Admission and Coding Information

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

1. Reporting MTF	2. MTF Location
[redacted] H -	IZ

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted] b(6)-4	~~EQN~~	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number
		~~99~~ 20	[redacted] b(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	19:30	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
NO	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU1	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
EXPIRED		2003-10-30

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AAJ - NEUROLOGY		2003-10-30

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-30

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO HEAD OPEN SKULL FX.

Procedure Narrative(s): NONE.

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

Trauma 9 Inj 369

25 HD DX: [redacted] E [redacted] b(6)-4

Cause Death #1 Blood N

Acq N

b(6)-2

Admitting Officer (Signature as required) [redacted]

Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 22452

Automated Facsimile

PATIENT TREATMENT RECORD - COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	43Y	X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]						
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Carded for Record Only (CRO)		19:30	AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-03				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-30	[redacted] b(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] b(6)-2			2003-10-30				

31. Selected Administrative Data

Marital Status: Z DoB: 1960-01-07

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: SHOOTOUT WITH 134TH AR

34. Diagnosis / Operations and Special Procedures:

GSW TO R FLANK WITH ILIAC FX

ID

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	5	5

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	[redacted]	0	5	5

Signature of Attending Medical Offic[redacted]

Signature of PAD or Medical Records Officer

MAJ [redacted] b(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 22453

b(6)-4

A.# [redacted]

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

Offense against Civilian(s) [check one] If "Other" then describe: RPG to convoy, Ambush

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 485(3))
- [x] Other

Offense against Coalition Forces [check one] If "Other" then describe:

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [x] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

Apprehending Unit: 1/34 MAR		Location Grid:	
Date of Incident: (D/M/Y) 30/10/03 to 30/10/03	Time of Incident: 1915 hrs to hrs	Date of Report: (D/M/Y) 30/10/03	Time of Report: 2100 hrs

Detainee # 1256, [redacted] M L	Key Connected Person: [ ] Victim: [ ] Witness
Last Name: [redacted] b(6)-4	Last Name:
First Name: [redacted] Given Name:	First Name: Given Name:
Hair Color: brn / Scars/Tattoos/Deformities:	Hair Color: brn [redacted] / Scars/Tattoos/Deformities:
Eye-Color: brn / Weight: lb / Height: in	Eye-Color: / Weight: lb / Height: in
Address:	Address:
Place of Birth: IRAQ	Place of Birth:
Ethn/Tribe/Sect: / Sex: [x] M [ ] F / Phone#: / DOB D/M/Y: 7/1/60 / [ ] Mobile [ ] Regular	Ethn/Tribe/Sect: / Sex: [ ] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:

Total Number of Persons Involved: 2 (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information	Vehicle Number ___ of ___ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband [ ] Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No		
Type:	Model:		Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:	Where Found:		Owner:

Name of Assisting Interpreter: [redacted] b(6)-2 Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): MAJ [redacted] Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature: b(6)-2	Signature:
Email: [redacted] Unit Phone: [redacted]	

MEDCOM - 22454

Date:

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? fired RPG at Coalition and ran

Who witnessed this [redacted] or the reason for detention? Give names, contact numbers, addresses. [redacted] b(4)-2

How was this person traveling (car, bus, on foot)?

Who was with this person? Iraqi Civilian

What weapons was this person carrying? RPG

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: Fired RPG to Convoy Running From Site and was shot, Ambush Sustained GSW to Buttocks Brought To [redacted] b(4)-2 by 159th MedEvac picked up at Robins Airfield

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

43-yo [redacted] → s/p GSW / IED to right flank.

PMH – ϕ
PSH – Bladder stone removal
NKDA

PHYSICAL EXAMINATION

P-78 BP- 122/78

awake & alert
abd – soft, ϕ peritoneal signs
entry wound R side, no exit wound
foot drop on R, unable to move R leg, some sensation in foot, lateral lower leg

X ray – bullet in spine, ~L4/L5, shattered thru iliac spine

⊕ rectal tone

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

A: GSW R side c LE paralysis.
Hemodynamically stable.

P: CT Abd / pelvis.

b(6)-2

SIGNATURE [redacted]	DATE 30 Oct 03	IDENTIFICATION NO. 2100	ORGANIZATION
PATIENT'S ID [redacted] (ed or written entries give Name last, first, grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

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

[redacted]

b(6)-4

Transfer Summary – Patient [redacted] b(6)-4

43 yo Iraqi EPW sustained GSW to right flank on 30 October 2003. History of bladder stone removal in the past, otherwise no pertinent medical history, no allergies.

On presentation to ER, had a 2x2 cm entrance wound over the right iliac crest, and able to palpate fragments of the iliac wing through the wound. Also had a right footdrop, decreased sensation in the foot and lower leg. Rectal exam was WNL.

Radiographs revealed a comminuted fracture of the right iliac crest, but a stable pelvis. There was a bullet fragment lodged within the body of L-5.

Neurology consult was obtained. Absent DTR's on right, 0-1 motor on right, and decreased sensation on right only, with intact bulbocavernosus reflex and peroneal sensation. Impression was of a lumbar plexus injury.

CT scan obtained which shows iliac crest fracture, and fragment in canal of L-5. Abdomen without pathology. Neurosurgery consult – no indication for removal of fragment, and concurred with diagnosis of lumbar plexus injury.

Hospital Course – Patient taken to OR on 30 Oct 03, had I+D of right iliac crest, with irrigation with 6 liters, and wound packed loosely. Taken back to OR on 1 November, had wound irrigated. Very loose 2x4 segment of iliac crest excised, and wound closed in layers over a penrose drain.

Plan: Remove penrose drain in 48 hours. Dry dressing changes. Ambulate as tolerated. Currently on Ancef 1 gram Q 8 hours and Gentamycin 400 mg q day.

[redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS I**

DATE	NOTES
31OCT.03 0100	Pt A+Ox3, VSS, speaking arabic + english, LS CTA (B), (+)BS x4, abd soft flat nontender, peripheral pulses +2 equal (B), cap ref < 3sec, dsg (R) flank saturated ∈ blood, reinforced dsg ∈ surgi pads + 4x4's, IV (R) FA intact infusing LR @ 100cc/hr, ∅ s/sx of infex or infiltration, foley to gravity draining c/y urine, NPO, 2 point restraint ∈ s/sx of complications. b(6)-2 [redacted] 9IW
	I Concur with above assessm [redacted] CTR
31Oct03 1715	Assume care of PT @ 0600. A+Ox3, VSS Foley to gravity ∈ clear yellow urine. ∅ c/o pain today. Activity consisted of laying in bed. Reinforced dsg to (R) Flank, saturated blood. PT in 2pt restraint ∅ signs of irritation b(6)-2 Will cont. to monitor. 9I USPC [redacted]
31Oct03	Surgery Pt. doing very well. No complaints. started diet and ambulation; planned for washout tomorrow per Orthopedics 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.	

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

LAST NAME	FIRST NAME		ID NUMBER

DATE	NOTES
31OCT.03 2000	Pt asleep, easily aroused, VSS, dsg + chux pads saturated c̄ blood, Δ'd CDI, wound packed, covered c̄ 4x4's and surgi pads, ∅ c/o pain or discomfort, HL IV intact, ∅ s/sx of infex, LS CTA (B), ⊕BSx4, peripheral pulses+2 equal (B), cap ref <3 sec, 2 point restraint s̄ s/sx of complications. [redacted]
1NOV03 0520	VSS, AO. Resident [illegible] drainage to (R) flank. Taken to OR [redacted]
1NOV03 1005	Ortho Op note b(6)-2 All
	Pre Op Dx - GSW to (R) ilium
	Post Op Dx - Same
	Procedure - I+D, DPC (R) ilium exit GSW
	Surgeon - [redacted]
	CBL - MAC
	Findings - Wound clean [illegible]. Removed one 2x4 cm rotated fragment. Closed in layers over penrose drain.
	Plan: Remove drain in 48 hours. Mobilize.
	[redacted]

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

MEDCOM - 22459

ACLU-RDI 1670 p.8

DOD-036035

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

b(a)-2 tnl

DATE	NOTES
1NOV.03 2100	Pt A+Ox3, VSS, peripheral pulses equal Ⓑ, Ⓡ flank wound sutures CDI, penrose drain in place draining small amount of blood, dsg 1'd, Ø c/o pain, LS CTA Ⓑ, ⊕BSx4, pt consumed most of diet, IV SL flushes well, Ø s/sx of infection, voiding cyu via urinal, 2 point restraint ≤ any complications. [redacted] qiw
Ø2 NOVØ3 1300	Rt A10, VSS, LCTAB, ⊕BSx4, drsg to Ⓡ flank c̄ scant amt of bloody drainage. Ø c/o pain @ this time. Ⓛ leg c̄ +1 pedal pulses, Ⓡ leg c̄ +2 pedal pulses. Pt has more strength & movement to Ⓡ leg. Pt unable to wiggle toes to Ⓛ foot. ⊕ sensation to Ⓑ feet. Pt refused to get OOB because he could not move his Ⓛ foot. Plan: notify MD, PT consult? Will monitor [redacted] qiwmb.
2NOVØ3 2030	Pt A+Ox3, VSS, Ⓡ flank dsg 1'd, scant blood drainage from penrose drain, sutures + penrose drain intact, Ø s/sx of infex on wound, left LE pulse weaker than RLE, equal Ⓑ, Ø c/o pain, pt unable to move toes on RLE, LS CTA Ⓑ, ⊕BSx4, voiding cyu per urinal, 2 point restraint, Ø complications. [redacted] qiw I cm cm with abx

STANDARD FORM 509 (REV. 5/[redacted]) BACK
USAPA V1.00

#[redacted] MEDCOM - 22460

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/3/03 1040	A & O. Able to make needs known. VSS. (R) flank dsg Δ done. Wound c sutures & penrose intact. Small amount of bloody drainage noted. NL patent & fluided. O2 pt restraint & compromise to skin or circulation. Medicated c Percocet two tabs p.o. in preparation for pain control during transfer to [redacted]. Will continue to monitor & provide emot[redacted] support. [redacted] mds
11/3/03 1050	Transferred to 21ST CSH [redacted] mds

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

MEDCOM - 22461

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: # [redacted] blu-2

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 30 OCT 03 | TIME: 1950

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE 43	HOME PHONE		FLYING STATUS			
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

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

CURRENT MEDICATIONS: 0

ALLERGIES: 0

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

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

CHIEF COMPLAINT: GSW R. thigh

CATEGORY OF TREATMENT

☐ EMERGENT
☑ URGENT
☐ NON-URGENT

TIME: 1950

INITIALS: MM

VITAL SIGNS

TIME	1950				
BP	132/68				
PULSE	78				
RESP	22				
TEMP	97.5				
WT					

LAB ORDERS

☑ CBC/DIFF	ABG	☑ PT/PTT	BHCG/URINE/BLOOD/QUANT	
URINE C&S	UA MSCC/CATH		CHEM: 12 c 4yes	
BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 99% — blu-2 — ☐ MONITOR — ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2040	fentanyl 100	[redacted]			

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

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

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

[redacted] blu-1

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

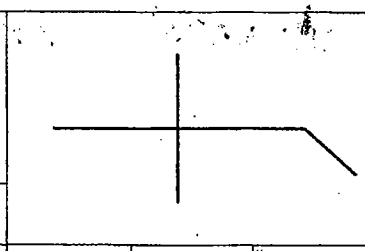
MEDCOM - 22462

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC, H/H, PLT; SMAC



ABG/PULSE OX: SUP 02 | PH | PO2; PCO2 | SAT | OTHER

RADIOLOGY — Check if read by radiologist ☐ — RESULTS

PT

U/A: DIP; MICRO

EKG INTERPRETATION

APTT | BHCG | ETOH | GLU

PROVIDER HISTORY/PHYSICAL

43 y old EPW C GSW to R. ~~thigh~~ hip, Pt A+OX3, vitals stable at present time, PPP, skin cool + dry — [redacted] 2 CTAs b6-2

Pt is 43yo Iraqi ♂ s/p GSW to Ⓡ flank c/ bilateral iliac fx, + wound penetrating c ∅ exit wound. PMH-∅ PSH-bladder surgery

CV: RRR & Ⓝ

Lungs: CTA Ⓑ

Abd: soft, NT/ND, No rigidity

CT Abd/pelvis:
- free air Retroperitoneally
- ∅ in peritoneum.
- open iliac crest fx.

Flank: Ⓓ entrance wound; Ⓡ flank, iliac fx palpated + wound extends ventral + superior. serous drainage, Minimal.

Rectal: ⊖ guiac Ⓓ Brown copper GS exam

Neuro: Ⓡ Leg ∑ Hip/knee & foot ext/flexion, Ⓓ foot Drop. ∅ DTR Ⓡ

xrays: Ⓓ Ⓡ iliac fx, Ⓓ Bullet Lodged in L5.

CONSULT WITH	TIME	ACTION
NS		
GS		
Ortho	2130	admit
Lumbar Plexopathy.		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

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

DIAGNOSIS — Deficits on Ⓡ to level of L2 (Lumbar Plexopathy)
- GSW to Ⓡ flank → stable, lodged in L5.

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 43 HEIGHT: WEIGHT: 60 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): None 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): 27

4. PROPOSED SURGICAL PROCEDURE:
I & D (R) hip

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

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

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

[redacted]
b(6)-4

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

MEDCOM - 22464

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

10. OR [redacted] LETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 30 0403 DATE

11. POSTOPERATIVE EVALUATION:
Bowel pad site clear, dry, intact. Able to move awake, DRESSING dry clean.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] b(6)-2	[redacted]
DATE: 30 0403 TIME: 2210	DATE: 300403 TIME: 2320

REVERSE OF DA FORM 5179, JUN 91 MEDCOM - 22465 USAPA V1.01

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the pro[illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATI[illegible]OM VIA Litter BY Anesthesia

2. PATIENT IDENT[illegible]RD REVIEWED AND PROCEDURE VERIFIED BY [redacted] (Emergency)

3. DATE 30 OCT 03 TIME PATIENT ARRIVED IN SUITE 2213

4. PATIENT IN ROOM TIME 2215 b(6)-2 NUMBER 1 - Emergency

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: able to move UE. awake, alert. NPO ?? Pt allergies

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) R placed - on bed, arms on arm boards <90°. Placed in (R) side up. (L) arm on arm board (R) arm across on pillow pillow under between legs. Strap above Knees. axilla. Gel pads

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

COMMENTS:

8. SKIN PREPARATION free of pressure

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

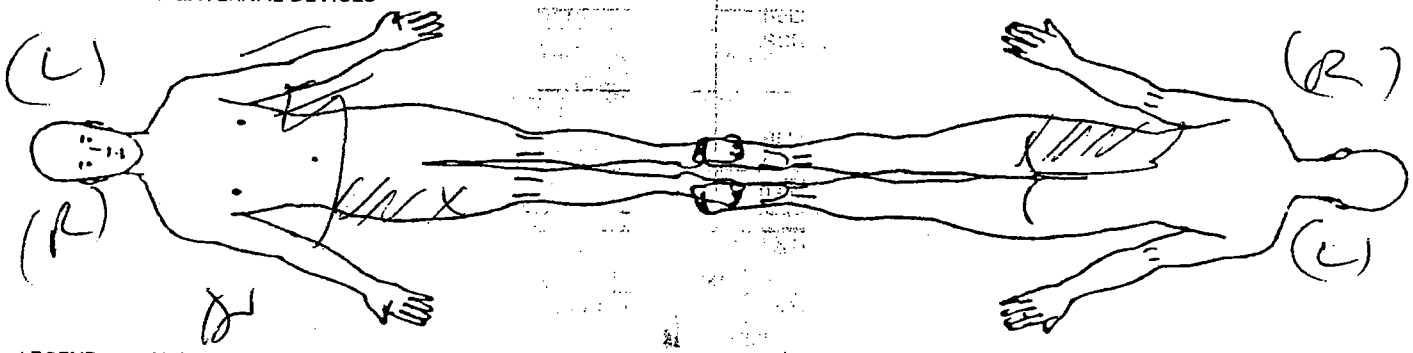
PREP SOLUTION (Specify) Betadine

SITE: (R) Back BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO Call 30

☒ ESU NO: Valley Lab 40 Room 1 Log 30

GROUND PAD: BRAND Kendall Polyhesive

LOT NO: 65705 11/2004

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 22466 I IS OBSOLETE. USAPA V1.00

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

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): Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	16fr Foley	3/8 Penrose	
SITE	Bladder	(R) hip	

19. ADDITIONAL INFORMATION

S# [redacted] blood T: [redacted] Type anesthetic: General

Wound site clean, dry, intact. pre-prep SP

20. OPERATION(S) PERFORMED

I&D (R) hip.

21. PATIENT TRANSFERRED TO blood PACU TIME 2316 METHOD wheeled

22. REGISTERED NURSE SIGNATURE [redacted] RN

MEDCOM - 22467

REVERSE OF DA FORM [redacted]

USAPA V1.00

b(6)-2 All

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the pro[illegible] agenc[illegible] the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATI[illegible]OM
VIA Litter BY Anesthesia

2. PATIENT IDENT[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted]

3. DATE 1 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0915 NUMBER 2 # 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* A. lateral on padded OR table position supported by bean bag. Axillary roll (B) Axilla. Pillow between arms and legs.

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

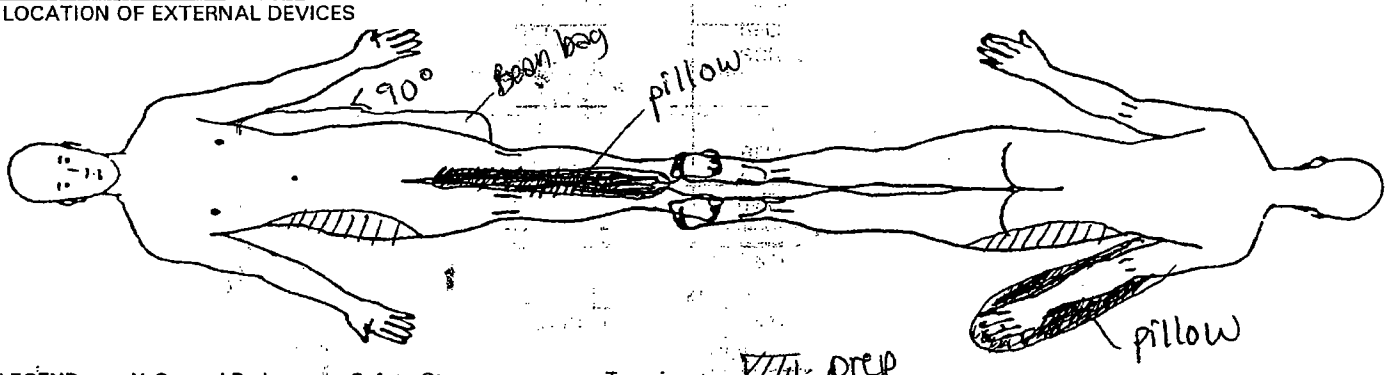
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) hip BY WHOM: 1LT [redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet ////: prep

INITIAL: PFC [redacted] 1LT

C = Correct I = Incorrect

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

SCRUB: PFC [redacted]
CIRCULATOR: 1LT [redacted]

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

[redacted]
b(6)-4

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

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9 % NaCl - 0.5

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. (R) Hip	2.	3.

Fluffs

19. ADDITIONAL INFORMATION WC : IV

Surgeon: Dr. [redacted]
Anesthesia: MAJ [redacted]

b(6)-2
ANT

20. OPERATION(S) PERFORMED

I&D (R) Hip

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 22469 USAPA V1.00

511-119

NSN 7540-00-634-4124

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.

b(a)-4

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 22470

Ward/Section: EMT	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] blw-2	DATE: 30OCT03	TIME: 2002
SSN/PSEUDO SSN: [redacted] 66-4		

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
30/10/03 20:15
REFERENCE RANGE: MALE
PATIENT #: [redacted] blw-1
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: blw 0000100684

ALB	3.8	3.3-5.5	G/DL
ALP	62	26-84	U/L
ALT	25	10-47	U/L
AMY	37	14-97	U/L
AST	40*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CHOL	♦♦♦	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	199*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
30/10/03 20:14
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100697

GLU	199*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	441*	39-380	U/L
NA+	127*	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

				tCO_2	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] 66-4	DATE: 30OCT03 TIME: 2002	SSN: [redacted] 66-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs	85	Mono	3
Bands	4	Eos	1
Lymph	7	Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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)
Propofol	(mg)
Succ/Vec	(mg)
Fentanyl	(cc)
	( )
Robinul	( )
Neostigmine	)
VOLAT AGENT: Forane 2% del	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS

LINE site R hand A-L	☐ Warmed
20 g IV	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 134/76; HR- 77

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 2215 30 45 2300 15 30 45 2400 15 30 45 0100 15

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

	2215	30	45	2300	15	30	45	2400	15	30	45	0100	15
VT - ml	830	790	810										
f - breaths/min	10	10	10										
Peak inf pres / PEEP	23	22	22										
MODE - S(pon), A(ssist), C(on)	CV	CV	CV										

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	37	34	33									
BP/oth	FIO2 (Frac or %)	61%	65	62									
ART line	SpO2 (%)	100%	100	100									
Steth- PC/ES	ECG	SR	SR	SR	ST								
✓ Gas analyzer	TEMP-site												
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

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

TOTALS: TOTAL EBL <50; TOTAL URINE 15

FLUIDS - SUMMARY: CRYSTALLOID 1200; COLLOID-; BLOOD-

REMARKS (Code drugs with numbers, events with letters)

(1) V/S Taken
(2) Inducted c Lidocaine 20mg Diprivan 170mg Anectine 100mg Intubated
(3) Procedure began
(4) Procedure ended
(5) Suctioned & cath, extubated To recovery

RECOVERY AT: PACU ICU ____ (Specify); OTHER ____

CONDITION: Extended

RESP- 24 SpO2- 100

BP- 127/99 HR- 96

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2130	2214	2325
PROC	Ready	Begin	End
	2232	2246	2303

PROCEDURES and CPT Codes: (1) Wash-out & Packing (2) (3) HIP (4) Wound

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: Gen Endo

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: #8.0 ET tube c #4 MG Blade

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

[redacted] - 4

SURGEONS: [redacted] b(4) - 1

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR

DATE: 30 Oct '03

PAGE 1 OF

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

MEDCOM - 22473

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)	30	45	1000
Cine ( )	100		
Propofol ( )	100		
Succ ( )	100		
Fentanyl ( )	100	50	
( )			
Versed ( )	3		
VOLAT AGENT Forane % del	2.5	1.5	1.2 X
% e.t.			
AIR L/Min	0		
N2O L/Min	0		
O2 L/Min	6	2	2 6

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

FLUIDS

LINE site (R) fem	☐ Warmed	200 #2 ~ ~ 700
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	
URINE -	1500

TOTALS

TOTAL EBL	TOTAL URINE
0	1000

FLUIDS - SUMMARY

CRYSTALLOID- 700

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 130/82

HR- 91

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME 30 45 1000 15 30 1103

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

Resp rate

BR (transduced): ╪

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	1400	780	760	710
f - breaths/min	10	8	8	8
Peak inf pres / PEEP	28	22	22	22
MODE - S(pon), A(ssist), C(on)	S C	C	C	C

MONITORS/ACCESSORIES

✓	BP/Auto Cuff	✓	ET CO2 (torr)	34	29	32 33
	BP/oth	✓	FIO2 (Frac or %)	.77	.77	.77 .77
	ART line	✓	SpO2 (%)	100	100	100 100
	Steth- PC/ES	✓	ECG	SR	SR	SR SR
	Gas analyzer	✓	TEMP-site	Skin	→	→
			N-M Block (T/4)			
	Warming blkt					
	Conv warmer					

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

RECOVERY AT 1016

PACU ICU _____ (Specify)

OTHER _____

CONDITION: 96.5

RESP- 16 SpO2-

BP- 132/66 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	938	915	1010
PROC	Ready	Begin	End
	920	937	

PROCEDURES and CPT Codes:

1410 (R) Hip

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

[redacted]

b(6)-4

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

0 ETT mac 4 Grade I view

SURG [redacted]

b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 2-1

DATE: 1 NOV 03

PAGE 1 OF 1

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

MEDCOM - 22474

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Oct 03	Neurology Note
2100	43 y/o Iraqi EPW who presents s/p GSW to (R) flank/pelvis with (R) LE plegia. No other reported injuries.
	Focused Neuro exam: awake alert, moving upper extremities purposefully. motor exam in LE's reveals 0-1/5 strength diffusely in (R) LE, moves (L) LE well. DTR's → absent (L) knee jerk / (L) ankle jerk, 2+/4 elsewhere, ↓ pinprick over (R) distal lateral leg/foot. retained perineal sensation intact bulbocavernosus (per EMT)
	CT reveals iliac crest fracture with penetration of canal at L5 level ⌀ hematoma
	Imp: (R) lumbar plexus injury / lumbosacral nerve root injury 2° to GSW
	Plan: (1) clinical case reviewed with neurosurgery (Dr [redacted] and no clear role for surgery due to essentially a double crush injury of the plexus/roots
	[redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Oct 03 2305	Ortho Op Note Pre-Op Dx - GSW with open (R) clavicle fx Post Op Dx - same Procedure - I+D (R) clavicle Surgeon - [redacted] b(6)-2 EBL - min Findings - Comminuted iliac crest fractures, but stable pelvis, Encysted 6 liters, packed with 4 gauzes. PLAN: Repeat I+D in 48-72 hours. [redacted] COL KL

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	30OCT03	2250 HOURS	
1	Admit to Ward		✓
2	Staff: Ortho; Alberston; GS		[redacted]
3	Dx: GSW to R flank & L ilium		Fracture
4	Condition: stable		
5	NKDA		
6	Vitals: q 4°x2; then q 6°		
7	Activity: Bed [redacted] rest		

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
8	Foley to gravity		
9	I+O's		
10	Incentive Spirometry 10x/hr while awake		
11	Diet: NPO x meds to sips		
12	IVF: LR @ 100cc/hr		
13	MSO4 2-4mg IV q 2-4 hr prn severe pain		
14	Percocet 1-2 p.o. q 4-6° prn pain		
15	Tylenol 650mg p.o. q 6°		

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
16	Ancef 1 gram IVPB q 8°		
17	Gentamycin 400mg IVPB q 24° 1st dose in ER (four hundred milligrams)		
18			

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. 165 | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	31OCT03	1601 HOURS	
1	Lovenox 30mg SubQ BID		
2	TKO IVF		
3	Advance diet to Regular as tolerated		

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 31 OCT 03 TIME OF ORDER 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) NPO after midnight for surgery 1 Nov 03 b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] 1 NOV @ 0400 [redacted] RN 1635 31 OCT 03

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 1 Nov 03 TIME OF ORDER 1009 HOURS

(1) Resume previous orders

(2) Regular diet

(3) Hep lock IV

(4) D/C Foley

(5) Up ad lib with crutches

OOB to chair

1505 1 NOV 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER [redacted]

noted [redacted]

1 Nov 03 2251

(1) Transfer to 21st CSH [redacted]

b(6)-2

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

24° / 0500 2 NOV 03

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER [redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 22478

ACLU-RDI 1670 p.27

DOD-036054

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.

Month: Oct/Nov Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (NOV) 30	31	1	2	3	4	5	6	7
31Oct	[redacted]	VS Q4 x2; then	D	/	[redacted]							
		Q6°	N									
31Oct	[redacted]	Activity Bed rest	D	/								
			N									
31Oct	[redacted]	Foley to gravity	D	/								
			N							D/C ↓		
31Oct	[redacted]	I+O's	D	/								
			N									
31Oct	[redacted]	Incentive Spirometer	D	/								
		10x/hr WA	N									
31Oct	[redacted]	Diet NPO ☒ ice chips	D	/								
			N		D/C 31OCT03							
31Oct03	[redacted]	Adv diet to regular	09	/								
		as tol.	15	/								
			18	/								
			22									
1NOV	[redacted]	Up ad lib c Crutches	09									
			15									
			18									
1NOV	[redacted]	OOBTC TID	7	/	/	/						
			14	/	/	/						
			21	/	/	/						

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW to (R) Flank c Iliac fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 22479

b(6)-2

Verity 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
30 Oct	[redacted]	Admit to Ward	30 Oct	0045	—	[redacted]
30 Oct	[redacted]	Staff Ortho [redacted] GS [redacted]	30 Oct	0045	—	[redacted]
31 Oct	[redacted]	Condition Stable	31 Oct	0045	—	[redacted]
31 Oct	[redacted]	NPO p MN 10/31 for Surgery	31 Oct	0600	—	[redacted]
		1 NOV 03				
By 1 NOV	[redacted]	Resume Previous Orders	1 NOV	1500	—	[redacted]
1 NOV	[redacted]	D/C Foley	1 NOV	1530	—	[redacted]
		✓				
1 NOV	[redacted]	Transfer to [redacted] b2-2				

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

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo.____ Yr.____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	3
31 Oct	[redacted]	IV LR @ 100 cc/hr	D	/	> D/C			
	-----		N	[redacted]				
31 Oct	[redacted]	Tylenol 650 mg PO						
	-----	Q6°						
31 Oct	[redacted]	Ancef 1 gram IVPB Q8°	08	/	[redacted]			
	-----		16	/				
	-----		24	/				
31 Oct	[redacted]	Gentamycin 400 mg	X					
	-----	IVPB Q24°	10	[redacted]				
	-----	1st dose in AM	X					
31 Oct	[redacted]	Tylenol 650 mg PO	06	/	[redacted]			
	-----	Q6°	12	/				
	-----		18	/				
	-----		24	/				
31 Oct 03	[redacted]	Lovenox 30 mg SQ BID	10	/				
	-----		22	/				
31	[redacted]	TKO IVFs	06 18	/	> D/C'd 1 Nov 03			
	-----		18 06	/				
1 Nov	[redacted]	Hep IV	6	/	/	[redacted]		
	-----		18	/	[redacted]			

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to (R) Flank & Iliac fx

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 4870 MEDCOM - 22481
EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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
		D/C'd				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
31 Oct [redacted]		MSO4 2-4 mg IV	D/T 31 Oct 0225 4mg
		@ 2-4 hr prn N	D/I [redacted]
		Severe pain	I/E
31 Oct [redacted]		Percocet 1-11	D/T 31 Oct 2
		p.o Q4-6° prn	D/I [redacted]
		pain	E/I
		~~Tylenol 650 mg~~ Error	
		~~p.o Q~~	

*U.S. GPO: 1998-454-110/95216

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 Oct 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 2320
Allergies: ______ OR Intake: Crystalloid 1200 Colloid ______
Pre-op V/S: 134/76 77 OR Output: UOP 100 EBL 50cc
Procedures: I&D of R hip Meds/Times: Foran Deprivan

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

Airway: Nasal, Oral (circled), ETT, Trach, Other

Pre Op Meds History

Time	2320	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								
SaO2	44	100	98	99	98	97	100	98								
FiO2		10L	8	8	8	4										
Methods	RA	FM	FM	FM	FM	FM	RA	RA								
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR		18	24	26	28	23	18									
T		97					97									

Time	2320	2350						
Pain (0-10)	0	0						
LOS								

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2320	NS/LR	100/800	Ø FA/Ø hand	[redacted]	200

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	0	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	1	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.	4	10	10

Codes

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

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

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

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

(Continue on reverse)

PREPARED BY [redacted] LPN b(6)-2 written entries give: Name – last, grade; date; hospital or medical facility)

DEPARTMENT/SERVICE/CLINIC: ICU3/PACU

DATE: 30 Oct 03

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

[redacted]

b(6)-4

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

MEDCOM - 22483

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

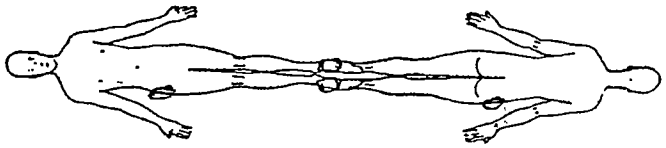
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R hip	gauze & tape	min
30'	R hip	" "	min
60'	R hip	" "	min
D/C	R hip	" "	min



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0020	Foley	clear / clear	290

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2320	ST	N	N

WAMC OP 173-E

NURSING NOTES

2325: Pt arrived to PACU via litter, Sao2 94% room air & oral airway in place. Pt put on 10 l/s non rebreather & Sao2 100%. Pt starting to awake, will cont to monitor. [redacted]

2350: Pt on 4 l/s non rebreather & oral airway removed. Pt awake & following command occassionally. Denies pain @ this time. [redacted]

0020: Pt transported to [redacted] via litter in stable condition. [redacted]

b/o - 2

AM

Discharge Criteria:

Date: 31 Oct Time: PARS:
BP: 118/67 T: 97.4 HR: 73 RR: 22 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: 2400 Output: 290
Additional Data:
Transferred To: ICU 2
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted]

Admission and Coding Information

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

1. Reporting MTF	2. MTF	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	IZ b(6)-4	[redacted]	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1960-01-07	43Y	X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number
		~~99~~ 20	[redacted] b(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	19:30	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
N/A	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
	0	BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Carded for Record Only (CRO) b2-2		Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - [redacted] Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH 21		2003-11-03

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS	A IIAI	2003-10-30

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-30

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO R FLANK WITH ILIAC FX

Trauma 9 Inj 569

Procedure Narrative(s):

~~80861~~ Dx: 95533 99912 3441 Px: 7760

Blood N

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

b(6)-2

Admitting Officer (Signature, as required) [redacted]

Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 22485

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register No.	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-2					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	34Y	X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]	b6-4				ICU2	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		19:30	-				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-A	2004-01-29				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-30	[redacted] b(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] b(2)-2			2003-10-30				

31. Selected Administrative Data

Marital Status: DoB: 1969-07-11

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: SHOOTOUT WITH 134TH AR

34. Diagnosis / Operations and Special Procedures:

GSW TO BACK

Dx 876.0 E991.2

Px 99.29

35. Total Days This Facility b(6)-2

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	91	91

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
[redacted]	[redacted]	0	0	91	91

[redacted]

Automated DA FORM 3647, May 79

MEDCOM - 22486

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26jan04 @ 0410.	Assumed care @1900. AAOx3. VSS. afebrile. colostomy bag intact and dry around site. Soft stool. Access draining in small amt about twice since 1900. Skin integrity intact. ds able to move. Eating and taking Ensure for supplement. Encouraged use of ICS. Voiding clear yellow urine in sufficient amounts. no c/o pain. b(6)-2 [redacted]
27Jan04 @0605	- Bile colored emesis about 100cc. Pt. [redacted] aware. phenergan ordered. Pt. slept well throughout night. VSS. AF. O2 sat 99%. afebrile voiding clear yellow urine.
27Jan04 @0814	Assumed pt. VS wnl, IV @ foot, pt AAO to verbal stimulus, @ pain. Will draw labs [redacted]
27Jan04 1033	Pt. @ foot IV d/d, IV in @ wrist and double lumen hep lock in @ forearm flushed c NS & heparin - patent. Will cont. to monitor [redacted]
27 Jan 04 @ 2330	Assumed care of Pt @ 1900. VSS. @ complaints of pain/discomfort. Colostomy bag intact. Pt AAOx3. 2x2 placed on abd due to minimal oozing of blood. IV in @ arm patent. @ skin compromise from restraints. Will continue to monitor [redacted]
28 Jan 04	(1630) ASSUMED CARE OF PT AT 0700. VSS AAO x 3. IV [redacted] STILL TO R ARM INTACT & SIGNS OF INFILTRATION. IV TO L FOREARM, NVC & COLOSTOMY CARE GIVEN & SIGNS OF INFECTION. COLOSTOMY

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont	BAG CHANGE, CLEAN - INTACT PT UP OOBTC TOLERATED WELL. [redacted] 91LPN/b
28 Jan 04 2310	Assumed care of Pt @ 1900. VSS. A+Ox3. Pt had 2/10 pain. IV to (R) arm patent. Colostomy cleaned and changed. Pt turns himself side to side. Restraints intact & skin compromise. Will continue to monitor. [redacted] 91W/f
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0C

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 Jan	1400 HOURS	

Bolus 1L NS over 20
then 1mm NS @ 75cc/hr

[redacted]

25 Jan 04
1400

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

27 Jan 04 0600 HOURS

1. phenergan 12.5 mg IVP Q 8 hr prn nausea/vomiting
2. CT abd/pelvis ± IV contrast
3. renal panel, CBC, PT/PTT x 1
4. T&C x 2 u
5. NPO p MN
6. on call to OR 28 Jan 04

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER

[redacted] HOURS

[redacted] MC

28 Jan 04 0810

1. advance diet as tolerated
2. OR on hold - will reschedule

[redacted] MC

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

29 JAN 04 0710 HOURS

NPO

[redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

"USE BALL POINT P[redacted] MEDCOM - 22489 N PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4	24 JAN 04	HOURS	
	1 D/C NPO		
	2 REGULAR DIET c		
	3 ensure @10		
	4 NPO p midnight		
	0916.		
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted]		HOURS	
	b(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

☆U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

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

MEDCOM - 22490

b(2)-2

1. Reporting MTF	2. MTF Lo	Admission and Coding Information
[redacted]	IZ	For use of this form, see AR 40-400; the proponent agency is OTSG

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(6)-4		FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1969-07-11	34Y	X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] b6-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		19:30	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
N/A	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU2	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-A		2004-01-29

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
-		2003-10-30

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-30

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO BACK

Procedure Narrative(s):

T: 1 Dx: 8760
Inj: 450 E9912

Cause of Injury Narrative: SHOOTOUT WITH 134TH AR

Admitting Officer (Signature, as required)	S
[redacted] b(6)-2	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 22491

Automated Facsimile

IN[illegible]TIENT TREATMENT RECORD C[illegible]ER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	36Y	X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	23:11	AAJ - ~~NEUROLOGY~~ Neurosurgery					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	HOME	2003-11-10					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-10-30	[redacted] b6-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 - [redacted] b2-2 - Iraq		2003-10-30					

31. Selected Administrative Data

Marital Status: Z DoB: 1967-10-10

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

OPEN DEPRESSED SKULL FX

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

35. Total Days This Facility b(6)-2

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	[illegible]	Total Sick Days
[redacted]	[redacted]	0	[redacted]	[redacted]	10

Si[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 22492

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 yo ♂ Iraqi s/p ~~motor~~ fragment wound to Ⓡ forehead from attack in Balad @ 1900 this evening. Pt. was awake, alert with CI evidence of ~~bye~~ depressed metal/bone fragments for Ⓡ frontal lobe.
No neuro deficit ~~to~~ c chronic ipselateral lower facial weakness.

PHYSICAL EXAMINATION
A&O x 3 normal mental

~~HEAD~~: Ⓡ forehead open depress skull fx w/ pulsatile CSF bone / brain exposed.

Pupil: Briskly/Reactive/EOMI ~~motor~~ Symetric/Equal no drift

Ⓡ extremity superficial injuries to Ⓡ knee/thigh

Lungs: CTA Heart RRR s murs

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

Ⓡ. Open depressed skull fx from penetrating brain injury.

b(6)-2

[redacted]

PATIENT'S IDENTIFICATION	DATE 10/30/03	IDENTIFICATION NO.	ORGANIZATION
(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 22493

b(2)-2 [redacted] auma Flow Sheet

Time of Arrival 1940
Name/Rank IRAQI # [redacted]
Unit
SSN:
DOB AGE: 40 SEX M
Location of Unit: N/A

Chief Complaint Multiple Shrapnel Wounds
Time of C/C: 1845 LOC Duration UNK
Transported by: (Air) Ground Amb Military Vehicle
Medications NONE
Allergies: NKA

Airway ☑ Clear ☐ Obstructed Intubated ☐ Tube size ____
C Spine: ☑ Immobilized ☐ Cleared · Time: 2000
Breathing: ☑ Normal ☐ labored ☐ shallow ☐ assisted ☐ absent ☐ trach deviation
Circulation: IV's on Arrival 18G to @ AC
Pulses: Upper ☑ Lower ☐ Carotid ☑
Skin: ☑ Cool ☑ Dry ☐ Diaphoretic ☐ pale ☐ flushed ☐ mottled ☐ cyanotic
Chest: Breath Sounds: Clear ☑ R ☑ L
Decreased ☐ R ☐ L Absent ☐ R ☐ L Wheezing ☐ R ☐ L
Rales ☐ R ☐ L Ronchi ☐ R ☐ L
Moves upper Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N
Moves Lower Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N

PROCEDURES
C Collar ☑ Backboard ☐ NG/OG ____ FR Foley ____ FR
CT 2015 FR ☐ L R ☐ Rectal Tone + ✓ − ____
O2 ☑ Device NRB % 10L
Radiology: Time 2010 XRAYS: (Chest) (C Spine)
Other Bil femurs, (R) tib-fib, pelvis
Labs: (CBC) (CHEM 7, Liver Panel UA T&C Units ____
OTHER T+S
Monitor (+) EKG (+)

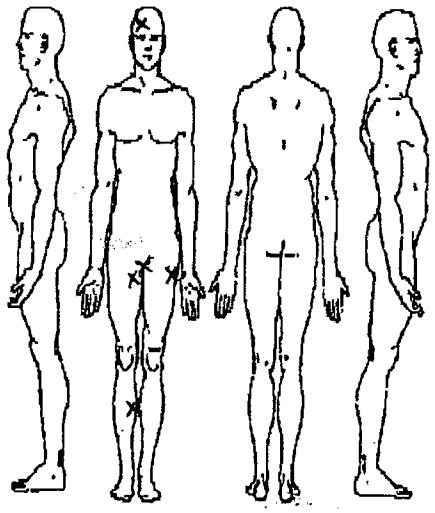
MEDICATIONS/PROCEDURES DONE IN THE FIELD

NONE

MEDS/FLUIDS	TIME	INIT	MEDS/FLUIDS	TIME	INIT
1000cc NS	1950	[redacted]			
~~100~~ 0.5cTD IM	1985				
Ancef 2gm. IV	2045				
Dilantin 1g IV	2215				
		b(6)-2			

Time	1945	2000	2015	2030	2045	2100	2115	2130	2150	2215
BP	136/90	134/79	147/91	143/87	140/86	142/91	134/81	142/85	136/86	142/87
P	91	87	80	81	91	79	79	77	81	76
R	22	20	20	20	18	18	18	18	18	16
T	97° @									
SAO2	100%	97%	98%	100%	100%	100%	100%	99%	98%	98%
GCS	15									

A - Abrasion
AP - Amputation
AV - Avulsion
B - Burn
C - Contusion
DP - Decreased Pulse
E - Ecchymosis
F - Fracture Closed
FO - Fracture Open
IV - IV Lines
GSW - Gunshot Wound
H - Hematoma
L - Laceration
LS - Sutured
P - Pain
SW - Stab Wound
S - Scar
SP - Splint
T - Tenderness
SR - Shrapnel



NOTES

(1940) 40 ♂ Iraqi civilian presented via medevac for multiple shrapnel wounds sustained. Airway patent. 10L O2 via NRB. Lungs CTA. x1 IV present - patent. Wounds to forehead, @ pelvis, bilateral femurs, (R) tib-fib, and genitalia @ minimal bleeding. VSS. A:Ox3. @ Calm / cooperative.
(1950) 18Ga #2 placed in @ AC. Labs to process. @ pain in neck ~~after~~ c-collar placed. Dressings placed on wounds.
(2010) Pt. transported to XR via gurney. @ cardiac monitors in place. O2 @ 4L via NC. @ Condition stable. NAD.
(2055) XR complete. Pt. transported to CT for head/neck studies. Condition stable. (2125) Pt. returned to EMT from CT. @ Tolerated well. Pt. dx c intracranial injuries 2° to shrapnel. Prepared for evac to [redacted]

CON'T NOTES ON REVERSE SIDE

GLASCOW COMA SCALE

1. Eye Opening:

Spontaneous	4
To Voice	3
To Pain	2
None	1

2. Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Words	2

3. Motor Response

Obeys Commands	6
Purposeful Movement	5
Withdraws (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	

GCS ON ARRIVAL 15

GLASCOW COMA SCALE (PEDIATRIC)

1. Eye Opening

Spontaneous	4
Speech	3
Pain	2
None	1

2. Best Verbal

Oriented, Smiles, Cries	5
Confused	4
Inapprop/inapprop cry	3
Incomprehensible/grunts	2
No response	1

3. Best Motor b2-2

Spontaneous	6
Localizes Pain	5
Withdraws to Pain	4
Decorticate (Flexion)	3
Decerebrate (Extension)	2
None	1

GCS ON ARRIVAL b6-2

NOTES (CON'T)

↑HoB. IVF ↓. Wounds cleaned and re-dressed. ~~excluding~~ Wound to forehead re-dressed. Tolerated well. VSS, NAD.

2215 Dilaudid 1gm IV infusion started @ approx. 200cc/hr. 16FR Foley catheter place ∈ approx. 1200cc return. @ clear/ straw colored urine. Pt. tolerated well. VSS. @ cardiac monitors in place.

2230 Pt. prepared for transport to helipad via ground ambulance and air evac to [redacted]. Report called to [redacted] by CP1 [redacted] - flight attendant. VSS. @ Cardiac monitors in place. Condition stable. [redacted] T, AN

2230-1200 cc removed from foley [redacted] /AN

2300-Enroute-P83, Sat> 96%. RR 22. Pt stable, comfy. [redacted]

BLU-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/31/03	Brief OR note
0115	Pre-op Dx: S/P Penetrating Wound to (R) Frontal Lobe
	Post-op Dx: Same
	Proced: (R) Frontal Craniotomy, Debridement of Depressed Skull fx
	Surg: [redacted] b(6)-2
	EBL: 150cc
	Drain: 0
	Anesth: GETA
	Fluids: 1L 0.9NS
	U/O: 300cc.

b(6)-2

[redacted]

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

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 OCT 0230	Received patient via stretcher from OR. Transferred c 4 person lift to bed. Connected to monitor, temp taken, VSS. Drsg to skull CDI. 2 PIV - ® AC HL, 18G. © AC 18g c D5NS c 20K @ 125cc/h. Foley to gravity, light clear yellow urine. 2 small wounds upper thigh c blooded tinged dressing, Δ @ 0220. Drsg to (B) lower extremities CDI. Will monitor. [redacted] (b)(6)-2
0600 31 Oct	Received report from night shift. Pt resting [redacted] (b)(6)-2 comfortably in bed. Ø c/o. Interpiter in for neuro assessment PERRLA 3 x 3, follows commands, equal strength in both sides of UEL ext. HOB ↑ 30°, tolerating PO sips of water well. will continue to monitor
1200 31 Oct	Ø significant change in neuro status since this AM, Neurologically intact, taking PO well; will continue to monitor

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.

SI [redacted] p (b)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1988)
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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/21/03	Neurosurgery POD #1 S/P (R) Frontal Debridement & Ext Depressed Skull Temp: 99.6 Dsg - clean dry / drsng intact Motor - moving symetrically Eyes: pupils PERRLA w/ cons/ EOMs A/B: Advance Diet. Dc [redacted] to obtain of ICU [redacted]

[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

MEDCOM - 22498

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES b(6)-2
1NOV03 @0145	Pt transferred from ICU2. via W/C, placed in bed ī 2pt restraints, on ī S/Sx of skin/circulation compromise. VSS, Alert, speaks arabic, follows commands, equal strengths BIL UE/UE, PERRLA, slight (R) sided facial weakness noted. Drsg to head ī marked drainage noted. LS CTA, HRR, +BS, void per foley. no S/Sx of skin integrity issues. O2 2LNC, sats 98-99%. Plan: monitor neurological status, pain control, Dilantin as ordered. Will monitor [redacted] PT
1NOV03 @1600	Pt A+O×3, V.S.S. ± T-100.2°F, Pt. given T.S., pt. demonstrated correct use, Pt. has productive cough, emesis basin @ bedside, Pt. drowsy, PERRLA, Pt. slurs speech. Pt. tolerating PO fluids well. Bowel sounds hyperactive, Foley draining clear amber urine to gravity, MD Δ'd DRSNG to skull FX ī DRY gauze @ 1230, staples intact, MD to Δ DRSNG QD. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL, [redacted] RT.
2NOV @0230	assumed care of pt @1800. VSS, no c/o. Alert, speaking Arabic, slight slurred speech noted ī (R) side facial droop/eyelid droop noted; Equal strengths (BIL) UE/LE. Head dsg CDI, Δ'd by MD earlier today. LS CTA, + productive cough (CONT)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

LAST NAME	ME	MID	L	ID NUMBER

DATE	NOTES
	b(6) - 2 A 11
2NOV	(CONT) noted. Tol clear liq diet, requesting an apple per interpreter. Foley draining amber urine QS. IVFs cont to (L) FA IV & difficulty. 2pt restraints on S/SX & skin/ circulation compromise. Plan: Monitor neuro status, IVFs as ordered, pain control pru- [redacted]
2NOV 03 1400	Pt. resting quietly in bed, V.S.S. A+O x3, @ C/O pain. D5 NS ± 20 KCl infusing. Foley to gravity, amber urine. Pt. tolerating liquid diet well. @ BS all four quads. BS diminished in lower lobes bilat., L.S. at bedside. Pt. encouraged to deep breath & cough, Pt. has productive cough, dark brown mucus. PERRLA, (R) sided facial droop, slurred speech. MD removed DRSNG to skull FX & incision, staples intact, edges well approximated, @ drainage Pt. has superficial shrapnel wounds to (L) thigh, DRY DRSNG applied, scant drainage. Will advance pt. diet to regular for dinner tonight. Pt. in 2-point restraints, @ signs of skin breakdown. Pt. has generalized weakness, but is able to Δ position on own. Pt. is on Bedrest. All other assessments WNL. [redacted] RLT, RN
2NOV 03 2200	USS alert & oriented. MAE. (R) sided facial droop PERRL. Hand grips & foot flexion strength equal (L) FA IV patent & infusing D5NS ± 20 mEq KCl @ 125 cc/hr. Foley to gravity drainage clear amber urine. @ C/O PN. Tolerated regular diet for dinner consumed 60% of meal. Breath sounds diminished in lower lobes. Use Incentive Spirometer prompts @ 900 cc/sec. - [redacted]

STANDARD FORM 509 (REV. 9/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

b(6)-2 A11

DATE	NOTES
3 NOV 03 0945	VSS, AO. LSCLAB. ⊕ pulses to all extremities. HRR. BS ⊕ x4. Staples to forehead & incision CDI. Cleaned off dried blood from forehead. CNS intact to all extremities. Neuro V's ⊕. PERRLA & tracks well. Slight swelling above Ⓡ eye. x1 Episode of emesis. Ate small amount of AM breakfast. D5NS c̄ 20K. [redacted]
3NOV.03 1930	Pt A+Ox3, VSS, staples to incision on forehead CDI, foley to gravity draining cyu urine, ate most of diet, pt able to move all exts, peripheral pulses +2 equal Ⓑ, D5NS c̄ 20KCL running @ 125cc/hr, ∅ s/sx of infex or infiltration, 2 point restraint s̄ any complications. [redacted]
4 NOV 03 1120	VSS. AO. Sutures & Staples CDI and OTA. Ambulated x1 to BR s̄ difficulty and performed oral care and verbal usf appropriately. F/G draining light yellow urine, Q5 ⊖ c/o pain @ this time. No s/s infection to wound area on forehead. ⊕ pulses to all extremities. PERRLA and tracks well. CNS intact. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 22501

staples & sutures to small fix "CDI s̄ s/s infection. ETG voiding light amber urine s̄ difficulty. Resting comfortably in bed. [redacted]

1400 Transferral to ICW-2 per approval from PAD and determination of civilian status based on medical record. [redacted]

b(6)-2

MEDCOM - 22502

ACLU-RDI 1670 p.51

DOD-036078

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4NOV03 2000	USS, Alert & Oriented Neuro status stable. Staples alone prehead intact. Ambulated to BR with assist of walker. Gait unsteady without walker. Foley to gravity drainage clear yellow urine. Consumed 100% of regular diet for dinner. (L) FA IV patent & intact infusing D5 NS @ 20 mEq KCl @ 125 cc/hr. Denies HA, NV or [redacted] 2C7 [redacted] Cont care as planned.
4NOV03 0520	C/O pain to (L) FA IV. (L) FA IV R/O painful to touch, Ø flash back, Ø swelling noted. IV D/Ced. Restarted 18g 1¼ in cath to (R) FA x 1 attempt. Will continue care as planned [redacted]
	b(6)-2 ANA

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)-9

PROGRESS NOTES
Medical Record

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

MEDCOM - 22503

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

11/7/03

Trauma

Pt cont to do well

Plan D/c foley, IV

OOB → ambulation

Drain clear dry well opposed

b(6)-2 DAM

[redacted]

11/8/03

Trauma

Pt doing well ↓ (R) shoulder pain

staples intact

wound healing well

A/P: Pt doing well plan. OOB → Ambulation

PT for (R) Shoulder

[redacted]

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

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

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MEDICAL RECORD	PROGRESS NOTES

DATE

11/9/03
10:56

NOTES:

Neurosurgery Narrative Summary / Discharge Note

Pt. SIP open depressed skull fracture with bone, metal debris into frontal lobe (R) hemisphere. Pt initially came in GCS 15 w/open wound leaking blood/CSF & was dressed. Pt. was taken to the OR where the skull fragments/hematoma were debrided & injured scalp repaired. Pt. did well post op has been OOB ambulating and doing well. Pt. has Tolerated regular diet P activity and normal mentation/speech and level of personal interaction relatively unaffected.

Dx (R). Open Depressed Skull fracture w/ (R) Frontal lobe Injury
Hematoma
(2). CSF leakage / Scalp Defect Repair

MEDS (1). DMantin 300 mg po
f/u (2). ON in one week for suture removal

[redacted] b(6)-2

Neurosurgery 207th CSH
Neuro

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
Dilantin

PROGRESS NOTES
Medical Record

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 5 NOV 03 Diagnosis: Transfer from Depressed skull fracture POD: POD:

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	4	Mobility	No limitations	4	4
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4	4	Nutrition	Excellent	4	4
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	4	Friction and Shear	No apparent problem	3	3
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score *Total Score:*_____

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: frontal lobe Size: 10 cm Drainage: 0

Tubes: 0 Pins: 0 Appearance: staples/sutures OTA

Dressing change: 0

Burn wound (s): Yes__ No X % BSA_____ Partial_____ Full_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Pressure Ulcer (s): Yes___ No X

Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____

Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough_____ Tunneling_____

Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates_____

Type of dressing change: Wet-to-dry_____ Comfeel dressing_____ Carrasyn-V Gel_____ Alginate_____

Physician notified/consulted for wound debridement: Yes___ No X Date/time MD notified_____

CNS notified/consulted for Stage II and greater: Yes____ No X

Nutrition Referral: Yes_____ No X

Physical Therapy Referral: Yes_____ No X

Action taken:_____ Date & Time 5 NOV 03

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

[redacted] b(6)-4

MEDCOM - 22506

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 05 NOV 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

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

Time 1355 To ECW2 From ECW1 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

Procedure/Diagnosis Shrapnel wounds to head & knee B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes Foley

Intake (IV, po) D5NR20K Output (EBL, other) _____ Voided ☐ No ☑ Yes Amount: _____

Medication _____

Other depressed skull fracture, Ambulates c walker

Report From LT [redacted] blue-2 Received By LT [redacted]

VITAL SIGNS

TIME:	0400																
BP ARTERIAL LINE																	
BP CUFF	134/80																
TEMPERATURE	98.7																
PULSE	81																
RESPIRATORY RATE	16																
OXYGEN (L/%)																	
PULSE OXIMETER	99%																
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:	1500	0510	0400					
PAIN INTENSITY (10 / 5 / 0)	0	x						
MED ADMINISTERED (Y/N)	NA	NA						
RELIEF ACCEPTABLE (Y/N)	NT	NA						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1500		2310
*Skin breakdown prevention	NA		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

[redacted] blue-4

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

MEDCOM - 22507 IN REQUIRED (Specify): _____

b(6)-2 ANI

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: INITIALS:	TIME: 2310 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)*	☑	☐	☑
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.	☐ Foley to gravity	☐	☐ Foley to gravity draining clear yellow urine
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
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Depressed skull Fx c staples to occipit	☐	☐ Staples and sutures to frontal lobe open to air
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.	☑	☐	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS: [redacted]
IV patency ✓ q 6 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr: PRN
IV site care provided:	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RFA / OK	IV Site #1:	IV Site #1: ⓒ Forearm / Ok
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

blw-2

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 / OTHER

TIME:	1500		2310
ID band visible/legible	[redacted]		[redacted]
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
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:	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 ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR blw-2	BEDREST ☐ SELF ~~AMBULATE~~ ☑ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR blw-2

TEACHING

TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS: [redacted]
CONTENT: -Plan of care	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	blw-2 ☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C [redacted] blw-2

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 2ct AN	2
	[redacted] AN	3

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1500: Awake & alert. Denies pain @ this time. Transferred from ICW1 @ 1400 - ambulatory. VSS, will continue to [redacted]

blw-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 08 DEC 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY:

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:	1200	2000	0000	0400												
BP ARTERIAL LINE																
BP CUFF	127/77	134/82	126/76	130/80												
TEMPERATURE	98.6	98.6	98.6	97.9												
PULSE	75	79	80	94												
RESPIRATORY RATE	16	16	16	16												
OXYGEN (L/%)																
PULSE OXIMETER	95%	97	96%	99%												
O_2 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:	0445	0400														
PAIN INTENSITY (10 / 5 / 0)	X	X														
MED ADMINISTERED (Y/N)	N	N														
RELIEF ACCEPTABLE (Y/N)	NA	NA														

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	0645
*Skin breakdown prevention	IV
*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/d-M

DIAGNOSIS: shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

b(6)-7 RM

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: 0645 INITIALS: [redacted]	TIME: 1900 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.	☑ ✗ language barrier	☑ neuro ✓s WNL	☐
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.	☐ Foley to gravity	☐ foley to gravity	☐
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.	☐ Amb ⊼ difficulty	☑	☐
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 / Sutures to frontal lobe intact ∅ drainage	☐ Sutures et staples to frontal lobe intact. DSG infection	☐
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.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0645 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: assess	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) FA / OK	IV Site #1: (R) FA / OK	IV Site #1:
IV Site #2:	IV Site #2: [redacted]	IV Site #2:
Comments: D5 1/2 ⊼ 20Kcl @ 100	Comments: D5 1/2 D5NS ⊼ 20K CL @ 125cc/hr	Comments:

b(6)-2

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:	0645				
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					
Notify MD abnormal labs					
Incontinent urine/stool					
Linen change prn					
Turn/reposition q2h					
ROM q2h if immobile					
Antiembolic hose					

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
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

TEACHING

TIME: 0645 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: plan of care, call for assist	CONTENT:	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]	1

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0645	Frontal Lobe	Staples/Sutures intact Ø drainage	Assess

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 7 Nov 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

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:	0100	2200	0400														
BP ARTERIAL LINE																	
BP CUFF	124/86	136/76	124/74														
TEMPERATURE	99.2	98.8	98.6														
PULSE	97	90	75														
RESPIRATORY RATE	16	16	16														
OXYGEN (L/%)																	
PULSE OXIMETER	102	98%	96%														
O2 METHOD		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:	0100	0400	1530	2230	0400												
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X	X												
MED ADMINISTERED (Y/N)	N	N	N	N													
RELIEF ACCEPTABLE (Y/N)	N/A	NA	NA	NO													

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)																	

SPECIAL NEEDS

TIME:	0100	1530	2230	0400													
*Skin breakdown prevention	[redacted]																
*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

C [redacted]

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

blw-2 AM

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: 0855 INITIALS: [redacted]	TIME: 1530 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.	☑ NV ✓ WNL	☑	☐ language 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.	☑	☑	☑
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.	☑ Foley to gravity	☑ Foley d/c'd	☑
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.	☐ Sutures / Staples to Frontal Lobe	☐ staples to anterior scalp intact. sm. open sore to penis	☐ Staples & Sutures intact to frontal lobe
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.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0855 INITIALS: [redacted]	TIME: 1530 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Assess	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed: WNL
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1:	IV Site #1: RFA UP / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5 1/2 NS @ 125cc	Comments:	Comments: IV access

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 / OTHER

TIME:	0855	1530	2230
SAFETY: ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
OTHER: Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h		NA	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED:	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 to BR, 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:	0855	1530	2230
INITIALS	[redacted]	[redacted]	[redacted]
CONTENT:	. CALL FOR ASSIST .	Plan of care	call for assistance if needed plan of care
	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b/w-2
A-N

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] SPC/SIGNING	1
[redacted]	[redacted] 9/10/16 SGT	2 N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	Frontal lobe	Staples/sutures intact, drainage	Assess
		penis	sm open scar, min amt bleeding	Cleaned c NS, OTA

SECTION IV - NOTES

1200 Foley DC'd DTV by 2000, pt understands. IV DC'd. sm open area noted to penis. Sm amt of bleeding. Cleaned c NS. left OTA [redacted] ret from 1530, Awake + alert, Denies pain @ this time. [redacted] to monitor.

b(6)-2

MEDCOM - 22518

MEDCOM FORM 689-R (TEST) (MCHO) MAR 00

5E

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8 NOV 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 9 | 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 _____ 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:	1200	2000	0400														
BP ARTERIAL LINE																	
BP CUFF	141/85	142/88	129/86														
TEMPERATURE	99.6	99.1	98.6														
PULSE	85	94	71														
RESPIRATORY RATE	16	12	16														
OXYGEN (L/%)																	
PULSE OXIMETER	97	98%	95%														
O2 METHOD		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:	0736	1200															
PAIN INTENSITY (10 / 5 / 0)	0	X															
MED ADMINISTERED (Y/N)	N	N															
RELIEF ACCEPTABLE (Y/N)	Y	N/A															

SPECIAL NEEDS

TIME:	0736		1980														
*Skin breakdown prevention			N/A														
*Falls prevention protocol																	
*Restraint protocol																	
*Seizure precautions																	
*Isolation precautions																	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)																	

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

PATIENT IDENTIFICATION

Civ [redacted]

blw-4

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: 30 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

EQUIRED (Specify): _____

MEDCOM - 22519

MEDCOM FORM 689-R (TEST) (MCHO) MAR 00 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 1

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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: 0750 INITIALS: [redacted]	TIME: INITIALS:	TIME: 1930 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.	☐ UNABLE TO ASSES ORIENTATION D/T LANGUAGE BARRIER PT IS ALERT AT RESPONSIVE	☐	☐ Pt alert and responsive lethargic
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.	☐ SCALP LAC ESTAPLES INTACT NO SEPARATION	☐	☐ staples to frontal lobe intact
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ no % pain	☐	☐ 0 c/o pain
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: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ 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: _____ _____	IV Site #1: _____ _____	IV Site #1: _____ _____
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 0740					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	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 / OTHER

	TIME: 0740		1930
ID band visible/legible	✓		
Orient to environment prn	✓		
Side rails (2/4) up	✓		
Bed position low	✓		
Call light within reach	✓		
Review & post lab results	✓		
Notify MD abnormal labs	✓		
Incontinent urine/stool	✓		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: no complaints	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 ☒ SELF AMBULATE ☐ ASSIST BSC BRP CHAIR # TIMES/SHIFT

TEACHING

TIME: 0730 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: INFORM STAFF OF PAIN CALL FOR ASSISTANCE	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

CN [redacted] b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted]	D
		5

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9 Nov 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 10 | HOSPITAL DAY: 10

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:	1200	2000	0400														
BP ARTERIAL LINE	/	/	/														
BP CUFF	119/79	121/78	126/80														
TEMPERATURE	98.3	98.8	98.4														
PULSE	100	98	88														
RESPIRATORY RATE	14	14	20														
OXYGEN (L/%)	/	/															
PULSE OXIMETER	97%	98	99%														
O_2 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:	2000								
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	N								
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

Civ [redacted]

DIAGNOSIS: shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: 30 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

b14)-2

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: 1230 INITIALS:	TIME: 1915 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.	☐ Dox2 & c/o dizziness ø vertigo PERRLA/EOM's	☑	☐
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 removed sutures intact ø S/Sx of infx	☐ Sutures to anterior scalp 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.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: NO	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: Access	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

b(6)-2

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 / OTHER

	TIME:	1230	1915		
SAFETY	ID band visible/legible				
	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				
	Linen change prn				
	Turn/reposition q2h	✓			
	ROM q2h if immobile	✓			
	Antiembolic hose	✓			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	REG		Reg
PERCENT CONSUMED:	75%		
HOW TOLERATED:	well		
	☑ 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:	1230	1915	
INITIALS:	[redacted]	[redacted]	
CONTENT:	-Orient to Staff - wound care - d/c pending	-Plan of care -	
	☑ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION

Civ [redacted]

b(6)-4

INITIALS	SHIFT
[redacted]	1
RLT, Ae	5

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1915: Awake & alert, Denies pain or discomfort [redacted] Ambulating well. Will continue to monitor. [redacted]

b(4)-2

MEDCOM - 22525

5E

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 10 NOV 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 11 | HOSPITAL DAY: 11

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:	0830	1600															
BP ARTERIAL LINE																	
BP CUFF	148/77																
TEMPERATURE	98.8																
PULSE	65																
RESPIRATORY RATE	16																
OXYGEN (L/%)																	
PULSE OXIMETER	98																
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:	0705	1600															
PAIN INTENSITY (10 / 5 / 0)	0																
MED ADMINISTERED (Y/N)	Y																
RELIEF ACCEPTABLE (Y/N)	Y/N																

SPECIAL NEEDS

TIME:	0705																
*Skin breakdown prevention																	
*Falls prevention protocol																	
*Restraint protocol																	
*Seizure precautions																	
*Isolation precautions																	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)																	

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

PATIENT IDENTIFICATION

b(6)-4

C [redacted]

DIAGNOSIS: Shrapnel wounds to head + knee

DRG: _____ ADMISSION DATE: 30 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

EQUIRED (Specify): _____

MEDCOM - 22526

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: 0715 INITIALS: [redacted]	TIME: INITIALS:	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.	☐ PT NOT VERBALLY RESPONSIVE TO STAFF. DOES COMMUNICATE THRU HAND SIGNALS	☐ bilat = 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.	☒	☐	☐
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.	☐ SCALP LACS & STAPLES REMOVED, NO OPENINGS OR SEEPAGE	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☒ PT DENIES	☐	☐
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: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ 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: _____ _____	IV Site #1: _____ _____	IV Site #1: _____ _____
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 0705					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	Θ					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	Θ					
PERIPHERAL PULSE	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: 0705		
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			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE:	TYPE:
PERCENT CONSUMED: 85%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: NO C/O	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; CHAIR; # TIMES/SHIFT b(6)-2	BEDREST ☐ SELF; AMBULATE ☐ ASSIST; BSC; BRP; CHAIR; # TIMES/SHIFT	BEDREST ☐ SELF; AMBULATE ☐ ASSIST; BSC; BRP; CHAIR; # TIMES/SHIFT

TEACHING

TIME: 0710 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: POSS d/c TODAY ALERT STAFF TO ↑ in PAIN CON'T TO MOTOR NEURO;	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b(6)-4

[redacted]

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] SAT, 9142006	D
	b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

10NOV03
1335 PT D/C'd TO HOME c̄ FAMILY. PILANTIN ÷ TID SE [redacted] EEDS TO
F/U IN ONE WEEK. TRANSLATOR SAYS FAMILY HAD Ø QUESTION, [redacted] SGT, [illegible]

b(6)-2

MEDCOM - 22529

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.

1. AGE 40

HEIGHT:

WEIGHT: 80

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

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

4. PROPOSED SURGICAL PROCEDURE:
Creni, elevate depressed Fx, debridement

NPO since 1800

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition: open non-dom type of crani

Tobacco ___ ppd X ___ vrs Body Piercing ___ Diabetes (Y) (N) ROM Scalp ASA/Motrin W 72hrs (Y) (N)
ETOH ___ Implants ___ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ___ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ___ potential for anxiety related to: ___ 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	O. Pt. verbalizes any specific anxiety. O. Pt. Exhibits relaxed body posture.	O. Allow pt. to verbalize freely. O. Explain Or environment and answer questions regarding surgery. O. Offer comfort measures. (e.g. warm blanket. touch). O. Explain all nursing procedures before they are done. O. Remain with pt. Whenever possible. O. Maintain family interface. Parents to stay with pt.
B. AERATION ___ Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	O. Pt. will be able to breath without difficulty during immediate intraoperative phase.	O. Offer to elevate head of litter or offer pillow. O. Observe pt. While awaiting surgery for signs of distress. O. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT ___ Potential Impairment of Skin Integrity due to: ___ 1) Intraoperative Immobility ___ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ___ 5) Pooling of Prep Solutions	O. Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	O. Utilize pressure preventing devices on OR table and accessories. O. Check for proper positioning and support to maintain good body alignment. O. Pad pressure points. O. Place ESU ground pad on non compromised skin surface area. O. Keep prep fluids form pooling.

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

[redacted]

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since ___ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend: ___

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION Potential for inadequate tissue perfusion due to: 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices 5) Hypothermia	Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. O Check that safety straps are correctly applied. O Offer pillow for under knees. O Place and take down legs from stirrups with slow bilateral motion. O Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. Potential Impairment of Mobility due to: 1) Pain 2) Intra operative Hazzards 3) prosthesis 4) Positioning 5) Transfer pt. To/form OR table E.2. Potential Discomfort Due to: 1) Length of Surgery 2) Positioning 3) Arthritis	pt. will be transferred to OR table without difficultly. pt. will be not experience unnecessary physical discomfort.	O Have sufficient people available for transfer. O Insure proper body alignment. O Allow patient to lie in position of comfort while waiting for surgery. O Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. Diminished visual perception due to being: 1) pre-medicated 2) W O GLASSES F.2. Potential for Decreased Communicatlon due to: 1) Diminished Hearing 2) Language Barrier F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o pt. will be made aware of surroundings prior to anesthesia induction. o pt. will be transferred safely to OR table. o pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	O Introduce self. keep pt informed as to where he. she is and what is happening. O Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. O Address pt. from _____ side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above Interventions.

10. OR [redacted] ERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] 30 OCT 03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

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

DATE: 30OCT03 TIME: 2350

13. PREOPERATIVE EVALUATION PREPARED BY (Signature [redacted]

DATE: 31 OCT 03 TIME: 0140

REVERS OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT** — P(b)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA litter — BY ares staff

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY [redacted]

3. DATE: 31 OCT 03 — TIME PATIENT ARRIVED IN SUITE: 0356

4. PATIENT IN ROOM — TIME: 2358 — NUMBER: 2 - 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

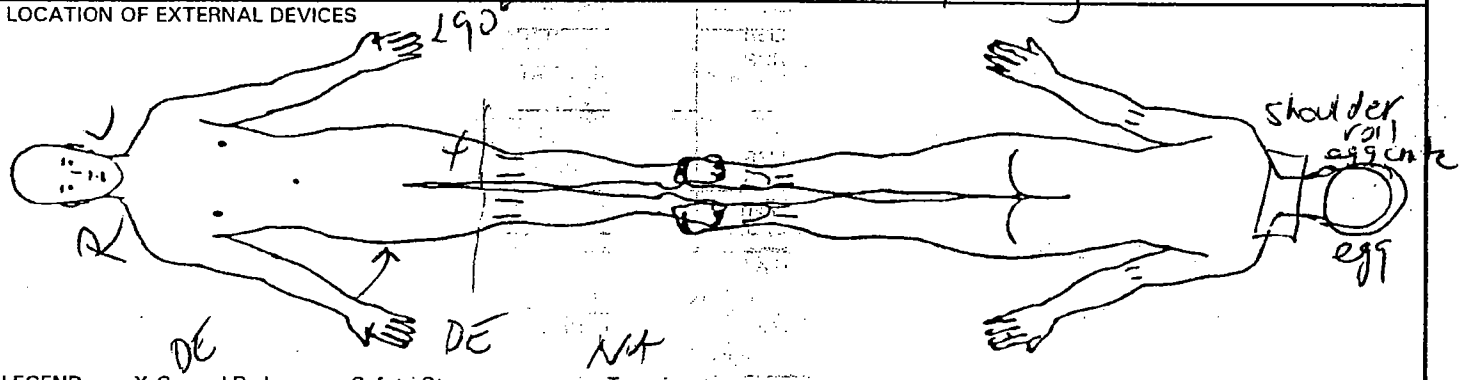
COMMENTS: Pt placed on padded OR table (L) arm extended on armboard @ <90° (R) arm tucked @ sheet

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: forehead to (R) BY WHOM: [redacted] P(b)-2
SITE: face - shaved hairline BY WHOM:
COMMENTS: ø pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	✓	C	C	SGT [redacted]	[redacted]
Needle Sharp	☑ Yes	☐ No	✓				
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

[redacted] P(b)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 50/50

☒ ESU NO: R8B 10239S
GROUND PAD: BRAND Valleylab
LOT NO: 7001

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: See above - 35

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 22532

13. PROSTHESIS, IMPLANTS [ ] ES [X] NO IF YES NAME: ID NU ER UFAC RER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Epi 1:100,00 Lidocaine 1% + Epi 1:100,00	70 cc	Intraop	inject	[redacted]	[redacted]
gelfoam	QS	intraop	topical		
surgicel	QS	intraop	topical		
Thrombin	QS	intraop	topical		

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S): 0.9% NaCl b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

TYPE/SIZE	1. 16 Fr Foley EMT	2.	3.
SITE	1. Bladder	2.	3.

19. ADDITIONAL INFORMATION

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

Anesthesia- CRT

Foley draining clear light yellow urine

geta

20. OPERATION(S) PERFORMED

Craniectomy elevate depressed fracture i debridement b(6)-2

21. PATIENT TRANSFERRED TO ICU 1 TIME 0140 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 22533 USAPA V1.00

ICU1

Patients Name: [redacted] 1647

Date: 31OCT

0140 Arrived from OR

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP																					135/68	121/78	139/72	118/65	114/65
TEMP																					98F				
HR																					130	95	101	96	97
RR																					25	15	16	13	10
SaO2																					~~100~~	4L	4L	4L	
FiO2																					100	~~100~~	100	100	95
Source																					NC	NC	NC	NC	NC
MAP																					95	97	92	87	84

Recovery Vitals

NIBP TREND 10/31/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN mmHg	RR RPM
03:00	101	100	120 / 72	92	16
02:55	99	SNSH	126 / 73	94	14
02:50	96	100	121 / 66	91	11
02:45	92	100	129 / 67	95	15
02:40	101	100	127 / 77	96	19
02:35	99	100	124 / 74	93	15
02:30	97	100	120 / 72	90	18
02:25	98	100	121 / 73	96	14
02:20	99	100	119 / 73	96	18
02:15	95	100	127 / 75	94	15
02:10	88	100	123 / 75	94	12
02:05	101	100	122 / 71	97	14
02:00	95	SNSH	121 / 78	97	15
01:50	103	SNSH	122 / 68	92	24
01:45	130	100	135 / 68	95	25
01:43	IMAI	OFF	ERR# 2		

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	01	02	03	04	05
IVF															125	125	125	125
IVPB																		
NGT																		
PO																		
Total																		

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
URINE																					250	500	400	500	400	1050
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 22534

DOD-036110

ACLU-RDI 1670 p.83

NEUROLOGICAL ASSESSMENT

COMA SCALE

	HOURS	02	03	04	05
EYES OPEN	SPONTANEOUSLY 4		X	X	X
	TO SPEECH 3	X			
	TO PAIN 2				
	NO EYE OPENING 1				
BEST VERBAL RESPONSE	ORIENTED 5				
	CONFUSED 4	X	X	X	X
	VERBALIZES 3				
	VOCALIZES 2				
	NO VOCALIZATION 1				
BEST MOTOR RESPONSE	OBEYS COMMANDS 6				X
	LOCALIZESPAIN 5	X	X	X	X
	FLEXION WITHDRAWAL 4				
	ABNORMAL FLEXION 3				
	EXTENSION TO PAIN 2				
	NO RESPONSE 1				

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

LIMB MOVEMENT

		02	03	04	05
ARMS	NORMAL POWER				
	MILD WEAKNESS	B	B	B	B
	SEVERE WEAKNESS				
	ABNORMAL FLEXION				
	ABNORMAL EXTENSION				
	NO RESPONSE				
LEGS	NORMAL POWER				
	MILD WEAKNESS	B	B	B	B
	SEVERE WEAKNESS				
	ABNORMAL FLEXION				
	ABNORMAL EXTENSION				
	NO RESPONSE				

R Right
L Left

Record Separately if there is a Difference between the tow sides

PUPILS

		02	03	04	05
RIGHT	SIZE	3	3	3	3
	REACTION	+	++	++	++
LEFT	SIZE	3	3	3	3
	REACTION	+	++	++	++

++ Brisk
+ Slow
No Response

PUPIL SCALE: 2 3 4 5 6 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		02	03	04	05
upper	R	++	++	++	++
	L	++	++	++	++
lower	R	++	++	++	++
	L	++	++	++	++
	R				
	L				
	R				
	L				
	R				
	L				

++ Normal
+ Weak
– Absent
D Doppler
R Right
L Left

b(6)-4

SI [redacted] 310C

NEUROLOGICAL ASSESSMENT

HOURS: 6 7 8 9 10 11 12 13 14 15 16 17 18

COMA SCALE

EYES OPEN
- SPONTANEOUSLY 4
- TO SPEECH 3
- TO PAIN 2
- NO EYE OPENING 1

4 4 4 4 4 4 4 4 4

BEST VERAL RESPONSE
- ORIENTED 5
- CONFUSED 4
- VERBALIZES 3
- VOCALIZES 2
- NO VOCALIZATION 1

5 5 5 5 5 5 5 5 5

BEST MOTOR RESPONSE
- OBEYS COMMANDS 6
- LOCALIZESPAIN 5
- FLEXION WITHDRAWAL 4
- ABNORMAL FLEXION 3
- EXTENSION TO PAIN 2
- NO RESPONSE 1

6 6 6 6 6 6 6 6 6

LIMB MOVEMENT

ARMS
- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

RL RL RL RL RL RL RL RL RL

LEGS
- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

RL RL RL RL RL RL RL RL RL

PUPILS

RIGHT	SIZE	3 3 3 3 3 3 3 3 3
	REACTION	+ + + + + + + + +
LEFT	SIZE	3 3 3 3 3 3 3 3 3
	REACTION	+ + + + + + + + +

PUPIL SCALE: 2 3 4 5 6 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the tow sides

+ – Brisk
\+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS: 6 7 8 9 10 11 12 13 14 15 16 17 18

~~07~~ VE	R	+ + + + + + + + + + + + +
	L	+ + + + + + + + + + + + +
LE	R	+ + + + + + + + + + + + +
	L	+ + + + + + + + + + + + +
	R	
	L	
	R	
	L	
	R	
	L	

+ + Normal
\+ Weak
– Absent
ó Doppler
R Right
L Left

MEDICAL RECORD	VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR NOV 19 03	DAY	1	1	2 NOV	3 NOV 03	4 NOV 03	5 NOV 03	6	7
	HOUR								

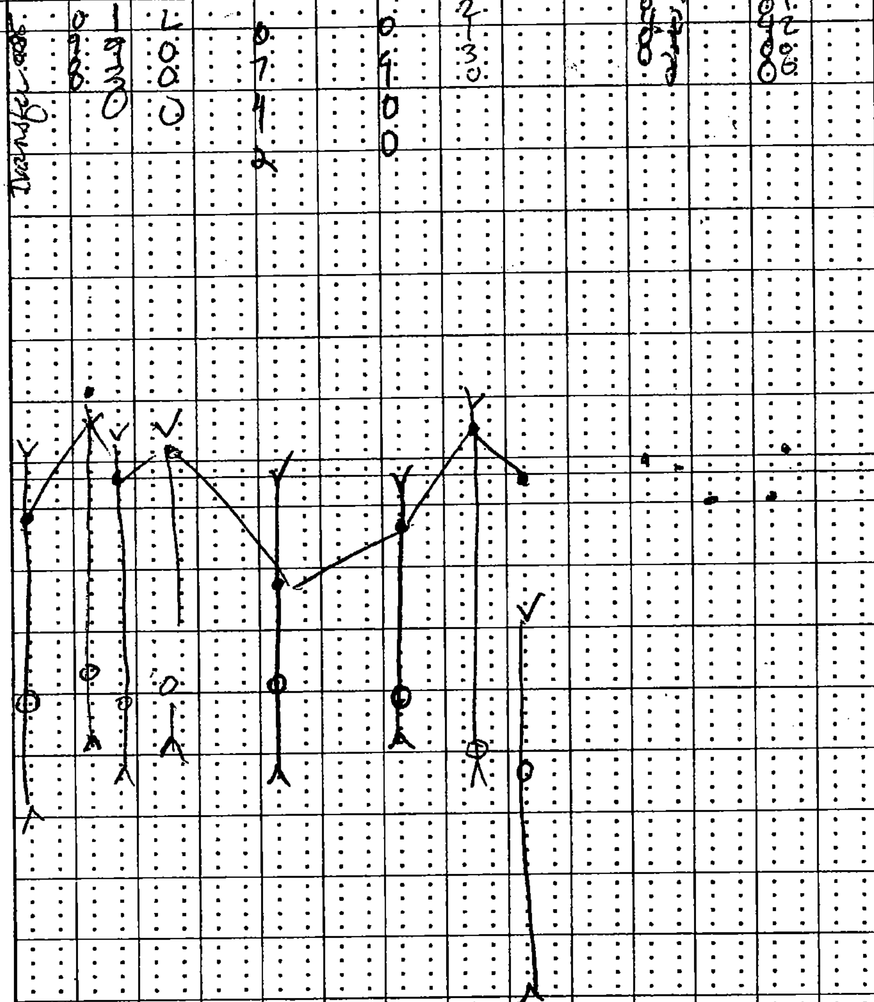
PULSE (O) / TEMP. F (•) / TEMP. C

Pulse scale: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

Temp. F scale: 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

Temp. C scale: 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: 20 | 18 | 20 | 18 | | | 22 |

BLOOD PRESSURE	132/72	134/70	135/83	129/79	127/84	139/78	103/42
				91	91	80	79
				96.1	97.9	99.5	98.6
HEIGHT: WEIGHT →				98%	97%	96%	97%
	98% RA	96% RA	97%		RA		RA
	99% 2LNC	95% 96% RA					

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

1B-[redacted]

b(6)-4

MEDCOM - 22537

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 8 | 9 | 10

19 | HOUR: 01 | 02 | 06 | 10

PULSE (O) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

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

LAST, FIRST, MI. [redacted] | DATE 31 Oct | TIME 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 16 g/dl (F)
Hct		
MC		
Plt		
Lym		
(E		
Segs		
Bane		
Lym		
Atyp		
RBC Morp		
Spun Hema		
Sed R		
Other		

ID: [redacted] 31-10-03
WB 04:27

			Patient Limits	
WBC	13.0 H	x10^3/uL	4.5	10.5
RBC	4.69	x10^6/uL	4.00	6.00
Hgb	13.3	g/dL	11.0	18.0
Hct	43.1	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	160.	x10^3/uL	150.	450.
LY%	8.2 *L	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App...		N/A

PICCOLO
31/10/03 04:30
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100684

GLU	172*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	429*	39-380	U/L
NA+	130	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	106	98-108	MMOL
tCO2	19	18-33	MMOL

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

nit Crossmatch
TH EVERY UNIT OF BLOOD ESTED)

PE	CROSSMATCH

REMARKS: CBC Chem 7

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

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 31 OCT	TIME 0400	SSN/PSEUDO SSN:

(i STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: Chem 7

REPORTED BY:	DATE:	LAB ID NO.:

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)								TOTALS
Propofol (ML)	200							200
Suc/Vec (mg)	100	5			(20)			100/5
Fentanyl (cc)	2	1	2		(20)			5cc
Neostigmine/Robinul				4/.7				
VOLAT AGENT Forane % del	1 — 1.5	1.5 —	1 —	1 —	1 —	1 — X		
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	8 — 2 — 2	2	2 —	2 —	2 —	8 —		

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

TOTAL EBL: ~~1000~~ 250

TOTAL URINE: 300

FLUIDS SUMMARY
CRYSTALLOID- 1000
COLLOID-
BLOOD-

FLUIDS

LINE site		
0.9% NS RFA ☐ Warmed	500↑	
0.9% NS LAC ☐ Warmed	(1000)	1000↑
☐ Warmed		
☐ Warmed		

LOSSES
EST BLOOD LOSS
URINE - 300

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

TIME → 0000 x 0030 x 0100 x 0130 x

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP- 145/77 / HR- 80

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME-

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

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

VENTIL

VT - ml	910	920	950	840			
f - breaths/min	12	12	10	8	10	12	20
Peak inf pres / PEEP	22	23	23	20			
MODE - S(pon), A(ssist), C(on)	S/A/C	CV	CV	CV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	30	30	37	45	40	45
BP/oth	FIO2 (Frac or %)	.81	.80	.81	.82	.81	.81	.81
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	37.2	37.3	37.1	37	36.8		
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

REMARKS
Code drugs with numbers, events with letters

To OR #2 - Arrived Pre-Op - Smooth IV Induction - RSI c CP. Eyes taped shut. Difficult ... placement
0021 Local 1% Lido Sign 1:? Injection by Surgeon 70cc
0110 Extubation - laryngeal spasm O2 100% mask - Suc 20mg IVP - Ass. Ant vent.
0140 SV O2 100% ... NC. to ICU

RECOVERY AT: Body
PACU (ICU) 0140 (Specify)
OTHER
CONDITION: T-38 ...
RESP- 22 SpO2- 100%
BP- 110/56 HR- 128

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2350	2358	0150
	Ready	**Begin**	**End**
PROC	0005	0022	0120

PROCEDURES and CPT Codes: Debridement & Repair of penetrating skull injury

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #8.0 ETT DLx1 (+) VC (+) S=55 (+) ET CO2 @ 23 cm teeth

SURGEONS: Armonda

PROCEDURE LOCATION: OR #2

DATE: 30 Oct 03

ANESTHETISTS: Serafin

PAGE 1 OF 1

MEDCOM - 22541

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex (X) MALE ( ) FEM

PROPOSED PROCEDURE: craniectomy elevate depressed fx, debridement
SURGICAL SERVICE: neurosurg
NPO SINCE: 1800

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS: +
TOBACCO: ____
ETOH: Ø
DRUGS: Ø

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: ____

Ø hematoma, Ø ML shift on CT, ABO X3

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	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

LHR

PHYSICAL EXAMINATION
BP 87 HR 76 R 16 T ____
Pain Scale 0-10 3
HEENT - Teeth solid
Trachea ML
TMJ/Neck FROM
Oropharnyx mp II
Nares N/A
CHEST: RRR
CARDIAC: CTAB
EXTREMITIES:
IV Access: AC Bilat
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 1800

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

C-spine clear; DL OK, no need for mannitol/lasix

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

+/- a-line

The patient/legal [redacted] and agrees. Questions answered.
Signed: [redacted] Date: 10/30/03 Time: 2330 Hrs

POST-AN[redacted] ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

GSW Rt Frontal ✝ BLEs

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ER → EPW
[redacted]

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted] CT	10/31/03 _____ HOURS	
	① TX to ICU	
	② Dx: s/p open depressed skull fracture	
	③ Advance diet as tol	
	④ d/w Ds 0.9 NS w/ 20 KCl @ 125 cc/hr	
NURSING UNIT: ICU / ROOM NO. [redacted] / BED NO.: 4	⑤ Foley to gravity	
	⑥ Dilantin 300 mg po qhs	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
8/16/24	⑦ Amcf ign IVPB q 8° x 48°	
	⑧ Bed Rest.	
b(6)-2 [redacted]		
NURSING UNIT: 3SW / 4 NOV 03 / ROOM NO.: 0445 / BED NO.		
PATIENT IDENTIFICATION	DATE OF ORDER 11/7/03 / TIME OF ORDER _____ HOURS	
	① D/C IV	
noted 7 NOV 1145 b(6)-2 [redacted]	② D/C Foley	
	③ Vitals [redacted] b(6)-2	
NURSING UNIT: 8 NOV 03 / ROOM NO.: 0215 / BED NO.: [redacted]	1 U/A 24° Chart ✓	
PATIENT IDENTIFICATION	DATE OF ORDER 11/8/03 / TIME OF ORDER 0404 _____ HOURS	
	① PT for (R) Shoulder [redacted] b(6)-2	b(6)-2 [redacted] SPEC/ANIMO 8 NOV 03 0905
NURSING UNIT / ROOM NO. / BED NO.		

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

MEDCOM - 22543

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU		

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	10/31/03	01:15 HOURS	
1	Admit ICU		
2	Dx: Open Skull Fracture		
3	S/P Debridement Skull Fracture Evacuation Mortar/Metal Frags (R) Frontal Lobe		
4	VSQ		
5	HOB 30°		
6	Vitals w/ neuro Vs q 1°		

PATIENT IDENTIFICATION

[redacted] b(6)-2 NOTED 31OCT 0155 ILT/AN

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
7	NPO	HOURS	
8	IVF 0.9NS w/20 KCL 125 cc/hr		
9	Foley to Gravity		
10	Ancef 1gm IVPB q 8°		
11	Tylenol Suppository PRN pain q 4-6°		
12	Protonix 100mg q 8°		
13	~~Foley Gravity~~ I/O's		
14	CBC, Chem 7 now & in Am.		

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

b(6)-2 [redacted] HOURS

NURSING UNIT	ROOM NO.	BED NO.
24° Chart Check 0300 31OCT		

[redacted] ILT/AN

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	
	10/31/03	1:36 HOURS	
1	Advance to Coma Diet		

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

b(6)-2

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

MEDCOM - 22544

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4		DATE OF ORDER: 11/9/03 TIME OF ORDER: ____ HOURS	
	1	D/C to home	
	2	D/C Standing orders.	
		[redacted]	
		b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
		24°V 10 NOV 03 0327 [redacted]	24 [illegible]
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.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 22545

b1(2)-7

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 ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10	11	12
31	[redacted]	DIET: advance	6	/	[redacted]											
		clears to regular	10	[redacted]												
31	[redacted]	Foley to gravity	6	/	[redacted]											
			18	[redacted]												
31	[redacted]	Bedrest	6	[redacted]												
			18	[redacted]												
31	[redacted]	N10: neurological	6	[redacted]												
		status Vs Q8	18	[redacted]												
06 Nov	[redacted]	Braden Scale q 7d	06-18 18-06	[redacted]												
7 NOV	[redacted]	VS QS	D	/	/	/	/	/	/	[redacted]						
			N	/	/	/	/	/	/	/						

DC'd 17 NOV 1120

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open depressed skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted] b1(2)-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

MEDCOM - 22546
EDITION OF 1 DEC 77 MAY BE USED
USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo NOV Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	[redacted]	TX ICW#1				
8		PT for (R) shoulder therapy	8 NOV	~~today~~		
9	[redacted]	D/C home				
9		D/C staples only				
		b(6)-2				

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ~~NOV~~ OCT Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	01	02
31OCT	[redacted]	VSI	06	/			
			18	[redacted]			
31OCT	[redacted]	Vitals ē Neuro ✓ q1°	06	/			
			18	[redacted]			
31OCT	[redacted]	HOB 30°	06	/			
			18	[redacted]			
31OCT	[redacted]	NPO Clear liquids	06	/			
			18	[redacted]			
31OCT	[redacted]	Foley to gravity	06	/			
			18	[redacted]			
31 OCT	[redacted]	I:O's	06	/			
			18	[redacted]			

b(4)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
open Skull Fx
s/P Debridement Skull Fx Evacuation
(Mortar/Metal Frags ® Frontal Lobe)

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

PATIENT IDENTIFICATION:
SI: [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

MEDCOM - 22548

EDITION OF 1 DEC 77 MAY BE USED

USAPA V1.00

Verity 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
31OCT	[redacted]	Admit ICU	31OCT	✓	0140	[redacted]
31OCT	[redacted]	CBC, Chem 7 now	31OCT	✓	OR	[redacted]
31OCT	[redacted]	CBC, Chem 7 in AM	31OCT	0400	0400	[redacted]

	----	b(6)-2				

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(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 31 1 2 3 4 5 6 7 8 9 10
31	[redacted]	D5NS @ 20KCL @ 125	[redacted]	[redacted] DC'd 1100 031150
31	[redacted]	Dilantin 300mg po QHS	[redacted]	[redacted]
31	[redacted]	Ancef 1gm IVPB q8° x48h	[redacted]	[redacted] Completed
		b(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open depressed skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-1

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 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 22550

D/W-2

CLINICAL RECORD

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

Mo. OCT Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	01	02
31 OCT	[redacted]	IV D5 0.9NSC 20KCl	06	/			
	-----	@ 125 cc/°	18	[redacted]			
31 OCT	[redacted]	Ancef 1gm IVPB q8°	06	/			
	-----		14	/			
	-----		22	[redacted]			
31 OCT	[redacted]	Dilantin 100mg q8°	06	/			
	-----		14	/			
	-----		22	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open Skull Fx
s/P Debridement Skull Fx Evacuation (Mortar/Metal Frags ® Frontal lobe)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

SI [redacted]

D/W-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 1 FEB 79 4678 EDITION OF MEDCOM - 22551 . EXHAUSTED.

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													
31OCT	[redacted]	Tylenol supp PRN Pain q4-6°	D T	D I												

*U.S. GPO: 1998-454-110/95216

MEDCOM - 22552

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: Iraq Civilian | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

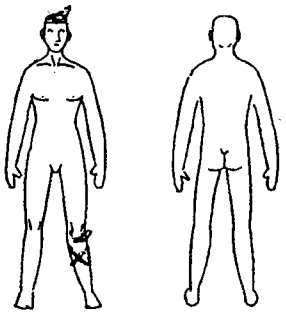
2. UNIT / UNITÉ

FORCE / ÉLÉMENT | NA[redacted]

A/T | AF/A | N/M | MC/M | BC/BC | DISEASE / MALADIE | PSYCH/[illegible]CH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- [X] HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- [X] OTHER (Specify) / AUTRE (Spécifier)

multiple shrapnel to head & (L) lower leg

b(6)-2

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS: 78 | TIME / HEURE: 1845

6. TOURNIQUET / GARROT: [X] NO / NON | [ ] YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: [ ] NO / NON | [ ] YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV: 18S/Hep | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

dressing to head and (L) lower leg
IV started 1851 (L) arm L.R 1000ml
1850 = 72/12
1855 = 95/12
O2 given 6L/min
1900 = 72/12
1905 = 76/12

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE: 1910 IVS

11. PROVIDER [redacted] | DATE/DATE (YYMMDD): 980703

DD Fo[illegible] | DEC 91 | [illegible] of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

☆U.S. GOVERNMENT PRINTING OFFICE: 2001–478-671

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89 b/a)-2

SHIFT ASSESSMENT

		TIME:	INITIALS:	TIME: 0200	INITIALS: [redacted]
NEURO	PUPILS			PERRLA 2mm sluggish	
	SENSORIUM			Responds to pain, sometimes to tur	
	EXTREMITY MOVEMENT			Moving all extremities	
	SEDATION			ϕ	
	PAIN CONTROL			ϕ	
				Drsg to skull, CDI	
RESP	RESPIRATORY PATTERN			RRR	
	BREATH SOUNDS			CTA (B)	
	SECRETIONS			ϕ	
	O2 SOURCE/FLOW/SAO2			NC 4L 100%	
	VENTILATOR SETTINGS			NA	
CV	CARDIAC RHYTHM			ST SI/ST	
	CAPILLARY REFILL			<3 sec x 4 extremities	
	PULSES			+2 upper +2 lower	
	EDEMA			ϕ	
GI	ABDOMEN			Flat, Soft, Nontender	
	BOWEL SOUNDS			(+)	
	BOWEL MOVEMENT			(-)	
	NGT/OGT			None	
	TUBE FEDDINGS			N/A	
	DRAINS			ϕ	
GU	VOIDING			Foley to Gravity	
	COLOR/CLARITY			Clear Light yellow	
SKIN	COLOR			Normal for Race	
	INTEGRITY			Lac to head - Drsg CDI	
				Lac to (L) thigh - Drsg E S/S drains	
				Drsg to (B) LE CDI	
ACCESS	#1 TYPE/LOCATION/SIZE			PIV R AC 18G	
	DRESSING CONDITION			CDI	
	IV FLUID/RATE			HL	
	#2 TYPE/LOCATION/SIZE			PIV L AC 18G	
	DRESSING CONDITION			CDI	
	IV FLUIDS/RATE			D5NS @ 20K @ 125 cc/°	

(Continue on reverse)

PREPARED BY: [redacted] b(6)-2 ILT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 31 OCT 03

PATIENT (Maiden entries give: Name – last, first, middle; [illegible])

NAME: [redacted]

RANK:

AGE:

UNIT: b(6)-4

GENDER: (F)

STATUS: US: AD / CIV

IRAQI: CIV (EPW) SI

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 7

USAPPC V2.00

MEDCOM - 22554

AL RECORD-SUPPLEMENTAL M... DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(6)-2

		SHIFT ASSESSMENT		
		TIME: 0800 INITIALS: [redacted]	TIME: 1830	INITIALS:
NEURO	PUPILS	Perrla 3mm sluggish [redacted]	PERRLA 3mm Sluggish	
	SENSORIUM	(+) color, motion & sensation x 4 ext	Alert Follows simple commands	
	EXTREMITY MOVEMENT	mae	~~sedated & some movements of ext. noted. Propofol, MSO4 mg~~	
	SEDATION	Ø A+O x3	Ø pain or sedation control	
	PAIN CONTROL	denies	D/sg to head CDI	
RESP	RESPIRATORY PATTERN	even & unlabored	RRR	
	BREATH SOUNDS	CTA-E dim bases	Diminished Bases	
	SECRETIONS	Ø cough, Ø secretions	Ø cough or secretions	
	O2 SOURCE/FLOW/SAO2	2LNC 100%	NC 2L SaO2 > 95%	
	VENTILATOR SETTINGS		Ø	
CV	CARDIAC RHYTHM	SiSr NSR Ø ectopy	RRR SR 81/52	
	CAPILLARY REFILL	< 3sec cap refill x	< 3 sec x 4 sec	
	PULSES	+2 pulses x 4 ext	+2 upper, +2 lower	
	EDEMA	Ø	Ø	
GI	ABDOMEN	flat, NT, ND,	Flat, soft, nontender	
	BOWEL SOUNDS	hypoactive BS Ø BM	(+)	
	BOWEL MOVEMENT		(-)	
	NGT/OGT		NA	
	TUBE FEDDINGS		None	
	DRAINS		None	
GU	VOIDING	clear light yellow	Foley to gravity	
	COLOR/CLARITY	adequate amt	clear light yellow	
SKIN	COLOR	normal for race	Normal for Race	
	INTEGRITY	multiple shrapnel wounds head dressing c blood stain Ø progression	shrapnel wounds to head, (L) thigh, (B) LE.	
ACCESS	#1 TYPE/LOCATION/SIZE	(L) & (R) SC PIV	PIV (L) FA 18G	
	DRESSING CONDITION	Ø S/S of infxn,	CDI started 31 Oct	
	IV FLUID/RATE		D5NS @ 20K @ 125 cc/h	
	#2 TYPE/LOCATION/SIZE			
	DRESSING CONDITION			
	IV FLUIDS/RATE			

(Continue on reverse)

PREPARED BY (Sig...): b(6)-2 [redacted], ILT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 31 Oct 03

PATIENT'S ID [redacted] (For written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: SI [redacted] RANK: AGE:

UNIT: [redacted] b(6)-4 GENDER: 07

STATUS: US: AD / CIV IRAQI: CIV / EPW SI

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

DA FORM 4700, MAY 78

MEDCOM - 22555

USAPPC V2.00

ICU1

Patients Name: [redacted] b(6) 4

Date: 31 Oct

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	116/66	117/65	121/66	118/71	119/69	124/70	127/69	123/72	120/71	112/73	131/80	131/74		123/72	131/74	123/72	119/69	118/69	125/77	140/74						
TEMP			99.7			99.0				99.2																
HR	98	98	88	97	96	90	92	88	92	86	95	91		88	97	80	92	96	86	87						
RR	16	16	15	14	15	18	18	19	18	18	18	18		18	18	18	10	15	16	16						
SaO2	95	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	98	98						
FiO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L						
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC						
MAP	84	85	88	89	88	92	91	93	91	93	100	96		93	100	93	88	91	92	102						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125						
IVPB									150									100								
NGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
URINE	450/450	225/675	225/900				600/1500					800	1300	125/125	175/300	175/475	175/650	175/825	175/1000	200/1200						
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 22556

DOD-036132

ACLU-RDI 1670 p.105

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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME:_____ ETA:_____ UNIT:_____

MED COM: [Y] [N] _____

ARRIVAL STATUS

TIME 2315 ☐ IV x 2 ☐ O_2 15 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes: Ativan Ketamine

Allergies: ☐ UKN ☐ None ☐ Yes:_____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake _____hrs

LMP:_____ ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT_____ ☐ _____

☐ Secretions_____

BRETHING

☐ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] = [R]

CIRCULATION

PULSE: ☐ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warm ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ _____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6 = 15

SPHINCTER TONE: ☐ WNL ☐ None

HEAD

PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @_____

JVD: [Y] [N]

HEART

RHYTHM: ☐ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender:

PELVIS

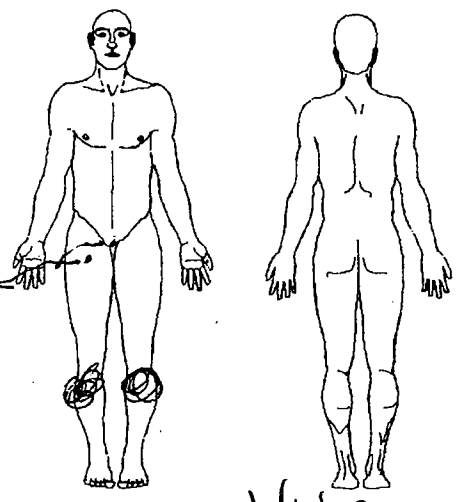
☐ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

Heme +/- Prostate: ☐ WNL ☐ Abnl

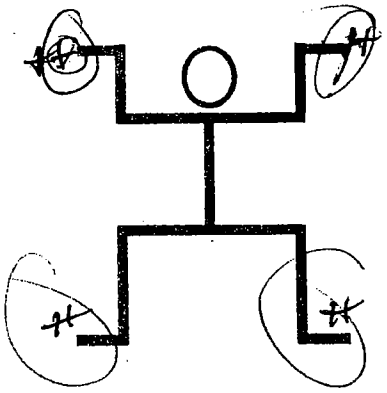
USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



b(6)-2

VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN [redacted]

PHYSICIAN [redacted]

(Continue on reverse)

PREPARED [redacted]

DEPARTMENT/CLINIC ENT

DATE

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

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

TIME	PROCEDURE	ACCOMPANED BY	RETURN
1340	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
1335	1	19	Y	N				
[illegible]	1	18	Y	N				
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☐ CBC ☐ Chem ☐ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

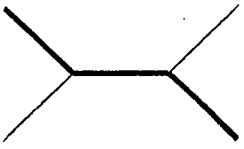
X-RAYS

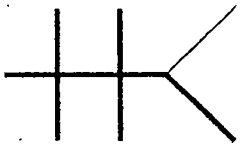
TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC: 

Chem: LFTs 

P7/077

UA –

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]		1342	
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

☐ Stretcher ☐ Wheelchair

Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp: 97.5

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
2315	153/72	81	SR	18	100%	∅					
	/										
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
(4) - Spontaneous	(5) Oriented	(6) - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

2315 40 Y/O presents to ED c/o
pain to his forehead [illegible] states
he was hit by another prisoner
in his head [illegible]
[illegible] floor [illegible]
[redacted] dressed, ED requested
[redacted] examining by Dr [redacted]
b(6)-2

MEDCOM - 22559

ACLU-RDI 1670 p.108

DOD-036135

[redacted] b(2)-2

7 Sept 2003

MEMORANDUM FOR Rear Area Operation Center, Baghdad

Subject: Patient Follow up

1. The following Iraqi civilian was seen at the 28th CSH as a patient and is authorized 1 follow up visit(s) on the date below:

FOLLOW UP VISIT DATE: 17 Sept 03

PATIENT NUMBER: 1180

NAME: [redacted] b(4)-4

2. The patient can be escorted to the 28th CSH during regular visiting hours (1000 and 1400) after the necessary security precautions have been performed.

3. The POC for this memorandum is the undersigned at [redacted] b(4)-4

//original signed//
[redacted] b(4)-2
LTC, MC
Deputy Commander for Clinical Services

0580 - 28th CSH -	IZ	For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-2	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1967-10-10	7. Age at Admission 36Y	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 23:11	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER b2-2	Ward: ICU1	Name / Relationship of Emergency Addressee	Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: 0580 [redacted] - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-10		
24. Clinic Svc - Admitting AAJ - ~~NEUROLOGY~~ Neurosurgery	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-30		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-30		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: OPEN DEPRESSED SKULL FX

Dx: 80309 7194 1

Px: 0202 8731

Procedure Narrative(s):

Cause of Injury Narrative:

Adm[redacted]

Si[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 22561

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	SAHOLE, HAMDE	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	32Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted]		ICU2

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	A11-ARMY ACTIVE DUTY			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	18:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-04

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-31	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 - [redacted] Iraq	2003-10-31	

31. Selected Administrative Data

Marital Status:

DoB: 1971-01-28

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury: IED

34. Diagnosis / Operations and Special Procedures:

SHRAPNEL CHEST, GSW R ARM

Dx 861.31
864.10
E991.9

Proc 87.44
87.41
34.04

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	5	5

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	5	5

Signature of Attending Medical Officer [redacted] MD

Signature of PAD or Medical Records Officer [redacted]

MEDCOM - 22562

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

32 yo I Detainee s/p IED explosion c multiple cbrlt + back wounds

PMH ⊖ PSH ⊖

meds none

PHYSICAL EXAMINATION

PE - VSS
Lungs - clear
Heart - RR
Abd - nontender

cbrlt + flank multiple wounds ⊖ s/s bleeding

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

Imp - 1) IED c pulm contusion + liver laceration

Plan - Obs IN ICU, follow H/H + CTR

[redacted]

DATE 21 Oct | IDENTIFICATION NO. | ORGANIZATION

(*Written entries give Name last, first, date; hospital or medical facility*) | REGISTER NO. | WARD NO.

b(6)-2

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

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 ✓

DATE	NOTES
31Oct03 2350	auscultated lung sounds very diminished throughout. Pt c/o pain to (R) UQ. sats 99%. ∅ S/Sx resp distress @ this time. will monitor. ——— [redacted] LTAN
01Nov03 0200	Pt resting HOB ↑ 45° sats 97% on RA ∅ S/Sx resp distress noted. LS CTA very dim (B). Will monitor. Last H/H 13.4 + 42.2 ∅ sig ↓ since previous H/H of 13.9 + 43.4. next draw @ 0245, will compare to results from 0045. ——— [redacted] LTAN
0400	Pt resting HOB ↑ 30° sats 97% on RA ∅ S/Sx resp distress, LS ↓ CTA (B). Last H/H from 0045 was 13.3 + 41.2, @ 0250 was 13.3/40.[redacted] will cont. to monitor Q2°. ——— [redacted] LTAN
0600	LS ↓ CTA (B) sats 99% on RA ∅ S/Sx resp. distress. will monitor. ——— [redacted] LTAN
1Nov03 0700	pt awake - eyes open spon. moves all ext - ∅ Resp distress - equal rise + fall of chest lung sounds ↓ throughout Sats remain 98% on RA - NSR - abd soft c/o slight abd pain to (R)UQ - surgical wounds to (R) arm clean + dressed c 4x4 ——— con't [redacted]

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

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

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

REGISTER NO. | WARD NO. ICU2

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1NOV03	0700 - (R) pectoral area swollen tender to touch
	bruising noted - afebrile 98.6 - will Report [redacted]
	CBC
1NOV03	0820 - pt c transfer orders to CPW ward
	wenated s difficulty pt asleep [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 22565

ACLU-RDI 1670 p.114

DOD-036141

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
01NOV03	(1740) Pt admitted to unit from ICU in stable cond. Ambulatory. ϕ c/o pain. VSS. Drsgs to shrapnel wounds to @ arm/shoulder Δd. Small amount sero-sang drainage noted. IVFs infusing into IV in @ dr c̄ S/Sx infection/infiltration. Tol. reg. diet well. Voiding c̄ difficulty. 2-point restraints in place c̄ S/Sx complications. Will cont. to monitor. [redacted] AN
01NOV03 1900	VSS alert & oriented. @ AC IV leaking around cath. IV D/Ced & cath intact. Restarted IV @ FA 18g 1¼ inch X1 attempt & IV infusing LR @ 40cc/hr. @ Arm/shoulder dsg dry & intact. SOB → ambs to BR without difficulty. Consumed 70% of Regular diet for Dinner. Will continue care as planned. [redacted] b/w-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]		

PROGRESS NOTES
Medical Record

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

LAST NAME	NAME	M	TIAL	ID NUMBER

DATE	NOTES
11/2	DC SUMM. adm. t 10/31 d/c 11/2 (pending) d/c dx - IED to liver + lung operation - Ø hx - pt hit ē IED to chest + abd. No pneumo or hemo-thorax. Multiple xrays (ant ⊖. Abd sound thru liver + observed ⊖ Δ in exam + H&H stable. DC in good condition b/(d)-2 [redacted]
Ø2 NOVØ3	(1125) Assumed care of Ø600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb well. Drsgs to shrapnel wounds on Rarm/shoulder. Δd. Small amount of sero-sang drainage noted. Tol reg diet well. Voiding ⊼ difficulty. 2 point restraints in place ⊼ S/Sx complications. Will cont. to monitor. [redacted]
Ø2 NOV 03 2000	Temp 100.6 @ 1857hrs. Tylenol PO given. Temp 99.1 @ 2000hrs. Amb to BR Independently. Drsg dry & intact to (R) shoulder/arm. Consumed 75% of Recently diet for dinner. Voids clear amber urine. [redacted]

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

b/(d)-2

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

3NOV03@1400 Pt. resting quietly in bed, V.S.S. A&O×3. Ø C/O pain. Pt. in 2 point restraints, Ø signs of skin breakdown. Pt. has superficial shrapnel wounds to chest, No orders for DRSNG Δ·Δ. DRSNG's intact, Ø [redacted] All other assessments WNL. [redacted] RCT, RN

3NOV03@2300 assumed care of pt @ 1800. VSS, C/O n/a, Tylenol given & good relief noted. Drsgs to chest wounds CDI. LS CTA @ BS, tol reg diet well, void per toilet S difficulty. + BM S difficulty. Pain monitor drsgs, pain control prn. 2pt restraints MS S/Sx of skin/circulation compromise. WW monitor [redacted]

3NOV03 Surgery [redacted] b(6)-2

4NOV03 0700 Assumed care of pt A&O×3. Lungs clear & CTA. Active BS. Urinating S difficulty ambulates well S diff. OK for discharge shrapnel wound to @ shoulder and axillary region healing minimal bleeding Afebrile will cont to monitor. [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.

EDW [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 V1.0C

AUTHORIZED FOR LOCAL REPRODUCTION

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

11/1/3
0700

Surgery
no problems overnight
afeb vss
Hgb stable
✓CNR + pwb transfer to floor
may d/c to camp next
24-48°

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.

b/(6)-4

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

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT
(Doctor)

TIME SEEN BY PROVIDER

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

32 yo Iraqi ⓓ Detainee c ~~ED~~ Explosion c ⓡ axilla & tricep wounds. Currently 4/10 Pain in shoulder.

PE: VSS, gen NAD Sats
CV: RRR ⊘ Ⓜ
Lys: ↓BS ⓡ Base, o/w good air exchange Ⓑ.
Abd: Benign Chest: Ⓣ hematoma TTP R chest,
Ext: ⓡ posterior trap + axilla c wounds, open

A/P: Shrapnel wounds - Ⓣ intrathoracic
→ CT A/P/chest Mo intracranial wounds.
→ tetanus
← Ancef 1gm IM

CONSULT WITH	TIME	ACTION
GS -		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] USAMHS

DIAGNOSIS: Shrapnel Wounds, Ⓣ intrathoracic Wounds.

CODES: b/w-2

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

11

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 553 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 22570

038

558-104

7540-01-075-3784

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted]

RECORDS MAINTAINED AT 16(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 31 Oct 08 | TIME 1715

TRANSPORTATION TO FACILITY wheel Veh 16

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW dist (L) shoulder/(L) arm

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1715

INITIALS: MJ

VITAL SIGNS

TIME	1715	1811	1860			
BP	114/72	108/71	112/69			
PULSE	108	88	88			
RESP	20	18	18			
TEMP						
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 98% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1733	16GA Angiocath IV	[redacted]			
1740	.5 / Tylenol IM	[redacted]			

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW [redacted] 61W-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)

[redacted]

MEDCOM - 22571

ACLU-RDI 1670 p.120

DOD-036147

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 19 2003 | DAY: 01 02 03/4 NOV | HOUR: 1200 1600 2000 0800

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 18 20 20 18

BLOOD PRESSURE: 124/66 | no/67 | 114/62 | 113/61 | 111/69 | 105/68

Pulse: 124/R | 99 | 101H

Temp: 100.6 | 100.3 | 97AT

HEIGHT: | WEIGHT → 97% | 97% | 98%

97(BA) 98 97(BA) N/A

Record special data only when so ordered

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

[redacted]

b(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 22572

b(4)-2

Ward/Section: ICU2 | REQUESTING PHYSICIAN: Dr [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 31Oct03 | TIME: 2320 | SSN/PSEUDO: [redacted]

b(4)-4

b(4)-4

(Hematology) CBC

TEST	RESULT		REF. RANGE
ID: [redacted]			31-10-03
WB			23:29
			Patient Limits
WBC	13.2 H	x10^3/uL	4.5 10.5
RBC	4.71	x10^6/uL	4.00 6.00
Hgb	13.4	g/dL	11.0 18.0
Hct	42.2	%	35.0 60.0
MCV	89.7	fL	80.0 99.9
MCH	28.6	pg	27.0 31.0
MCHC	31.8 L	g/dL	33.0 37.0
Plt	440.	x10^3/uL	150. 450.
LY%	16.5	%L	20.5 51.1
LYM	2.2 *	x10^3/uL	1.2 3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

b(4)-4

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 22573

b(6)-2

Ward/Section: ICU2 | REQUESTING PHYSICIAN: Dr [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 31OCT03 | TIME: 2045 | SSN/PSEUDO: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
W	ID: [redacted] WB	31-10-03 20:52
		Patient Limits
	WBC 16.9 H	x10^3/uL 4.5 10.5
	RBC 4.85	x10^6/uL 4.00 6.00
	Hgb 13.9	g/dL 11.0 18.0
	Hct 43.4	% 35.0 60.0
	MCV 89.5	fL 80.0 99.9
	MCH 28.7	pg 27.0 31.0
	MCHC 32.1 L	g/dL 33.0 37.0
	Plt 450. H	x10^3/uL 150. 450.
	LY% 10.3 *L	% 20.5 51.1
	LYM 1.7 *	x10^3/uL 1.2 3.4
Seg		
Band		
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

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

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted] | DATE: 31 OCT 03 | LAB ID NO.:

MEDCOM - 22574

b(6)-2

Ward/Section: ICU2	REQUESTING P[redacted] DY		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 #[redacted]		TIME 0250	SSN/PSEUDO SSN: #[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	ID: [redacted]	01-11-03
RE	WB	03:01
Hg		Patient Limits
Hc	WBC 11.3 H	x10^3/uL 4.5 10.5
M	RBC 4.54	x10^6/uL 4.00 6.00
	Hgb 13.3	g/dL 11.0 18.0
Pl	Hct 40.2	% 35.0 60.0
	MCV 88.6	fL 80.0 99.9
Ly	MCH 29.2	pg 27.0 31.0
	MCHC 33.0 L	g/dL 33.0 37.0
	Plt 411.	x10^3/uL 150. 450.
	LY% 20.6 *	% 20.5 51.1
	LYH 2.3 *	x10^3/uL 1.2 3.4
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 22575

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6) # [redacted]	TIME: 0050	SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC ID: [redacted] WB		4.8-10.8 x 10³
		01-11-03
		01:08
		Patient Limits
WBC	12.6 H x10^3/uL	4.5 10.5
RBC	4.59 x10^6/uL	4.00 6.00
Hgb	13.3 g/dL	11.0 18.0
Hct	41.2 %	35.0 60.0
MCV	89.9 fL	80.0 99.9
MCH	28.9 pg	27.0 31.0
MCHC	32.2 L g/dL	33.0 37.0
Plt	451. H x10^3/uL	150. 450.
LY%	20.2 *L %	20.5 51.1
LY#	2.5 * x10^3/uL	1.2 3.4
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 22576

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

LAST, FIRST: [redacted] | DATE: [illegible] | TIME: [illegible] | 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 =======
31/10/03 18:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100684

GLU	98	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	133	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	23	18-33	MMOL

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

======= PICCOLO =======
31/10/03 18:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100697

ALB	4.6	3.3-5.5	G/DL
ALP	72	26-84	U/L
ALT	69*	10-47	U/L
AMY	56	14-97	U/L
AST	64*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
GGT	48	5-65	U/L
TP	7.8	6.4-8.1	G/DL

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

						CL		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

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

b(6)-2

Ward/Section: EMT | REQUEST [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6) [redacted] | DATE: 31OCT | TIME: 1806 | SSN/SERVICE NO./DOD ID NO.: [redacted] SSN: b(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
W	[redacted]	4.8-10.8 x 10^3
R	ID [redacted]	31-10-03
H	WB	18:04
H		Patient Limits
M	WBC 26.2 H x10^3/uL	4.5 10.5
Pl	RBC 5.14 x10^6/uL	4.00 6.00
Ly	Hgb 14.9 g/dL	11.0 18.0
	Hct 46.2 %	35.0 60.0
	MCV 90.0 fL	80.0 99.9
	MCH 29.1 pg	27.0 31.0
	MCHC 32.3 L g/dL	33.0 37.0
	Plt 558. H x10^3/uL	150. 450.
	LYX 4.6 *L %	20.5 51.1
	LYH 1.2 * x10^3/uL	1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: DT [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4# [redacted]	DATE: 1 Nov 03	TIME: 0800
		SSN/PSEUDO #[redacted] b(6)-4

(Hematology)

TEST	RESULT	REF. RANGE
ID: [redacted]		01-11-03
WB		05:43
		Patient Limits
WBC	12.1 H	x10^3/uL 4.5 10.5
RBC	4.58	x10^6/uL 4.00 6.00
Hgb	13.4	g/dL 11.0 18.0
Hct	41.2	% 35.0 60.0
MCV	89.9	fL 80.0 99.9
MCH	29.2	pg 27.0 31.0
MCHC	32.5 L	g/dL 33.0 37.0
Plt	406.	x10^3/uL 150. 450.
LY%	20.4	% 20.5 51.1
LYM	2.5 *	x10^3/uL 1.2 3.4
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<40 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 22579

b(6)-2

Ward/Section: KW1 | REG [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-4 | DATE | TIME 1745 | SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted]		4.8-10.8 x 10^3
ID# [redacted]		01-11-03
WB		18:03
		Patient Limits
WBC	13.6 H x10^3/uL	4.5 10.5
RBC	2.42 *L x10^6/uL	4.00 6.00
Hgb	14.3 * g/dL	11.0 18.0
Hct	21.9 *L %	35.0 60.0
MCV	90.3 * fL	80.0 99.9
MCH	58.9 *H pg	27.0 31.0
MCHC	65.3 *H g/dL	33.0 37.0
Plt	220. * x10^3/uL	150. 450.
LY%	16.6 *L %	20.5 51.1
LY#	2.3 * x10^3/uL	1.2 3.4
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
[redacted]		01-11-03 07:54
		Patient Limits
WBC	13.6 H x10^3/uL	4.5 10.5
RBC	4.92 x10^6/uL	4.00 6.00
Hgb	14.3 g/dL	11.0 18.0
Hct	43.9 %	35.0 60.0
MCV	89.3 fL	80.0 99.9
MCH	29.1 pg	27.0 31.0
MCHC	32.6 L g/dL	33.0 37.0
Plt	472. H x10^3/uL	150. 450.
LY%	16.8 *L %	20.5 51.1
LY#	2.3 * x10^3/uL	1.2 3.4
Nit		Negative
Leuk		Negative
HCG		Negative

KW1

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

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

ICU2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/31 TIME OF ORDER ____ HOURS

1) admit to ICU
2) dx - IED chest + abd
3) VS q1°
4) H/H q 2° call for any sig ↓

[margin: 2000 1Nov03]

PATIENT IDENTIFICATION

[redacted]

ICU2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

5) LR 125cc/hr
6) NPO
7) Tylenol 650mg po q4° c cycle KO
8) cont pulse ox
9) CXR in AM

[margin: 2/0 Chart / Warden LCTAW]

[right margin: noted 31Oct03 [redacted]]

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICU2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

10) chest tube set at bedside

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

ICU2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 31Oct03 TIME OF ORDER 2120 HOURS

① Activity: Bedrest
VO. Dr [redacted] / [redacted] LTAN

b(6)-2

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

MEDCOM - 22581

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3 NOV 03 TIME OF ORDER ____ HOURS

To Iraqi hsp today

b(6)-2

LIST TIME ORDER NOTED AND SIGN

[redacted]

3 NOV 03 0900

b(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

JAV 0315 4 NOV 03

DATE OF ORDER 3 NOV 03 [illegible]00 HOURS

(1) DISREGARD LAST MD ORDER, (TO IRAQI HOSP. TODAY)

N.O. DR. [redacted] 2 CT, AAN

b(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICW

DATE OF ORDER 4 NOV 03 TIME OF ORDER ____ HOURS

to EPW camp

b(6)-2 and 12

[redacted]

4 NOV 03 0900

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDE[illegible]

[redacted]

b(6)-2

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 1 APR 79 REP. ES EDITION OF 1 JUL 77, WHICH MAY BE US.

MEDCOM - 22582

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
11/1		
1) ICU → ICW		
2) Dx- IED		
3) VS q4°		
4) Gen Diet.		
5) LR 40 cc/hr		
6) Tylenol 650mg po q4° prn		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER HOURS	
7) Tylenol #3 1-2 po q4° prn severe pain		
8) cancel previous lab order		
9) CBC at 3 PM call if Hgb < 12.0		

Noted [redacted] b(6)-2 approved 2045

PATIENT IDENTIFICATION [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER HOURS	
10) Xray (CXR) 11/2 early AM " Fru IED chest		
11) Plan transfer to Prison 11/2		

PATIENT IDENTIFICATION [redacted] b(6)-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER HOURS	
11/2		
d/c to Prison		
d/c hep lock		
ambulate		

Noted [redacted] b(6)-3 approved

038

DA FORM 4256 APR 79 03 REPLACES EDI MEDCOM - 22583

[redacted] b(6)-2

b/w-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 11 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 01 02 3 4
01 Nov 03	[redacted]	VS q 4°	03 13	[redacted]
			19 06	
01	[redacted]	Gen diet	07 13	
			19 06	
01 Nov 03	[redacted]	Ambulate	07 13	/
			19 06	/

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b/w-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 — MEDCOM - 22584 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

b(4)-2-KN

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
01 NOV03	[redacted]	ICU → ICW	01 NOV03	—	—	[redacted]
01	[redacted]	Cancel previous lab order	01	—	—	[redacted]
01	[redacted]	CBC at 3pm	01	1500	1745	[redacted]
01	[redacted]	X-ray (CXR) 1½ early AM. F/U ED chest	02 NOV03	0	0600	[redacted]
01	[redacted]	Plan transfer to prison 11/2				
02 NOV	[redacted]	D/C to prison				
3 NOV	[redacted]	To Iraqi hospital today	3 NOV	DISREGARD		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
01 NOV03	[redacted]	call MD if Hgb <12.0 (c CBC @ 3pm 01 NOV)	

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. Oct Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2
31 Oct	[redacted]	V/S Q 1°	06	✓	[redacted]	
			18			
31 Oct	[redacted]	H+H Q2° call for any Sig ↓	06	✓		
			18		[redacted]	
31 Oct	[redacted]	NPO	07	✓		
			12	✓		
			17	✓		
31 Oct	[redacted]	Continuous pulse Ox	010	✓	[redacted]	
			18	[redacted]		
31 Oct	[redacted]	Activity: Bedrest	06	✓	[redacted]	
			18	[redacted]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 1ES chest + abdomen

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

MEDCOM - 22586

USAPA V4.00

plus-2 AM

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Oct Yr 2003	
Order Date	Clerk [redacted]	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31 Oct	[redacted]	Admit to ICU - Dx IED chest + abd	31 Oct	—	1930	[redacted]
31 Oct		CXR in AM	31 Oct	~~0400~~	done	
31 Oct		Chest tube sat check q4h	31 Oct	—	done	

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

0141-2

CLINICAL RECORD

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

Mo Oct Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2
31 Oct	[redacted]	LR @ 125cc/hr	00	/		
			18	[redacted]		
31 Oct	[redacted]	Tylenol 650mg PO Q4	04	/		
		c sips H2O	08	/		
			12	/		
			16	/		
			20	[redacted]		
			24			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IEA chest + abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted] 0101-4

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

MEDCOM - 22588

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 01
01 Nov 03	[redacted]	UR 4pcc/hr	06 18 18 06	[redacted] DC 02 Nov 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 22589

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
02 NOV [redacted]	D/C heplock	02 NOV			[redacted]
	b(6)-2 AR				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
01 NOV	[redacted]	Tylenol 650mg po q4° pm	D/T	02 NOV 1740	02 NOV 1900	3 NOV 2000											
			D/I	"	"	[redacted]											
01	[redacted]	Tylenol #3 1-2 po q 4 to pm severe pain	D/T	2 NOV 0330													
			D/I	"	[redacted]												

*U.S. GPO: 1998-454-110/95216

MEDCOM - 22590

b/u-4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	2030	INTILAS		INTILAS		INTILAS
NEURO	PUPLIS		2mm brisk reaction					
	SENSORIUM		Alert follows					
			Commands MAE					
			Sport. restraints					
			on (B) arms					
RESPIRATORY	RESPIRATION PATTERN		RR 20's unlabored					
	BREATH SOUNDS		even ↑+↓ (B) CSCTA					
	SECRETIONS		∅ cough/secretions					
SKIN	COLOR		WNL intact, post					
	INTEGRITY		(D) Shoulder shrapnel					
			Sm amt drng noted					
IV SITE	LOCATION		18G (L) AC infusing					
	CONDITION		LR @ 125 cc/hr ∅					
			S/Sx infection					
			noted					
GASTRO	ABDOMEN		(+) BS x 4 quads					
	BOWEL SOUNDS		abd sft non-tender					
			non-distended					
GU	URINE		void spont.					
	COLOR/CLARITY		∅ UOP @ this time					
CARDIOVASCULAR	CARDIACRHYTHM		SR 80's ∅ ectopy					
			B/P stable 2+ pulses					
			all extrem. ∅ edema					
			noted.					

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC ICU2

DATE 31 Oct 03

PATIENT'S INDICATIONS *(For typed or written entries give: Name - Last, First, middle; grade; date; hospital or medical facility)*

[redacted] b/u-4 EPW

32 y.o. ♂

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 22591

WAMC OP 375 (Redesignated) 1 APR 90 (HSXC - NU)

DATE 31 Oct 03 | DX GSW head/chest (R) arm | HOSPITAL DAY

VITAL SIGNS

TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~06~~	~~06~~	~~07~~	~~07~~	~~08~~	~~09~~	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	113/69	115/69	107/56	107/62	109/61	113/64	112/63	114/65	112/61	108/59	110/68							
Temperature	99.5							98.9										
Pulse	83	77	83	72	79	79	78	80	74	73	83							
Respiratory Rate	26	18	21	17	8	18	11	14	14	16	12							
Sats	99	97	97	95	100	98	97	99	97	98	99							
Source	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA							

INTAKE

TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~09~~	10	11	12	13	14	15	8°T
LR	125	125	125	125	125	125	125	125	125	125	125							
LVPB																		
Blood																		
Bolus																		
TOTALS	125	250	375	500	625	750	875	1000	1125	1250	1375							

OUTPUT

		HOUR / TOTAL																	
URINE				550/650			450/1000				350/1350								
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	07	08	09	10	11	12													
	BP Arterial Line																			
	BP Cuff	110/68	132/70																	
	Temperature	98.6	-																	
	Pulse	89	78																	
	Respiratory Rate	18	14																	
	SaO2	98%	99%																	
INTAKE	TIME	07								8° T										8° T
	LR	125	125																	
	Oral	60																		
	TOTALS																			
OUTPUT	URINE HOUR / TOTAL	200																		
	URINE sp gr																			
	URINE S/A																			
	NG OUTPUT																			
	NG pH																			
	NG GUIAC																			
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

copy for record [redacted] b(6)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 347)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 388)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-99, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 426)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 497)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: RPG + 5m ARMS ATK Wear ARM OF 315

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: 4/1 FA		Location Grid:	
Date of Incident: (D/M/Y) 31/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #		Key Connected Person: ☐ Victim ☐ Witness	
Last Name: SADDAM HUSSEIN		Last Name:	
First Name: HUSSEIN Given Name:		First Name: Given Name:	
Hair Color: BLK	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: BRN Weight: lb Height: in		Eye-Color: Weight: lb Height: in	
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect: Sex: ☒ M ☐ F Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular		Ethn/Tribe/ Sect: Sex: ☐ M ☐ F Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information Vehicle Number ____ of ____ Vehicle(s)			Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband ☐ Weapon		Photo Taken of Suspect with Weapon/Contraband. Yes/ No	
Type:		Model:	Color/Caliber:
Serial No:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print):		Supervising Officer's Name (Print):	
Last, First MI		Last, First MI	
Signature: [redacted] FL CPT		Signature:	
Email: [redacted]		Email:	
Unit Phone: [redacted] e / /		Unit Phone:	Date: / /

6/6/2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? [illegible]
[illegible]
[illegible]

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying? Hand Guns

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

b(6)-2

Additional Helpful Information: [illegible] [redacted]
[illegible] at [redacted]

b(6)-4

MEDCOM - 22595

Admission and Coding Information

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

1. Reporting MTF	2. MTF Loc			
[redacted]	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1971-01-28	32Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		20	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			18:00	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78 ~~A11~~ ARMY ACTIVE DUTY			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICU2	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted]		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-04		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
ABA - GENERAL SURGERY		2003-10-31		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-10-31		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SHRAPNEL CHEST, GSW R ARM

Procedure Narrative(s):

Cause of Injury Narrative: IED

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	[redacted] SPC, 91G/U

Automated Facsimile - DA FORM 2985, MAR 2000 MEDCOM - 22596

9	10	11	12	13	14	NAME (Last, First, Middle Initial)	4. PAY GRADE 16 17	5. SEX 18

6. DATE OF BIRTH (YYYYMMDD) 19 20 21 22 23 24 25 26	7. AGE AT ADMISSION 27 28 29	8. RACE 30	9. ETHNIC BACK-GROUND 31	RELIGION

10. LENGTH OF SERVICE 32 33 34	ETS	11. FMP 35 36	12. SOCIAL SECURITY NUMBER 37 38 39 40 41 42 43 44 45

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS 46	HOUR OF ADMISSION	BRANCH / CORPS

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION 73 74	22. MTF TRANSFERRED TO 75 76 77 78 79 80	23. DATE OF DISPOSITION (YYMMDD) 81 82 83 84 85 86

24. CLINIC SVC - ADMITTING 87 88 89 90	25. MTF TRANSFERRED FROM 91 92 93 94 95 96	26. DATE THIS ADMISSION (YYMMDD) 97 98 99 100 101 102

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

FOR LOCAL USE

Dx 86131
86410
E9919

Pr 8744
8741
3404

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

[redacted] b(6)-2

b(6)-1

INPATIENT TREATMENT RECORD COVER SHEET

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

1.					3. GRADE	ADMISSION REMARKS
					NA	
4. SEX	5. AGE	6. RACE	RELIGION	LENGTH OF [illegible]	10. PREVIOUS ADMISSION	
M	52	UNK	UNK	NA NA	NO	
11. FMP	12. SSN		13. ORGANIZATION		14. WARD	
NA			NA		ICW1	
15. FLYING STATUS	16. DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
NA		NA	NA		NBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	0240	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	21	01NOV03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	31OCT03	b(6)-2 Dr. [redacted]

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

31. [illegible] ADMINISTRATIVE DATA

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: SHRAPNEL WOUNDS

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, MAY 79 MEDCOM - 22598 PPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

52yo ♂ EPW s/p fragment wounds to (R) forearm and lower back. Pt ambulated into EMT.

(R) Med Hx
Asthma NKDA Meds (R)

PHYSICAL EXAMINATION BP 167/95 HR 103 RR 16 Ax-98.2 ra

HEENT - clear
CV - RRR
Lungs - CTA (B)
Abd - obese / tender
Back - wound to (R) back

Ext
wound to
(R) forearm
Negative CT scan for intra-abdominal shrapnel

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

A/P: Shrapnel injury
(1) Admit + observe

b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	31 OCT 03		

PAT ON (*For typed or written entries give Name: last, first, middle; grade; date; hospital or medical facility*)

REGISTER NO.	WARD NO.

EPW
[redacted]
b(6)-4

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

117

MEDCOM - 22599

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1NOV03 2114Z	Pt. A&O, V.S.S. Ø C/O pain. DRSNGS CDI. Pt. to be D/C'd to EDW camp. [redacted] 2LT, AN

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTIO

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 OCT 03 1715	SZ/D Frag's & penetrating Fragment Wounds to (R) FA and Lower Back. Pt ambulated into Exit after being seen @ Iraqi hosp.
103	EKG RA and LA & AS ordered.
16 96/KA 167/95	1730 IGM Ancef IM Given. .5 of Tetmax IM given [redacted] b(6)-2
NKDA Ø Meds PMH Asthma	PE: VSS, Gen NAD Back c Multiple shrapnel wounds All c hemostasis. (R) forearm superficial CV: RRR @ (M) Lungs: CTA (B) Abd: Soft, NTP, BBS, obese Ext: Pulses 2+ x4 Xrays c? intraabd, Wound. CT @ for intraabd. A/P: Superficial Shrapnel Wounds, Stable. - Admit for OBS, Pain, DISP IN AM. [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPA[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.)*

EV EPW

[redacted] b(6)-4

REGISTER NO.	WARD NO.

MEDCOM - 22601

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

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

01 NOV 03

0930

Discharge Summary

52% ♂ EPW, s/p schrapnel injury to (L) back & (R) forearm with negative CT scan for intrathoracic or intraabdominal schrapnel & Pt to be returned to EPW camp. Pt requires q 3 day dressing change to (R) forearm and back & will prescribe 10 days of antibiotics and Percocet for pain.

[redacted]

b(6)-2

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

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

REGISTER NO.

WARD NO.

EPW

#[redacted]

b(6)-1

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

MEDCOM - 22602

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT DAY 31

2003 HOUR 2400

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 136/78 80 96 75

HEIGHT: WEIGHT → 151

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 22603

b(6)-2

Ward/Section: LMT | REQU[redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 30Oct03 | TIME: 1910 | SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted]		
WB		31-10-03 19:07
		Patient Limits
WBC	14.5 H	x10^3/uL 4.5 10.5
RBC	5.24	x10^6/uL 4.00 6.00
Hgb	14.7	g/dL 11.0 18.0
Hct	46.3	% 35.0 60.0
MCV	88.4	fL 80.0 99.9
MCH	28.1	pg 27.0 31.0
MCHC	31.8 L	g/dL 33.0 37.0
Plt	438.	x10^3/uL 150. 450.
LY%	13.4 *L	% 20.5 51.1
LY#	2.0 *	x10^3/uL 1.2 3.4

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
RBC		Negative
WBC		Negative

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 19:10

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.2 sec.
Ratio = 1.2
Calculated INR = 1.28
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :19:08
Card Lot :080201
Operator :[redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 19:16

Patient ID: [redacted]
Test Name :APTT
Test Result:= 24.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :19:14
Card Lot :030201
Operator [redacted]

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
		Negative

Microbiology

		Negative
		Negative

Microscopic Urinalysis

Blood Bank

Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Directigen		Negative	ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward/Section: EMT

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

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

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

DATE: 31OCT03 TIME: 1910

SSN/REF ID NO.: [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		25-27 mmol/L (art) 24-29 mmol/L (ven
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
31/10/03 19:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100494

GLU	238*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	138	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	♦♦♦	98-108	MMOL/L
tCO2	27	18-33	MMOL/L

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

CL - 105

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
31/10/03 19:08
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: [redacted] DR #: 000
SERIAL #: 0000100684

ALB	3.9	3.3-5.5	G/DL
ALP	106*	26-84	U/L
ALT	27	10-47	U/L
AMY	46	14-97	U/L
AST	28	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
GGT	24	5-65	U/L
TP	8.7*	6.4-8.1	G/DL

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

tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE:

LAB ID NO.:

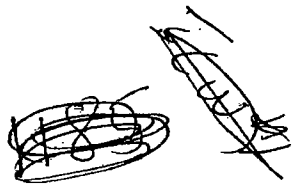
*U.S. GPO: 1992-316-809/60175

0-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

INATION(S) REQUESTED



CT abd/ Pelvis c IV+oral Contrast

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.

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

PREGNANT ☐ YES ☐

TELEPHONE/PA

TOR

DATE REQUEST

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

Rlo intraabd frag. (xray c frag. appearing intra GSW

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

LOGIC REPORT

1) (L) flank shrapnel.

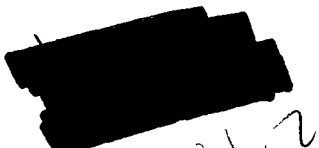
2) Else normal.

[redacted] MD

b(6)-2

T'S IDENTIFICATION *(For typed or written entries give: last, first, middle, Medical Facility)*

LOCATION OF MEDICAL RECORDS



b(6)-2

MEDCOM - 22606

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 30 OCT 83 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to
2. Px - Schrapnel wounds
3. Condition - stable
4. Vitals - per floor routine
5. Allergies - NKDA
6. Activity - OPW partial
7. Nursing - notify MD for temp > 100.4 / BP > 170/90 or < 90/50 HR > 120 or < 50 RR > 25 or < 10
8. Diet - Regular
9. IVR [redacted] Heplock
10. LABS - P
11. Meds - Percocet - 1-2 PO q 4-6 PRN Ancef - 1 g IVPB q 8° x 3 doses
12. Wash out wounds [redacted] HOURS
- Dress
- Floor XT

PATIENT IDENTIFICATION

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24°V INDV @ 624 [redacted] b(6)-2 T/TH/V

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

MEDCOM - 22607

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]				8 NOV 03	0938 HOURS	
			(1)	D/C IV Abx		
			(2)	D/C to OPD Comp [redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
b(6)-2 [redacted] 8 NOV 03 0938						
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.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

MEDCOM - 22608

D(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 ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4
31	[redacted]	VITALS: routine	6	[redacted]			
			18				
31	[redacted]	ACT: EPW protocol	6	[redacted]			
			18				
31	[redacted]	Notify MD for:	6	[redacted]			
		T > 100.4	18				
		BP > 170/90 < 90/58	/				
		HR > 120 < 80	/				
		RR > 25 or < 10	/				
31	[redacted]	DIET: regular	6	[redacted]			
			18				

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Shrapnel wounds

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

PATIENT IDENTIFICATION:
[redacted]
D(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 — MEDCOM - 22609 — USAPA V1.00

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	
31	[redacted]	admit ICU, stable					
31	[redacted]	wash out wounds & dress on floor x1					
01 Nov 03	[redacted]	D/C to EPW camp					
		b(6)-2					

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

USAPA V1.00

b(6)-2

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 31	1	2	3
31	[redacted]	IVF-heplock	6	[redacted]			
			18	[redacted]			
31	[redacted]	Ancef + gm IVPB	6	[redacted]			
		q8° x 3 doses	14	[redacted]			
			22	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
shrapnel wounds

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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 22611

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
01 NOV 03	[redacted]	DIC IV ABX	01 NOV 03			
		b(6)-2				

Order/ Explr Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
PRN	[redacted]	Percocet 1-2 po q4-6° prn	D/J
			D/1

*U.S. GPO: 1998-454-110/95216

b(6)-4

[redacted]

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: RPG 5m HEMS ATK NEAR ABI 31 Ja

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: 4/1 FA		Location Grid:	
Date of Incident (D/M/Y): 31/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #: [redacted]		Key Connected Person: ☐ Victim ☐ Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted] Given Name:		First Name: Given Name:	
Hair Color: BLK	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: BRN Weight: lb Height: in		Eye-Color: Weight: lb Height: in	
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: ☒ M ☐ F; Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F; Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	

Total Number of Persons Involved: (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number of Vehicle(s)	Owner:	
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband ☐ Weapon		Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:	Model:		Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details	Where Found:		Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print):	Supervising Officer's Name (Print):
Last, First MI	Last, First MI
Signature: [redacted] PT M53	Signature:
Email: b(6)-2	Email:
Unit Phone: [redacted] Date: / /	Unit Phone: Date: / /

MEDCOM - 22613

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? DURING A RIOT NEAR ABU GHARAB THIS PERSON WAS DETAINED FOR SMALL ARMS ATKS ON US FORCES.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying? SM. ARMS (HAND GUNS)

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: ADDITIONAL INFORM CAN BE SOUGHT FROM 4/1 PA AT FALLUJIRA CONTACT # 5517129

MEDCOM - 22614

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]	29	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	
NA	Z	0240	b(4)-4 NA

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O b(2)-2	ICU1	UNK

NAME AN[redacted]	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21		031101

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABAA		031031

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		031031

FOR LOCAL USE

DX: SHRAPNEL WOUNDS

Dx: 879.5
876.0
E991.9

Proc: 88.19
88.01

Inj Trauma
443 1

881.10
876.1
E993

88.01

ADMITTING OFFICER (Signature, as[redacted] b(4)-2

SIGNATURE OF ADMITTING CLERK

DA FORM 3005, MAR 80

MEDCOM - 22615