NSN 7540-00-634-4165

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D ® hand, © feet, ® calf.

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

Wash out ® hand © feet, ® calf

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

   a. The name of the patient and his/her family is not used to identify said pictures.

   b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 CPT [illegible] *(Signature of Witness, excluding members of operating team)* | (b)(6)-2 *(Signature of Patient)* | 8/9/03 *(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, ______ sponsor/guardian of ______ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | *(Signature of Sponsor/Legal Guardian)* | *(Date and Time)*

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

(b)(6)-4

REGISTER NO. | WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDUR

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D (R) Thumb, Cement/antibiotic spacer

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be washout (R) Thumb, cement/antibiotic spacer
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2 MD
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above and hereby request such procedure(s) be performed.

(b)(6)-2 (Signature of Witness, excluding members of operating team) | (b)(6)-2 (Signature of Patient) | 8/12/03 (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, ______ sponsor/guardian of ______ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | (Signature of Sponsor/Legal Guardian) | (Date and Time)

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

(b)(6)-4

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-11

MEDCOM - 1518

*U.S. Government Printing Office: 1991 — 312-071/4019

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE Partial thickness vs Full thickness skin graft to (R) hand & (R) calf

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be Partial thickness vs Full thickness skin graft to (R) hand & (R) calf
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 (b)(6)-2 8/18/03

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, ______ sponsor/guardian of ______ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

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

Iraqi (b)(6)-4

REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1519

*U.S. Government Printing Office: 1991 — 312-071/40193

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

IRAQI

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 JULY 2003 — TIME OF ORDER: 2215 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU, Dr (b)(6)-2, ortho
2. DX: (R) tibia fx s/p exfix (open tibia fx)
   GSW (R) UE, (B) LE
   open (L) knee, open (L) foot 2nd MT fx
   open (R) thumb prox. phalanx + MC s/p (b)(6)-2
   (b)(6)-2
3. Cond: stable
4. Vitals: q 1°

DATE OF ORDER — TIME OF ORDER — HOURS

5. Diet: clears → Regular diet as tolerated
6. IVF: LR 100 cc/° until adequate po then ↓ 50 cc/
7. meds:
   ancef 1g IVPB q 8°
   gentamicin 80mg IVPB q 8°
   Tylox 1-2 po q4-6° prn pain
   MSO4 2mg-4mg q 1° prn breakthrough pain.

(b)(6)-2

DATE OF ORDER — TIME OF ORDER

8. Act: Bedrest c̄ BRP — HOURS
9. Al: NKDA
10. Nonweight bearing (B) LE

(b)(6)-2

(b)(6)-2

Chart ✓ 27 JUL 03 0100 (b)(6)-2

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: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
IRAQI (b)(6)-4		26JUL03 — 2225 HOURS	
	1)	MSO4 1-5mg Q5min IV TOTAL 20mg NTE	(b)(6)-2
	2)	WEAN O2 TO KEEP SpO2 ≥ 95%	
		(b)(6)-2 CANA	
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.			

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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 27 July 03 — TIME OF ORDER: 0800 HOURS

1. NPO p MN

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Jul 03 — TIME OF ORDER: 1008 HOURS

1. in/out catheter now please since ⊕ c/o if no void - leave in if residual >400cc. thank mucho
2. (1) if no void 6° p last void, (b)(6)-2 may see #1 order) this date (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Jul 03 — TIME OF ORDER: 2145 HOURS

1. Δ vitals to q shift

(b)(6)-2

noted 2220 27 Jul (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 27 July 03 2345 (b)(6)-2

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.

ICE: 1994-383-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 July 2003 TIME OF ORDER: 1130 HOURS

LIST TIME ORDER NOTED AND SIGN

1. admit ICU 1, ortho, Dr (b)(6)-2
2. Dx: Multiple ortho injuries (B) LE, (B) UE s/p ExFix, I+D, tendon repair
3. cond: good
4. vitals: q 1° x one shift then q 4° if stable
5. all: NKDA
6. act: ~~BRP~~ Bedrest; Non weight bearing (B) UE

(b)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

7. Diet: clear → reg as tolerated
8. IVF: NS @ 100cc/° until adequate PO then ↓ to 50cc/°
9. meds:
   - ancef 1 g IVPB q 8°
   - Gentamicin 80mg IVPB q 8°
   - Tylox ii PO q 4-6° prn pain relief
   - MSO4 2mg - 4mg IV q 1° prn breakthrough pain.

DATE OF ORDER | TIME OF ORDER | HOURS

10. Radiograph order see request per Dr (b)(6)-2
10. ~~keep chest flat~~
11. please keep wounds on (L) arm and (R) neck clean/moist 4x4 (open undressed wounds) (b)(6)-2 wet to dry dressing q d
12. (b)(6)-2

DATE OF ORDER: 28 Jul 03 TIME OF ORDER: 1210 HOURS

(b)(6)-2

MSO4 1-5 mg IV q 8 minutes PRN not to exceed 20 mg Thank you (b)(6)-2 CPT/CRNA

(b)(6)-2

1300 28 Jul 03

(b)(6)-2

Chart ✓ 28 JUL 2003

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

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

MEDCOM - 1523

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
(b)(6)-4

IW#1

DATE OF ORDER: 28 JUL 03 — TIME OF ORDER: 1700 HOURS — LIST TIME ORDER NOTED AND SIGN

Tylenol 650 mg po Q4 hrs prn

V.O. Dr. (b)(6)-2 (b)(6)-2 /1740

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 28 JUL 03 — TIME OF ORDER: 2100 HOURS

① MSO4 2mg bolus IVP now for severe pain and may repeat in 1/2 hour if still severe pain.

(b)(6)-2

PHILLIPS
LTC (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 28 Jul 03 / 2320 (b)(6)-2

PATIENT IDENTIFICATION

Noted (b)(6)-2 29 JUL 03 0420

DATE OF ORDER: 29 JUL 03 — TIME OF ORDER: 0400 HOURS

MSO4 - 2-4 mg IV q1° prn breakthrough

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Start 29 JUL 0825 (b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-2

DATE OF ORDER: 29 JUL 03 — TIME OF ORDER: 1044 HOURS

① Continue to encourage pointance through days
② NPO p MN in anticipation of OR in the am.

(b)(6)-2

(b)(6)-2 (signature)

ROOM NO. | BED NO.

✓ 29 Jul 03 2340 (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 (b)(6)-4 (b)(6)-2

ICU #1

DATE OF ORDER: 29 JUL 03 | TIME OF ORDER: 1150 HOURS | LIST TIME ORDER NOTED AND SIGN

1. MSO4 2mg IVP now for breakthrough pain (b)(6)-2

(b)(6)-2 LTC DDS (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 29 Jul 03 | TIME OF ORDER: 1730 HOURS

Noted 1730 (b)(6)-2

1. demerol 25mg IV c̄ 12.5mg phenergan slow IVP now; may repeat 25mg demerol in 1/2 hr if need more relief (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓29 Jul 03 2340 (b)(6)-2 LTAN

PATIENT IDENTIFICATION | 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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 30 July 2003 TIME OF ORDER: 1145 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU, Dr (b)(6)-2 ortho
2. Dx: multiple ortho procedures bone graft (R) ASIS (L) hand, (R) foot Ex Fix on (R) LE
3. Cond: good
4. Vitals: routine
5. All: NKDA
6. Act: OOB to chair c̄ asst at least bid;
   a) non weight bearing (B) LE
   b) Encourage deep breathing tid or incentive spirometry qid
7. Diet: Clears to regular as tolerated
8. Meds:
   a) ancef 1g IVPB q8°
   b) ~~Gentamicin 80mg~~ (b)(6)-2 q8
   c) Tylox ii po q4-6° prn pain relief
   d) motrin 800mg po tid scheduled
   e) MSO4 2mg-4mg IVP q1° prn breakthrough pain
   f) Colace 100mg po bid
9. IVF NS @ 100cc/° until adequate po intake then ↓ to 50cc/°
10. Encourage po intake - supplement c̄ Ensure/soft diet prn
11. Dressing changes:
    a) leave alone (R) hand and (L) leg
    b) clean/dress/then bacitracin on neck, arm wound (L) (superficial wounds)
    c) dressing changes to (R) leg - wet to dry bid & replace splint/ACE wrap (to start tm 2240, Dr (b)(6)-2 to asst 1st time)

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

V 30 Jul 03 2240 (b)(6)-2

LTC (b)(6)-2

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

MEDCOM - 1526

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 30 Jul 03 TIME OF ORDER 2300 HOURS

LIST TIME ORDER NOTED AND SIGN

Maalox 30cc p.o. x1 now (b)(6)-2 30 Jul 03

V.O. (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 31 July 03 TIME OF ORDER 1730 HOURS (b)(6)-2

1 Maalox 30cc po q 6° prn Heartburn.

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

✓ 31 Jul 03 2155 (b)(6)-2

DATE OF ORDER 31 July 2003 TIME OF ORDER 2030 HOURS

1 ensure ī can bid to increase protein intake

(b)(6)-2

(b)(6)-2

Noted 31 Jul 2036 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 1 Aug 03 (b)(6)-2 2205

TIME OF ORDER 1 Aug 03 0340 HOURS

1 Zantac 150 ā p.o. BID

(b)(6)-2

1/1/03 0640

FAMILY PRACTICE

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

MEDCOM - 1527

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 1AUG03 TIME OF ORDER: 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

Benadryl 50mg PO q6° prn

itching VO (b)(6)-2

(b)(6)-2

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

NURSING UNIT ROOM NO (b)(6)-2

√ 1Aug03 ... NFAN 2205

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 4 Aug 03 TIME OF ORDER: 1137 HOURS

① D/C Cola (b)(6)-2 MD

Lieutenant Colonel ... Corps

Chief (b)(6)-2 Department of Medicine

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

NURSING UNIT ROOM NO. BED NO.

√ 5Aug03 0715 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 5 Aug 03 TIME OF ORDER: 1210 HOURS

1) admit to ICU, Provost, ortho
2) Dx: multi ortho trauma, s/p washout, modify skin flap - debride
3) cond: good
4) all: NKDA
5) act: Nonweight bearing Ⓑ LE; OOB tid into chair - can assist briefly c̄ Ⓛ LE

(b)(6)-2 (b)(6)-2 ... 1515 8/4/03 (b)(6)-2

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

Encourage deep breathing; IS

6) Vitals: routine
7) Diet: clears to regular as tolerated supplement c̄ ensure ican tol
8) Meds: ancef 1g IVPB q8°
   Tylox i-ii po q4-6° prn
   Motrin 800mg i po tid prn pain relief
   ~~IVF NS or LR @ 50cc/°~~ HLIV Ⓓ (contd)

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.

√ 5Aug03 0200 (b)(6)-2

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

MEDCOM - 1528

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 5 aug 03 — TIME OF ORDER: 1710 HOURS — LIST TIME ORDER NOTED AND SIGN: (b)(6)-2

10) (R) hand dressing changes ~~by surgeon~~
11) (R) leg dressing changes wet to dry bid - replace splint / ACE wrap
12) continue cleansing remaining lacs/abrasions - then layer bacitracin TID (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 5 AUG 03 2200 (b)(6)-2 UTAN

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 6 aug 03 — TIME OF ORDER: 0930 HOURS

1) Zantac 150mg po bid please

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 6 aug 03 — TIME OF ORDER: 1130 HOURS

1) (R) hand dressing changes bid - clean gently. xeroform over donor site. Dry dressing in webspace & over incisions. Kerlix - no more wet to dry. thanks (most welcome!)

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 6 AUG 03 2300 (b)(6)-2 (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 7 aug 03 — TIME OF ORDER: 1937 HOURS

1) clindamycin 150mg po qid
2) DC IV and IV Abx
3) D/C (R) hand dressing changes - Dr (b)(6)-2 will do hand dressings

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 7 AUG 03 2025 (b)(6)-2 (b)(6)-2

DA FORM 4256, 1 APR 79 — REPLACES ... WHICH MAY BE USED.

MEDCOM - 1529

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

noted 8 Aug 03 (b)(6)-2 0822

DATE OF ORDER: 8 aug 03 TIME OF ORDER: 0830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Just do dressing Δ's on (R) LE until surgeon determines (L) LE -
2. Routine (bathing) cleanup OK for superficial lacs/abrasions on torso and d/c bacitracin

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 9 Aug 03 TIME OF ORDER: ______ HOURS

(b)(6)-2

- IV Ancef q8° 1gm
- NPO → plan I&D (R) Thurs @ 1500hrs

(b)(6)-2

noted 9 Aug 03 1150

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

8/19/03 1110

DATE OF ORDER: 8/19/03 1110 (b)(6)-2 TIME OF ORDER: ______ HOURS

(b)(6)-2

D/C CLINDOMYCIN.

V.O. (b)(6)-2 / LT (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

Charted

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 1530

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
(b)(6)-2

DATE OF ORDER 8/9/03 TIME OF ORDER ______ HOURS | LIST TIME ORDER NOTED AND SIGN

To ICW Dr (b)(6)-2
Dx: s/p R Thumb I&D
L foot I&D
Regular Diet
WEDA
vitals q8°
NUTRITION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

meds:
Tylox 1-2 Tabs po q 6° prn pain
Ancef 1 gram IV q8°
CBC weekly
Resume dressing changes
R calf BID wet to Dry

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER
R hand dressings ______ HOURS
to be changed by
Dr (b)(6)-2 BID
(b)(6)-2
✓ chart 10AUG03 1500
(b)(6)-2

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.

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	↓	ORDERS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 Noted 10 Aug 03 (b)(6)-2 NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER 8/10/03 TIME OF ORDER ______ HOURS Δ skin meds to q4-6 hrs prn pain (b)(6)-2	
PATIENT IDENTIFICATION (b)(6)-2 Noted Aug 03 10... NURSING UNIT / ROOM NO. / BED NO.	(1)	DATE OF ORDER 10 Aug 03 TIME OF ORDER 1000 HOURS Patient may have food brought in from outside (b)(6)-2 MD LTC, MC (b)(6)-2 FAMILY PRACTICE	
PATIENT IDENTIFICATION Noted 10 Aug 03 1830 (b)(6)-2 NURSING UNIT / ROOM NO. / BED NO. ✓ 10 Aug 03 2210 (b)(6)-2 ...UTAN	(1)	DATE OF ORDER 10 Aug 03 TIME OF ORDER 1700 HOURS Benadryl 50mg po q 6° prn itching (b)(6)-2 (b)(6)-2 LTC DDC MC	
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER TIME OF ORDER ______ HOURS (crossed out)	

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

(b)(6)-2

DATE OF ORDER 8/12/03 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

TR ICU I Dr (b)(6)-2

s/p I&D (R) Thumb

vitals q 8°

NKDA

Nwr (R) LE WBAT (L) LE

LRO (b)(6)-2

Ancef 1g q 8°

Noted

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

Gentamycin 80mg IV q 8°

X 72 hours

Tylox 1-2 PO q 4° prn pain

OOB to chair TID.

SGT (b)(6)-2 to see for ambulation assistance & Quad strengthening

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

/12/03 1600

Anesthesia Post Op Recovery

Morphine 2-4mg IV PRN Pain

May Repeat q 5 minutes for total dose of 20mg in 2 hrs.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED

8° C/d (b)(6)-2

CPT/AN 2120 (b)(6)-2

PATIENT IDENTIFICA (b)(6)-2

DATE OF ORDER TIME OF ORDER

12 Aug 03 2314 HOURS

Benadryl 50mg PO x 1

noted (b)(6)-2 2320 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

MEDCOM - 1533

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

Noted (b)(6)-2 1730 13AUG03

DATE OF ORDER 13Aug03 TIME OF ORDER 1730 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Phenergan 25mg po q6° prn nausea

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 13AUG03 2320 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 14AUG03 TIME OF ORDER 1000 HOURS

cont wet to dry dressing Δ's to (R) LE Bid (+) (L)

U.O. Dr. (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 14AUG03 2325 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 15AUG03 TIME OF ORDER 1400 HOURS

(1) HLIV - pt c̄ good UOP / po intake (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 15AUG03 2206 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 16Aug03 TIME OF ORDER 1115 HOURS (b)(6)-2

(1) continue Ensure 1-2 cans qd for supplementation

(b)(6)-2

(b)(6)-2

(b)(6)-2 16Aug03

NURSING UNIT | ROOM NO. | BED NO.

FORM 4256, APR 79 — REPLACES EDITION OF 1 ... MAY BE USED.

MEDCOM - 1534

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 17 aug 03 TIME OF ORDER: 0925 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO p MN
2. surgery in am

(b)(6)-2

Noted 17 AUG 2100 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

V 17AUG03 2210 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER: 18 AUG 03 TIME OF ORDER: 0100 HOURS

AMBIEN 10mg po (one time order only)

0100

(b)(6)-2

NURSING UNIT | ROOM NO.

Shift Chart ✓ 8/18/03 1150 (b)(6)-2

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.

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	18 aug 03	1015 HOURS	
	1) admit to ICW, (b)(6)-2		
	2) (b)(6)-2 s/p skin grafts		
	3) cond: good		
	4) vitals: routine		
	5) All: Ø NKA		
NURSING UNIT / ROOM NO. / BED NO.	6) Act: bedrest / Non wt bearing @ LE		
	7) Diet: clears → reg as tolerated		
PATIENT IDENTIFICATION (b)(6)-2	DATE OF ORDER	TIME OF ORDER	
	8) IVF NS or LR @ 100cc/hr until adequate po then TKO	HOURS	(b)(6)-2
	9) meds: Vancef 1g IVPB q8° x 5 days		@ 0430
	Tylox i-ii po q4-6° prn pain relief		
	Motrin 800mg po q8° prn pain relief		1100
	MSO4 1-4mg IVP q1° prn severe / breakthrough pain		
NURSING UNIT / BED NO.	10) Do not Δ dressing on R hand or R LEG -		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	can change dressing as previously done on L LE → wash + dry	HOURS	
	11) continue Ensure 1-2 cans po for supplementation		foot - pt can try c̄
	12) Phenergan 25mg po q6° prn Nausea		L hand
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		
	(b)(6)-2		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	18 aug 03	1112 HOURS	
	1) Benadryl 25mg IVP now for drug rxn - localized		
	2) Demerol 50mg IV with Phenergan 12.5mg slow IVP x 1 dose for breakthrough pain		
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		
	... 18 Aug (b)(6)-2		

Margin note: 8/18/03 1130

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED. 1015 (b)(6)-2

MEDCOM - 1536

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 18aug03 TIME OF ORDER: 1430 HOURS

LIST TIME ORDER NOTED AND SIGN: 1430

1. HLIV ...
2. (L) leg - keep foot clean / dry - pt can asst c̄ hygiene

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 18 Aug 03 2210 (b)(6)-2 ... ✓ 19 Aug 03 2230 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 20 Aug 03 TIME OF ORDER: 1340 HOURS

1. Transfer to [illegible] / Dr (b)(6)-2
2. Dx: s/p skin graft
3. Cond: good
4. NKDA
5. Vitals - Q shift
6. Diet - Regular - May consume outside food brought by family.
7. HLIV.
8. Meds: Ancef 1 gm IVPB q 6° x 5 days total
   - Tylox 1-2 po q 4-6° prn pain
   - Motrin 800 po TID prn pain
   - MSO4 1-4 mg IV q 2° prn breakthru
9. Diet - Ensure 1 can per meal
10. Phenergan 25 mg IV q 6° prn
11. Benadryl 25 mg [illegible] prn itching

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 ✓ (b)(6)-2 ... 23 AUG 03 2235

DA FORM 42[...] 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY [...]

FAMILY PRACTICE

MEDCOM - 1537

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER: 8/24/03 | TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

- WBAT (L) LE
- Toe touch weight bearing (R) LE
- OOB to Chair TID
- Crutches for ambulation → Sgt (b)(6)-2 to see for ambulation assistance

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

noted [illegible] MAJ [illegible]

DATE OF ORDER | TIME OF ORDER ____ HOURS

- D/C [illegible]
- Chloroquine 500mg PO QD.
- Dressing d/c's [illegible] MD
- Δ vitals to q8h

(b)(6)-2

NURSING UNIT (b)(6)-2 | BED NO. 2574/25

0600

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER: 8/28/03 | TIME OF ORDER ____ HOURS

- D/C to EPW Camp

8/29/03

- Place [illegible] on 7 Sept 03 @ 0900hrs
- Rx Chloroquine
- WBAT (L) LE
- 25% WB (R) LE

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER | TIME OF ORDER

Non weight bearing ____ HOURS
(R) Thumb

(b)(6)-2

MD

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

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. Jul 03

CLINICAL RECORD

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	(b)(6)-2	DATE COMPLETED
26 Jul	(b)(6)-2	DX: (R) Tibia fx S/P exfix (open tibia fx); GSW (R) UE, BLE, open (L) knee, open (L) foot 2nd MTP, open (R) thumb prox. phalynx & MC S/P Kwire. Condition: stable	D E N		
26 Jul		VS q1°	D E N		d/c 27 Jul
26 Jul		Diet: Clears to reg. as tolerated	07 12 17		
26 Jul		Act: Bedrest c BRP	D E N		
26 Jul		Non-wt bearing BLE	D E N		
27 Jul		Δ Vitals to Q shift	D E N		

ADDITIONAL PAGES IN USE: [X] YES [ ] NO

PAGE NO: 1

ALLERGIES: [ ] YES [X] NO
NKDA

PRIMARY DIAGNOSIS: (R) TIB FX S/P open TIB FX, GSW RUE, BLE.

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

PATIENT IDENTIFICATION: Iraqi (b)(6)-4

MEDCOM - 1539

USAPA

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Jul Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 Jul	(b)(6)-2	Admit to ICU-1 / (b)(6)-2				
27 Jul		NPO p̄ MN	26 Jul	MN	2215	(b)(6)-2
			7/28/03	0001		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
7/23/03	(b)(6)-2	I+O CATH IF NO VOID. LEAVE IN IF RESIDUAL >< 100 >400cc	

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 Jul. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28
26 Jul	(b)(6)-2	Ancef 1g IVPB q8°	07	(b)(6)-2		
			15			
			23			
26 Jul	(b)(6)-2	Gentamycin 80mg IVPB q8°	07			
			15			
			23			
26 Jul	(b)(6)-2	IVF: 100cc/° until adequate PO then ↓ 50cc/hr (LR)	D			
			E			
			N			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION

Iraqi (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

MEDCOM - 1541

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
26 Jul	(b)(6)-2	Tylox T-II PO q4-6° PRN pain	(b)(6)-2
26 Jul	(b)(6)-2	MS04 2mg-4mg q1° PRN breakthrough pain	

MED[illegible] RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 28	29	30
28July03	(b)(6)-2	vitals q 1° x on shift then q 4° if stable	D	(b)(6)-2		
	(b)(6)-2		E			
			N			
28July		Act: Bedrest; Non-weight bearing (B) LE	D			
			E			
			N			
28July		Diet: Clears → Reg as tolerated	D			
			E			
		Encourage PO intake through day	N			
29Jul / 28July		IVF: NS @ 100cc/h until adequate PO then ↓ to 50cc/h	D			
			E			
			N			
28July		Ancef 1g IVPB q8	07			
			15			
			23			
28July		Gentamicin 80mg IVPB q8°	07			
			15			
			23			
28July		Please keep wounds on (L) arm and (R) knee neck clean/moist 4x4 [illegible] undressed	D			
			E			
			N			
28July03		Wet to dry dsg QD on (open undressed wounds)	10	(b)(6)-2		

PATIENT IDENTIFICATION

DIAGNOSIS: Multi ortho injuries (B) LE s/p Ex fix I+D tendon rep

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM - 1543

ADMINISTRATION RECORD

ORDER EXPIRATION DATE	TRANSCRIBER REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
28 July	(b)(6)-2	Tylox II po q4-6° prn pain relief (N.a. Give either tylox or tylenol - do not exceed 4g/24°)	28 Jul 1800; 28 Jul; 29 Jul 0345; 29 Jul 0715; 29 Jul 1120; 29 July; 30 Jul 0445 (b)(6)-2
28 July	(b)(6)-2	MSO4 2mg-4mg IV q 1° prn breakthrough pain	28 Jul 4mg 1945; 28 Jul 4mg 2100; 28 Jul 4mg 2330; 29 Jul 4mg 0320 (b)(6)-2 Δ'D
28 July	(b)(6)-2	Tylenol 650 mg po Q 4hrs prn	28 Jul 1710 (b)(6)
29 Jul	(b)(6)-2	MSO4 2-4mg IV q 1° Prn breakthrough	29 Jul 0400; 29 Jul 08; 29 Jul 2210; 29 Jul 1100 4mg; 29 Jul 1630 4mg IV; 29 July 1710 4mg IVD; 30 Jul 0415 (b)(6)-2

CODES: Initials only = Medication administered
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD
For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
28July03	(b)(6)-2	Admit to ICU#1, Ortho, (b)(6)-2	28July03	(b)(6)-2
28Jul		Radiograph order see request per	28Jul03	
		Dr (b)(6)-2		
28July		MSO4 2mg bolus IV now for severe pain	28Jul 21	
		may Repeat in 1/2 hr if still severe pain	28Jul 2130	
			30Jul03 0001	
29Jul		NPO p MN in anticipation of OR in the Am	29Jul03 1150	
29Jul		MSO4 2mg IVP Now For Breakthrough Pain	29Jul03 1930	
29Jul		Demerol 25mg c 12.5mg Phenergan slow IVP now;		
		may repeat 25mg demerol IV 1/2hr if need more relief		

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: S/P Ex fix, I&D, tendon repair; Multi ortho injuries (B) LE, (B) U

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM - 1545

MC V1.00

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	DATE ADMINISTERED 30	31	1	2	3	4	5	6	7
30 July 03	(b)(6)-2	VITALS: Routine (Q4° x24 - Post op)	D E N	(b)(6)-2								
30 July 03		ACTIVITY: OOB TO CHAIR c ASST. AT LEAST BID; NON WEIGHT BEARING (R) LE (Can assist briefly c (L) LE) 8/3/03	D E N									
30 July 03		ENCOURAGE DEEP BREATHING TID OR INCENTIVE SPIROMETRY QID	D E N									
30 July 03		DIET: CLEARS TO REGULAR AS TOLERATED	D E N									
30 July 03		ENCOURAGE PO INTAKE - Supplement c ENSURE / SOFT DIET PRN	D E N									
30 Jul 03		DRESSING CHANGES: A) LEAVE ALONE (R) HAND & (R) LEG B) CLEAN/DRESS/THIN BACITRACIN ON NECK ARM WOUND (L) Superficial Wounds C) DRSG A's TO (R) LEG - & (R) Wet to dry BID & RePLACE Splint/ACE WRAP	11 23 08 20									
30 July 03	11	IVF NS @ 100cc hr until ADEQUATE PO INTAKE THEN ↓ TO 50cc/hr.	D E N									

DIAGNOSIS: MULTIPLE ORTHO PROCEDURES: (R) GRAFT (R) IC ICE (L) HAND, (R) EX FIX (R) LE.

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medications: 12 13 14 20 21 22 04 05 06

PATIENT IDENTIFICATION

(b)(6)-4

DATE	REVIEWER INITIALS	ROUTE, FREQUENCY, REASON	TIME/DATE/REASON/INITIALS/EFFECTIVENESS
30JUL03	(b)(6)-2	TYLOX II po q 4-6° PRN PAIN RELIEF	1225 30Jul (b)(6)-2; 0010 31JUL; 2330 1510; 1AUG 1820; 2AUG 0?; 3AUG 2340
30JUL03	(b)(6)-2	MSO4 2mg-4mg IVP q1° PRN BREAKTHROUGH pain	
31JUL03	(b)(6)-2	Maalox 30cc Po Q6° PRN FOR Heartburn	31JUL03 1150 (b)(6)-2; 31JUL 2345; 3AUG 1500
1AUG03	(b)(6)-2	Benadryl 50mg PO q6° PRN Itches	1AUG 2200 50mg (b)(6)-2

CODES: Initials only = Medication administered
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*

*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	30	31	1	2	3	4	5	6						
30 Jul 03	(b)(6)-2	ANCEF 1g IVPB Q8°	07	(b)(6)-2													
			15														
			23														
30 Jul 03		Motrin 800mg PO tid	08														
		SCHEDULED ē FOOD or Milk	16														
			24														
30 Jul 03		Colace 100mg PO BID	10									D/C 4Aug03 1435					
			22														
31 JUL 03		Ensure ī can bed to	10														
		increase protein intake	22														
1 AUG 03		ZANTAC 150mg ī PO	10														
		BID	22														

MEDCOM - 1548

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
30Jul03	(b)(6)-2	Admit to ICU, Dr (b)(6)-2 ORTHO. Cond. GOOD	30Jul	30Jul 1145
30Jul03		DRESSING Δ'S to Start in 24° - Dr (b)(6)-2	31Jul	(b)(6)-2
		TO ASSIST 1ST TIME		

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: MULTIPLE ORTHO PROCEDURES: BONE GRAFT Ⓡ ICLEG, Ⓛ HAND, Ⓡ FOOT EX FIX Ⓡ L

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 5 6 7 8 9 10 11 12 13
8/4/03	(b)(6)-2	Act: Nonweight bearing (B) LE; OOB tid - chair Can assist briefly c̄ (L) LE.	D E N	(b)(6)-2
8/4/03		Encourage deep Breathing; IS	D E N	D/C 9 Aug 03
8/4/03		V. Sals: Routine (q Shift)	D E N	
8/4/03		Diet: Clears to Reg as Tol c̄ Ensure - T can Bid.	07 12 17	
8/4/03		Ancef 1Gm IVPB q8°	07 15 23	D/C 7 Aug
8/4/03		(R) Hand dressing Δ's BID	08 20	1st @ 8/6/03
8/4/03 8AUG03		(R) Leg dressing Δ's Wet to Dry Bid (Replace Splint/ACE Wrap)	09 21	D/C 8AUG03 0832
8/4/03		Cont. cleansing Remaining LACS/ Abrasions - Thin layer Bcr. BID	09 21	
8/4/03		HLIV (Flush q Shift)	D E N	D/C 7 Aug 03
8 AUG 03		Zantac 150mg PO Bid	08 20	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Multi-ortho trauma, s/p washout, debride, Skin Flap Modification

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(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

MEDCOM - 1550

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 03

Order Date	Clerk Nurse (Verify by Initialing)	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/5	(b)(6)-2	Admit to FCU, Prevost, Ortho	8/5/03	ASAP	1210	(b)(6)-2
		Condition Good				
(b)(6)-2		~~Restart IV~~ (b)(6)-2				
9 Aug03		NPO → Plan I+D® Thumb @1500	9 Aug03	1500		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
8/4/03	(b)(6)-2	Tylox I-II PO q4-6° PRN Pain Relief.	5 Aug 03; 6 Aug; 7 Aug; 8 Aug [illegible] (b)(6)-2
8/4/03		Motrin 800mg I PO TID PRN	7 Aug03 [illegible] (b)(6)-2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. Aug Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12AUG	(b)(6)-2	Vitals q 8°	D	(b)(6)-2													
			E														
			N														
12AUG		NWB (R) LE WBAT (L) LE	D														
			E														
			N														
12AUG		LR @ 60cc/hr	D								DC'd						
			E														
			N														
12AUG		Ancef 1 gram IV q 8°	03														
			11														
			19														
12AUG		Gentamycin 80mg IV q 8° x72 hours	04														
			12														
			20														
12AUG		OOB to chair TED	D								written 16AUG 2230 (b)(6)-2						
			E														
			N														
14AUG03		cont wet to dry dressing changes to (R) + (L) LE Bid	10														
			22														
15AUG03		HL Flush	D														
			E														
			N														
16Aug03		Continue ensure i-2 cans qd for supplements	10														
			22														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
s/p I&D (R) thumb

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:
(b)(6)-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

MEDCOM - 1552

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12AUG	(b)(6)-2	TO ICU 1 Dr (b)(6)-2	12AUG	/	/	(b)(6)-2
12AUG		SGT (b)(6)-2 to SEE for Ambulation			13 AUG (b)(6)-2	
		ASSISTANCE & QUAD strengthening				
12AUG03		Benadryl 50mg PO X1	12AUG03	2315	Done	
15AUG		HLIV c good uop/po intake	15AUG	/	/	
17AUG		NPO p MN	18AUG	MN	Done	
17AUG		Surgery IN AM	18AUG	AM		
18AUG03		Ambien 10mg po (one time order only)	18AUG	0100	Done	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED				
12AUG	(b)(6)-2	Tylox 1-2 tabs	Date Time	12 Aug 1645	12 Aug 2230	16 Aug 1910	17 Aug 2010
		PO q 4-6° prn	Amt	(2)	(2)	2	2
		PAIN	Init I/E	@	BKT	(b)(6)-2	
13Aug		Phenergan 25mg PO	=1730 13Aug				
		q 6° PRN Nausea					

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* Mo 08 Yr. 03

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

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 18 19 20 21 22 23 24 25 26
8/18/03	(b)(6)-2	VITALS: Routine	D	(b)(6)-2
			E	
			N	
8/18/03		ACT: BEDREST	D	
		NON WT BEARING	E	
		(B) LE (R) LE WBAT (L) LE	N	
8/18/03		DIET: CLEARS → REG	D	
		AS TOLERATED	E	
			N	(b)(6)-2
8/18/03		IVF: NS or LR @	D	30
		100cc/hr until Adequate	E	
		PO THEN TKO	N	
8/18/03		ANCEF Q 8° X 5 DAYS	02	/ / / / / / / /
		(1gm)	10	/ / / / / / / /
			18	/ / / / / / / /
8/18/03		Do NOT Δ DRSG'S	D	
		on (R) HAND on (R)	E	
		LEG	N	(b)(6)-2
8/18/03		WET TO DRY DRSG	10	
		Δ TO (L) LE BID	22	
8/18/03		ENSURE 1-2 CANS	10	
		PO FOR SUPPLEMENTATION	22	
18 AUG		HL IV	02	
		no. flush q shift	10	
			18	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: MULTI ORTHO S/P SKIN GRAFTS

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION: (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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 08 Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 AUG03	(b)(6)-2	Admit to ICU#1 (b)(6)-2 ORTHO	8/18		1015	(b)(6)-2
18 AUG03		Condition: Good	8/18		1015	
18 AUG03		BENADRYL 25mg IVP NOW FOR	8/18	NOW	1112	
		DRUG REACTION LOCALIZED				
18 AUG		Demerol 50mg IV c Phenergan				
		12.5 mg Slow IVP x 1 dose for				
		Breakthrough Pain				

Order/Expir Date	Clerk/Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED	
8/18	(b)(6)-2	TYLOX I-II PO Q	8/18 1100 II PO (b)(6)-2	8/18 1700 II PO (b)(6)-2
		4-6° PRN PAIN RELIEF		
8/18		Motrin 800mg PO		
		Q8° PRN Pain Relief		
8/18		MSO4 1-4mg IVP	8/18 0855 4mg IV (b)(6)-2	
		Q1° PRN SEVERE		
		BREAKTHROUGH		
		Pain		

CLINICAL RECORD

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

Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29
20 AUG	-----	Vitals – Q shift	D	/						
	-----		E	/	D/C 24 Aug DB					
	-----		N	(b)(6)-2						
20 AUG	-----	Diet – Regular	B	/						
	-----	may have food from	L	/						
	-----	family – c̄ 1 can ensure per meal	D	/						
24 Aug	(b)(6)-2	WBAT (L) LE; Toe touch	D	/						
	-----	wt bearing (R) LE	E	/						
	-----		N	/						
24 Aug	-----	OOB to Chair TID	D	/						
	-----		E	/						
	-----		N	/						
	-----	Crutches for ambulation	D	/						
	-----	(Sgt Hensingdose for amb	E	/						
	-----	assistance)	N	/						
24 Aug	(b)(6)-2	Dsg Δ's By MD	D	/						
24 Aug		Vitals q day	D	/						

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P skin grafts

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

(EPW)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 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

2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				
			Mo 8 Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 AUG	(b)(6)-2	Transfer to ICU-2 DR (b)(6)-2 cond stable - good	/	NOTED		//
28		D/C to EPW Camp 8/29/03.	8/29	ASAP		
28		F/U c̄ 21st CSH on 7 Sept 03 @ 0900		D/C noted/ orders.		
		Rx Levoquin				
		WBAT (R) LE				
		25% WB to LE				
		Non wt bearing to therapy				

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	23	24	25	26	27	28	29							
20 AUG	(b)(6)-2	IV - Heplock - flush	D	/													
		Q shift	E	/	D/C 24 Aug 03												
			N	(b)(6)-2													
24 Aug	(b)(6)-2	Levaquin 500mg po qd	10	/	(b)(6)-2												

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P skin grafts

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

(EPW)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

MEDCOM - 1558

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)	Mo 8 Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED	
20 AUG	(b)(6)-2	Tylox T-TT po Q4-6°	28Aug 0035	28AUG 2115
		prn pain	(b)(6)-2	
20 AUG		Motrin 800mg po		
		TID prn		
20 AUG		MSO4 1-4mg IV Q2°		
		prn		
20 AUG		Phenergan 25mg IV		
		Q6°		
20 AUG		Benadryl 25mg IV		
		Q4-6° prn itching		

MEDCOM - 1559

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. 08 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23	24	25	26
18 Aug 6	(b)(6)-2	① leg - Keep foot	D	(b)(6)-2								
		clean/dry - Pt can	E									
		assist c hygiene	N									

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: MULTI ORTHO S/P skin GRAFT

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

(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

MEDCOM - 1560

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
8/18	(b)(6)-2	PHENERGAN 25mg	
		PO Q6° PRN	
		NAUSEA	

MEDCOM - 1561

CLINICAL RECORD

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

Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8 9 10 11 12 13 14 15 16 17 18
8/6/03	(b)(6)-2	(R) Hand Dressing Δ's Bid. Clean gently - Xeroform over donor site. Dry dressing in webspace + over incisions - Kerlix - NO MORE wet-to-dry THANX.	08, 20	(b)(6)-2 (b)(6)-2 D/C 7Aug03
7Aug03	(b)(6)-2	Clindamycin 150mg PO QID	06, 12, 18, 24	(b)(6)-2 D/C ew 9Aug03
9Aug03	(b)(6)-2	Ancef 1gm q8 IV 19 ←	03, 11, 19	(b)(6)-2
9Aug03 / 10AUG03	(b)(6)-2	Regular Diet (b)(6)-2 10AUG03 per Co... Pt may have food brough in from outside.	B, L, D	
9Aug03	(b)(6)-2	Vitals q 8°	D, E, N	
9Aug03	(b)(6)-2	NWB (B) LE	D, E, N	
9Aug03	(b)(6)-2	LR @ 100 cc/hr	D, E, N	
9Aug03	(b)(6)-2	Resume DRSG Δ to (B) LE BID wet to dry	09, 21	

ALLERGIES: [ ] YES [ ] NO
NKDA.

PRIMARY DIAGNOSIS: Mult. Ortho Trauma

ADDITIONAL PAGES IN USE [ ] YES [ ] NO

PAGE NO. ____

PATIENT IDENTIFICATION:
(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						04	05	06

MEDCOM - 1562 ... BE USED UNTIL

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

SINGLE ORDER, PRE-OPERATIVES

Mo. ______ Yr. ______

Order Date	Clerk/Nurse	Single Order, Pre-Operatives	Date to be Given	Time to be Given	Time Given	Init
7 Aug	(b)(6)-2	DC IV and IV ABX	7Aug03	now	(b)(6)-2	(b)(6)-2

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED	
9Aug	(b)(6)-2	Tylox I-II po q 6° prn pain	2220 [illegible]	0415 [illegible]
10AUG			> DC 10 AUG 0930 CS	
10AUG		Tylox I-II po q 4-6 prn	1935 10AUG II CS	2150 [illegible]
		Benadryl 150mg PO Q 6° prn itching	10AUG 1830	11AUG 0340 [illegible]
[illegible]			(b)(6)-2	

☆U.S. GPO:1998-432-786/85214

MEDCOM - 1563

...CAL RECORD - MEDICATION ADMINIST... TION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRAT... DATE ADMINISTERED												
				9	10	11	12	13	14	15	16	17	18	19	20	22
9Aug03	(b)(6)-2	(R) HAND DRSG Δ by	09	✓	Q (b)(6)-2	(b)(6)-2			no	DR						
		DR (b)(6)-2 BID	21									(b)(6)-2				
16Aug		OOB to chair TID	10	/	/	/	/	/	/	/	/					
			14	/	/	/	/	/	/	/	/					
			18	/	/	/	/	/	/	/	/					

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: washout (L) leg (R) thumb [illegible] (b)(6)-2

ALLERGIES: Ø

AIRWAYS: ETT Nasal Oral Trach Time DC'D

PHYSICIAN: (b)(6)-2

ANESTHESIA BY (b)(6)-2

Gen Spinal MAC Axillary Local Bier Epidural Other

OXYGEN: Mask Nasal Prongs Face Tent Blow-By Liter/min. %

ASA History Ø X Tobacco abs

Cardiac Rhythm

IV#1 Patent Infiltrated Site Rate Gauge

IV#2 Patent Infiltrated Site Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	117/54	74											Blanche Pulse Warm Moves Y N
2225	131/40	126	28	98	93.3 ax	1	2	2	1	0	6	6L Face mask	Blanche Pulse Warm Moves Y N
2230	121/77	114	25	94	98 po							2L NC	Blanche Pulse Warm Moves Y N
2235	141/79	108	28	97								2L	Blanche Pulse Warm Moves Y N
2240	139/79	112	22	95%	95 ax	2	2	2	1	2	9	1L	Blanche Pulse Warm Moves Y N
2300	121/57	69	12	99									Blanche Pulse Warm Moves Y N
2315	122/63	75	12	95									Blanche Pulse Warm Moves Y N
Refer to ICU Flowsheet for further info.													Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°

T-4 T-10

DRESSING: Status Location
Gauze
Opsite
Bandaid
Steri-strips
Collodian
Peri-pad
Coban
Cotton Balls
Ace Wrap

See Back

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU / ICW 1

DATE: 26 JUL 03

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

(b)(6)-2

22410

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

L CX FIX
(L) shoulder

2 mg versed
250 fent
20 MSO4
) during case

2 gms Ancef 2000
Gent 2020

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	1300 RL		OR	EBL	100
			OR	Urine	Ø
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1045 - PT arrived to PACU 1025 - turning in bed
crying - mult lacerations covering most of body
Face - 3 lacerations on chin - O2 2 l NC sats 99%
(L) arm - open wound on shoulder, IV (L) FA
s̄ s/s of infection or infiltration - LR c̄ 001 LCl @ 100cc
mult. laceration (L) ~~arm~~ hand - major wound middle finger
(R) arm: shoulder ~~dsg~~ no dressing CDI, 2 lacerations near
elbow, wrist/arm - Dressings CDI
abd: abrasions - old - healing well
(L) leg: mult small lacerations on thigh, ace wrap
to entire lower 1/2 of (L) leg - CDI - able to
wiggle toes - good cap refill
(R) leg: mult. small healing laceration on thigh, EX FIX
on lower 1/2 extremity - dressing CDI, good cap refill -
able to wiggle toes
Refer to critical care flow sheet for more details

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
(b)(6)-2	MSO4	5mg	IV	1035		
	MSO4	5mg	IV	1030		
	MSO4	5mg	IV	1040		
	MSO4	5mg	IV	1055		
	Tylox	2	PO	2315		

(b)(6)-2

DISPOSITION SUMMARY: Nursing Care Problems No.'s ____________ Resolved; No.'s ____________ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: ____________
Report given to ____________ MEDCOM - 1566 ore ____________ Safety Straps ____________
Time out ____________ Patient released by Anesthesia

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date) 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

nilles ndon epair

PROCEDURE: (R) Tibia Ex-fix, I+D LE (R) Hand tendon repair, I+D (R) Hand & Shoulder

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: ______ Time DC'D ____ ETT Nasal Oral Trach

OXYGEN: Mask (Nasal Prongs) Face Tent Blow-By

Liter/min. 6 ______ %

ASA ___ History ______

Cardiac Rhythm ______

IV#1 (L) FA Patent 100cc/hr Infiltrated

Site ______ Rate 100 Gauge 18g

IV#2 ______ Patent LR Infiltrated

Site ______ Rate ____ Gauge ____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												
PRE-OP	112/59	92	21	100%	99.3 O								
1135	132/68	118	25	100%	94.3 AX	2	2	2	1	1	8	Received from OR	
1140	143/94	107	32	100%	94.5 AX	2	2	2	1	1	8	6L NC	
1145	135/79	121	24	99%	95.4 AX	2	2	2	2	1	9		
1200	136/75	115	22	98%	97.2 AX	2	2	2	2	2	10		
1215	143/63	98	23	97%	97.8 AX	2	2	2	2	2	10	3L NC Sat 97%	
1230	141/60	95	21	97%	98.6 O	2	2	2	2	2	10	Pt recovered, kept on ICU#1	
	/												
	/												
	/												
	/												
	/												
	/												

Neuro-Vascular (each row): Ext: L R Upper Lower; Pulse DP PT RAD; Blanche / Pulse; Warm / Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°

T-4 T-10

DRESSING: Status Location

Gauze, Opsite, Bandaid, Steri-strips, Collodian, Peri-pad, Coban, Cotton Balls, Ace Wrap

(R) Hand gauze has small amount of bloody drainage (L) Hand C,D,&I dressing Both lower extremities have Ace wraps, (R) LE has ex-fixator

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU#1

DATE: 28 Jul 03

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

(b)(6)-4

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

FH MDA OP 132-11a (Rev) 1 Sep 99

DA FORM 4700 1 MAY 78

MEDCOM - 1567

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	1800 LR		OR	EBL	Minimal
	LR	200	OR	Urine	none
TOTAL		2000	TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Received pt from OR via litter @ 1135. Pt complaining of pain and positioning of RLE. Pain medication administered as ordered. O2 @ 10L NC, changed to 3L (See front). Pt had x-ray of RLE. Pt IV site in LFA infiltrated, anesthesia replaced a new line in (L) FA, which infiltrated as well. Anesthesia placed another line which has remained patent, LR at 100 cc/hr. Pt has ace bandages wrapped around both lower extremities, C,D,+I. RLE has external fixator. L+R Hands have gauze and ace wraps, a small amount of drainage on (R) Hand gauze. (R) Shoulder also has ace wrap, C,D+I. Pt recovered to ward (ICU #1)

PT c VSS. Pain Controlled. No Δ's from [redacted] assessment [illegible] above [redacted] ICT, [illegible] 1WMC

MEDICATION GIVEN BY: [redacted] MEDICATION RECEIV[redacted]

MEDICATION GIVEN BY	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
[redacted]	Fentanyl	25 ~~mg~~ ug	IV	1140		Ø
1C[redacted]	Fentanyl	25 ug	IV	1143		Ø
1LT[redacted]	MSO4	5 mg	IV	1200		Ø
1LT[redacted]	MSO4	5 mg	IV	1210		Ø
1LT[redacted]	MSO4	5 mg	IV	1220		Ø
	MSO4	5 mg	IV	1238		+

DISPOSITION SUMMARY: Nursing Care Problems No.'s________ Resolved; No.'s________ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I
Report given to N/A PAR Score 10 Safety Straps N/A
Time out N/A Nurse Sig[redacted] [redacted]

MEDCOM - 1568

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date) 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

PROCEDURE: LE washout, bone graft, (R) Hand washout (LE wash out)
PHYSICIAN: (b)(6)-2
ANESTHESIA: (Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: ____ Time DC'D ____
ETT Nasal Oral Trach
OXYGEN: RA
Mask Nasal Prongs Face Tent Blow-By
Liter/min. ____ %

ASA ___ History ____
Cardiac Rhythm ____
IV#1 (L) FA (Patent) Infiltrated
Site ____ Rate 50 cc/hr Gauge 18 g
IV#2 ____ Patent Infiltrated
Site ____ Rate ____ Gauge ____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												
PRE-OP	118/63	89	16	99%	99°	2	2	2	1	2	9	RA Received from OR	
1157	123/69	129	23	97%	97°	2	2	2	1	2	9	All extremities X4	Pulse normal, Warm, Moves (Y)
1202	113/54	116	19	93%	97°	2	2	2	1	2	9		
1207	118/62	135	29	94%	97°	2	2	2	2	2	10		
1222	115/55	131	29	95%		2	2	2	2	2	10		
1237	103/51	133	29	100%		2	2	2	2	2	10	Recovered \ Stay ICU*1	
1252	119/60	108	13	99%	98°	2	2	2	2	2	10		
	/												
	/												
	/												
	/												
	/												
	/												

Neuro-Vascular: Extr: L R Upper Lower; Pulse DP PT RAD; Blanche Warm; Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

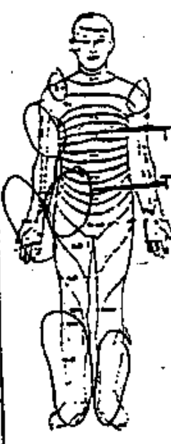
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	CDI	LLE
Opsite	C, D, + I	(L) shoulder
Bandaid	LS (R) Sh C, D, I	(R) shoulder
Steri-strips	C, D, + I	(R) upperarm
Collodian	C, D, + I	(R) forearm and hand
Peri-pad	C, D + I	(R) LE
Coban	C, D, + I	(R) Abdomen
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Signature) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU *1

DATE: 30 JUL 03

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

Iraqi (b)(6)-4

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

FH MDA OP 132-11a (Rev) Sep 99

DA FORM 4700, 1 MAY 78

MEDCOM - 1569

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	800 cc LR	800	OR	EBL 100 cc	100cc
			OR	Urine no urine	0
TOTAL		800	TOTAL		100cc

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Received pt @ 1157 from OR via liter. Pt bandages and dressings all intact (see front). Pt complaining from pain from (R) Abdomen graft. Pt given Tylox as ordered. Pt sats 97% on RA. Pt able to move all fingers and toes. IV NS infusing @ 50cc/hr to (L) FA 18g, patent and ∅ sign of infection or infiltration. Pt recovered, to stay on ward. SPC (b)(6)-2

1200 Pt A&OX3. VSS. Moves all extremities. Cap refill < 3 secs. Drsg CD&I. External fixation & splint to RLE CD&I (b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
SPC (b)(6)-2	Tylox	2 tabs	PO	1225		

DISPOSITION SUMMARY: Nursing Care Problems No.'s________ Resolved; No.'s________ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I (b)(6)-2 PAR Score 10 Safety Straps X
Report given to N/A released by Anesthesia (b)(6)-2
Time out 1152 Nurse Signature

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date) 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

PROCEDURE: Washout / Closure
PHYSICIAN: (b)(6)-2
ANESTHESIA BY (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: ______ Time DC'D ______
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Prongs Face Tent Blow-By
Liter/min. RA ______ %

ASA II History Smoke
Cardiac Rhythm SR
IV#1 ✓ Patent Infiltrated
Site (L) ARM Rate TKO Gauge 18
IV#2 ______ Patent Infiltrated
Site ______ Rate ______ Gauge ______

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Blanche Pulse Warm Moves Y N
PRE-OP	/												Blanche Pulse Warm Moves Y N
1210	124/90	95	15	96%	97.5	2	2	2	1	2	9	R.C.	Blanche Pulse Warm Moves Y N
1215	132/90	91	15	95%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1220	124/88	104	16	96%	98.5	2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1225	126/95	95	15	95%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1240	114/62	88	13	96%	98.5	2	2	2	1	2	9	Tx - [illegible]	Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												

Neuro-Vascular: Ext: L R Upper Lower; Pulse DP PT RAD

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

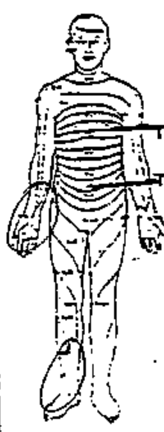
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C/D/I	(R) ↑↓ EXT.
Opsite		
Bandaid		
Steri-strips		
Collodion		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 LPN

DEPARTMENT/SERVICE/CLINIC: ICW #1

DATE: 5 Aug 03

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

(b)(6)-4

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

FH MDA OP 132-11a (Rev) Sep 99

FORM MAY 78 4700

MEDCOM - 1571

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	900	OR	EBL	/
			OR	Urine	/
TOTAL			TOTAL		/

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S ______ IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Rcd from OR via gurney - see icu flowsheet for further assessment. (b)(6)-2

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

MEDICATION RECEIVED IN PACU/ICU

DISPOSITION SUMMARY: Nursing Care Problems No.'s ______ Resolved; No.'s ______ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: N/A ~ icu #1 Recovery.
Report given to ______ PAR Score ______ Safety Straps ______
Time out ______ Nurse Si... ______ MEDCOM - 1572 Anesthesia ______

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date) 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

PROCEDURE: I/P WASHOUT

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: Time DC'D ETT Nasal Oral Trach

OXYGEN: Mask Nasal Prongs Face Tent Blow-By Liter/min. %

ASA ___ History ___

Cardiac Rhythm ___

IV#1 ___ Patent Infiltrated Site L ⓐARM. Rate ___ Gauge ___

IV#2 ___ Patent Infiltrated Site ___ Rate ___ Gauge ___

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS
PRE-OP	/											
PRE-OP	115/60	100										
1545	127/76	89	17	98%	97.7 (A)	1	2	2	1	2	8	Rc'd -> OR.
1550	119/68	89	19	98%		1	2	2	1	2	8	
1555	131/69	94	16	98%		2	2	2	1	2	9	
1610	123/71	84	15	99%		2	2	2	1	2	9	4mg MSO4 - @
1625	124/66	86	13	96%	98.3 (o)	2	2	2	2	2	10	4mg MSO4 - @
1640	135/61	84	16	99%	-	2	2	2	2	2	10	
	/											
	/											
	/											
	/											
	/											
	/											

OTHER — Neuro-Vascular: Extr: L R Upper Lower; Pulse DP PT RAD; Blanche Pulse; Warm Moves Y N (repeated per row)

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

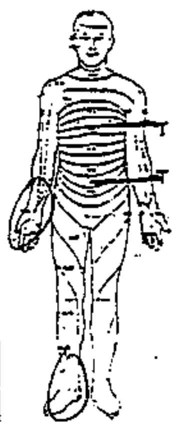
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status / Location
Gauze: C/D/I — (R) ↑↓ EXT.
Opsite
Bandaid
Steri-strips
Collodian
Peri-pad
Coban
Cotton Balls
Ace Wrap

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 LPN.

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 12 Aug 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

FH MDA OP 132-11a (Rev)

DA FORM 4700, 1 MAY 78

(b)(6)-2 9

MEDCOM - 1573

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	400	OR	EBL	—
			OR	Urine	—
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
(b)(6)-2	MSO4	4mg	IV	1608		
	MSO4	4mg	IV	1631		

DISPOSITION SUMMARY: Nursing Care Problems No.'s________ Resolved; No.'s________ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: N/A Recovered to Unit.
Report given to ________ PAR Score ________ Safety Straps ________
Time out ________ Nurse Si\[illegible\] MEDCOM - 1574 Anesthesia ________

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date) 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

PROCEDURE: Debride wound

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: ______

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: ______

AIRWAYS: ______ Time DC'D ____ ETT Nasal Oral Trach

OXYGEN: Mask Nasal Prongs Face Tent Blow-By

Liter/min. ______ %

ASA ___ History ______

Cardiac Rhythm ______

IV#1 1100 Patent Infiltrated

Site (L) AC Rate ____ Gauge ____

IV#2 ______ Patent Infiltrated

Site ______ Rate ____ Gauge ____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
1622 ~~PRE OP~~ POST OP	123/67	110	20	94	98.5								Extr: L R Upper Lower Pulse OP RT RAC
1627 ~~PRE OP~~	115/63	105	24	94									Blanche Pulse Warm Moves Y N
1632	122/64	106	20	92									Blanche Pulse Warm Moves Y N
1637	123/63	109	20	93									Blanche Pulse Warm Moves Y N
1642	129/62	110	24	92									Blanche Pulse Warm Moves Y N
1647	115/66	117	20	95									Blanche Pulse Warm Moves Y N
1702	122/64	110	20	94									Blanche Pulse Warm Moves Y N
1707	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

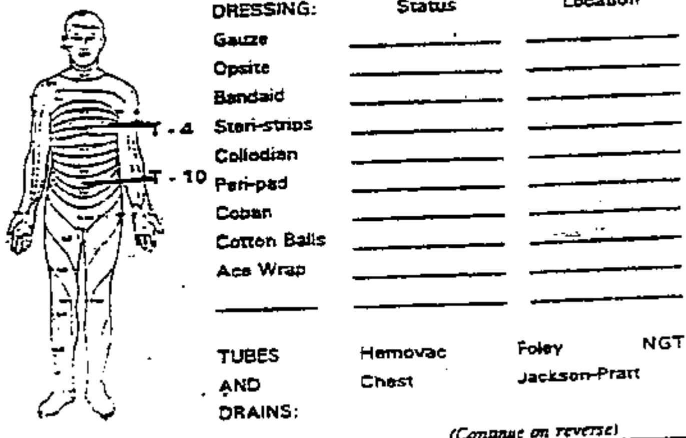
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE 12 Aug 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 4700, 1 MAY 78

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1575

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR			OR	EBL	
			OR	Urine	
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1620 Assumed care of pt from OR. 20g to (L) FA, NS @ KVO sleeping arouses to physical stimuli. (b)(6)-2
1645 Pt awakens to verbal stimuli
1700 Pt transferred to ICU care. Will follow via progress note (b)(6)-2

MEDICATION GIVEN BY: | MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s____________Resolved; No.'s______________Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:________________________
Report given to________________________ PAR Score__________ Safety Straps__________
Time out__________ Nurses Signature Anesthesia__________

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Skin graft x 2

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: — Time DC'D —

ETT Nasal Oral Trach

OXYGEN: RA

Mask Nasal Prongs Face Tent Blow-By

Liter/min: NA %

ASA 2 History

Cardiac Rhythm NSR

IV#1 (L) Hand (Patent) Infiltrated

Site (L) Hand Rate 100 cc/hr Gauge 18 g

IV#2 ____ Patent Infiltrated

Site ____ Rate ____ Gauge ____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												
PRE-OP	191/62	78											
1045	101/65	100	19	98%	94 3 AX	1	2	2	0	1	6	Received pt from OR	Blanche (Warm) Pulse normal Moves (Y) N
1050	111/62	75	19	95%	94 5 AX	2	2	2	1	1	8		Blanche (Warm) Pulse normal Moves (Y) N
1055	119/79	77	13	100%	94 3 AX	2	2	2	1	1	8		Blanche (Warm) Pulse normal Moves (Y) N
1100	133/71	70	12	99%	94.7 AX	2	2	2	2	1	9		Blanche (Warm) Pulse normal Moves (Y) N
1115	115/90	71	12	99%	94.9 o	2	2	2	2	1	9		
1130	122/71	65	11	97%	95.3 o	2	2	2	2	1	9	Pt recovered	
1140	/				96 o	2	2	2	2	2	10	to ward	
	/												
	/												
	/												
	/												
	/												

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

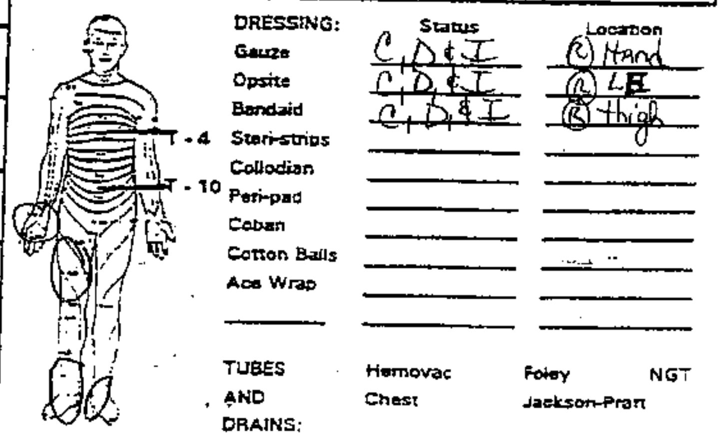
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C, D & I	(R) Hand
Opsite	C, D & I	(L) LE
Bandaid	C, D & I	(R) thigh
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 18 AUG 03

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

(b)(6)-4

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

DA FORM 4700, 1 MAY 78

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1577

2 Versed
250 fentanyl
10mg morphine

- 4 morphine
2 Tylox
1112 25mg Benadryl

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	700cc LR	700cc	OR	EBL Minimal	Minimal
			OR	Urine Ø	Ø
TOTAL		700cc	TOTAL		Minimal

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

@1045 Received pt from OR via liter. Pt had skin graft x2 with bandage over donor site (R) thigh, clean, dry, and intact. Bandages on (R) Hand, (R) LE, and (L) LE all clean, dry, and intact. All pulses strong, brisk cap refill. Pt complaining of pain, given 4mg MSO4 @ 1055, pt had localized systemic (b)(6)-2 reaction from IV site in (L) Hand extending up to the elbow. Pt was itching (R) Arm and complaining of pain, arm had multiple patches of raised and irregularly shaped patches. Pt given Benadryl as ordered. The raised patches dissolved within minutes. Pt had Ø SOB vital signs stable. SPC (b)(6)-2 [illegible]

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
LT (b)(6)-2	morphine	4mg	IV	1055		
SPC (b)(6)-2	Tylox	2 tabs	PO	1100		
LT	Benadryl	25 mg	IV	1112		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: _____
Report given to _____ PAR Score _____ Safety Straps _____
Time out _____ Nurse S _____ Patient released by Anesthesia _____

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF — MTF LOCATION (State or Country Code.)
1 2 3 4 5 6 7 8
(b)(3)-1

3. REGISTER NUMBER
9 10 11 12 13 14 15
0 0 (b)(6)-4

NAME (Last, First, Middle Initial)
(b)(6)-4
(b)(6)-4
(detainee)

4. PAY GRADE
16 17

5. SEX
18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)
19 20 21 22 23 24 25 26

7. AGE AT ADMISSION
27 28 29

8. RACE
30

9. ETHNIC BACKGROUND
31

RELIGION

10. LENGTH OF SERVICE
32 33 34

ETS

11. FMP
35 36
9 8

12. SOCIAL SECURITY NUMBER
37 38 39 40 41 42 43 44 45
0 0 0 0 0 0 (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS
46

HOUR OF ADMISSION
1822

BRANCH / CORPS

14. FLYING STATUS
47 48 49

15. BENEFICIARY CATEGORY
50 51 52
K 7 8

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

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
0

WARD
ICU

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
B C0, 21st Combat Support Hospital, Mosul, Iraq

21. TYPE OF DISPOSITION
73 74
0 1

22. MTF TRANSFERRED TO
75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y Y Y M M D D)
81 82 83 84 85 86 87 88
2 0 0 3 0 8 2 9

24. CLINIC SVC - ADMITTING
89 90 91 92
B I A A

25. MTF TRANSFERRED FROM
93 94 95 96 97 98

26. DATE THIS ADMISSION (Y Y Y Y M M D D)
99 100 101 102 103 104 105 106
2 0 0 3 0 7 2 6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)
107 108

28. MTF OF INITIAL ADMISSION
109 110 111 112 113 114
(b)(3)-1

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
115 116 117 118 119 120 121 122
2 0 0 3 0 7 2 6

FOR LOCAL USE
(b)(6)-2
(b)(6)-4

[illegible handwritten codes] 801.1 7854 78 830 8662 7801 7997 8821 8664 8822 8673

(b)(6)-2

(b)(6)-2

LTC, MC

DA FORM 2985, MAR 2000 — MEDCOM - 1579 — V1.00

INPATIENT TREATMENT RECORD COVER SHEET (For Plate Imprinting)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Iraqi ON # (b)(6)-4 (EPW)

(b)(6)-4

(b)(6)-4

(b)(3)-1

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

18Y

ADMITTING OFFICER

Brizuela

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION

D/C

26. DATE OF DISPOSITION

24 Aug 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

- GSW to Ⓡ abdomen 879.2 ICD9FY02
- Exploratory lap 54.11 ICD9FY02
- Repair of Liver laceration. 50.61 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

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

36. TOTAL DAYS ALL FACILITIES

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

(b)(6)-2 ... OFFICER (b)(6)-2

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 76 IS OBSOLETE.

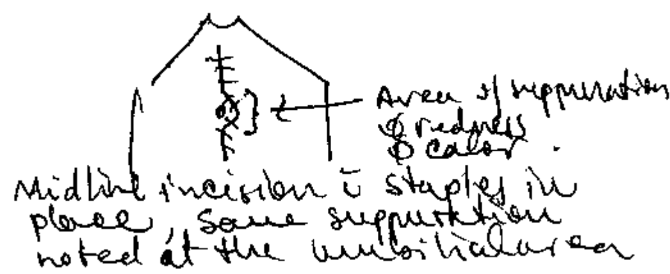
MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

18 y/o Iraqi EPW stating that was hit by an RPG. He was taken to FST where he underwent Exp lap for hemoperitoneum, liver lac repair (RL lobe). EBL 200 cc. He was transported via AERVAC to 21st CSH for further evaluation. Pt had a Tmax of 101 ~~[illegible]~~ prior to departure.

PHYSICAL EXAMINATION

GEN: AOx3, NAD
HEENT: unremarkable
HEART: RRR Ø m/r/g
LUNGS: CTA BL Ø W/R
BACK: Dressing located Ⓡ flank
ABD: BS⊕ | ND | surgically tender, Midline incision c̄ staples in place, some suppuration noted at the umbilical area
EXT: Ø edema, Ø cyanosis



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

A: ① s/p Ex lap
② liver lac repair

P: - admit to ICU 2
- See orders.

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
[signature]	21 AUG 03		

MAJ (b)(6)-2

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

REGISTER NO.	WARD NO.

Iraqi Civ # (b)(6)-4 (EPW

(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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03 0215	BRIEF OP NOTE:
	PROCEDURE: Exploratory lap, Cauterization and drainage of (R) lobe liver laceration, Irrigation/debridement (R) flank wound
	PRE-OP DIAGNOSIS: hemoperitoneum
	POST-OP DIAGNOSIS: Liver laceration, GSW (R) flank
	SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2
	EBL: 200 cc
	FLUIDS: 3800 cc Crystalloid, $\bar{c}$ u PRBC
	UOP: 1300 cc
	TT: Ø ⊕ NGT
	POST-OP PLAN: JP Drain in RUQ
	(b)(6)-2 MD

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.

LOG#: IRAQI National
SSAN#: (b)(6)-4
NAME:

PROGRESS NOTES
Medical Record

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

PREVIOUS EDITION IS USABLE AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 0220HRS	Received pt from OR, S/P exp lap c̄ liver lac repair. Pt sleepy, arousable to verbal commands, follows simple commands. ASG to fibe mid dsg [illegible] breaths, jet gained abdomen. 18 F NG to Rt naris clamped @ this time, placement verified via auscultation. O2 3L via NC. Lungs CTA, resp even. Pt on [illegible] in sinus tachy @ this time. Ø ectopy noted. Large midline lx 4 dsg to ASG c/D/I @ this time. JP drain to RLQ c̄ small amount blood draining. [illegible] hypoactive @ this time. 4x4 dsg to Rt lower back c/D/I. Foley cath draining clear yellow urine to gravity. 14g IV to Rt wrist c̄ NS @ KVO. 14g IV to Lt AC infusing LR @ 100cc/h. Will continue current care — Spc (b)(6)-2 91C
VS BP 130/70 R-28 POx 98% P-130 T-98.0	
0230HRS	Pt resting quietly, VS BP 130/65 HR 100 R-26 SPO2 95% on 3L O2 via NC — Spc (b)(6)-2 91C
0235HRS	Toradol 30mg IV administered @ this time as per MD order, Ø adverse reactions noted. Spc (b)(6)-2 91C
0240HRS	Ancef 1 gram administered IV @ this time as per MD orders, Ø adverse reaction noted — Spc (b)(6)-2 91C

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.

IRAQI National

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0245HRS	VS BP-134/72 P-103 R-24 SPO2 98% on 3L O2 via NC, Blood drawn for lab as per MO order @ this time, awaiting results. Pt resting quietly @ this time, resp even/unlabored. Will continue c current care ——— Spc (b)(6)-2 91C ——
0250HRS	Received lab results, WNL, labs attached to SF600 @ this time. ——— Spc (b)(6)-2 [illegible] ——
0300HRS	Pt resting quietly in bed VS BP-120/68 P-97 R-20 SPO2 98% remain on 3L O2 via NC. Pt s complaint @ this time. Remains on tele in NSR, ∅ ectopy noted. Will continue current care ——— Spc (b)(6)-2 91C ——
0315HRS	Pt moaning @ this time, asked pt if in pain, pt nodded yes and guarded ABD. VS BP-128/64 P-92 R-24 SPO2 98% on 3L O2 via NC. MSO4 2mg IV administered @ this time. Pt tolerated well. Will continue c current care — Spc (b)(6)-2 [illegible]
0325HRS	Zantac 50mg administered IV @ this time — Spc (b)(6)-2 [illegible]
0330HRS	VS BP-120/62 HR 85 R-21 SPO2 100% O2 3L via NC. Asked pt if pain has improved to ABD, pt nodded yes. pt resting quietly. Mod amount bloody drainage noted to JP Bulb, small amount bloody drainage present to the ABD drsg @ mid drsg, ∅ active bleeding noted. Will continue current care ——— Spc (b)(6)-2 [illegible] ——
Late Entry	0230HRS 1400cc clear yellow urine drained from Foley ——— Spc (b)(6)-2 91C ——

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 1584

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 03 0310HRS	30cc bloody drainage drained from JP bulb @ this time —— Spc (b)(6)-2
0400hrs	Pt resting quietly. VS BP 117/63 P-93 R-19 SpO2 98%
	Pt on RA @ this time. Will continue c current
	Care —— Spc (b)(6)-2
0420HRS	VS BP-128/58 P-94 R-22 SpO2 96% on RA. NG tube
	Rt now clamped @ this time, pt denies nausea.
	O2 DC'd. Lungs CTA. Abd soft tender (b)(6)-2
	hypoactive x 4 quads. Mid abd dsg c small
	amount bloody drainage @ mid dsg. JP drain c
	small amount bloody drainage @ this time. IV
	to Lt Arm DC'd, ck infusing @ 100cc/hr to Rt
	Arm via IV. Foley remains draining clear
	yellow urine in sufficient amounts. Dsg
	to Rt Lower back c small amount bloody
	drainage present. Report given to Spc (b)(6)-2
	Spc verbally stated understanding. Pt to Sc transferred
	to patient hold. Pt medicated c 3mg MSO4 IV
	@ this time for pain prior to movement.
	Monitor DC'd @ this time. Pt transferred
	to Patient Hold. —— Spc (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.

IRAQI National

(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

5-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17aug03		0430	Iraqi civilian admitted into Pt hold via litter.
VS-> 0440			Pt is sedated, recovering from GS wounds to the back
Bp - 130/64			4th 1000cc LR bag @ 100cc/hr. 800cc of yellow urine
PR-99			drained from Drain bag —SPC (b)(6)-2
RR-18		0530	SpO2 level is @ 89%, O2 given via Nasal Cannula SPC
SpO2-91%			SpO2 level went up to 96% —SPC (b)(6)-2
		0711	Bag #5 500cc LR hung to infuse 100cc/hr —SPC (b)(6)-2
VS=>0800		0740	800cc Yellow Urine drained from bag —SPC (b)(6)-2
Bp 119/71		0815	Pt alert and responsive, Pt is answering questions SPC (b)(6)-2
PR-74	0930	VS-	BP 110/61 P72 R16 SpO2 97% RA T 97.4 orally
RR-18			300cc clear yellow urine emptied from foley bag
SpO2-100%			20cc bloody drainage from JP drain. Pt arouses
			to voice, answers questions appropriately & able
			to follow commands. Moaning intermittently
			but declines med for pain when offered. (b)(6)-2
—VS—	1130	—	BP 109/59 P90 R16 SpO2 96% — (b)(6)-2
		1240	2mg MS IV - pt c/o pain to abd, moaning [illegible]
—VS—		1430	BP 111/57 P87 R16 SpO2 96% - 1 gram Ancef
			mixed in 10cc NS given IV over 10 min. (b)(6)-2 RN
		1550	Pt c/o pain to abd - & pain to IV site - IV restarted
			in LAC c 18g Jelco. 3mg MS given for pain
			(b)(6)-2 PT, RN
		1600	Bag #6 500cc LR hung to infuse — [illegible]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

Iraqi Civilian

(b)(6)-4

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
— VS —		1630	BP 118/60 P81 R 16 SpO2 96% RA - T 98.7
			600cc clear yellow urine emptied from foley
			Pt resting quietly - NAD — (b)(6)-2
— VS —		1830	BP 111/63 P88 R16 SpO2 96% (b)(6)-2
		2130	PT MOANED c̄ c/o DRSG PAIN @ MIDLINE
· VS @ 2130 —			2mg MSO4 IVP — (b)(6)-2 LPN —
B/P 115/63		2230	PT EASILY AROUSED TO VOICE. NG TUBE D/C'D
P 85 R 16			PER SURGEON. CURRENTLY RESTING SUPINE
O2 96% ON RA			NAD — (b)(6)-2 LPN —
TEMP 98.8°F ORAL		2230	*NOTE → PT UP TO CHAIR AS TOLERATED /
			ZANTAC PO IN THE A.M. — (b)(6)-2 LPN
— 18 AUG 03 —	0230		1g ANCEF IVPB. 2mg MSO4 IVP c̄ 10cc NS FLUSH
			500cc DRK. YEL. URINE DRAINED VIA FOLEY.
- VS @ 0530			20cc BLOODY DRAINAGE VIA JP EMPTIED — (b)(6)-2 LPN
B/P 126/73	0530		BAG #7 500cc LR @ 150cc/hr. IV SITE ØEEE — (b)(6)-2 LPN
P 90			
R 16	0800		2mg MSO4 IVP c̄ 10cc NS FLUSH — (b)(6)-2 LPN
O2 96% ON RA	0800		DRSG CDI, Ø FOUL ODOR NTD — (b)(6)-2 LPN
TEMP 99.6°F ORAL	1140		2mg MSO4 IVP c̄ 10cc NS flush — (b)(6)-2

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03	Surgeon's note
1030 A	
	No problems overnight
	AF, VSS
	UO - adequate
	Abd - soft, hypoactive BS
	JP Drainage ~ 20 cc
	P/ Evacuate to CSH today
	OOB → Chair (b)(6)-2
	Continue NG

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.

Iraqi DPW #1

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	History and physical
	18 yo Iraqi EPW says he was WL by
	RPG. to FST where ex lap performed
	for Hemoperitoneum. Findings @ Rt Lobe
	Liver Lac. Hemostasis Achieved EBL 200.
	JP left in Abd. Now Tx for care.
	NKDA Psx as Above meds
	PMH Ø TOB Ø
	exam
	NCAT Back — entrance wound
	neck NT Ødeformity
	Chest CBTA
	ext ØCCE Abd NABS
	TTP ND
	GU WNL
	LABS 14.9 / 47.6 / 244; 136 / 104 / 7 / 100; 3.7 / 23 / 0.6; TP 6.6 Alb 3.4; LFT WNL
	A/P Liver Lac stable post op.
	Admit ICU x24hrs
	IVF
	Clears.

(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. ICU

EPW

(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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	History and physical
	18 yo Iraqi EPW says he was WI by
	RPG. to FST where ex lap performed
	for Hemoperitoneum. findings @ [illegible] lobe
	liver lac. Hemostasis achieved EBL 200.
	JP left in Abd. Now Tx for care.
	NKDA PSH as above meds
	PMH Ø FOR Ø
	exam
	NCAT Back entrance wound
	neck NT Ø deformity
	Chest CBTA
	ext Ø CCE Abd NABS
	TTP ND
	[illegible]
	Labs 14.9 / 47.6 / 244 136 / 104 / 7 / 100 3.7 / 23 / 0.6 TP 6.6 Alb 3.4 LFT WNL
	A/P Liver lac stable post op.
	Admit ICU x24hr
	IVF
	Clears.

(b)(6)-2

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

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

REGISTER NO. | WARD NO. ICU

EPW

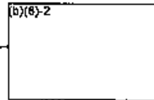
(b)(6)-4

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)*
19 Aug 03 -	
	S/P X/lap doing well tolerating
	diet.
	Will DC JP today
	(b)(6)-2
20AUG03	Progress notes
	Pt stable s/p ex-lap c liver lac
	VSS Tmax 101
	Lungs: CTA
	Cor: RRR
	ABD: soft mild TTP +BS
	JP: s/s
	Plan clear liquid diet
	Ambulate
	DC (b)(6)-2
21 Aug	c/o Nausea in flight.
	Pt given phenergan @ 2100 hrs
	(b)(6)-2
	[redacted] /Flt medic

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 -	
	S/P X/lap Doing well [illegible]
	Diet.
	Will DC JP today
20AUG03	Progress note
	Pt stable s/p 3x-lap c̄ [illegible]
	VSS Tm 101
	Lungs: CTA
	CV: RRR
	ABD: soft, mild TTP [illegible]
	JP: [illegible]
	Plan clear liquid diet
	Ambulate
	DC 

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

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
21 Aug 03	(2200) Admitted to ICU2 via litter c̄ x2 restraints to UE, NAD, moved s̄ difficulty from litter to bed, breathing regular, unlabored Alert, movement x4 extremities, responds to commands, speaks small amount of English — (b)(6)-2 MPC BS
21 Aug 03	(2230) VS PSO2 97%, P=79, B/P 143/72 (98) R=14 bpm T=99.3 UO 475cc yellow c̄ sediment — (b)(6)-2
21 Aug 03	(2250) 2mg MSO4 administered by RN on duty, Physicians check lower midline abd incision, A wet to dry dressing placed over abd — (b)(6)-2
21 Aug 03	(2300) Assessment complete, Alert, responds to commands PERRLA, skin warm dry no Breakdown pulses present normal x4 extremities, midline incision clean, intact, bandage (gauze c̄ tape) CDI abd flat, ridged, tender, client c/o pain to abd when palpated, (2) FA heplock CDI no s/s of infiltration, Ø c/o numbness to LE's, bandage to back intact, dry, urinated c̄ difficulty s̄ pain, will continue to monitor per physicians instruction — (b)(6)-2
21 Aug 03 2300	Restraints to bed MPC BS — (b)(6)-2

(Continue on reverse side)

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

Iraqi # (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
22Aug03	(0245) Inserted IV heplock to (R) AC, client tolerated D/C (L) FA heplock, catheter intact (0250) provided pain meds (0215) V/S 166pm T=96.8 B/p 120/62 (83) P=75 PSO2 97% client resting c̄ HOB elevated drinking fluids s̄ difficulty, breathing regular unlabored — [(b)(6)-2]
22Aug03	0615 - Nursing Notes: Assumed pt care. Pt A&O X3, speaks English well, ø c/o pain. SB 55, VSS, BP 117/65, RR18, Pulse OX 98% on room air, T 96.8 Pt denies being a prisoner, pt also states he "will not drink water or eat food." IV HL in (R) AC patent & flushes easily. Pt has midline abdominal incision c̄ staples c̄ dressing to lower portion of suture line. Exit wound (R) upper lateral back 1 cm deep & 1 cm diameter c̄ small amt of exudate repacked wet to dry. Abdominal incision approximately 25 cm in length (B) lungs CTA. [(b)(6)-2] LPN
Gen	Surg Note
22AUG03	HD#2 POD#5 s/p Ex lap / Liver lac repair
0855	VSS. Afebrile. Pain control c̄ po meds. Wounds (back & front) C/D. Minimal secretion noted on front ABD incision. ø erythema. Tolerating po clear diet. Will continue with post op care. Needs to ambulate
	[(b)(6)-2] MD
	MAJ, MC, USA

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S. Government Printing Office: 1990-262-081/20138

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22Aug03	0840 = Nursing Notes: Pt urinated 150cc of clear yellow urine per urinal. (b)(6)-2
22Aug03	0900 - Nursing Notes: Abd dressing changed, abd open section of incision 7.75 cm long & 5cm wide, wound pink c̄ minimal bleeding, Ø odor, Ø exudate. Will continue to monitor. (b)(6)-2
22Aug03	0930: Nursing Notes: Pt sitting up in chair @ bedside. Pt ambulated c̄ minimal difficulty. Pt medicated previously @ 0835 c̄ Tylox ii po per prn physician pain order. Will continue to monitor. (b)(6)-2
22Aug03	1400 - B/P 121/66, P-72, T-97.9, R-20, mean-88, Denies c/o pain, Ø SOB, Staples to midline ABD CDI, Dressing to mid lower ABD CDI, Dressing to Ⓡ ↓ BACK CDI, IV to Ⓡ AC s̄ redness swelling or warmth. will continue to monitor. urine clear & yellow 300 cc (b)(6)-2
22Aug03 2200	V/S 97% R=18bpm P=93 B/P 126/66 (89) T=99.8 Motrin administered, pt alert obeys commands NP C BS temp warm dry, resting c̄ HOB elevated 30° midline incision CDI wet to dry lower midline

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.

Iraqi CIV (b)(6)-4 (EPW)

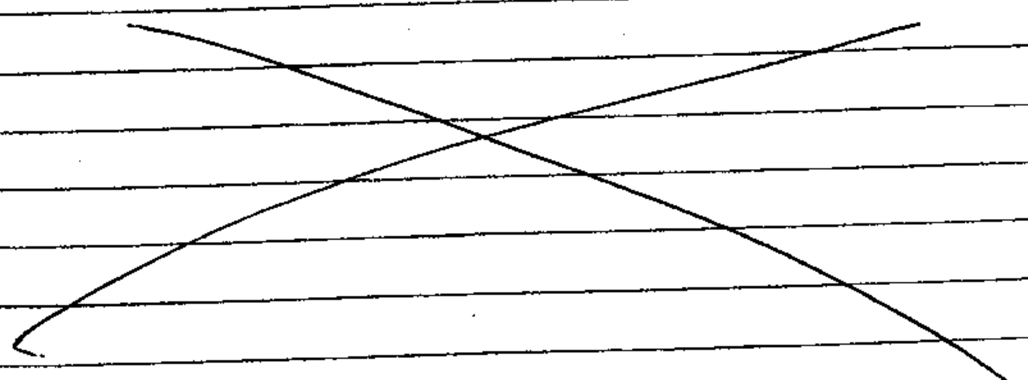
(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	NOTES
22Aug03 2200	(continued) incision CDI, tender and c/o pain denies pain medication @ this time, bandage to (R) lower back intact, Ointment to (L) heel where breakdown is apparent. Gauze c̄ tape over blister on lateral (R) heel. pulses present x4 LS CTA, breaths deep, regular, unlabored, Ø SOB NAD, moves ext x4 pupils reacting to light. Flushed (R) AC heplock Heplock CDI, patent s̄ sx of infiltration s̄ c/o pain @ site. (b)(6)-2
23Aug03	(0015) Sat @ side of bed s̄ difficulty (b)(6)-2
23Aug03	(0000) Urinated in urinal s̄ difficulty c/o pain to and UTA pain scale Administered pain medication per physicians instruction, pt resting comfortably following medication administration (b)(6)-2
23Aug03	(0215) V/S R=18bpm P=78 b/p= 115/65, T=98.6 pSO2 97% Ø SOB Ø c/o pain, will continue to monitor q2 am
0840	T 98°F BP 123/73, HR 94, RR 16, SpO_2 97% on RA; NAD; VSS; dressings Δ'd; CDI, MD looked at wounds; lung sounds clear, bowel sounds active x4 quad; pt sitting up in chair eating breakfast (b)(6)-2



STANDARD FORM 509 (REV. 5-99) BACK

FPI LEX Printed on Recycled Paper

MEDICAL RECORD | PROGRESS NOTES

DATE

23AUG03
1025

HD#3 POD#6 (DOS 17AUG03)
S/P EXLAP / Liver Lac Repair

Currently remains afebrile, tolerating diet, pain control c̄ po meds. Continue c̄ wound care vertical abdominal incision → staples in place ∅ signs of erythema. Small area at the umbilical was noted c̄ secretions and it was open and currently undergoing wet to dry dressing changes. (R) back wound entrance (about 2-3cm in circumference with no sign of infection. Continues c̄ BID dressing changes.

Plan: - staples to be removed by tomorrow AM
- pending transfer to EPW camp where he will continue to have Dressing changes BID and F/U @ (b)(3)-1 in a week after his transfer.
- Will continue on po Meds for his pain control.

(b)(6)-2 , MD
MAJ, MC, USAR

(Continue on reverse side)

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

Iraqui # (b)(6)-4 (b)(6)-4 EPW
(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDICAL RECORD

PROGRESS NOTES

DATE

?AUG 03 HD#4 POD#7 (DOS 12AUG03)
DOS s/p ExLap / Liver Lac repair.

Pt is doing well today. Remains afebrile, ambulating, voiding without difficulties. Back wound c̄ no signs of infection. Abdominal wound continues to heal well. Rest of the incision with ∅ signs of infection. Staples removed and steristrips applied.

Plan: ① Will continue c̄ po meds for his pain
② Start on Colace 100 mg PO QD
③ Pending transfer to EPW camp. Once D/C he will have Dressing changes BID and F/U in 3 days. to assure no infection present.

(b)(6)-2 (b)(6)-2 MD
(b)(6)-2 MAJ, [illegible]

(Continue on reverse side)

REGISTER NO. WARD NO.

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

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
23Aug03 1425	V/S: T-98.6 P-83 R-16 B/P 120/68 SpO2 97% KA Assessment completed. A+O×3. Breath sounds CTA Apex to Base (B). Peripheral pulses strong, Bowels sounds active ×4. Midline abdominal incision c staples CDI, dressings to abdomen and back intact. IV site CDI, Ø S/S of infection. Ø c/o pain. Resting comfortably. Motrin 800 mg po given. (b)(6)-2
23 Aug 03 1930	T-98.7 P-88 R-16 B/p 131/71 SpO2-98%
23 Aug 03 2230	Took over care VSS T 98° P 86 R 12 BP 122/69 sat's 99% A/O×3, PERRL Chest CTA Heart RRR Abd soft Ⓣ tenderness Stapled mid Abd. C-D-I MAE Has Ø c/o discomfort at this time. IV site to Ⓡ FA patent. Will cont to monitor per the orders (b)(6)-2
0300 Aug 24, 03	Resting with eyes closed. NAD. Will cont to monitor per orders. (b)(6)-2
0315 Aug 24, 03	T. 98° P 76 R 12 BP 120/60 sat's 99% RA
0915	BP 121/52, HR 91, RR 14, SpO2 97% on RA, T 97.1 VSS; NAD, lung sounds clear, BS active ×4 quad. (b)(6)-2 WMLC DC

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
24Aug03 1100	IV DC'd; catheter was intact; will cont to monitor [(b)(6)-2]
24Aug03	2030 D/C'd ē MP's vitals within normal limits [(b)(6)-2] discharge instructed sent ē MP's medications &

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

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

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I TO BE COMPLETED BY PRIVILEGED PROVIDER	SECTION II TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE
1. DATE OF PROCEDURE/ADMISSION: 21 AUG 03 2. ADMITTING/DIAGNOSIS: Exp lap / Liver LAC 3. PERTINENT LAB, X-RAY, FINDINGS:	1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER 2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☑ OTHER 3. PATIENT EDUCATION: Completed and patient prepared for home care. ☐ YES ☐ NO If no, explain: Patient ☐ states ☐ demonstrates understanding of home care needs. Printed educational materials provided:
4. PROCEDURES, TREATMENT, HOSPITAL COURSE: -GSW to (R) back -S/P Exp Lap -S/P (R) lobe Liver LAC repair.	4. Clinical outcomes met and post-discharge/release referrals made. ☑ YES ☐ NO If no, explain: 5. If transferred to another health care facility, report called to nurse. ☐ YES ☐ NO If no, explain:
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE: - GSW to (R) back - S/P Exp Lap - S/P (R) lobe Liver lac	6. NUTRITION CARE - Comments:
6. ACTIVITY: Ad lib 7. DIET: regular 8. MEDICATIONS: ☒ Medications have been prescribed for home use. See separate list and special instructions or see below. Motrin 800mg PO TID PRN Tylox 1-2 tab PO Q3-4° PRN Colace 100mg PO QD PRN constipation	7. MEDICATIONS: Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST Printed medication literature provided. ☐ YES ☑ NO Patient states understanding of prescribed medications. ☐ YES ☒ NO [handwritten: interp] 8. EQUIPMENT/SUPPLIES PROVIDED:
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*: 1) Needs BID Dressing changes for his (R) back wound and abdominal wound 2) F/u in ~~[struck]~~ 3 days at Spec Clinic @ 1030 AM	9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. DISCHARGING PROVIDER (b)(6)-2 (b)(6)-2 MD MAJ, MC, USA *(Printed or Stamped Name)*	10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
PATIENT IDENTIFICATION (b)(6)-4 Iraqi # (b)(6)-4	(b)(6)-2 24 Aug 03 *(Date and Time)* I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS. *(Patient/Responsible Adult's Signature)* *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD

INTRA... ..RAT... ..OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY ATLS

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

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0105

4. PATIENT IN ROOM TIME 0105 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Spc (b)(6)-2 Spc (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: x1 Roll under Bilat Shoulders

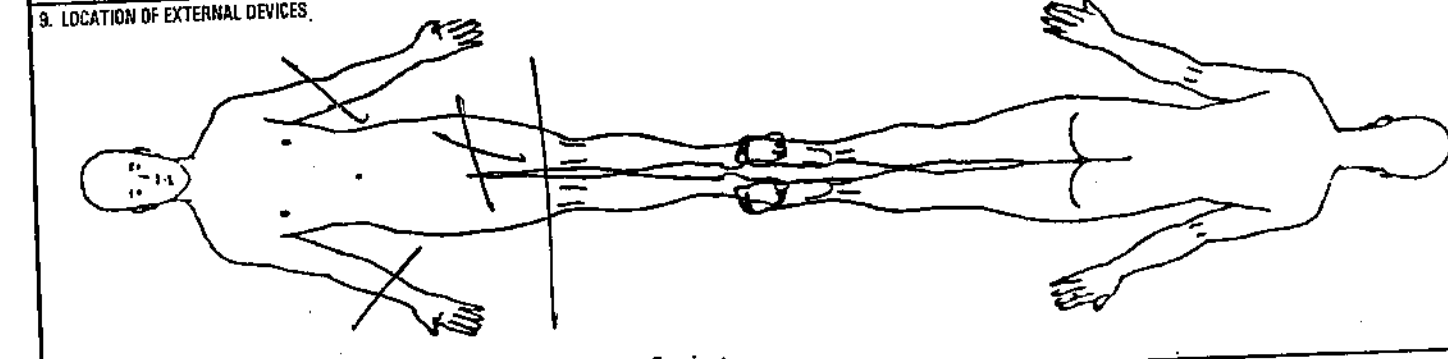
8. SKIN PREPARATION

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

COMMENTS: Removal Midline ABd + Lf thigh

PREP SOLUTION *(Specify)* Beta/Beta BY WHOM: Spc (b)(6)-2
SITE: Mid ABd
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad - Safety Strap --- Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count 0152	Final Closing Count 0200
Sponge	[X] Yes	[ ] No	5+5	10	10
Needle Sharp	[X] Yes	[ ] No	16+3+1	19+1	20
Instrument BLADE	[X] Yes	[ ] No	2+1	3	3
Other Bovie Tip	[X] Yes	[ ] No	1	1	1

SCRUB Spc (b)(6)-2 CIRCULATOR Spc (b)(6)-2

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

LOG# (b)(6)-4
SSAN#
NAME:

IRAQI CIVILIAN

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[ ] ESU NO: Cut 30/Coag 30
GROUND PAD: BRAND
LOT NO:
[ ] ESU NO: ~~Cut 60/Coag 60~~
GROUND PAD: BRAND
LOT NO:
[ ] BIPOLAR NO: ~~Cut 80/Coag 80~~

USAPA V1.01

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

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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE MAJ (b)(6)-2 MO

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Foley 16F	2. NG 18F	3. Jason Pratt
SITE	1.	2. Rt Nare	3. RLQ

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform c 4x4
Min Asd.
Large Bulky

19. ADDITIONAL INFORMATION
Assisted By Dr (b)(6)-2
Foley cath placed by Dr (b)(6)-2 clear yellow urine present. NG placed to Rt nare per anesthesia.

IN 0105
CUT 0123
CLOSE 0152
OUT 0219HRS
LOG # IRAQI National
SSAN# (b)(6)-4
NAME:

20. OPERATION(S) PERFORMED
Exploratory LAP
Repair Liver Lac
JP placement

21. PATIENT TRANSFERRED TO ICU
TIME 0219hrs.
METHOD Litter

22. REGISTERED NURSE S(b)(6)-2
SPC [illegible]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☒ NO IF YES NAME: ID NUMB... RER

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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE MAJ (b)(6)-2 MC

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Foley 16F	2. NG 18F	3. Jackson Pratt
SITE	1.	2. Rt Nare	3. RUQ

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform c 4x4
Mini Abd.
Large Bulky

19. ADDITIONAL INFORMATION
Assisted By Dr (b)(6)-2
Foley cath placed by Dr (b)(6)-2 clear yellow urine present. NG placed to Rt nare per anesthesia.

IN 0105
CUT 0123
CLOSE 0152
OUT 0219HRS

LOG #
SSAN# IRAQI National (b)(6)-4
NAME:

20. OPERATION(S) PERFORMED
Exploratory LAP
Repair Liver Lac
JP placement

21. PATIENT TRANSFERRED TO ICU TIME 0219hrs. METHOD Litter

22. REGISTERED NURSE SI(b)(6)-2 SPC

MEDICAL RE[illegible] -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 08MAR8

INITIAL SHIFT ASSESSMENT		Time: 1700 Initals: [illegible]	Time: Initals:
NEURO			
	Pupils		
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern		
	Breath Sounds		
	Secretions		
	Cough		
SKIN	Color		
	Integrity		
	Backside		
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen		
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device		
	Color / Clarity		

(Handwritten across assessment column: See [illegible])

(Continue on reverse)

(b)(6)-2

...n entries give: Name – last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

DEPARTMENT/SERVICE/CLINIC
ICU3, (b)(3)-1

DATE
18 Aug 03

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU1

Patients Name: (b)(6)-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP											142/65	139/71		135/61	129/69		135/73	131/65	133/64	141/74	129/63	138/69	135/63	130/62	131/62	
TEMP											99.9				100.5		100.9		100.5				100.3			
HR											106	96		88	97	98	102	95	101	106	100	107	107	104	107	
RR											23	23		22	24	23	20	15	18	26	24	24	21	18	20	
SaO2											97	97		96	95	98	96	97	95	94	95	96	93	95	94	
FiO2											RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF											150	150		150	150	150	150	150	150	150	150	150	150	150	150	
IVPB											50									50						
NGT																										
PO												50														
Subtotal											200	200														
~~PO~~ Total											200	400		550	700	850	1000	1150	1300	1500	1650	1800	1950	2100	2250	2250

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[illegible]											~~800~~ 800	800		30				250					250		100	
N																										
STOOL																										
DRAIN JP												25			Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	30	Ø	Ø	
Subtotal												825		855				1105					1385		1485	1485
Total												825														

MEDCOM - 1606

ICU1

Patients Name: EPW # (b)(6)-2 Date: 19 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	124/		120/73	129/65		135/72	140/72		138/64	137/62																
NBP	71																									
TEMP	100					100.5			100.5																	
HR	93		93	97	/	105	117	123	127	102																
RR	28		19	25		19	24	24	27	19																
SaO2	98		98	99		96	97	96	98	97																
FiO2	RA		RA	RA		RA		RA	RA																	
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF LR	150	150	150	150	150	150	150	150	150	150	150	150														
IVPB			50								50															
NGT																										
PO													(1900)													
Total	150	300	450	600	750	900	1050	1200	1350	1500	1650	1800														

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[illegible]			300	300	200	200	200		300	150	150	350														
NGT																										
STOOL																										
DRAIN JP	Ø									30	DC															
Total	Ø		300	600	800	1000	1200		1500	1680	1830		(2180)													

Drawn 17 Aug 03 0248hrs

EC8+

Pt Name:____________

Glu________129 mg/dL

BUN_________10 mg/dL

Na_________142 mmol/L

K__________3.8 mmol/L

Cl_________111 mmol/L

TCO2________21 mmol/L

AnGap_______15 mmol/L

Hct_________41 %PCV

Hb*_________14 g/dL

*via Hct

pH_______7.262

PCO2______44.0 mmHg

HCO3________20 mmol/L

BEecf_______-7 mmol/L

Sample Type_:

17AUG03 02:44

Oper: 111

Physician: [signature] (b)(6)-2

Ser# 43006

Ver: JAMS046A
CLEW A93

MEDICAL RECORD — ANESTHESIA

DRUG	Units		TOTALS
Thiopental	mg	225	225 mg
Anectine	mg	120	120 mg
Norcuron	mg	8	8 mg
MSO4	mg	10	10 mg
Neostigmine	mg	4	4 mg
Robinul		0.8	0.8
VOLAT AGENT Sevo	% del	2 — 2 — 2 X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	5 — 5	

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

TOTAL EBL: 200

TOTAL URINE: 1200

FLUIDS SUMMARY
CRYSTALLOID— 3800
COLLOID—
BLOOD— 350

FLUIDS: LINE site — (#1), (#2) — Warmed

LOSSES: EST BLOOD LOSS / URINE —

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

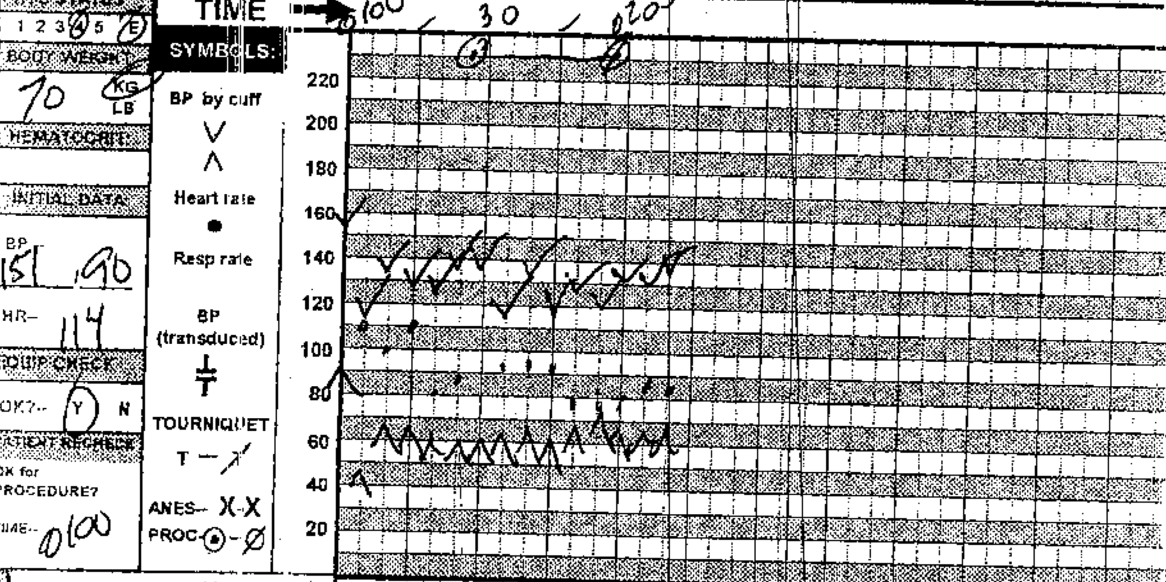
BODY WEIGHT: 70 KG

BP: 151/90
HR— 114

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME— 0100

TIME: 0100 — 30 — 0200



REMARKS—
Code drugs with numbers, events with letters

2772274

OCW Reversed.
ST, TOF, SV, oropharynx suctioned
Extubated.

MONITORS						
MODE— S(pont) A(ssist) C(ont)	S	C	C	C	S	S
ET CO2 (torr)	4	4	4	4		
FIO2 (Frac or %)	.3	.3	.3	.3		
SpO2 (%)	100	100	100	100		
ECG	ST	ST	ST	SR		
TEMP- site						
N-M Block (T/4)	0/4	0/4	1/4	4/4 4/4		

BP/Auto Cuff, BP/oth, ART line, Steth- PC/ES, Gas analyzer, Warming blkt, Conv warmer

FST

RECOVERY AT 0218 — PACU
CONDITION: Alert, SV
RESP— 24 SpO2— 97%
BP— 122/70 HR— 105

	Start	Room	End
ANES	0100	0105	0220
	Ready	Begin	End
PROC	0110	0120	0152

EVENTS — Position

PROCEDURES and CPT Codes: Liver Laceration Repair + Drain, Ex Lap

ANESTHETIC TECHNIQUES: GETA

AIRWAY MANAGEMENT: RSI c CP, DLx1 c 3 mac, grade I, 8.0 OETT, atraumatic intubation, BBS(+), (+) ETCO2, secured 22cm @ incisors, FST

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

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

ANESTHETIST (b)(6)-2

PROCEDURE 628 FST
LOCATION OR
DATE 17 AUG 03
PAGE 1 OF

MEDICAL RECORD — ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 1609

Doctor's Orders—Post-OP 126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: s/p Exploratory lap, liver laceration
☐	☑	3. Condition: ☐ Critical ☐ Guarded ☒ Stable ☐ VSI ☐ SI
☐	☑	4. Allergies: See SF 558 Ø
☐	☑	5. Vitals: ☒ Unit SOP ☐ Notify Dr. for SBP < 80 or > 160 DBP < 40 or > 100, HR < 60 or > 130, RR < 6 or > 30, or Temp > 38.5
☐	☑	6. Activities: ☒ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	(a) Propaq monitor w/ Pulse-ox
☐	☑	(b) O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=____ Vt=____ RR=____ PEEP= FIO_2=
☐	☑	(d) ☒ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☑	(e) I's & O's
☐	☑	(c) Suction NT ETT PRN
☐	☐	~~d. CT to ☐ H_2O seal or ☐ Suction at~~
☐	☑	8. Diet: ☒ NPO ☐ Clear fluids as tolerated ☐ Other:
☐	☑	9. IV: ☐ NS or ☒ LR TRA 100cc/hr ~~☐ DEXTRAN or~~ ☐ Hespan X 500 cc bolus titrated then ____ cc/hr ~~☐ Albumin 100cc X~~ ____ TRA ____ cc/hr ☒ ~~When tolerating PO~~ fluids, complete current fluid then SL.
☐	☐	10. ~~BLOOD~~: ☐ T&S or ☐ T&C ____ units ☐ Transfuse ____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X | e ☐ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☑	(c) Cefazolin 1 gram IV q 12h x 4 doses 1st dose @ 0240hrs [illegible]
☐	☑	(d) Phenergan 12-25mg Titrate ☒ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	(h) MSO_4 1-3mg Titrate ☒ IV ☐ IM Q10min PRN Pain
☐	☑	(i) Robinul 0.1mg IV X 1
☐	☑	(j) Zantac 50 mg ☒ IV or ☐ IM or ☐ 6.25mg/hr infusion q 12h 1st dose @ 0325 [illegible]
☐	☐	k. Tetanus Immune Globulin
☐	☑	(l) Toradol ☒ IV 30mg or ☐ IM 60 mg Done @ 0235hrs [illegible]
☐	☐	~~m. Maintain sedation/~~paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☑	(12) LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☒ CMP Done @ 0248hrs [illegible]
		13. Additional: → Clamp, ✓ Residual q 4h & PRN NG → ~~CLWS or Gravity drainage~~ Foley → urimeter JP — Bulb suction
(b)(6)-2		Signature: (b)(6)-2

LOG# 1 Aug 03 0230hrs. PT NAME: (b)(6)-4 DR SSAN# 10JAN03

MEDCOM - 1610

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

Iraqi CiV # (b)(6)-4 (EPW)

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 AUG 03 TIME OF ORDER: 2230 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU 2
2. Diagnosis: s/p Exp lap Liver Lac Repair
3. Condition stable
4. Service: Gen Surgery Dr. [redacted] B6-2
5. Vitals: Q 4°
6. Allergies: NKDA

PATIENT IDENTIFICATION

DATE OF ORDER ↓↓ TIME OF ORDER ↓↓ HOURS

7. Diet: clears and advanced as tolerated
8. Tylox i-ii tab po PRN pain Q 3-4 hrs
9. Motrin 800 mg po tid
10. phenergan 25 mg po Q 6° PRN N/V
11. Dressing change on wound on his back BID.
12. Morphine 2 mg IV now x 1

21 Aug 03 (b)(6)-2 2330

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ↓↓ TIME OF ORDER ↓↓ HOURS

13. Heplock IV site DC old one and place new one — done
14. Abdominal wound wet to dry changes BID

(b)(6)-2 MD

MAJ, MC, USA

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ MB 21 Aug 03 @ 2345

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Aug 03 TIME OF ORDER: 1000 HOURS

1. D/C staples.
2. Colace 100 mg QD
3. Continue Dressing changes for back and abdominal wounds. BID

B6-2 (b)(6)-2

(b)(6)-2 MD

MAJ, MC, USA

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 1611

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: Iraqi # (b)(6)-4

DATE OF ORDER: 24aug03 — TIME OF ORDER: 1000hrs HOURS — LIST TIME ORDER NOTED AND SIGN

VODr (b)(6)-2 / (b)(6)-2 MAGW

Δ vs to q shift

(b)(6)-2 , MD

MAJ, MC, USAR

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Iraqi # (b)(6)-4

DATE OF ORDER: 24AUG03 — TIME OF ORDER: 1035 HOURS

① D/C to EPW camp —

(b)(6)-2 MD

MAJ, MC, USAR

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Iraqi # (b)(6)-4

DATE OF ORDER — TIME OF ORDER — HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Iraqi # (b)(6)-4

DATE OF ORDER — TIME OF ORDER — HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 — REPLACES ED ... Y BE USED. — MEDCOM - 1612

(GREEN) EPW

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.

Aug 8 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24
21Aug	(b)(6)-2	Vitals: Q4°	D	/	(b)(6)-2		
			E	/	(b)(6)-2		24aug03
			N	(b)(6)-2			
21Aug	(b)(6)-2	Diet: clears &	D	/	(b)(6)-2		
		advanced as tolerated	E	/	(b)(6)-2		
			N	(b)(6)-2			
21Aug	(b)(6)-2	Dressing Δ on wound	08	/	(b)(6)-2		
		on his back BID	20	/	(b)(6)-2		
				/	/		
21AUG	(b)(6)-2	Abdominal wound	08	/	(b)(6)-2		
24aug	(b)(6)-2	wet to dry Δ BID	20	/	(b)(6)-2		
		Vitals q shift	D	/	/	/	(b)(6)-2
			E	/	/	/	
			N	/	/	/	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to Ⓡ abd / Exp lap

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

PATIENT IDENTIFICATION:

Iraqi # (b)(6)-4 EPW

(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

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON MEDICATION)

Mo 08 Yr 03

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	(b)(6)-2	Admit to ICU2/Gen Surgery Dr (b)(6)-2	21AUG	2200	2200	(b)(6)-2
21		Condition stable	21AUG	2200	2200	

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

EPW

(MAR)

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General	Mo 8 Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24
21 Aug	(b)(6)-2	Motrin 800mg PO	08	/	(b)(6)-2		
		TID	14	/	(b)(6)-2		
			22	/	(b)(6)-2		
21 Aug	(b)(6)-2	IV Heplock	D	/	(b)(6)-2		
			E	/	(b)(6)-2		
			N	(b)(6)-2			
24 Aug 03	(b)(6)-2	Colace 100mg PO QD	08	/	/	/	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW to (R) abd / Ex lap

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

PATIENT IDENTIFICATION:
Iraqi # (b)(6)-4 EPW

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

Verify by initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)	Mo 08	Yr 03		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	(b)(6)-2	Morphine 2mg IV now x 1	21AUG	NOW	2250	(b)(6)-2
21		Heplock IV site D/C old one &	22Aug	0245	0245	
		place new one	–	–	–	–

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
21AUG	(b)(6)-2	Tylox i - ii tabs	22Aug03 [illegible]	22Aug03 2003	23Aug03 2003	24Aug03 0900									
		PO PRN q 3-4 hrs pain	0250 /	0835 / BC	0050 / 2200	ii / [illegible]									
21Aug	(b)(6)-2	Phenergan 25 mg													
		PO Q6° prn N/V													