PROGRESS NOTES

DATE

09:38 (R) Cooling bath given. Tylenol po given (b)(6)-2

Voided (900a) Void 450ml @ 1100Z RS dry runny.

11:37 (R) O2 sat 97% RR - 24, HR - 106, BP 103/42 temp (102.2°F)

Remains Febrile despite tylenol ; cooling bath.

1800a In MD informed. Out with dox (b)(6)-2

+1000a

2200

@ c 1800a

1445Z 5Apr03 assumed care of pt. changed Δ to (R) flank. packed W-D dressing sterile condition. 121/44 P116 POX 92% RA RR, 20 & looking comfortable. (R) arm in splint - good CMS to fingers. Patent PIV to (L) AC. Lungs CTA. Temp 99' axillary. HS normal, BS present all 4 quads; pt. voids on his own clear yellow urine. (b)(6)-2 CPT AN.

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
APR03 0202	Pt to ICW #1, Alert + cooperative, (L) arm in splint cast CMS intact + RUE. (R) flank area dressing intact, slightly soiled ē serosanguineous fluid wound red ē granulation tissue, dressing posterior to that CD+I. Lungs clear throughout, S_1 + S_2 clear and crisp, peripheral pulses palpable & correspond ē heart sounds. Pulses bounding. Abd soft, nontender BS (+) X4. Restarted IV in (L) forearm. BP 130/80 HR 98 RR 20 T= 101.0. Tylenol 650 mg PO given for ↑ temp. Pt denies pain. (b)(6)-2
0435	APR03 Vitals – Temp 99.4, BP 130/78, Pulse 88, SpO_2 98% Resp 20 (b)(6)-2
0440	Apr 03 Pt alert + cooperative PERRLA, S_1S_2 heart sounds present, and lungs clear bilaterally. +2 peripheral pulses in all 4 extremities. (R) UE in splint cast Pt has full sensation and cap refill <3 sec in RUE. Able to move all fingers in (R) hand. Dressing intact in (R) flank area. Dressing is soiled at this time. Abdomen is soft & non-tender ē hypoactive bowel sounds. @ forearm IV patent ē LR running at this time Pt denies pain but stated he is hungry (b)(6)-2 24/AW
0715	APR03 5mg of MORPHINE for PAIN. SgC (b)(6)-2 9/AW

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

BRANCH/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

Doc 's Orders

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/6/03 0340	(1) ADMIT (R) FA / (R) FINGER INJURY IN MCWR 1
	(2) Dx: see (1)
	(3) Condition Stable
	(4) VITALS q shift
	(5) Diet: Regular
	(6) FLUIDS: LR @ 75/°
	(7) x-ray (R) FA (AP/LAT)
	(8) MEDS:
	ANCEF 1 gm IV Q 8°
	CLOT 350mg IV q day
4/6/03 0725	(1) MSO4 2-5mg + VQ 3° PRN
	(2) Tylenol, MOTRIN, VICODEN, T3 PRN PO @ appropriate intervals
4/9/03 1240Z	(1) D/C Ancef/Gent IV 72°
	(2) ADD Keflex 500g PO QID ↑ Ancef/Gent D/C's

[(b)(6)-2]

HOSPITAL OR MEDICAL FACILITY	STATUS	TAINED AT
SPONSOR'S NAME	SSN/ID NO.	

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

REGISTER NO.	WARD NO.

[(b)(6)-4] [(b)(3)-1]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
Apr 03 1445	Pt c/o HA. admin 1 tab Tylenol (500mg) PO per dr. order (b)(6)-2 2LT/AN
APR03 1700	RR 20 TMP oral 99.9 HR 71 SPO2 RA 97% BP 108/48. Pt walking, c no pain. Replaced dressing, 3 capadicins, No complaints (b)(6)-2 LPN, SGT
AR 03 1800	Ancef 1gm IV (b)(6)-2 LPN, SGT
2110	T3 i for pain & fever TMP 99.6 (b)(6)-2 LPN, SGT
AR03 0324	1gm Ancef IV. Pt laying in bed c/ no complaints. LPN, SGT
3.31	Pt tmp 99.3 orl (b)(6)-2 LPN, SGT
April 03 0430	VS obtained, RR 24, T 99.8°F, BP 122/60, O2 sat on RA 98% and P 75. Pt denies any pain at this time (b)(6)-2 2LT/AN
4/8/03 0450Z	(R) open ulnar fx / (R) FLANK DEEP SOFT TISSUE WOUND AF/VSS ANCEF/GENT (R) ARM SPLINTED / Dressing c/d/i (R) FLANK: Dressing mild yellow/green/white & blood O/W Surgery (R) flank - Delayed Primary Closure? EVAC Priority
	(b)(6)-2
BAR03-0540Z	pt. given 2T3s PO for pain. Spe (b)(6)-2

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT (0085)

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

(b)(6)-4 (b)(3)-1

PROGRESS NOTES
Medical Record

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

DATE	NOTES
4/6/03 0720	(R) ULNAR FX (R) FLANK Deep Soft Tissue Injury VS: 99.4 130/78 88 SpO2 98% RA R-18 (R) FA Splinted / Dressing C/D/I (R) Flank good granulation 6X3cm wound w→D Δ'D P) ① AMOX / GENT ② SWAC ③ Wound care ④ Pain Control ⑤ Regular Diet

0603 0800Z 350mg Gent IV ↑ at this time. Pt resting quietly — 2LT IAN (b)(6)-2

0603 1641 RR 24 HR 85 SpO2 98% RA Tmp 101° ORAL 134/84 no change since last exam

1701 Pt ↑ T 3 for fever & pain (b)(6)-2 — APAP, SGT

1900 Pt recieved anceft 1g IV ← (b)(6)-2 → SPC

0320 Pt slept through night ↓ complaints. Vitals 5d/Heart Tmp 99.6° — WPN SGT

0603 0500 130/80, 90 HR, 20 Resp, 99° Temp (b)(6)-2 — 2LT AW

0603 0600Z Pt receiving 350 mg Gent IV at this time — 2LT IAN (b)(6)-2

0603 ⑥ ULNA FX — AMOX/GENT

1552 ⑥ FLANK Deep Soft Tissue INJURY

VSS / AF

(R) FA SPLINTED — C/D/I (original dressing placed 4/5/03)

(R) FLANK - pseudomonas colonization 6X3cm WOUND entrance/exit w→D Δ'D

P) ① EVAC Priority ② WOUND CARE ③ Discuss Soft Tissue c Surgeon

DATE	NOTES
8Apr03	
1200Z	Pt c/o pain. admin 2 Tylenol #3 tabs (PO) —— (b)(6)-2
1210 Z	Pt's temp 101.8. admin 800mg motrin for fever —— (b)(6)-2
1300 Z	Pt temp now 100.4 —— (b)(6)-2
8APR03 1630	RR20 97%O2 RA 70HR tmp 99.6 118/60: Pt Given Tylenol Two TAB 500 for Fever
1953	Ancef IV and MSO4 5mg for c/o PN —— (b)(6)-2
9Apr03	@ 0420 Bp 119/60 p84 T-100.7 RR-16 P... 98
9April03	4mg MSO4 IVP for pain — (b)(6)-2 SGT 91W20
9April03	Dressing Δ —— (b)(6)-2 SGT 91W20
9April03	0800 Pt c/o Pain Received ii T3 PO —— (b)(6)-2
4/9/03 1233z	Ⓡ open ulnar fx ANCEF/GENT D 3/3
	Ⓡ Flank Deep Soft Tissue wound
	VS: 118/60 84 100.7 16 98% SaO2 (08Apr03) Tmax 101.8
	Ⓡ arm splinted / Dressing intact
	Ⓡ Flank ⊕ serosanguinous Drainage ∅ necrosis
	w→D dressing Δ'D
	P) Eval Priority
	D/C Ancef/Gent p 72°
	will start Keflex 500mg po QID
	(b)(6)-2
9April03 1305	Pt c/o of Abd pain; Pt states has no Bowel Movement x6 Days, did rectal exam, exam was neg, Continue to monitor —— (b)(6)-2

PLEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1/10/03 1020	Transfer for NSG Note: See Med Com Form 689. R.. for Transfer in note. (b)(6)-2 (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

OT (b)(6)-4

PROGRESS NOTES
Medical Record

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

EPW # (b)(6)-4

509-113

NSN 7540-00-634-4122

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
14 April 03	pt admitted to ICU # 3 @ 12:15. A+O x 3, MAE, VSS, BP 148/71 (100), HR - 114 sinus tach, O2 sat 100% on RA, temp 38.4°C. BBS CTA, RLL ↓ fine crackles, Good pulses, cap refill < 2 sec. Abd. soft, but tender. (R) Flank GSW covered with dressing. Significant amount of pain in this area. (R) UE (forearm) c̄ penetrating wound. Pending XR. Awaiting OR. Foley to SD c̄ good amount of urine. IVF infusing via 2 HL's (LUE). Labs (CBC, lytes) within acceptable limits (b)(6)-2
12:40	Seen by surgery & anesthesia. Abx given. Awaiting
UO - 800cc	OR. T3:00(Z). CXR done.
15:17	Post-Op: HR - 85 NSR, BP 127/55, Temp - 37.5°C, RR - 19 bpm, O2 sat 97% on RA. Resting comfortably
2200 Z	Foley D/cd. Pt was complaining of pain + discomfort from cath.
15 April 03 05:25 (Z)	Pt resting comfortably, BP - 101/43 HR - 107 RR - 28 O2 sat - 99% RA VSS (R) UE immobilized. No neurovascular deficits. (R) Flank dressing saturated with serous - sang. drainage (reinforced.) Pain well controlled. temp 98.3°F. Will cont. with pulmonary toileting
08:00	101.3°F, HR - 115, 98% O2 sat on RA, BP 111/48 RR - 20 bpm. Medicated for pain c̄ good results.
0912 Z 05 Apr 03	NPN C/o ↑ Temp to Translator T - 101.6 F RN Notified (b)(6)-2

(Continue on reverse side)

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

EPN # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY (b)(3)-1 | RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS | CITY | STATE | ZIP CODE

ARRIVAL: DATE *(Day, Month, Year)* 4 Apr 03 | TIME 1145 Z | TRANSPORTATION TO FACILITY

SEX: M | AGE | DUTY/LOCAL PHONE: AREA CODE | NUMBER | HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2569 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: PCN

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT: DATE LAST VISIT | 24 HOUR RETURN: ☐ YES ☐ NO

TETANUS: DATE LAST SHOT | COMPLETED INITIAL SERIES: ☐ YES ☐ NO

CHIEF COMPLAINT: (R) Flank Laceration (L) Arm Injury

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1150 | INITIALS: A

VITAL SIGNS

TIME	1150				
BP	105/59				
PULSE	115				
RESP	34				
TEMP	100.4				
~~WT~~ SPO2	98%				

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X 2			
☒ CHEM 7			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	IV LR			1155	18g (L) Bicep

DISPOSITION: ☐ HOME ☐ FULL DUTY | MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS. | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE: FCC

TIME OF RELEASE: 1215

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW #

(b)(6)-4

(b)(6)-4

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 6-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	WBC	
	H/H	
	PLT	
PT		
APTT		
SMAC		
BHCG	ETOH	GLU

ABG/PULSE OX		
SUP O2	PH	PO2
PCO2	SAT	OTHER
U/A	DIP	
	MICRO	

RADIOLOGY	Check if read by radiologist ☐
RESULTS	
EKG INTERPRETATION	

PROVIDER HISTORY/PHYSICAL

EPW s/p GSW (R) flank >24° ago - has (B) UE injuries s/p GSW. Arms are bound @ wrists.

Limit exam.

Meds: Ø   All: PCN   Surg Hx: Ø   Tob: ⊕

PE: Head: NC/AT [illegible]
Con: [illegible]
Pul: CTA b/l
Abd: NT/ND S-
B/E: FROM/MAEW x (B) UE - bound - 6cm x 3cm wound to [illegible] (R) arm

Abd wound / flank 8cm deep flank extends to deep soft tissue Ø evidence of [illegible]

A/P: wounds 24° ago - explore wound debride / possible [illegible]

CONSULT WITH	TIME	ACTION
CBC, amylase		
Chem 7		
X-ray (R) arm		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

Penetrating Wounds (R) flank + Arm

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

AL RECORD - PATIENT ACTI\ , FL SHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

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

Time 1020 To ICW3 From ____ ☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ____ Physician (b)(3)-1

Procedure/Diagnosis GSW Ⓡ Anesthesia (Specify): -0-

LOC AAOX3 B/P 130/70 P 96 R 20 T 100.6

Dressing/cast Ⓡ arm + Ⓡ flank stained / old odor Neurovascular checks AAOX3

Intake (IV, po) NA Tubes None

Output (EBL, other) ____ Voided ☒ No ☐ Yes Amount: ____

Medication Keflex [illegible] po QID

Other ____

Report From [illegible] Received By (b)(6)-2

VITAL SIGNS

TIME:	1020															
BP ARTERIAL LINE	Ø/10															
BP CUFF	130/70															
TEMPERATURE	100.6															
PULSE	96															
RESPIRATORY	20															
OXYGEN (L/%)	—															
PULSE OXIMETER	98%															
O_2 METHOD																

Oxygen Method Key: NC = Nasal cannula, MT = Mist tent, NR = Non rebreather, PR = Partial rebreather, FM = Face mask, A = Aerosol, VM = Venturi mask, TC = Trach collar

PAIN

TIME:								
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)								
RELIEF ACCEPTABLE (Y/N)								

SPECIAL NEEDS

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

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

YESTERDAY'S WEIGHT: ____

TODAY'S WEIGHT: ____

WEIGHT CHANGE: ____

*Per hospital policy.

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

PATIENT IDENTIFICATION

OD (b)(6)-4 (b)(3)-1

DIAGNOSIS: ____

DRG: ____ ADMISSION DATE: ____

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: ____

ISOLATION REQUIRED (Specify): ____

II - PATIENT ASSESSMENT - REVIEW OF

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been **MET**. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1030 INITIALS: (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ 4/10/03	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ RRR	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ CTA Bilat	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ vds (+)	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ DSG replaced (R) flank ē Saline/H_2O_2 - repacked wet to dry, wound (R) flank ē good granulation.	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Grimaced when dsg. changed (R) flank. Foul odor to dsg. yellow/green D/C.	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ Speaks no English. Interpreter present.	☐	☐

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

TIME: ____ INITIALS: (b)(6)-2	TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____
IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____
IV site care provided: ____	IV site care provided: ____	IV site care provided: ____
IV tubing changed: ____	IV tubing changed: ____	IV tubing changed: ____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ____ ____	IV Site #1: ____ ____	IV Site #1: ____ ____
IV Site #2: ____ ____	IV Site #2: ____ ____	IV Site #2: ____ ____
Comments: * IV site dc'd (L) ↑ forearm 2° ∅ date, dsg. dirty, peeling off.	Comments:	Comments:

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

∅ S+S infection.

MEDICAL RECORD

LRMC INTRA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA BY ANES

2. PATIENT IDENTIFIED RECORD REVIEWED [illegible] VERIFIED BY (b)(6)-2 [illegible] IAN

3. DATE 4APR03 TIME PATIENT ARRIVED IN SUITE 1330

4. PATIENT IN TIME 1330 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: ON BEAN BAG BUMP TO (R) HIP / ROLL 4 (R) SHOULDER TO SUPPORT / PILLOW 4 (R) LEG

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: NA

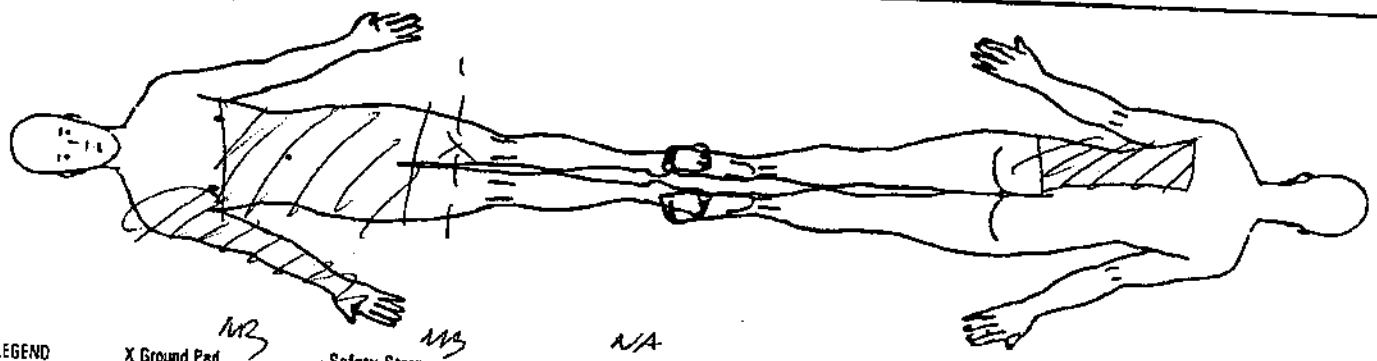
PREP SOLUTION (Specify) BETA / BETA

SITE: (R) FLANK BY WHOM: BOTH

SITE: (R) ARM BY WHOM: BOTH

COMMENTS: NO POOLING

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C – Correct I – Incorrect

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

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

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;) (b)(6)-4 EPW

(b)(6)-4

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

☐ ESU NO: ORG82

GROUND PAD: BRAND VALLEY

LOT NO: 38592

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUMBER: MANUF

MEDICATIONS/ORDERS

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

DICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

)UND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NS

THER ORDERS	TIME	CARRIED OUT BY

HYSICIAN'S SIGNATURE

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

LABORATORY SPECIMENS

6.

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* FLANK / 4X8 SILK TAPE (R) ANN FLUFFS / KERLIX ACE WRAP

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16Fr Foley	2.	3.
SITE	1. BLADDER	2.	3.

19. ADDITIONAL INFORMATION
The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the NA side.

Verified by: NA (Patient/guardian) NA (Surgeon) NA (Anesthesia) NA (Operating Room Nurse)

20. OPERATION(S) PERFORMED
WOUND EXPLORATION (R) FLANK
DEBRIDEMENT (R) FOREARM

21. PATIENT TRANSFERRED TO ICU 3 TIME METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ/AN

REVERSE OF DA FORM 5179-1, OCT 87

EUL OP 358, 2 Mar 00
RC apprvl - 3 Feb 00

USAPA V1.00

(THIS FORM IS SUBJECT TO THE PRI ...T OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205

ANESTHESIA RECORD

Cefotetan 2Gm in ICU

Page 1 of 2

ANES. START	IN OR	ANES. END	DATE
1230	1320	1508	4 APR 03

OPERATION PERFORMED: X-lap washout (R) open I&D washout

SURGEON(S): (b)(6)-2 / (b)(6)-2

TOTS	SURG START	DRESSING	OR NO
1325	1353	1455	

PREOPERATIVE

☒ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 40
☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1320

Pre-Anesthetic State:
☒ CALM ☐ APPREHENSIVE ☐ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☒ ANES. MACHINE # _____ & EQUIP. CHECKED
☒ NON-INV. B/P ☒ PNS
☒ CONT. EKG ☐ V LEAD EKG
☒ ESOPH. STETH. ☐ PRECORD STETH.
☒ PULSE OXIMETER ☒ O2 ANALYZER
☒ END TIDAL CO2 ☐ MASS SPEC.
☒ TEMPERATURE N.P
☒ WARMING BLANKET ☐ FLUID WARMER
☒ AIRWAY HUMIDIFIER
☐ N / G TUBE ☐ O / G TUBE
☒ IV(s) 18G (L) arm

☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☒ FOLEY INSERTED: ☐ O.R. ☒ FLOOR
EYE CARE ointment
☒ PRESSURE POINTS CHECKED / PADDED
Arms on arm board

ANESTHETIC TECHNIQUE

☐ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☐ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

☒ INTUBATION ☒ ORAL ☐ NASAL
☐ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☒ STYLET USED
ATTEMPTS 1 ☐ BLADE #4 MAC
ETT SIZE 8 ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☒ CUFFED 10 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT _____ CM H2O
ETT SECURED AT 23 CM
☒ BREATH SOUNDS
☒ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ VIA SIZE

RECOVERY

IN PACU	CONDITION		
O2	stable		
	PULSE	RESP	O2 SAT
		16	
REMARKS	RA		TEMP

SENT TO: PARRS:

FLUIDS TOTALS

	IN	OUT
Colloid	900	EBL 150
Crystalloid	1000	Urine 200
		Gastric

AGENTS	1315	30	45	1400	15	30	45	1500	TOTALS
Fentanyl cc	2			1	0.5	0.5			
SUX mg	120								
Propofol cc	160								
Versed				3/2/2					
Ephedrine									
Robinul/Neostigmine	5	5	5			4/0.8			
N2O L/min Air	1	1	1	1	1	1	X		
O2 L/min	5	0.8	0.8	0.8	0.8	0.6			

FLUIDS								
LR		1000	LR 1500					
NS		500						
Urine			60			240		
EBL			150					

MONITORS								
EKG	ST	ST	ST	SR	ST	SR		
% O2 Inspired	.9	.32	.32	.44	.38	.36		
O2 Saturation	100	100	100	100	100	100		
End Tidal CO2	43	40	31	35	52	53		
Temperature N.P			37.4		378	377		
PNS			9/4	9/4	9/4			

TIME

VITAL SIGNS	PRE-OP VALUES
B/P	110/60
P	90
R	16
SAT	
H/H	27

RESP	1315	30	45	1400	15	30	45	1500
Tidal Volume	710	710	710	SV	21	SV	SV	
Resp Rate	10	10	10			20		
Peak Pressure	21	24	24					
Symbols for Remarks	SV							
Position	supine	(R)	lat					

SYMBOLS
X ANESTHESIA
◉ OPERATION
V ^ B/P CUFF PRESSURE
⊥ T ARTERIAL LINE PRESSURE
● PULSE
○ SPONTANEOUS RESP
Φ ASSISTED RESP
⊗ CONTROLLED RESP
T TOURNIQUET
F CRYSTALLOID FLUID
B BLOOD

REMARKS: ☒ Patient reevaluated. No change from preop plan / evaluation.
☒ Significant changes from preop plan / evaluation.

BP cuff (R) calf 2° UE injuries and IV
1458 open edges SV oropharynx suctioned extubated (+) pressure

Tourniquet Time:

(b)(6)-2
MA / CRNA
PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION
(b)(6)-4

(b)(3)-1 [redacted] ON: (b)(6)-4 [redacted] Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

HEIGHT	WEIGHT 70 kg
B/P	P	R

PREOPERATIVE VITAL SIGNS:

PROPOSED OPERATION: I/D Rt Arm wound / Lt Flank wound

CURRENT MEDICATIONS ☑ NONE

PREVIOUS ANESTHESIA / OPERATIONS ☑ NEGATIVE

ALLERGIES ☐ NKDA PCN

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☑ NEGATIVE

AIRWAY / TEETH / HEAD & NECK: Class [illegible] uvula exposed chin → m 3FB open 3FB

SYSTEM			WNL	COMMENTS
RESPIRATORY: Asthma, Dyspnea, Recent cold	Bronchitis, Pneumonia, SOB	COPD, Productive Cough, Tuberculosis	☑	Tobacco Use: ☐ No ☑ Yes ___ Pack/Day for ___ Years Last [illegible] [illegible]
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever	Arrhythmia, Hypertension, MVP	CHF, MI, Pacemaker	☑	
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn	Cirrhosis, Jaundice, Ulcers	Hepatitis, N&V	☑	Ethanol Use: ☐ No ☐ Yes Frequency ______
NEURO/MUSCULOSKELETAL: Arthritis, Neuromuscular disease, Syncope, Weakness	Back problems, Headaches, Paralysis, Seizures	CVA/Stroke, Loss of consciousness, Paresthesia, TIAs	☑	
RENAL/ENDOCRINE: Diabetes, Urinary retention	Renal failure/Dialysis, Urinary tract infection	Thyroid disease, Weight loss/gain	☑	
OTHER: Anemia, Malignancy	Bleeding tendencies, Sickle cell trait	Hemophilia, Transfusion history		

PERTINENT STUDY RESULTS

Chest X-ray	Pulmonary Studies
EKG	
LFTs	
Urinalysis	Thyroid	FBS
Hgb / Hct / CBC	Lytes

PROBLEM LIST / DIAGNOSES

ASA (1) 2 3 4 5 (E)

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered. Patient / legal guardian voices understanding and gives consent for :

Local / MAC, SAB, Epidural, IVR, (General Anes.)

Other: ______

Appropriate alternative as backup.

NPO status explained.

EPW

PATIENT'S SIGNATURE ______ DATE ______

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 [redacted] DATE 4 APR 03

PHYSICIAN DATE ______

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ______

TIME: ______

SIGNED: ______

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Cefotetan 2Gm in ICU

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1230	1320	1508	4APR03

OPERATION PERFORMED: X-Rap washout (R) arm I&D washout

SURGEON (b)(6)-2 / (b)(6)-2

TOTS	SURG START	DRESSING	OR NO
1325	1353	1455	

PREOPERATIVE

☒ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 4°
☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1320

Pre-Anesthetic State: ☒ CALM ☐ APPREHENSIVE ☐ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☒ ANES. MACHINE # ☒ & EQUIP. CHECKED
☒ NON-INV. B/P ☒ PNS
☒ CONT. EKG ☐ V LEAD EKG
☒ ESOPH. STETH. ☐ PRECORD STETH.
☒ PULSE OXIMETER ☒ O2 ANALYZER
☒ END TIDAL CO2 ☐ MASS SPEC.
☒ TEMPERATURE n.p.
☒ WARMING BLANKET ☐ FLUID WARMER
☒ AIRWAY HUMIDIFIER
☒ N / G TUBE ☐ O / G TUBE
☒ IV(s) 18G (L) arm
☒ ARTERIAL LINE
☒ CENTRAL LINE
☒ SWAN-GANZ
☒ FOLEY INSERTED ☐ O.R. ☒ FLOOR
☒ EYE CARE eyetape
☒ PRESSURE POINTS CHECKED / PADDED Arms on arm board
☐

ANESTHETIC TECHNIQUE

☒ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☒ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

☒ INTUBATION ☒ ORAL ☐ NASAL
☐ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☒ STYLET USED
☒ ATTEMPTS 1 ☐ BLADE 4 MAC
☒ ETT SIZE 8 ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☒ CUFFED 10 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ___ CM H2O
☒ ETT SECURED AT 23 CM
☒ BREATH SOUNDS
☒ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ MASK SIZE

RECOVERY

IN PACU	CONDITION	PULSE	RESP	O2 SAT	TEMP
02	stable		16		

REMARKS: PCA

DIRT TO: PARRS:

FLUIDS TOTALS

IN		OUT	
Lactated Ringer's	1900	EBL	150
PS	1000	Urine	200
		Gastric	

AGENTS / FLUIDS / MONITORS

								TOTAL
Fentanyl cc	2			1	0.5	0.5		
SUX -g	120							
Propofol -g	180							
VEC -g								
Ephedrine	5	5	5	3	2	2		
Robinul/Neostigmine -g						4/0.8		
N2O L/min AIR								
O2 L/min	5	1 / 0.8	1 / 0.8	1 / 0.8	1 / 0.8	1 / 0.6	X	
LR		1000	LR 2 1500					
PS		500						
Urine			600			200		
EBL				150				
EKG	ST	ST	ST	ST	ST	ST		
% O2 Inspired	.9	.32	.32	.44	.38	.36		
O2 Saturation	100	100	100	100	100	100		
End Tidal CO2	43	40	37	35	52	53		
Temperature n.p.			37.4		37.8	37.7		
PNS		9/4	9/4	9/4	9/4			

TIME / VITAL SIGNS

	PRE-OP VALUES
B/P	110/60
P	90
R	16
SAT	
H/H	27

RESP								
Tidal Volume	710	710	710	SV		SV	SV	
Resp Rate	10	10	10		21	20		
Peak Pressure	21	24	24					
	SV							

Symbols for Remarks

Position: Supine 2 (R) Lat

REMARKS:
☒ Patient reevaluated. No change from preop plan / evaluation.
☒ Significant changes from preop plan / evaluation.

BP cuff (R) cuff 2° UE injuries and IV

1458 open eyes SV oropharynx suctioned extubated (+) pressure

Tourniquet Time:

(b)(6)-2

MD / CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION # (b)(6)-4

SYMBOLS
X ANESTHESIA
⊙ OPERATION
∨ ∧ B/P CUFF PRESSURE
⊥ T ARTERIAL LINE PRESSURE
● PULSE
○ SPONTANEOUS RESP
Φ ASSISTED RESP
⊠ CONTROLLED RESP
T TOURNIQUET
F CRYSTALLOID FLUID
B BLOOD

MEDICAL RECORD SUPPLEMENTAL ME

REPORT TITLE

POST ANESTHESIA CARE RECORD

Time In: | Procedure: | PASS APPROVED (Date)

Physician: | Anesthesia Provider: | ASA Grade (I – V):

Pre-Op Vitals: T= P= R= BP= SaO2=

ANESTHESIA: General Spinal Epidural Sedation Local Nerve Block:
Intrathecal w/ narcotic: time:
Other:

REVERSALS: Narcotic: No / Yes time:
Muscle Relaxant: No / Yes time:

Allergies: PCN
Latex allergy: N / Y
Medical/Birth Hx:
Complications:
Tourniquet time:

INTAKE: OR / PACU
Crystalloids /
Blood Prod /
Colloids /
Irrigations /
Other /

OUTPUT: OR / PACU
Urine /
EBL /
Drains /
Emesis /
Other /

VITAL SIGNS | **POST ANESTHESIA RECOVERY SCORE** | **PAIN ASSESSMENT** | **OTHER**

Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	Derm Level	N/V	Nurse action				Init
:17	127/55	37.5	85	19	97%	RA															
:35	125/56	37.3	87	17	99%	RA															
:45	135/57	37.2	88	19	99%	RA															
:00	133/60		85	20	100%	RA															

. SIGNS
blood pressure
ilse
spirations
mperature ax = axillary
= oxygen saturation

Activity (Act)
2 = Moves 4 extremities
1 = Moves 2 extremities
0 = Moves 0 extremities

RESPIRATIONS (Resp)
2 = Cough/deep breath
1 = Dyspnea, airway
0 = Apnea

CIRCULATION (Circ)
2 = 20% +/- PRE-OP BP
1 = 20% - 50% +/-
0 = 50% +/-

LEVEL OF CONSCIOUSNESS (LOC)
2 = Fully awake
1 = Verbally aroused
0 = Unresponsive
No nystagmus w/ ketamine

SKIN
2 = Pink
1 = Pale, dusky
0 = Cyanotic

uction IS = Incentive spirometry D/DB = cough/deep breath HOB = elevate head of bed ES = elevate extremity ICE = cold compress CDI = clean/dry/intact Init = initials
atient teaching = see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow-by Other:
r Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp
leeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:
on Codes: H = head F = face Fd = fundus Tr = throat N = neck Sd = shoulder B = back Ch = chest ABD = abdomen U = umbilicus UE = upper extremity LE = lower
ty Ht = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

PROBLEM/COMPLAINT For analgesic include Quality, Intensity (0-10), and Location	MED DOSE/ROUTE	INIT	REASSESSMENT/RESPONSE For analgesic include Quality, Intensity (0 – 10), and Location	TIME	INIT

ED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | (Continue on reverse) DATE

T'S IDENTIFICATION (For typed or written entries give: title; grade; date; hospital or medical facility) Name – last,

EPW # (b)(6)-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | RO (b)(6)-2 O.

PATIENT IDENTIFICATI

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ______ HOURS | LIST TI ORDE NOTED A SIGN

1. Admit Patient to ICU #3
2. Diagnosis: ~~[illegible]~~ GSW [illegible]/[illegible]
3. Condition: ~~Stable~~/Serious/Critical
4. Allergies: ~~NKDA~~ PCW
5. Vital signs q hr/(q2hr)/q6hr/q8hr/q shift
6. Cardiac respiratory monitoring
7. Diet: (NPO)/ regular/ soft/ clear liquid

DATE OF ORDER | TIME OF ORDER ______ HOURS

8. Activity: AD LIB/ Strict BR/ BR with BSC/ NWB R or L LE
9. HOB up 30 degrees
10. Nursing I/O; CDB/ NG to LIS/ LCS
11. Labs: Chem 7/ H/H/ PT/PTT/ CBC q AM/ 4 hrs/ 8 hrs/ BID
12. EKG q AM

DATE OF ORDER | TIME OF ORDER ______ HOURS

13. PCXRAY q AM/QOD
14. IVF NS/ (LR) D5NS/ D51/2NS To run @ 150 cc/hr.
15. Ancef 1 GM IV Q 8 hrs
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs.
18. O2 titrate to keep SPO2 >
19. Versed gtt 1-10mg/hr IV titrate to

DATE OF ORDER | TIME OF ORDER ______ HOURS

Ramsey Scale of

20. Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of
21. Vecuronium 1mcg/kg/min
22. MSO4 1-2 MG IV q 3-5 min PRN ~~HR PRN Pain~~ BV
23. Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24. MOM 30cc PRN Gastric upset

CG

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

AL RECORD · DOCTOR'S OR

For use of orm, see AR 40-66, the proponent a[illegible] is -

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

PATIENT IDENTIFICATION

O.D. # (b)(6)-4

NURSING UNIT: ICW3 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	10APR03	1815 HOURS	
(1)	ADMIT: To ICW-3 (ortho)		
(2)	Dx: ~~(1) forearm~~		
	(1) (R) ulna- fx		
	(2) (R) flank deep soft tissue injury		
(3)	CONDITION: Stable		
(4)	VITALS: TID		
(5)	ACTIVITY: As tolerated		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER / TIME OF ORDER	HOURS
(6)	ALLERGY: NKDA	
(7)	NURSING: Dry dressing packing QD	
(8)	DIET: ~~Asp~~ Regular (No pork)	
(9)	MEDS: (1) Keflex 500mg PO QID	
	(2) Percocet ii tabs PO Q6°	
	(3) Motrin 800mg TID WF	
	(b)(6)-2 MD	(b)(6)-2 CPT, MC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER / TIME OF ORDER	HOURS
	10 Apr 03	1900
	Valium 5-10mg PO. q 4-6hrs as needed for pain	
	(b)(6)-2 (b)(6)-2 (b)(6)-2	4 days

noted 10 Apr 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER / TIME OF ORDER	HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

"USE BALL POINT [illegible] N PAPER REQUIRED"

MEDCOM - 3660

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TI ORDE NOTED SIGN

25 NS/ LR bolus X liters

26 Neuro checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift

27 Vascular checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED N

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

5 APR 03 | 0915 HOURS

1 Advance diet to clear liquid

2 Tylenol 650mg po. x 1

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo 04 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				04 05
04	(b)(6)-2	Vital signs q hr (q 2hr / q6h4 / q8hr /	07	(b)(6)-2
	.....	q shift) 4 to 5 Apr 03	19	
	.....	Cardiac Respiratory Monitoring	07	
	.....		19	
04	(b)(6)-2	Diet: NPO / Regular / Soft / Clear	07	Regular
	.....	Liquid	19	X Sprite
	.....	Activity: Ad Lib / Strict BR / BR with	07	
	.....	BSC / NWB R or L LE	19	
04	(b)(6)-2	HOB up 30 Degrees	07	(b)(6)-2
	.....		19	
	.....	Nursing I/O, CDB / NG to LIS / LCS	07	
	.....		19	
	.....	Labs: Chem 7 / H&H / PT/PTT /	04	
	.....	CBC q AM / 4 hrs / 8 hrs / BID	08	
	.....		12	
	.....		16	
	.....		20	
	.....		24	
	.....	EKG q AM / QOD	06	
	.....	PCXRAY q AM / QOD	06	
	.....	Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07	
	.....	q shift	19	
	.....	Vascular checks nq 1hr / 2 hr / 4 hr /	07	
	.....	6 hr / q shift	19	
05	(b)(6)-2	Advance diet as	07	X (b)(6)-2
	.....	tolerated	19	X
	.....			

ALLERGIES: [X] YES [ ] NO — PCN

PRIMARY DIAGNOSIS: (R) Flank penetrating wound (L) Forearm injury

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO — PAGE NO:

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

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

Treatment Facility: (b)(3)-1

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

Mo 04 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
04	(b)(6)-2	Admit Patient to ICU #3	04/04/03	12:15	12:15	[illegible]
04		Diagnosis: GSW to (R) Flank, (R) Forearm	↓	↓	↓	↓
04		Condition: Stable / Serious / Critical	↓	↓	↓	↓
04		Allergies: ~~NKDA~~ PCN	↓	↓	↓	↓
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. 04 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Tylenol 325mg ii PO Now	4APR03	2332(2)	2332(2)	(b)(6)-2
05	(b)(6)-2	Tylenol 650mg po x1	5Apr	9:37	9:37	
05		200 mcg Fentanyl } For dressing change	5	14:56	14:56	
05		10 mg MSO4 }	↓	↓	↓	
05		2 mg Versed } (b)(6)-2	↓	↓	↓	

POST-OP

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED (INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION)			
04	(b)(6)-2	MSO4 1-2mg IV Q 3-5min prn pain	2315 5APR03 2mg IV (b)(6)-2	5Apr03 2mg IV	5Apr 2mg IV	5Apr 2mg IV
			(b)(6)-2			

MEDCOM - 3664

CLINICAL RECORD

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

Mo. 4 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6 7 8 9 10
4/16/03	-Nurse-	[illegible]	08	[b)(6)-2] D/C
			[b)(6)-2]	
			14 [b)(6)-2]	
4/16/03	NURSE	[illegible]	08 [b)(6)-2]	D/C
4/16/03	NURSE	M SO4 2-5mg IV Q 3° prn	PRN 0715 2.5mg [b)(6)-2] 800	
			PRN [b)(6)-2] 0500	
			PRN	
4/16/03	[b)(6)-2]	Tylenol #3 1 tab prn	[b)(6)-2] 2J 0540 [b)(6)-2] 1045	
4/16/03		LRQ 75°	04 [b)(6)-2]	
			16 2C	
		Tylenol #3 1 tab PO prn pain	[b)(6)-2] 0540 2145	
4/9/03	[b)(6)-2]	Keflex 500mg PO QID	06 [b)(6)-2] 1000	
			12 1400	
			18 [b)(6)-2]	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: DCW3

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

OD [b)(6)-4] [b)(3)-1]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD

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

Mo. 04 Yr. 05

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR.	DATE DISPENSED (b)(6)-2: 04/05
(b)(6)-2	(b)(6)-2	LR @ 150 cc/hr	07	(b)(6)-2
			19	
(b)(6)-2	(b)(6)-2	Cefoxitin 2 gm IV Q 8 hrs	04	
			12	
			20	

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
(R) Flank penetrating wound
(R) Forearm injury

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

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

DISPENSING TIMES
USE PENCIL, CIRCLE MED TIMES

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

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 4 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12
(b)(6)-2 TO Apr 03	(b)(6)-2	Keflex 500mg PO QID	06	/		
			12	/		
			18	(b)(6)-2		
			24			
(b)(6)-2 Apr 03	(b)(6)-2	Percocet 1 Tab PO Q6°				
10 Apr 03	(b)(6)-2	Motrin 800mg TID c food	07	/		
			13	/		
			19	(b)(6)-2		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Ulnar Fx
Fl-L deep soft tissue injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

CD # (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 4 yr 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
10Apr03	(b)(6)-2	Percocet 1/1 tabs po q 6 prn	10Apr03 1945 (b)(6)-2
.....	.....		
10Apr03	(b)(6)-2	Valium 5-10mg po every 4-6 hrs prn	
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

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

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

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 (b)(3)-1 Ext #3	15B. DESTINATION FACILITY PHONE NUMBER		

DIAGNOSIS

@ flank GSW s/p exploex
GSW @ arm s/p IMN

X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

PHYSICIANS ORDERS

a. DATE	20b. TIME	20c. ALLERGIES
3 APR 03	0450	NKA

d. 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

e. IV / BLOOD

f. 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: ___

g. ALTITUDE RESTRICTION: Yes / No ___ feet

h. RECORDS TO ACCOMPANY PATIENT

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

i. MEDICATIONS / TREATMENTS

Cefox. 1gm IV q8°
Percocet 1-11 p.o. q6° 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.			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

36 y.o. ♂ s/p GSW @ flank exploex, s/p GSW @ arm c fracture s/p IMN

Stable for export

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

FO

OD (b)(6)-4 (b)(3)-1

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

6. AGE 36 | 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. ADMPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

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

17. DIAGNOSIS

(R) flank GSW s/p exploration
GSW (R) arm s/p IMN

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 5 APR 03 | 20b. TIME 0450 | 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. T / 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

Ceftoxitin 1gm IV Q8°
Percocet 1-11 p.o. Q6° 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.			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

36 y.o. ♂ s/p GSW (R) flank exploration, s/p GSW (R) arm c fracture s/p IMN

Stable for export

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF LOCATION (State or Country Code.): (b)(3)-1 — K U

NAME (Last, First, Middle Initial): EPW (b)(6)-4 OD#

3. REGISTER NUMBER: (b)(6)-4

4. PAY GRADE: X X

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19680919

7. AGE AT ADMISSION: 36Y

8. RACE: Y

9. ETHNIC BACK-GROUND: 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE:

ETS:

11. FMP: 99 20

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only): IRAQI CIVILIAN

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 1500

BRANCH / CORPS:

14. FLYING STATUS:

15. BENEFICIARY CATEGORY: K 9 K78

16. ZIP CODE OF RESIDENCE: 093 00000

17. UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA:

PREV. ADMISSION: YEAR: X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1

WARD: ICU5

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION: 2 2

22. MTF TRANSFERRED TO: (b)(3)-1

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030415

24. CLINIC SVC - ADMITTING: A B A A

25. MTF TRANSFERRED FROM: (b)(3)-1

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030410

27. LOCATION OF OCCURRENCE (Battle Casualty Only): K U

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D):

FOR LOCAL USE

GSW (R) Flank (R) Forearm

~~E991.9~~ 881.00 DX: 8795

~~8991.4~~ B1392

E9912

Px. 5411

7962

Trauma

1

21

Surgery

450

CODE:

ADMITTING OFFICER (Signature, as required)

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

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 3671

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	~~28~~ 34	IRAQI				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICW 2

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
DIR	2200	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	EVAC	11 APR 03

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW R Thigh Dx: 890.0 Trauma Inj
0 450

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
7	7				7

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

SI (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 A USAPPC V1 F

MEDCOM - 3672

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Shrapnel (R) thigh

GSW

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 589
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.804-8
OCTOBER 1975 539-106

1-C

MEDICAL RECORD - SUPLEMENTAL MEDICAL DATA

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

REPORT TITLE

TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 26 Mar 09 Arrival Time: 2130 Sex: M F Age: 20s Wt: ____

Allergies: NKDA per chart Tetanus Status: UTD Unknown

LMP: Last Meal: unk

Chief Complaint: GSW @ thigh

PMH: Medications:

Treatments PTA:

VITAL SIGNS: BP: 119/71 P: 111 RR: 20 TEMP: SAO2: 96 2 RA

CHEST
TRAUMA ☑ YES ☒ NO
PAIN ☐ YES ☐ NO
SOB ☐ YES ☐ NO
LUNG SOUNDS
R L
☑ ☑ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☑ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☒ DISTENDED
☐ TENDER
BOWEL SOUNDS
☒ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R____mm L____mm
GLASCOW SCORE:____

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASGOW COMA SCALE

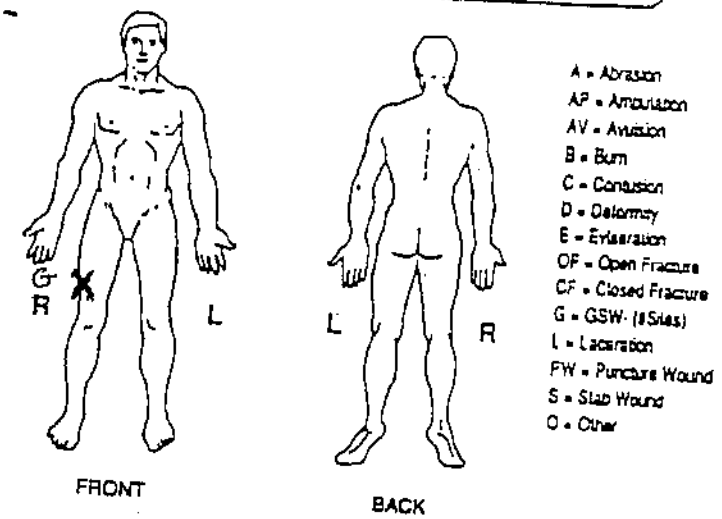
1. EYE OPENING	2. VERBAL RESPONSE	3. MOTOR RESPONSE
Spontaneous - 4	Oriented - 5	Obedient - 6
To Voice - 3	Confused - 4	Purposeful - 5
To Pain - 2	Inappropriate - 3	Withdrawal - 4
None - 1	Incomprehensible - 2	Flexion - 3
	None - 1	Extension - 2
		None - 1

EXTREMETIES
☒ DISTAL PULSES
☒ RT X 2 ☒ LT X 2
☒ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS:

TREATMENTS
2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
OLEY: #
HEST TUBE ☐ R ☐ L DPL ☐ POS ☐ NEG
CM H20

SPLINTS:



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisseration
OF = Open Fracture
CF = Closed Fracture
G = GSW- (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

PREPARED BY (Signature & Title) (Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: 399th CSH DATE

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

(6X8)-4

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

DD. MAY 78

IV SOLUTIONS/SITES

TIME	SITE/SIZE	IV FLUID/BLOOD	AMOUNT INFUSED	OUTPUT
				CHEST TUBE:
				EMESIS:
				NG TUBE:
				URINE:
				EBL:
				OTHER:

TOTAL IN:_____ OUTPUT:_____

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA
OTHER:_____
XRAYS:

MEDICATIONS

TIME	MED	DOSE	ROUTE	INITIALS

PROCEDURES/PROGRESS NOTES

VS

(b)(6)-2 96 SpO2

111 hr

119/78bp

MEDICAL RECORD	PROGRESS NOTES

DATE	
	Ward MO Admit Note
3/24/03	CC: Mild pain (R) thigh / GSW
1500	HPI: 34 yo Iraqi civilian noncombatant going to grocery
GMT	store in taxi w/ family. Driver intoxicated/speeding
	+ sped twd US check point, vehicle fired upon & pt
	sustained GSW (R) distal lat. thigh. Brought via
	helo casevac to surg. Co.; c/o mild pain (R) thigh.
	PMH Ø
	Alls: NKMA
	PE: 98.6 139/67 94 18
	Alert, speaking clearly, WDWN ♂ NAD
	Heent unremark
	Neck: Ø Trauma
	C/L: RRR S1S2 CTA (B)
	Abd benign
	GU nl
	Ext: 1.2 cm superficial penetrating wound (R)
	lat thigh; small amt necrotic tissue @
	rim of wound; slight oozing of blood,
	Ø erythema
	Ø exit wound
	DP/PT pulses strong (R)
	Normal sensation & full strength LE's (B)

(Continue on reverse side) over

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

PROGRESS NOTES

DATE	
	(ATP) GSW (R) lat distal thigh, exit wound bullet either w/in thigh or did not penetrate - Irrigate wound & bandage - Ancef x1 - Pain meds prn - Td at next echelon - Frequent wound & pulse VS. - Routine Medevac. [redacted] MC
1800	pt arrived via litter ad Security escorts. Pt alert responds to Commands upon interpreter. RESP Reg Lungs CTA Bil. Pt denies CP SOB @ this time. Bowel Sounds x4 quadrand. non tender upon palpation. Pt with superficial lateral GSW to R lateral thigh. D-DSG DONE By MD. good pedal pulses Noted Bilateral. Pt c/o PAIN given T32tabPO @ 1840.
1	Will continue to assume care (Medevac) ↑1000cc@KVO infusion [redacted]
1900	pt c/o PAIN to (R) lateral thigh. MSO4 mg given IV. will reassess in 30min VS stable 117/65 P 75 R 16 [redacted]
2020	Pt VITAL SIGNS TAKEN, ALERT WOUND DRESSING CHANGED, 4x4 SATURATED C BLOOD
BP 134/61	& DRAINAGE. PEDAL PULSES (B), CAP REFILL INTACT. Pt complained of
T 99.1°	pain upon changing of dressing. Will continue Pt. care [redacted]
P-82	
2240	Pt. woke up from sleep drank H2O P.O- V.S. Stable. Dressing saturated
	c blood. Strong pedal pulse (B). I.V. site intact + patent. (B) cap refill < [redacted]
0120	Pt. woken up for assessment. V-S: Stable. Pt in no apparent discomfort. Wound [redacted]
	Pedal pulses strong (B) & Cap-refill. will continue pt. care [redacted]

NSN 7540-00-634-4176 | 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 Mar	
0744	pt sleeping awakens easy some ant pain asks for shot
	VSS CV RRR Abd soft
	thigh GSW ⊕ Ext warm ⊕ dstl pulse
	moving Ext warm thigh
	A/P GSW thigh
	Keep IV OK PO food
	pain meds PRN (b)(6)-2
~~1000~~	~~Pt has folley cath~~
1000	Folley cathere placed - 800cc on placement.
1100	Pt tolerating pain well. VSS, RRR
	GSW (R) lateral thigh ⊝ signs of infection
	minor oozing of blood. ~~positi~~ ⊕ minor edema ⊝ erythema
	applied d/d dressing. ⊕ Pedal pulses Bilat. — (b)(6)-2
1130	Output from Folley 400cc. Pt sleeping. Changed IV fluid.
	1000 ml LR KVO. (b)(6)-2
3/25/07	Pt was unable to void this am → Foley placed, total 800 cc out
1231	likely 2° to retention 2° to Morphine; Pt will ↓ doses morphine →
	trial w/ Foley out.
1245	DC catheter. Pt tolerated well 900cc (b)(6)-2
1440	Applied D-Drsg Ø signs of infection (b)(6)-2 Mc
	⊝ oozing of blood ⊕ pedal pulses. Pt tolerating pain well. (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX (b)(6)-2
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 3678

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25MAR03 1545	Pt tolerating pain well. V/S stable. Pedal P intact bilaterally.
1620	Administered Phenergan 25mg IVP.
1715	~~U/O 500ml, Out 300ml~~, U/O 300cc
25MAR03	Pt in bed resting comfortably. ⌀ c/o acute pain or distress. Physical exam
1730	unremarkable. Dsg to (R) leg c̄ slight drainage noted. ⌀ ~~new~~ dressing Δ
	required at this time. (R) foot c̄ ⊕ pulses and warm to touch. Will cont
	to monitor ——— (b)(6)-2 [redacted]
25MAR03	
2030	Applied D-Drsng ⌀ sign of infection. ⊖ oozing of blood. ⊕ Pedal P. Pt
	tolerating pain. ——— (b)(6)-2 [redacted] LN
2210	DC IV. Pt tolerated pain. ——— LN
2215	U/O 200ml.
0200	(R) leg Dsg changed. Sanguinous Drainage, Semi Soaked.
26MAR03	
0416	Pt is in good general condition, ~~AVPU(x3)~~ ALERT PT ALERT EQUAL/NORMAL LUNG SOUNDS BILAT
	NORMAL HEART RATE / BOUNDING PULSES ON ALL 4 XTREMITIES. DRESSING TO LAT (R) THIGH
	C/D/I. WILL CONTINUE TO MONITOR PT. HM3 (b)(6)-2 [redacted]
0632	VS - 130/70 PR-68 R-12. URINE OUTPUT 200 CC. PT IN GOOD GENERAL
	CONDITION. WILL CONT TO MONITOR. HM3 (b)(6)-2 [redacted]
	Hm3
	NFE N
	over

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	HD# 3 GSW (R) thigh NOTES
3/26/03	(S/O) 0 complaints Taking PO, ambulating V/S AF (R) LE: Wound: 0 further bleeding, erythema strong DP pulse From ER (A/P) GSW (R) Thigh stable, 0 complications, awaiting transfer. [b)(6)-2] CCDR Signs, MC
3/26/03 1400	V/S. Pt up and walking, tolerating pain well, 0-Drsg A. 0 signs of infection, minor oozing of blood. 0 erythema, pedal pulses strong, intact. Will continue to monitor. [b)(6)-2]
3/26/03 1530	Transfer Summary Pt HD#3 s/p GSW to (R) thigh, no exit wounds, Wound irrigated & bandaged only. Meds: T#3 or morphine prn pain Diet: Regular Stable, NVI throughout. Transfer today [b)(6)-2] CT MEDEVAC

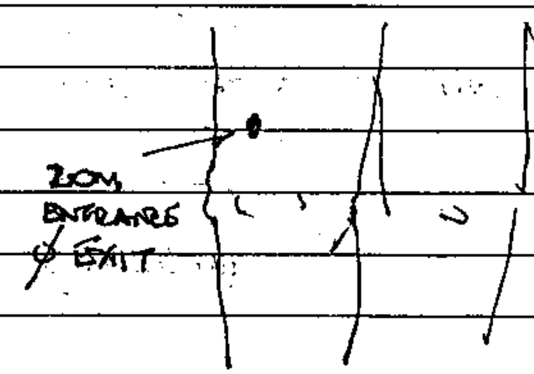
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	IMP: GSW (R) DISTAL LATERAL THIGH
	• CONSERVATIVE MGMT TO DATE - STABLE
	PLAN: X-RAY (R) FEMUR
	TETANUS BOOSTER
	CONTINUE CURRENT MGMT
	NV ✓
	[redacted]
	MD
26 MAR 03	.5 g Tetanus adm IM per [illegible] 2320 - Pt denies [redacted]
2320	Pain. Dsg D'd
	Gave Pt meal - did not eat - withheld Motrin Pt denies
	pain currently [redacted]
27 MAR 03	Pt slept quietly through night - Drsg (R) thigh intact, VS taken
0645	through. [redacted]
27 MAR 03	PN HD 3
1015	Pt Doing well. ∅ c/o Pain
	Ambulatory
	VSS / AFEB X Ray (R) thigh: ∅ Fx
	Wound c/D/I
	NVI
	IMP: HD 3 s/p GSW (R) LAT THIGH
	PLAN: CONT CURRENT MGMT
	TO MIN CARE WARD TODAY [redacted]
	MD

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Mar 03	20+ yo ♂ c̄ wound (R) thigh – ? possible broken nose
2210	unable to communicate to full pain level. Unk allergy / Med /
	Surg hx / meds. Drsg applied (R) thigh – drsg on
	dry intact. (B) nostril packed. Head restraint applied
	to c/o ? assault. (b)(6)-2
26 MAR 03	ADMIT H&P
2240	34 y.o. IRAQI CIVILIAN NONCOMBATANT PER TRANSFER NOTE
	(NO TRANSLATOR AVAILABLE) SUSTAINED GSW (R) DISTAL LAT
	THIGH 24 MAR 03. WOUND IRRIGATED OUTPT – PT WALKED
	AND NO THROUGHOUT INPT STAY @ PREVIOUS FACILITY.
	TRANSFERRED IN STABLE CONDITION
	GEN: NAD
	HEENT: NOSTRILS PACKED (B) ? NOSE INJ SUSTAINED
	WHILE IN MOTOR VEHICLE
	C/L: CTA (B)
	ABD: SOFT NT/ND (+) BOWEL SOUNDS
	LE: (R) DP/PT PULSES INTACT
	(R) THIGH SWOLLEN BUT SOFT
	WOUND SITE C/D/I – DSG Δ'D
	DIFFICULTY c̄ (R) LE ROM RAISE
	OTHERWISE NL MOTOR EXAM →



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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - 3682

MEDICAL RECORD	PROGRESS NOTES
DATE 27 MAR	Pt c/o GSW to (R) thigh. (+) ABC's (+) cap refill < 2 sec c (+) ROM, PN to (R) leg c flexing, no other apparent injurys (BP 120/50 pulse 80 RR 16 Temp. 96.5 [redacted]
	By Spc [redacted]
27MAR03 1625	See A.01 progress note HD #3 SHRAPNEL (R) thigh Q DAY Dressing Δ c Bacitracin Ointment Nasal packing? – Probably not needed) Cont current care [redacted] Ancef 1 gm IM now (~1100)
27MAR 2030	T3 c/o pain for serous @ leg pain –
28MAR03 0630	pt a/ox3 no c/o pain. Drsg C/D/I
BP 100/60	Lungs CTA bilat Abd soft non tender no D.S. [illegible]
P. 80	USS no other Complaints @ this time [redacted]
R. 16	
T 97.1	
28Mar03 0822	pt. currently in no pain, has small saturation in dressing, has good ROM, can bend his knee w/some help, has distal pulses +2. Spc [redacted]
1039	asked pt. about nasal packing, he stated he has chronic disease, & wants to leave packing in place. Spc [redacted]

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

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

BED

PROGRESS NOTES

DATE	
28 Mar 03	1400 - Dsg Δ to (R) thigh. pt ambulatex I. pt c/o mild discomfort during irrigation/cleaning of GSW site. GSW has white exudate & small amount of necrosis. Will continue to maintain. —Sgt [redacted]
	1700 - C/o Pain to GSW site on (R) thigh, pt was given 650mg tylenol & 800mg Motrin. Spc [redacted]
28 Mar 03	NO 4
0820	(R) thigh shrapnel
	AMBULATING NEUROVASCULAR INTACT
	C/ evidence of infection [redacted]
	D/C soon
28 Mar 03 2009	BP 118/54 P 58
	Pt has no complaints SPC [redacted] 91W
29 Mar 03 0840	Dressing Change to R thigh. PT in mild discomfort. PT given 800mg Motrin Sgt [redacted] 91W20
29 Mar 03 0905	BP - 118/76 P. 80 R 16 Sgt [redacted] 91W20
29 Mar 03 1230	RT C/O Rinsed Pain. Gave PT 650mg tylenol PO Sgt [redacted] 91W20
29 Mar 03 1715	BP - 118/58 P-70 R-16

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
24MAR03	(R) thigh shrapnel
2020	wounds healing well
	P/C (b)(6)-2
26 MAR03 2030	Dressing Δ. Wounds look good, pt has Ø complaints.
	SPC (b)(6)-2 91W
27 MAR 03 2110	VS BP 110/60 P Ø R Ø T
30 MAR 03 1800	Δ dressing for (R) thigh ̄s s/s of infx. (b)(6)-2 91W/MC
	BP 108/68 P 80 Temp 97.7 R:16 — SPC (b)(6)-2 91W
30 Mar 03	Tylenol 975 mg po for C/O pain (R) thigh 10 mi
1830	
31 MAR 03 205	VS BP 10/60 HR 73 R 12 T 97.3 Dressing Δ given
	975 for pain @ site. ——— Spc (b)(6)-2, 91W
31 MAR 03	FP PN GSW R thigh : wound ̄s s/sx infection
0830	NVI distally ; PRN Pain control.
	Encourage Ambulation (b)(6)-2 , MD
	(b)(3)-1
31 Mar 03 0958	BP 110/46 P-76 - R-14 (b)(6)-2 SGT 91W2
2115 31 Mar 03	BP 114/62 P 68 R 16 T 98.3 Dressing Δ done
	minimal pus drainage noted (b)(6)-2 SGT 91W30

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 APR 03	FP PN / VSS AF
0800	R Thigh: minimal SEPD sanguinosa D/C.
	Imp. GSW R Thigh — Doing well.
	Plan: Local wound care. ; pir pain control /
	[b)(6)-2]
	CPT Imes

STANDARD FORM 600 (REV. 6-97) **BACK**

*U.S. GPO: 2002 - 491-600/50618

511-118

NSN 7540-00-634-4129

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° 37.0° | 36.7° | 36.1° | 35.6° | 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

I/O

BLOOD PRESSURE

Record special data only when so ordered

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	26 Mar 21 / 27 Mar 01
POST- DAY	2300 / 0645
MONTH-YEAR	DAY
19	HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

962 / [b)(6)-2]

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[b)(6)-4]

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

*U.S.GPO:1996-404-763/40069

NSN 7540-0

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
3/24/03			Admit EPW to Evac Ward		
1450 GMT			Dx: GSW (R) distal lat thigh		
			Condition: stable Triage Delayed		
			Allg: NKDA		
			VS ~~q4hrs~~ q2° x2; if stable then q4°		
			Dorsalis Pedis Pulse check q2°		
			Activity: Bed Rest		
			Diet: Regular		
			IV: KVO first liter then Hep lock		
			Meds: Tylenol #3, 1-2 tabs q4° prn pain		
			check wound q8° for evidence of infection		
~~MAR 04~~ ~~1829~~			~~Pt received [illegible] tablet med~~	(b)(6)-2 [redacted]	
				LCDR R Sams, MC	
MAR 03 1829			Pt received i T3 for pain		
			[illegible] u/nc 3/24/03		
3/24/03 1542 GMT			Morphine 4 mg IV push now		
			Morphine 2-4 mg IV q2° prn for pain		
			Phenergan 25 mg IVP q6° prn nausea		
			Thanks (b)(6)-2 [redacted]		
			(b)(6)-2 [redacted]	LCDR R Sams, MC	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, ... medical facility)

(b)(6)-4 [redacted]

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)

3/25/03
1903 Zulu ① D/C IV

② D/C IV Mech

③ Tylenol #3 2 tabs PO q 4-6° prn pain

Morphine 2-4 mg ~~IM~~ KW q 4° prn severe pain

(b)(6)-2

CAPT, MC, USN

3/26/03 ① Transfer per PMR
1530 ② See transfer summary

(b)(6)-2

MD
TMCUSNR

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(b)(6)-4

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	26 MAR 03	2230		
1	ADMIT TO ICU 2			
2	DX: GSW (R) THIGH			
3	COND: STABLE			
4	VS PER SHIFT - INCLUDE DISTAL PULSE ✓			
5	ACT: AD LIB - ENCOURAGE AMBULATION W/ CRUTCHES OR ASSISTANCE			

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	HOURS	
6	ALL NKDA (ADR TRANSFER NOTE)			
7	DIET: REGULAR			
8	MOTRIN, 800 mg PO TIDWM			
9	VICODIN, 1-2 TAB PO Q6 HR PRN BREAKTHROUGH PAIN			
10	DRESSING CHANGE DAILY - ALERT MD IF SIGNS INFECTION			

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	HOURS	
11	TETANUS 0.5 mg IM X 1			
	~~27 MAR 03 / 1620~~			
	27 MAR 03 / 1620			
1	ADMIT TO MCW			
2	GSW (R) thigh			
3	Condition Stable			
4	V/S's Q4hrs BID			

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	HOURS	
5	Ancef Rg IVP			
6	Motrin 800mg PO PRN			
7	Narcotics prn breakthrough pain			

(b)(6)-2

(b)(6)-2

(b)(6)-2

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. 3 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26 27 28
26 Mar 03	[b)(6)-2	Reg Diet	0	
26 Mar 03	[b)(6)-2	NPO after MN		
26 Mar 03		V.S q shift x Distal Pulse check	8a	
26 Mar 03	[b)(6)-2	Calcaneal Amputation - x Sutures		
26 Mar 03	[b)(6)-2	Darvocet A-65 q 4	8a	
26 Mar 03	[b)(6)-2	Reg Diet	07	
			11	[b)(6)-2
			17	
26 Mar 03	[b)(6)-2	NPO after MN	24	[b)(6)-2
26 Mar 03	[b)(6)-2	V.S q shift x Distal Pulse check	06	[b)(6)-2
			14	
			22	[b)(6)-2
26 Mar 03	[b)(6)-2	Encourage Adult x Activities	06	
			14	
			22	
26 Mar 03		Darvocet A-65 q 4	10a	[b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: G.A.W @ Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD

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

Mo. 3 Yr. 01

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
	(b)(6)-2	Motrin 800mg tid prn	26	
			06	/
			14	/
			22	/

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW @ Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

A FORM 1 FEB 79 **4678** EDITION OF MEDCOM - 3693 (HAUSTED.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 7 Yr. 01

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26 mar 01	(b)(6)-2	Tetanus 0.5 Im x 1	26 mar 01	2300	2300	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
26 mar 01 / 29 mar 01	(b)(6)-2	Vicodin 1-2 Tab po q6h PRN	

*U.S. GPO: 1998-454-110/95218

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER (9–15): [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) (19–26): 19 20 61 91 23 24 25 26 — 1 9 8 3 0 1 0 1

7. AGE AT ADMISSION (27–29): 34 yrs

8. RACE (30): X

9. ETHNIC BACK-GROUND (31): 9

RELIGION:

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36): 20

12. SOCIAL SECURITY NUMBER (37–45): [b)(6)-4] 7

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46): 2

HOUR OF ADMISSION: 2000

BRANCH / CORPS:

14. FLYING STATUS (47–49):

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

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 2 0 0 0 0

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

18. MOS (64–70):

19. TRAUMA (71): 9 IN

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 2 Direct

WARD: ICW 2

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): 0 5

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 2 0 0 3 0 4 1 1

24. CLINIC SVC - ADMITTING (87–90): A B A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 2 0 0 3 0 4 0 4

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

28. MTF OF INITIAL ADMISSION (105–110):

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

FOR LOCAL USE

Dx: GSW ~~Shrapnel Flesh Wound~~ (R) thigh

Dx: 8900

E9912

Proc: 8827

Trauma: 1 9 0

IV: 450

ADMITTING OFFICER (Signature, as required): [b)(6)-2] [b)(6)-2] MAJ, MC

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

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

IN. .ENT TREATMENT RECORD COVER SHE

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

1.	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4 20	EPW (b)(6)-4 (b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	46	IRAQI				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICU 2

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
DIR	2200	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	EVAC	5 APR 03

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

R Upper Back & Flank GSW
E991.2 876

Debridement wound 86.28

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
12	12				12

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

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AU

USAPPC V1 10

MEDICAL RECORD	PROGRESS NOTES
DATE	(b)(3)-1
BP: 119/69	46 yo AM
P: 100	GSW x 2
R: 18	1) (L) upper back ? entrance/exit
T:	2) (R) buttock ? entrance/exit
O2 SAT:	? stool in wound on (L) buttock
96%	No other injuries noted
ALLERGIES	
NKDA	(PB) WN/WD AM NAD
PMH:	Alert, conversant c interpreter
ϕ	NC/AT PERRL dpl cl
PSH:	Neck supple, FROM, nontender
ϕ	Chest - CTA =BS
	CV - RRR
	Abd - soft, min tender, BS ⊕
	Pelvis - stable
	Rectal - large deficit in post wall of rectum
	@ 6-7 cm. Gross blood in stool. Tx coccyx.
	Ext - AT, FROM
	Neuro - nonfocal
	(AP) GSW (L) upper back 2 chest ok.
	GSW to buttock c rectal injury.
	INF. Triple abx. To OR for EUD, wound exploration,
	debride. Repl lap c diverting colostomy

(Continue on reverse side)

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

NAME: (b)(6)-2

SSN: (b)(6)-4

UNIT: (b)(3)-1

REGISTER NO.

WARD NO. (b)(3)-1

PROGRESS NOTES

Medical Record

STANDARD FORM 519 (REV. 7-91)
Prescribed by GSA/ICMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE

24 MAR03

OPERATIVE NOTE

DIAGNOSIS: GSW to back
GSW to buttock/rectum

PROCEDURE: 1) I+D GSW sites
2) Procto
3) Repl lap
4) Diverting sigmoid colectomy
5) Distal stump washout

SURGEON: Peoples/Craig

FINDINGS: (1) upper back GSW. No entrance into chest. (2) buttock GSW c (1) side prob exit c stool in wound. Also bone fragments in wound. At expl lap contusion/hematoma in mesorectum. No intraperitoneal soilage.

FLUIDS:

EBL: 100 cc

End sigmoid colostomy.

Distal sigmoid (Hartmans) tacked to peritoneum @ colostomy site.

No comps.

To SICU stable, extubated.

(b)(6)-2

MD

(Continued on reverse side)

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

REGISTER NO. | WARD NO.

02 (b)(6)-4

(b)(3)-1

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

25 MAR 03

POD # (b)(6)-4 S/P diverting colostomy / distal rectal w/o / paraneal drainage for GSW to rectum.

Comfortable AVSS

Abd soft, NT/ND, BS +/-

Incis C/D/I

Ostomy pink

(B) buttocks wounds putting out small amt stool.

A/P) DC NGT — clvs this pm

Dressings Aid

Cont Cefotetan

Ambulate

(b)(6)-2

WD

EPW # (b)(6)-4 [redacted]

24 MAR 03

Surgery

POD # (b)(6)-4 [redacted]

s/p I+D, expl lap, diverting colostomy for rectal inj assoc GSW.

VSS this AM.

Comfortable

Abd soft   Chest CTA

Dressings intact

A/P) stable postop

MSO4 2 Q2H

Cont qd

Δ (L) buttock dressing

144 | 111 | 29 / 231

4.4 | . |

39 / 13

CXR ⊖ PTX from (R) post chest wound.

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

MEDCOM - 3700

Name:
SSN:
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE: 24 MAR 03
TIME: 0330

Additional Orders/Charting:

24 MAR 03 0945
1) MSO4 2mg Q2H
2) Q6 buttock dressing
(b)(6)-2

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** s/p exp lap | colostomy | ileostomy
3. Condition: VSI SI Stable
4. **Allergies:** NKDA
5. **VS:** Q5min x 3; Q15 min x 3, then Q1 hr; Q2 hrs; Q4 hrs; Notify MD for SBP: > 180 or < 90; DBP: > 100 < 50; HR: > 120, < 60; RR: > 20, < 10; Temp: > 102
6. **IVF: IVF:** LR @ 75 cc/hr; NS @ _____ cc/hr; Albumin @ _____ cc/hr; Hespan @ _____ cc/hr
7. Monitor: Cardiac; Pulse Ox; Neuro Q ___ m/hr; A-line;
8. I&O: Q1 hr; Q ___ hrs
9. Drains: NG to Low/Cont suction; ~~Foley~~ to gravity
10. ~~CT #1: 20 cm H2O suction, H2O seal;~~ Heimlich
11. ~~CT #2: 20 cm H2O suction, H2O seal;~~ Heimlich
12. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN Hct now & Q ___ hrs; Chem now & Q ___ hrs; UA
13. **BLOOD:** T&S ____ units; T&C ____ units; Transfuse: ___ units PRBC or Whole Blood for Hct < ___%
14. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB; _____ Keep Stats > 92%, > 95%, _____
15. **VENT:** SIMV; TV: ____; RR: ___; Fio2: ___%; PEEP ABG Q ___ hrs;
16. X-Ray: CXR in AM.
17. **MEDS:**
Morphine 2, 4, or 6 mg IVP Q 30 min/hr prn Pain
Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
Zofran 2-4 mg IVP Q 6 hrs prn Nausea
Zantac 50 mg IVPB Q 8 hrs
~~Drip: Dopamine: (400mg/250cc) 2--10 mcg/kg/min~~
~~Drip: Epi: (8mg/250cc) 0.01-0.1 mcg/kg/min~~
~~Drip: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg~~
~~Drip: Ativan 0.05-0.1 mg/kg IV over 2-5 min; (2-4mg IV)~~
~~Drip: Norepi/Levophed: (8mg/250) 0.01-0.2 mcg/kg/min~~
Cefotetan 1 gm IVPB Q12H.

18. ~~**BURNS:** IVF: 4cc/% BSA burn/kg = total 24 hr fluids; Give ½ over 1st 8 hrs from Time of Burn~~
19. ~~**Head Injury:** Neuro checks (GCS) Q ___ min/hrs;~~ C-Spine: Clear/NOT Clear; Keep Head in midline position; Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-50 min Notify MD for Mental Status changes
20. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;

MD (b)(6)-4

(b)(3)-1 Post-OP Orders, By (b)(6)-2 as of 29 Nov 2001
(b)(6)-2 MD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0800 28 Mar 03	emptied foley output was 1100 mL (b)(6)-2 [redacted] SGT/4IW
28 MAR 03 0820	Keep midline wound uncovered mmv @1000 D/C IV mmv @1000 D/C Foley Keflex 500g PO Q6° Regular Diet (b)(6)-2 [redacted]
28 Mar 03 1000	Took out foley output was 50 mL, also had to replace colostomy bag feces was weeping into wounds. Irrigated the wounds and changed dressing and informed patient to make staff aware if colostomy bag falls off. (b)(6)-2 [redacted] SGT/4IW
28 Mar 03 1130	gave patient keflex 500mg PO (b)(6)-2 [redacted] SGT/4IW
28 MAR 03 1610	P-91 SaO2 - 97% R-16 B/P - 127/60 T-101.2° Acetaminophen 325mg po tabs ii taken (b)(6)-2 [redacted]
1847	T - 99.1 (o) [illegible]
28 Mar 03 2200	Pt given 500 mg Keflex PO. Lungs CTA x 4 lobes. Colostomy intact LUQ s̄ stool @ this time. Hypoactive BS x 4 quads. Tolerating PO's well. (b)(6)-2 [redacted] SSG/LPN
2350	Pt had 500cc of urin output c̄ some difficulty SR (b)(6)-2 [redacted]
29 Mar 03 0600	BP - 120/68 RR - 16 Sats - 98% via RA P - 90 Temp - 98

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 MAR 03	Surgery Post [b)(6)-4] S/p GSW to rectum Comfortable T 99 95 132/72 Sat 97% Abd soft, NT/ND, BS ⊕ Ostomy pink, edematous Dressings intact. Amb Stable Ambulate Clear liquids Δ dressings (2) buttocks Cont abx [(b)(6)-2] ND
26Mar03 1733	Changed dressing on (2) buttocks, wound was clean + looked to be healing well. SPC [(b)(6)-2]
26Mar03 2134	I agree with above assessment, tolerating PO water + crackers, having a small amount of gas passage in colostomy [(b)(6)-2] JCT/AN
27Mar03 1950	Pt admitted to new location. Pt sleeping stable condition [(b)(6)-2]
28Mar03 0012	No changes from previous exam except output (stool) in colostomy [(b)(6)-2] JCT/AN
28 Mar 03 0050	VSS, colostomy bag changed 25 mg Benadryl given for sleep [(b)(6)-2] JCT/AN

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

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

OD/FPW # [b)(6)-4]

[b)(3)-1]

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Mar 03 1150	Requests antacid tab. Given one Pk
29 Mar 03 1330	POD# (b)(6)-4 s/p GSW to Back AND GSW buttock ... Rectum s/p X-LAP c Diverting sigmoid Colostomy (B)
	C/O foul odor and (L) buttock pain
	AF/VSS
	Midline incision healing well
	Colostomy red/beefy - good output
	(L) buttock wound c purulent
	→ Bandage and wound soaked c fecal material
	? Fistula
	(R) smaller buttock wound c fecal drainage
	A/ ? Fistulous tracts (B)
	P/ Confer c Surgery
	Continue wound care
	(b)(6)-2
29 Mar 03	Pt. Assessment completed. Pt. colostomy emptied and dressings [illegible] see physician note above. No s/s of infection noted at this time. Chucks replaced + patient cleaned. All assessments WNLs ~~[illegible]~~ Error other

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

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

REGISTER NO. | WARD NO.

OD (b)(6)-4 (b)(3)-1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Continued —	Thus was mentioned above. Wd s/s of infection and no c/o pain —
	(b)(6)-2 ALTAN

STANDARD FORM 600 (REV. 6-97) **BACK**

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Mar 03 0400	Pt given 50 mg Keflex PO. Dsgs D'd to (L) buttocks draining liquid feces. Dsg D'd to (R) buttocks. BP- 130/90. Pulse- 80, Resp 20, Temp- [redacted] 55g/LPL
29 Mar 03 1030	Pt assessment completed. Pt colostomy, LQT Abdomen w/ stool present bowel sounds are Hyperactive x4 Pt complains
1440	Pt Colostomy emptied. [redacted] 2LT AN
1945	No Δs from previous exam, dsg D'd to (L) buttock, stool in dressing. SO my Benedryl given For c/o not sleeping VS- 130/72, P 90, Sp02 100, T 98.6 [redacted] 1CT/400
30 Mar 03 1100	POD # [redacted] S/P GSW to Back & GSW (R) buttocks Ann Rectum S/P K-Cap & Diverting Sigmoid Colectomy Ø Complaints Ø Temp recorded today otherwise good vitals Colostomy looks good & good output (R) buttock wounds draining pus / fecal matter P) NPO Surgery today [redacted]
30 Mar 03	Pt. assessment completed. Pt is NPO awaiting surgery. Dressing D'd dressing was saturated fecal contents. Wounds on (L) + (R) Butt were (Cont→)

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

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

REGISTER NO.	WARD NO.

EPW # [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
(Continued)	cleaned and irigated with NS. Colostomy was emptied, cleaned and reapplied. All other assessments WNL's. No c/o pain at this time. [redacted] SLT AN
30 Mar 03 1236	B/P 120/64 P: 95 SAT 96% Temp: 100.4
31 Mar 03 0930	IV infiltrated, D/C'd.
31 MAR 03 0950	18g IV done in (L) [redacted] Saline Lock NS [redacted]
31 MAR 03 1002	4mg MSO4 IV push [redacted]
31 Mar 03 1015	DSG ✓ done by Surgery Service to (L) hip [redacted] COM
3/31/03 1102	AOD # [redacted] S/P GSW to Back & GSW to Buttocks and Rectum S/P ex Lap & Diverting Sigmoid colectomy VS Temp ? Buttock wound & gas gangrene R/O NPO FURTHER Surgical Debridement Midline incision looks good Remove Staples & Sutures
	[redacted]
31 March 03 1630	ERROR Pt c/o Pain Tx c 2.5mg MSO4 [redacted] SLT AN

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50616

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Brief Op Note
30 Dec 03	Dx: Infected buttock wound
17:30	Proc: I&D (R) buttock
	Procto c̄ [illegible] Hartmann pouch
	Surg: (b)(6)-2 [redacted]
	An: (b)(6)-2 [redacted]
	Findgs: Grossly necrotic subcutaneous fat
	c̄ cavity diving down into gluteus
	Widely debrided + drained c̄ penrose.
	(b)(6)-2 [redacted]
	~~B/P 118/60~~
2130	B/P 118/60 P86 R10 SAO2 96 T 99.3 Pt states some
	PN and vertigo. Pt dressing and collostomy are good SPC (b)(6)-2 [redacted]
2220	Pt given 2mg MSO4 IV and gentamyoson SPC (b)(6)-2 [redacted]
	Pt also given Phenagran 12.5mg IV SPC (b)(6)-2 [redacted]
2250	Pt given Gentamycsin 240mg IV SPC (b)(6)-2 [redacted]
2400	Gave Pt 3.0g Unison IV. Pt c/o PN, Pt was
	given Vicodin. SPC (b)(6)-2 [redacted]

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

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

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

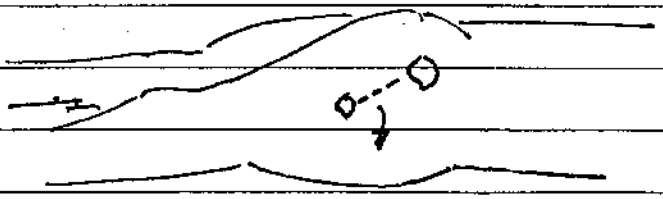
OO (b)(6)-4 [redacted] ((b)(3)-1 [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 MAR 03	OP NOTE
1715	PRE OP DX = GSW (L) BUTTOCK/ABDOMEN
	↳ S/P EX LAP / DIVERSION 3/24/03
	↳ S/P (L) BUTTOCK WASHOUT/DEBRIDEMENT 3/30/03
	FECAL DRAINAGE VIA BUTTOCK WOUND R/O ABSCESS/FISTULA
	POSTOP DX: SAA
	ADD DISTAL RECTUM TRAUMA - PENETRATION OF GSW
	PROCEDURE: DEBRIDEMENT OF (L) BUTTOCK WOUND / IRRIGATION
	RE-EX-LAP
	OSTOMY TAKEDOWN FOR DISTAL WASHOUT
	REPLACEMENT OF ~~COLOSTOMY~~ OSTOMY
	SURGEONS: (b)(6)-2 MD ASSIST: (b)(6)-2 MD
	IVF:
	EBL: 150 cc
	ANESTH: (b)(6)-2 (b)(6)-2, MD
	COMPS: NONE
	FINDINGS: 
	STOOL/DRAINAGE FROM BUTTOCK WOUNDS - WOUNDS JOINED FOR EXPLORATION

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

OP/EPW (b)(6)-4

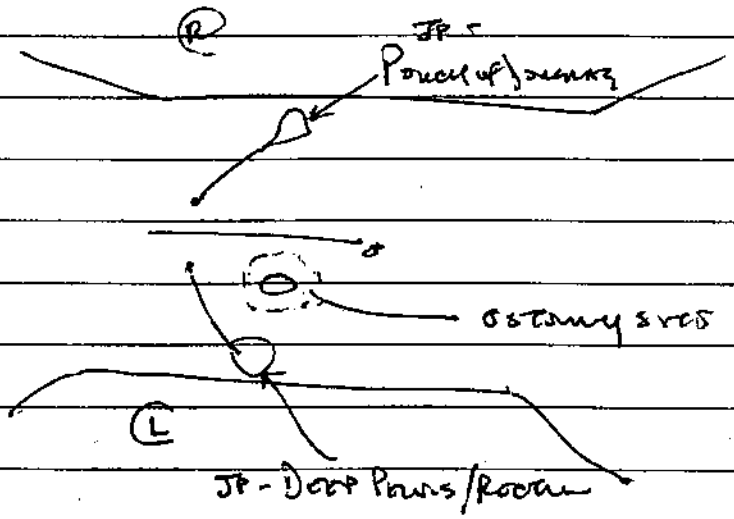
(b)(3)-1

PROGRESS NOTES
Medical Record

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

DATE	NOTES

GSW PATH TRACKED TO PELVIS.
EX LAP FOR PELVIC EXPLORATION. RETROPERITONEAL MOBILIZATION OF DISTAL RECTUM. GSW INJURY TO RECTUM 4 cm FROM ANAL VERGE & OPEN DRAINAGE of SUCUS FROM APERTURE.
COPIOUS IRRIGATION OF PELVIS
OSTOMY TAKEDOWN FOR DISTAL WASHOUT & IRRIGATION UNTIL CLEAN OUTPUT FROM RECTUM. REPEAT COPIOUS IRRIGATION of PELVIS.
JP PLACED IN DEEP PELVIS ADJACENT TO LOWER RECTUM
JP PLACED IN POUCH OF DOUGLAS



OSTOMY REVISED AND WOUND FASCIA CLOSED - SKIN OPEN.
PT TO PROCEDURE WAS EXTUBATED & DISPOSITION
TO BE IN STABLE CONDITION

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Mar 07 1830	Patient arrived FR RR in stable condition. Confused, non-cooperative. Several attempts made @ pain control. D order for meds by Dr. [b)(6)-2] IV flowing @ 140 cc/hr c OR release equally. Bandages CDI x abdomen. JP #1 & #2 present & serosanguinous fluid. Bowel sound hyper. [b)(6)-2]
1845	Sats >95% on Room Air [b)(6)-2]
2200	Pt alert c/o severe abdominal pain, S/P wound debridement of GSW to abdomen. BS hypoactive x 4. Lungs CTA @ Dressing to abdomen C, D, I. VSS, PAO2 95% on RA. Given 10 mg MSO4, which put the patient into a deep sleep for 2 hours. Pt voiding via Foley 730 cc/hr, dark yellow urine. Pain control is the main issue with this pt. Will continue to monitor [b)(6)-2] 91C3H
0100	Pt again c/o pain to abdomen. D'd pain control meds to 100 mg Demerol. Pt saturating 95% on RA, [b)(6)-2] 91C3H
0300	Pt c/o pain. Given 70 mg of Demerol + 12.5 phenergan. Checked JP drains. One had come open. Closed + reapplied suction. Pt c/o dizziness, stating "I feel as if to die". Checked VS, stable & slight tachycardia (rate 123). See flow sheet. UOP 730 cc/hr via foley. Dark yellow, ↓ sediment. [b)(6)-2] SSG, 91C3H

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

OD [b)(6)-4] [b)(3)-1]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1 APR 03 0750	Patient alert & oriented, speaks some english. Medline incision dressed. To perform W/D & the APN. LUE ⊖ wrist intact. JP x 2 to lower abdominal area, producing moderate amounts of Serosanguinous fluid. Foley draining quant. Sufficient Bronze colored urine. ⊖ dyspnea, CTA, breathes equal bilaterally. Tan Cordis c CT/AN
1015 (2)	Δ dressing to ⊖ buttock. ⊕ foul odor & debridement of necrotic tissue ⊕ fecal material irrigated, flap of buttock packed c W/D dressing c Kerlix, covered c abd. pad & reinforced. Small entrance wound to ⊕ buttock c purulent drainage & S. Derm. irrigated c sterile water & packed c W/d gauze covered, reinforced. Entrance hole approx 3cm diameter. Premedicated c 3mg MSO4, 5mg MSO4 Post dressing Δ. N
1 April 2003 1300 Z time	Pt's wound noted; still has some drainage. Will Δ & Rocephin & po. Flagyl
01 APR 03 2 1715	TSP 100/68 HR 96 SPO2 95 ▷ 44

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1APR03	Pt Alert + Oriented x3, NAD. Dressing to Abdomen is
1839Z	CDI, Dressings to (B) Buttocks. (R) buttock has a 4x4
	gauze covering wound, which is CDI. (L) Buttock has
	a dressing which covers entire buttock, exterior of
	dressing is clean, dry, and intact, however the
	interior gauze appears saturated by serous
	fluid. pt has no complaints at this time.
	(b)(6)-2 91C3H
1Apr03	Pt Transferred from [illegible] – Pt alert – Drained 450
1944	cc [illegible] urine from fog – LR @ 160ch – (R) Fp.
	JP #2 (R) [illegible] – [illegible] – serosang., Lo [illegible] – c/d/i
	(L) buttock Drg – intact, [illegible] – c/d/i (L) [illegible]
	[illegible] x4 [illegible]. + lung sound (R) lower lobe (b)(6)-2
2216	Δ'd outer Drg (L) buttock – (saturated) – (b)(6)-2
4/2 20	– 1,000cc LR (b)(6)-2
4/04/03 0215	↑ 50cc LR (b)(6)-2
0100 4/2	Fog output since 1944 = 500 cc [illegible] urine
	JP #1 – 25cc s/s d/c JP #2 10cc s/s d/c (b)(6)-2
	ABD drg intact – [illegible] pink
	(b)(6)-2

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* (b)(6)-4

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02APR03	S/P ex-lap c̄ diversion (24MAR03)
	D+I Ⓛ buttock (30MAR)
	Dressing Δ today (Gen. Surgery) [redacted]
	Rocephin / Flagyl
4-2 1000	pt A/O, follows simple commands, R-ON RA, lungs CTA,
	CV- B/P stable, pulses +/+, GI ML INC well to [illegible], green
	serous drg noted dressing changed, Ⓛ ABD colostomy min serous
	drg, JP x2 to bulb sx min drg. GU - foley to gravity
	urine [illegible] amber output min, LR 140cc/HR, Skin
	warm dry, dressing changed BL buttocks wet to dry mult.
	pt denies pain, NPO, [illegible] to mouth [redacted]
2APR03	Assessment complete - pt speaks - understands some English
1720	[illegible] BS Ⓑ upper quads - mod brown liquid stool w colostomy - stoma appears
	WNL, IV site Ⓡ FA patent, foley patent - c/g/u Ⓛ Rhonchi
	Ⓛ LLobe - + congested Ⓡ LLobe - Requested pt to cough - coughed
	up clear sputum, A&O day, Ⓛ Ⓡ buttock Drsg c/d/intact Ⓛ JP x4
	[illegible] Ⓡ JP 2 mod ss d/c pt denies pain [redacted]
1940	100mg Demerol for pain IV [redacted]
0055 4/3	100 Demerol + 12.5mg Phenergan IV [redacted]
4/3 0100	Foley output 400cc dk amber urine JP #1 15cc ss d/c
	JP #2 10cc ss d/c. mod brown liquid stool w colost -
4-3-02	0800- Δ'ed Ⓛ buttock dressing w/d [illegible] DR. [redacted] still foul smelly c̄ mod
	stool serous leakage, Δ'ed Ⓡ buttocks [illegible] w/d [illegible] Δ'ed ML
	ABD INC drsg, drainage serous c̄ green spots DR [redacted] said pseudomonas
	colonization [illegible] Δ'ed colostomy, stoma pink c̄ min stool. JP x2
	c̄ min drg, pt alert responds speaks little English. Pt needed
	c̄ 5mg of [illegible] 2mg [illegible] DR [redacted] [redacted]

OD [redacted]

STANDARD [redacted] BACK

*U.S. GPO: 2002 - 491-600/50516

MEDCOM - 3714

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 Apr 03 2000	Assessment completed - ↓ LS Ⓑ lower lobes, Pt resting - easily aroused. Hypoactive BS x upper quads. Med old Dsg c/d/i, return from colostomy site - MW brown liquid stool in bag - JP 1+2 ē MW ss d/c - Foley drained - 1500cc DK amber urine Ⓡ buttock Dsg c/d/i. — [redacted]
3 Apr 03 2153	Gave pt 1 Maalox ... for Heartburn — [redacted]
3 Apr 03 2115	12.5 mg phenergan + 100 mg Demerol for pain + nausea — [redacted]
0500 4/4	Foley out put 450, JP 1 10cc JP2 60 cc both ss d/c - Colostomy 450cc liquid brown stool. Pt ℅ ... tired — [redacted]
4 Apr 03 1600	Assessment completed crackles - Ⓡ FA, Foley patent 500cc amber urine in bag. ... CTA ... Ⓡ - Med old dsg c/d/i - [illegible] Colostomy ē MW liquid brown stool. Ⓡ Ⓛ ... old [illegible] - will ... for lower ... — [redacted]
	Pt requesting med to sleep - 10 mg Ambien po — [redacted]
4/5/03 0020	... by ... per ... — [redacted]
0114	Emptied 350cc liquid brown stool ... + Dsg - med old Ⓛ upper back + Ⓡ buttock — [redacted]

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

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

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

00 [redacted] [redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
05APR03 0430	VST 99.1 AX BP 140/78 R 18 P 97; DSG (L) Back CDI; DSG (L) Buttock Appears in need of dressing. Colostomy looks good Ø sign infection (2) JP's empty. SPC (b)(6)-2 q1 WMle
0700	Pt leaving Board. Did not receive 0700 meds. SPC (b)(6)-2 q1 WMle

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA field litter BY (b)(3)-1

2. PATIENT IDENTIFIED VERIFIED BY (b)(6)-2 — SPECIFIED PROCEDURE ex lap

3. DATE 24 MAR 03 TIME PATIENT ARRIVED IN SUITE 1115

4. PATIENT IN ROOM TIME 0115 NUMBER 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt sleepy upon arrival

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

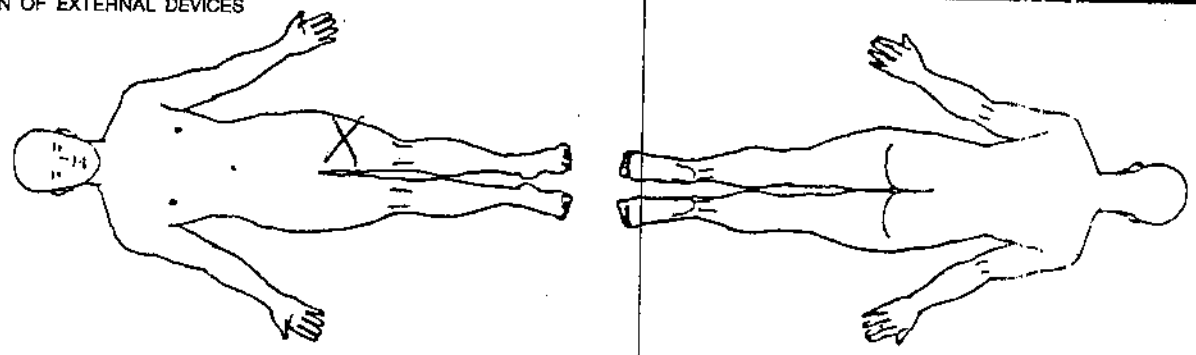
COMMENTS: Debridement of posterior wounds, then supine for exploratory laparotomy

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: DR. (b)(6)-2

PREP SOLUTION (Specify) Beta/Beta BY WHOM: Cpt (b)(6)-2
SITE: Back
SITE: Abd BY WHOM: Cpt (b)(6)-2
COMMENTS: Rectum

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

OD (b)(6)-4

(b)(3)-1

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

☐ ESU NO: F1048
GROUND PAD: BRAND Valley Lab
LOT NO: 36098

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ Y. IO IF YES NAME: ID NU F JFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED Y	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Penrose 7/8	2.	3.
SITE	1. (L) buttock	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

4X8
Colostomy bag
Fluff
Silk tape

19. ADDITIONAL INFORMATION

DR. (b)(6)-2

DR. (b)(6)-2

Anes - (b)(6)-2 CRNA - Gen

20. OPERATION(S) PERFORMED

Exploratory Laparotomy, Colostomy, I&D of Wounds

21. PATIENT TRANSFERRED TO ICU TIME 0315 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

VERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

OD (b)(6)-4 (b)(3)-1

MEDCOM - 3718

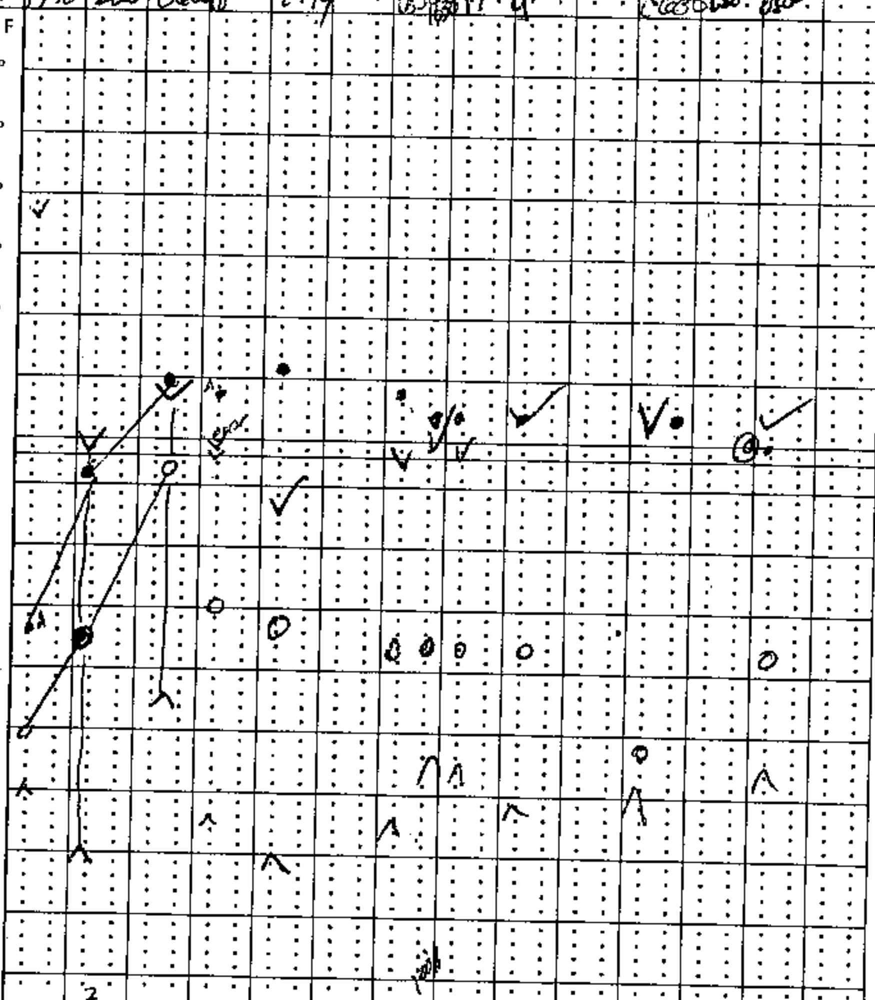
MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR DAY	31 MAR 03	1 APR 03	1 APR	2 APR	03 APR	04 APR	05 APR
19 HOUR	1930 2200	0600 1000	1944	[illegible]	[illegible]	0600 1000	0500

PULSE (O) — TEMP. F (•) — TEMP. C

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



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	18	22		16	16	16	16	16	16	R
BLOOD PRESSURE	166/71	122/60	138/86	126/66	111/60 97	128/64 96	131/78	135/65 56		
SpO2	95%	95%	100%	93%			100.0	98.6		

Record special data only when so ordered

HEIGHT:	WEIGHT →					
Urine	900	700 350	950	600	450	
JP 1	35	75 15	25		10	
JP 2	25	75 5	10		60	
Colost					450	

IV 4/4 JP1 - 5 / PO 2 - 15 / 240 1440 Colo 350

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

REGISTER NO. [illegible] WARD NO.

I 1440 O 1670

D/EPW (b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 3719

EPW # (b)(6)-4

Vital Signs

Time	BP	HR	SpO2	RR	Pain
0900	115/73	86	100	13	nothing
0000	113/68	96	100	13	nothing ~~dressing Δ'd on~~
0100	119/74	94	100	14	nothing
0200					
0300					
0400					
0500					
0600					
0700					
0800					
0900					
1000					
1100					
1200					
1300					
1400					
1500					
1600					
1700					
1800					

MEDICATIONS

DUE:
- 1200 Zantac 50 mg IVPB Q8h / 2mg MSO4
- 1300
- 1400 2mg MSO4
- 1500
- 1600 2mg MSO4
- 1700
- 1800 2mg MSO4 / Cefotetan 1g Q12°
- 1900
- 2000 Zantac 50 mg IVPB @ 8h / 2mg MSO4
- 2100
- 2200 2mg MSO4
- 2300
- 2400 2mg MSO4

I & O

Time	IN	OUT
0900	80 cc LR	100/100
1000	80 cc LR	100/200
1100	80 cc LR	100/300
1200		
1300		
1400		
1500		
1600		
1700		
1800		
1900		
2000		
2100		
2200		
2300		
2400		

NOTES

1000 Dressing Δ'd on (L) posterior thigh 2 Kerlex & 3" tape. Dressing on Abdomen cDI.

OD (b)(6)-4 (b)(3)-1

EPW # (b)(6)-4

LR @ 75 cc/hr

I+O ~~150~~

0400 100

0500 200 / 300

0600 250 / 550

0700 100 / 150

0800

0900

1000

1100

1200

1300

LABS

DRAW H&H in AM

Na 144 K 4.4 Cl 111 Bun 29

Glu 231 HCT 39 Plat 13

X-RAY

CXR in AM

MEDS

MORPHINE 4mg IVP Q30min prn pain

Zofran 2-4mg IVP Q 6h prn nausea

Zantac 50mg IVPB Q8h

0400 ✓

1200

2000

Cefotetan 1g IVPB Q12H.

0000 ✓

1800

Gentamycin 240mg IVQD

☐ 2300 30 MAR

☐ 2300 31 MAR

☐ 2300 01 APR

Pain Management

0245 4 mg MSO4

0955 4 mg MSO4

1200

1400

Unasyn 3 Gm IV Q6°

31 MAR ☐ 0000 ☐ 0600 ☐ 1200 ☐ 1800

01 APR ☐ 0000 ☐ 0600 ☐ 1200 ☐ 1800

02 APR ☐ 0000 ☐ 0600 ☐ 1200 ☐ 1800

(b)(6)-4 (b)(3)-1

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS — MG / MCG / ML, "( )"=CONSTANT INFUSION

DRUG	(Units)								
Fentanyl	(cc)	5		5					
Ketamine	(mg)	50							
Sux	(g)	100							
Vec	(mg)	5	5	5					
Mag	(g)								
Morphine / Dilaudid	(g)					10	3/.4		
VOLAT AGENT: Forane	% del / % e.t.	1.5	1	1	1	1			
AIR	L/Min								
N2O	L/Min								
O2	L/Min	3	3	3	3	3	3	3	3

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

FLUIDS

LINE site: 18G (R) ☑ Warmed — 1000 —— 1000 ——
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES

EST BLOOD LOSS
URINE — 600

PHYS STATUS: 1 2 3 4 5 E

TIME → 0115 | 30 | X | 0200 | X | 30 | C | 0300

BODY WEIGHT: KG / LB

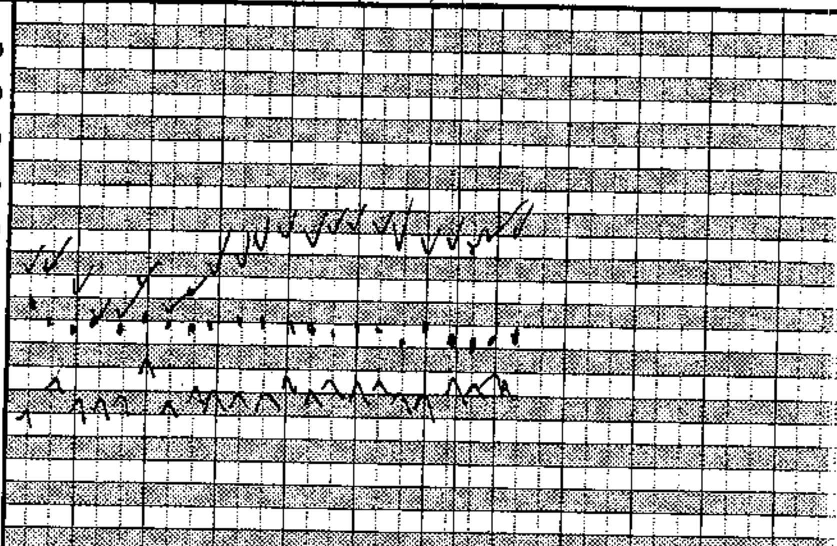
HEMATOCRIT:

INITIAL DATA: BP — / ; HR —

EQUIP CHECK: OK? — Y N

PATIENT RECHECK: OK for PROCEDURE? TIME —

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



VENTS / MONITORS / ACCESSORIES

VT — ml									
f — breaths/min									
Peak insp pres / PEEP									
MODE — S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S
BP/Auto Cuff — ET CO2 (torr)		35	40	30	30	30	29	36	
BP / oth — FIO2 (Frac or %)	.40	.40	.41	.39	.36	.38	.38	.38	
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	
Steth — PC/ES — ECG	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer — TEMP — site									
N-M Block (T/4)				4/4		0/4			
Warming blkt									
Conv warmer									

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

TOTALS

TOTAL FENT: 50 mg
TOTAL URINE: 600 ml

FLUIDS — SUMMARY
CRYSTALLOID — 1600 ml
COLLOID —
BLOOD —

REMARKS —

Code drugs with numbers, events with letters

0100 in room monitors placed 02 x ...
0105 RSI
0200 Clindamycin 900
0230 Unasyn 3Gms
0250 Gentamicin 380mg
0300 Rev 4/4 Reversal given
0300 B.V. Full, Commands, Suctioned, Extubated
0310 to ICU

RECOVERY AT

PACU ICU ______ (Specify)
OTHER ______
CONDITION:
RESP — SpO2 —
BP — HR —

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0100	0100	0310

	Ready	Begin	End
PROC	0110	0115	0300

PROCEDURES and CPT Codes: Exp laparotomy, Colostomy, R + D GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — MAC 3 ATV 8.0 ... BBS (E) ... x4 ... atraumatic

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

(b)(3)-1

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETIST: (b)(6)-2 CRNA

(b)(6)-2

PROCEDURE LOCATION

DATE: 24 Mar 03

MEDICAL RECORD — ANESTHESIA

PAGE 1 OF

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 3722

☆ U.S. GPO: 1999 – 528-336/10065

(THIS FORM IS SUBJECT TO THE PRIVACY A[illegible] 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[illegible]

ANESTHESIA RECORD

Page 1 of

ANES.	IN OR	ANES. END	DATE
16[illegible]	1623		3/30/2003
TOTS	SURG START	DRESSING	OR NO
1638	1644	1720	

OPERATION PERFORMED: [illegible] TO DISTAL STUMP

SURGEON(S): (b)(6)-2

PREOPERATIVE

☒ IDENTIFIED ☒ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 3/29
☒ PRE-OP MEDICATION: √

Drug	Dose	Route	Time
Versed	2mg	IV	1620

Pre-Anesthetic State:
☒ CALM ☒ AWAKE
☐ APPREHENSIVE ☐ SEDATE
☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☐ ANES. MACHINE # ____ & EQUIP. CHECKED
☒ NON-INV. B/P ☐ PNS
☒ CONT. EKG ☐ V LEAD EKG
☐ ESOPH. STETH. ☐ PRECORD STETH.
☒ PULSE OXIMETER ☒ O2 ANALYZER
☒ END TIDAL CO2 ☐ MASS SPEC.
☐ TEMPERATURE
☐ WARMING BLANKET ☐ FLUID WARMER
☐ AIRWAY HUMIDIFIER
☐ N / G TUBE ☐ O /G TUBE
☒ IV(s) [illegible]
☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
☐ EYE CARE
☐ PRESSURE POINTS CHECKED / PADDED
☒ [illegible] ☐

ANESTHETIC TECHNIQUE

☒ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK
☐

INDUCTION

☒ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☒ INTRAVENOUS ☐ RECTAL
☐

AIRWAY MANAGEMENT

☒ INTUBATION ☒ ORAL ☐ NASAL
☐ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☒ STYLET USED
☒ ATTEMPTS x 1 ☒ BLADE 3.0 MAC
☒ ETT SIZE 7.5 ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☒ CUFFED [illegible] ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ____ CM H2O
☒ ETT SECURED AT 21 CM
☒ BREATH SOUNDS = [illegible]
☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ LMA SIZE
☐

RECOVERY

TIME IN PACU	CONDITION		
1740	STABLE		
B/P	PULSE	RESP	O2 SAT
120/75	81		98
REMARKS			TEMP 98.3 ax

REPORT TO: PARRS:

FLUIDS TOTALS

IN		OUT	
Crystalloid	700 / LR	EBL	100
		Urine	
		Gastric	
Blood			

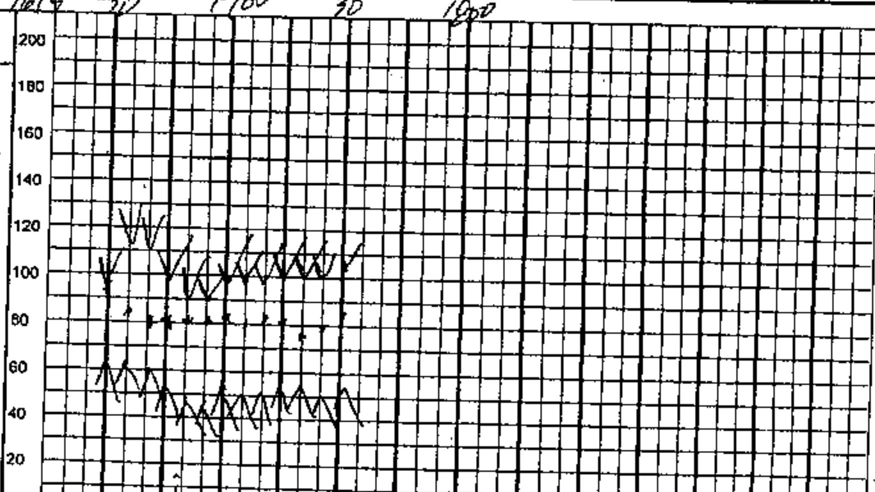
AGENTS / FLUIDS / MONITORS

	1630		1700		1800
Versed	2				
Propofol	150	50			
[illegible]	100				
[illegible]		5			
N2O L/min 150		1.5	1.2	[illegible]	
O2 L/min / AIR	4	2/2	1/2	1/2	
Fluids: LR	500		500		
Urine					
EBL					
EKG	SR	SR	SR	SR	SR
% O2 Inspired	.54	.59	.53	.43	.55
O2 Saturation	100	100	100	100	100
End Tidal CO2	30	28	27	28	40
Temperature	—	—	—	—	—
PNS	—	—	—	—	—

TOTAL

TIME 1630 30 1700 30 1800

PRE-OP VALUES: B/P 112/62; P 84; R 14; SAT 100% RA; H/H



RESP					
Tidal Volume	700	1.0	1.1	1.0	
Resp Rate	10	10	10	8	
Peak Pressure	30	28	29	29	
P 500	100	100	100	100	

Symbols for Remarks: X ⊙

Position: [illegible] semi-recumb.

SYMBOLS: X ANESTH; ⊙ OPERAT; V/Λ B/P CU PRESS; ARTER LINE PRESS; ● PULS; ○ SPONTA-NEOUS RE; ASSIST RES; ⊠ CONTRO RES; T TOURNI; F CRYS LOID F; B BLOC

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation.
☐ Significant changes from preop plan / evaluation.

Tourniquet Time:

PATIENT'S IDENTIFICATION: # (b)(6)-4

PHYSICIAN / CRNA: (b)(6)-2

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 29 MAR

MEDCOM - 3723

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE (M / F) HEIGHT WEIGHT

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM			WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma Dyspnea Recent cold	Bronchitis Pneumonia SOB	COPD Productive Cough Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years	Chest X-ray Pulmonary Studies
CARDIOVASCULAR Angina Exercise Tolerance Murmur Rheumatic fever	Arrhythmia Hypertension MVP	CHF MI Pacemaker	☐		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction Hiatal Hernia Reflux/Heartburn	Cirrhosis Jaundice Ulcers	Hepatitis N&V	☐	Ethanol Use: ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis DJD Neuromuscular disease Syncope Weakness	Back problems Headaches Paralysis Seizures	CVA/Stroke Loss of consciousness Paresthesia TIAs	☐		
RENAL/ENDOCRINE Diabetes Urinary retention	Renal failure/Dialysis Urinary tract infection	Thyroid disease Weight loss/gain	☐		Urinalysis Thyroid FBS
OTHER Anemia Pregnancy	Bleeding tendancies Sickle cell trait	Hemophilia Transfusion history			Hgb / Hct / CBC Lytes

PROBLEM LIST / DIAGNOSES

ASA
1
2
3
4
5
E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE DATE

EVALUATOR(S) SIGNATURE

CRNA DATE

PHYSICIAN DATE

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE:

SIGNED: TIME:

OD (b)(6)-4

(b)(3)-1

(THIS FORM IS SUBJECT TO THE PRIVACY AC[T] ... 974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[...]

ANESTHESIA RECORD

Page 1 of 1

ANES. S[TART]	IN OR	ANES. END	DATE
15[...]	1525		31 MAR 03
TOTS	SURG START	DRESSING	OR NO
1530	1542	1712	

OPERATION PERFORMED: I&D Buttocks, Ex lap

SURGEON(S) (b)(6)-2

TOTAL

PREOPERATIVE

- [x] IDENTIFIED
- [ ] ID BAND
- [ ] QUESTIONING
- [ ] CHART REVIEWED
- [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
midaz	2mg	IV	1520

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [x] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # & EQUIP. CHECKED
- [x] NON-INV. B/P
- [ ] PNS
- [x] CONT. EKG
- [ ] V LEAD EKG
- [ ] ESOPH. STETH.
- [ ] PRECORD STETH.
- [x] PULSE OXIMETER
- [x] O2 ANALYZER
- [ ] END TIDAL CO2
- [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N/G TUBE
- [ ] O/G TUBE
- [x] IV(s) PIV (R) arm
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE taped
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL
- [ ] REGIONAL
- [ ] LOCAL / MAC
- [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION
- [x] RAPID SEQUENCE
- [x] INTRAVENOUS
- [ ] INHALATION
- [ ] INTRAMUSCULAR
- [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION
- [ ] ORAL
- [ ] NASAL
- [x] DIRECT VISION
- [ ] BLIND
- [ ] AWAKE
- [ ] FIBER OPTIC
- [x] STYLET USED
- [x] ATTEMPTS x1
- [x] BLADE Mil 2
- [x] ETT SIZE 7.0
- [ ] DOUBLE LUMEN
- [ ] STRAIGHT
- [ ] RAE
- [ ] ANODE
- [x] CUFFED 6 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [x] ETT SECURED AT 20 CM
- [x] BREATH SOUNDS Bilat
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE
- [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA
- [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS / FLUIDS / MONITORS

Time: 1530 X 1600 X 30 X 1700 X 30 X 1800

AGENTS							
Propofol	200						
Sux	100						
Fentanyl	150	50					
Vec		4	2				
Neostigmine					5		
Robinul					1	4	
MSO4							
150		1.5 2.0 2.0 2.0 .5 .4 X					
~~N2O L/min~~ Air							
O2 L/min	2	1 1 1 1 1 1 6					

FLUIDS: Urine; EBL

MONITORS								
EKG	ST	SR	SR	SR	SR	SR	SR	SR
% O2 Inspired	1.0	.55	.54	.54	.58	.58	.50	1
O2 Saturation	100	100	100	100	100	100	100	100
End Tidal CO2		36	38	32	34	34	34	38
Temperature								
PNS			0/4	4/4	0/4	0/4	4/4	[illegible]

VITAL SIGNS

TIME: 1530 X 1600 X 30 X 1700 X 30 X 1800

PRE-OP VALUES: B/P; P; R; SAT; H/H

Scale: 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RESP										
Tidal Volume	SV	670	670	660	630	700	SV	SV		
Resp Rate	14	12	10	10	10	10	12	16		
Peak Pressure		28	29	30	31	31				

Symbols for Remarks

Position: [supine]

SYMBOLS: X ANESTH.; ⊙ OPERAT[ION]; ∨ ∧ B/P CU[FF] PRESS[URE]; ARTER[IAL] LINE PRESS[URE]; • PULS[E]; ○ SPONTA[NE]OUS RE[SP]; ASSIST[ED] RES[P]; CONTRO[LLED] RES[P]; T TOURNI[QUET]; F CRYST[AL]LOID F[LUID]; B BLO[OD]

REMARKS: [ ] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

1720 - out OR to ICU stable

RECOVERY

TIME IN PACU	CONDITION
1722	Stable

B/P	PULSE	RESP	O2 SAT
	80	14	97

REMARKS

TEMP

REPORT TO: PARRS:

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	2000	EBL	100
		Urine	1100
		Gastric	
Blood	0		

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

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION (b)(6)-4

EPW

OD (b)(6)-4 (b)(3)-1

OD (b)(6)-4 (b)(3)-1

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA CARE UNIT ORDERS		
1	OXYGEN: 2 litres via Mask /Prongs to maintain O2 Sats greater than 94%;	(b)(6)-2	(b)(6)-2
	Wean to room air.	1724	1749
2	IVF: LR @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-5 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
5	~~ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1~~		
6	~~DROPERIDOL: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1~~		
7	~~REGLAN: Give 10 mg IV PRN nausea X 1~~		
8	Release from "PACU" when Aldrete score is 9 or greater		
9	Call Anesthesia for any questions or concerns		
	SIGNED (b)(6)-2		

PATIENT IDENTIFICATION

RA # (b)(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS | LIST TIME ORDER NOTED AND SIGN

30 Mar 03 1730 TO JCU
SIP IVD bullock wound
Condition stable
VS per routine
NKDA
Return by adult
If pt does not vomit,

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

may place foley.
Regular diet PO
LR @ 100cc/hr
MSO4 4mg IV Q1° prn pain
Phenergan 12.5mg IV Q4° prn nausea
Unasyn 3.0g IV Q6°
Cefazolin 2g IV Q8h

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

Tylenol 650mg PO Q4° prn 1005
DC IVF

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

3/31/03 1105
① NPO NOW
② OR call to OR today

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

OD (b)(6)-4

(b)(3)-1

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

NT IDENTIFICATION

ePW (b)(6)-4

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
31 Mar 03	TS 1 CW	
1730	S/P Debridement, on table	
	washout, pressure dressing	
	Condition stable	
	VS per routine	
	NKDA	
	Bedrest	

NSING UNIT	ROOM NO.	BED NO.

TIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	
	Foley	
	Stoma care	
	JP x 2	
	Diet to Dy to mid line	
	NPO	
	LR @ 140cc/hr	
	MS 4mg IVQ4hrprn	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	
	Phenergan 12.5mg IVQ4hrprn nausea	
	Unasyn 3.0g IVQ6°	
	Ceftriaxone 2g IV Qd	
	O2 2L NC	

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	
	Demerol 100mg IV X1	
	VO. Dr (b)(6)-2 / LT (b)(6)-2	
	(b)(6)-2	
	(b)(6)-2	
	31 March 2003 1900	
	↑ Morphine sulfate 2-30mg IV q 2	
	or Demerol 100mg IV q 1 hr prn	

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2

12
1 0

CLINICAL RECORD - DOCTOR'S ORDERS

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

ALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD
D, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

IFICATION	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
# (b)(6)-4	1 April 2003	1300Z		(b)(6)-2
	① Δ antibiotics & Ranitidine Tyg IV qd & Flagyl 500mg po BID			(b)(6)-2 (b)(6)-2 1500
				(b)(6)-2 (b)(6)-2 Hm LTC

UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	HOURS	
IDENTIFICATION						(b)(6)-2
PW # (b)(6)-4			4/3/02			(b)(6)-2
			0524			
			04 APR 03	0455		(b)(6)-2
			① Zantac 150 mg po bid			
			② Dressing Open Hom. Surgery			(b)(6)-2

RSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	HOURS	
ATIENT IDENTIFICATION			4/5/03			(b)(6)-2
			Atbm - 1g po qm w-			

NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	HOURS
PATIENT IDENTIFICATION (b)(6)-4					
OD (b)(3)-1					

NURSING UNIT	ROOM NO.	BED NO.

REPLACE ...ION OF 1 JUL 77, WHICH MAY BE USED.

non Meds

CLINICAL RECORD

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

Mo. 03 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5
31 Mar	(b)(6)-2	VS per routine	2 04 16	07 19	(b)(6)-2				
			2 16 04	19 07					
31 Mar		Bedrest	2 04 16	07 19					
			2 16 04	19 07					
31 Mar		Foley	2 04 16	07 19					
			2 16 04	19 07					
31 Mar		Stoma care	2 04 16	07 19					
			2 16 04	19 07					
31 Mar		JP x 2	2 04 16	07 19					
			2 16 04	19 07					
31 Mar		Wet to dry to midline	2 04 16	07 19					
			2 16 04	19 07					
			2						
31 Mar		diet Diet to open ASAP (b)(6)-2 4/3/07	2 04 16	07 19					
			16 04	19 07					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Debridement Washout

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

PATIENT IDENTIFICATION:
OD/EPW (b)(6)-4
(b)(3)-1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

non Meds

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 03 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials (b)(6)-2
31 Mar	(b)(6)-2	Condition stable	done		1845	
31 Mar		Admit to ICU	done		1845	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

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

Recurrent Medications and Treatments		3/24/03 date	25	26	27
Zantac 50mg IV q8°	07	0	(b)(6)-2		
	14	(b)(6)-2			
	22				
Cefotaxime 1gm IVPB q12°	02				
	14	(b)(6)-2		(b)(6)-2	
W/D dressing BID two sites	07	per doc	(b)(6)-2		
	14	1809 (b)(6)-2			
	22				
Vital signs					
O2 sats @ 1110 94% RA (94°)	4			99-2 130/73 P84	
	8		100.9 87% P102 130/80	129/70 97% 85 99.1	
	12	97.0 140/80 140 22	99.8 P 94 132/72 95		
	16	144/80 97% 102 98	96% 125/74 100.6 97		
	20	T. 100.2 BP 140/80 98% P 107 R 20		P82 127 T97.9 72	
	13½ 24	93% on RA 101 98.9		1197.3 89 98.8 20	
PRN Medications and Treatments					
Morphine 4mg q 30 min pain	d/t amt/int	24 March 03 1400 (b)(6)-2	24 March 03 1820 (b)(6)-2	24 March 03 4 2630 mg (b)(6)-2	
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: OD (b)(6)-4

SSN:

Unit: EPW (b)(3)-1

Dx: GSW back + buttox

All:

Blood type:

diet npo

(b)(6)-4 # on pt Hold Log

IVF	Time	amount	Total	26	27
OR IPACH		1000	1000 2000		
LR 75 cc/hr 1000 ml 1100					
Hourly Input and Output		IV		(b)(6)-2	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100			300	900
	1200				
	1300				
	1400				450
	1500				
	1600				
8 hour totals					
	1700	300 cc			
	1800				
	1900				
	2000				
	2100				
	2200				
	2300				
	0000				
8 hour totals					
24 hour totals					

Total input:
Total output:
Balance:

In/Out

25 March
0649 650cc
1412 700cc

26 March
0504 900cc

OR IPACH

24 hour
600cc

CLINICAL RECORD

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

Mo 03 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31 1 2 3 4 5
31 Mar	(b)(6)-2	LR @ 146 cc/hr	07 19	(b)(6)-2
			19 07	(b)(6)-2
		NS 4hr		
31 Mar		O2 2L NC	07 19	(b)(6)-2
			19 07	(b)(6)-2 (b)(6)-2
31 Mar		Unasyn 3gm IV q8	06	(b)(6)-2
		q6°	12	
			18	D/C'd
			24	
31 Mar		Clindamycin 250mg IV Qd	10	D/C'd
31 Apr		Rocephin 1 Gm IV qday	07	(b)(6)-2 (b)(6)-2
9 Apr		Floxyl 500mg PO BID	09	(b)(6)-2 (b)(6)-2
			16 (b)(6)-2	(b)(6)-2
			(b)(6)-2	
4 Apr		Zantac 150mg PO BID	07	(b)(6)-2
			16	(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Pressure area S/P Debridement/Washout

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

PATIENT IDENTIFICATION:
OD/EPW (b)(6)-4

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 03 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31 Mar	(b)(6)-2	Demerol 100mg IV x 1	done	1830	1830	(b)(6)-2
4 Apr		Ativan 1/2 po X 1 now	now	now	0028	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
31 Mar	(b)(6)-2	MS 4mg IV Q1° PRN Pain	d/c 31 Mar @ 1910 (b)(6)-2
31 Mar	(b)(6)-2	Phenergan 12.5 mg IV Q4° prn nausea	1 APR 0200 (b)(6)-2; 1 APR 1930 (b)(6)-2 12.5 mg; 4/3 (b)(6)-; 4/3 2150; 4/4
31 Mar	(b)(6)-2	↑MS 2-30mg IV q2h prn or Demerol 100mg IV q1h prn	31 Mar 10mg 1845 (b)(6)-2; 31 Mar 5mg 1915 (b)(6)-2; 31 Mar [illegible] (b)(6)-2; 31 Mar [illegible] 10mg; 31 Mar 2300 10mg; 01 APR 0105 10mg; 1 APR 0445 6mG (b)(6)-2; 2 APR (b)(6)-2; 4-3 2015 (b)(6)-2
			31 Mar 1830 100mg (b)(6)-2; 31 [illegible]; 01 APR 0800 70mg; 01 APR 1930 50mg (b)(6)-2; 4/2 1710; 4/3 1005; (b)(6)-2; 4/3 2115
3/31	(b)(6)-2	Demerol 100mg [illegible] (b)(6)-2 [illegible]	

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

MEDCOM - 3735

Initial Assessment

Date _____ Time _____

(b)(3)-1

ICU____
OR____

NEUROLOGICAL ASSESSMENT

2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level of Consciousness
- X Awake
- X Alert
- __ Drowsy
- __ Restlessness
- __ Lethargic
- __ Unconscious

Orientation: ?
- __ Time
- __ Place
- __ Person

Eyes Open:
- X Spontaneous
- __ To Speech
- __ To Pain
- __ No Response

Best Verbal:
- X Oriented & Converses
- __ Disoriented & Converses
- __ Inappropriate Words
- __ Incomprehensible Sounds
- __ No Response

Best Motor:
- X Obeys Commands
- X Localizes Pain
- __ Extension
- __ No Response

Motor Ability & Strength:

	X Strong	Weak	Absent
RA			
LA			
RL			
LL			

PSYCHOLOGICAL
- __ Calm
- __ Combative
- __ Cooperative
- __ Anxious

INTEGUMENTARY

Color:
- X Normal
- __ Pale
- __ Flushed
- __ Cyanotic
- __ Jaundiced

Skin:
- X Warm
- __ Diaphoretic
- __ Cool
- __ Clammy

RESPIRATORY
- X Unlabored
- __ Labored

Breath Sounds:
- X Clear Bilaterally
- __ Absent R L
- __ Rales R L
- __ Wheezes R L

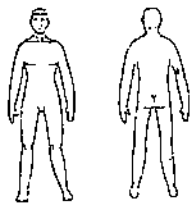
ABDOMINAL
- X Soft
- X Tender
- __ Rigid
- __ Non-Tender
- __ Distended
- __ Rebound

Bowel Sounds:
- X Active
- __ Hypoactive
- __ Hyperactive
- __ Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial		
Femoral		
Pedal		
Edema		

0-Absent 2-Normal
1-Weak 3-Bounding



24 Mar 03

Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
2145		100	18	118/68	EPW ♂ to ATLS c #4 wounds to back/buttocks
2240		110	18	131/58	Bleeding controlled. Pt
2255		104	17	125/62	Awake/responsive - non-
					English speaking. Lungs
					CTA (B), Sats 96% RA.
					Abd [b)(6)-2] Abd tender. Foley
					in place 1900cc clear
					yellow urine @ arrival.
24 Mar 03 0330					Pt to ICU s/p ex lap ? colostomy (end sigmoid)
					NG tube present. 5L O_2 via facemask 100% SpO_2 Foley to
0357		121	23	165/93	gravity drainage c clear amber urine. Kerlix
0525		98	15	145/74	dsg to (R) buttock dry+intact. Kerlix dsg to
0530		97	15	149/76	(L) buttock c penrose drain dry+intact at this
0545		95	15	150/75	time. Will continue to monitor. Midline abd.
0500		88	12	137/72	dsg dry+intact c ostomy present. IV NaCl
0415		86	12	125/70	0.9% infusing at TKO via 18 ga needle -
					[b)(6)-2] SSCor/Lev

Allergies

Time	IV MEDICATIONS (dose/route site)
2200	5cc 5mg Morphine
2205	.5cc Tetnus
2300	100cc 1gm Ancef
0400	100cc Zantac 50mg IVPB
0600	100cc Cefotetan 1g IVPB

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric
	0400	1000ml	100	N/A	0
	Total:				

Pertinent Lab Values
24 MAR 0045
Na 144
K 4.4
Cl 111
Bun 29
Glu 231
Hct 38 Hbg 13

Allergies
PMH/PSH
OD#
EPW #
46 y/o ♂

(b)(6)-4

(b)(6)-4

(b)(3)-1

(b)(6)-4

ATLS WORKUP SHEET

DA FORM 4700 274th FST OP 1

INPATIENT TREATMENT RECORD COVER SHEET

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

1 [illegible] (b)(6)-4	2 (b)(6)-4					3 GRADE CIV	ADMISSION REMARKS
4 SEX F	5 AGE	6 RACE	RELIGION Muslim	8 LENGTH OF SVC —	9 ETS —	10 PREVIOUS ADMISSION —	
11 PMP 99	12 SSN (b)(6)-4		13. ORGANIZATION —			14 WARD PEDS	
15 ETHNIC STATUS —	16 RATING/ OSC —	17 DEPT / BEN —	18. BRANCH/CORPS —	19. UIC/ZIP		20 TYPE CASE IMG	
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DLR				22. HOUR OF ADMISSION 1200	23 CLINIC SERVICE AAAA		
24 NAME/RELATIONSHIP OF [illegible] (b)(6)-4				25. TYPE DISPOSITION DOW	26. DATE OF DISPOSITION 27may03		
27a ADDRESSEE (Include ZIP Code) VA				27b. TELEPHONE NO	28. DATE OF THIS ADMISSION 27may03	ADMITTING OFFICER MAJ (b)(6)-2	
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ					30. DATE OF INITIAL ADMISSION	31 UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31 SELECTED ADMINISTRATIVE DATA

32 CAUSE OF INJURY ☐ Check if Continued on Reverse

33 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Open head Injury - 873.8 Trauma Inj

Severe Neurologic damage 781.99 9 999

80065

E9919

34 Total Days This Facility ☐ Check if Continued on Reverse

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

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS THE OFFICE OF THE SURGEON GENERAL.

NAME AND LOCAL [illegible] (b)(3)-1

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

~~PVT~~ (b)(6)-4 COD (b)(6)-4

(b)(6)-4

Patient's name (Last, first, middle initial), Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 1350 27 mar 03

3. MEDICAL EXAMINER/ CORONER'S CASE: ☐ YES ☐ NO

4. RELIGION: UNK

5. CHAPLAIN NOTIFIED: ☒ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH: mother of patients at this Facility. ~~Father~~ are

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)*: Open head Injury	16 hours
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)*: (1) Open head injury (exposed brain parenchyma)	16 hours
	(2) Severe neurologic damage	16 hours
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
29 mar 03	(b)(6)-2 MAJ, MC	(b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER(Specify)					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 1 OCT 72 3894 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

*U.S. GPO: 1993-342-027/60481

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms): Unknown Identified as EPW # (b)(6)-4

GRADE Grade: CIV

BRANCH OF SERVICE Arme: IRAQ

SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale: (b)(6)-4

ORGANIZATION Organisation: IRAQ Civilian (b)(6)-4

NATION *(e.g., United States)* Pays: IRAQ

DATE OF BIRTH Date de naissance: Unknown

SEX Sexe: ☐ MALE Masculin ☒ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
☐ CAUCASOID Caucasique	☒ SINGLE Célibataire	DIVORCED Divorcé	☐ PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*: UNK
☐ NEGROID Négroïde	☐ MARRIED Marié		☐ CATHOLIC Catholique	
☒ OTHER (Specify) Autre *(Spécifier)*: IRAQ	☐ WIDOWED Veuf	SEPARATED Séparé	☐ JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent: Unknown (b)(6)-4

RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit: Father

STREET ADDRESS Domicile à (Rue):

CITY OR TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris):

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]	Open head Injury	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Open head injury (exposed brain parenchyma)	16 hours
ANTECEDENT CAUSES — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	Severe neurologic damage	16 hours
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès:
- ☐ NATURAL Mort naturelle
- ☒ ACCIDENT Mort accidentelle
- ☐ SUICIDE Suicide
- ☐ HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée: ☐ YES Oui ☒ NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie: Physician

NAME OF ~~PATHOLOGIST~~ Nom du pathologiste: (b)(6)-2 MAJ, MC

SIGNATURE: (b)(6)-2

DATE Date: 29 MAR 03

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES
Circonstances de la mort suscitées par des causes extérieures: Blast injury causing penetration of skull and exposure of brain.

AVIATION ACCIDENT Accident d'Avion: ☐ YES Oui ☒ NO Non

DATE OF DEATH *(Hour, date)* Date de décès *(Heure, le jour, le mois, l'année)*: 1355 (local) 27 MAR 2003

PLACE OF DEATH Lieu de décès:

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus.

NAME OF MEDICAL OFFICER ... militaire ou du médicin sanitaire: (b)(6)-2

TITLE OR DEGREE Titre ou diplôme: MD

GRADE Grade: MAJ / O-4

INSTALLATION OR ADDRESS Installation ou adresse: (b)(3)-1 IRAQ

DATE Date: 29 MAR 03

SIGNATURE: (b)(6)-2

[1] State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
[2] Préciser la condition qui a contribué à la mort, mais ... aucun rapport avec la maladie ou à la condition qui a pro... la mort.

DD FORM 1 APR 77 2064 REPLACES DA F... 565, 1 JAN 72 AND DA FORM 3565-R(PAS), 26 ... WHICH ARE OBSOLETE.

(b)(6)-4

Died here 27th March.

Father + mother also treated here, now in Nasr Gen. Hospital. Three other child died on site.

The Guardian
The Observer

[redacted]
Correspondent

119 Farringdon Road,
London EC1R 3ER,
Telephone: (+44)20727[redacted] (b)(6)-4
ed.vulliamy@guardian.co.uk

b-6-3

+ Steve Connors (PWJ).

(REMOVE, CHOOSE AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

DISPOSITION OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER

INSTALLATION OR ADDRESS	DATE	SIGNATURE

NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY
GRID Sec. 05 (b)(6)-4	

TYPE OF DISPOSITION	DATE OF DISPOSITION
☐ BURIAL ☐ CREMATION ☐ REMOVAL *(Specify)*	

REGISTRATION OF VITAL STATISTICS

REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER

NAME OF FUNERAL DIRECTOR	ADDRESS

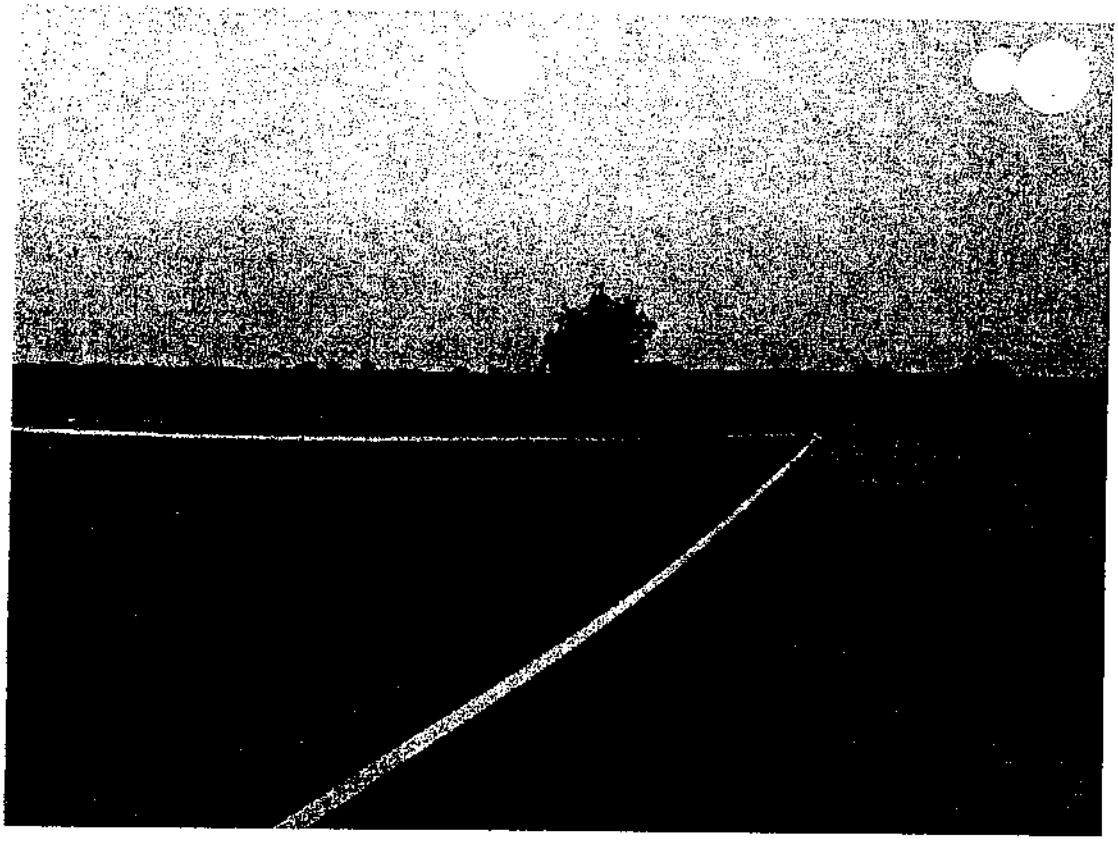
SIGNATURE OF AUTHORIZED INDIVIDUAL

GRID Series

(b)(6)-4

GRID Series

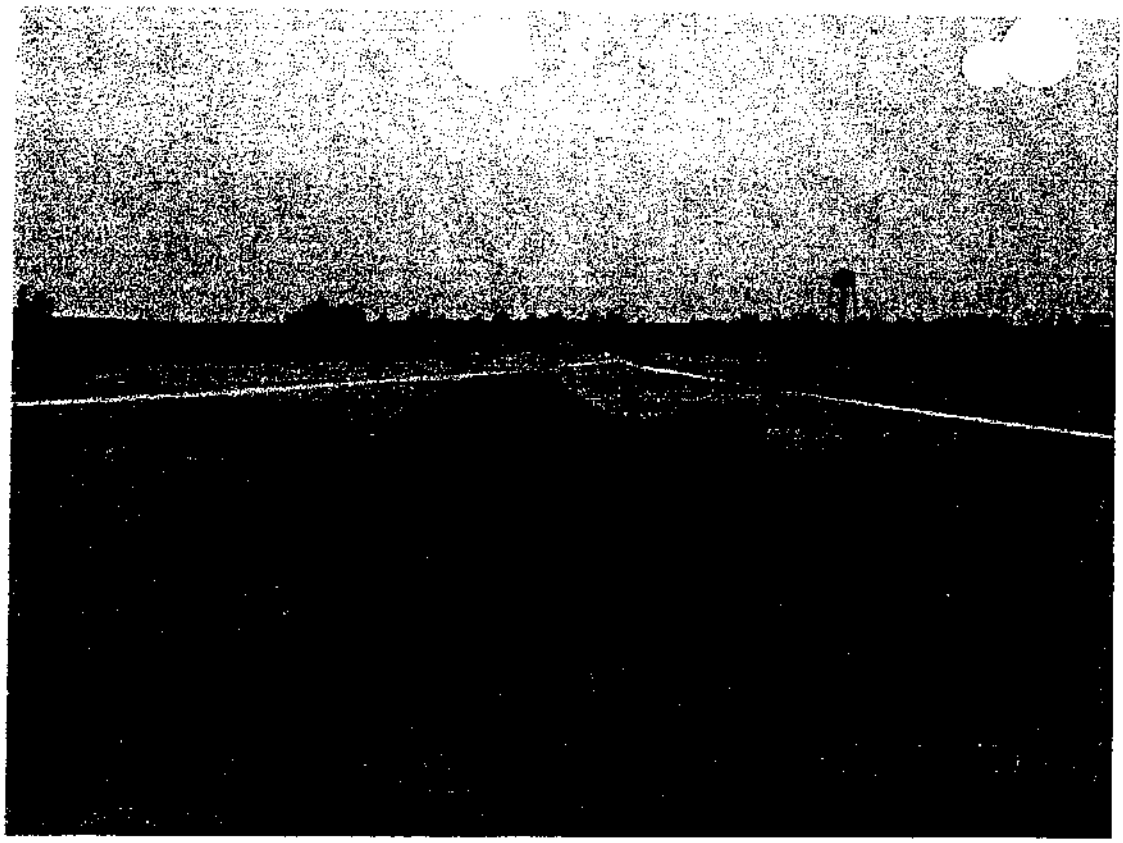
(b)(6)-4



(b)(6)-4

(b)(6)-4

EOH (b)(6)-4



(b)(6)-4

father)

(b)(6)-4

mother)

father (b)(6)-4

mother (b)(6)-4

For use of this form, see A... proponent agency is the Office of the Surgeon General

MEDICAL RECORD - SUPLEMENTAL ...L DATA

T-c

REPORT TITLE

TRAUMA FLOWSHEET — INITIAL ASSESSMENT

OTSG APROVED (Date)

Date: 27 Mar 03 Arrival Time: ______ ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Allergies: ______ Sex: M (F) Age: ______ Wt: 20 kilo(s)

Tetanus Status: UTD Unknown

LMP: Last Meal:

Chief Complaint: OPEN HEAD INJURY

PMH:

Medications: MSO4 TIL MOTE FOR PAIN

Treatments PTA:

VITAL SIGNS: BP: P: RR: TEMP: SAO$_2$:

CHEST
TRAUMA ☒YES ☐NO
PAIN ☐YES ☒NO
SOB ☒YES ☐NO
LUNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS ☐ YES ☐ NO
GUIAC TEST ☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☒ NO R 2 mm L 2 mm
GLASCOW SCORE: ______

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

Pinpoint -

EXTREMETIES
☐ DISTAL PULSES
☐ RT X 2 ☐ LT X 2
☐ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES

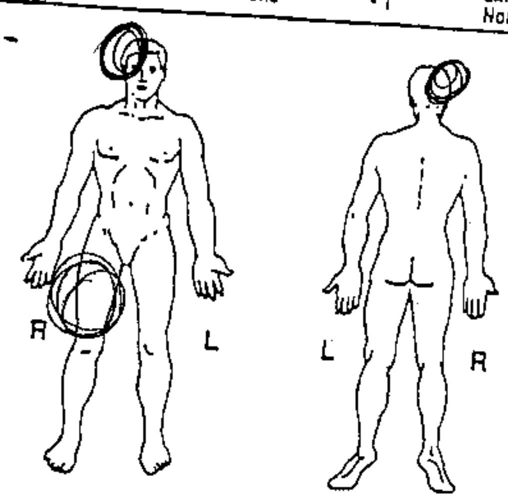
Deceased BSS (local)

(b)(6)-2

EXCEPTIONS TO ABOVE PARAMETERS:

MAST, NC

SPLINTS:



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Ostomy
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW- (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

BRAIN MATTER

TREATMENTS
O2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐Y ☐N EKG ☐Y ☐N
NG TUBE #
FOLEY: #
CHEST TUBE ☐R ☐L DPL ☐ POS ☐ NEG CM H20

PREPARED BY (Signature & Title)

(Continue on reverse)

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

DATE 27 March 03

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

(b)(6)-4

OD EPW (b)(6)-4

IRAQ CIV

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

...00, MAY 78

MEDCOM - 3748

IV SOLUTIONS/SITES

TIME	SITE/SIZE	IV FLUID/BLOOD	AMOUNT INFUSED	OUTPUT
				CHEST TUBE:
				EMESIS:
				NG TUBE:
				URINE:
				EBL:
				OTHER:

TOTAL IN:__________ OUTPUT:______

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT
1300		84	38		pupils pinpointed, non reactive
1315		120	40		Pupils Pinpointed NR L - No reaction to Pain ful stimuli
1330		132	28		Pupils Pinpointed NR-L - NR to painful stimuli
1345		120	22		Pupils Pinpointed NR-L - NR To painful stimuli
1346		∅	∅		∅ agonal Respirations Noted, ∅ 5 min No resp Noted

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA

OTHER:________________

*XRAYS:*______________________________

MEDICATIONS

TIME	MED	DOSE	ROUTE	INITIALS

PROCEDURES/PROGRESS NOTES

Pt is a 4 yo female c̄ open head injury. Exam c̄ pinpoint pupils, not responsive to pain. ∅ posturing HR 140 RR 30. Continue as per prior plan c̄ pain management. (b)(6)-2 MD 5011.

12:50 ⊕ BS BILATERAL, ST - 140'S, ⊕ BS PINPOINT PUPILS, NOT AROUSABLE, DO NOT RESPOND TO PAIN STIMULI; CONTINUE TO MONITOR ———— [illegible]

~~1300~~

1350 - Ch (b)(6)-2 notified & Last rites given by chaplain (b)(6)-2

MEDICAL RECORD - SUPLEMENTAL ...CAL DATA

For use of this form, see A ...0-... ...ne proponent agency is the Office of the Surgeon General

REPORT TITLE

TRAUMA FLOWSHEET

INITIAL ASSESSMENT | ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL | OTSG APROVED (Dat

Date: 22 mar 03 Arrival Time: _____ Sex: M (F) Age: _____ Wt: 20 tonnos

Allergies: _____ Tetanus Status: UTD Unknown

LMP: Last Meal:

Chief Complaint: Open Head injury

PMH: Medications: MSO4 DILAUDID FOC Pkg

Treatments PTA:

VITAL SIGNS: BP: P: RR: TEMP: SAO_2:

CHEST
TRAUMA ☐YES ☑NO
PAIN ☐YES ☑NO
SOB ☐YES ☑NO
LUNG SOUNDS
R L
☑ ☑ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☑ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

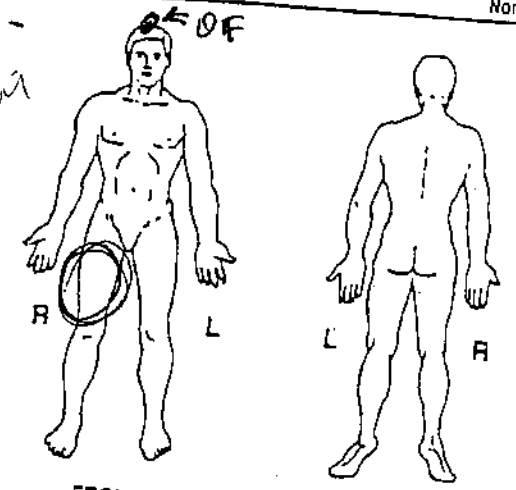
NEURO
PERRL ☐ YES ☒ NO R 2 mm L 2 mm
GLASGOW SCORE: 5

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASGOW COMA SCALE

1. EYE OPENING	2. VERBAL RESPONSE	3. MOTOR RESPONSE
Spontaneous - 4	Oriented - 5	Obedient - 6
To Voice - 3	Confused - 4	Purposeful - 5
To Pain - 2	Inappropriate - 3	Withdrawal - 4
None - 1	Incomprehensible - 2	Flexion - 3
	None - 1	Extension - 2
		None - 1

EXTREMETIES
☑ DISTAL PULSES
☐RT X 2 ☐LT X 2
☐MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES
EXCEPTIONS TO ABOVE: Flexor



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW - (Size)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

BRAIN MATTER

PARAMETERS:
TREATMENTS: (b)(6)-2
2: LPM NC
TT # MM
IONITOR ☐Y ☐N EKG ☐Y ☐N
IG TUBE #
OLEY: #
HEST TUBE ☐R ☐L

SPLINTS: Expectant
ORAL AIRWAY
NASAL AIRWAY
DPL ☐ POS ☐ NEG
CM H20

REPARED (b)(6)-2 MAJ MC

(Continue on reverse)

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

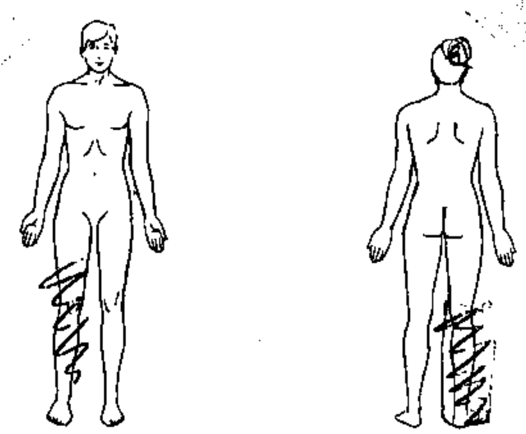
OD
EPW
(b)(6)-4

IRAQ CIV

DEPARTMENT/SERVICE/CLINIC (b)(3)-1 | DATE

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

00. MAY 78



1851	1920		
/	/	/	/
68	156		
16	20		

IV Lactated Ringers ___ IM ___

0 0

II II

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

1740 3/26/03

H 037118 -2-3

unknown age ♀ c̄

wound Ⓡ parietal area/occipital

area c̄ open skull

brain matter, Ⓡ LE injury

fixed to rt gaze 4mm - ↓ Reacts

moving rt side, groans - Murmur

? following command intermittent

purposeful movement ? ... ?

- IV access - injury 24hrs

Rocephin 1 gram

 1gm Rocephin IM ... (1935)

0

II (b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(6)-4
2. MTF LOCATION (State or Country Code): IZ
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): EPW# (b)(6)-4 (b)(6)-4
4. PAY GRADE: CIV
5. SEX: F
6. DATE OF BIRTH (Y Y Y Y M M D D): 19 19 49 49 Ø 1 Ø 1
7. AGE AT ADMISSION: 0 4 1
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 2 Ø
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only): - Iraq Civilian
13. MARITAL STATUS: S
HOUR OF ADMISSION: 1200
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: Ø 9 3 3 Ø Ø Ø Ø Ø
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 9 inj
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: C CRO
WARD: MORGUE
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: (b)(6)-4
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF TREATMENT FACILITY: (b)(3)-1 IRAQ
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 4 ~~DOW~~ 30
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 2003 Ø 3 2 7 1250
24. CLINIC SVC - ADMITTING: A A A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 2003 Ø 3 2 7
27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

Dx: 8738 Open head Injury
78199 (Exposed brain parenchyma)

Trauma 9
Inj 999

Dx 80065
E 9919
Inj 443
trauma 1

ADMITTING: (b)(6)-2
(b)(6)-2
MAJ, MC
SIGNATURE: (b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 3752

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4	NAME (Last, First, MI) EPW# (b)(6)-4		3 GRADE
(b)(6)-4 Iraqi	7 RELIGION	8 LENGTH OF SVC / 9 ETS	10 PREVIOUS ADMISSION No
	13 ORGANIZATION		14 WARD ICW2
99 (b)(6)-4	18 BRANCH/CORPS	19 UIC/ZIP	20 TYPE CASE INJ
	21 SOURCE/AUTHORITY FOR ADMISSION Direct	22 HOURS OF ADMISSION 2300	23 CLINIC SERVICE ABAA
	25 TYPE DISPOSITION Evac	26 DATE OF DISPOSITION 4 Apr 03	
	27b TELEPHONE NO.	28 DATE OF THIS ADMISSION 27 Mar 03	
(b)(3)-1		30 DATE OF INITIAL ADMISSION	

SIGNATURE OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

ADMINISTRATIVE DATA

SIGNIFICANT OPERATIONS AND SPECIAL PROCEDURES

open head wound 873

35 Total Days This Facility				
a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
8	8			8

36 Total Days All Facilites				
a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD

ATTENDING OFFICER (b)(6)-2

LTC, MC
GENERAL SURGEON

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 75 IS OBSOLETE

MEDCOM - 3753

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4	2. NAME (Last, First, MI) RPN # (b)(6)-4			3. GRADE	ADMINISTERING SERVICE
(b)(6)-4	4. RACE Black	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No
		13. ORGANIZATION			14. WARD
99	(b)(6)-4				
	16. RATING (MOS)	17. DEPT REN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE IN
	21. PERSON/AGENCY FOR ADMISSION Direct		22. HOURS OF ADMISSION 2300	23. CLINIC SERVICE ABAA	
	24. NEXT OF KIN/EMERGENCY ADDRESSEE		25. TYPE DISPOSITION Evac	26. DATE OF DISPOSITION 4 Apr 03	
	27. NEXT OF KIN/EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 27 Mar 03	
	(b)(3)-1			30. DATE OF INITIAL ADMISSION	

29. PRINCIPAL AND SPECIAL PROCEDURES

open head wound 873.8

Trauma Inj

9 999

35. Total Days This Facility				
a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
8	8			8

36. Total Days All Facilities				
a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD

LTC, MC
GENERAL SURGEON

(b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 79 IS OBSOLETE

MEDCOM - 3754

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27mar03	lac to (R) eyebrow 2ed dressing. swelling and bruising under and over eye. Abrasion lac to (R) flank. small red Ring 1/2 cm - Ø c/o N/V. [redacted] 91WM620
	Tetanus Tox 0.5cc IM [redacted]
28MAR03	28MAR03 /0750
1600	HR:90bpm R: T: 98.8 BP: 100/61 Dressing 2ed to (R) eyebrow and (R) flank. 0.5cc Tetanus given (R) Buttock IM. Ø c/o pain. [redacted] 91WM62
28MAR03	Motrin 400 mg 7 PO q 6° prn HA/pain [redacted]
1940	400 mg Motrin given for headache. [redacted] 91WM62
29MAR03	
0615	T: 97.9 oral 81/43 p87
0730	Pt rested throughout night. No complaints of pain after Tylenol given. Dressing changed over the eye to make smaller and more comfortable. Only complaint is new drug "oily" Gave report on pt. [redacted] assume [redacted]
0820	received report. will continue to monitor. [redacted] 91WM620
	1340 BP 98/49 P: 85 T: 98.7 Ø c/o pain [redacted]

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

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

REGISTER NO.	WARD NO.

EPN [redacted]
Civilian female.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29MAR03	(1900) - pt. ate dinner and snacks throughout day.
	[redacted] 91WM6
30MAR03	0633 pt rested throughout night, is resting now, no
	signs of pain or distress. [redacted] 91WM6
0730.	report received. pt. eating rice and fruit. ø c/o pain
0940	- c/o pain under (R) eye. 400mg motrin given. dressing
	Δ^ed to eye and back. (1600) ø c/o pain. eating
	dinner (1750) R: 24 T: 98.4 P: 73 SpO2 98.
pt	pulled scab under (R) eye. ø c/o pain at this
	time.
31MAR03	T: 97.9 oral R: 20 SpO2: 98 P: 74 pt rested throughout
	night w/ no c/o pain. interacted with other females
	and children in room.
31Mar03	Pt. said she had slight pain
	Gave 400mg of Motrin Oral suspension
	[redacted] 91WM6
~~31Mar03~~	~~9:04 T 98.8 P 98 (R) ... 97% ...~~ [redacted]
	~~Pt. displays distress when ...~~
	~~medical equipment~~ [redacted] ~~91WM6~~
31MAR03 2000	No sign of Distress. Chatting and playing with her sister
	SPC [redacted] 91WM6
0745 01APR03	Pt. eating veggies & Rice, chicken & tomato (0830)
	small amount of pain above (R) eye. 400mg motrin given
	PO. will continue to monitor (1230) bandage Δ on
	(R) eye. ø c/o pain at this time. [redacted]
1Apr03	T 99.5 BP 115/97 P 91 No c/o pain
	No c/o temperature [redacted]
02APR03	(0600) pt. awake. ø c/o pain eating. [redacted] 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-800/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03 APR 03 0350	Pt rested well through night. Removed dsg from OD over the eye. No signs of infection. Pt c/o pain through shift. [(b)(6)-2] 2WMSG
03 Apr 03 0650Z	Pt assessment c no change. Laceration to OD healing well open to air & signs of infection or irritation noted. Plan for D/C home today [(b)(6)-2] [(b)(6)-2] [(b)(6)-2] MSG
4 APR 03 0250Z	slept throughout night, c/o Pain - laceration to above the eye noted c drainage or infection [(b)(6)-2] 2WMSG

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

OD [(b)(6)-4]

PROGRESS NOTES
Medical Record

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

J-01

CAL RECORD - SUPLEMENTAL M...IC... ...TA

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

REPORT TITLE

TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 27 MAY Arrival Time: 1300 Sex: M F Age: 13YOM Wt: ____

Allergies: NKDA Tetanus Status: UTD Unknown

LMP: Last Meal:

Chief Complaint: lacs / abrasions

PMH: Medications:

Treatments PTA:

VITAL SIGNS: BP: P: RR: TEMP: SAO_2:

CHEST
TRAUMA ☑ YES ☐ NO
PAIN ☑ YES ☐ NO
SOB ☐ YES ☑ NO
LUNG SOUNDS
R L
☑ ☑ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☑ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☑ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☑ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☑ YES ☐ NO R____mm L____mm
GLASCOW SCORE: 15

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASGOW COMA SCALE

1. EYE OPENING	2. VERBAL RESPONSE	3. MOTOR RESPONSE
Spontaneous - 4	Oriented - 5	Obedient - 6
To Voice - 3	Confused - 4	Purposeful - 5
To Pain - 2	Inappropriate - 3	Withdrawal - 4
None - 1	Incomprehensible - 2	Flexion - 3
	None - 1	Extension - 2
		None - 1

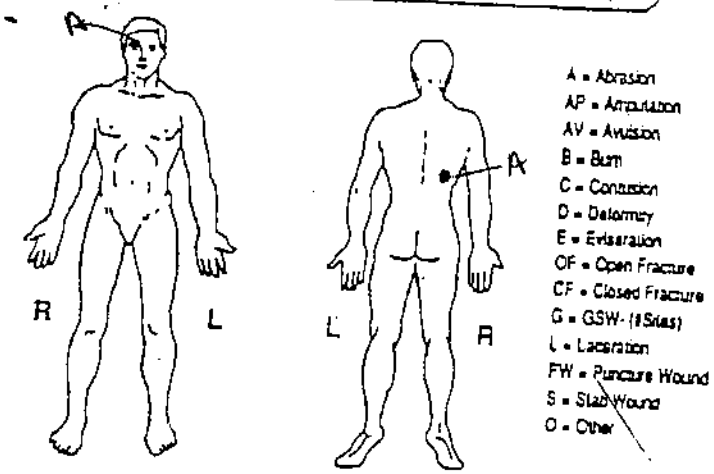
EXTREMETIES
☑ DISTAL PULSES
☐ RT X 2 ☐ LT X 2
☐ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS:

TREATMENTS:

SPLINTS:

2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
IG TUBE #
OLEY: #
HEST TUBE ☐ R ☐ L DPL ☐ POS ☐ NEG
CM H20



FRONT BACK

A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisseration
OF = Open Fracture
CF = Closed Fracture
G = GSW - (# Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

RE[illegible] (b)(6)-2 MD (b)(6)-2

(Continue on reverse)

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

EPW (b)(6)-4

Civilian

DEPARTMENT/SERVICE/CLINIC (b)(3)-1 DATE

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

DD. MAY 78

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)(6)-4	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	EPW # (b)(6)-4	16 17	18

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 Iraqi	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 9 9	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	2300	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 D	ICU2	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	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
73 74 EVAC	75 76 77 78 79 80	81 82 83 84 85 86 87 88 2 0 0 3 0 4 0 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92 A B NA	93 94 95 96 97 98	99 100 101 102 103 104 105 106 2 0 0 3 0 3 2 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

open head wound

ADMI (b)(6)-2 , MD (required) (b)(6)-2

LTC, MC
GENERAL SURGEON

(b)(6)-2

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
1	3	9	N																

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
		8	7	3																			

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

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

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	1	0	0				

USAPA V1.00

MEDCOM - 3760

1. ... 2. ... LOCATION (State or Country Code.)

(b)(6)-4 | 7: I | 8: Z

ADMISSION AND CODING INFORMATION

For use of this form ...

3. REGISTER NUMBER (9–15): (b)(6)-4

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

GRADE (16, 17): — F

6. DATE OF BIRTH *(YYYYMMDD)* (19–26): 1 9 9 0 0 1 0 1

7. AGE AT ADMISSION (27–29): 1 3 4

8. RACE: X (30) Iraqi

9. ETHNIC BACKGROUND (31): 9

RELIGION

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): S

HOUR OF ADMISSION: 2300

BRANCH / CORPS

14. FLYING STATUS (47–49): —

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

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 0 0 0 0 0

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

18. MOS (64–70): —

19. TRAUMA (71): 9 Inj

PREV. ADMISSION YEAR — X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): 22

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

23. DATE OF DISPOSITION *(YYYYMMDD)* (81–88): 2 0 0 3 0 4 0 4

24. CLINIC SVC - ADMITTING (89–92): A B A A

25. MTF TRANSFERRED FROM (93–98):

26. DATE THIS ADMISSION *(YYYYMMDD)* (99–106): 2 0 0 3 0 3 2 7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (107–108): I Z

28. MTF OF INITIAL ADMISSION (109–114):

29. DATE INITIAL ADMISSION *(YYYYMMDD)* (115–122):

FOR LOCAL USE

Open head wound Dx: ~~8738~~ Trauma 9 Inj 989

Dx 8730
E9289

ADM (b)(6)-2 MD (If required) (b)(6)-2 (b)(6)-2

LTC, MC
GENERAL SURGEON

DA FORM 2985, MAR 2000 MEDCOM - 3761

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4 | NAME: EPW (b)(6)-4 | 3 GRADE

Iraqi | LENGTH OF SVC | 9 ETS | 10 PREVIOUS ADMISSION: No

99 | (b)(6)-4 | 13. ORGANIZATION | 14. WARD: ICU3

18. BRANCH/CORPS | 19. UIC/ZIP | 20. TYPE CASE: INJ

17. ADMISSION AUTHORITY FOR ADMISSION | 22. HOURS OF ADMISSION: 2000 | 23 CLINIC SERVICE: ABAA

25. TYPE DISPOSITION: EVAC | 26. DATE OF DISPOSITION: 2 Apr 03

27b TELEPHONE NO | 28. DATE OF THIS ADMISSION: 29 Mar 03

(b)(3)-1 / IRAQ | 30 DATE OF INITIAL ADMISSION

L TIB/FX /Cast Post 823.
Scraped Injury E99/ L 93.53
Back 876.0

35 Total Days This Facility	OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
4	4			4

36 Total Days All Facilites	OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD
LTC, MC
GENERAL SURGEON

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF [illegible] (b)(6)-2

(b)(6)-2 mh

MEDCOM - 3762

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4 | NAME (b)(6)-4 MI | 3. GRADE

EPW

RACE: Iraqi | 7. RELIGION | 8. LENGTH OF SVC | 9. ETS | 10. PREVIOUS ADMISSION: No

99 | (b)(6)-4 | 13. ORGANIZATION | 14. WARD: ICU3

SEX | BEN | 18. BRANCH/CORPS | 19. DIC/ZIP | 20. TYPE CASE: INJ

21. ADMISSION AUTHORITY FOR ADMISSION | 22. HOURS OF ADMISSION: 2000 | 23. CLINIC SERVICE: ABAA

24. NAME OF EMERGENCY ADDRESSEE | 25. TYPE DISPOSITION: Evac | 26. DATE OF DISPOSITION: 2 Apr 03

27. EMERGENCY ADDRESSEE (Include ZIP Code) | 27b. TELEPHONE NO | 28. DATE OF THIS ADMISSION: 29 Mar 03

(b)(3)-1 / IRAQ | 30. DATE OF INITIAL ADMISSION

31. DIAGNOSES AND SPECIAL PROCEDURES

L TIB/FX /Cast Post 823.

Schraped Injury E99/ L 93.53

Back 876.0

35. Total Days This Facility

a. OTHER DAYS	b. CONV. LV/COOP CARE DAYS	c. SUPPLEMENTAL CARE DAYS	d. BED DAYS
4			4

36. Total Days All Facilities

a. OTHER DAYS	b. CONV. LV/COOP CARE DAYS	c. SUPPLEMENTAL CARE DAYS	d. BED DAYS

(b)(6)-2 MD

LTC, [illegible]

GENERAL SURGEON

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 3647, MAY 79 | EDITION OF [illegible] | (b)(6)-2

(b)(6)-2

MEDCOM - 3763

558-104 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 3 Apr 03 | TIME: 0820

TRANSPORTATION TO FACILITY

SEX: M | AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2a68 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Shrapnel wounds to back

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☑ NON-URGENT

TIME: 0825

INITIALS

VITAL SIGNS

TIME	0825				
BP	115/73				
PULSE	100				
RESP	24				
TEMP	98.1				
WT	5'02" / 0070				

LAB ORDERS

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

X-RAY ORDERS

☑ CXR PA & LAT/PORTABLE	☐ C-SPINE	
☐ ACUTE ABDOMEN	☐ LS SPINE	
☐ SINUS	☐ HEAD CT	
☐ ANKLE R/L	4 AP Pelvis	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0825	IV LR		(b)(6)-2	0825	VSS @ A
	Foley		(b)(6)-2	0831	

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ DETERIORATED ☑ UNCHANGED

ADMIT TO UNIT/SERVICE: ICU

TIME OF RELEASE: 0855

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW II (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐	
	H/H			SUP O2	PH	PO2	RESULTS		
	PLT			PCO2	SAT	OTHER			
PT				U/A	DIP		EKG INTERPRETATION		
APTT	BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE AND STAMP
			JEFFREY HERMANN MD MAJ, USA, MC DEPT OF OB/GYN
DIAGNOSIS Scrapped knee to the back			CODES

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

EPW # 44

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

CLINICAL RECORD

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

Mo. Apr Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 03 04
03	(b)(6)-2	IVF NS / (LR) / D5NS D5 1/2NS To run	07	ec X 3 dc 03 April 03
		@ 125 cc/hr	19	X X 3
		Ancef 1 GM IV q 8 HRs		
		Gentamycin IV Q		
		Cefoxitin 2 gm IV q 8hrs		
		02 titrate to keep SPO2 >	07	
			19	
		Versed gtt 1-10mg/hr titrate to Ramsey	07	
		scale of	19	
		Fentanyl gtt start at 50mcg/hr titrate for	07	
		adequate pain control MAX Dose of	19	
		Vecuronium 1mcg/kg/min	07	
			19	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Shrapnel injury to the back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Treatment Facility: (b)(3)-1

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLA. (NON-MEDICATION)			Mo April Yr 03	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
03	(b)(6)-2	Ancef 1 gm IV x 1 now	03	9:30	9:30	(b)(6)-2
03		Tol. 0.5 mg IM x 1 now	03	10:00	10:11	
03		Tetnus Immunoglobulin 250 units IM x 1 now	03	10:00	10:11	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
03 -	(b)(6)-2	Morphine Sulfate 2-4 mg IV q 1 hr PRN pain	
-----	-----	Phenergan 12.5-25mg IV q 4-6 hrs prn N/V	
-----	-----	MOM 30cc PRN Gastric Upset	
-----	-----	NS / LR bolus X ___ liters	
03 -	(b)(6)-2	Motrin 800 mg tpo q8h prn pain	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

CLINICAL RECORD

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

Mo. Apr Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 03	04
03 Apr	-----	VS q 8 hrs	07	(b)(6)-2	
	-----		19		
03	-----	Diet: Regular	07	(b)(6)-2	
	-----	when xR's elegroed	19		
03	-----	Stanlet BR c restrains	07	(b)(6)-2	
	-----		19		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Schrapnel injury to the back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 3768

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo April Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
03	(b)(6)-2	Admit to ICU #3	03	09:00	09:00	(b)(6)-2
03		Dgn: Shrapnel injury to the back.	03			
03		Condition: Stable	03			
03		Allergies: NKDA				

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

☆ U.S. GPO:1997-418-290/55267

03 1148 APR03

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (b)(6)-4 [redacted] (b)(6)-4 [redacted]

2. SSN trauma # (b)(6)-4 [redacted]

3a. STATUS Iraqi EPW

3b. SERVICE

4. PRECEDENCE U P R — R: X

5. GRADE

6. AGE 32

7. SEX [X] Male [ ] Female

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A-5F) [X] AMBULATORY [ ] LITTER

11. ACCEPTING PHYSICIAN

12. CITE/AUTHORITY NO. 2001769

13. APPT/SURG DATE

14a. ORIGINATING FACILITY (b)(3)-1 [redacted]

14b. ORIGINATING FACILITY PHONE NUMBER FCU #3

15a. DESTINATION FACILITY (b)(3)-1 [redacted]

15b. DESTINATION FACILITY PHONE NUMBER

16. NUMBER OF ATTENDANTS 16a. MEDICAL 0 16b. NON MED Security (b)(6)-2 [redacted]

17. DIAGNOSIS

1) Schrapnel penetrating trauma to the back

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

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.		X	AMBULATORY
b.		X	CARDIAC HX	g.		X	VISION IMPAIRED	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOIDING PROBLEMS	m.		X	SELF-MEDS
d.		X	RESPIRATORY	i.		X	BOWEL PROBLEMS	n.		X	ADEQUATE SUPPLY OF MEDS
e.		X	CARRIERS	j.		X	SELF-CARE	o.		X	OTHER

19. [X] BATTLE CASUALTY [ ] DISEASE [ ] NON-BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 3APR03 20b. TIME 1010 20c. ALLERGIES NKA

20d. DIET [X] REG [ ] SOFT/NA [ ] CARDIAC [ ] DIABETIC ___ CALS

RENAL ___ Gm prot ___ Gm Na ___ mEq K ___ mg PO4

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

PEDIATRIC: AGE ___ OTHER (Specify) ___

SSN: Change to D10 at ___ only for rest of ___ days

TUBE FEEDING ___ at ___ strength at ___ daily

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION		ORTHOPEDIC BRACES	
NG TUBE		IV PUMP		CHEST TUBE/HEIMLICH	
STRYKER FRAME		TRACH		RESTRAINTS	
INCUBATOR	X	MONITOR		OTHER (Explain in 23)	
		FOLEY			

O2: LITERS: ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		X-RAYS		FINANCIAL
X	INPATIENT RECORDS		OB RECORDS		OTHER (Specify)
	NARRATIVE SUMMARY		DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS

MSO4 2-4mg Q2° PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

32 y/o ♂ Iraqi EPW sustained a schrapnel injury on 02 Apr 03 to the back in a fight with helicopters. Arrived H-D stable.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

24. (b)(6)-2 [redacted] PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(6)-4
2. LOCATION (State or Country Code.): IZ
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): EPN (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19710101
7. AGE AT ADMISSION: 32Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 20
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: E
HOUR OF ADMISSION: 2000
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K98 K98
16. ZIP CODE OF RESIDENCE: 093 00000
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 9 inj
PREV. ADMISSION: YEAR: NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: E1
WARD:
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
(b)(3)-1 IRAQ
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 22
22. MTF TRANSFERRED TO: (b)(3)-1
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030402
CLINIC SVC - ADMITTING: AABA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030327
27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D):

FOR LOCAL USE

Dx: 82380 L TIB-FX/Cast Post Trauma 90 Inj 459
8760
Pr: 9353

ADMITTING OFF (b)(6)-2 MD
LTC, MC
GENERAL SURGEON

(b)(6)-2

DA FORM 2985, MAR 2000 (b)(6)-2 EDITION OF MAR 89 IS OBSOLETE (b)(6)-2 USAPA V1.00

MEDCOM - 3771

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)(6)-4
2. [illegible]LOCATION (State or Country Code.): 7 8
(b)(6)-4
3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4
NAME (Last, First, Middle Initial) EPW
4. PAY GRADE: 16 17
5. SEX: 18
6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26
7. AGE AT ADMISSION: 27 28 29
8. RACE: 30 — Iraqi
9. ETHNIC BACK-GROUND: 31
RELIGION
10. LENGTH OF SERVICE: 32 33 34
ETS
11. FMP: 35 36 — 99
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: 2000
BRANCH / CORPS
14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52
16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61
17. UNIT LOCATION (State or Country Code): 62 63
18. MOS: 64 65 66 67 68 69 70
19. TRAUMA: 71
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — D
WARD: ICU 3
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 — EVAC
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 0 2
24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B A A
25. MTF TRANSFERRED FROM: 93 94 95 96 97 98
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 3 2 7
27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108
28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

L TIB FX / Cast Post

ADMITTING OF (b)(6)-2 MD
LTC, MC
GENERAL SURGEON

(b)(6)-2