ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2860

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	66		Mus			NO	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
20			EPW			ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
						INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
	1030	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to bilateral arms

CODING iNFORMATION: E970

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19730101	044			MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1030	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	1C 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		B	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	(b)(6)-4	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)	24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
XFR	(b)(3)-1	030405 R00			

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		030405

FOR LOCAL USE

DX: GSW To Bilateral Arms

Dr: 28[illegible]

12 [illegible] 1

ADM (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2862

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	20		MUS			NO	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
						ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
			EPW			INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1030z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 1. Shrapnel injury to R mid/upper back s/o cheat tube

2. L Buttocks shrapnel injury

CODING INFORMATION: E992

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U P R X | 5. GRADE

6. AGE 20 | 7. SEX MALE / FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) AMBUL / LITTER X | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE (b)(6)-4 | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER Icu #3 | 15b. DESTINATION FACILITY PHONE NUMBER | 0 | 0

17. DIAGNOSIS
Shrapnel @ upper chest
chest tube
shrapnel @ buttock

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 5APR03 | 20b. TIME 1230 | 20c. ALLERGIES NKA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC | CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION	TRACTION	X FOLEY CATH
	NG TUBE	IV PUMP	ORTHO BRACES
	STRYKER	TRACH	X CHEST/HEIMLICH
	INCUBATOR	MONITOR	RESTRAINTS
			OTHER (USE 23)

OXYGEN: PERCENT or LITERS | ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

Y	OUTPATIENT RECORDS		XRAYS	OTHER:
	INPATIENT RECORDS	X	OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS
Ancef 1 gm IV Q8°
WF LR @ 125 ml/hr.
MS04 2-3 mg IV Q1° PRN pain

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		X	Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.		X	Vision Impaired	o.			Other:
h.		X	Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE
Navy Tragic MC multiple
Shrapnel WNDS @ back/shoulder
& buttocks. S/P tube
thoracostomy

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

24. S

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF F

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 — (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26 — 1 9 8 3 0 1 0 1	27 28 29 — 2 0 Y	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45 — (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1030Z	EN

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 — K 1 Y	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 — ERA	ICU 3	(b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	(b)(6)-4
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 — XFR	75 76 77 78 79 — (b)(6)-2	81 82 83 84 85 86 — 0 3 0 4 0 5 — 1830

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 — 0 3 0 4 0 5

FOR LOCAL USE

Dx 1. Shrapnel Injury to @ mid/upper back s/p accident/blast
2. @ buttocks shrapnel injury

Dx: 8760
8771
E9419

Inj Trauma
4/4/3 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)				3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4					
4. SEX: M	5. AGE: 42	6. RACE	7. RELIGION: MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION: NO
11. FMP	12. SSN		13. ORGANIZATION: EPW			14. WARD: ICU3
15. FLYING STATUS: NO	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE: INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1050z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
Wife/ (b)(6)-4	XFR	030407

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030407	Col (b)(3)-1

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030407	

31 SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: L Open elbow FX
L Thigh GSW
R Shoulder GSW

CODING INFORMATION: E 991.9, ~~E 812.59~~, E 820.13

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, MI) (b)(6)-4 | 2. SSN | 3a. STATUS CIV | 3b. SERVICE | 4. PRECEDENCE U P R | 5. GRADE

6. AGE 60 | 7. SEX MALE ✓ FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F)– AMBUL | ✓ LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)- | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS
Ⓛ Shoulder shrapnel
Ⓛ Side chest wound
Ⓛ forearm fx

18. ✗ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS
20a. DATE | 20b. TIME | 20c. ALLERGIES

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD 18g Ⓛ wrist LR

20f. SPECIAL EQUIPMENT
SUCTION | TRACTION | FOLEY CATH
NG TUBE | IV PUMP | ORTHO BRACES
STRYKER | TRACH | ✓ CHEST/HEIMLICH
INCUBATOR | MONITOR | RESTRAINTS
| | OTHER (USE 23)
OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT
OUTPATIENT RECORDS | XRAYS | OTHER:
INPATIENT RECORDS | OB |
NARRATIVE SUMMARY | DENTAL |
FINANCIAL | |

20i. MEDICATIONS / TREATMENTS
MSO4 @ 0524Z 05 Apr
Ancef 1gm q8hrs 1st dose 051300ZAPR05
Phenergan 12mg IVP PRN

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		✗	Hypertension	i.		✗	Bowel Problem
b.			Cardiac Hx	j.	✗		Self-care
c.			Diabetes	k.		✗	Ambulatory
d.			Respiratory	l.		✗	Ambulatory Aid
e.			Ears/Sinus	m.		✗	Self-meds
f.			Motion Sick	n.		✗	Adequate Supply of Meds
g.			Vision Impaired	o.		✓	Other:
h.		✗	Voiding Prob.				

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE
2° GSW (shrapnel) to Ⓛ shoulder
Chest tube to 25cm H2O c̄ cont sx Drg 0 d c̄
Drainage Ⓛ forearm

23. ASSESSMENT / PROGRESS NOTES
DATE / TIME

Wrong pt = (b)(6)-4
this chart (b)(6)-4

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Ex

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	Mus
1 9 6 1 0 1 0 1	4 2 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1050Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 9	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 ERA	ICU 3	(b)(6)-4
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XFR	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 4 0 7 1030

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 5

FOR LOCAL USE

Dx (L) Open Elbow Fx
(L) Thigh GSW
(R) Shoulder GSW

Dx 81250
8900
2200
2202

PR: 3404

Tm 450

Trauma 1

ADMITTI (b)(6)-4

SIGNATURE OF ADMITTING CLERK

Spc (b)(6)-4

DA FORM 2965, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2868

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	1920		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
		EPW	

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ GEN	18. BRANCH/CORPS	19. LIC/ZIP	20. TYPE CASE
NO					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1050z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030406

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINSTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW R leg

CODING INFORMATION: E970

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

U60630APR03
060430APR03

1. NAME (Last, First, Middle Initial)	SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
[redacted]	[redacted]			U P R X	[redacted]

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITF
20	X MALE / FEMALE			AMBUL X / LITTER		[redacted]

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
	[redacted]	[redacted]	16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER 558-[redacted] ICU #3	15B. DESTINATION FACILITY PHONE NUMBER	Ø	Ø

17. DIAGNOSIS

GSW ⓑ knee
ⓑ Forearm fracture
GSW ⓞ thigh
2° Burn ⓐ chest

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			[redacted] Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
5APR03	2015	NKA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ OTHER *(Specify)* ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION	TRACTION	FOLEY CATH
	NG TUBE	IV PUMP	ORTHO BRACES
	STRYKER	TRACH	CHEST/HEIMLICH
	INCUBATOR	MONITOR	RESTRAINTS
			OTHER *(USE 23)*

OXYGEN: PERCENT or LITERS | ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IVG8°
MSO4 2-4 mg IVQ1° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

20yo Iraqi S/P multiple GSW's, S/P washout, Stable for X-fer.

23. ASSESSMENT / PROGRESS NOTES

DATE / TIME	NOTES

[redacted]

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19840301	204			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1050Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 98	

17. UNIT LOCATION (State or Country Code)	18. MDS	19. TRAUMA	PREV. ADMISSION YEAR / NO
			X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ER A		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
N/A (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
XFR	(b)(3)-1	030401 1830

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030405

FOR LOCAL USE

GSW (R) leg

Inj Trauma

450 1

Lx 8910

81380

8900

94525

E9912 + E9248

Proc 9659

ADMITTING OFFICER (Signature, as required) (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 298

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is D[illegible]

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4				
4. SEX: m	5. AGE: 13 Y	6. RACE	7.	9. ETS	10. PREVIOUS ADMISSION
11. FMP	12. SSN: (b)(6)-4		13. ORGANIZATION		14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN: EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) eye
Head Injury GC 5-3
mangled (R) foot

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) [b(3)-1] | 2. MTF LOCATION (7–8) (State or Country Code.)

3. REGISTER NUMBER (9–15) [b(6)-4] | NAME [b(6)-4] | 4. PAY GRADE (16–17) | 5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26): 1 9 9 0 0 1 0 1 | 7. AGE AT ADMISSION (27–29): 1 3 | 8. RACE (30) | 9. ETHNIC BACKGROUND (31) | RELIGION: N.S.

10. LENGTH OF SERVICE (32–34) | ETS | 11. FMP (35–36): 2 0 | [b(6)-4]

ORGANIZATION (Active Duty Only) | 13. MARITAL STATUS (46) | HOUR OF ADMISSION: 1020 | BRANCH / CORPS

14. FLYING STATUS (47–49) | 15. BENEFICIARY CATEGORY (50–52): EPW | 16. ZIP CODE OF RESIDENCE (53–61)

17. UNIT LOCATION (State or Country Code) (62–63) | 18. MOS (64–70) | 19. TRAUMA (71) | PREV. ADMISSION: YEAR | NO: X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) | WARD: ICU3 | NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY | TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): XFR | 22. MTF TRANSFERRED TO [b(3)-1] (75–80) | 23. DATE OF DISPOSITION (YYMMDD) (81–86): 0 3 0 4 0 6 1800

24. CLINIC SVC - ADMITTING (87–90) | 25. MTF TRANSFERRED FROM (91–96) | 26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104) | 28. MTF OF INITIAL ADMISSION (105–110) | 29. DATE INITIAL ADMISSION (YYMMDD) (111–116): 0 3 0 4 0 6

FOR LOCAL USE

(1) GSW (L) eye
(2) Head injury GCS (3)
(3) Multiple (R) foot

DX: 8715
8739
95977
E9912

ADMITTING OFFICER (Signature, as re[illegible]) [b(6)-2] | SIGNATURE OF ADMITTING CLERK [b(6)-2]

DA FORM 2985, MAR 89 | EDITION OF MAY 79 IS OBSOLETE | USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. REDGRON	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
m							
11. EMP	(b)(6)-4		13. ORGANIZATION			14. WARD	
20							
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
		K78					
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION	23. CLINIC SERVICE			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION			
				03-04-10			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION		ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	
				03-04-06			

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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

35. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE: U / P / R X | 5. GRADE

6. AGE: 25 | 7. SEX: X MALE / FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F): AMBUL X / LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 14b. ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #3 | 15a. DESTINATION FACILITY | 15B. DESTINATION FACILITY PHONE NUMBER | 16. # OF ATTENDANTS: 16a. MED Ø / 16b. NON-MED Ø

17. DIAGNOSIS: S/P GSW (L) foot / (R) thigh

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Bleeding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 6 APR 03 | 20b. TIME: 1730 | 20c. ALLERGIES: NKDA

20d. DIET: X REG | DIABETIC | CARDIAC | CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	ORTHO BRACES
NG TUBE		IV PUMP	CHEST/HEIMLICH
STRYKER		TRACH	RESTRAINTS
INCUBATOR		MONITOR	OTHER (USE 23)

OXYGEN: PERCENT cc LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS	X	XRAYS	OTHER:
X INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Tylenol 650mg p.o. Q6H

Keflex 500mg p.o. QID

21. PRE-FLIGHT VITALS

21a. DATE / TIME: | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE

a 25 y.o. Iraqi POW S/P GSW (L) foot / (R) thigh S/P debridement EST 5 APR 03 Pt. stable for transport.

23. ASSESSMENT / PROGRESS NOTES

DATE / TIME

24. (b)(6)-2 SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19780101	27			MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1020	A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	KTZ EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	IGU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
XFR	(b)(3)-1	030401 0500

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030406

FOR LOCAL USE GSW (L) FOOT + (R) T-thigh

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

For use of this form, see AR 40-400; the proponent agency is U [illegible]

1. (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP: 20	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN: 178	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-07
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION / ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INITIAL ADMISSION: 03-04-06 / 32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
(b)(6)-4				U P R X	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/ALTH #
32	X MALE / FEMALE			AMBUL X / LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS
			16a. MED / 16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3	15B. DESTINATION FACILITY PHONE NUMBER	Ø / Ø

17. DIAGNOSIS
GSW ① Shoulder, ② thigh
s/p ex lap @ forearm, ③ leg

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. / PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
6APR03	1600	NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER *(Specify)*
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	TRACTION		FOLEY CATH
SUCTION			ORTHO BRACES
NG TUBE		IV PUMP	CHEST/HEIMLICH
STRYKER		TRACH	RESTRAINTS
INCUBATOR		MONITOR	OTHER *(USE 23)*

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS
Keflex 500 po qid
IVF LR @ 125 ml/hr.

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.		X	Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		X	Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE
32 y.o. ♂ s/p multiple GSW's
s/p ex lap, s/p wash out,
stable on x-port.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. S (b)(6)-2 NG PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6	7 8	9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC / BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 7 1 0 1 0 1	3 2 4		9	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	(b)(6)-4
		2 0	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1020	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8 EPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
O E.R.		
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
KFR		0 3 0 4 0 7 0830

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 6

FOR LOCAL USE

GSW to L Shoulder L thigh
Shrapnel to R forearm, R leg

450 1

(b)(6)-2

ADMITTING OFFICER (Signature, as required) (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FOR EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	35					

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20	(b)(6)-4		

16. FLYING STATUS	18. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW KAG			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	26. TYPE DISPOSITION	28. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LVICOOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LVICOOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-4 [redacted]

1. NAME (Last, First, Middle Initial) (b)(6)-4 [redacted] | 2. SSN | 3a. STATUS EPW | 3b. SERVICE Army | 4. PRECEDENCE U P (R) | 5. GRADE

6. AGE 23 | 7. SEX ☒ MALE ☐ FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5R) AMBUL ☒ LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4 [redacted]

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS

(R) open tib/fib Fx

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE | 20b. TIME | 20c. ALLERGIES

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT
SUCTION | TRACTION | FOLEY CATH
NG TUBE | IV PUMP | ORTHO BRACES
STRYKER | TRACH | CHEST/HEIMLICH
INCUBATOR | MONITOR | RESTRAINTS
OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT
OUTPATIENT RECORDS | XRAYS | OTHER:
INPATIENT RECORDS | OB
NARRATIVE SUMMARY | DENTAL
FINANCIAL

20i. MEDICATIONS / TREATMENTS

IV-D c FLT

Post-op splint

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE

(R) open tibia/fibula fx

23. ASSESSMENT / PROGRESS
DATE / TIME | NOTES

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

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES E[redacted]ion)

ADMISSION AND CODING INFORMATION

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

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

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

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

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) 1 9 6 8 0 1 0 1

7. AGE AT ADMISSION (27 28 29) 3 5 Y

8. RACE (30)

9. ETHNIC BACK-GROUND (31) 9

RELIGION: M v S.

10. LENGTH OF SERVICE (32 33 34)

ETS

11. FMP (35 36) 2 0

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46)

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS (47 48 49)

15. BENEFICIARY CATEGORY (50 51 52) K 7 8 EPW

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) B

PREV. ADMISSION — YEAR — X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) EmT

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73 74) XFR

22. MTF TRANSFERRED TO (b)(3)-1 (75 76 77 78 79 80)

23. DATE OF DISPOSITION (Y Y M M D D) (81 82 83 84 85 86) 0 3 0 4 1 0 0500

24. CLINIC SVC - ADMITTING (87 88 89 90)

25. MTF TRANSFERRED FROM (91 92 93 94 95 96)

26. DATE THIS ADMISSION (Y Y M M D D) (97 98 99 100 101 102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103 104)

28. MTF OF INITIAL ADMISSION (105 106 107 108 109 110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111 112 113 114 115 116) 0 3 0 4 0 6

FOR LOCAL USE

GSW (R) Lower Leg Dx: 82392 E9712

Trauma

Dx: 8202

IM Nail

450

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 7[illegible] USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE			ETS	10. PREVIOUS ADMISSION
M	30					

11. FMP 20	12. SSN	13. ORGANIZATION	14. WARD

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) S. Houlder

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CONV CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CONV CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (Last, First, Middle Initial) (b)(6)-4 | SSN | 3a. STATUS: EPW | 3b. SERVICE | 4. PRECEDENCE: U / P / R ✓ | 5. GRADE

6. AGE: 32 | MALE ✓ / FEMALE | BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F): AMBUL ✓ / LITTER | 11. ACCEPTING MO | (b)(6)-4 #

13. APPT/SURG DATE: 6 April 08 | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS: 16a. MED 1 / 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3 | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS: GSW - (L) shoulder / chest (R) LOC

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE: 6 APR 08 | 20b. TIME: 1500Z | 20c. ALLERGIES: NONE

20d. DIET: REG | 3GM NA | CARDIAC | DIABETIC | CALS

RENAL: Gm Prot ___ Gm Na ___ MagK ___ mg PO4 ___

NPO | TUBE TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ | OTHER (Specify)

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

✓	SUCTION		TRACTION	FOLEY CATH
	NG TUBE		IV PUMP	ORTHO BRACES
	STRYKER		TRACH	CHEST/HEIMLICH
	INCUBATOR		MONITOR	RESTRAINTS
				OTHER (USE 23)

OXYGEN: PERCENT or LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / (No) feet

20h. RECORDS TO ACCOMPANY PATIENT

✓	OUTPATIENT RECORDS	✓	XRAYS	OTHER:
✓	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

IVF LR @ 100 cc/hr.

S/P EX LAP TODAY

Rocephin 1gm IV Q24° x 3 days (starting 6 APR)

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME: 6 APR 08 | 21b. TEMP: | 21c. PULSE | 21e. BP: 128/73

21d. RESP: 20

22. BRIEF NARRATIVE

S/P GSW (L) chest / shoulder

S/P EX LAP

S/P splenectomy

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES
6 APR	EX LAP Done. NO DECOMPRESSIVE Tube
	A/B:

24. STAMP (b)(6)-2

F Form

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

110

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) | 2. MTF LOCATION (7–8) (State or Country Code) | (b)(3)-1

3. REGISTER NUMBER (9–15) | (b)(6)-4 | (b)(6)-4

4. PAY GRADE (16–17)

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 19730101

7. AGE AT ADMISSION (27–29): 304

8. RACE (30)

9. ETHNIC BACK-GROUND (31)

RELIGION: Must Mus

10. LENGTH OF SERVICE (32–34)

ETS

11. FMP (35–36): 20

12. SOCIAL SECURITY NUMBER (37–45) | (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46)

HOUR OF ADMISSION: 1905

BRANCH / CORPS

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52): KTS EPW

16. ZIP CODE OF RESIDENCE (53–61)

17. UNIT LOCATION (State or Country Code) (62–63): LZ

18. MOS (64–70)

19. TRAUMA (71): B

PREV. ADMISSION: YEAR | X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): O

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY | (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): XFR

22. MTF TRANSFERRED T (75–80) | (b)(3)-1

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 030410 0500

24. CLINIC SVC - ADMITTING (87–90)

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (Y Y M M D D) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104): LZ

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116): 030406

FOR LOCAL USE

GSW (L) shoulder

Trauma

Orders 450

DX: 8300 8911 E9910.

RX: 8021 8202

AD | (b)(6)-2

SIGNATURE OF ADMITTING CLERK | (b)(6)-2

DA FORM 2885, MAR 89

MEDCOM - 2885

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	(b)(6)-4					3. GRADE	ADMISSION REMARKS
(b)(6)-4							
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	(b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) Leg

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
		GFW		U P R	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)–	11. ACCEPTING MD	12. CITE/AUTH #
37	MALE / FEMALE			AMBUL / LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS
			16a. MED / 16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

(L) FEMUR FRACTURE

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER *(Specify)*

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER *(USE 23)*

20g. OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS		XRAYS	OTHER:
INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

20i. MEDICATIONS / TREATMENTS

(L) femur external fixator

I & D

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

(L) distal femur fx

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 A ... al version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19730101	31	W	9	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	(b)(6)-4
		20	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1356Z	EDW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	7CW3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
XPR		030410 0500

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030406

FOR LOCAL USE

GSW left leg

Dx: S72.142A

1

ADMITTING OFFICER (Signature as required) (b)(6)-2	SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 \ EDITION OF MAY 79 IS

MEDCOM - 2888

.NPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is 01.

1. REGISTER NUMBER	2. NAME (Last, First, MI)						3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4							
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN		13. ORGANIZATION				14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K-78 EPW	18. BRANCH/CORPS	19. DIC/ZIP			20. TYPE CASE	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R	5. GRADE
		AD			

6. AGE	7. SEX MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F) AMBUL / LITTER	11. ACCEPTING MD	12. CITE/AUTH # (b)(6)-4
				AMBUL X		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS 16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

(L) AK AMPUTATION FMW. 6JW

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER *(Specify)*

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		FOLEY CATH
	NG TUBE		IV PUMP		ORTHO BRACES
	STRYKER		TRACH		CHEST/HEIMLICH
	INCUBATOR		MONITOR		RESTRAINTS
					OTHER *(USE 23)*

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

(L) MANGLED LEG

Sp (L) AKA

20i. MEDICATIONS / TREATMENTS

(L) AKA

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) | 2. MTF LOCATION (7–8) (State or Country Code.) (b)(3)-1

3. REGISTER NUMBER (9–15) (b)(6)-4 | (b)(6)-4

4. PAY GRADE (16–17) | 5. SEX (18) M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 8 5 | 7. AGE AT ADMISSION (27–29): 1 7 Y | 8. RACE (30) | 9. ETHNIC BACK-GROUND (31) | RELIGION: MVS

10. LENGTH OF SERVICE (32–34) | ETS

11. FMP (35–36): 2 0

12. SOCIAL SECURITY NUMBER (37–45) (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46): 1

HOUR OF ADMISSION: 1905

BRANCH / CORPS

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52): K 7 8 EPW

16. ZIP CODE OF RESIDENCE (53–61)

17. UNIT LOCATION (State or Country Code) (62–63)

18. MOS (64–70)

19. TRAUMA (71): B

PREV. ADMISSION: YEAR | NO ☒

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 2

WARD: FCV3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): XFR

22. MTF TRANSFERRED TO (75–80) (b)(3)-1

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 0 3 0 4 0 7 0800

24. CLINIC SVC - ADMITTING (87–90)

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (Y Y M M D D) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116): 0 3 0 4 0 6

FOR LOCAL USE

(L) Lower Extremity Traumatic Amputation

Dx: 8973 V7912

Trauma

$1,150

ADMITTING OFFICER (Sig (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, M ITION OF MAY 75 APPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1500	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030410

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030406	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(6)-2	0330406	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO SCROTUM

CODING INFOMATION: 991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDDP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDDP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle,Initial) (b)(6)-4	2. SSN (b)(6)-4	3a. STATUS ITAM	3b. SERVICE	4. PRECEDENCE U / P / R X			5. GRADE
6. AGE 32	7. SEX X MALE / FEMALE	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)– AMBUL / X LITTER		11.ACCEPTING MD	12.CITE/AUTH # (b)(6)-4
13.APPT/SURG DATE (b)(6)-4	14a. ORIGINATING FACILITY (b)(3)-1			15a. DESTINATION FACILITY			16. # OF ATTENDANTS 16a. MED 1 16b.NON-MED 0
	14b.ORIGINATING FACILITY PHONE NUMBER ICU #3			15B. DESTINATION FACILITY PHONE NUMBER			

17. DIAGNOSIS

GSW to scrotum and L medial thigh c cellulitis

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 06APR03 | 20b. TIME 1528 (Z) | 20c. ALLERGIES NKDA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC | CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ | OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		FOLEY CATH
	NG TUBE		IV PUMP		ORTHO BRACES
	STRYKER		TRACH		CHEST/HEIMLICH
	INCUBATOR		MONITOR		RESTRAINTS
					OTHER (USE 23)

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°

Percocet 1-2 p.o. Q6° PRN pain

Motrin 800mg p.o. TID PRN pain

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b.TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

S/P GSW x II on 3 Apr 03; Hx to MASH from FST 06 Apr 03 c noted cellulitis around medial thigh wound. Given IV Ancef.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-4

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26 — 1 9 7 1 0 1 0 1	27 28 29 — 3 2 4	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 — 2 0 CPW	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1500Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 — K 7 8	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71 B	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 XPR	75 76 77 78 79 80	81 82 83 84 85 86 — 0 3 0 4 1 0 0500

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 — 0 3 0 4 0 6

FOR LOCAL USE

GSW To Scrotum

(b)(6)-2 | SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE — USAPPC V1.00

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
143	144	145	146	147	148	149	150
	E	9	9	1		2	

37. SECOND DIAGNOSIS							
151	152	153	154	155	156	157	158

38. THIRD DIAGNOSIS							
159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS							
167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS							
175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS							
183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS							
191	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS							
199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*							
207	208	209	210	211	212	213	214

45. SECOND PROCEDURE							
215	216	217	218	219	220	221	222

46. THIRD PROCEDURE							
223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE							
231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE							
239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE							
247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE							
255	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE							
263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

MEDCOM - 2895

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	23		MUS			NO	
11. PMP	12. SSN		13. ORGANIZATION			14. WARD	
						ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ SEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
			EPW			INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0505	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030409

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030407	(b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030407	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW BUTTOCK, THIGH, AND BACK

CODING INFORMATION: 991.9

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial): (b)(6)-4
2. SSN: (b)(6)-4
3a. STATUS
3b. SERVICE
4. PRECEDENCE: U | P | R [X]
5. GRADE
6. AGE: 23
7. SEX: [X] MALE | FEMALE
8. WEIGHT
9. BLOOD TYPE
10. CLASSIFICATION (1A TO 5F): AMBUL | [X] LITTER
11. ACCEPTING MD
12. CITE/AUTH #
13. APPT/SURG DATE
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3
15a. DESTINATION FACILITY
15B. DESTINATION FACILITY PHONE NUMBER
16. # OF ATTENDANTS: 16a. MED: Ø | 16b. NON-MED: Ø

17. DIAGNOSIS

GSW Buttocks, thigh, Back

18. [✓] BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (*Please indicate Yes or No on clinical issues. Explain YES comments in Section 23*)

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.		X	Bowel Problem
b.		X	Cardiac Hx	j.		X	Self-care
c.		X	Diabetes	k.		X	Ambulatory
d.		X	Respiratory	l.		X	Ambulatory Aid
e.		X	Ears/Sinus	m.		X	Self-meds
f.		X	Motion Sick	n.		X	Adequate Supply of Meds
g.		X	Vision Impaired	o.		X	Other:
h.		X	Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 07 April 03
20b. TIME: 0600 Zulu
20c. ALLERGIES: Penicillin
20d. DIET: [X] REG | 3GM NA | CARDIAC | DIABETIC | CALS
RENAL: Gm Prot | Gm Na | MagK | mg PO4
TUBE TYPE: cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (*Specify*)
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr
20e. IV / BLOOD: LR
20f. SPECIAL EQUIPMENT: SUCTION | TRACTION | FOLEY CATH | NG TUBE | IV PUMP | ORTHO BRACES | STRYKER | TRACH | CHEST/HEIMLICH | INCUBATOR | MONITOR | RESTRAINTS | OTHER (*USE 23*)
OXYGEN: PERCENT or LITERS | ROUTE:
VENT SETTINGS:
20g. ALTITUDE RESTRICTION: Yes / No ___ feet
20h. RECORDS TO ACCOMPANY PATIENT: [X] OUTPATIENT RECORDS | INPATIENT RECORDS | NARRATIVE SUMMARY | FINANCIAL | XRAYS | OB | DENTAL | OTHER:

20i. MEDICATIONS / TREATMENTS

Clindamycin 900 mg IVPB q 8°

Morphine 2-4 mg IV q 2° PRN

21. PRE-FLIGHT VITALS

21a. DATE / TIME: 07 April 03
21b. TEMP:
21c. PULSE
21d. RESP:
21e. BP

22. BRIEF NARRATIVE

Pt shot in Buttocks, thigh and Back EPW at detention center. Pt stable now seen at first time wound packed. Will airvac

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN: (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4		M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	8. RACE	9. ETHNIC / BACK-GROUND	RELIGION
(b)(6)-4	19801012 3Y		9	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	5	0505 Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	IW3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
XPR	Najaf	030409 0800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		050407

FOR LOCAL USE

GSW Buttock, thigh, and Back

TRAUMA

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

45

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSO USAPPC V1.00

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1										35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139		140	141	142
2	3	F																		

36. FIRST DIAGNOSIS (Principal Diagnosis)								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166
	E	9	9	1		9																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206

44. FIRST PROCEDURE (Principal Diagnosis)								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
271	272	273	274	275	276	277	278
0	0	0	0				

MEDCOM - 2899

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	41		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
		EPW	ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0750	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030409

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030409	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030409	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO L LOWER EXTREMITY

CODING INFORMATION: E991.2

DX 8910 E9912

Transfer Form 1 450

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19621001	41			Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		0750Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K78	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
EMT	Icu3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
XFR		030409 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION (b)(3)-1	29. DATE INITIAL ADMISSION (Y Y M M D D)
	(b)(3)-1	030409

FOR LOCAL USE

GSW to Left Lower Extremity

ADMITTING OFFICER (Typed) (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM

EDITION OF MAY 79 I

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)						3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4							
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
M	42						NO	
11. FMP	12. SSN			13. ORGANIZATION			14. WARD	
	(b)(6)-4						ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
NO			EPW				INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE			
EMT				0745				
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION			
			XFR		030409			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER	
					030409		MAJ (b)(6)-2	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	
(b)(3)-1					030409			

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO BOTH LEGS/CALFS

CODING INFORMATION: 991.2

Dx 8910
E9912

Inj Trauma
450 1

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COMP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COMP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

[b(6)-4]

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15		16 17	18
[b(6)-4]	[b(6)-4]		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 6 4 0 1 0 1	4 2 Y			Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	[b(6)-4]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		
GPW	M	0745Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
N O	R 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR [X] NO
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		
EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[b(3)-1]		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR	[b(3)-1]	0 3 0 4 0 9 0800

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
	[b(3)-1] [b(3)-1]	0 3 0 4 0 9

FOR LOCAL USE

GSW to both legs / [b(6)-2]

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[b(6)-2]	[b(6)-2]

DA FORM 2985, MAR 89 EDITION OF MAY 79 I USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SH

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

(b)(6)-4			(b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC		9. ETS	10. PREVIOUS ADMISSION	
11. FMP: 20	12. SSN: (b)(6)-4			13. ORGANIZATION			14. WARD	
16. FLYING STATUS	18. RATION OSS	17. DEP'S BEN: F78		18. BRANCH/CORPS		19. UIC/ZIP	20. TYPE CASE	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION.	22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-10	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INITIAL ADMISSION: 03-04-09	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U P R | 5. GRADE

6. AGE | 7. SEX MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) AMBUL LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 14b. ORIGINATING FACILITY PHONE NUMBER 558- (b)(3)-1 | 15a. DESTINATION FACILITY (b)(3)-1 | 15B. DESTINATION FACILITY PHONE NUMBER | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

17. DIAGNOSIS

17yom old Iraqi male
S/P GSW (L) Arm

18. ☑ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 09 April 03 | 20b. TIME 1545 Zulu | 20c. ALLERGIES NKDA

20d. DIET ☑ REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD IV KVO with

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

☑ OUTPATIENT RECORDS		XRAYS	OTHER:
INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

20i. MEDICATIONS / TREATMENTS

An inj 1 gram IVPB
q 6°
Morphine 2-4mg IV
q 2° PRN

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

Pt chart Rt Arm S/P Surgery
at last Arm Tube. Pt awake
Pt awake appears to be
recently post op. S/P FHD
brought out of Rt calcium fx
plan Evac

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

DD Form 3899 (433 AE: Excel version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
(b)(3)-1	

REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19860101	174			

LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1530Z	EPW

FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78	

UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		INJ	YEAR / X NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O ERA		

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
XFR		030410 0500

CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030409 0735

LOCAL USE

DX: GSW R/ARM

DX 8840
E9412

Inj Forearm
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	SPC (b)(6)-2

FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4				
4. SEX: m	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP: 20	12. SSN: (b)(6)-4		13. ORGANIZATION			14. WARD
16. FLYING STATUS	18. RATING/ DSG	17. DEPT./ SERV: XT8	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INITIAL ADMISSION: 03-04-07	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

(b)(3)-1

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U P R | 5. GRADE

6. AGE | 7. SEX ☐MALE ☐FEMALE | 8.WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) AMBUL ☐LITTER | 11.ACCEPTING MD | 12.CITE/AUTH # (b)(6)-4

13.APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b.NON-MED

14b.ORIGINATING FACILITY PHONE NUMBER | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS

OSC (L) ankle sprain

18: ☐BATTLE CASUALTY ☐DISEASE ☐NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE | 20b. TIME | 20c. ALLERGIES

20d. DIET ☐REG ☐3GM NA ☐CARDIAC ☐DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr. 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION	TRACTION	FOLEY CATH
	NG TUBE	IV PUMP	ORTHO BRACES
	STRYKER	TRACH	CHEST/HEIMLICH
	INCUBATOR	MONITOR	RESTRAINTS
			OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	XRAYS	OTHER:
☐	INPATIENT RECORDS	OB	
	NARRATIVE SUMMARY	DENTAL	
	FINANCIAL		

20i. MEDICATIONS / TREATMENTS

Ciprofloxacin 750 mg PO q 8h

morphine 1-4 mg IV/IM q 3-4h PRN pain

Phenergan 25 mg IV q 4-6h PRN

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	l.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b.TEMP: 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE

yo A w/ sharpnel injury to (L) ankle 2 days ago

PT. referred ortho for further care

Pt. will require surgery for his (L) ankle

23. ASSESSMENT / PROGRESS

DATE / TIME NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

DR. ORTHOPEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

[b(3)-1]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
[b(3)-1]	

REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[b(6)-4]	[b(6)-4]		M

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC	RELIGION
19760701	46Y		BACK-GROUND	MOS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	[b(6)-4]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1745	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[b(3)-1] IRAQ	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
XFR	[b(3)-1]	030410 0500	

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030407

FOR LOCAL USE

Shrapnel Injury
(L) Ankle ? Intra-articular
fragment

Dr 3911 In Trauma
4413 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[b(6)-2]	[b(6)-2]

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20	(b)(6)-4		

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BDN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		KTS			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03-04-10

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	03-04-07	

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4 (b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4
2. SSN
3a. STATUS
3b. SERVICE
4. PRECEDENCE U P R 2
5. GRADE

6. AGE 33
7. SEX ✓MALE FEMALE
8. WEIGHT
9. BLOOD TYPE
10. CLASSIFICATION (1A TO 5F) ✓AMBUL LITTER
11. ACCEPTING MD
12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE
14a. ORIGINATING FACILITY (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)-1
15a. DESTINATION FACILITY
15B. DESTINATION FACILITY PHONE NUMBER
16. # OF ATTENDANTS 16a. MED 16b. NON-MED

17. DIAGNOSIS
GSW (L) Ring Finger/ Hand
... finger

18. ✓BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (*Please indicate Yes or No on clinical issues. Explain YES comments in Section 23*)

	YES	NO	ISSUE		YES	NO	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.		✓	Cardiac Hx	j.		✓	Self-care
c.		✓	Diabetes	k.		✓	Ambulatory
d.		✓	Respiratory	l.		✓	Ambulatory Aid
e.		✓	Ears/Sinus	m.		✓	Self-meds
f.		✓	Motion Sick	n.		✓	Adequate Supply of Meds
g.		✓	Vision Impaired	o.		✓	Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS
20a. DATE 09 ... 03
20b. TIME 2106 Z
20c. ALLERGIES

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC CALS
NPO RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (*Specify*)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT
SUCTION | TRACTION | FOLEY CATH
NG TUBE | IV PUMP | ORTHO BRACES
STRYKER | TRACH | CHEST/HEIMLICH
INCUBATOR | MONITOR | RESTRAINTS
OTHER (*USE 23*)
OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT
OUTPATIENT RECORDS | ✓XRAYS | OTHER:
✓INPATIENT RECORDS | OB
NARRATIVE SUMMARY | DENTAL
FINANCIAL

20i. MEDICATIONS / TREATMENTS
Cefoxitin 1 gm IVPB q6h
Morphine 1-4 mg IV/IM q4-6 hr prn
Phenergan 25mg iv q4-6h prn

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE
33 y/o ... c 2 day old ...
... to (L) ...
Pt. ... to ... for further treatment.

23. ASSESSMENT / PROGRESS
DATE / TIME | NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN/M.D.
(b)(6)-2
... ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — (b)(3)-1 [redacted]

2. MTF LOCATION: 7 8 *(State or Country Code.)*

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4 [redacted]

NAME *(Last, First, Middle Initial)*: (b)(6)-4 [redacted]

(b)(6)-4 [redacted]

4. PAY GRADE: 16 17

5. SEX: 18 — M

6. DATE OF BIRTH *(YYYYMMDD)*: 19 20 21 22 23 24 25 26 — 1 9 7 0 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 3 3 Y

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION: Mus

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 — 2 0

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4 [redacted]

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 1745 z

BRANCH / CORPS: EPW

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8 — EPW

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 — B

PREV. ADMISSION: YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — ERA

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — XFR

22. MTF TRANSFERRED TO: 75 76 77 78 — (b)(3)-1 [redacted]

23. DATE OF DISPOSITION *(YYMMDD)*: 81 82 83 84 85 86 — 0 3 0 4 1 0 — 0500

24. CLINIC SVC - ADMITTING: 87 88 89 90

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION *(YYMMDD)*: 97 98 99 100 101 102

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*: 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION *(YYMMDD)*: 111 112 113 114 115 116 — 0 3 0 4 0 7

FOR LOCAL USE

GSW (L) Index finger

Infection r.t.

(b)(6)-4 [redacted]

Dx 8831

E9912

Px 9921

450 1

ADMITTING OFFICER *(Signature, as required)*: (b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK: Spc (b)(6)-2 [redacted]

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4				
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M							
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
20	(b)(6)-4						
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
					03-04-10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	
					03-04-07		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U P R ✓ | 5. GRADE

6. AGE 33 | 7. SEX ✓MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) AMBUL ✓ LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)-1 | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS
GSW Right Humeral open
(L) Hemothorax.

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.		✓	Cardiac Hx	j.		✓	Self-care
c.		✓	Diabetes	k.		✓	Ambulatory
d.		✓	Respiratory	l.		✓	Ambulatory Aid
e.		✓	Ears/Sinus	m.		✓	Self-meds
f.		✓	Motion Sick	n.		✓	Adequate Supply of Meds
g.		✓	Vision Impaired	o.		✓	Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS
20a. DATE 09 APR 03. | 20b. TIME 2117 Z. | 20c. ALLERGIES
20d. DIET NPO | REG | 3GM NA | CARDIAC | DIABETIC | CALS | RENAL Gm Prot Gm Na MagK mg PO4 | TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH | PEDIATRIC: AGE | OTHER (Specify) | TPN: Change to D10 at cc/hr for max of days | TUBE FEEDING: at strength at cc/hr
20e. IV / BLOOD
20f. SPECIAL EQUIPMENT: SUCTION | NG TUBE | STRYKER | INCUBATOR | TRACTION | IV PUMP | TRACH | MONITOR | FOLEY CATH | ORTHO BRACES | CHEST/HEIMLICH | RESTRAINTS | OTHER (USE 23)
OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:
20g. ALTITUDE RESTRICTION: Yes / No feet
20h. RECORDS TO ACCOMPANY PATIENT: OUTPATIENT RECORDS | ✓ INPATIENT RECORDS | NARRATIVE SUMMARY | FINANCIAL | ✓ XRAYS | OB | DENTAL | OTHER:

20i. MEDICATIONS / TREATMENTS
(1) (L) Posterolateral Thoracotomy & Decortication
Cefoxitin 1gm IVPB q 6h
morphine 2-4mg IM/IV q 4-6h PRN pain
Phenergan 25mg IV q 4-6h PRN
(2) I&D (R) Humerus & External Fixator

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21d. RESP: | 21e. BP

22. BRIEF NARRATIVE
33 y/o EPW.
s/p GSW to (R) humerus and (L) chest.
5 days ago.
Pt. has chest tube.
Pt. is referred to [illegible] for further care.
(needs out of (R) arm Fx + Ex Fix)
Pt will require surgery to (R) arm.

23. ASSESSMENT / PROGRESS
DATE / TIME | NOTES

24. S (b)(6)-2 M.D.
ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

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

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

4. PAY GRADE: 16 17
5. SEX: 18 — M

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26 — 1 9 7 0 0 1 0 1
7. AGE AT ADMISSION: 27 28 29 — 3 3 Y
8. RACE: 30
9. ETHNIC BACKGROUND: 31
RELIGION: MUS

9. LENGTH OF SERVICE: 32 33 34
ETS:
11. FMP: 35 36 — 2 0
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: 46
HOUR OF ADMISSION: 1795Z
BRANCH / CORPS: EPW

14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8 — EPW
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 — I — INJ
PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — O
WARD: ICU 3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

21. TYPE OF DISPOSITION: 73 74 — XFR
22. MTF TRANSFERRED TO: (b)(3)-1 — 75 76 77 78 79 80
23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86 — 0 3 0 4 1 0 — 0500

24. CLINIC SVC - ADMITTING: 87 88 89 90
25. MTF TRANSFERRED FROM: 91 92 93 94 95 96
26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104
28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110
29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116 — 0 3 0 4 0 7

FOR LOCAL USE

Opn GSW Rt humerus
Inj Trauma
450 1

Dx: 81230 8602 E9912
Pr: 2961 3891/2 3404

ADMITTING OFFICER (Signature, as required): (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE — USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4				
4. SEX: M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP: 20	12. SSN: (b)(6)-4	13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSB	17. DEPT./ SEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY			30. DATE OF INTIAL ADMISSION: 030405	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE: U P R X | 5. GRADE

6. AGE: 37 | 7. SEX: X MALE / FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F): AMBUL / X LlitTER | 11. ACCEPTING MD | 12. CITE/ALITH # (b)(6)-4

13. APPT/SURG DATE: (b)(6)-4 | 14a. ORIGINATING FACILITY: (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS: 16a. MED | 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER: ICU # 3558 (b)(3)-1 | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS

GSW @ flank s/p ex lap

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 10 APR 03 | 20b. TIME: 0410 | 20c. ALLERGIES: NKA

20d. DIET: REG | 3GM NA | CARDIAC | DIABETIC | CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER *(Specify)*
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER *(USE 23)*

OXYGEN: PERCENT or LITERS | ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
X	INPATIENT RECORDS	X	OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Cefoxitin 2gm IVQ8°
MSO4 2-4mg IVQ2° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

22. BRIEF NARRATIVE

37 y.o. Iraqi from GSW comp c h/o abd GSW. Pt. taken for ex lap, found to have small liver lac. Pt. stable for E-S pt

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. S (b)(6)-2

FF:

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1	REPORTING MTF	2	MTF LOCATION
1-6	(b)(6)-2	7-8	(State or Country Code)

3	REGISTER NUMBER	NAME (Last, First, Middle Initial)	4	PAY GRADE	5	SEX
9-15	(b)(6)-4	(b)(6)-4	16-17		18	M

19	DATE OF BIRTH (YYYYMMDD)	7	AGE AT ADMISSION	8	RACE	9	ETHNIC BACKGROUND	RELIGION
19-26	19660701	27-29	37Y	30		31		MUS

32	LENGTH OF SERVICE	ETS	11	FMP	12	SOCIAL SECURITY NUMBER
32-34			35-36	20	37-45	(b)(6)-4

ORGANIZATION (Active Duty Only)	13	MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	I	1745	EPW

47	FLYING STATUS	15	BENEFICIARY CATEGORY	16	ZIP CODE OF RESIDENCE
47-49		50-52	K78 CPW	53-61	

62	UNIT LOCATION (State or Country Code)	18	MOS	19	TRAUMA	PREV. ADMISSION
62-63		64-70		71	B INJ	YEAR / NO ☒

72	SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ERA	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

73	TYPE OF DISPOSITION	22	MTF TRANSFERRED TO	23	DATE OF DISPOSITION (YYMMDD)
73-74	XFR	75-80	(b)(3)-1	81-86	030410 0500

87	CLINIC SVC - ADMITTING	25	MTF TRANSFERRED FROM	26	DATE THIS ADMISSION (YYMMDD)
87-90		91-96		97-102	

103	LOCATION OF OCCURRENCE (Battle Casualty Only)	28	MTF OF INITIAL ADMISSION	29	DATE INITIAL ADMISSION (YYMMDD)
103-104		105-110		111-116	030405

LOCAL USE

DX CSW to RLQ ABD

DX 86410 PX 99111

INJ TRAUMA

450 1

ADMITTING OFFICE	(b)(6)-2	SIGNATURE OF ADMITTING CLERK	(b)(6)-2
		Epc	

DA FORM 2981

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
			MUS			Ø	
11. FMP		12. SSN		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
						INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1ØØØZ	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		Ø3 Ø4 1Ø
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	**27b. TELEPHONE NO.**	**28. DATE OF THIS ADMISSION** / **ADMITTING OFFICER**
		Ø3 Ø4 1Ø
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	**30. DATE OF INITIAL ADMISSION**	**32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED**
(b)(3)-1	Ø3 Ø4 1Ø	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

(b)(6)-4

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS | SERVICE | [redacted] PRECEDENCE X R | 5. GRADE

6. AGE 35 | 7. SEX X MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | CLASSIFICATION | AMBUL | ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/ORIG DATE | ORIGINATING FACILITY (b)(3)-1 | 15a. DEST (b)(3)-1 | CITY | 16. # OF ATTENDANTS | 16a. MED | 16b. NON-MED

ORIGINATING FACILITY PHONE NUMBER: Icu #3 558-(b)(3)- Grnr | 15b. DEST FACILITY PHONE NUMBER

17. DIAGNOSIS

(R) Eye (R) face injury
(R) eye orbital blowout fracture,
(R) maxillary open fracture

18. X BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

20. ORDERS

20a. DATE 10 APR 03 | TIME 0630 | 20c. ALLERGIES NKDA

20d. DIET | REG | NA | CARDIAC | DIABETIC | RENAL | Prot | Mag | mg | TUBE | cc/hr, 1/2, 3/4, FULL STRENGTH | MEDIATE | OTHER (Specify) | TPN | 10 at | cc/hr max | TUBE | at | strength

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT | SUCTION | TRACTION | NG TUBE | MONITOR | OXYGEN | or | LITERS | ROUTE

20g. ALTITUDE | Yes / No

20h. RECORDS | ANY FILM | RECORDS | XRAY | OTHER | RDS | OB | MARY | DENT

20i. MEDICATIONS / TREATMENTS

Cefoxitin 2 gm IV q8
MSO4 2-4 IV Q1° PRN (b)(6)-2

19. CLINICAL (Please indicate Yes or No on clinical issues. Explain YES comments in section 23)

	YES	NO	
i.			Bowel Problem
j.			Self-care
k.	X		Ambulatory
l.			Ambulatory Aid
m.			Self-meds
n.			Adequate Supply of Meds
o.			Other:

g. X

PRE-FLIGHT VITALS: 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE

35 y/o c penetrating wound to (R) face / (R) eye
Pt is awake & breathing
Transfer to Rear ASAP
Pt. needs ENT & oral-maxillofacial surgery

23. DATE | ASSESSMENT / PROGRESS NOTES

10 Apr Transferred from FST to (b)(3)-1

(b)(6)-2

25. NAME (b)(6)-2 SURGEON

ADMISSION AND CODING INFORMATION

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

1. ING MTF	2. MTF LOCATION	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6	7 8 (State or Country Code)	9 10 11 12 13 14 15	[b(6)-4]	16 17	18
[b(3)-1]		[b(6)-4]			M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	Muslim
1 9 6 8 0 1 0 1	3 5 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	[b(6)-4]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	10 00Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8 EPW	

17. UNIT LOCATION (State or Country Code)	18. MDS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR / NO
		B	X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
0 EMT		

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[b(3)-1]	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	DATE OF DISPOSITION (YYMMDD)
73 74	75 76 77	81 82 83 84 85 86
2 1	[b(3)-1]	0 3 0 4 1 0 1253

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 0

FOR LOCAL USE

® eye + ® face injury Blood injury Dx: 8026 Pr: 9921
8025
E 9419

1 Inj 449 Trauma 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[b(6)-2]	[b(6)-2]

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS O USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU 3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
	1040	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03 04 10

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		03 04 10	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	03 04 10	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CODP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CODP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

1. NAME (Last, First, Middle Initial) [b)(6)-4]		2. SSN		3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R X		5. GRADE	[b)(6)-4]
6. AGE 35	7. SEX X MALE / FEMALE	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F) AMBUL / X LITTER		11.ACCEPTING MD		12.CITE/AUTH # [b)(6)-4]	
13.APPT/SURG DATE	14a. ORIGINATING FACILITY [b)(3)-1]			15a. DESTINATION FACILITY [b)(3)-1]		16. # OF ATTENDANTS			
	14b.ORIGINATING FACILITY PHONE NUMBER ICU #3			15B. DESTINATION FACILITY PHONE NUMBER		16a. MED Ø	16b.NON-MED Ø		

17. DIAGNOSIS

GSW ⓛ buttocks

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
10 APR 03	1000	NKA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER (USE 23)

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Ancef 1gm IV Q8°

Percocet 1-2 p.o. Q6° PRN pain

MSO4 2-4mg FV Q2° PRN

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	l.		/	Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b.TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

35 y.o. ♂ c. GSW ⓛ buttocks. Proctoscopy reveals ↓ rectal involvement. PT. stable for X-port

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

[b)(6)-2] G PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6	7	8
(b)(3)-1 [redacted]							

2. MTF LOCATION *(State or Country Code.)*

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4 [redacted]						

NAME *(Last, First, Middle Initial)*

(b)(6)-4 [redacted]

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26
1	9	6	8	0	1	0	1

7. AGE AT ADMISSION

27	28	29
3	5	Y

8. RACE

30

9. ETHNIC BACKGROUND

31

RELIGION

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
2	0

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4 [redacted]								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46

HOUR OF ADMISSION

1040

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
B

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
O

WARD

3ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(3)-1 [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74

XFR

22. MTF TRANSFERRED TO

(b)(3)-1 [redacted]

75	76	77	78	79	80

23. DATE OF DISPOSITION *(YYMMDD)*

81	82	83	84	85	86
0	3	0	4	1	0

1253

24. CLINIC SVC - ADMITTING

87	88	89	90

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(YYMMDD)*

97	98	99	100	101	102

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION *(YYMMDD)*

111	112	113	114	115	116
0	3	0	4	1	0

FOR LOCAL USE

Dx GSW to (L) buttock (Dx 8770 Pr [illegible])

ADMITTING OFFICER *(Signature, as required)*

(b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK

(b)(6)-2 [redacted]

DA FORM 2985, 1[redacted] EDITION OF MAY 79 IS OBSO[redacted] USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU 3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
	1040	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03 04 10

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		03 04 10	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	03 04 10	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

1. NAME (L (b)(6)-4 nitial) | 2. SSN | TYPE | 3a. STATUS: EPW | 4. PRECEDENCE U P (R) | 5. GRADE

6. AGE ~28 | 7. SEX (X) MALE / FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION: AMBUL X | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | ORIGINATING FACILITY (b)(3)-1 | 15a. DEST (b)(3)-1 | 16. # OF ATTENDANTS | 16a. MED Ø | 16b. NON-MED Ø

ORIGINATING FACILITY PHONE NUMBER: Facility 858 (b)(3)-1 | 15B. DEST FACILITY PHONE NUMBER

17. DIAGNOSIS

GSW (L) shoulder
(L) thigh wound

18. (X) BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE: 10 April 03 | TIME: 0700Z | 20c. ALLERGIES

20d. DIET: REG / RENAL / TUBE / PEDIATRIC / TPN / TUBE FEEDING

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT: SUCTION / TRACTION / IV PUMP / TRACH / MONITOR

OXYGEN: ___ or LITERS ___ ROUTE

20g. ALTITUDE RESTRICTION: Yes / No

20h. RECORDS TO ACCOMPANY PATIENT: X RECORDS X | XRAY | OB | DENT | OTHER

20i. MEDICATIONS / TREATMENTS

MSO4 2-4mg IV Q4h PRN
Ancef 1g IV Q8h

19. CLINICAL ISSUES: Please indicate Yes or No on clinical issues. Explain YES comments in section 23)

	YES	NO			YES	NO	
a.		✓		i.		✓	Bowel Problem
b.		✓		j.		✓	Self-care
c.		✓		k.		✓	Ambulatory
d.		X		l.		X	Ambulatory Aid
e.		X		m.		X	Self-meds
f.		✓		n.		X	Adequate Supply of Meds
g.		✓	Oxygen required	o.		X	Other:
h.		X		p.			

21. PRE-FLIGHT VITALS
21a. DATE | 21b. TEMP: | 21c. PULSE | 21d. RESP: | 21e. BP

22. BRIEF NARRATIVE

EPW s/p GSW to (L) shoulder and (L) thigh wound, s/p I&D.

23. DATE | ASSESSMENT / PROGRESS NOTES

24. STAMP ... (b)(6)-2 | 25. ... | SIGNATURE OF FLIGHT SURGEON

AF Form 3899

MEDCOM - 2926

(b)(6)-4 | (b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

REGISTER NUMBER (9–15)	NAME (Last, First, Middle Initial)	4. PAY GRADE (16–17)	5. SEX (18)
(b)(6)-4	(b)(6)-4		M

DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
19750101	28Y			

LENGTH OF SERVICE (32–34)	ETS	11. FMP (35–36)	12. SOCIAL SECURITY NUMBER (37–45)
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
		1040	

14. FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	R 7 8 EPW	

17. UNIT LOCATION (State or Country Code) (62–63)	18. MOS (64–70)	19. TRAUMA (71)	PREV. ADMISSION YEAR / NO
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D EMT	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80) (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD) (81–86)
XFR		030401 1253

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030401

FOR LOCAL USE

Dx GSW to Abdomen and (L) thigh

Dx 8000 Proc: 8900 E9912

USO 1

ADMITTING OFFICER (Signature, (b)(6)-2 | (b)(6)-2

DA FORM 2985, MAR 8 EDITION OF MAY 79 IS OB USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03-04-11

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	03-04-10	

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

(b)(6)-4

(b)(6)-4

2. SS

3a. STATUS: SPW

3b. SERVICE

4. PRECEDENCE: U | P | R

5. GRADE

AGE | 7. SEX: MALE / FEMALE | 8. WEIGHT | 9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F) — AMBUL / LITTER: X

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

APPT/SURG DATE

14a. ORIGINATING FACILITY: 212TH MASH

14b. ORIGINATING FACILITY PHONE NUMBER: 558-4987

15a. DESTINATION FACILITY (b)(3)-1

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED | 16b. NON-MED

DIAGNOSIS

(1) GSW chest

(2) GSW femur

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voice Prob.				

BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

PHYSICIANS ORDERS

DATE | 20b. TIME | 20c. ALLERGIES

DIET: REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ Mag ___ mg PO4

TUBE TYPE ___ cc/hr 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE | OTHER (Specify)

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength ___ cc/hr

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP

21d. RESP:

22. BRIEF NARRATIVE

GSW chest & (L) femur

prior treatment (chest)

c F/T

IV / BLOOD

SPECIAL EQUIPMENT: SUCTION | NASO-TUBE | STRYKER | INCUBATOR | TRACTION | IV PUMP | TRACH | MONITOR | FOLEY CATH | ORTHO BRACES | VEST/HEIMLICH | RESTRAINTS | OTHER (USE 23)

OXYGEN: PERCENT or LITERS | ROUTE

VENT SETTINGS:

ALTITUDE RESTRICTION: Yes / No ___ Feet

RECORDS TO ACCOMPANY PATIENT: OUTPATIENT RECORDS | INPATIENT RECORDS | NARRATIVE SUMMARY | FINANCIAL | XRAY | CB | DENTAL | OTHER:

MEDICATIONS / TREATMENTS

(1) Ex fixator (L) femur c I&D

(2) Re-I&D (R) chest

(3) Initial debridement (R) chest - (FST)

23. DATE / TIME | ASSESSMENT / PROGRESS NOTES

(b)(6)-2

24. STAMP AND SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

DD Form 3899 ... ES Ex...

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1
2. MTF LOCATION (7–8) (State or Country Code)
3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE (16–17):
5. SEX (18): M
6. DATE OF BIRTH (YYYYMMDD) (19–26): 19740101
7. AGE AT ADMISSION (27–29): 33Y
8. RACE (30):
9. ETHNIC BACK-GROUND (31):
RELIGION: MOS
10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 20
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46):
HOUR OF ADMISSION: 1900Z
BRANCH / CORPS: EPW
14. FLYING STATUS (47–49):
15. BENEFICIARY CATEGORY (50–52): K78
16. ZIP CODE OF RESIDENCE (53–61):
17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–71):
19. TRAUMA:
PREV. ADMISSION: YEAR: ; ND: X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72):
WARD: ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION (73–74): XFR
22. MTF TRANSFERRED TO (75–78): (b)(3)-1
23. DATE OF DISPOSITION (YYMMDD) (81–86): 030411 0630
24. CLINIC SVC - ADMITTING (87–90):
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION (YYMMDD) (97–102):
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION (YYMMDD) (111–116): 030410
FOR LOCAL USE

OGSW Rt ChA
(2) Femur fracture

ADMITTING OFFICER (Signature, as required): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2965, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SI

For use of this form, see AR 40-400; the proponent agency is U[illegible]

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 80	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-11		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INITIAL ADMISSION 03-04-10		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (Last, First, Middle Initial) (b)(6)-4
2. SSN (b)(6)-4
3a. STATUS: Iraqi
3b. SERVICE
4. PRECEDENCE: U | P ✗ | R
5. GRADE
6. AGE: 25
7. SEX: ✗ MALE | FEMALE
8. WEIGHT: 75 kg
9. BLOOD TYPE
10. CLASSIFICATION (1A TO 5F): AMBUL | ✗ LITTER
11. ACCEPTING MD
12. CITE/AUTH # (b)(6)-4
13. APPT/SURG DATE
14a. ORIGINATING FACILITY (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER 558 (b)(3)-1
15a. DESTINATION FACILITY (b)(3)-1
15B. DESTINATION FACILITY PHONE NUMBER
16. # OF ATTENDANTS
16a. MED | 16b. NON-MED

17. DIAGNOSIS
1) DM
2) (L) fibular fracture
3) (L) closed malleolar fracture (Medial, displaced)
4) (R) ulnar nerve injury

18. ✗ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE
a.		✗	Hypertension	i.		✗	Bowel Problem
b.		✗	Cardiac Hx	j.		✗	Self-care
c.	✗		Diabetes	k.		✗	Ambulatory
d.		✗	Respiratory	l.		✗	Ambulatory Aid
e.		✗	Ears/Sinus	m.	✗		Self-meds
f.		✗	Motion Sick	n.	✗		Adequate Supply of Meds
g.		✗	Vision Impaired	o.			Other:
h.		✗	Voiding Prob.				

20. PHYSICIANS ORDERS
20a. DATE: 10 Apr 03
20b. TIME: 2040
20c. ALLERGIES: NKDA
20d. DIET ✗ REG | 3GM NA | CARDIAC | DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC; AGE ___ OTHER (Specify)
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr
20e. (IV) BLOOD: LR @ 125 cc/hr
20f. SPECIAL EQUIPMENT
SUCTION | TRACTION | ✗ FOLEY CATH
NO TUBE | IV PUMP | ORTHO BRACES
STRYKER | TRACH | CHEST/HEIMLICH
INCUBATOR | MONITOR | RESTRAINTS
| | OTHER (USE 23)
OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:
VENT SETTINGS:
20g. ALTITUDE RESTRICTION: Yes / (No) ___ feet
20h. RECORDS TO ACCOMPANY PATIENT
✓ OUTPATIENT RECORDS | XRAYS | OTHER:
✓ INPATIENT RECORDS | OB |
NARRATIVE SUMMARY | DENTAL |
FINANCIAL

20i. MEDICATIONS / TREATMENTS
Percocet 1-2 PO q4-6 PRN pain
Motrin 800mg PO q8 PRN pain
Regular insulin (sliding scale)

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

22. BRIEF NARRATIVE
S/p MVA c̄ possible GSW 6 Apr 03; seen by FST + (R) LE cast placed for (L) fib fracture. Transferred to MASH → noted (L) malleolar fx → cast placed. DM controlled. Rec'd tetanus booster, IV Ancef (sliding scale Reg I)

23. ASSESSMENT / PROGRESS
DATE / TIME | NOTES

24. STAMP AND SIGNATURE OF PHYSICIAN
(b)(6)-2
MAJ, USA, MC
MD
DEPT OF OB/GYN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code.)

REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4
4. PAY GRADE: 16 17
5. SEX: 18 M

DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26 = 19780101
7. AGE AT ADMISSION: 27 28 29 = 25 Y
8. RACE: 30 = Z
9. ETHNIC BACKGROUND: 31 = Z
RELIGION: Muslim

LENGTH OF SERVICE: 32 33 34
ETS:
11. FMP: 35 36 = 20
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: 46 = Z
HOUR OF ADMISSION: 1900Z
BRANCH / CORPS:

FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 = K78 EPW
16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 = 093020000

UNIT LOCATION (State or Country Code): 62 63
18. MOS: 64 65 66 67 68 69 70
19. TRAUMA: 71
PREV. ADMISSION: YEAR / Y NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 = 0 EMT
WARD: ICU 3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

TYPE OF DISPOSITION: 73 74 = 1 XFR
22. MTF TRANSFERRED TO: (b)(3)-1 — 75 76 77 78 79 80 = (b)(3)-1
23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86 = 030411 0930

CLINIC SVC - ADMITTING: 87 88 89 90 = ABAA
25. MTF TRANSFERRED FROM: 91 92 93 94 95 96
26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102

LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104 = IZ
28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110
29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116 = 030410

FOR LOCAL USE

Dx: 1) DM - no DKA
2) (R) LE fracture
3) Multiple (D) LE scrapped wounds

PI: 8248
25000
8911
E8199

Pr 0331
9921

102 9

ADMITTING OFFICER: (b)(6)-2
SIGNATURE: (b)(6)-2

DA FORM 2985 EDITION OF MAY 79 IS OBSOLETE USAPPG V1.00

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX: M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP: 20	(b)(6)-4			ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN: K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION.				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION: 03-04-11		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION: 03-04-10	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(3)-1

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. S... | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE: U / P X / R | 5. GRADE

6. AGE: 21 | 7. SEX: X M / FEMALE | 8. WEIGHT | 9. ... TYPE | 10. CLASSIFICATION (1A TO 5F) — AMBUL X LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG... | 14. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY (b)(3)-1 | 16. # OF ATTENDANTS: 16a. MED Ø | 16b. NON-MED Ø

14. ORIGINATING FACILITY ... PHONE NUMBER: ICU #3 558-(b)(3) | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS

GSW face
(R) mandible fracture
open fracture (L) fibula

18. X BATTLE ... DISEASE ... NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	ISSUE	YES	NO		ISSUE	YES	NO
a.	Hypertension		/	i.	Bowel Problem		/
b.	Cardiac Hx		/	j.	Self-care		/
c.	Diabetes		/	k.	Ambulatory	X	
d.	Respiratory		/	l.	Ambulatory Aid		/
e.	Ears/Sinus		/	m.	Self-meds		/
f.	Motion Sick		/	n.	Adequate Supply of Meds		/
g.	...Impaired		/	o.	Other:		
h.	...Prob.		/				

20. ... MEANS OF ORDERS
20a. DATE: 11APR03 | 20b. TIME: 0135 | 20c. ... RG...
20d. DIET: X ... REG / TUBE / PED / TPN / TUBE ... Gm NA / CARDIAC / Prot Gm Na / cc/hr, 1/2, 3/4, FULL / OTHER (S...) / ...010 cc ... cc/hr for ma... / at ... strength
20e. IV / BLOOD
20f. SPECIAL ... SUCTION / NG / STR... / INC... / TRACTION / IV PUMP / TRACH / MONITOR
OXYGEN: ... or LITERS ... VENT
20g. ALTITUDE ... Yes / No
20h. RECORDS ... PATIENT: OUT... / X INP... / NAT... / FIN... — COPIES X / ORDERS / SUMMARY / XR... / OR... / DE...
20i. MEDICATIONS / TREATMENTS

Ancef 1gm IV Q8°
MSO4 1-2 mg IV Q1° PRN pain

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

22. BRIEF NARRATIVE

21 y.o. Iraqi c̄ GSW (R) face & (B) LE's
Pt. c̄ (R) mandible Fx c̄ retained shrapnel. Comminuted Fx (L) fibula
S/P LLE fasciotomy. Stable for evac.

23. ASSESSMENT / PROGRESS NOTES
DATE / TIME

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

...F Form 3890 ... (Electronic version)

MEDCOM - 2935

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 8 2 0 1 0 1	2 1 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1900 Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8 EPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		
O ERA	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	(b)(3)-1 75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 1 1 0630

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 0

FOR LOCAL USE

(R) Complex Mandibular Fx
(C) Acute
Inj Trauma
450 1

DX 80230 Pr 8314
82391 9921
E9912
E9919

ADMITTING OFFICER	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4				
4. SEX: M	6. AGE	5. RACE	7. RELIGION: MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. PAY GRADE: 80	12. SSN: (b)(6)-4		13. ORGANIZATION		14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN: K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-11		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY			30. DATE OF INTIAL ADMISSION: 03-04-10		32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (b)(6)-4

2. SSN

3a. STATUS EPW

3b. SERV

4. PRECEDENCE: U | P ✓ | R

5. GRADE

6. AGE: 21

7. SEX: ✓ MALE | FEMALE

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5…): AMBUL | ✓ LITTER

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

APPT/SURG DATE: 10 APR 03

ORIGINATING FACILITY (b)(3)-1

FACILITY PHONE NUMBER (b)(3)-1 ICU #3

15a. DESTINATION FACILITY (b)(3)-1

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED: 0 | 16b. NON-MED: 0

17. D… GSW CHEST

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIAN ORDERS

20a. DATE: 10 APR 03

20c. ALLERGIES

20d. DIET: NPO
(GENERAL / TUBE / TPN / DIABETIC CALS / MagK mg PO4 / FULL STRENGTH (Specify) / max of days / length at cc/hr)

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT: SUCTION / NG TUBE / STRYKER / MONITOR — Central Line

✓ FOLEY CATH
ORTHO BRACES
✓ CHEST/HEIMLICH
RESTRAINTS
OTHER (USE 23)

OXYGEN: PERCENT 3L | ROUTE:
VENTILATOR

20g. ALTITUDE RESTRICTION: feet

20h. RECORDS TO ACCOMPANY: ✓ OUTPATIENT | INPATIENT | X-RAYS ✓ | LAB | DENTAL | OTHER:

MEDS
Ancef 1gm IV Q8°
O_2
Keflex (b)(6)-2
MSO4 2-4mg Q1° PRN pain

19. CLINICAL ISSUES (✓ to indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE
a.			Hypertension	i.			Bowel Problem
b.			Cardiac	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sickness	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding				

21.
21a. DATE / TIME
PRE-FLIGHT VITALS: 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

22. BRIEF NARRATIVE
GSW CHEST
S/P EX LAP / THORACOTOMY
CT / Foley / Central Line

23. DATE / TIME | ASSESSMENT / PROGRESS NOTES

(b)(6)-2

24. STAMP AND SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (…)

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	MUS
1 9 7 2 0 1 0 1	3 1 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		Z O	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1900Z	E PW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR [X] NO
		B	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
O		

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XPR	(b)(3)-1	0 3 0 4 1 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 0

FOR LOCAL USE

65W Cl 65J

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

EDITION OF MAY 79 IS O

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M		O	Muslim			No	
11. FMP		12. SSN		13. ORGANIZATION		14. WARD	
K78						ICU3	
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
N						B	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1900z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	11 Apr 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		10 Apr 03	LTC (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	10 Apr 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX. Soft Tissue Injury Left/ Case 4

CODING INFOMATION: 729.6

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
				2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle Initial) [b)(6)-4]	2. SSN	3a. STATUS EPW	3b. SERVICE	4. PRECEDENCE U P R	5. GRADE
6. AGE 27	7. SEX X MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)-- AMBUL X LITTER	11. ACCEPTING MD	12. CITE/AUTH # [b)(6)-4]
13. APPT/SURG DATE	14a. ORIGINATING FACILITY [b)(3)-1]		15a. DESTINATION FACILITY [b)(3)-1]		16. # OF ATTENDANTS 16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER 358-[b)(3)-1]		15B. DESTINATION FACILITY PHONE NUMBER			

17. DIAGNOSIS
(1) SOFT TISSUE INJURY (L) KNEE & FOOT

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS
20a. DATE | 20b. TIME | 20c. ALLERGIES

20d. DIET | REG | GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER *(Specify)*
TPN: Change to D10 at cc/h for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER *(USE 23)*

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS		XRAYS	OTHER:
INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP: 21d. RESP:	21c. PULSE	21e. BP

22. BRIEF NARRATIVE

2 RIGID SPLINT & FJT IMMOBILIZED
WHEELCHAIR ASSIGNMENT (L) FOOT &
(R) BKA

20. MEDICATIONS / TREATMENTS

DATE / TIME	NOTES
FJT (1 JD)	
2/22/10 (RE 1 JD)	
S/P BKA (R) (FJT)	

23. ASSESSMENT / PROGRESS

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

DD Form 3899 (433 AES Excel version)

(b)(6)-4 [redacted] (b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1 [redacted]

2. MTF LOCATION (7–8) *(State or Country Code.)*

3. REGISTER NUMBER (9–15): (b)(6)-4 [redacted]

NAME *(Last, First, Middle Initial)*: (b)(6)-4 [redacted]

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH *(YYYYMMDD)* (19–26): 1 9 7 5 0 1 0 1

7. AGE AT ADMISSION (27–29): 2 8 Y

8. RACE (30):

9. ETHNIC BACKGROUND (31):

RELIGION: Muslim

LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36): 2 0

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4 [redacted]

ORGANIZATION *(Active Duty Only)*:

13. MARITAL STATUS (46):

HOUR OF ADMISSION: 1900 Z

BRANCH / CORPS:

FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K 7 8 EPW

16. ZIP CODE OF RESIDENCE (53–61):

UNIT LOCATION *(State or Country Code)* (62–63):

18. MOS (64–70):

19. TRAUMA (71): B

PREV. ADMISSION: YEAR ☐ NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 EMT

WARD:

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*:

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

TYPE OF DISPOSITION (73–74): XFR

22. MTF TRANSFERRED TO (75–80): (b)(3)-1 [redacted]

23. DATE OF DISPOSITION *(YYMMDD)* (81–86): 0 3 0 4 1 1 0030

CLINIC SVC - ADMITTING (87–90):

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(YYMMDD)* (97–102):

LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116): 0 3 0 4 1 0

FOR LOCAL USE

SOFT TISSUE INJURY
LEFT FLANK/CHEST

DX: 959.11
Injury E928.9
AD
DX 285 / 820

(b)(6)-2 [redacted]

ADMITTING OFFICER *(Signature, as...)*

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

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
No					

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1035z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	14 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		11 APR 03	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 IRAQ	11 APR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO L SIDE OF HEAD, WRIST

CODING INFORMATION: 991.2

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (b)(6)-4 | SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U / P X / R | 5. GRADE

6. | MALE X | FEMALE | WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) | AMBUL | LITTER X | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(6)-1 | 14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(6)-1 ICU #3 | 15a. DESTINATION FACILITY | 15B. DESTINATION FACILITY PHONE NUMBER | 16. # OF ATTENDANTS: 16a. MED 0 | 16b. NON-MED 0

17. DIAGNOSIS
① maxillary/orbital open fracture c partial vision loss
② wrist/hand open fracture

18. BATTLE CASUALTY X | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.	X		Vision Impaired	o.			Other:
h.			Voiding Prob				

20. PHYSICIANS ORDERS

20a. DATE 11APR03 | 20b. TIME 1250 | 20c. ALLERGIES NKDA

20d. DIET X REG | GM NA | CARDIAC | DIABETIC | CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER (USE 23)

OXYGEN: PERCENT or LITERS | ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

X	OUTPATIENT RECORDS	X	XRAYS	OTHER:
	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS
Heparin 5000 units SQ BID
Ancef 1gm IV Q8°
MSO4 2-4mg IV Q1-2 PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE
33 y.o. Iraqi ♂ c shrapnel to ① face c maxillary sinus/orbital fx & ② wrist/hand open fx. ① will need orbital maxillofacial reconstructive surgery.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

PCL XL error

Subsystem: IMAGE

Error: MissingData

Operator: ReadImage

Position: 33

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19700101	334	0	9	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1035Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 EMT	1C43	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
XFR	(b)(3)-1	030414 0030

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030411

FOR LOCAL USE

GSW to @ side of head @ wrist

Dx: 8025
8029
91410
81510
E9012

Trauma
1

450

SUBMITTING OFFICER (Signature as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE — USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	(b)(6)-4	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4			

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20			

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW K-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

102

1. NAME (b)(6)-4	SSN	3a. STATUS	VICL	4. PRECEDENCE U P R X	5. GRADE
6. AGE 23	7. SEX M FEMALE	8. WEIGHT	9. BLOOD TYPE	2. CLASSIFICATION (IF 5F) AMBUL X	11. ACCEPTING MD	12. CITE/AUTH # (b)(6)-4
13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY		16. # OF ATTENDANTS 16a. MED 9	16b. NON-MED 9
	14b. ORIGINATING FACILITY PHONE NUMBER ICU#3 558- (b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER			

17. DIAGNOSIS
(a) Femur fracture
(b) tib-fib fracture
(c) foot fracture

18. X BATTLE ASUALTY | DISEASE | NON-BATTLE INJURY

19. CLINICAL STATUS (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Anemia	m.			Self-meds
f.			Sickle	n.			Adequate Supply of Meds
g.			Unpaired	o.			Other:
h.			Psych Prob.				

20. PHYSICIANS ORDERS

20a. DATE 11/9/03 | 20b. TIME 1040 | 20c. ALLERGIES NKDA

20d. DIET X | GM NA | CARDIAC | DIABETIC
RENAL Gm Prot Gm Na MagK mg P
TUBE Y cc/hr, 1/2, 3/4, FULL STRENGTH
PED TRIC BASE OTHER (Specify)
TPN Change to 1010 at cc/hr for max of days
TUBE FEEDING at strength

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUC		TRACTION		FOLEY CATH	
NG		IV PUMP		CHEST/HEL	
STR		TRACH		RESTRAINTS	
INC		MONITOR		OTHER (US	

OXYGEN: TYPE or LITERS ROUTE
VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION: Yes / No

20h. RECORDS CARRIED WITH PATIENT

OUT		RECORDS	X	XRAYS	OTHER
X INPA		ORDS		OB	
NARR		MARY		DENT	
FINA	CIAL				

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IVP @8
MSO4 2-4 mg IV q1° PRN pain
Toradol 30 mg IV @8° PRN pain (b)(6)-2

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

25 y.o. ♂ c (B) GSW's x 6 11/9/03
Stable for x-port to LA

23. ASSESSMENT / PROGRESS NOTES

DATE / TIME

24. (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (Medical version)

(b)(6)-4

Code #

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19780101	254	0	9	MJ3

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1036Z	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 EPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
		I	/ NO

21. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O EMT	IW3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

22. TYPE OF	22. MTF TRANSFERRED	23. DATE OF DISPOSITION (YYMMDD) 0630
XFR	(b)(3)-1	030414

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030411

FOR LOCAL USE

@ femur / @ tib/fib open fx

Dr: 8210
8287
82130
82512

(b)(6)-4

ADMITTING OFFICER (Signature as required)
(b)(6)-2

SIGNATURE OF ADMITTING CLERK
(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS O USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20		EPW	IUC3

15. FLYING STATUS	16. RATING/ OSC	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1037z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030414

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030411	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030411	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: R femur, L headwound

CODING INFORMATION: 829.1

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1. NAME (Last, First, Middle Initial)	SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R X	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)–	11. ACCEPTING MD	12. CITE/AUTH #
	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
			16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER Fwd#3 558-(b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS
(1) (R) Femur Fracture
(2) (L) Foot Soft Tissue Injury

18. X BATTLE CASUALTY / DISEASE / NON BATTLE INJURY

19. CLINICAL ISSUES *(Please Indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
4 APR 03	1500	NKA

20d. DIET: X REG / 3GM NA / CARDIAC / DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ OTHER *(Specify)* ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION		FOLEY CATH
	NG TUBE		IV PUMP		ORTHO BRACES
	STRYKER		TRACH		CHEST/HEIMLICH
	INCUBATOR		MONITOR		RESTRAINTS
					OTHER *(USE 23)*

20g. O2 ___ PERCENT or ___ LITERS ROUTE:
VENT SETTINGS:

20h. ALTITUDE RESTRICTION: Yes / No ___ feet

20i. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS	X	OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE
(1) (R) Femur fx
(2) (L) foot
s/p ORIF

24. MEDICATIONS / TREATMENTS
(1) (R) Femur IVD
Ex. Fixation
(2) (L) foot I+D

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Exce

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

[b)(3)-1]

9	10	11	12	13	14	15
REGISTER NUMBER						
[b)(6)-4]						

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

16	17	18
4. PAY GRADE		5. SEX
		M

19	20	21	22	23	24	25	26	27	28	29	30	31
DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND
											0	9

RELIGION: Mus

32	33	34
LENGTH OF SERVICE		

ETS

35	36
11. FMP	
2	0

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

ORGANIZATION (Active Duty Only)

46
13. MARITAL STATUS

HOUR OF ADMISSION: 10372

BRANCH / CORPS

47	48	49
FLYING STATUS		

50	51	52
15. BENEFICIARY CATEGORY		
E	7	8

EPW

53	54	55	56	57	58	59	60	61
16. ZIP CODE OF RESIDENCE								

62	63
UNIT LOCATION (State or Country Code)	

64	65	66	67	68	69	70	71
18. MOS							19. TRAUMA
							F

PREV. ADMISSION: YEAR [ ] [X] NO

72
SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
3

EMT

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include Zip Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [b)(3)-1]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

73	74
TYPE OF DISPOSITION	
	XPR

75	76	77	78	79	80
22. MTF TRANSFERRED TO [b)(3)-1]					

81	82	83	84	85	86
23. DATE OF DISPOSITION (YYMMDD)					
0	3	0	4	1	4

0630

87	88	89	90
CLINIC SVC - ADMITTING			

91	92	93	94	95	96
25. MTF TRANSFERRED FROM					

97	98	99	100	101	102
26. DATE THIS ADMISSION (YYMMDD)					

103	104
LOCATION OF OCCURRENCE (Battle Casualty Only)	

105	106	107	108	109	110
28. MTF OF INITIAL ADMISSION					

111	112	113	114	115	116
29. DATE INITIAL ADMISSION (YYMMDD)					
0	3	0	4	1	1

LOCAL USE

(R) Femur fx, (L) head wound

ADMITTING OFFICER (Signature, as required) [b)(6)-2]

SIGNATURE OF ADMITTING CLERK [b)(6)-2]

DA FORM 2965, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)						3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4							
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
M			MUS				NO	
11. FMP	12. SSN		13. ORGANIZATION				14. WARD	
20			EPW				IUC3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ DEN	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
		K-78					INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1015z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030414

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030411	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030411	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to R knee,

CODING INFORMATION: 991.2

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. N	3a. STATUS EAD	3b. SERVICE	4. PRECEDENCE U P (IR)	5. GRADE

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11.ACCEPTING MD	12.CITE/AUTH #
	MALE FEMALE			AMBUL LITTER 24		(b)(6)-4

13.APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS
			16a. MED 16b.NON-MED
	14b.ORIGINATING FACILITY PHONE NUMBER Fax #3	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

(R) OPEN PATELLAR FX

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
11 APR 03	K 80	NKA

20d. DIET: REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	ORTHO BRACES
NG TUBE		IV PUMP	CHEST/HEIMLICH
STRYKER		TRACH	RESTRAINTS
INCUBATOR		MONITOR	OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS		XRAYS	OTHER:
INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

20i. MEDICATIONS / TREATMENTS

LD OPEN PATELLA FX

(4/8)

RE LD " (4/11)

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx.	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b.TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

(R) OPEN PATELLAR FX

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTEND[illegible]CIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 A[illegible]ersion)

(b)(6)-2

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

REPORTING MTF 1 2 3 4 5 6

2. TF LOCATION 7 8 *(State or Country Code.)*

(b)(3)-1 [redacted]

REGISTER NUMBER 9 10 11 12 13 14 15

(b)(6)-4 [redacted]

NAME *(Last, First, Middle Initial)*

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

4. PAY GRADE 16 17

5. SEX 18 — M

DATE OF BIRTH *(YYYYMMDD)* 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION 27 28 29

8. RACE 30 — 0

9. ETHNIC BACKGROUND 31 — 9

RELIGION Mus

LENGTH OF SERVICE 32 33 34

ETS

11. FMP 35 36 — Z 0

12. SOCIAL SECURITY NUMBER 37 38 39 40 41 42 43 44 45

(b)(6)-4 [redacted]

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS 46

HOUR OF ADMISSION 10152 ~~1033Z~~

BRANCH / CORPS

FLYING STATUS 47 48 49

15. BENEFICIARY CATEGORY 50 51 52 — K 7 8 — EPW

16. ZIP CODE OF RESIDENCE 53 54 55 56 57 58 59 60 61

UNIT LOCATION *(State or Country Code)* 62 63

18. MOS 64 65 66 67 68 69 70

19. TRAUMA 71 — I

PREV. ADMISSION YEAR — NO ☒

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 — 0 E/MT

WARD ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(3)-1 [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION 73 74 — XFR

22. MTF TRANSFERRED TO 75 76 77 78 79 80

(b)(3)-1 [redacted]

23. DATE OF DISPOSITION *(YYMMDD)* 0630

81	82	83	84	85	86
0	3	0	4	1	4

CLINIC SVC - ADMITTING 87 88 89 90

25. MTF TRANSFERRED FROM 91 92 93 94 95 96

26. DATE THIS ADMISSION *(YYMMDD)* 97 98 99 100 101 102

LOCATION OF OCCURRENCE *(Battle Casualty Only)* 103 104

28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110

29. DATE INITIAL ADMISSION *(YYMMDD)*

111	112	113	114	115	116
0	3	0	4	1	1

LOCAL USE

® Knee GSW

Dx: 8221
E9912

Trauma / Injury
GSW

Acme

ADMITTING OFFICER *(Signature, as required)*

(b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK

(b)(6)-2 [redacted]

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBS[redacted] USAPPC V1.00

MEDCOM - 2955

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20		EPW	IUC3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
	1039z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030414

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030411	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030411	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to L knee, open patella Fx

CODING INFORMATION: 991.2

Dx 8221
E9112

Pr 7816
9927
9659

Trauma Unit
450 1

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERV | 4. PRECEDENCE U P ✓R | 5. GRADE

6. AGE | 7. SEX X MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5) AMBUL | X LITTER | 11. ACCEPTING MD | 12. (b)(6)-4

13. APPT/SURG DATE: 11 APR 03

14a. ORIGINATING FACILITY: (b)(3)-1 [redacted]

14b. ORIGINATING FACILITY PHONE NUMBER: [redacted] Ru #3 (b)(3)-1

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS — 16a. MED: Ø — 16b. NON-MED: Ø

17. DIAGNOSIS: GSW (L) femur

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIAN'S ORDERS

20a. DATE: 11 APR 03 | 20b. TIME

20c. ALLERGIES

20d. DIET: (REG) LOW NA | LOW CARB | DIABETIC CALS

RENAL ___ gm Prot ___ gm NA ___ MagK ___ mg PO4

TUBE ___ TYPE ___ FULL STRENGTH

PEDIATRIC (Specify)

TPN: Change ___ max of ___ days

TUBE FEED ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT: SUCTION | NG TUBE | STRYKER | INCUBATOR | FOLEY CATH | ✓ ORTHO BRACES | CHEST-HEIMLICH | RESTRAINTS | OTHER (USE 23)

OXYGEN: ___ PERCENT ___ LITERS ___ ROUTE:

VENT SETTINGS

20g. ALTITUDE RESTRICTION Yes No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT: ✓ OUTPATIENT | INPATIENT | NARRATIVE | FINANCIAL | XRAYS | OTHER: | OB | DENTAL

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV q8°
Untouched / GSW
Ex Fix (L) femur

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding				

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE

GSW (L) femur
Ex Fix Application

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

24. ... PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4 (b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		0	9	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1039Z ~~1217Z~~	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 EPW	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		I	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	Icu3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	DATE OF DISPOSITION (Y Y Y Y M M D D)
XFR	(b)(3)-1	20030401

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
		20030411

FOR LOCAL USE

GSW to ② knee, open patella fx

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 8 USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
m	30y						
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
20	(b)(6)-4						
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
		K-78					
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION	23. CLINIC SERVICE			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION		ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle Initial) # [redacted]		SN		3a. STATUS	3b. SERVICE		4. PRECEDENCE U / P / R X		5. GRADE E-6		
6. AGE 30	7. SEX MALE X / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)-- AMBUL / LITTER X			11. ACCEPTING MD		12. CITE/AUTH # [redacted]		
13. APPT/SURG DATE	14a. ORIGINATING FACILITY [redacted] (b)(3)-1			15a. DESTINATION FACILITY			16. # OF ATTENDANTS				
	14b. ORIGINATING FACILITY PHONE NUMBER 558-[redacted] (b)(3)-1			15B. DESTINATION FACILITY PHONE NUMBER			16a. MED	16b. NON-MED			

17. DIAGNOSIS

S&SW shrapnel wounds (B) legs / (B) butt

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	Y		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE 11APR03 | 20b. TIME 1925 | 20c. ALLERGIES NKDA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC | CALS

RENAL Gm Prot ___ m Na MagK ___ mg PO4

TUBE TYPE ___ cc/hr 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ | OTHER *(Specify)*

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	FOLEY CATH
NG TUBE		I. PUMP	ORTHO BRACES
STRYKER		TRACH	CHEST/HEIMLICH
INCUBATOR		ONITOR	RESTRAINTS
			OTHER *(USE 23)*

OXYGEN: ___ PERCENT or ___ ITERS | ROUTE: ___

VENT SETTINGS:

20h. ALTITUDE RESTRICTION: Yes / No feet

20i. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	Y	XRAYS	OTHER:
Y	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20j. MEDICATIONS / TREATMENTS

Ancef 1gm IV q8°

Tylenol #3 1-2 p.o. Q6° PRN

(b)(6)-2

21. [redacted] (b)(6)-2

AF [illegible] 3899 (435 AES Excel version)

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

30 y.o. Inj: 09 C

extensive (B) LE shrapnel wounds

S/P I&R

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

c/det#

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)
(b)(6)-4	

REGISTER NUMBER: (b)(6)-4

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

4. PAY GRADE	5. SEX
16 17	18
	M

DATE OF BIRTH (YYYYMMDD): 19730101

7. AGE AT ADMISSION: 30

8. RACE: 0

9. ETHNIC BACKGROUND: 9

RELIGION: Mus

LENGTH OF SERVICE:

ETS:

11. FMP: 20

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only): EPW

13. MARITAL STATUS:

HOUR OF ADMISSION: 1047z

BRANCH / CORPS: EPW

FLYING STATUS:

15. BENEFICIARY CATEGORY: K 7 8 EPW

16. ZIP CODE OF RESIDENCE:

UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA:

PREV. ADMISSION: YEAR: ; NO: ☑

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: O

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

TYPE OF DISPOSITION: XFR

22. MTF TRANSFERRED TO: (b)(3)-1

23. DATE OF DISPOSITION (YYMMDD): 030414 0630

CLINIC SVC - ADMITTING:

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYMMDD):

LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYMMDD): 030411

LOCAL USE

Shrapnel wounds to buttock

DX: 8911
8771
E9912
Trauma

ADMITTING OFFICER (Signature as required): (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

(b)(6)-4

DD FORM 2585, MAR 89 EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20			

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW IK-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

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

1. Name (Last, First, Middle Initial) (b)(6)-4

4. PRECEDENCE — U / P / R X

5. GRADE

6. AGE: 55

7. SEX: X MALE / FEMALE

10. CLASSIFICATION — LITTER X

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPROX SURG DATE

14a. ORIGINATING FACILITY

14b. ORIGINATING FACILITY PHONE NUMBER — [redacted] Ical #3 ~(b)(3)-1

15b. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS — 16a. MED / 16b. NON-MED

DIAGNOSIS

GSW (R) leg
Burn (L) foot

BATTLE CASUALTY: Y

PHYSICIAN OR

DATE: 11APR03 — TIME: 1730

ALLERGIES: NKDA

CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES answers in Section 23)

ISSUE	YES	NO	ISSUE	YES	NO
Hypertension		/	i. Bowel Problem		/
Cardiac Hx		/	j. Self-care		/
Diabetic		/	k. Ambulatory	X	
Respiratory		/	l. Ambulatory Aid		/
Ears/Sinus		/	m. Self-meds		/
Motion Sick		/	n. Adequate Supply of Meds		/
Vision Impaired		/	o. Other:		/
Hearing Prob.		/			

RENAL — Gm Pr

TUBE TYPE — cc

PEDIATRIC AGE

TPN

BLOOD

SPECIAL EQUIPMENT — SUCTION / NG TUBE / STRYKER / INCUBATOR / VENTILATOR

PRE-FLIGHT VITALS — 21b. TEMP: — 21c. PULSE — 21e. BP — 21d. RESP:

BRIEF NARRATIVE

55 y.o. Iraqi ♂ c
GSW (R) leg / Burn (L) foot
S/P I&D @ FST

OUTPATIENT — INPATIENT: Y

MEDICATIONS

Ancef 1gm IV Q8°
Silvadene BID to (L) foot
Tylenol #3 I-II p.o. Q6°
MSO4 2-4mg IV Q 2° PRN pain

ASSESSMENT / PROGRESS NOTES

DATE — TIME

(b)(6)-2

SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) | 2. MTF LOCATION (7–8) (State or Country Code.)

3. REGISTER NUMBER (9–15) | NAME (Last, First, Middle Initial) | 4. PAY GRADE (16–17) | 5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26): 19480101 | 7. AGE AT ADMISSION (27–29): 054 | 8. RACE (30): 0 | 9. ETHNIC BACKGROUND (31): 9 | RELIGION: MU3

10. LENGTH OF SERVICE (32–34) | ETS | 11. FMP (35–36): 20 | 12. SOCIAL SECURITY NUMBER (37–45)

ORGANIZATION (Active Duty Only): EPW | 13. MARITAL STATUS (46) | HOUR OF ADMISSION: 1847Z | BRANCH / CORPS: EPW

14. FLYING STATUS (47–49) | 15. BENEFICIARY CATEGORY (50–52): K78 EPW | 16. ZIP CODE OF RESIDENCE (53–61)

17. UNIT LOCATION (State or Country Code) (62–63) | 18. MOS (64–70) | 19. TRAUMA (71): I | PREV. ADMISSION: YEAR | NO: X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): D EMT | WARD: ICU3 | NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE | ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY | TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): KFR | 22. MTF TRANSFERRED TO (75–78) | 23. DATE OF DISPOSITION (YYYYMMDD): 20030401

24. CLINIC SVC - ADMITTING (89–92) | 25. MTF TRANSFERRED FROM (93–98) | 26. DATE THIS ADMISSION (YYYYMMDD) (99–106)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108) | 28. MTF OF INITIAL ADMISSION (109–114) | 29. DATE INITIAL ADMISSION (YYYYMMDD): 20030401 (115–122)

FOR LOCAL USE

Dx: GSW (R) leg
(L) foot burn
Scrapnel (R) chest wall

(b)(6)-4

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000 | EDITION OF MAR 89 IS OBS | USAPA V1.00

...PATIENT TREATMENT RECORD COVER SHEET

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

1. PATIENT NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4						
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	50						
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
		K-78					
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

1. NAME (Last, First, Middle Initial) (b)(6)-4	3a. STATUS	3b. SERVICE	4. PRECEDENCE U P R X	5. GRADE
6. AGE 50 / 7. SEX X MALE / FEMALE	9. BLOOD TYPE	10. CLASSIFICATION (PATIENT) AMBULATORY / X LITTER	11. ACCEPTING MD	12. (b)(6)-4
13. APPT/SURG DATE	14a. ORIGINATING FACILITY [redacted] (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
	14b. ORIGINATING FACILITY PHONE NUMBER ICU #3 [redacted] (b)(3)-1	15b. DESTINATION FACILITY PHONE NUMBER	16a. MED Ø	16b. NON-MED Ø

17. DIAGNOSIS

GSW ® leg / © Foot

DM

HTN

18. BATTLE CASUALTY Y — NON-BATTLE INJURY

20a. DATE 11 APR 03 — 20b. TIME 1245 — 20c. ALLERGIES NKDA

20d. DIET: X REG / RENAL / TUBE / PEDIATRIC / TPN / TUBE

20e. BLOOD

20f. SPECIAL EQUIPMENT: SUCTION / NG TUBE / STRYKER / INCUBATOR — X (CHEST) TRACES / EIMUCH / NTS / (USE 23)

20g. OXYGEN / VENT SETTINGS

20h. RECORDS: OUTPATIENT / X INPATIENT / NARRATIVE / FINAL — X X-RAYS

20i. MEDICATIONS

Heparin 5000 u SQ BID

Ancef 1 gm IV Q 8°

MSO4 2 mg IV Q 1° PRN pain

22. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

YES	NO	ISSUE		YES	NO	
X		a. Hypertension	i.		/	Bowel Problem
	X	b. Cardiac	j.		/	Self-care
X		c. Diabetes	k.	X		Ambulatory
	/	d. Respiratory	l.		/	Ambulatory Aid
	/	e. Ears/Sinus	m.		/	Self-meds
	/	f. Motion Sick	n.		/	Adequate Supply of Meds
	/	g. Vision Impaired	o.		/	Other:
	/	h. Bleeding				

21. PRE-FLIGHT VITALS

21a. DATE	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

BRIEF NARRATIVE

~50 y.o. ♂ c mult shrapnel WNDS to ® LE / © foot, initial I&D 9 APR. Pt. stable for x-sport.

23. ASSESSMENT / PROGRESS

DATE	TIME	NOTES

24. (b)(6)-2

SIGNATURE OF FLIGHT SURGEON

MEDCOM - 2966

FORMER COMMANDERS

	(b)(6)-2	
CPT		January 1985 to July 1985
CPT		July 1985 to September 1986
CPT		September 1986 to May 1987
CPT		May 1987 to July 1988
CPT		July 1988 to March 1989
MAJ		March 1989 to July 1990
LTC		July 1990 to December 1990
COL		December 1990 to April 1991
MAJ		April 1991 to December 1991
LTC		December 1991 to July 1992
LTC		July 1992 to November 1992
LTC		November 1992 to July 1993
LTC		July 1993 to July 1995
LTC		July 1995 to July 1997
LTC		July 1997 to June 1999
LTC		June 1999 to June 2001

(b)(6)-4

Cod # 991.2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4 (b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19530101	50Y	0	9	Mus.

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1947z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K74 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
6 EMT	Icu3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 | TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED (b)(3)-1	23. DATE OF DISPOSITION (Y Y Y Y M M D D) 0630
XFR		20030414

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
		20030411

FOR LOCAL USE

Dx: 1) (B) LE 95W5

2) Abdominal Schrapnel wound

3) DM

4) HTN

E918 E9500 E849 E911 E9912

ADMITTING (b)(6)-2 -2 MAJ, USA, MC DEPT/SER OB/GYN

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 2968

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER	2.	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20	(b)(6)-4		

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPU K-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

(b)(6)-4

RU #3.

1. NAME (Last, First, Middle Initial) (b)(6)-4	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R	5. GRADE
6. AGE 22	7. SEX ✓MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F) AMBUL / ✓LITTER	11. ACCEPTING MD
12. CITE/AUTH # (b)(6)-4					
13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY		16. # OF ATTENDANTS 16a. MED / 16b. NON-MED	
	14b. ORIGINATING FACILITY PHONE NUMBER	15B. DESTINATION FACILITY PHONE NUMBER			

17. DIAGNOSIS

(R) open TIB-FIB fracture
2° GSW

18. ✓BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.		✓	Cardiac Hx	j.		✓	Self-care
c.		✓	Diabetes	k.		✓	Ambulatory
d.		✓	Respiratory	l.		✓	Ambulatory Aid
e.		✓	Ears/Sinus	m.		✓	Self-meds
f.		✓	Motion Sick	n.		✓	Adequate Supply of Meds
g.		✓	Vision Impaired	o.		✓	Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 11 Apr 03 | 20b. TIME: 1700 | 20c. ALLERGIES: NKDA

20d. DIET: ✓REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION	TRACTION	FOLEY CATH
NG TUBE	IV PUMP	ORTHO BRACES
STRYKER	TRACH	CHEST/HEIMLICH
INCUBATOR	MONITOR	RESTRAINTS
		OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS	XRAYS	OTHER:
✓INPATIENT RECORDS	OB	
NARRATIVE SUMMARY	DENTAL	
FINANCIAL		

20i. MEDICATIONS / TREATMENTS

Morphine 1-4 mg IV q 4-6 hrs PRN pain
Phenergan 25mg IV q 4-6 hrs PRN
Ancef [illegible] q 8hrs.

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE

22 y o. [illegible] male GSW
sustained GSW to (R) leg, open tib-fib fx
[illegible]
[illegible] to [illegible] for further care

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

24. STAMP AND SI[illegible]
(b)(6)-2
LTC, MC, USA
ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(6)-4

code# 823.40

ADMISSION AND CODING INFORMATION

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

Field	Entry
1. REPORTING MTF (1–6)	(b)(3)-1
2. MTF LOCATION (State or Country Code.) (7–8)	I Z
3. REGISTER NUMBER (9–15)	(b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
	(b)(6)-4
4. PAY GRADE (16–17)	
5. SEX (18)	M
DATE OF BIRTH (YYYYMMDD) (19–26)	1 9 8 1 0 1 0 1
7. AGE AT ADMISSION (27–29)	2 2 Y
8. RACE (30)	0
9. ETHNIC BACKGROUND (31)	9
RELIGION	Mos
LENGTH OF SERVICE (32–34)	
ETS	
11. FMP (35–36)	2 0
12. SOCIAL SECURITY NUMBER (37–45)	(b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS (46)	
HOUR OF ADMISSION	1247z
BRANCH / CORPS	
FLYING STATUS (47–49)	
15. BENEFICIARY CATEGORY (50–52)	K 7 8 EPW
16. ZIP CODE OF RESIDENCE (53–61)	
UNIT LOCATION (State or Country Code) (62–63)	
18. MOS (64–70)	
19. TRAUMA (71)	I
PREV. ADMISSION YEAR	NO ☒
SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	C EMT
WARD	ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
TYPE OF DISPOSITION (73–74)	XFR
22. MTF TRANSFERRED TO (75–80)	(b)(3)-1
23. DATE OF DISPOSITION (YYMMDD) (81–86)	0 3 0 4 1 4 0630
CLINIC SVC - ADMITTING (87–90)	
25. MTF TRANSFERRED FROM (91–96)	
26. DATE THIS ADMISSION (YYMMDD) (97–102)	
LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	
28. MTF OF INITIAL ADMISSION (105–110)	
29. DATE INITIAL ADMISSION (YYMMDD) (111–116)	0 3 0 4 1 1

FOR LOCAL USE

Dx: (R) open tib-fib fx

Dx 823.92
Trauma 1
450

ADMITTING OFFICER (Signature, as required) (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE — USAPPC V1.00

MEDCOM - 2971

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EFW K-78			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.00

1. NAME (Last, First, Middle Init) (b)(6)-4 (b)(6)-4

6. AGE ~19 | 7. SEX MALE / FEMALE | WEIGHT | BLOOD TYPE | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U / P / R X | 5. GRADE

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY [redacted] (b)(3)-1 | 10. CLASSIFICATION (1A TO 5F)-- AMBUL / LITTER | 11. ACCEPTING MD | 12. CITIZENSHIP # (b)(6)-4

14b. ORIGINATING FACILITY PHONE NUMBER Iraq 3 [redacted] (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED Ø 16b. NON-MED Ø

17. DIAGNOSIS
s/P (R) BKA

15B. DESTINATION FACILITY PHONE NUMBER

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.		/	Bowel Problem
b.			Cardiac Hx	j.		/	Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		/	Ambulatory Aid
e.			Ears/Sinus	m.		/	Self-meds
f.			Motion Sick	n.		/	Adequate Supply of Meds
g.			Vision Impaired	o.		/	Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE 11 APR 07 | 20b. TIME 1255 | 20c. ALLERGIES NKDA

20d. DIET: REG / 3GM NA / CARDIAC / DIABETIC / CALS
RENAL Gm Prot Na MagK mg PO4
TUBE TYPE cc/hr 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

20e. IV: BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		SUCTION	FOLEY CATH ✓
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		BEACH	CHEST/HEMLICH
INCUBATOR		MONITOR	RESTRAINTS
OXYGEN: L/min PERCENT or		WATERS	OTHER (SEE 23)
VENT SETTINGS:			ROUTE:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
P	INPATIENT RECORDS	✓	OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS
Cefazolin 2gm IV Q8°
Heparin 5000 units SQ BID
MSO4 2-4mg IV Q1° PRN pain

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE
27 y.o. Iraqi s/P traumatic (R) BKA, stable for evac

23. ASSESSMENT / PROGRESS NOTES
DATE / TIME

(b)(6)-2
SICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

code # 991.82

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (2–6): (b)(3)-1

2. MTF LOCATION (7–8) *(State or Country Code.)*: I Z

3. REGISTER NUMBER (10–15): (b)(6)-4

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

(b)(6)-4

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH *(YYYYMMDD)* (20–26): 1 9 7 6 0 1 0 1

7. AGE AT ADMISSION (27–29): 2 7

8. RACE (30): 0

9. ETHNIC BACKGROUND (31): 9

RELIGION: Mus

LENGTH OF SERVICE (33–34):

ETS:

11. FMP (35–36): 2 0

12. SOCIAL SECURITY NUMBER (37–45): 0 0 2 0 0 2 0 1 6

ORGANIZATION *(Active Duty Only)*: EPW

13. MARITAL STATUS (46):

HOUR OF ADMISSION: 1852

BRANCH / CORPS: EPW

FLYING STATUS (48–49):

15. BENEFICIARY CATEGORY (50–52): K 7 8 EPW

16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION *(State or Country Code)* (62–63):

18. MOS (64–70):

19. TRAUMA (71): I

PREV. ADMISSION YEAR: — NO: X

20. SOURCE OF ADMISSION / AUTHORITY FOR ADMISSION (72): 0 EMT

WARD: ICU3

NAME / RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*:

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

21. TYPE OF DISPOSITION (73–74): XFR

22. MTF TRANSFERRED TO (75–80): (b)(3)-1

23. DATE OF DISPOSITION *(YYMMDD)* (81–86): 0 3 0 4 1 4 0030

24. CLINIC SVC - ADMITTING (87–90):

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(YYMMDD)* (97–102):

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116): 0 3 0 4 1 1

FOR LOCAL USE

GSW to (R) leg s/p BKA

ADMITTING OFFICER *(Signature, as required)*: (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE — USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-2		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		(b)(6)-4 (b)(6)-4			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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 Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) [b(3)-1]
2. MTF LOCATION (7–8) (State or Country Code.)
3. REGISTER NUMBER (9–15) [b(6)-4]
NAME (Last, First, Middle Initial) [b(6)-4] [b(6)-4]
4. PAY GRADE (16–17)
5. SEX (18): M
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26)
7. AGE AT ADMISSION (27–29)
8. RACE (30): O
9. ETHNIC BACK-GROUND (31): 9
RELIGION: Mus
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35–36): 20
12. SOCIAL SECURITY NUMBER (37–45) [b(6)-4]
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION: 1252
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52) [b(6)-4] [b(6)-2]
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62–63)
18. MOS (64–70)
19. TRAUMA (71): I
PREV. ADMISSION YEAR [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): O EMT
WARD: IC13
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [b(6)-4]
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION (73–74): XFR
22. MTF TRANSFERRED TO (75–80) [b(3)-1]
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 20130403 0415
24. CLINIC SVC - ADMITTING (89–92)
25. MTF TRANSFERRED FROM (93–98)
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106)
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108)
28. MTF OF INITIAL ADMISSION (109–114)
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122): 20030401 1
FOR LOCAL USE

R foot 2/3/4TH MT FRACTURE
DX: 82525
EXT TRAUMA
OPEN

ADMITTING OFFICER [b(6)-2]

[b(6)-2]

DA FORM 2985 N OF MAR-8

USAPA V1.00

MEDCOM - 2976