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]	[redacted] b(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	25Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted]		ICU1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
NO	K78-PRISONER OF WAR/INTER			BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	18:10	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-02

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-31	[redacted] b(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-10-31	

31. Selected Administrative Data

Marital Status: DoB: 1978-07-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: GSW BUTTOCKS

34. Diagnosis / Operations and Special Procedures:

DIVERTING COLOSTOMY/ SUPRAPUBIC TUBE PERUNEAL DRAINAGE

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	3	3

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	3	3

Signature of Attend[redacted]	Signature of [redacted] or Medical Records Officer
[redacted]	[redacted]

Automated Facsimile - DA FORM 3647, May 79 b(6)-7

MEDCOM - 22618

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

IRAQI MALE S/P GSW TO (R) Buttock. C/O (L) hip/leg pain, ↓ belly pain.
Alert + Oriented on arrival

PMHx: ASTHMA.
PSHx: ↓
Meds: unknown
All: unknown

PHYSICAL EXAMINATION T- P-135 149/118 12
HEENT - NC/AT PERRLA EOMI
Neck - (-) JVD
Chest - few wheezes to (R) side, Good air entry
CVS - Tachy (+)S1N1R
Abd - Mild distention nontender +BS ↓urinary
Pelvis - tender (L) pelvis / stable Entry wound (R) buttock
Rectal - destroyed rectal vault ~~connecting to~~ Foley catheter felt (-) blood (-) meatus
Ext - (-)
~~Emp: 6~~

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

Dx: GSW to perineum
Plan Need emergent exlap for diverting colostomy / suprapubic tube pelvic washout + drainage
with Urology

[redacted]
MAJ, MC.
[redacted] GENERAL SURGERY

DATE	IDENTIFICATION NO.	ORGANIZATION
31 OCT 03		

(*Typewritten entries give Name last, first, middle initial; 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

DATE	NOTES
31 OCT 03 2130	b(6)-4 PT [redacted] Bed #2 received from OR intubated. Per anesthesia PT received 2 U PRBC, 1L Crystalloid during operative procedure. Upon transfer to bed PT was monitored. BP 107/59 P-133 RR 16 Sao2 75-83. PT then connected to ventilator with Sao2 per above, he was immediately suctioned and medicated w morphine 10mg and Sao2 improved to 88-97%. Upon auscultation breath sounds were noted to have Expiratory wheezes. Blood gas, was PH 7.170 PCO2 50.3 PO2 45. PEEP ↑ to 8 & ABG was repeated for verification and PH 7.2[illegible], PCO2 [illegible] PO2 108 HCO3 18 MD at bedside monitoring events. b(6)-2 [redacted] WT/AN
2330	PT was hypotensive BP 90's/[illegible]. PT received 3L NS bolus. Received orders to transfuse 2U PRBC. Unit #'s 1645515 & 55FH63488 transfused without any RXN. PT SBP remains with map 65. b(6)-2 [redacted] WT/AN
0100	5cmg hydrocortisone iv administered. TLC placed to transfuse CVP = 10-13. [redacted] b(6)-c
0230	Albumin 5% ordered with transfuse ASAP [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

MEDCOM - 22620

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0330	ABGs 3 morning Labs Sent. PT STILL hypotensive. Albumin being transfused at this time. Will continue to monitor BP — [redacted] LT/AN
0430	BP drops to 60/35 (55). MD aware and ordered Neosynephrine 10mcg/min titrate to effect. Will monitor BP for effectiveness of med. K-Sent
0447	BP to Manual Cuff Now 103/51 A-line 83/55. Will continue to monitor and titrate Neo accordingly. — [redacted]
0450	Albumin 5% Completed. [redacted] LT/AN
0452	Fio2 to 95% — [redacted] LT/AN
0500	Neo titrated down to 7.5mcg/min. Sao2 100% — [redacted] LT/AN
0506	PT restarted on MSOS 2mg & Versed 2mg. [redacted]
0530	PT BP dropped to 87/48. Neo drip increased to 25mcg/min. Will continue to monitor. [redacted]
0630	Fio2 to 85% — [redacted]
	blood to All

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

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
1700 1 Nov	Dayshift nursing note: Received report from previous nurse. Pt hemodynamically unstable & acidotic at start of shift. Fluid resuscitated w/ total of 5% Albumin 1500 cc & 1 L NS to CVP of 16, Excellent UOP. Neo @ 25 mcg/min titrated to map of 65 now @ 10 mcg/min. Pt had episode of hypotension total of 2 amp Calcl & 2 Amp of Epi given. Epi gtt started and titrated to SBP > 90 now @ 1028 mcg/kg/min BP- 96/46 (65). Acidosis resolved w/ a total of 9 amps $NaHCO_3$ & vent changes. Pt now with decreasing O_2 requirements. Current vent settings P-5, 50% FiO_2, TV-800, Sm- 14, PIP- hi 20's, ABG @ 1600- pH-7.33, PCO_2-37.4, PO_2-181, HCO_3-20, SaO_2-100, BE-6, Plan to keep epi @ current rate for inotropic support & wean neo off. Colostomy beefy red, Ø air in bag. Dressing on Superpubic cath & JP drain replaced as needed. K-3.3 replaced w/ 40 mEq. Vecuronium gtt started @ 7 mg/hr, 10 mg Vec IVP loading dose given.

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

PART/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. 6/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES	
1830 01 NOV 03	Received report on PT 1188, Bed #2, unstable BP. PT is medically paralyzed on Vecuronium 7mg/h, Versed - 2 mL/hr & MSO4 - 2 mL/hr. PERRLA 2mm sluggish. moderate bloody secretions from nostrils suctioned frequently. PT vented @ ETT #8.5. RR 14 TV 800 PEEP 7 FiO2 50%. Lungs coarse with no wheezes. Scheduled neb treatment given. PT Tachycardic 150's. BP 90/30's and continues to slowly trend down. Pulses diminished throughout. JP drain & suprapubic catheter patent and draining. Abd sounds hypoactive. midline incision CDI. Will continue to monitor progress. K. Stewart.	
1850	CBC/PT/PTT drawn and sent to Lab. ABG by I Stat @ PH 7.30 PCO2 41.5 PO2 84 Hct 21 Sat 95%. PEEP dropped to 5cm/H2O & FiO2 to 45% per orders to keep PO2 >/= 65. Received CBC/PTT results & coags out of range and H/H 10.2/17.9. AT this time BP drop to 72/37. MD notified and ordered 1L Lip bolus. Post bolus PT remains hypotensive and neosynephrine ↑ to 15mcg/min with no effect. MD was called STAT to bedside	

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]

b7(c)-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
	and CBC & BP status was brought to his attention immediately. ½ Amp Epinephrine was given, followed by another with adequate results BP 192/74. PT return to hypotensive state shortly after. 4U PRBC was rapidly transfused followed by 4 Amp bicarb, 1 Amp CaCl, 1g mag+ due to acidotic state. PH 7.165 Pco2 48.7 Po2 60 Hco3 18 Sa02 86 BE: -11. Subsequently, Epi drip was running at 4mcg/min. and PT had echo done at bedside [redacted] was shocked with 200J 300J, 360J. Around 1926 BP normalized to 106/41. PH 2000hrs PH 7.251, Hco3 49.5 Po2 215 Hco3 22 [redacted]
2005	Start to wean Epi drip by 0.5cc per 1. Drip weaned to 3 mcg/min. [redacted]
2100	Epi drip wean to 4 mcg/min. [redacted]
2200	Istat done ABG WNL. Hct 60%. Epi @ 2mcg/min. [redacted] 1LT/AN
2300	Hct @ 55%. K+ 2.8. received order for 1gm mg+ & 40 KCl. Epi @ 2.1 mcg/min. will monitor K+ & repeat 40 meq if K+ < 3.5.
0100	Post K+ Run analysis. K+ 4.0 to Istat & 3.8 by chem8. Will hold 2nd dose of 20meq KCl X2 as ordered. PH: 7.461 Pco2 32.7 Po2 106. RR @ 16 & [redacted] and rate. Will continue ABG Q1H. [redacted] 1LT/AN
	b(6)-2 A11

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	6 W/ 2 AT
0300	ABG Sent. Results attached to progress notes. PT continues to have fluctuation in BP MAP between bottom 50's [redacted]
0440	DR [redacted] at bed side. BP drops [redacted] 70's/50's. HR 150's. IV LR bolus given @ minimal effect. Per Physician PT is perfusion as evidenced by UOP 300 cc/hr & CVP 13. Will continue to monitor progress [redacted] LT/AN
1000	PT remain closely guarded. VS unstable, remain on epinephrine drip titrated to maintain MAP > 65. Increased rate to 3.0 mcg/min @ this time MAP (56) heart rate 144.
1051	↑ Neo to 15 mcg/min due to MAP 57. BP now 86/45 MAP 61. Will titrate to effect to ↓ Epi [redacted]
1107	BP 116/62. MAP 82. Neo ↓ 12.5 mcg/min & Epi 2.5 mcg/min. HR 144. ABG sent. [redacted]
1210	Hobfoil MD for VBA 81/41 MAP < 60. Ordered to titrate Neo to 19.9 mcg/min & epi @ 2 mcg/min. UO > 50 cc/hr. May try Robinul as a last resort. Continue to closely monitor hemodynamic states. [redacted] mcj/AN

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02 Nov 03	A1 received a total of 2L LR, ē ⊕ result. BP 85/48
1400	ē MAP 64. Epinephrine 1.6 mcg/min. Nalbutamine on hold
1430	per dr Alexa, neosynephrine 19.9 mcg/hr. Titrate
	downward but keep MAP >60. BP 94/55 (70) - 133 - 16
	SAO_2 96% [redacted] Maj/AN
1615	A new femoral A-line (L) started @ 1500, working well.
	current BP 90/44 - 132 - 6 - 58 - 93% 60%. Bloody secretions
	noted from the nostrils. MD made aware. Albumin
	drip in progress @ 125 cc/hr until complete. T 96.6.
	Neo @ 19.9 mcg/min, epi drip @ 1.6 mcg/min. LE NV sluggish
	but ē blood return, cool to touch. Flowen red (dark)
	noted "perfusing" putting watery yellow discharge.
	Continue to monitor [redacted] Maj/AN
1700	Albumin drip completed. BP 81/46 - 128-16 - Sat 91%. All
	extremities are edematous + cool to touch. Continue to
	monitor. [redacted] Maj/AN
1805	ABG 1645: pH 7.29, PCO_2 45.1, PO_2 55, HCO_3 22, SAO_2 84%.
	MD notified ordered to ↑ RR 18 + ↑ FIO_2 65% repeat
	ABG in 30 minutes (1835) [redacted] Maj/AN
1850	ABG done Po_2 52. ↑ FIO_2 to 95% [redacted] Maj/AN
3 Nov 3	Code Note
	pt asystolic, 2 Atropine + 8 epi
	ē $NaHCO_3$ + Ca ⊖ response ē
	CPR + bagging. Code called 0054
	[redacted]

[redacted] b(6)-4

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
02 NOV 2003 1800	Received pt # 1188. Bed # 4 in unstable condition. BP 78/47 MAP 56. CVP 10. RR 18 HR 128. PT is being managed on Epinephrine 2mcg/min and Neosynephrine 20 mcg/min. Pt has LR running at 125 cc/hr. and with fluid resuscitation & titration of medication staff was unable to maintain MAP 760. PT at change of shift vented with 8.5 ETT. 26 cm H2O. RR 16 Sao2 91 PEEP 10 Fio2 55%. ABG was drawn and PH 7.356, Pco2 41.7, Po2 52 & Sao2 85%. Per MD order RR ↑ 18 & Fio2 ↑ 65%. PT continues to be watched closely through titration of medication and respiratory assessment & suctioning of thin secretions but large amount of bloody secretions nasally. AT 1930 another ABG was drawn with Chem 8, CBC & PT/PTT. ABG shows abnormal values of Po2 73 & Sao2 94%. Glucose on chem 8 39, Kt 4.8 Cl 111. PLT 51

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.

EPH [redacted] b1(a)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1988)
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	and Coags out of Range for analysis. PT went into respiratory distress with Sao2 60[redacted] then 40, frothy sputum at mouth and BP in low teens in a rapid period of time. Bagging began immediately and cardiac arrest / respiratory arrest code called for assistance. Upon their arrival No pulse was confirmed and CPR began followed by drugs according to ACLS protocol. PT received drugs documented on Arrest flow sheet. After regaining pulse & improvement of respiratory status PT was noted to have compartment syndrome to abdomen and transfered to OR for exploration and washout. At 2215 PT returned from OR & see OR flow sheet). PT at this time with Sao2 92%, Tachycardic & MAP < 60. PT MAP onto 50's & 1/4 Amp of Epi from OR given with temporary ↑ in BP. PT was then restarted on previous medication of 1mcg/min Epi and neosynephrine 20mcg/min. Epi was titrated to 8.5 mcg/min and neo to 30 mcg/min to maintain MAPs. PT then repeated 1st code episode of rapid desaturation 60's then 50's and likewise reduction in BP rapidly. Labs were

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

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Nov 03	BRIEF OP NOTE
2200	PREOP: ABDOMINAL COMPARTMENT SD. NECROTIC PERINEUM
	POSTOP: [redacted]
	PROCEDURE: IRRIGATION AND PLACEMENT OF SILO BAL
	IRRIGATION / DESCIDIMENT PERINEUM
	SURGEON: [redacted] ASST: [redacted]
	ANEST: [redacted]
	EBL: 100 INF: 1500 UO: 250
	FINDINGS - NORMAL ABD. CONTENTS
	NECROTIC PERINEUM
	COMPLICATION: Ø
	DISP TO ICU STABLE W OPEN ABD
	[redacted] blu-z A11

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont 2-mpw	drawn and PH 7.318 • PCO_2 37.8 PO_2 69 BE -7 SaO_2 92 • Late Entry: AT this
(Late Entry)	Gas result MD was on floor and ordered 2 amp bicarb • RT then Cardiac arrest team was called and Pt was pulseless, CPR began and ACLS protocol was followed with guidance from physicians in attendance (Total drugs administered per code sheet) • PT expired at 0054 • All lines were removed, ABD sutured and face photograph taken. PT then transferred to morgue •

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

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

[redacted] b(a)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 22630

510-112

NSN 7540-00-634-412

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 OCT 03			Prep - Perineal GSW c rectal/ urethral injury
@ 2100			Pentop - Sand
			Procedure - Ex Lap & diverting colostomy
			Suprapubic tube & Perineal urethral
			c placement of presacral drain
			Surgeon: [redacted] b(6)-2
			Asst: [redacted]
			Anest: GETA
			EBL: 500cc 600-700
			IVF: 10L crystalloid
			2 units PRBC
			Findings - disrupted urethra
			- destroyed distal rectum
			Comp: 4
			Drains: JP x 3 prs of pelvis
			Foley in prostate
			2 Penroses along tracts
			to ICU critical

b(6)-2

[redacted] MAJ, MC.
GENERAL SURGERY

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

(Continue on reverse side)

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

038

MEDCOM - 22631

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

Emergency Case | Pt intubated

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

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Ex lap

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco_____ppd X___vrs Body Piercing _____ Diabetes (Y) (N) ROM _____ 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. pt. intubated	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] b(a)-4

[redacted]

31Oct03 b(2)-2

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: /

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA VI.0

MEDCOM - 22632

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	O 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	O pt. will be transferred to OR table without difficultly. O 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 Communication due to: ___ 1) Diminished Hearing ___ 2) Language Barrier F.3. ___ Potential Injury due to Dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	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. pt. intubated	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 either 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 NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] CPT IAN 31 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) intubated

LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities intubated

☐ Transferred to Litter With roller due to spinal

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

DATE: 31 Oct 03 TIME:

13. PREOPERATIVE [redacted] BY (Signature and Ti[redacted] CPT IAN

DATE: 31 Oct 03 TIME: 2140

REVERS OF FORM 5179, JUN 91

USAPA V1.0

MEDCOM - 22633

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPE[illegible] M
VIA Litter BY Anesthesia

2. PATIENT IL[illegible] IFIEL[illegible] AND PROCEDURE
VERIFIED BY CPT [redacted]

3. DATE 31 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1855 [illegible]UMBER 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EMERGENCY CASE S/P GSW
Pt. intubated in EMT b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	SPC [redacted] (2030-EOC)
ASSIGNED CIRCULATOR	1LT [redacted] b6E (out @ 1930)	RELIEF CIRCULATOR	
	CPT [redacted] b6E	INT:	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

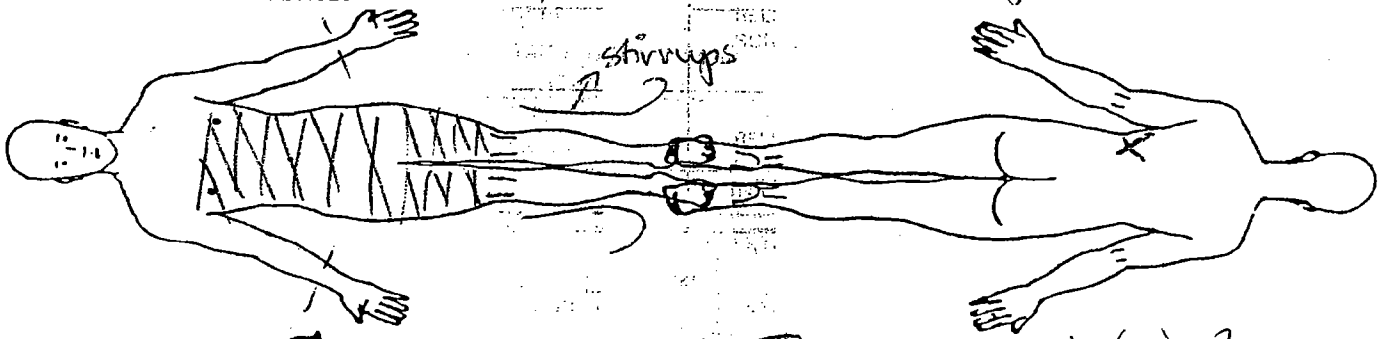
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine Scrub / Betadine Paint
SITE: Nipples to thighs and side to side BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Stra[redacted] = = = Tourniquet [redacted] prep area b(6)-2

Initial: PFC [redacted] CPT

C = Correct I = Incorrect Turnover: [redacted]

10. COUNTS

			Turnover Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	C	C	C
Needle Sharp	☒ Yes	☐ No	C	C	C
Instrument	☒ Yes	☐ No	C	C	C
Other	☐ Yes	☒ No			

SCRU[redacted] CIRCULATOR [redacted]

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

[redacted] b(6)-2
[redacted]
31 Oct 03 b(2)-2

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

☒ ESU NO: VL Force 40 CUT: 30 COAG: 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 EXP: 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 22634

13. PROSTHESIS, IMPLANTS ☐ YES — IF YES NAME: ID NUMBER — URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIA[redacted] b(6)-2

15. X-RA[redacted]OOM — IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 4x8 Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE x2	1in Penrose 16F FIC	10mm JP	Triple Lumen Surg Drain
SITE	1. Suprapubic	2. (R) Abdomen	3. Rectum

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] Dr [redacted] DV [redacted] GETA
Anesthesia: MAJ [redacted] b(6)-2
- DA 5179 Initiated

20. OPERATION(S) PERFORMED
Ex lap; Suprapubic Catheter Placement, Sigmoid Colon Resection, Colostomy, Debridement of Rectum, Presacral Drain Placement

21. PATIENT TRANSFERRED TO ICU b(6)-2 — TIME see DA 7389 — METHOD Litter

22. REG[redacted] SIGNATURE [redacted] CRT/AN

REVERSE OF DA FORM 5179-1, OCT 87 — MEDCOM - 22635 — USAPA V1.00

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

b(6)-2

1. PATIENT TRANSPORTED TO OPL ...OM — VIA letter BY ones
2. PATIENT [redacted] VERIFIED BY [redacted] PROCEDURE PTN
3. DATE 02 NOV 03 — TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM — TIME 2043 — NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted] Perez b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] MAJ [redacted]	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS (Specify)

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

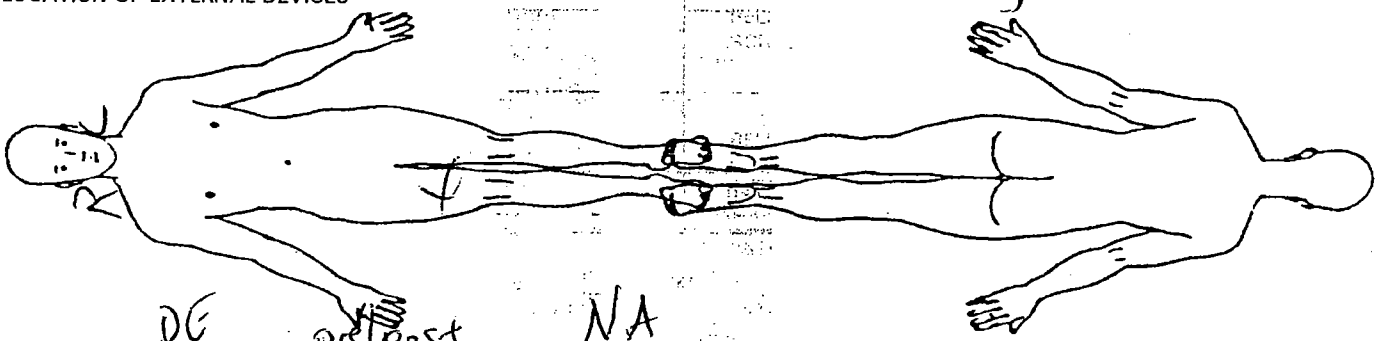
COMMENTS: pt placed on padded OK table c arms on armboards @ <90°. Legs crossed secured c 3" silk tape over Beta-Betx

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: abd
SITE: groin - thighs
BY WHOM [redacted]
BY WHOM [redacted] pos. approved surgeon
COMMENTS: c pooling

9. LOCATION OF EXTERNAL DEVICES



DG pre/post NA

LEGEND X Ground Pad — Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Initial Other	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	✓	C	C
Needle Sharp	☒ Yes	☐ No	✓		
Instrument	☒ Yes	☐ No	✓		
Other	☐ Yes	☐ No			

SCRUB [redacted] CIRCULATOR [redacted]

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

[redacted]

b(6)-2

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

☒ ESU NO: VL FORM 40 30/30
GROUND PAD: BRAND RBE 105301
LOT NO: 65706
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

MEDCOM - 22636

13. PROSTHESIS, IMPLANTS ☐ YES IF YES NAME: ID NUMBER; JRER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPE[redacted] IF YES, SITE
YES ☐ NO ☐

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION (Specify)
Rectum
Lap
S/o Sag
10 BMN
Laps
Blue towel
JP X1
Rectal bag
1 Lap
4x9
Abd
1 Cm 1

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP X 1	2.	3.
SITE	1. a Sd	2.	3.

19. ADDITIONAL INFORMATION
Boardman
[redacted] b(6)-2
Jeta
Stas - Chemo - Weber
Foley draining amber colored urine 5 difficulty

20. OPERATION(S) PERFORMED
Ex Lap & S/o-Sag placement
I+D Rectal wound & packing

21. PATIENT TRANSFERRED TO b(6)-2 ICU TIME 2206 METHOD Intubated Settles & O2 monitor

22. REGISTERED [redacted] MAN [redacted] 1A1 AN

REVE[redacted] 1, OCT 87 MEDCOM - 22637 USAPA V1.00

b(2)-2

[redacted] VENTILATOR FLOW SHEET

ICU #1

b(2)-2 pt [redacted] 8.0 ETT 23 cm

GSW thru peritoneum - testicles

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
31 Oct	2200	SIMV	14	700	50	5	37	14	136	95	107/59							BR
	2345	SIMV	14	800	100	5	38	21	146	92	106/55							DOK Atro
1 Nov	0000	SIMV	14	800	100	5	33	16	144	92	99/56							DOK
	0300	SIMV	14	800	100	5	33	15	144	92	78/55							DOK ↓ 95%
	0600	SIMV	14	800	90	8	26	14	144	100	76/57							DOK A16+Atro
	0800	SIMV	9/8	800	50	8	32	18	152	98	82/53							RAH
	1030	SIMV	18	800	50	8	31	18	153	98	86/56							RAH
	1200	SIMV	14	800	50	8	33	14	140	100	102/63							RAH
	1400	SIMV	14	800	50	8	33	14	140	100	100/61							RAH
	1800	SIMV	14	600	50	7	31	20	138	100	90/44							BR
	2000	SIMV	14	800	100	5	32	21	128	89	96/52							BR
	2300	SIMV	18	800	50	7	38	18	145	100	78/57							DOK
2 Nov	0000	SIMV	18	800	50	7	40	18	149	100	74/48							DOK
	0200	SIMV	18	800	50	7	42	18	152	100	80/47							DOK A16+Atro
	0400	SIMV	16	800	50	7	33	16	158	96	105/49							DOK
	0600	SIMV	16	800	55	7	32	16	150	92	100/44							DOK - pt receiving blood
	0800	SIMV	16	800	55	7		16	147	94	52/46							RAH
	1000	SIMV	16	800	55	7	35	16	142	94	50/46							RAH
	1330	SIMV	16	800	60	8	40	16	135	94	84/46							RAH
	1600	SIMV	16	800	60	8	40	16	136	95	94/52							BR
	1900	SIMV	16	800	60	8	38	16	130	97	96/52							BR
	2000	SIMV	16	800	100	8	41	16	133	94	88/41							BR
	2200	SIMV	18	800	100	10	39	18	123	86	84/32							DOK - A16+Atro+ABG
3 NOV	2004	PT expired																DOK - PT coded @ 2200 - DK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Istat : ABG's.
	2326
PH	7.318
PCO_2	37.9
PO_2	69
HCO_3	19
BE	-7
SO_2	92
Na^+	148
K^+	3.8
HCT	35
Hb	12
* 2 amps DPCards	
@ 2345	

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] p 16) - 4

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

MEDCOM - 22639

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | ABG Log | **PROGRESS NOTES**

DATE	NOTES		
2200	Fio2 100 (T) 96	2300 (T) 99 Fio2 60	0400
PH	7.363	7.399	7.461
PCO2	40.1	35.6	32.7
PO2	297	150	106
BE	-3	-3	-3
HCO3	23	22	23
SO2	100	99	98
Na+	154	153	152
* K+	2.7 *	* 2.8	4.0 LAB 3.8
HCT	40	40	40
Hb	14	14	14

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. 5/18)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1