *(Specify)* b(6)-2

SIGNATURE OF PERSON NOTING ABOVE

CPT [redacted]

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

SEX M

WARD ICW 2

#[redacted]

b(6)-4

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 - 19344

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)* ____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 Sep 03

DATE AND HOUR REQUIRED:

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

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (R) BKA (L) T:6-R6 FX = EF.

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.

VOLUME REQUESTED *(If applicable)*: ____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NK

SIGNATURE OF VERIFIER:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] b(6)-2

TRANSFUSION NO.

PATIENT NO. 790

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DONOR	RECIPIENT
ABO B	ABO B
Rh neg	Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19Sept03

REMARKS: 25 Sept 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)* 0740 ON *(Date)* 19Sep03

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)*: CPT [redacted] b(6)-2

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

SGT [redacted] Cpn, AMC

PRE-TRANSFUSION

TEMP. 99.4 PULSE 117 BP 118/81

DATE OF TRANSFUSION: 19Sept03

TIME STARTED: 0755

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE	COMPLETED	INTERRUPTED
1 Unit ML	0845	19Sept03		

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)* ____

SIGNATURE OF PERSON NOTING ABOVE: CPT [redacted] b(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

SEX	WARD
M	ICU2

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 - 19345 MEDICAL RECORD COPY

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Portable XR (R) (L) TIBIA AP+LAT [redacted]				ICU-I	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED

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

Flu Isolate

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

RADIOLOGIC REPORT

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

MEDCOM - 19346 [illegible]TATION [illegible]IT

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

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CT head	21 / M	EMT	
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Pri[redacted]		TELEPHONE/PAGE NO.
	SIGNATURE OF [redacted]STOR		DATE REQUESTED 18 Sep 03

b(6)-2

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

s/o head injury

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

RADIOLOGIC REPORT

Normal (mod artifact)

[redacted]

b(2)-2

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

[redacted]

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 19347 JLTATION ORT

1 — MEDICAL RECORD

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

NSN 7540-01-165-7294

591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATIONS (S) REQUESTED

(L) leg
AP Lateral
SIP external Fixation

AGE	SEX	SSN (Sponsor)	WARD/CLINC	REGISTER NO.
	M	XX [redacted]	ICU 2	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)
Dr. [redacted]

TELEPHONE/PAGE NO.

DATE REQUESTED
18 Sep 03

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

b (6)-2

SIP Ankle external Fixation

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*

XX [redacted]

b (6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REPORT
MEDICAL RECORD

MEDCOM - 19348

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

MEDICAL RECORD - DOCTOR'S ORD.

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. SATS >90%		
(3)	Morphine / Meperidine 1-2 mg IV now and 1-2 mg q 3-5 min prn pain for a max dose of 10 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] b(6)-2 30 Sep 03 1337		

PATIENT IDENTIFICATION

[redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis:

Height: Weight: Diet:

Allergies:

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 19349

(b)(2)-2

CLINICAL RECORD - DOCTOR'S (
use of this form, see AR 40-66, the proponent ...cy is OTSG

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

PATIENT IDENTIFICATION

[redacted]

b(4)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 4

DATE OF ORDER: 16 Sept 03 | TIME OF ORDER: 1515 | HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
S/P ③ Tib Ex Fix
④ BKA
Cond stable
Vitals QP & SAT
All ?
Act Bed rest

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 4

DATE OF ORDER | TIME OF ORDER | HOURS

I/O, Foley care
incentive spirometry
~~NPO~~ Regular Diet
IVF LR @ 150
Meds
MSO4 2-10mg QI° PRN pain
Percocet 1-2 tab PO Q6° PRN
Pax
Ancef 1gm IV Q8°
Gentamicin 400mg IV QD
Penicillin 3 million Units IV Q6°
LABS: CBC in AM

PATIENT IDENTIFICATION

[redacted]

b(4)-4

Noted [redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 4

DATE OF ORDER | TIME OF ORDER | HOURS

Tylenol 650mg PO Q6° PRN fever
XR - AP + LAT ④ TIBIA post Ex Fix

b(4)-2

[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO: 4

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

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

MEDCOM - 19350

CLINICAL RECORD - DOCTOR'S ORDER

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

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

Noted

DATE OF ORDER: 18/9/03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Infuse 1u PRBC now. Then do CBC Q1° post transfusion. [redacted] b(6)-2

V.O. Dr [redacted] CPT [redacted]

Noted/done CPT [redacted] 60/18/9/03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19/9/03 TIME OF ORDER: 0800 HOURS

(1) Transfuse 2u PRBC b(6)-2

[redacted]

Noted Spc [redacted] 0800 19/9/03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9-19-03 TIME OF ORDER: 1715 HOURS

NPO p MN b(6)-2

[redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DATE OF ORDER: 20 sep 03 TIME OF ORD[redacted] 1030 HOURS b(6)-2

(1) ↓ IVF to 50 cc/h

noted @ 1100h 20 sep 03

b(6)-2 [redacted]

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

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

MEDCOM - 19351

CLINICAL RECORD - DOC. ... DERS

For use of this form, see AR 40-66, the propo... 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.
ICU #2		4

Before Surgery in EMT

DATE OF ORDER: 18 Sep — TIME OF ORDER: 1000 HOURS

Admit
Cond fair
Diet NPO
IV LR at 150/h
gent 400 mg IV q d dm
Amp 1 gm IV q 6 h
PCN ag 3 million IV q 6 h

[redacted]

b(6)-2

Noted @ 1040 18 SEP 03 [redacted]

b(6)-7

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

Foley to gravity drain
CBC lytes am 19 Sep

[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

MEDCOM - 19352

LINICAL RECORD - DOCTOR'S ORDER

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]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9-21-03 | TIME OF ORDER: 1330 HOURS | LIST TIME ORDER NOTED AND SIGN

- Transfer to ICW - Dr. O
- s/p (R) BKA, left tib/fib Fx
- stable
- Routine vitals
- Bed rest
- Regular Diet, NPO p MN tonight
- Heplock IV

PATIENT IDENTIFICATION

b(6)-4

[redacted]

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

DATE OF ORDER: | TIME OF ORDER: HOURS

b(6)-2

[redacted]

- Levoquin 500mg IV qD
- Percocet 1 po q4° PRN pain
- Demerol 50-75mg IVP q4° PRN breakthrough
- Phenergan 25mg IVPB q6° PRN nausea
- Ambien 10mg po qHS PRN insomnia
- Reinforce Dressings PRN

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

b(6)-2 [redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/22/03 | TIME OF ORDER: 0520 HOURS

b(6)-2

Resume preop orders
meds, activities & regular diet

[redacted]

b(6)-2

2?° / 2215 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: | TIME OF ORDER: HOURS

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

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

MEDCOM - 19353

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(a)-4
[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/24/03 TIME OF ORDER: 2240 HOURS
LIST TIME ORDER NOTED AND SIGN

- Stable
- Routine vitals
- OOB to chair QID
- Daily wet to dry dressing Δ's left leg and BID pin site care
- Regular Diet
- Heplock IV

PATIENT IDENTIFICATION
b(a)-4
[redacted]
[redacted]
b(a)-2

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: TIME OF ORDER: HOURS

- Levoquin 500mg QD
- Percocet ii po q4° prn
- MSO4 2-8mg IVP q1° prn breakthrough
- Phenergan 25mg IVP q6° prn nausea
- Ambien 10mg po qHS prn
-

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

PATIENT IDENTIFICATION
b(a)-4
[redacted]
noted 26 Sept @1430
[redacted]
b(a)-2

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9-26-03 TIME OF ORDER: 1430 HOURS

① X-Ray Ⓛ TIBIA AP & LAT

[redacted]

9/29/03 1750
NPO p MN
b(a)-2
[redacted]

b(a)-2
[redacted]
9/29/03

PATIENT IDENTIFICATION
b(a)-4
[redacted]
[redacted]
noted 9/29/03
[redacted]
b(a)-2

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/29/03 TIME OF ORDER: 1300 HOURS

- Post IM nailing Ⓛ TIBIA, skin grafting
- Routine vitals
- Bed rest
- Incentive Spirometry
- Elevate Ⓛ LE on pillow, do not remove dressing
- Regular Diet

(cont)

chart cont →

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

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

MEDCOM - 19354

ACLU-RDI 1651 p.114

DOD-032928

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
EPW b(6)-4 CIV # [redacted] ICW 1 Nursing Unit: ICW #2 / Room No.: / Bed No.: 4 noted [redacted]	(Cont) 9/29/03 1300 HOURS - Heplock IV - Levoquin 500mg IVPB qd - Ancef 1gm IVPB q8° x 3 doses - Percocet ii PO q4° prn pain - MSO4 2-8mg IVP q 2° prn breakthrough - Phenergan 12.5-25mg IVPB q 6° prn nausea - Ambien 10mg po qHS prn	06 14 22
EPW [redacted] CIV [redacted] b(6)-4 ICW 1 Nursing Unit: ICW #2 / Room No.: / Bed No.: 2140 4 Chart [redacted]	DATE OF ORDER / TIME OF ORDER ____ HOURS - Lovenox 30mg SQ BID b(6)-2 [redacted] 1 OCT 03	2100
EPW b(6)-4 CIV [redacted] ICW 1 2140/2330 Nursing Unit: ICW #2 / Room No.: / Bed No.: 4 30CT03 [redacted]	3OCT03 0900 HOURS ① Leave Ⓡ stump OTA and Ⓛ thigh OTA w/ xeroform gauze in place. VO [redacted] b(6)-2	
EPW b(6)-4 CIV # [redacted] noted [redacted] 7 OCT 1910 [redacted] ICW 1 b(6)-2 Nursing Unit: ICW #2 / Room No.: / Bed No.: 4	7OCT03 1900 HOURS ✓ Daily dressing Δs Ⓛ leg. Apply Bacitracin to skin graft site. ✓ Remove sutures Ⓡ stump ✓ D/C IV levoquin ṗ tonight's dose. - Start oral levoquin 500mg po qD tomorrow. [redacted]	

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

2140 ✓ [redacted] 7OCT @ 2000 b(6)-2

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

MEDCOM - 19355

ACLU-RDI 1651 p.115

DOD-032929

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
b(6)-4 [redacted]	10-13-03	1020 HOURS	
	Radiology AP + LAT (L) TIB/FIB		
	b(6)-2 [redacted]		
NURSING UNIT [redacted] ROOM NO. [redacted] BED [redacted]			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
noted 10/14/03@ 0820 [redacted] b(6)-2	10-14-03	0800 HOURS	
	D/C to EPW Hosp today		
	[redacted] b(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLA[CES] MEDCOM - 19356 [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. SEP 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
18 SEP 03	[redacted]	DIET: NPO Regular	06	[redacted]					
			18						
18 SEP 03	[redacted]	FOLEY TO GRAVITY DRAINAGE	06						
			18						
[redacted]									
18/9	[redacted]	VS Q1° x 8hrs	00						
			18						
18/9	[redacted]	ACT: Bed Rest	00						
			18						
18/9	[redacted]	F/O c Foley	00						
		care	18						
18/9	[redacted]	LABS: CBC in AM	04	/					
18/9	[redacted]	Incentive Spirometer	00						
			18	~					
18 SEPT	[redacted]	NPO @ MIDNIGHT	00	/			/		

ALLERGIES: ☐ YES ☐ NO
UNKNOWN

PRIMARY DIAGNOSIS:
S/P ① EPI B/FIB FX
② BKA

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 19357

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo SEP Yr 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18SEP	[redacted]	ADMIT TO ICU2	18SEP		1600	[redacted]
18SEP	[redacted]	Condition: ~~Faie~~ stable	18SEP		1600	[redacted]
18SEP	[redacted]	CBC [redacted]	19SEP	AM		
18/9	[redacted]	XRAY - AP/Lat (L) TIBIA s/p ex fix	18Sept	~~ADMIT~~	~~1800~~	[redacted]
	-----	upon ICU2 admission	18Sept			
18/9	[redacted]	TRANSFUSE 1u PRBC NOW x1	18/9	1600	1600	[redacted]
	-----	CBC 1° p PRBC infusion	18/9	1900	1900	[redacted]
~~19/9~~	[redacted]	~~Transfer 2u PRBC~~	~~19/9~~			
19/9	[redacted]	CBC 1° p tx 2u PRBC	19/9	1000	1000	[redacted]

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

USAPA V1.00

MEDCOM - 19358

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. 09 Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27 28 29 30 Oct 02
19Sep03	[redacted]	VS-routine	06 18 18- 06	X [redacted]
19Sep03	[redacted]	Bedrest	06 18 18- 06	X [redacted]
		Roll on side frequently		[redacted]
19Sep03	[redacted]	Dsg Δ and pin care QDay	10	X [redacted] DC
19Sep03	[redacted]	NPO p MN	06 18 18- 06	X [redacted] DC
20Sep03	[redacted]	Regular diet	06	[redacted]
			18	
20	[redacted]	Pin care to ex-fix	10	
		BID	22	
20	[redacted]	Silvadene cream and	10	
		dsg Δs to ⓑ feet BID	22	
22	[redacted]	Dry dsg Δ to	10	
		femur. DO NOT	22	
		remove packing.	X	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: ⓡ femur fx / foot burns
S/P I+D ⓡ femur

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

PATIENT IDENTIFICATION:
EPW# [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 - 19359

b(6)-7 A71

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — Mo 09 Yr 2003: SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 Sep 03	[redacted]	admit to ICU #1 - Condition	19 Sep 03	~~2030~~		[redacted]
	-----	Stable	✓	✓	✓	✓
19 Sep 03	[redacted]	To OR Tomorrow	20 Sep 03	—		
20 Sep 03	[redacted]	Resume previous orders	20 Sep 03	—		
22	[redacted]	NPO p MN 23 Sep For SX 24 sept	23	2359	—	
24 Sep 03	[redacted]	Resume previous orders	24 Sep 03	—		
24	[redacted]	Continue BID dsg as to feet and thigh - Do not remove packing	24	—		
24	[redacted]	NPO p MN 25 Sep 03 for OR 26 Sep 03	26 Sep 03	0001	—	
26 Sep 03	[redacted]	Resume previous orders	26 Sep 03	—		

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

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. 9 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 21	22	23	24	25	26	27	28	29	30	1	2	3	4
9/21	[redacted]	Routine vitals	06/18	[redacted]													
			18/06														
9/21		Bedrest	06/18														
			18/06														
9/21		Regular diet	06/18														
			18/06														
9/24		OOB to [redacted] QID	08														
			12														
			16														
			20														
9/24	[redacted]	Daily WTD drsg NS	08				[redacted]										
		(L) leg ~~and~~	X														
9/24	[redacted]	BID [redacted] care	10				[redacted]										
			22														

ALLIERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) Tib/Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

[redacted]

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 — ...ISED. — USAPA V1.00

MEDCOM - 19361

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/21	[redacted]	Transfer to ICU — Dr [redacted]	9/21	1415		
9/21	[redacted]	Stable	9/21	noted		
9/21	[redacted]	NPO p MN tonight	9/21	2400	—	
22 Sep 03	[redacted]	Resume previous orders (meds, activity, reg diet)	22 Sep 03		—	
9/29	[redacted]	NPO p MN	9/29	2401		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
9/21	[redacted]	Reinforce dsg PRN	
-----	-----		
-----	-----		
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-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

b(6)-2 A11

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 13	14	15	16	17	18	19
30SEP	[redacted]	Routine VS	06	[redacted]						
			18							
30SEP	[redacted]	Bedrest	06							
			18							
30SEP	[redacted]	Incentive Spirometer	6							
			18							
30SEP	[redacted]	Reg diet	06							
			18							
7OCT	[redacted]	daily dress Ⓡ leg	10							
		(apply bacitracin	X							
		to graft site)*	X							
30SEP	[redacted]	elevate Ⓛ LE	06							
			18							
7OCT	[redacted]	leave Ⓡ stump OTA	06							
		Ⓛ thigh c xeroform	18							
		gauze in place.								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) tib-fib fx

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO ✓

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(4)-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 - 19363

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/14	[redacted]	D/C. to EPW hosp. today	10/14/03			

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

b(c)-2 #1

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)** | Mo. 10 Yr. 2003

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 COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 30 1 2 3 4 5 6 7 8 9 10 11 12
30Sept	[redacted]	Routine Vitals	06 18	[redacted]
30 Sept	[redacted]	Bed rest	06 18	
30 Sept	[redacted]	Incentive Spirometer	06 18	
30 Sept	[redacted]	Elevate (L) LE on pillow. Do Not Remove Dressing	06 18	
30 Sept	[redacted]	Regular Diet	06 18	
30 Oct	[redacted]	Leave (R) stump OTA and (L) thigh OTA and w/xeroform gauze in place	06 18	
7 Oct	[redacted]	daily drsg Δ's to (L) leg	10	
7 Oct	[redacted]	apply bactroban to skin graft site	10	
7 Oct	[redacted]	elevate (L) LE	06 18	
7 Oct		leave (R) stump OTA and (L) thigh w/xeroform gauze in place	06 18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Post Tm Nailing (L) Tib; Skin graft

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(2)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 10 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/5/03	[redacted]	XR-AP+LAT (L) Tibia	10/6/03	1300		
7oct	[redacted]	Remove sutures to (R) stump	7oct	done		[redacted]
7oct	[redacted]	X Ray AP/LAT (L) TIBIA			do	

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

MEDCOM - 19366

USAPA V1.00

b(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. SEP 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
18Sept	[redacted]	IV; LR @ 150cc/h	06	[redacted]		SW		
			18					
18Sept	[redacted]	Gentamicin 400mg IV	10	[redacted]				
		QD (Am)						
18Sept	[redacted]	IM CEF	06	[redacted]				
			14					
			22					
18Sept	[redacted]	PCN 3million IVPB	06	[redacted]				
		Q6hrs	12					
			18					
			24					
20 Sep 03	[redacted]	↓ IVF (LR) TO 50cc/h	06					
			18					

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS: SIP (R) BKA (L) TT FIB FX c EXFIX

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 - 19367

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18/9	[redacted]	Transfuse 1u PRBC now x1	18/9	[redacted]	1620	[redacted]
19/9	[redacted]	Transfuse 2 u PRBC	19/9	[redacted]	0845	[redacted]

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
18/9	[redacted]	MSO4 2-10mg IVP	19/9 0940	19/9 0940	19/9 1500											
-----	-----	Q1° PRN PN	5mg [redacted]	3mg	[illegible]											
18/9	[redacted]	Percocet i - ii tabs	18Sep 2010	[illegible]	~~19/8 0940~~	19/8 0940	19/8 1500	19/9 2300	20Sep 1250	21Sep 2100	21Sep 2350	22Sep 1115				
-----	-----	PO Q6 hr PRN PN	ii [illegible]	ii [illegible]	[illegible]	2 tabs [redacted]	2 tabs	ii	2 tabs	ii PO	ii PO	ii				
18 Sep	[redacted]	Tylenol 650mg PO q6° prn	21 Sep ii													
-----	-----	FEVER	1050 (Li)													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

MEDCOM - 19368

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. 09 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE DISPENSED 19 20 21 22 23 24 25 26 27 28 29 30 1 2
AS 8Ø3	[redacted]	IV: LR @ 125cc/hr	06 18	X [redacted]
		HL when td. po well	18 06	[redacted]
20 SEP Ø3	[redacted]	Ancef 1gm IVPB q	08	/ [redacted]
		8°	16	/ [redacted] EDC d 24 SEP Ø3
		C	24	/ [redacted]
20	[redacted]	Gentamycin 400mg	20	/ [redacted]
		IVPB q day		
24 SEP Ø3	[redacted]	Ciprofloxacin 400mg	10	/ [redacted]
		IVPB q 12°	22	/ [redacted]

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
(R) femur fx, foot burns
s/p (R) femur

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

PATIENT IDENTIFICATION:
EPW# [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 MEDCOM - 19369 D UNTIL EXHAUSTED. USAPA V1.00

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
19 Sep03	[redacted]	Tylenol 650mg PO Q4 hrs PRN	D/T/I	23Sep 1335 II [illegible]
19 Sep03	[redacted]	MSO4 2-8mg IVP Q 2-4 hrs PRN	D/T/I	20Sep03 0110 5mg [redacted]; 20Sep03 0545 5mg [redacted]; 21Sep03 0045 4mg; 22Sep 1520 4mg; 22Sep 2315 4mg; 23Sep 0140 5mg; 24Sep 0130 5mg; 24Sep 1024 5mg; 24Sep 1650 5mg [redacted]
19 Sep03	[redacted]	Phenergan 25mg IV or PO Q6 hrs prn	D/T/I	20Sep03 0110 25mg IV [redacted]
20Sep03	[redacted]	Percocet 1-2 po q4-6° prn	D/T, D/I	20Sep 1730 [illegible]; 21Sep 0030 II; 21Sep 1730 II; 22Sep 0500 2; 22Sep II; 22Sep 2315 II; 23Sep 0555 II; 23Sep 1210 II; 23Sep 1805 II; 23Sep 2355 II; 24Sep 1825 [illegible]; 25Sep 0030 [illegible]; 25Sep 1400 II; 25 SEP 1930 2 [redacted]
19Sep	[redacted]	MSO4 2-8mg IVP q2-4° prn	D/T, D/I	24Sep 2030 5mg; 26Sep 1400 5mg; 2 OCT 1400 5mg; [illegible] [redacted]
20Sep	[redacted]	Percocet 1-2 po q 4-6°	D/T, D/I	25Sep 2330 2; 26Sep 1130 II; 27Sep 0300 II; 27Sep 1130 II; 27Sep 1600 II; 28Sep 2020 II; 29Sep 0115 II; 29Sep 1200 II; 29Sep 1915 II; 29Sep 0315 II; 30Sep 0940 II; 30Sep 1620 [illegible]; 30 2040 2 [redacted]
30Sep	[redacted]	Percocet 1-2 PO Q4-6	D/T, D/I	1 Oct 0200 [redacted]

USAPA V1.00

MEDCOM - 19370

ACLU-RDI 1651 p.130

DOD-032944

CLINICAL RECORD	TH...PEUTIC DOCUMENTATION CARE PL... (...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 [redacted]	HR	DATE DISPENSED		
		~~ERROR~~		~~1~~	~~2~~	~~3~~
		~~Percocet 1-2 PO q4-6°~~	D/	~~10 OCT 1832~~	~~10 OCT 2330~~	
		~~PRN~~	D/	~~"~~	~~"~~	
			[redacted]			

5/ω-2
All

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 19371

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ *Yr.* _____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
20 Sep	[redacted]	Percocet 1-2 PO Q4-6 PRN	D/T/I	10CT03 1832	10CT03 2330	11	2 Oct 2030									
		b(6)-2 A11														

USAPA V1.00

CLINICAL RECORD

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

Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27 28 29 30 1 2 3 4
9/21	[redacted]	Heplock N	06	[redacted]
			18	
			18	
9/21	[redacted]	Levaquin 500mg IV	10	1
		q D		1
		b(6)-2 All		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: R DKA, L Tib/Fib Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

0 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

MEDCOM - 19373

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

ACLU-RDI 1651 p.133

DOD-032947

Verify by Initialing	THERAPY DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Sep Yr. 03

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

b(6)-2 All

Order/ Exp Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
9/21 Exp 9/24	[redacted]	PERCOCET ii po ē 4° prn pain	Date: 21Sep, 21Sep, 22Sep, 22Sep, 22Sep, 22Sep, 22Sep, 22Sep, 23, 23Sep, 24Sep, 24Sep, 25Sep, 9/25 Time: 1500, 1914, 0300, 0855, 1535, 1935, 0020, 0820, 808, 1905, 0544, 1347, 0400, 0800 Dose: ii, 2, 2, ii, ii, ii po, ii, ii, 1440, 2, 2, 2, 2, ii (two) Init: [redacted] I/E: E
9/21 Exp 9/24	[redacted]	Demerol ~~50-70~~ 50 - 75mg IVP ē 4° prn breakthrough	Date: 24Sep, 23Sep Time: 0600, 2030 Dose: 75, 75 Init: [redacted] I/E D/C'd 24Sep [redacted]
9/21	[redacted]	Phenergan 25mg IVP ē 6° prn nausea	24Sep [redacted]
9/21 Exp 9/24	[redacted]	Ambien 10mg po ē HS prn insomnia	D/T D/I X
24	[redacted]	MS04 2-8mg IVP Q 1° prn breakthrough pain	D/T: 9/25 0430, [redacted] 1100, 1400 D/I: 6mg 7Δ, 4mg, 5mg [redacted]

USAPA V1.00

b(6)-2 All

CLINICAL RECORD

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

Mo. 10 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20
30SEP	[redacted]	Heplock IV	06	[redacted]							
	-----		18	[redacted]							
	-----	Lovenox 30mg SQ	10	[redacted]							
30SEP	[redacted]	BID	22	[redacted]							
7OCT	[redacted]	Levaquin 500mg	10	[redacted]							
	-----	PO Q day.	X								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) TIB-FIB FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

b(6)-4

epw # [redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
30SEP03	[redacted]	Percocet II PO	D/I	2050 9 tabs	2115 11 tabs	1900 12 tabs	2015 13 tabs										
		Q4° PRN PAIN	D/I	II	II	2	II	[redacted]									
30Sep	[redacted]	MSO4 2-8mg IVP Q2° pm breakthrough pain	D/I														
			D/I														
30Sep	[redacted]	Phenergan 12.5-25mg IV q6° pm nausea	D/I														
			D/I														
30Sep	[redacted]	Ambien 10mg PO QHS PRN	D/I														
			D/I														

[redacted]

*U.S. GPO: 1998-454-110/95218

MEDCOM - 19376

b(6)-4

28 F/c
40.

H/H

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: ______
Time In: ______
Allergies: ______
Pre-op V/S: ______
Procedures: ______

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3L   Colloid 3U PRBC 1000
OR Output: UOP 500   EBL 300
Meds/Times: 20mg MSO4
80mcg Narcan

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1530	1535	1540	1600	1615	1630	1645
SaO2	100	100	97	97	91	96	100
FIO2	RA	RA	RA	RA	RA	RA	RA
Methods							
BP	118/64	113/70	133/66	111/67	110/68	115/69	118/73
RR	14	15	15	15	13	15	16
T	98			98			

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

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	PRBC	1U	[illegible]	[illegible]	1unit

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity: (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway: (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	1
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, ˇ = Cuff BP, = Pulse

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICW2

DATE: 18 9 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78   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	LLE	elevated	+	+	<3sec	W	B
15'							
30'							
45'							
60'							
90'							
D/C	LLE	elevated	+	+	<3sec	W	B

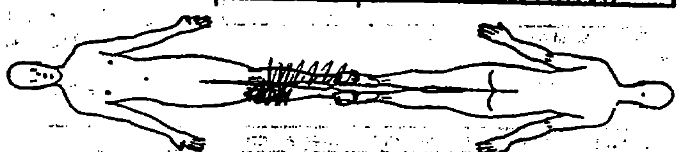
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	RLE / LLE	Ace / fixator	minimal
30'			
60'			
D/C	RLE / LLE	ace / fixator	minimal



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1600	Foley	clear	300

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt awakens to stimuli c̄ RR in the teens. C-collar on - C-spine cleared - ∅ orders for precautions for log rolls - MDs visited pt x2. X-ray of LLE not done. (B) legs elevated. IV's intact. 1u PRBC infused w/o complications. VSS - cont to monitor

CPT [redacted] b(6)-2

Discharge Criteria:
Date: 18/9/03 Time: 1845 PARS: 9
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10):
Intake: — Output: —
Additional Data: —
Transferred To: [redacted] ICU 2
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] ICU 2 b(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDCOM - 19378

ACLU-RDI 1651 p.138

DOD-032952

INITIAL SHIFT ASSESSM

b(6)-2

		Time: 10 Inital [redacted]	Time: 193 Initals: [redacted]
NEURO	Pupils c-collar	3mm Sluggish	3mm
	Sensorium ↑ 2° ESPINE	Awakens to stimuli	awake to stimuli / alert to
	LOC / GCS	ASA 9, Sleeping s/p surgery / anesthia (20mg MS04 80mg Narcan)	place-self
CARDIAC	Cardiac Rhythm	HR 102's ST c RRR ∅ ectopy	HR 100-110 RRR
	PRI: / QRS:		
	Pulse Strength	UE 2+ Bilat / LLE DP 2+ / (R) Popliteal	⊕ pulse to (B) UE, bounding to
	Cap Refil / JVD	⊕ pulse.	(L) LE (R) BKA, ⊕ femoral pulse
	Edema	NO edema Noted @ this time.	⊖ edema noted
	Chest Pain	NONe	⊖
RESP	Respiratory Pattern	EQUAL BBS c soft Rhonchi to	CTA, RR + ⊖
	Breath Sounds	UR chest wall. Otherwise CTA	⊕ cough, non-productive,
	Secretions	∅ secretion - SPO2 98-100% RA	⊖ secretions
	Cough	∅ cough ⊕ gag	
SKIN	Color	Normal for race (IRAQI)	Normal for race
	Integrity	RLE c Ace wrap (BKA s/p) Both elevated	(R) LE - BKA - ace wrap
	Backside	LLE c EX FIX + Ace wrap	(L) LE - ex fix - ace wrap
IV	Access Devices	1Leg (L) AC - Patent / intact	(L) AC 18G - patent + intact / HL
	Location	(R) Bicept 18g Patent / HL	(R) AC[1] 18G - patent - LR @ 150cc/HR
	Condition	(R) AC 1Leg Patent	(R) AC[2] 16G - patent + intact / HL
GI	Abdomen	Flat SOFT NTND c BSx4	soft, non-distended
	Bowel Sounds	∅ BM	⊖ BM
	Stoma/Ostomy	Reg diet when awakens.	tolerated Reg diet well.
GU	Device	#16 Foley Placed 18/9/03	16 F Foley to gravity
	Color / Clarity	CYU. 40 - 300cc @ 1600.	Clear yellow urine

PREPARED BY (Signature & Title) b(6)-2

CPT [redacted]

DEPARTMENT/SERVICE/CLINIC

ICU #1 [redacted]

DATE 18/9/03

(b)(2)-2

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

NAME: # [redacted] RANK: AGE:

UNIT: 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 - 19379

PT'S NAME:

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

DATE: 18 Sep03

ICU2

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP											118/73	122/72	122/74	121/73	119/81	121/73	12?/74	129/75	124/77	12?/74	123/76	123/64	125/71	12?/72
TEMP										983	983	983	984	979		982		985		983		100	999	1025
PULSE											100	102	104	101	115	110	107	109	104	105	118	121	124	134
RESP											15	16	17	17	20	25	18	17	15	19	22	24	23	23
SP02											99	98	98	98	98	98	97	96	98	96	95	94	94	95
FIO2											RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
MIVF											150	150	150	150	150	150	150	150	150	150	150	150	150	15
IVPB										1u PRBC			50/100			50		50/100						~~220~~ 15
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE										300	10	24	55	500	80	70	100	180	70	[illegible]	100	340	220	
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

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b(6)-2

INITIAL SHIFT ASSESSM[ENT]

		Time: Initals:	Time: 1900 Initals: [redacted]
NEURO	Pupils		2mm BRISK EQUAL & ROUND
	Sensorium		MAE c̄ DIFFICULTY BILATERAL LLE 2° [illegible]
	LOC / GCS		ALERT AND APPROPRIATE; FOLLOWS SIMPLE COMMANDS
CARDIAC	Cardiac Rhythm		ST c̄ HR 100S Ø ECTOPY
	PRI: / QRS:		
	Pulse Strength		3 PULSES BUE 2+ RLE FEMORAL
	Cap Refil / JVD		2+ LLE DP. CAP REFILL BRISK
	Edema		ØJVD 2+ NON PITTING LLE @
	Chest Pain		FOOT
RESP	Respiratory Pattern		
	Breath Sounds		BBS CTA c̄ EQUAL UNLABORED BREATHING RR 20S.
	Secretions		Ø SECRETIONS
	Cough		Ø COUGH
			SPO2 100% IN 2L NC
SKIN	Color		NORMAL FOR RACE
	Integrity		INTACT s̄ EVIDENCE OF
	Backside		SKIN BREAKDOWN
IV	Access Devices		
	Location		14G RAC MEDIAL; 18G RAC LATERAL
	Condition		16G LAC PATENT AND INTACT.
			Ø S/S OF INFECTION.
GI	Abdomen		
	Bowel Sounds		FLAT SOFT NT ND c̄ ⊕BS
	Stoma/Ostomy		⊕BS x4
			Ø
GU	Device		
	Color / Clarity		FC c̄ YELLOW URINE [illegible]cc/HR
			CLEAR Ø SEDIMENT [redacted]

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted] (b)(2)-2

DATE: 19 SEPT 03

[redacted] (For typed or written entries give: Name – last, first, [redacted] hospital or medical facility)

NAME [redacted] RANK: AGE:

UNIT: 1C42 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 - 19381

PT'S NAME: [redacted] D(4)-4 ID#: DATE: 19 SEPT 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	122/60	121/75	122/75	131/74	135/74		140/72	137/78		134/79	104/65	133/90	123/73	129/78	135/80	146/60	135/76	131/70	124/61	108/70	117/60	124/69	130/62	118/66
BP NIBP															109/94		100/5		99/2					
TEMP	101.3	99.4	100.4			101.4			101.3		101.4		101.7											
PULSE	120	106	103	100	100	100	123	104	99	114	118	106	104	105	120	112	106	102	90	94	92	92	97	129
RESP	22	19	19	19	19	18	21	19	21	23	21	19	19	21	16	21	21	23	16	17	17	18	19	20
SP02	94	100%	100	100	100	99	100	100	99	100	97	94	100	100	100	98	99	99	99	98	97	96	96	96
FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA	RA	RA	RA	RA
	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	2LC	NC	NC	RA	RA	RA	RA	RA	RA	RA
INPUT																								
IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	15
IVPB	1u PB	1u		100			50			IVPB 50	50					50								
										IVPB 100	100					100								
PO	✓	200		300			300																	
NGT																								
O.R. IN																								
SUB TOTAL	500	400	150	550	150	150	500	150	150	150	350	150	150	150	150	300	150	150	150	150	150	150	150	15
TOTAL		1200		1900	2050	2200	2700	2850	3000	3150	3500	3650	3800	3950	4050	4350	4500	4650	4800	4950	5100	5250	5400	55
OUTPUT																								
URINE	150	110	100	300	300	200	200	200	200	200	200	200	200	190	200	180	200	200	280	200	230	200	200	250
NGT	✓																							
STOOL	✓																							
O.R. OUT		110	100	300	300	200	200	200	200	200	200	200	200	190	200	180	200	200	280	200	230	200	200	250
SUBTOTAL	150	260	360	660	960	1160	1360	1560	1760	1960	2160	2360	2560	2750	2950	3130	3330	3530	3810	4010	4240	4440	4640	489
TOTAL																								
BALANCE																								+660

MEDCOM - 19382

DOD-032956

ACLU-RDI 1651 p.142

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

		Time: 0645 Inital[redacted]	Time: 1800 Initals: [redacted]
NEURO	Pupils	2mm Ⓑ, Brisk PERRLA	3mm
	Sensorium	- Movement all extremities x Ⓑ LE (Ext Fix)	movement x4 extremities
	LOC / GCS	Ⓟ movement toes Ⓓ LE. Alert/responds to all commands/gestures appropriately	Alert / responds appropriately to commands / gestures
CARDIAC	Cardiac Rhythm	ST @ 98 bpm	ST @ 103
	PRI / QRS:	S_1S_2 ~ Ⓝ	RRR
	Pulse Strength	3+ Ⓑ UE ; 2+ Ⓛ LE ~ doppler ; 2+ Ⓟ LE FEMORAL	3+ Ⓑ UE, 2+ Ⓛ LE, 3+ Ⓡ LE FEM
	Cap Refil / JVD	Brisk < 3sec x 3 extremities ; Ø JVD	<3 sec x3, Ø JVD
	Edema	2+ pitting edema Ⓛ Foot	2+ pitting edema to Ⓛ Foot
	Chest Pain	Ø	Ⓝ
RESP	Respiratory Pattern	Equal rise/fall of chest. RR 16-20	RRR @ 18-24
	Breath Sounds	CTA all lobes ; SaO_2 96% ~ 2L O_2 NC	CTA to all lobes
	Secretions	Absent	Ⓝ secretions
	Cough	absent	Ⓝ cough
		Ø difficulty breathing / Ø SOB	SaO_2 95-97% on RA
SKIN	Color	Normal for nationality	Normal for race
	Integrity	intact throughout. Copious serosanguinous foul	Ⓛ LE, Ex Fix, Ace wrap, CDI
	Backside	smelling discharge Ⓑ LE's Ⓛ > Ⓡ ; Backside unremarkable	Ⓡ BKA, Ace wrap, scant amount of serro-sanguinous DRNG
IV	Access Devices	# 18ga Ⓟ Medial AC patent / intact	18 G Ⓡ Bicep ; 50 cc LR / HR
	Location	# 18ga Ⓟ AC lateral patent / intact	16 G Ⓛ AC ; patent / intact
	Condition	# 16ga Ⓛ AC patent / intact	14 G Ⓡ AC ; patent / intact
		LR @ 150cc/h Ⓟ AC	
GI	Abdomen	Soft, flat, non-distended, non-tender	soft, non-distended, non-tender
	Bowel Sounds	hypoactive all quads	hypoactive x4 quads.
	Stoma/Ostomy	absent	Ⓝ, Ø N/V
		Ø nausea / Ø vomiting	
GU	Device	Foley cath patent / intact [16 fr]	16 FR Foley cath to gravity
	Color / Clarity	Yellow clear ~ U/O ~ 100-150cc/h	clear, yellow

[redacted] (Name & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

[redacted] RT/AT (b)(6)-2 | ICU #1, [redacted] (b)(6)-2 | 20 Sep 03

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

NAME: #[redacted] RANK: AGE:

UNIT: GENDER: ♂

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

S/P EX FIX LLE
BKA LLE

PT'S NAME: #[redacted]

DATE 20 SEP 03

TO OR

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
INV																								
BP	125/68	122/71	110/69	118/68	125/71	119/67	119/73	112/53				137/63	140/59	137/78	115/60	120/57	114/63	124/65	117/62	112/(54)	129/70	133/71	111/58	129/63
P	98 av		99 av		100 av	100 av	100 av	98 (t)				94	100	100	101	100	99	98	99		100	99	100	99
PULSE	104	100	101	104	99	98	94	86				86	96	96	108	88	89	89	88	89	87	97	89	90
RESP	22	21	23	16	21	22	22	14				14	18	20	18	13	16	16	16	23	26	20	16	19
SP02	96%	96%	96%	98%	96%	96%	97%	99%		95		97	95	96	96	96	95	95	95	95	95	96	95	94
FIO2	21	Ø	—	—	—	—	—					—	—	—	—	—	—	—	—	—	—	—	—	—
MODE	NC	Ø	—	—	—	—	—					RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
IV	150	150	150	150	50	50	50	50				50	50	50	50	50	50	50	50	50	50	50	50	50
IVPB	150					100	100					100				50		100						100
PO						30																		
NGT																								
O.R. IN																								
UB TOTAL	300	150	150	150	50	180	150	50				1350	1400	1450	1500	1600	1650	1800	1850	1100	1150	1200	1250	1400
TOTAL	300	450	600	750	800	980	1150	(200)																
OUTPUT																								
URINE	400	475		200		275						40	260	190	180	460	40	380	20		190	380	2.1.0	40
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL	400	475		200		275						1750	1650	1840	2020	2480	2520	2960	2970		3110	3490	3730	3770
TOTAL	400	875		1075		1350																		
BALANCE																								

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

Date: 20-SEP-03 Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1655
Allergies: ______ OR Intake: Crystalloid 700 Colloid ______
Pre-op V/S: ______ OR Output: UOP 400 EBL 50
Procedures: [illegible] (R) BKA Meds/Times: 250 Fent 10 [illegible]
closed (R) [illegible]

Pre Op Meds ______ History ______

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

Airway: Nasal, Oral, ETT, Trach, Other

Time	1655	1700	1705	1720	1735	1750
SaO2	94		92		97	98
FIO2	RA		RA	RA	RA	RA
Methods						
RR	27		14	18	20	15
T	97					98
Time	1655					
Pain (0-10)	0					
LOS						

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1730	LR	500cc	(R) Arm		50 cc/hr

X-rays: ______ Labs: ______

Post-Anesthesia Recovery score

Criteria	ADM	30"	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	10

Codes

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

V/S: X = A-line BP, ˅ = Cuff BP, • = Pulse

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

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

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

(Continue on reverse)

PREPARED BY [redacted] b(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU 2 | DATE

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

[redacted] b(6)-4

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

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

MEDICATIONS

Allergies: NKDA

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

NURSING NOTES

– Received PT from O.R. VSS, [illegible] PT SAT 100% Non-Rebreather. Breath sounds clear B/laterally. ⊖ Respiratory distress. BS x4, non tender or abdominal distension noted. PT is able to move ⊕ arm to upper extremity. Ⓛ Leg ext-fix C/D/I c̄ ⊖ Drainage noted. Ⓡ Leg stump C/D/I c̄ ⊖ s/s of drainage or s/s of infection. Cap ref < 3 sec ↑ extremity. PT has L/R TICO w/ Ⓡ antecubital running well c̄ ⊖ s/s of infiltration or infection. Will cont to monitor PT for Δ's. [redacted]

1740 – PT is able to move Ⓛ ext fix b(6)-2 PT has ⊕ pedal pulse & sensation. PT is able to move toes. Will cont to monitor for Δ's. [redacted]

1750 – PT is Amenable to verbal stimuli. PT is currently SATing @ 98% on R/A. PT has voided 130cc clear color urine. Will cont to monitor. [redacted]

b(6)-2

NEUROVASCULAR

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

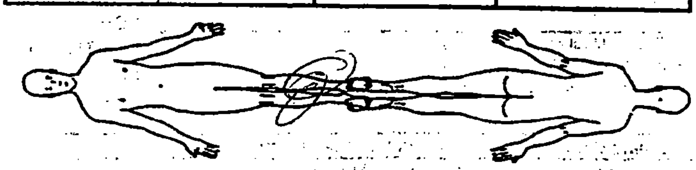
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

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?

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

WAMC OP 173-E

REPORT TITLE
INTENSIVE CARE NURSING [illegible] HEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0630hr Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	3mm • PEPRLA	
	Sensorium	— movement of (B) UE ŝ limitations; moves toes	
	LOC / GCS	(L) LE. Resting comfortably, but responds to gesturing/	
		verbal commands c̄ translation appropriately.	
CARDIAC	Cardiac Rhythm	ST @ 92bpm	
	PRI: / QRS:	$S_1 S_2$ ŝ (m) asymptomatic	
	Pulse Strength	3+ (B) UE, 2-3+ palpable (L) LE, 3+ (R) LE femoral	
	Cap Refil / JVD	< 3 secs x 3 extremities; Ø JVD	
	Edema	2+ pitting (L) LE	
	Chest Pain	absent	
RESP	Respiratory Pattern	RRR	
	Breath Sounds	CTA all lobes	
	Secretions	absent	
	Cough	absent	
		I.S. q̄ 2hr (Ø SOB / Ø difficulty breathing)	
SKIN	Color	normal for nationality	
	Integrity	intact > Ø skin breakdown	
	Backside	intact > Ø skin breakdown	
		(R) BKA ~~[illegible]~~ (dry, intact) (L) leg ace wrap, C, D, I	
IV	Access Devices	#16ga (R) medial AC patent / intact	
	Location	#18ga (R) lateral AC patent / intact	
	Condition	#16ga (L) AC patent / intact	
		LR @ 50cc/hr (R) AC	
GI	Abdomen	soft, flat, non-distended / non-tender	
	Bowel Sounds	hypo → hyperactive all quads	
	Stoma/Ostomy	N/A	
		Ø nausea / Ø vomiting	
GU	Device	foley cath patent / intact	
	Color / Clarity	yellow / clear Ø s/sx of infection	

(Continue on reverse)

[redacted] Title) [redacted] /AN b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted] b(2)-2

DATE: 21 SEP 03

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

NAME: RANK: AGE: 28yo

UNIT: GENDER: ♂

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

[redacted] b(6)-4

PT'S NAME: [redacted]

DATE: 21 SEP 03

[S/P EX FIX (D) LE] I&D = 20 SEP 03
[(R) BKA REVISION = 20 SEP]

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV																							
BP NIBP	101/58	117/67	119/67	115/69	119/71	115/67	127/65	120/65															
TEMP	99 oral		99 oral	100 TM	102.3	101.5	99.7	99.7															
PULSE	84	87	103	100	103	100	92	91															
RESP	18	19	22	23	16	19	17	21															
SP02	98%	96%	97%	98%	96%	96%	97	95															
FIO2	RA	RA	RA	RA	RA	RA	RA	RA															
INPUT																							
IV	50	50	50	50	50	50	100 SP	50															
2°(IVPB)	50			100		100																	
PO							100																
NGT																							
O.R. IN																							
SUB TOTAL	100	50	50	150	50	150	150																
TOTAL	100	150	200	350	400	550	700																
OUTPUT																							
URINE	75	350	300	200	200	50	620	56															
NGT	-																						
STOOL	-																						
O.R. OUT																							
SUBTOTAL	75	350	300	200	200	50	620	56															
TOTAL	75	425	725	925	1,025	1,075	1,695	1,751															
BALANCE																							

MEDCOM - 19388

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: 22 Sep 03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block

Time In: 0535

Allergies: NKA OR Intake: Crystalloid 1000 Colloid

Pre-op V/S: 120/68 103 OR Output: UOP EBL minimal

Procedures: (L) leg wb fx Meds/Times: 50 fentanyl

(R) BKA I&D washout (L)/(R) side

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	0535	0540	0545	0550	0555	0600
SaO2	98	98	98	97	97	97
FiO2	/	/	/	/	/	/
Methods	RA	RA	RA	RA	RA	RA
RR	12	12	10	11	12	10
T	97.3				97.5	

240 220 200 180 160 140 120 100 80 60 40 20

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR	1000	(L) FA	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	3 extrem 1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	9

Codes

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

V/S: X = A-line BP, ˇ = Cuff BP, • = Pulse

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

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

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY: [redacted] AN b.(6)-2 DEPARTMENT/SERVICE/CLINIC: ICU 3 DATE: 22 Sep 03

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

MEDCOM - 19389

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

NURSING NOTES

0535 Arrived to PACU @ 0538 via litter accompanied by CRNA & nurse. Pt very tired. Sats good on RA >98%. Won't move all extremities @ quest. Moves (L) LE & BUE. Dressings in place & clean. VSS [redacted]
(0605) Report given to Sgt [redacted] VSS. No Δ in pt. Arouses c verbal stimuli. [redacted] AN
0615 - VSS. Pt easily Arousable. ∅ c/o. Will continue to monitor. [redacted]
0630 - Pt to ICW #1 [redacted]

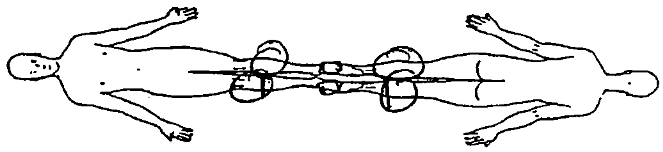
D/W-2 All

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg (R) stump	∅	UTA	P	B	W	PK
15'	(L) leg	∅	UTA	P	B	W	PK
30'	(L) leg	limited	+	P	B	W	PK
45'							
60'							
90'							
D/C	(L) leg	limited	+	P	B	W	PK

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) LE (R) stump	bandage/ace wrap	∅
30'	(L) LE, (R) stump	bandage/ace	∅
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0545	SR	∅	∅

Discharge Criteria:
Date: 22 Sept **Time:** 0625 **PARS:** 9
BP: 130/72 **T:** 97.5 **HR:** 83 **RR:** 11 **Sa02:** 96%
Pain Level at D/C (0-10):
Intake: 100 **Output:** ∅
Additional Data:
Transferred To: ICW #1
Report Given To: SGT [redacted]
Transferred Via: W/C [redacted] ey/ **Ambulance**
Transferred By: SGT [redacted]
Cleared IAW Recovery R[redacted]
Charge Nurse Signat[redacted] LT AN

WAMC OP 173-E

MEDCOM - 19390

ACLU-RDI 1651 p.150

DOD-032964

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 24 Sep 03
Time In: 2243
Allergies: NKDA
Pre-op V/S: 126/75 87
Procedures: Stump revis (R), w/b (R) LE

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

OR Intake: Crystalloid 1000 Colloid
OR Output: UOP EBL 100
Meds/Times: MSO4 10mg Phen 25mg Fent 250mcg

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

Airway: Nasal, (Oral), ETT, Trach, Other

Pre Op Meds / History

Time	2245	2300	2315	2330	2345	2400
SaO2	99	99	99	99	94	95
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120	V	V	V	V	V	V
100						
80	•	•	•	^	^	^
60	^	^				
40						
20						
RR	12	12	11	13	12	12
T	97					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2245	NS	300	(R) AC	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

Time	
Pain (0-10)	
LOS	

Patient teaching done: Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b(6)-2 USN, MC

DEPARTMENT/SERVICE/CLINIC: ICU #3 / PACU

DATE: 24 Sep 03

PATIENT'S IDENTIFICATION (If 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
		∅				

NURSING NOTES

2245: Pt arrived from O.R. via gurney c̄ oral airway in place SPO2 97% RA. Pt unable to follow commands @ this time due to sedations. Ex fix on (L)LE & oral airway removed. Will cont. to monitor. [redacted]

2315; pt awake, alert, MAE; ∅ s/s of hemorrhage; report given to nursing un[redacted]

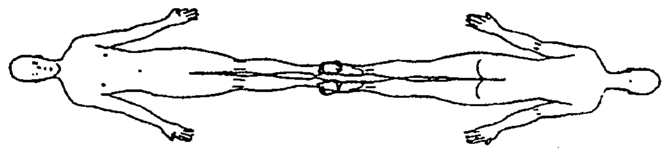
b(w)-2 AH

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)LE	none	–	P	B	W	N
15'	(L)LE	none	–	P	B	W	N
30'	(L)LE	∅	~	P	B	W	N
45'							
60'							
90'							
D/C	(L)LE	∅	–	P	B	W	N

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	(L) LE	ace wrap	∅
30'			
60'			
D/C	R/L LE	Ace	∅



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
	∅		

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2245	SR	∅	∅

WAMC OP 173-E

Discharge Criteria:
Date: 24 Sep 3 **Time:** 2325 **PARS:** ~~10~~ 9
BP: 125/54 **T:** 97.1 **HR:** 81 **RR:** 12 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: ∅ **Output:** ∅
Additional Data: ∅
Transferred To: ICW 2
Report Given To: [redacted]
Transferred V[redacted] **Ambulance**
Transferred By[redacted]
Cleared IAW Recovery[redacted]
Charge Nurse Signat[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDI[illegible]

use of this form, see AR 40-66; the proponent agency is the Office of Th[illegible] [illegible]eneral.

OTSG APPROVED *(Date)*

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

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

Time In: ______

Allergies: NKDA OR Intake: Crystalloid 700 Colloid Ø

Pre-op V/S: 128/67 / 98 OR Output: UOP Ø EBL min

Procedures: Washout EXFIX Meds/Times: 1156 Fent 10m

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

Pre Op Meds History

Time	1152	1157	[illegible]	1210	1225	1240
SaO2	93	95	94	99	95	95
FiO2						
Methods	RA	RA	RA	RA	RA	RA
RR	15	15	15	18	13	
T	94.2		96.8			

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1238	LR	250	L For	IV	250

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~~ 1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	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	Ø	Ø	Ø
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 91wm6

DEPARTMENT/SERVICE/CLINIC PACU

DATE 26 Sep 05

[redacted]

... IFICATION *(For typed or written entries give: Name — last, ...dle; 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
1220		4mg [illegible]	IVP			JB

NEUROVASCULAR

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

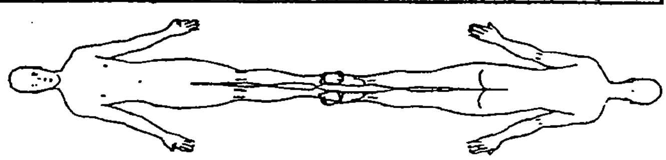
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLL	Curlex	Ø
30' 1223	LLL	Curlex	1 1/2" Diameter L shin
60'			
D/C 1240	LLL	Curlex	1 1/2" Diameter L shin.



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1240	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt Admitted to PACU
PARS Score 7 due to low motion & ↑ BP. S/P washout of ex FX
LLE. Dressing CDI. Pulse ox 94 on
RA ——— PFC [redacted]
Pt discharged to ICW by PFC [redacted]
via Litter. PARS score 9 Report
Given to SPC [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 26xx05 **Time:** 1240 **PARS:** 9
BP: 129/66 **T:** **HR:** 73 **RR:** 12 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 25cc **Output:** Ø
Additional Data: Ø
Transferred To: ICW
Report Given To:
Transferred Via: W/C [redacted]urney Ambulance
Transferred By: PFC [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDCOM - 19394

ACLU-RDI 1651 p.154

DOD-032968

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: 30 Sep 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1337

Allergies: NKDA OR Intake: Crystalloid 1600 Colloid

Pre-op V/S: 117/68 80 OR Output: UOP 0 EBL 0

Procedures: IM Nailing left leg Meds/Times: 500 Lev, 2gm Ancef

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

Airway: (Nasal), Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1337	1342	1347	1402	1410
SaO2	98	98	98	96	97
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140	V	V		V	
120		V			V
100	•	•		•	•
80	^	^		^	^
60		^			
40					
20					
RR	20	21	11	16	14
T	98				

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	10	W

Codes

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

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

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

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

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

(Continue on reverse)

b(6)-2 [redacted] SSG/CPT

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 30Sep03

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

[redacted]

b(6)-1

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

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

MEDCOM - 19395

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1415		Zofran 4mg	IV			Anesthesia

NURSING NOTES

Pt received from OR S/P IM nailing. VSS SpO2 98% No c/o pain arousable to verbal. Pt had nasal trumpet, pulled it out. — [redacted]

b(6)-2 A11

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L Leg	limited	+	P	B	WM	PK
15'	L leg	limited	+	P	B	WM	PK
30'							
45'							
60'							
90'							
D/C							

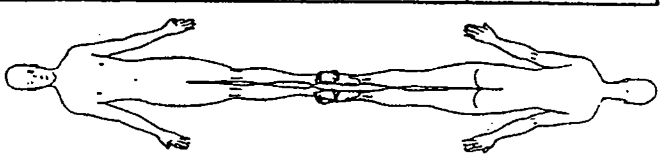
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L leg @1337	ace wrap	c/d/i
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1337	NSR	∅	∅

Discharge Criteria:
Date: 30Sep03 **Time:** 1410 **PARS:** 10
BP: 130/83 **T:** 95 **HR:** 95 **RR:** 14 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: L100 **Output:** ∅
Additional Data:
Transferred To: ICW2
Report Given To: ICW2 ILT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Room [redacted] **...e Signature:**

[redacted]

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE:	To provide commanders and law enforcement officials with means by which information may be accurately
ROUTINE USES:	Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE:	Disclosure of your social security number is voluntary.

1. L[redacted] b(2)-2	2. DATE *(YYYYMMDD)* 20030918	3. TIME 0980	4. FILE NUMBER
5. [redacted] b(6)-2	6. SSN [redacted]		7. GRADE/STATUS O-2
8. [redacted] (b)(2)-2 b(6)-2			

9. I, [redacted] b(6)-2, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

on 18 0300SEP03, TF ROC arrives on location after MP engage hostiles. We (20 personnel) swept area looking for casualties & Found none. We waited on site until sunrise and swept area again. We found one (enq) KIA and another WIA. CPL [redacted] treated WIA on site. WIA had two broken legs. One leg had local wound other (left) has a CY compound fracture. Discom ~~TOC instructed~~ (b)(2)-2 to take WIA to [redacted] clinic. They ([redacted]) did not have resources to care for WIA. We then took him to [redacted] We arrived approximately at 0855. [redacted] took vitals and he (b)(2)-2 was MEDEVAC @ 0920 (approximately). [redacted] refused DOA (KIA) and we took him to DISCOM TOC

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT [redacted] b(6)-2	PAGE 1 OF 1 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ TAKEN AT ____ DATED ____"

THE BOTTOM OF EACH ADDITIONAL ... MUST BE BE INDICATED. ... MUST BEAR THE INITIALS OF THE PERSON MAKI... STATEMENT, AND PAGE NUMBER

DA FORM 2823, DEC 1998 — DA FORM 2823, JUL 72, IS OBSOLETE — USAPA V1.00

MEDCOM - 19397

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

STATEMENT OF [redacted] b(6)-2 TAKEN AT _____ DATED 18 Sep 03

9. STATEMENT *(Continued)*

The WIA was found at a field about 200m from Ambush site. Blood trail led to the general direction of the WIA from the ambush site. All recovered weapons were found scattered at ambush site. Recovered weapon included 2 RPG's with multiple live rounds and 3 AK-47 with mutiple loaded magazines. The KIA was found in a canal in the ambush site bag on site and taken to [redacted] Mortuary Affairs.

b(2)-2

NOTHING FOLLOWS

INITIALS OF PERSON MAKING STATE [redacted] b(6)-2

PAGE 2 OF 2 PAGES

PAGE 2, DA FORM 2823, DEC 1998 USAPA V1.00

MEDCOM - 19398

STATEMENT O[redacted] TAKEN AT _____ DATED 18/9/03

9. STATEMENT *(Continued)*

[redacted] b(6)-2

(b)(6)-2

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR [redacted] b(6)-2

(Signature of Person M[redacted]

WITNESSES:

[redacted] b(6)-2

1 ADROC

[redacted] b(2)-2

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 18 day of SEPT, 2003

at [redacted]

[redacted] b(6)-2

(Signature of Person Administering Oath)

[redacted] b(6)-2

(Typed Name of Person Administering Oath)

CPT U.S. ARMY

(Authority To Administer Oaths)

ORGANIZATION OR ADDRESS

INITIALS OF PERSON MAKING STATE [redacted]

PAGE 3 OF 3 PAGES

PAGE 3, DA FORM 2823, DEC 1998

USAPA V1.00

STATEMENT OF _____ TAKEN AT _____ DATED _____

9. STATEMENT *(Continued)*

ICUZ

fried @ [redacted] b(2)-2

[redacted]

b(4)-4 has not processed

b(6)-2

RCPT

(b)(6) [redacted] ROC

[redacted]

AFFIDAVIT

I, _____, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE_____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, _____ at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____ _____
(Au... To Administer Oaths)

_____ MEDCOM - 19400 _____
INITIALS OF PERSON MAKING STATEMENT PAGE OF PAGES

ADMISSION AND CODING INFORMATION

For use of ... see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A I I D I [redacted] I	8: 2

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	[redacted] b(6)-4	16 17:	18: M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]	27 28 29: 2 8 Y	30: 2	31: 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:	NA	35 36: 99 20	37 38 39 40 41 42 43 44 45: [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	46: 2	1515	NA b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O	ICU2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: 4	75 76 77 78 79 80:	81 82 83 84 85 86: 0 3 1 0 1 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A E A A	91 92 93 94 95 96:	97 98 99 100 101 102: 0 3 0 9 1 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104:	105 106 107 108 109 110:	111 112 113 114 115 116: 0 3 0 9 1 8

FOR LOCAL USE

DX: Bilat. Tib/Fib Fx.

DX: 82392
8970
8993

PX: ~~7926~~
8314
7807
8415
8802
79160x2

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

SIGNATURE OF ADMITTING CLERK [redacted]

D [redacted] 89

MEDCOM - 19401

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]						NA	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	40	UNK	UNK	NA	NA	NO	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
99	[redacted]		NA			IAU	
15. FLYING STATUS	16. [illegible] OSG	17. DEPT/ EEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
NA	b(6)-4	NA	NA			NBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	1945	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	9/30/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	9/18/03	b(6)-2 [redacted]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) PARIETAL SKULL FX / EPIDURAL HEMATOMA

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	13	13

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	13	13

[redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

[redacted] b(6)-2

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

b(6)-2

MEDCOM - 19402

MEDICAL	ABBREVIATED MEDICAL RECORD

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

Iranian contractor mid-twenties s/p fall off the back of a truck LMTV this afternoon, with battle sign on (L) w/ (L) ear laceration. Pt. initially was reportedly GCS 15, then became confused with decreased responsiveness GCS 13-14 arousing to voice. Speaks Iranian difficult to translate w/ Arabic translators. C, T, L-spine & pelvis @ [redacted] reportedly was cleared. Referred for CT scan of head & R/O mass lesion.

(b)(2)?

PHYSICAL EXAMINATION

Awake, Alert but Combative requiring Sedation for Evaluation.

HEENT: (L) mastoid ecchymosis
pupils small reactive
dysconjugate w/ (L) exotropia
Blood dried (L) ear Ø otorrhea
Ø Rhinorrhea
Ø neck tenderness

Motor: Briskly, Strongly Moving Symmetrically
Resistant to all examination using UE/LE
Sen: Responds appropriately to peripheral stimulation overtly aggressively resistant
Unable to test Cerebellar fx due to uncooperative, nor station or gait.

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

(1) Dx: Basal Skull Fracture

(2) CT of Head

(3) HOB @ 30°

b(6)-2

[redacted]

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

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

REGISTER NO.	WARD NO.

Iranian Civilian / Contractor

[redacted]

b(6)-4

MEDCOM - 19403

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Sep03	
0200.	Sedation turned off. ABP low 100s/60s. Pt not moving. HR 90's. Will cont. to monitor
0230.	Washed dried blood from pts hands, face neck. Pt moving (B)UE towards face, bending knees. Pt calmed easily. Sedation remains off @ this time. Will monitor
0400.	Pt started to wake up. Moving all 4 extremities c nonpurposeful mvmt. Bucking the vent. Versed gtt started @ 2mg/hr and fentanyl restarted @ 50mcg/hr. Soft wrist restraints applied to prevent pt from pulling ETT. CBC, chem 8, ABG and coags drawn via A-line and sent to lab. Will monitor [redacted]
0430	ABG results: 7.31/39/80/20/-6/100%. ~~Hgb~~ H/H 11.8/35.7. No vent changes @ this time [redacted]
	Neurosurgery Brief - SP b(6)-2
9/19/03	Pt. sedated, periods of brisk movement of all 4
0551	extremities to minimal stimulation
	RRL 104/61 ventilated: SIMV (10)/40%/800 (TV)
	Head dressing intact Ear dry Drain: 140 cc total
	Pupils small brisk / dysconjugate gaze.
	pain briskly localizing (B) UE withdrawn LE
	no spontaneous eye opening nor to voice or stimulation
	ABG: ↓ Sedation & wake up for extubation &
	eye opening. Repeat CT last night demonstrated
	Complete removal of EDH. [redacted] b(6)-2

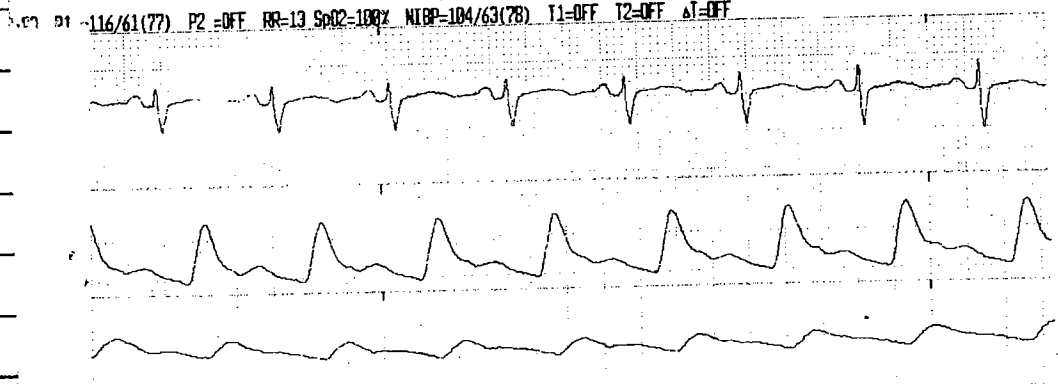
STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19Sep03. 0000	Pt admitted to ICU 1 from OR to CT Scan. Pt on monitor, ~~vented~~ intubated. Pt transferred from litter without incident. Pt connected vent. SIMV10, TV 800, FiO2 100%, Peep 5. SpO2 100%. HOB elevated to 30°. JP drain x1 to (L) parietal area c bloody drng noted. Gauze wrapping noted to head c bloody drng. Staples intact to (L) parietal area. Pt as A-Line to (R) radial, (R) IJ cordis and PIV x3. Will continue to monitor. b(6)-2 [redacted]
0020.	ABG via (R) radial A-line 7.29, 36.4, 181, -9, 18, 100%. FiO2 ↓ to 40% via RT. SpO2 maintained @ 100%. (R) FA 18G PIV NR flushing. DC'd c canula intact. Disp changed to (R) IJ cordis, (R) radial a line. No redness/drainage noted. (L) AC 18G PIV and (R) FA 14G PIV saline locked. Versed gtt started @ 4mg/hr, fentanyl gtt @ 50mcg/hr and D5.9NS + 20KCl @ 100cc/hr via cordis. Will monitor. b(6)-2 [redacted]



RELATIONSHIP TO SPONSI

)R'S ID NUMBER
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. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing Notes Con't.
19 SEP 03	VSS. Art care done. Pt resting in bed. Versed drip maintained at
0830	2 mg/h. Fentanyl drip at 50 mcg/h. Radial artery line dislodged.
0900	Now using NIBP to monitor BP. Dr [redacted] visited Pt. He is aware
	that A-line is out. He ordered Versed and Fentanyl drip increased.
	Versed drip increased to 4 mg/h. Fentanyl drip increased to 50 mcg/h.
1100	appears effective. Dilantin was given IVP given. VSS. No distress noted.
1200	VSS. 25cc bloody drainage emptied from JP. VSS. No distress noted. Pt sedated.
1300	Dr [redacted] visited Pt. He was informed that Pt has blood tinged drainage from nose
1500	left [redacted]. VSS. No distress noted. Pt sedated. Versed drip at 4 mg/h.
	Fentanyl drip at 50 mcg/h. Pt suctioned orally. [redacted]
1725	Dr [redacted] visited and examined Pt. He increased Vent Rate
	to 12 BPM. He is aware of Pt condition and VS. [redacted]
1800.	Received report from day shift. Pt intubated [illegible]
	@ this time. [redacted]
1900.	ABG results from prior shift c ↑ RR. 7.46/34.7/
	191/25/1/100%. No changes [redacted]
0200.	Pt continues to have periods of agitation. Pt bucks vent,
	moves extremities x4. Versed 1mg IVP given. Will
	cont. to monitor [redacted]
0430.	ABG drawn via (L) radial artery stick x 2 attempts. Sent
	to lab. CBC, Chem, Coags drawn via 14G PIV and
	sent to lab. ABG: 7.51/33.5/187/27/4/100% [redacted]
	b(6)-2 All

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 19406

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	b(6)-2
19Sep03	Updated Dr. [redacted] on pts progress. No new
0605	orders. Sedation turned off for prep to extubate [redacted]
0610	Report given to LT [redacted] Questions answered [redacted]
19SEP03	Received Pt in ICU Bed #1. Pt does not respond to verbal stimuli. Responds to
0610	pain stimuli. Pt also observed moving all extremities. PERLA 3mm
	Brisk. Cardiac Monitor shows SR. VSS. A-line to Right Radial artery good
	waveform NIBP does not correlate with A-line Currently using A-line
	values. Cordis to (R) IJ intact with IV Fentanyl drip at 50mcg/h, Versed
	drip at 2mg/h and [illegible] 20 kcl at 100 cc/h infusing #18 G access
	to (L) AC intact #14 G access to (R) forearm Both sites intact and (AL) ⊖ [illegible] all peripheral
	pulses ⊕. Pt orally intubated #8 ET 24cm lip line No signs of resp distress noted Vent
	settings AC Rate 10 TV 500 Peep 5 FIO2 40% Saturating 100% via pulse oximetry
	Salem Sump tube orally to intermittent suction. Bowel Sounds Hypoactive. Foley
	Cath in place draining clear yellow urine to bag. JP to head drain bloody drain
	noted. Surgical wound with staples intact to head. Ancef 1gm IV was given
	See Nsg assessment sheet and attached strips for more information [redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Sept 03	RT note: pt on vent settings A/C 10, 800, 100%, +5 PIP 22
	8.0 ETT 24 @ lip. Pt sedated. BBS CTA. MD states may extubate
	in am b(6)-2 Sgt [redacted] 91V20
0020	ABG: 7.29, 36.4, 481, -9, 18, 100%. ↓ FiO2 to 40% -Sgt
	Neurosurgery Note
9/20/03	Pt doing very well tolerated extubation and following
15.11	Commands, actually speaking & understanding English.
	Plan to D/c IJ
	Plan to Advance Diet
	Awake, alert oriented to Baghdad Hospital.
	Motor Symmetry movements (B) UE/LE
	Conjugate gaze
	A/P Pt doing very well ↑ Diet [redacted] a'd to
	nasal Canula
	[redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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 I

[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 - 19408

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20SEP03	Received report from day shift. Pt laying in bed resting. Responds to
(1815)	Verbal. Pt has JP from head & has been extubated. VSS. [redacted]
	done. [redacted]
	b(6)-2
	Neurosurgery Note
9/21/03	Pt. awake, alert. Tolerating Clears. Following
1300	simple commands. Speaks some English
	AFBTB
	[illegible] clean dry
	External auditory canal dry
	motor 5/5 (B) UE/LE w/o deficit
	A/P: Conts to improve neurologically. ↑ activity
	diet ↑ tx to ward. & Plan Tx to
	b(2)-2 [redacted]
	[redacted]
	b(6)-2

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

MEDCOM - 19409

ACLU-RDI 1651 p.169

DOD-032983

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Sep 08 0630	Received Pt in ICU Bed #1. Pt moves/responds to pain stimuli also has spontaneous movement of extremities. See Initial Shift assessment sheet for more information. DR [redacted] visited and examined. He is aware of Pt's GCS and ABG results. He D/C'ed JP drainage. He wants Sedation tapered down for possible Pt extubation. Pt's IV DSNSTKCL 20 kcl at 100 cc/hr continues. Fentanyl drip at 50 mcg/hr received Pt with Versed drip at 4 mg/hr. Versed drip decreased 2 mg/hr. Arterial line IVBS given. Pt urine output is pale clear (last 2 hours 320 and 400 cc respectively. DR [redacted] b(a)-2 aware.
0800	VSS. Pt care done. Fentanyl drip decreased to 40 mcg/hr
1000	Fentanyl drip tapered to 30 mcg/hr. Pt easily arousable opens eyes
1200	on his own and is tracking around bed. VSS. DR [redacted] visited Pt & the
1115	extubated Pt. Placed on Non Rebreather mask tolerating well Sat 100% via
	pulse oximeter. Resp 12-20 No distress noted. Fentanyl and Versed
	tapered to off. Pt resting in bed No distress noted [redacted]
1400	VSS No distress noted Pt maintained on NRM at 6L [redacted]
1500 b(6) b(6)-2	DR [redacted] visited and examined Pt. He ordered diet [redacted]
1530	to Room air tolerating well cardiac access D/C'ed. Pt resting in bed No [redacted]
1600	97-100% on Room air IVDSNSTKCL 20 kcl continues. Report given to nurse [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SP [redacted] (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 I

[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 SEP 03	Received Pt ī ICU I Bed #1. Pt A&O. Moves all extremities. See
0600	Intensive Care Nursing flow sheet for more information. No distress noted
	on Room air Sat 97-100% via pulse oximeter. Resp 14-22. IV [redacted]
	ē 20kcl at ... infusing. Acetaminophen administered. Pt resting in bed.
21 Sep 03	Received report from outgoing shift. Pt VSS, in bed
0930	resting. Follows simple commands, sometimes difficult to assess
	ē pt not speaking Arabic or English. Staples on the head
	D & I. Continue ē current POC. Neuro ✓ WNL. b(6)-2 [redacted] Maj/AN
1100	Pt up to BSC & then to chair. No BM noted @ this time.
	Tolerated getting out of bed. Had clear liquid but had
	emesis afterwards approx 100cc of juice, taken earlier.
	Staples to the head intact & dry. Bruises to the back, dry
	applied Bacitracin ointment. VSS. [redacted] Maj/AN b(6)-2
1415	Pt continue to do well. Neurologically intact. VSS. [redacted]
	transferring pt to ICW I. Report given to the nurse.
	Foley discontinued @ 1300, total of 1200 cc of clear yellow
	urine. Plan: Monitor urine output. ✓ Neuro status q4°
	✓ bruises in the flank area. [redacted] Maj/AN
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 19411

ACLU-RDI 1651 p.171

DOD-032985

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Brief Post-op Note
9/14/03	Pre-op Dx: (L) EDH posterior Temporal/Skull fx Extending to (L) mastoid
2330	Post-op Dx: Open Skull fx over (L) Sigmoid Sinus/Transverse Sinus.
	Procedure: (L) Pterional Craniotomy Evac of EDH/Repair over sinus
	Surgeon: [redacted]
	Anesth: GETA
	Drains: JP
	EBL: 250 cc
	Findings: (L) Transverse Sinus/Sigmoid Sinus Injury w/ Epidural Hematoma Skull fx over Sinus.
	Fluids:
	Comp
	b(6) - 2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK
☆ U.S. GPO:1998-432-786/75236

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Sep08	1914- pt. came in by Medivac, medic stated he fell off of a vehicle, unsure of how high, pt alert + reactive to pain, vitals- BP 105/64 P 119, R-20 O2 100%, temp 101.7— [redacted] 2CTAn
	1920- pt. uncooperative to treatment [redacted] Ativan IV push + 1 gm Dilantin IV over 1 hour given— [redacted] 2CTAn
	1926- 12.5 mg Phenergen IVP given— [redacted] CTAn
	1940- Foley cath in place, vitals Retaken- BP 106/63, P-111, R-20- SpO2 100% — [redacted] 2CTAn
	1950- pt. taken to CT, 2mg Ativan IV given [redacted] 2CTAn
	2007- BP 117/55, P-102. R-27 SpO2 91% [redacted] 2CTAn
	2020- Report called to TCU [redacted] 2CTAn
	2029- Pt. prepared to be taken to OR— [redacted] 2CTAn
	b(6)-2 All

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

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

#1 [redacted]

b(6)-4

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

MEDCOM - 19413

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/29/03	Neurosurgery Narrative
1200	40's ♂ Civilian suspected Afgan worker who fell off back of
MSS: ϕ	a truck 9/18/03 w/ ① Retromastoid ecchymosis with underlying parietal mastoid skull fracture ② Epidural hematoma & GCS 10 : Underwent
	emergent craniotomy evacuation of EDH. Did well post op currently
	tolerating regular diet supplemented w/ Soy shakes & Regular activity.
	Neurologically normal no visual, verbal motor nor cognitive deficits.
	Staples/Sutures removed Flap well healed.
	Plan: RTD no subsequent followup required.
	Dx: ① ② Acute Parietal Fracture w/ EDH

[redacted]

b(6)-2

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

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

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 - 19414

NSN 7540-01-075-3786

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

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

70s y/o [illegible] fell off moving vehicle unclear speed/height. Reported GCS 15. VSS reported
Neuro focal exam reported. Pt does not answer questions. Hx per medic

O: Alert/reactive to pain only. VSS, uncooperative — eyes open to pain, incoherent verbal, moves ext x4 spont 5/[illegible]
HEENT: OP/mo clear/moist neck: supple, ∅ stepoffs Head ⊕ lac (L) occipital c̄
TMs: (L) ⊕ blood in canal (R) clear/wnl PER sluggish 2-4 mm EOM = disconjugate c̄ [illegible]
Chest: CTAB CV: RRR no m/r/g Abd: soft, NT / ∅ guarding ⊕ ecchymosis (L) mastoid
Ext: 5/5 strength [illegible] (B), [illegible] to pain / cap refill <2sec rectal: NL tone, pt [illegible]

A/P clinically c/w ⊕ basilar skull fx c̄ [illegible]. Neurosurgery consult @ PE.

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND S[redacted]

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS
①
②

CODES

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

#
[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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: Iraqi Civilian

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 18 Sept 03 | TIME: 1914

TRANSPORTATION TO FACILITY: medevac

SEX: M

AGE:

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: TD 1500 1820

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: Head Injury

CATEGORY OF TREATMENT

☒ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: b(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	1915	1940	2007		
BP	105/64	106/63	117/55		
PULSE	119	111	122		
RESP	36 20	20	37		
TEMP		101.7			
WT	(00% O2	MR			

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	☒ UA MSCC/CATH		☒ UREM: 12 lytes
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 98 02 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1920	3 mg Ativan IV	[redacted]	[redacted] b(6)-2		[redacted] b(6)-2
	Tyco Diltiazem IV				
1926	12.5 Phenergan IV				
	Foley to gravity				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS/LIGHT DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 21 SEP 03 | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1445 To ICU 2 From ICU ☐ AMBULATORY ☐ CRUTCHES ☑ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis S/P R Parietal Skull Fracture c Epidural hematoma evacuation. B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks 4° - okay

Dressing/cast _____ Tubes Foley d/c'd

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication 1400 meds given.

Other _____

Report From MAJ [redacted] Received By LT [redacted]

VITAL SIGNS

TIME:	600	2000	2200	2400													
BP ARTERIAL LINE		—	—	—													
BP CUFF	96/60	109/70	90/52	109/63													
TEMPERATURE	100.7	100.4	100.1	100.7													
PULSE	94	96	96	98													
RESPIRATORY RATE	[redacted]	16	20	16													
OXYGEN (L/%)		—	—	—													
PULSE OXIMETER	98%	98%	98%	99													
O2 METHOD	RA	RA	RA														

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	1500	2000	2230														
PAIN INTENSITY (10 / 5 / 0)																	
MED ADMINISTERED (Y/N)	[redacted]	NA	N														
RELIEF ACCEPTABLE (Y/N)	NA		NA														

OTHER

TIME:																	
FINGER STICK GLUCOSE				NA													
INSULIN (Y/N)																	

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol	[redacted]	
*Restraint protocol	NA	
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b (4) - 4

DIAGNOSIS: S/P R Parietal Skull Fx c Epidural hematoma evac.

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ NC WNL	☐ Neuro ✓ WNL b(ce)-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ c/. liq. diet.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ Foley d/c'd.	☑ voids ∃ diff	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Generalized weakness.	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wound to ⓛ parietal skull staples to site intact	☐ ⓛ parietal skull c. staples & sutures intact	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b(ce)-2	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Redd[redacted] OK - No swelling/redness * - Central line)

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RAC / OK	IV Site #1: RAC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: D5½ NS c 20 KCL @ 100 cc/hr	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 1500					
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 1500	2230		
ID band visible/legible	[redacted]			
Orient to environment prn	[redacted]			
Side rails (2/4) up	NA			
Bed position low	↓			
Call light within reach	↓			
Review & post lab results	[redacted]			
Notify MD abnormal labs	[redacted]			
Incontinent urine/stool	NA			
Linen change prn	[redacted]			
Turn/reposition q2h	NA			
ROM q2h if immobile	↓			
Antiembolic hose	↓			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Cl. Lig.
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(6)-2	BEDREST ☐ SELF ~~AMBULATE~~ ☑ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 1500 INITIALS: [redacted]	TIME: 2235 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Plan of Care Orient to room.	CONTENT: Pain management call for assistance	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(6)-4	AM	[redacted] RLT, AM	2
	LD	[redacted] RN/MC	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1500	(L) parietal Skull	staples intact, No s/s infection	NA
	2030	(L) parietal skull	staples & sutures intact OTA, ∅ s/s of infection	assessed

SECTION IV - NOTES

1445: Transferred to ICW2 from ICU2 via wheelchair, VSS, NKDA. No c/o pain @ this time. Will continue to monitor. [redacted] ECT, Ar
0100 - IV to (R) FA infiltrated, site dc'd intact. New IV started c 20g x 1 stick in (R) FA good blood return & flushes well. Chem 7 drawn from (R) FA per orders. ∅ c/o's @ this time. Will cont to monitor [redacted] 91WM6
b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 4 | HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	2100	1330	1600	2010	0400												
BP ARTERIAL LINE																	
BP CUFF	112/82	88/60	100/60	90/53	99/52												
TEMPERATURE	98.6	100.8	100.4	100.9	99.7												
PULSE	72	66	97	71	68												
RESPIRATORY RATE	16	12	21	18	20												
OXYGEN (L/%)	2L	2L															
PULSE OXIMETER	96%	96%	98%	97%	99												
O2 METHOD	RA/FA	RA/FA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0800	1600	2000	2230													
PAIN INTENSITY (10 / 5 / 0)	0	1	0	X													
MED ADMINISTERED (Y/N)	N	N	NA	N													
RELIEF ACCEPTABLE (Y/N)		Y		NA													

OTHER

TIME:																	
FINGER STICK GLUCOSE		N/A															
INSULIN (Y/N)																	

SPECIAL NEEDS

TIME:	1600	2230															
*Skin breakdown prevention	[redacted]																
*Falls prevention protocol	NA	NA															
*Restraint protocol	NA																
*Seizure precautions	[redacted]																
*Isolation precautions	NA																

YESTERDAY'S WEIGHT: [redacted]

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C [redacted]

blw-4

DIAGNOSIS: SIP (2) Parietal Skull fx & Epidural hematoma

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

blue - 2

	TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ does not Speak English	☐ Pt seems very somnolent and affect seems flat. Generalized weakness d/t all activities. But movements seem appropriate.	☐ pt seems to respond appropr. Follows commands to certain extent 2° to lang barrier
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑ Cough & Deep Breathing Exercises completed c pt	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐ Tolerating CL foods well	☑ tolerating Clears
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ uses bathroom	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ generalized weakness	☐ generalized weakness	☐ Full ROM noted to all extremities
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples to (L) side of head intact	☐ horseshoe shaped suture line to (L) lobe of skull. Incision/suture line well approximated c	☐ staples to (L) side of head intact, Ø S/S infection
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ small amount of purulent drainage noted. Swabbed	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:		q 8 hr:	
IV site care provided:			
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(R) forearm / good	(R) forearm / OK	(R) FA / OK
IV Site #2:			
Comments:	IV fluids @ 100	D5NS c 20K @ 100/hr	D5NS c 20K @ 100°

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0730	1400	2330
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]	NA	
Bed position low	[redacted]		
Call light within reach	[redacted]		

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Clear liquid		cl
PERCENT CONSUMED:	50%		70%
HOW TOLERATED:	well		OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☒ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR b(a)-2 ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP (CHAIR) ☐ SELF ☒ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP (CHAIR) ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1400 INITIALS: [redacted]	TIME: 2330 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Staff orientation - Call for help - [illegible] - pain mgmt	CONTENT: Call for assistance pt needs to call if getting OOB Pain management	CONTENT:
☒ ~~Patient/Family Verbalizes Understanding~~ error [redacted]	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(a)-4	[redacted]	[redacted]	0
		[redacted]	14-22
		[redacted] LT/AN b(a)-2	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
2230	(L) side of skull	staples intact, open to air, Ø S/S inf.	Assessed

SECTION IV - NOTES

1400→ Assumed pt care. Assessment difficult 2° language barrier. Completed pt teaching but no interpreter available for pt's language. [redacted] /RN

1800→ Pt in chair x 20 minutes during shower. Ambulated x 100 feet. Both chair & ambulation were with assist. [redacted] /RN

22 Sep 03 2230 Pt sleeping, easily arousable c̄ verbal stimuli. Neurocheck intact, PERRLA, pupils responding briskly to light. Equal strength bilaterally to upper and lower extremities. Ø C/O pain. Will continue to monitor. [redacted] LT/RN

23 Sep 03 0400 Neurovascular check intact, WNL. PERRLA. Pupils reacting briskly to light. Equal strength bilaterally to both upper & lower extremities. Ø C/O pain. [redacted] LT/RN

b(6)-2 All

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 5 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	800	1250	1600	2000	2400	0400										
BP ARTERIAL LINE																
BP CUFF	98/58	104/66	110/80	96/50	89/50	86/46										
TEMPERATURE	98-9	100.1	98.2	100.5	100.3	100.2										
PULSE	79	89	86	88	83	77										
RESPIRATORY RATE	22	20	20	18	20	20										
OXYGEN (L/%)																
PULSE OXIMETER	100	96	98%	99%	99	99										
O2 METHOD	RA		RA	RA												
	[redacted]															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	1600	2000							
PAIN INTENSITY (10 / 5 / 0)										
MED ADMINISTERED (Y/N)	Y	N	N							
RELIEF ACCEPTABLE (Y/N)	Y	Y	N							

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	0800	1600	2300
*Skin breakdown prevention	[redacted]	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	[redacted]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

(1) [redacted]

b(6) - 4

DIAGNOSIS: S/P (L) Parietal Skull fx c epid. hematoma ev

DRG: _____ ADMISSION DATE: 18 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(6)-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ sutures down Ⓛ side of head	☐ Pt somewhat unstable when ambulating.	☐ Speaks Ⓓ English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ ABLE TO EAT REGULAR P.E. IN AM	☐ Tolerating CL but denies wanting anything more.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ INCISION SUTURED DOWN LEFT SIDE OF HEAD	☐ Sutures to Ⓛ scalp cont. ✓ IV	☐ Staples to Ⓛ Side of head
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑ Ⓓ C/O pain
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑ Pt just lays there.

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME:	0830 INITIALS: [redacted]	1600 INITIALS: [redacted]	2300 INITIALS: [redacted]
IV patency ✓ q __ hr:	IN D5NS 1 LITER	8	8
IV site care provided:			
IV tubing changed:			
IV Site #1 (LOCATION / CONDITION):	Ⓡ HAND	Ⓡ [redacted] FA ok	Ⓡ FA OK
IV Site #2:			
Comments:	D5NS c 20 MEQ KCL @ 100 cc/hr	D5NS c 20K @ 100cc/hr	D5NS c 20KCl @ 100cc/hr

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

Civ [redacted] b(6)-4

MEDCOM - 19426

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (2) side of [illegible] TIME:	830					
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

NA

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME:	830	[illegible]	2300
SAFETY	ID band visible/legible	[redacted]		
	Orient to environment prn			
	Side rails (2/4) up			
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results	[redacted]		
	Notify MD abnormal labs			
	Incontinent urine/stool	[redacted]		
	Linen change prn			
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: regular	TYPE: regular.	TYPE: Regular
PERCENT CONSUMED: 25%	PERCENT CONSUMED: 45%	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR ☒ SELF ☒ ASSIST # TIMES/SHIFT	~~BEDREST~~, ~~AMBULATE~~, BSC, BRP, CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: 1. PT TO ASK FOR PAIN MEDS. 2. TO REPORT NAUSEA/VOMITING	CONTENT: - staff orientation - Call for help used Farsi interpreter	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ [redacted] b(6)-4	[redacted]	b(6)-2	6-2
		[illegible]	14-22
		[illegible]	N

MEDCOM - 19427

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
0800	(L) SIDE OF HEAD	NORMAL, SLIGHT [illegible]	SUTURED.

SECTION IV - NOTES

0830 Pt alert and oriented x3. able to communicate via Kurdish interpreter. Pt involved in car accident, [illegible] passport in clothing. Sutures intact, pt able to [illegible] in bed. Encourage to participate in ADLs and ambulate — [redacted] b(6)-2

Complained of headache — Tylenol [illegible] - 2 tabs given [illegible]. Pt did not feel much [illegible] due to pain/discomfort (in headache), pt fell asleep after receiving [illegible] meds [redacted] b(6)-2

~~1400~~ error 1500 → Assumed pt care @ 1400. [redacted]

0400 - Temp 100.2 pt given [illegible] Tylenol, Will cont to monitor [redacted] 91Wm6

b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

CIU [redacted]

b(6)-4

MEDCOM - 19428

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 6e | HOSPITAL DAY: 7

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	1200	1600	2000	0400											
BP ARTERIAL LINE	—	—		—												
BP CUFF	81/46	89/50	88/60	83/44	94/62											
TEMPERATURE	99.1	99.6	101.0	100.0	99.4											
PULSE	81	69	83	89	90											
RESPIRATORY RATE	16	16	22	18	20											
OXYGEN (L/%)	—	—		—												
PULSE OXIMETER	100	99	99%	96%	97											
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800	1200	1600	2000				
PAIN INTENSITY (10 / 5 / 0)	X		X	X				
MED ADMINISTERED (Y/N)				N/A				
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	1600			2000				
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	[redacted]	1600	2400
*Skin breakdown prevention		N/A	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted]

b(4)

DIAGNOSIS: 3P (L) parietal skull fx & epid hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check √ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

bed-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ PT BIP 81/46 BEING MONITORED.	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ AMBULATES WITH ASSISTANCE TO BATHROOM - UNSTEADY GAIT.	☐ Ambulate c̄ assist, unsteady gait.	☐ ambulates c̄ assist
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ HEAD LACERATION c̄ SUTURES, AREA OF WOUND EDGES APPROXIMATED.	☐ Head lac post-aspect. sutures OTA.	☐ Head lac staples OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MILD PAIN p̄ MEDS GIVEN.	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0600 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
IV patency √ q ___ hr: TN	IV patency √ q 5 hr: PRN	IV patency √ q 8 hr:
IV site care provided:	IV site care provided: assessed.	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: RUE O/C	IV Site #1: RUE OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: PT ON D5NS – [illegible] @100 ml/hr	Comments: D5NS @100cc/hr.	Comments: D5NS @100cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (2) SIDE OF ITEM	TIME: 800					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE Jugular	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:			
ID band visible/legible	[redacted]	E	N
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: CLEAR.	TYPE: REGULAR	TYPE:
PERCENT CONSUMED: 70%	PERCENT CONSUMED: 70%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1600	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: 1. TO REQUEST PAIN MEDS FOR DISCOMFORT 2. TO DRINK AS MUCH AS TOLERATED. TO IMPROVE BP		CONTENT: Tylenol for fever		CONTENT:	
☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	b(6)-2	6-2
		[redacted]	E
			N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	ⓛ SIDE OF HEAD	SUTURE LINE APPROXIMATED, INTACT.	SUTURES, BACITRACIN TO WOUND SITE
1600	Parietal/occipital lobe.	ⓛ [illegible] x1 Sutures OTA, CDI.	assessed.
2400	ⓛ side of head	sutures/staples intact OTA	assessed

SECTION IV - NOTES

800 Pt assisted with AM care, ambulate to bathroom with assistance. Pt encourage to drink fluids. ē IV F D5NS ~20 mEq KCl @ 100 cc/hr, Pt medicated for mild pain. Pt resting quietly, no s/s of distress — [redacted]

1400. Pt assisted with fluid intake PO and with lunch. Pt has no fever and able to rest quietly. [redacted]

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 7 | HOSPITAL DAY: 8

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	1600	2000	2400	0400										
BP ARTERIAL LINE	—	—														
BP CUFF	94/52	90/56	88/60	96/56	89/48	92/54										
TEMPERATURE	99.4	99.5	100.1	100.9	99.0	99.3										
PULSE	90	79	97	89	70	69										
RESPIRATORY RATE	20	18	18	18	16	16										
OXYGEN (L/%)	—	—			2/SC											
PULSE OXIMETER	97	99	98%	98%	100	100										
O2 METHOD	—	—	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0900	1200	1600	2000				
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X				
MED ADMINISTERED (Y/N)	Y							
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	0900	1600						
FINGER STICK GLUCOSE	NA	NA						
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0900	1600	2300
*Skin breakdown prevention	NA	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	NA													

PATIENT IDENTIFICATION

[redacted] CW

blood-4

DIAGNOSIS: SP (L) parietal skull fx c epid-hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6) - 2

	TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ c/o HA	☐ c/o HA	☐ Speaks no english
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples to scalp intact	☐ Staples to occiput OTA, S S/S infection.	☐ Staples to (L) side of head intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o HA	☐ HA	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q 8 hr: Good	IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5NS @ 100 cc/hr infusing well S S/S of infection or infiltration	Comments: D5½NS @ 100cc/hr	Comments: D5NS @ KVO cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA		NA				
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0900	E	N
SAFETY			
ID band visible/legible	[redacted]	[redacted]	[redacted]
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
OTHER			
Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 20%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLS

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	~~BEDREST~~ ~~AMBULATE~~ BSC (BRP) CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST (AMBULATE) BSC BRP CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

b(6)-2

TEACHING

TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: -plan of care -pain management	CONTENT: -ambulate, drink fluids	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 2LT/AN	06-14
[redacted]	[redacted] CPT/AN	E
[redacted]	[redacted] glwome	N

b(6)-2

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2300	Side of head	Staples intact no S/S of infection	assessed

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 20 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 8 | HOSPITAL DAY: 9

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R 1 T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1552	2000	0400												
BP ARTERIAL LINE	/															
BP CUFF	95/54	100/76	85/70	86/50												
TEMPERATURE	99.3	98.7	97.6	98.0												
PULSE	69	81	86	64												
RESPIRATORY RATE	16	20	16	16												
OXYGEN (L/%)	/	/	/													
PULSE OXIMETER	100	98%	97%	100												
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0715	1420	2000													
PAIN INTENSITY (10 / 5 / 0)	X															
MED ADMINISTERED (Y/N)	Y	NA	N/A													
RELIEF ACCEPTABLE (Y/N)		NA														

OTHER

TIME:	0715															
FINGER STICK GLUCOSE	N/A															
INSULIN (Y/N)	1															

SPECIAL NEEDS

TIME:	0715	1420	2300
*Skin breakdown prevention	N/A	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

DIAGNOSIS: 3/P (L) parietal skull fx c epid hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0745 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☑	☐ Speaks @ english
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ generalized weakness	☐ generalized weakness	☐ generalized weakness
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ Sutures and staples to incision on R scalp - intact S/S infection	☐ Staples at Sutures @ side of head intact [redacted]
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 5/10 HA	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0745 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q	8 hr: Good	8 hr:	8 hr:
IV site care provided:	New IV placed		
IV tubing changed:	26 Sept 03 0745		
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(R) FA / OK	(R) FA / OK	(R) FA /
IV Site #2:	/	/	/
Comments:	D5 NS @ 100cc/hr infusing @ KVO well S s/s of infection or infiltration	D5 NS @ 100cc/hr	D5 NS @ 100cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE	N/A					
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0715	1420	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	N/A	N/A	
Bed position low	[redacted]		
Call light within reach	N/A	✓	
Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	N/A	N/A	
Linen change prn	[redacted]		
Turn/reposition q2h	N/A	N/A	
ROM q2h if immobile			
Antiembolic hose	✓	✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT b(6)-2	BEDREST (AMBULATE) BSC BRP CHAIR ☐ SELF ☑ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0715 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: -plan of care -pain management	CONTENT: plan of care	CONTENT:
☒ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 CIV [redacted]	b(6)-2 [redacted]	AN	0074
		LT, AN	2
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
0715	scalp	staples intact, no drainage noted, site S/S of infection	open to air
1420	⊖ parietal portion of scalp	Staples and sutures intact, No S/S infection	open to air
2330	(L) side of scalp	Staples & Sutures intact OTA	assessed
			b(6)-2

SECTION IV - NOTES

0745- New IV placed in (R)FA, D5 NS infusing well @ 100 c/hr [redacted]

1420: Awake + alert. No PO intake D5 NS infusing @ 100cc/hr, [redacted] pain or discomfort @ this time. will continue to monitor [redacted] 7/16