

PATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr [REDACTED]		2. Name [REDACTED] <i>blu-4</i>			3. Grade FGN		Admission Remarks
4. Sex M	5. Age 25Y	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [REDACTED]	13. Organization			14. Ward ICW1		
15. FlyStatus		17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP	20. Type Case DIS	
21. Source of Admission Direct from ER				22. Hour Of Adm: 09:05	23. Clinic Service ABF - ORAL SURGERY		
24. Name/Relation of Emergency Addressee				25. Type Disp TRF-OTH	26. Date of Disp 2003-11-09		
27a. Address of Emergency Addressee				27b. Telephone No	28. Date This Adm: 2003-11-07	Admitting Officer: [REDACTED] <i>blu-2</i>	
29. Reporting MTF [REDACTED] <i>b(2)-2</i>					30. Date Init Adm 2003-11-07	32. Units Blood Components	
31. Selected Administrative Data Marital Status: DoB: [REDACTED] In/Out Patient: Inpatient MOS: [REDACTED]							
33. Cause Of Injury:							
34. Diagnosis / Operations and Special Procedures: S/P CLOSED REDUCTION OF MANDIBLE FX <i>802.28</i> <i>E968.9</i> <i>76.75</i> <i>23.09</i>							
35. Total Days This Facility							
Absent Sick Days <i>0</i>		Other Days <i>0</i>	ConLv / Coop Care Days <i>0</i>		Supplemental Care <i>0</i>	Bed Days <i>2</i>	Total Sick Days <i>2</i>
Absent Sick Days <i>0</i>		Other Days <i>0</i>	ConLv / Coop Care Days <i>0</i>		Supplemental Care <i>0</i>	Bed Days <i>2</i>	Total Sick Days <i>2</i>
Signature of Attending Medical Officer [REDACTED] <i>b(2)-2</i>				Signature of R/D or Medical Records Officer [REDACTED]			

MEDCOM - 23351

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

25yo em S/P assault 8 days ago. Pt treated at another facility and had archbars & a few wires placed. Pt presents w/ loose archbars and not in IMF. Plain films show Bilateral mandibular body fractures.

Pmt: ϕ

Pst: ϕ

PHYSICAL EXAMINATION

meds: ϕ

all: NKDA

Heent NC/AT Peril eomI
 ϕ palpable facial steps
maxilla stable
mandible mobile + TTP ϕ archbars loosely placed on $\uparrow\downarrow$ jaws. ϕ IMF



CX RRR

dup CTA (B)

PROGRESS (Enter date of discharge and final diagnosis)

and soft NT/ND (B)S
out ϕ C/C

ATP S/P Assault 8 days ago ϕ poorly fixated mandible fx.

- ① to the OR for closed reduction of mand fx
- ② body txs.

blu)-2

[REDACTED]	DATE MAY 10 1975	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION	(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		WARD NO.
REGISTER NO.		WARD NO.	

[REDACTED]

b(4)-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

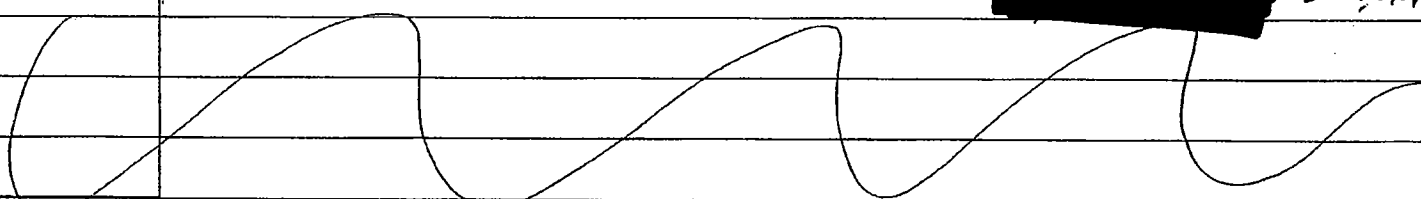
MEDCOM - 23352

MEDICAL RECORD PROGRESS NOTES

DATE NOTES

6 NOV @ 1945 Pt arrived to ward @ ~ 1920. Pt drowsy, but arousable. Able to follow commands. Pt moved self from gurney to bed. Suction at BS. Tested + is functioning properly. Wire cutters are hanging from IV pole. Med upt to 28 30mg IV Toradol + 12.5mg IV phenergan @ 1930. Pt HL at this time. HOB @ 30°. VSS. Lung sounds clear through all lobes. ⊕ bowel sounds. ⊕ pedal pulses BIL. ⊖ ~~to~~ S/Sx of bleeding in mouth. Minimal swelling around jaw area. Pt able to express needs at this time. Pt laying in bed. Urinates ~~xxx~~ 5 diff in urinal. W/U Plan: IV ABX, monitor airway, ~~_____~~ 24/A

7 NOV @ 1800 Pt. sitting up in bed. V.S.S. ⊖ c/o pain. Pt. taking PO fluids, tolerating well. Pt. has some swelling to mandible. Pt. ambulates well to BR & in hallway. IVSL ^{b/c} to ⊕ DAC, flushes well. Pt. in 2-point restraints, ⊖ signs of skin breakdown. All other assessments WNL. ~~_____~~ 26/A



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.

~~_____~~
b/w - 9

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

0871-

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
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DATE	NOTES
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1 NOV 02 2325 VSS. Pt c/o pain. medicated w 30mg Toradol IV. Pt found adequate relief. Jaw appears swollen. Pt tol PO diet BTS. Consumed juice + ensure through straw. Infusing IV ABX as per order. Urinating w difficulty. Lung sounds clear through all lobes. HOB @ 30°. Suction at BS. Wire cutters behind pt on IV pole. Pt asleep at this time. [REDACTED]

8 NOV 03 2140 Assumed care @ 0600; All vss, at 4:30 speaking arabic w c/o pain; pt mandible slightly edematous; P+Tol BTS diet, consumed juice for breakfast, 2 ensures for lunch; HOB ↑ to 30°, Suction & wire cutters @ BS; at voiding QS clear w urine w difficulty; Restraints in place, ⊕ circ, ⊖ skin break ↓, will cont to monitor [REDACTED]

8 NOV 03 2000 VSS Alert & Oriented. Denies NIV @ this time. Wire cutter @ BS along c center/duct. HOB ↑ 30°. Consumed 60% of BTS diet and 100% com of chocolate Ensure. OOB → AMB ad lib. No c/o pain or discomfort void or mtd. ⊕ FA IV with little swelling & pt c/o pain. ⊕ FA saline lock d/c'd w cath intact. Restated 20x 1/4" cath to ⊕ FA X1 attempt. 2+ restraints applied. Will check frequently to ensure proper circulation & prevent breaking off of skin integrity. [REDACTED] 207 AM

DLW-2 AM

MEDICAL RECORD PROGRESS NOTES

DATE NOTES

Transfer Summary

6 NOV 03 25 y.o. m. 8 DAYS S/P Assault. Pt
 @ 1742 was treated ^{initially} @ another facility.
 Pt presented to the [redacted] ^{Ob (2) - 2} c loosely
 fixated archbars and pt NOT
 in JMF. Plain films taken and
 bilateral body fr's seen c tooth
 #32 in the line of fit. Pt taken
 to the OR on 6 NOV 03 for closed
 reduction of bilateral mandible
 fractures with archbars and wire.

Procedure 6 NOV 03

① closed reduction of mandible fractures

DIC condition stable

DIC diet: Blended / full liquid

DIC meds ① tylenol c codeine elixer

10-15 cc po q 4-6^o pm pain

② Penicillin elixer 250mg/5ml

10ml po q 6^o x 7 days

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
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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.
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[redacted]
blw-d

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.0C

Transfer MEDCOM - 23355 summary

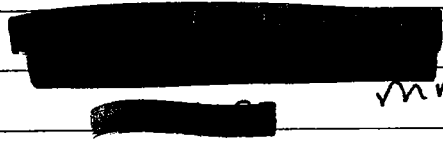
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
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DATE	NOTES
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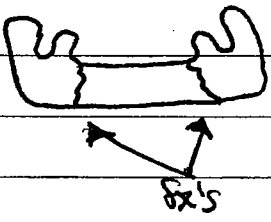
Follow up plan

① Pt needs to stay "wound shut" for 6 weeks - until week of 18 Dec 03

② Pt needs to have archbars and wires removed week of 18 Dec 03.



b(1)(2)-2
MAY 10c

MEDICAL RECORD	PROGRESS NOTES	
DATE	NOTES	
	<u>OMFS</u> Brief OP NOTE	
6 NOV 03 @ 1717	Pre OP dx: (B) mandibular body fr's Post op dx: Same Procedure: Closed reduction of fracture \bar{c} archbars and wires + ext #32  Surg: [redacted] bla-2 assist: [redacted] Anesth: NETA EBL: 450cc fluids: 800 cc LR comp: ϕ findings: extremely mobile #32 Cond: Stable extubated and breathing spontaneously and transferred to recovery 5erent.	
	bla-2 [redacted] MMSJ/DC OMFS	

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


[redacted]
bla-4

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

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
6 Dec 03			Assumed care of pt. transfer from DPC Lx Mandible fx. some sort of metal wire applied to teeth. No pain or discomfort lungs clear RRNR Active BS x4 gads Remains NPO q/c for surgery today Ambulates with difficulty urinating spontaneously EPW protocol restraints x2 Will cont to monitor
1400			

b(6)-2  0006

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

NURSING NOTES
Medical Record

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 25
 HEIGHT:
 WEIGHT: 70 kg

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

3. PREVIOUS SURGERY [] NO YES (type): See chart inc-previous jaw wiring

4. PROPOSED SURGICAL PROCEDURE:
CR of Mandible FX

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Intact
 Tobacco 0 ppsd 0 vrs Body Piercing 0 Diabetes (Y) (N) (N) ROM intact ASA/Motrin W 72hrs (Y) (N) (N)
 ETOH 0 Implants yes mouth Respiratory Disease (Asthma COPD) (Y) (N) (N) Anticoagulants (Y) (N) (N)
 Glasses/Contact (Y) (N) (N) Dentures 0 Hypertension (Y) (N) (N) Herbal Medicines (Y) (N) (N) MEDS: 0

6. PATIENT PROBLEMS AND NEEDS

A. PSYCHOSOCIAL
 potential for anxiety related to:
1) Surgical Procedure & Operating Room Environment
2) Separation Anxiety (Child)
 3) Surgical Outcomes

7. PATIENT GOALS AND EXPECTED OUTCOMES
 Pt. verbalizes any specific anxiety.
 Pt. Exhibits relaxed body posture.

8. OR NURSING INTERVENTIONS
 Allow pt. to verbalize freely.
 Explain Or environment and answer questions regarding surgery. *as possible*
 Offer comfort measures. (e.g. warm blanket, touch).
 Explain all nursing procedures before they are done. *as possible*
 Remain with pt. Whenever possible.
 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

Pt. will be able to breath without difficulty during immediate intraoperative phase.

Offer to elevate head of litter or offer pillow.
 Observe pt. While awaiting surgery for signs of distress.
 Assist anesthesia during intubation and extubation.

C. INTEGUMENT
 Potential Impairment of Skin Integrity due to:
 1) Intraoperative Immobility
 2) ESU Pad Placement
 3) Positional Aids
 4) Prosthesis
 5) Pooling of Prep Solutions

Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).

Utilize pressure preventing devices on OR table and accessories.
 Check for proper positioning and support to maintain good body alignment.
 Pad pressure points.
 Place ESU ground pad on non compromised skin surface area.
 Keep prep fluids form pooling.

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

[Redacted] b(2)-1 ICW,
[Redacted]
6NWS b(2)-2

VERIFICATIONS AT HOLDING AREA:
 ! ID/Allergy Band Y ! Dentures Removed N/A
 ! H & P Y ! Contacts Removed Y
 ! NPO Since mn ! Jewelry Removed Y
 ! UHCG/LMP 0 ! Body Pierce Removed N/A
 ! Consent/Blood Transfusion Signed/Witnessed/Dated N/A
 ! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon Y
 ! Contact precautions (Y)(N) (N)
 ! Family/Friend: 0

RM 5179, JUN 91

Previous editions are obsolete.

USAPA VI.0

MEDCOM - 23359

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

COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[Redacted] *[Signature]* 06 NOV 03 DATE

POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: Clean and Dry Red N/A DRESSING DRY & IN (Y) (N) *N/A*

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

LEVEL OF ACTIVITY: MOVES ALL EXTREMITIES Moves Upper Extremities

Transferred to Litter With roller due to spinal Gurney & sheet d/used

12. PREOPERATIVE EVALUATION PREPARED BY *[Redacted]* 13. POSTOPERATIVE EVALUATION PREPARED BY *[Redacted]*

DATE 06 NOV 03 TIME: 1530 MEDCOM - 23360 TIME: 1730

Am blue-2 unless noted diff.

MEDICAL RECORD		INTRAOPERATIVE DOCUMENT	
For use of this form, see AR 40-407, the content of the office of The Surgeon General.			
1. PATIENT TRANSPORTED TO OPERATING ROOM BY <u>ambulatory</u>	OPERATING ROOM BY <u>Anesthesia</u>	2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY <u>CPT [redacted]</u>	
DATE <u>6 Nov 83</u>	TIME PATIENT ARRIVED IN SUITE <u>1540</u>	4. PATIENT IN ROOM NUMBER <u>2-6</u>	

5. PREOPERATIVE EMOTIONAL STATUS

CALM ANXIOUS EXCITED CRYING ANGRY WITHDRAWN OTHER (Specify)

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	<u>PFC [redacted] 910</u>	RELIEF SCRUB	<u>[signature]</u>
ASSIGNED CIRCULATOR	<u>CPT [redacted] 66E</u>	RELIEF CIRCULATOR	<u>[signature]</u>

7. POSITION AND POSITIONAL AIDS (Specify) PT on padded OR bed Head on foam doughnut. Arms tucked at sides & sheets in CAP. Fingers wrapped around towels. Folded towels under heels.

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

COMMENTS: correct body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL: YES NO

DONE BY: OR NURSING UNIT

METHOD: DEPILATORY RAZOR CLIP

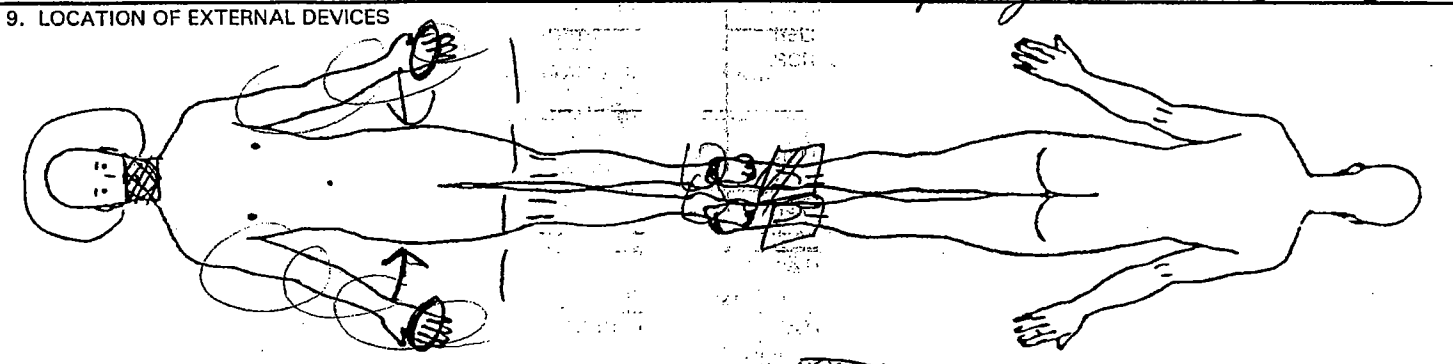
PREP SOLUTION (Specify) hibiclens

SITE: mouth/jaw/chin area BY WHOM: CPT [redacted]

SITE: teeth BY WHOM: CPT [redacted]

COMMENTS: chlorhexidine gluconate

COMMENTS: no pooling of solutions noted



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

10. COUNTS		C = Correct I = Incorrect		SCRUB		CIRCULATOR	
	Yes	No	First Closing Count	Final Closing Count			
Sponge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>C</u>	<u>C</u>	<u>PFC [redacted]</u>	<u>[redacted]</u>	<u>CPT [redacted]</u>
Needle Sharp	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>C</u>	<u>C</u>	<u>"</u>	<u>"</u>	<u>"</u>
Instrument	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>I</u>	<u>I</u>	<u>[redacted]</u>	<u>[redacted]</u>	<u>[redacted]</u>
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>I</u>	<u>I</u>	<u>[redacted]</u>	<u>[redacted]</u>	<u>[redacted]</u>

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

[redacted] 6 Nov 83

blaw-4

ICW

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 IF YES NAME: ID NUM [REDACTED] MANUFACTURER [REDACTED]
 Dr [REDACTED] O.M.S Set Cms load # [REDACTED]
 24 g wire - QS.

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% lidocaine c Epi 1:100,000		intra-op	local infiltration	[REDACTED]	Dr [REDACTED]

WOUND IRRIGATION YES NO; TYPE(S):
 0.9% NaCl - QS.

OTHER ORDERS

OTHER ORDERS	TIME	CARRIED OUT BY

PH [REDACTED]

15. X-RAYS IN ROOM IF YES, SITE
 YES NO

16. LABORATORY SPECIMENS

SPECIMEN (S)	NAME	NAME
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
FROZEN SECTION (FS)	NAME	NAME
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
CULTURE (C)	NAME	NAME
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
NAME	NAME	NAME
NAME	NAME	NAME

17. TUBES, DRAINS/PACKING YES NO

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

18. DRESSING/IMMOBILIZATION (Specify)
 NA

19. ADDITIONAL INFORMATION
 Surgeon: [REDACTED] WC-III
 Anesthesia: MAJ [REDACTED] CRNA
 Gen/NETA
 b/w-2 A71

20. OPERATION(S) PERFORMED
 DA 5179 initiated.
 Closed Reduction of Mandible Fx c Arch Bars + Wires
 Extraction of Tooth #32 1725

21. PATIENT TRANSFERRED TO
 ICU3 (PAW) [REDACTED] cpr/aw

TIME DATE 07/28/89 METHOD Gurney

MEDICAL RECORD **VITAL SIGNS RECORD**

HOSPITAL DAY														
POST-MONTH-YEAR	DAY													
19	NOV 7 18													
	HOUR	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400		
PULSE (O)	TEMP. F	92	96	98	98	98	98	98	98	98	98	98	98	TEMP. C
		105°	101°	101°	101°	101°	101°	101°	101°	101°	101°	101°	101°	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°
120	98.6°													37.0°
110	98°													36.7°
100	97°													36.1°
90	96°													35.6°
80	95°													35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD															
BLOOD PRESSURE		113/65	153/95	98/51	107/65										
HEIGHT:	WEIGHT →	5'7 1/2"	96 1/2	99 1/2	100 1/2										
Pulse		54	41	98	98										

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. _____


 6145-4

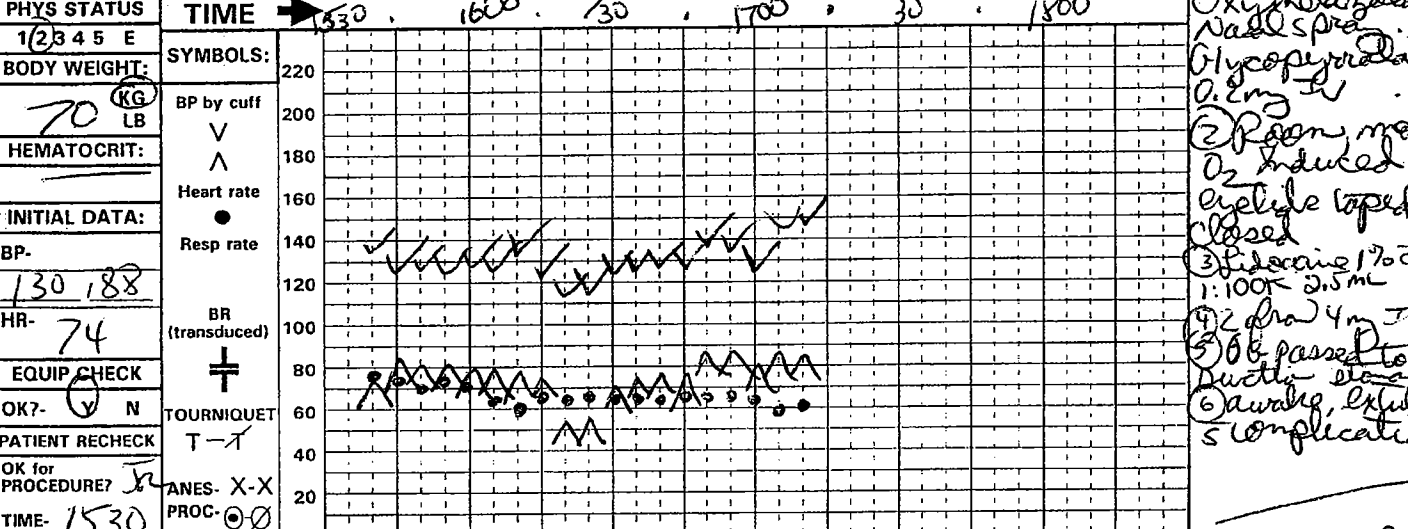
VITAL SIGNS RECORDS
Medical Record

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

ANESTHETIC AGENTS AND DRUGS CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML * = CONSTANT INFUSION	DRUG (Units)								TOTALS	TOTAL EBL
	Veced (mg)	2							2	150
Propofol (mg)	100							100		
Sevoflurane (mg)	200							200	TOTAL URINE	
Subst (mg)	100							100		
Fentanyl (mcg)	100	150						250		
MSO4 (mg)	5	5						10		
VOLAT AGENT	150% del. % e.t.	1.0	2.0	2.0	1.8	1.2	0.4X		FLUIDS - SUMMARY	
AIR	L/Min								CRYSTALLOID	
N2O	L/Min								800	
O2	L/Min	10	2	2	2	2	2	10	COLLOID	

FLUIDS	LINE site	EST BLOOD LOSS	URINE	REMARKS
	18U (ASA) Warmed			Code drugs with numbers, events with letters
	<input type="checkbox"/> Warmed			
	<input type="checkbox"/> Warmed			
	<input type="checkbox"/> Warmed			

LOSSES	EST BLOOD LOSS	URINE



VENTIL	VT - ml	800	790	770	770	800	780	750
	f - breaths/min	10	10	8	10	9	4	12
Peak inf pres / PEEP	17	17	18	18	19	17		
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	S	
BP/Auto Cuff	ET CO2 (torr)	22	33	35	32	32	41	56
BP/oth	FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6	0.6	0.6
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	arable						
	N-M Block (T/4)	BSS						
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS. EVENTS Position: ① ② ③ ④ ⑤ ⑥

PROCEDURES and CPT Codes: Closed Reduction of Mandible fx
 PATIENT IDENTIFICATION: [Redacted] blw-2 All
 ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GNTA
 AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLx1 MAC4 grade I new Pascal RME # 7.5 + McGill's + cords; 29cm @ mark + BBS + Sub F11
 SURGEONS: Vertkins
 PROCEDURE LOCATION: 2(2)
 DATE: 6 Nov 03
 PAGE 1 OF 1

RECOVERY AT 1720
 PACU ICU (Specify)
 OTHER
 CONDITION: Stable
 RESP: 20 SpO2: 100
 BP: 151/84 HR: 76
 ANESTHESIA / PROCEDURE TIMES
 US ANES Start Room End: 1530/1540/1730
 PROC ANES Ready Begin End: 1550/1600/1700

ANESTHESIA PLAN OF CARE PRF

PROCEDURAL ASSESSMENT (Sedation/

thesia)

Age 25 DAYS MOS YF

Sex (X) MALE () FEMALE

PROPOSED PROCEDURE: Closed reduction mandible
SURGICAL SERVICE: OFS
NPO SINCE: 1:00 6/20/03
Pental forcelite face

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

HABITS: TOBACCO: 1/2 CPD
ETOH:
DRUGS:

CURRENT MEDICATIONS:
() = ordered as premed

()
()
()
()
()
()

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

LABORATORY STUDIES:

HB/HCT: /
U/A:
OTHER:

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, Steroids N Y, Thyroid N Y
Neurological: Seizures N Y, Neuropathy N Y, Other N Y
Gynecological: Pregnancy N Y N/A
Other Significant Hx: N Y, N Y, N Y
Familial HX N Y

ASSESSMENT PAST SURGICAL/ANESTHETIC

(Crossed out box)

PHYSICAL EXAMINATION

BP 130/80 HR 59 R 20 T SaO2 99
Pain Scale 0-10
HEENT - Teeth intact, Trachea midline, TMJ/Neck FRO, Oropharynx MP III MOP, Nares patent
CHEST: TMD-3FB
CARDIAC:
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since 1500 6/20

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

Interpreter present; counselled for jaw wired closed Post of
INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardian understands and agrees. Questions answered.
Signed: [Redacted] Date: 6/20/03 Time: 1520 Hrs

POST-ANESTHETIC EVALUATION AND NOTE (NON ASU)
{ } MODERATE ANESTHETIC COMPLICATIONS { } OTHER

Signed: Date: Time: Hrs

Patient Identification: (Ward) # [Redacted] 51a)-4

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.

bleed - 2 An unless note differently

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
bleed-4 [REDACTED]			6 NOV 03	1328 HOURS	[REDACTED]
NURSING UNIT: ICW1			1 Admit to ICW-1 Dr [REDACTED] 2 Dx: mandible fx 3 cond: stable 4 Vitals: Per routine 5 aller: NKDA 6 Activ: Ad lib		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT: ICW1			7 Diet: NPO 8 Lev: BTS @ 125cc/hr 9 meds: Decadron 10mg IV on call to OR Ancy 2gm IV on call to OR 10 Void on call to OR.		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
bleed-4 # [REDACTED]			6 NOV 03	1707 HOURS	[REDACTED]
NURSING UNIT: [REDACTED]			1 Admit to PACU then ICW-1 Dr [REDACTED] 2 Dx: closed reduction of Bilateral mandible fx's 3 cond: stable text #32 4 Vitals: Per routine 5 Activ: Ad lib 6 aller: NKDA 7 Nurs: HOB ↑ 30° Yankauer suction to BS * wire cutters @ [REDACTED] @ all time		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT: [REDACTED]			8 Diet: BTS diet 9 Lev: HLIV then DIC when Clinda complete 10 meds: Clindamycin 900mg IV q8h X 7 days		

DA FORM 1 APR 79 4256

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


24° [REDACTED] 08/16
 Toradol 30mg IV q6h prn pain X 5 days
 Phenergan 12.5-25mg IV q4h prn N/V
 6 NOV @ 0130 [REDACTED]

MEDICAL RECORD - DOCTOR'S ORDERS
For use of this form, see MEDCOM Circular 40-5

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	6/20/03 1730 POST ANESTHESIA ORDERS (circled Items)	1730	
1	VS q 5 min X 15 min, then q 15 min until discharge.	1730	
2	Supplemental oxygen. $PR - SaO_2 < 95\%$	1730	
3	Morphine / Meperidine ___ mg IV now and ___ mg q 3-5 min prn pain for a max dose of ___ mg.		b(u)-2
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x ___.	1730	1748
5	Metoclopramide 10 mg IV prn N/V x 1.	1730	
X	Droperidol ___ mg IV prn N/V x 1.	1730	
X	Phenergan ___ mg IV prn N/V x 1.	1730	
X	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.	1730	
9	IVF: LR @ TKO cc/hr.	1730	
10	Discharge from recovery status when PACU discharge criteria met.		
	CRAT/MAJ		
	b(u)-2		

PATIENT IDENTIFICATION


b(u)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit 28th CSH	Room No.	Bed No.	Page No. 1 of 1
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MEDCOM - 23367

b(6)-2 #1 sales noted alt.

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
# bled-4 [REDACTED]			6 NOV 03	@ 1754 HOURS	
NURSING UNIT			<p>① all patient is eligible Okay to transfer to Prison camp hospital for remainder of weeks of fixation.</p>		
			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT			<p>② if pt NOT eligible for prison camp hospital pt must remain @ [REDACTED] for remainder of week etc.</p>		
			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT					
			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT					
			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT					
			DATE OF ORDER	TIME OF ORDER	
NURSING UNIT					

DA FORM 4256 1 APR 79

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

MEDCOM - 23368

0161-2

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo. // Yr. 2003	
VERIFY BY INITIALING		INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION					
ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED			
				6	7	8	9
11/6	[REDACTED]	Vitals per Routine	D				
11/6	[REDACTED]	Activity: Ad lib	D				
11/6	[REDACTED]	Diet: NPO	D				
11/6	[REDACTED]	NS Per Routine	D				
11/6	[REDACTED]	Activity Ad lib	D				
11/6	[REDACTED]	H2B ↑ 30°	D				
11/6	[REDACTED]	Yankauer Suction @ BS	D				
11/6	[REDACTED]	wire cutters @ available @ all times	D				
11/6	[REDACTED]	BTS Diet	D				

PRE OP

ALLERGIES: YES NO
NKIA

PRIMARY DIAGNOSIS:
SIP closed reduction of bilateral mandible fx
Mandible Fr

ADDITIONAL PAGES IN USE: YES NO
PAGE NO: _____

PATIENT IDENTIFICATION:

[REDACTED] 0161-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo <u>Nov</u> Yr <u>2003</u>
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/6	[REDACTED]	Admit to ICU-1 (DR [REDACTED])	11/6		1350	[REDACTED]
11/6	[REDACTED]	Condition Stable	11/6	noted		[REDACTED]
11/6	[REDACTED]	Void on call to OR	11/6			[REDACTED]
11/6	[REDACTED]	Admit to PACU → ICU 2	11/6	—	1930	[REDACTED]
-----	-----					
-----	-----	ICU-2: All				
-----	-----					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION							
			TIME/DATE COMPLETED							
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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																
				6	7	8	9													
11/6	[redacted]	Decadron 10mg IV																		
		on call for MR																		
11/6	[redacted]	IV: HL IV then D																		
		D/c when clinda N																		
		complete																		
11/6	[redacted]	Clindamycin 900mg	08																	
		IV Q 80 x 7 days	16																	
			24																	
		↑																		
		blues-2 A1																		

ALLERGIES: YES NO
NKDA

PRIMARY DIAGNOSIS:
S/P closed reduction of bilateral mandible fx
Mandible fx

ADDITIONAL PAGES IN USE:
 YES NO
PAGE NO. _____

[redacted]
blues-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

A FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.
MEDCOM - 23371

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Nov Yr. 03

Verify by Initialing

SINGLE ORDER, PRE-OPERATIVES

Order Date	Clerk/Nurse	Date to be Given	Time to be Given	Time Given	Initials
11/6	[Redacted]	11/6	o/c	DONE	[Redacted]
11/6	[Redacted]	11/6	o/c	DONE	[Redacted]
Decadron on call to OR					
Rincef 2gm IV on call to OR					

b(11)-2
A-11

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/Expir Date	Clerk/Nurse	MEDICATION, DOSE, FREQUENCY	PRN	TIME/DATE DISPENSED	
11/6	[Redacted]	Toradol 30mg IV	DI	6 NOV 1930	7 NOV 200
		Q6 ^o prn pain	DI		
		X 5 days	E/S		
		(DIC 11/11/03)	X		
11/6	[Redacted]	Phenergen 12.5-25mg IV Q4 ^o	DI	6 NOV 1930	12.5mg
		prn NIV	E/S		

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** DTSG APPROVED (Date)

Date: 11/06/03 Anesthesia Type (Circle): General Spinal Epidural
 Time In: 1718 IV Sedation Nerve Block
 Allergies: _____ OR Intake: Crystalloid 1000 Colloid _____
 Pre-op VIS: 130 OR Output: UOP _____ EBL _____
 Procedures: _____ Meds/Times: 2mg Valium, 250mg Ativan, 1mg Nal, 1mg Morphine

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

Time	1718	1722	1728	1735	1750	1805	1815
SaO2	94	93	95	95	94	94	96
FIO2	/	/	/	/	/	/	/
Methods	2D	8P	2A	2A	2A	2A	2A
240							
220							
200							
180							
160		118			160		
140		151	151	152	151		
120							
100							
80	84						
60							
40							
20							
JM	81	82	84	82	81		
RR	14	15	16	16	15		
T	97				97		

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
1718	<u>AL</u>	150	LA	TU	150
1752	<u>AL</u>	150	LA	TU	150

Post-Anesthesia Recovery score				
Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = Room Air NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2	VIS X = A-line BP = Cuff BP = Pulse
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10	

Time _____ Patient teaching done: Wound Care, Pain Management.
 Pain (0-10) _____ T, C, & DB, Incentive Spirometer, Comfort Measures
 LOS _____ Safety: SR up X 2, Falls Precautions. Privacy Maintained

PREPARED BY: [Redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC: PACU DATE: 11/06/03

PATIENT: [Redacted] Name: _____

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

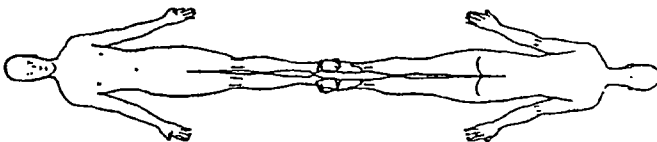
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1348	6	4mg Zofran	PO			[REDACTED]

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			
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1718	S.S.		PAES Sr.

WAMC OP 173-E

NURSING NOTES

1718 Pt responsive to physical stimuli - able to move all four extremities, Bilateral pedal and radial pulses (+). Pt has clear lung sounds and bowel sounds present.

1730 Pt alert and responsive - able to deep breathe through nostrils, also to swallow [REDACTED]

1758 - Pt responsive to verbal stimuli - able to open eyes and look around. Pt able to close eyes and remain quiet [REDACTED]

1858 'Pt alert and oriented x3. U/S stable - able to turn head and make sounds. Transferred to ICU [REDACTED]

b(a)-2 All

Discharge Criteria:
 Date: 11/26/13 Time: 1858 PARS: 10
 BP: 132/88 T: 96.8 HR: 54 RR: 13 SaO2: 97%
 Pain Level at D/C (0-10):
 Intake: 200 cc AL Output: _____
 Additional Data: _____
 Transferred To: ICU
 Report Given To: [REDACTED]
 Transferred Via: W/C Litter Gurney Ambulance
 Transferred By: [REDACTED]
 Cleared IAW Recovery [REDACTED]
 Charge Nurse Signature: [REDACTED]

b(2)-2

1. Reporting MTF [REDACTED]		2. MTF Location IZ		Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number [REDACTED]		Name (Last, First, MI) [REDACTED] b(2)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [REDACTED]		7. Age at Admission 25Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service ETS		11. FMP 99	12. Social Security Number [REDACTED] b(2)-4		
Organization (Active Duty Only)			13. Marital Status	Hour of Admission 09:05	Branch / Corps:
14. Flying Status		15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location		18. MOS		19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER		Ward: ICW1	Name / Relationship of Emergency Addressee		
Name and Location of Medical Treatment Facility: [REDACTED] b(2)-2			Address of Emergency Addressee		
21. Type of Disposition TRF-OTH		22. MTF Transferred To [REDACTED]	23. Date of Disposition (YYYYMMDD) 2003-11-09		
24. Clinic Svc - Admitting ABF - ORAL SURGERY		25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-07		
27. Location of Occurrence		28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-07		
<p>FOR LOCAL USE</p> <p>Type Patient (Inpatient / Outpatient): Inpatient</p> <p>Admission Diagnosis Narrative: S/P CLOSED REDUCTION OF MANDIBLE FX</p> <p>Procedure Narrative(s):</p> <p style="text-align: center;"> Dx: 9964 5258 PR: 7675 2309 </p> <p>Cause of Injury Narrative:</p>					
Admitting Officer (Signature, as required) [REDACTED]			Signature of Admitting Clerk [REDACTED] b(2)-2		

MEDCOM - 23375

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr [REDACTED]		2. Name [REDACTED]				3. Grade FGN		Admission Remarks
4. Sex M	5. Age	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO		
11. FMP 99	12. SSN [REDACTED]	13. Organization b(6)-4				14. Ward		
15. FlyStatus		17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP	20. Type Case BC		
21. Source of Admission Direct from ER				22. Hour Of Adm: 00:55	23. Clinic Service ABA - GENERAL SURGERY			
24. Name/Relation of Emergency Addressee				25. Type Disp EXPIRED	26. Date of Disp 2003-11-07			
27a. Address of Emergency Addressee				27b. Telephone No	28. Date This Adm: 2003-11-07	Admitting Officer: [REDACTED] b(6)-2		
29. Reporting MTF [REDACTED] b(2)2					30. Date Init Adm 2003-11-07	32. Units Blood Components		
31. Selected Administrative Data								
Marital Status:		DoB:						
In/Out Patient: Inpatient		MOS:						
33. Cause Of Injury:								
34. Diagnosis / Operations and Special Procedures:								
GSW LOWER BACK Dx: 9529 8761 8751 8797 E9912 Proc: 9904 (4) Ins Treatment 450 Cause death #1 Blood: PRBC (4) Auto: NO								
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	1	1			
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	1	1			
[REDACTED] Medical Officer				b(6)-2	Signature of PAD or Medical Records Officer: [REDACTED]			