(b)(3)-1

Automated Facsimile

# INPA...ENT TREATMENT RECORD CO... SHEET

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

| 1. Register Nbr | 2. Name | 3. Grade | Admission Remarks |
|---|---|---|---|
| (b)(6)-4 | (b)(6)-4 | FGN | |

| 4. Sex | 5. Age | 6. Race | 7. Religion | 8. LnthOfSvc | 9. ETS | 10. PrevAdm |
|---|---|---|---|---|---|---|
| M | | X | MUSLIM | | | NO |

| 11. FMP | 12. SSN | 13. Organization | 14. Ward |
|---|---|---|---|
| 99 | (b)(6)-4 | | ICU |

| 15. FlyStatus | 17. Dept / Ben | 18. BranchCorps | 19. UIC / ZIP | 20. Type Case |
|---|---|---|---|---|
| | K78-PRISONER OF WAR/INTER | | | DIS |

| 21. Source of Admission | 22. Hour Of Adm: | 23. Clinic Service |
|---|---|---|
| Direct from ER | 10:00 | AEA - ORTHOPEDICS |

| 24. Name/Relation of Emergency Addressee | 25. Type Disp | 26. Date of Disp |
|---|---|---|
| | TRF C-ACF | 2003-06-15 |

| 27a. Address of Emergency Addressee | 27b. Telephone No | 28. Date This Adm: | AdmittingOfficer: |
|---|---|---|---|
| | | 2003-06-11 | (b)(6)-2 |

| 29. ReportingMTF | 30. Date Init Adm | 32. Units Blood Components |
|---|---|---|
| (b)(3)-1 | ~~2003-06-11~~ | |

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW to Leg

965.4 891

35. Total Days This Facility

| Absent Sick Days | Other Days | ConLv / Coop Care Days | Supplemental Care | Bed Days | Total Sick Days |
|---|---|---|---|---|---|
| | | | | | |

35. Total Days This Facility

| Absent Sick Days | Other Days | ConLv / Coop Care Days | Supplemental Care | Bed Days | Total Sick Days |
|---|---|---|---|---|---|
| | | | | | |

| Signature of Attending Medical Officer | Signature of PAD or Medical Records Officer |
|---|---|
| (b)(6)-2 COL, MC | (b)(6)-2 (b)(6)-2 SSG, PAD ~~NCOIC~~ |

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 6117

| MEDICAL RECORD | ABBREVIATED MEDICAL RECORD |
|---|---|

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

See Admit H&P

(b)(6)-2

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. |
|---|---|---|
| | | |

**ABBREVIATED MEDICAL RECORD**
**Standard Form 539**

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

(b)(6)-4

MEDCOM - 6118

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

| DATE | SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 6/11/07 | Admit (K-tP |
| 1136 | 27 yo Iraqi s/p GSW (R) LEx 13Aug |
| | during hostile activity Seen @ FST, Tx to |
| | (b)(3)-1 now. |
| | [illegible] |
| | [illegible] |
| | [illegible] |
| | [illegible] |
| | [illegible], NAD |
| | Chest: CTA, equal |
| | [illegible] |
| | Abd: [illegible] |
| | Ext: (R) LEx T/T [illegible] through |
| | knee, [illegible], Neuro intact |
| | Xrays: (R) knee patella Fx, open joint (R) Air |
| | [illegible] |
| | A/ GSW (R) knee, open joint |
| | P/ OR washout |
| | (b)(6)-2 |
| | (b)(6)-2 |

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

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

REGISTER NO. | WARD NO.

(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

| DATE | SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry) |
| --- | --- |
| Urology 11 Jun 03 | Asked to see patient for Renal U/S because of poss flank pain. |
| | Renal U/S → (R) kidney - ∅ hydronephrosis |
| | ∅ stone |
| | GU- ↓↓ testis 9.4cm x 6.8 cm |
| | (+) hypospadias (L) kidney - ∅ hydronephrosis |
| | hooded foreskin ∅ stone |
| | ∅ hernia |
| | 10.8 cm x 7.3 cm |
| | UA / yellow / glu-neg / bld-neg / LE-neg / nitrite-neg |
| | 1.030 / pH 5.0 / Urob - 0.2 / |
| | Doubt renal calculi s̄ blood in urine and |
| | no evidence of hydronephrosis. (b)(6)-2 MD |
| | LTC, MC |
| 6/11/03 | Op Note Urology (b)(3)-1 |
| 1920 | Procedure: (R) Knee Arthrotomy |
| | (R) Knee Debridement, Placement of drain |
| | Surgeon: [illegible] |
| | An: GETA |
| | Findings: open (R) knee. Patella intact |
| | Fx. tibia plateau (Ascl) (gross [illegible]) |
| | Tourniquet Time: 2hr [illegible] |
| | Fluids: 300 cm |
| | (b)(6)-2 |
| | MD (b)(6)-2 |

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 11 Jun 03 | ORTHO CONSULT: |
| TIME: | 27 y/o M Iraqi EPW shot in (R) knee |
| T: | this AM (while attempting to shoot US troops) |
| R: | Brought by MPs. Awake + alert |
| B/P: | O: (R) KNEE: |
| P: | Entrance wound in sup. popliteal fossa (midline) |
| MED: | Exit wound at ~~inferior~~ patellar tendon. |
| | (-) LACHMAN (-) Post Lachman |
| ALLER: | (-) Ant/Post Drawer (-) MCL/LCL Laxity |
| | Rom: 0-90° |
| LMP: | MOTOR IP Q TA EHL GS |
| | (R) 5 4 ⟶ (Poor cooperation) |
| | (L) 5 ⟶ |
| TOB: | SENS - nl LT |
| | PULSES: (+) DP (+) PTA |
| ETOH: | Cap refill < 2 sec. |
| | (R) knee X-ray: (-) Fx / Dislocation, Small bony fragment |
| PMHx: | near inf pole patella, Free air in joint |
| | A: GSW (R) knee (through + through) |
| PSH: | penetrated joint, No apparent vascular injury |
| | Patient received instructions regarding diagnosis, plan of care, medications, follow-up, and verbalizes understanding. Initials: ______ P: 1) Evac to CSH for I+D |
| FMHx: | 2) |

| HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT |
|---|---|---|---|
| DISCOM AID STATION | | ARMY | D.A[illegible] (b)(6)-2 |
| SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR | (b)(6)-2 |

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or [...] Date of Birth; Rank/Grade.)* (b)(6)-2

REGISTER NO. MAJ [illegible] | WARD NO.

NAME AND RANK: (b)(6)-4

SSN:

UNIT AND UNIT PHONE:

DOB: 7 FEB 7[illegible]

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

MEDCOM - 6121

AUTHORIZED FOR LOCAL REPRODUCTION

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

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 11JUN03 | 1845: Nursing Transfer in note: Pt was transferred from ICU via stretcher. Pt is in two point hand restraints. Foley draining to gravity; urine is medium/straw colored. Hemovac draining serosanguinous fluid. IV to left arm area is CDI. Currently resting quietly s̄ any complaints. Pt asked staff if he could have a cigarette, and was told this was not allowed by the staff. No complaints at this time, will continue to monitor. (b)(6)-2 CPT AN |
| 11JUN03 | 1940: Respiratory assessment: pt O2 sats were 86% on room air. Breath sounds: wheezing that clears w/ cough. Placed on O2 @ 2-4L, sats back up to 100%. Pt encouraged to use incentive spirometer. Will continue to monitor (b)(6)-2 |
| 11JUN03 | 2000: respiratory re-assessment: Pt has O2 sats of 99-100% on room air (b)(6)-2 |
| 11JUN03 | 2035: Hemovac output: output was 25cc of serosanguinous fluid. While measuring output, |

| 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

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
| --- | --- |
| | pt. c/o pain and was given morphine 4mg. |
| | Will cont to monitor (b)(6)-2 |
| 12JUN03 2? | 0123 RN output (Hemovac) was 15cc. Urine output |
| | was 100cc (b)(6)-2 |
| 12JUN03 0430 | - RN note - pt c/o pain at approx. 0420. |
| | Temp slightly elevated, given percocet |
| | 2 tabs (b)(6)-2 |
| 12 0600 Jun 03 | Nursing Assessment: Pt is awake, alert. Blindfolded per MP SOP. Airway is intact. Breathing is |
| | even, unlabored but shallow. Atelectasis and minute wheezes noted to bases bilaterally. Pt's head |
| | raised & O2 @ 3L placed for sats in 70s. Abd is soft, nontender, s distention. BS ⊕ x4. |
| | Foley to gravity draining clear yellow urine. FROM to (B) UE, (L) LE. Neurovascularly intact |
| | to all extremities. (R) LE ROM limited by pain and posterior splint. Splint is from heel to mid |
| | thigh on (R) leg. Hemovac draining serosang fluid. IV to (L) AC flushes well & s s/s of infection or |
| | infiltration. (b)(6)-2 [illegible] |
| 6/12 | Surgery |
| | POD #1 s/p GSW (R) knee - ø complaints |
| | Tm [illegible] |
| | Drain 27cc |
| | Neuro/vasc intact |
| | D/C drain tomorrow, Cont Abx (b)(6)-2 |
| | [illegible] |
| | (b)(6)-2 |
| 12 1500 Jun 03 | Hemovac output = 5cc this shift. (b)(6)-2 [illegible] |
| 12 1505 Jun 03 | Hemovac DC'd. Tips of hemovac intact. (b)(6)-2 [illegible] |
| 1815 12JUN03 | Pt stable. Transferred off ward for |
| | questioning c MP. ø complaints (b)(6)-2 [illegible] |
| 2200 | Returned to ward in stable condition. |
| | ø complaints. PERRLA. Breath sounds clear |
| | after coughing. Abd soft, non-tender |

AUTHORIZED FOR LOCAL REPRODUCTION

**MEDICAL RECORD** | **PROGRESS NOTES**

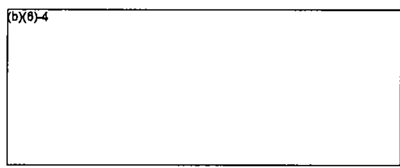
| DATE | NOTES |
|---|---|
| 12 JUN03 | NARRATIVE SUMMARY |
| 1600 | ADMISSION DX- (R) KNEE GSW c̄ OPEN JOINT |
| | & PATELLAR TENDON PARTIAL AVULSION (L) BUTTOCK SUPERFICIAL WOUND |
| | ORTHOPEDIC SERVICE |
| | DISCHARGE DX- SAME c̄ CONTUSION [illegible] TIBIAL (b)(6)-2 |
| | PLATEAU AT NOTCH |
| | PROCEDURE PERFORMED (R) KNEE ARTHROTOMY |
| | WITH DEBRIDEMENT AND REPAIR OF PARTIAL |
| | PATELLAR TENDON AVULSION. |
| | ADMITTED 11 JUN 03 DISCHARGED 12 JUN03 |
| | |
| | CLINICAL RESUME - 27 y/o IRAQI ♂ COMBATANT |
| | SHOT POST TO ANT THROUGH RIGHT KNEE BY |
| | 5.56 MM ROUND. ROUND MISSED NV BUNDLE, |
| | PASSED THROUGH CRUCIATES WITHOUT DISRUPTING |
| | THEM, & EXITING THE MEDIAL 1/3 OF THE |
| | PATELLAR TENDON c̄ ~30% DISRUPTION OF ITS |
| | SUBSTANCE. FORMALLY DEBRIDED THROUGH |
| | MEDIALLY BASED ARTHROTOMY 9 HR POST- |
| | INJURY & CLOSED OVER DRAINS. DRAIN |
| | OUTPUT <25 cc OVER LAST 12 HR & D/C'D. |
| | (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)*

| REGISTER NO. | WARD NO. |
|---|---|
| | |




**PROGRESS NOTES**
Medical Record

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

| LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER |
|---|---|---|---|
| | | | |

| DATE | NOTES |
|---|---|
| | RECEIVED TETANUS TOXOID & IV ANCEF. |
| | ARTHROTOMY IS CLOSED c̄ RUNNING |
| | ABSORBABLE SUBCUTICULAR. LAST |
| | SCHEDULED DOSE OF ANCEF TO BE |
| | ADMINISTERED AT 0600 14JUN03. |
| | |
| | ACTIVITY- WEIGHT BEAR AS TOLERATED |
| | IN SPLINTS. KNEE TO REMAIN |
| | SPLINTED FOR AMBULATION FOR |
| | FOUR WEEKS. CURRENT LOWGRADE FEVER 2° |
| | ATELECTASIS. NEEDS TO USE INCENTIVE SPIROMETER |
| | DIET REGULAR AS INSTRUCTED. |
| | |
| | MEDS ANCEF AS ABOVE |
| | PERCOCET i-ii PO q 6° PRN PAIN |
| | |
| | F/U WOUND ✓ BY MED. OFFICER IN 72° |
| | MAY F/U @ (b)(3)-1 FOR ANY SIGNS |
| | OF WOUND INFECTION. |
| | |
| | (b)(6)-2 |
| | LTC, MC |
| | ORTHOPEDIC SERVICE |

AUTHORIZED FOR LOCAL REPRODUCTION

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

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 12June03 | bowel sounds active x4 quads. (R) leg drsg CDI, wrapped c ace wrap. Voiding to urinal. Brisk cap refill and strong pulses x4 extremities. (b)(6)-2 |
| 13Jun03 0330 | Pt stable. Sleeping comfortably, easily arousable. (R) leg elevated, drsg CDI. Pt made to cough and deep breath to clear lungs Ø complaints [illegible] |
| 13 Jun 03 0800 | Nursing Shift note Pt arousable by verbal stimul tolerating PO intake, BS c slight wheezing, unable to fully expand lungs until repositioned to full upright. Blindfold in place. (L) knee w/ scant amount of serous drainage. NO major changes. Continue to monitor (b)(6)-2 [illegible] |
| 6/13/03 | Surgery POD #3 Doing well. [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] 0600 [illegible] [illegible] [illegible] [illegible] [illegible] (b)(6)-2 [illegible] |

| 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
USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

| MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
| 13JUN03 | 2250: Shift RN assessment note: Pt has c/o pain to leg x 2 this shift and was medicated with 2mg MSO4 @ 2030 + 2200; pt pointed towards rt leg both times and said "allum". After admin at 2230, pt appeared more comfortable. IV continues to infuse into Rt forearm. Pt did not have much of an appetite this shift ate approx. 10% of dinner. Is asking for water PO at regular intervals. Voiding in urinal QS. Bowel sounds present in all 4 quads. Resps even + unlabored w/ clear breath sounds. Will continue to monitor (b)(6)-2 |
| 140600 June 03 | Nursing Assessment: Pt is awake, alert, Ox3. Airway is intact. Breathing is even and unlabored but breath sounds are diminished in bases. Atelectasis also noted to bases. Abd is soft, nontender, and s distention. BS ⊕ x 4. Voids spontaneously. FROM to (B) UE and (L) LE. Limited ROM to (R) LE 2° splint & ACE. Neurovascularly intact to all extremities. IV to (R) UE infusing s difficulty. Drsg to RLE is CDI. Pt removed blindfold. Blindfold replaced; arm restraints tightened. Pt responded to English instructions s difficulty. (b)(6)-2 |

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

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

| MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| **DATE** | **SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)* |
| 6/14/07 | Surgery |
| | Afebrile D/C summary written O/L for d/c |
| | (b)(6)-2 |
| | [illegible] (b)(6)-2 |

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

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

| REGISTER NO. | WARD NO. |
|---|---|

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

NSN 7540-00-634-4176 600-108

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

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 15JUN03 | 0155: RN shift assessment: Pt has c/o leg pain x1 this shift (0015AM) and was given 2mg morphine; fell asleep s̄ any further complaints approx 15 minutes after administration. Wet to dry dressing was changed; some scant serosanguinous drainage noted during Δ. Pt refused to eat the majority of his dinner (opting to eat only fruit + cake). Rt leg ↑, pedal pulse palpable. Voiding s̄ any difficulties; QS. Bowel sounds present x4 quads. Continues w/ slight wheeze that clears w/ cough; resps are even + unlabored. Will continue to monitor —— (b)(6)-2 |
| 15Jun03 | 0410 Assessment: Pt sleeping, easily aroused. VSS, ⊕BS x4. Pt has inspiratory & expiratory wheezing, encourage pt to cough several times, ↓ wheezing noted. Drsg to Ⓡ LE CDI, Ⓡ foot c̄ brisk cap refill, ⊕ DP pulse. IVF NS @ 150, IV site to Ⓛ ac s̄ s/s infection —— 1Ω (b)(6)-2, AV |
| | 0710 ADL: Offer pt breakfast & attempt to feed, pt refuse. -1Ω (b)(6)-2 |
| | 0855 Drsg Δ: Δ drsg to Ⓛ outer thigh. Sm amt sero-sang drainage present on gauze. Wound is pink s̄ foul odor -1Ω (b)(6)-2 |

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| 6/18/03 | Surgery |
| | Wound OK |
| | Pt discon to CJ |
| | Plan at with PA. No further f/u at (b)(3)-1 |
| | necessary. (b)(6)-2 |
| | (b)(6)-2 |
| | [illegible signature] |

*U.S. Government Printing Office: 1995 — 387-722/20035

558-103 EMT

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

# EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER

ARRIVAL — DATE: DAY 11 MONTH Jun YR. 03 — TIME 1046

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE / AMBULANCE / OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Accutol XR (struck through)

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES: Acuzol

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): (b)(6)-4

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Gun shot wound to (R) knee

SEX: M — AGE: 27

POSSIBLE THIRD PARTY PAYER? YES / NO

TIME SEEN BY PROVIDER: 1100

VITAL SIGNS

| TIME | 1054 | 1108 | 1120 |
|---|---|---|---|
| BP | 123/63 | 100/54 | 112/47 |
| PULSE | 87 | 88 | 85 |
| RESP. | 18 | 18 | 18 |
| TEMP. | 98.6 | | |
| WT. (Child) | | | |

CATEGORY (See reverse): EMERGENT / URGENT / NON-URGENT

ORDERS

| ORDERS | INITS. | TIME |
|---|---|---|
| Cbc T+S Chem7 | KK | |
| Foley UA | | |
| Irrigate wnd | | |
| Restraints | | |
| Td .5cc IM | | |
| Ancef 1gm IV | | |

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

27 yo ♂ w/ Gun shot wound to (R) knee when fleeing after firing upon US Forces. Last Meal 1700 yest. 7/10 pain TOI @ ~0300 this AM.

PMH: Seasonal All, ? RLQ Intestin prob.
PSH
Tob +
⊕ EtOH

O: NAD in mild dist 2° to (R) Knee GSW. NonToxic Ap
⊖ Respir dist. ⊕ Alert x3.

HEENT: WNL.
Lungs: (B) CTA.
Cor: RRR ⊖ (m).
Abd: ⊕ BS. S. NT ND ⊖ Mas.
Ext: GSW to ML (R) popliteal fossa to lat ant Knee ⊖ Crepitus. ⊕ PT + DP pulses by palp, biphasic doppler pulses. warm CR < 2sec. N/V intact.

Fentanyl 100 ug IV — (b)(6)-2

ASSESSMENT/DIAGNOSIS: GSW (R) Knee.

DISPOSITION (Check all that apply): HOME / FULL DUTY / QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

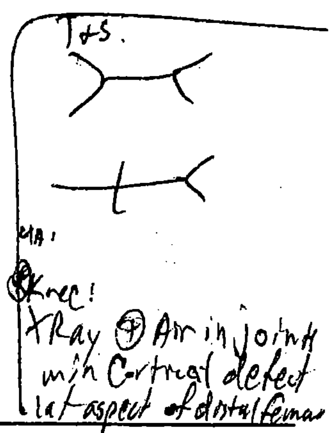
REFERRED TO (Indicate clinic): Ortho

EMERGENCY — X TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: X IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE:




(b)(6)-2 …E ON SF 507, IF NEEDED)

…DER AND IT STAMP: (b)(6)-2 MAJ MC

…TIENT (Include medications ordered, any limitations and follow-up)

To OR.

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

MEDICAL RECORD — INTRAOPERATI[…]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: anesthesia

2. PATIENT ID (b)(6)-2 [redacted] D AND PROCEDURE VERIFIED BY [redacted] LtAn

3. DATE: 11 Jun 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME: 1130 NUMBER: 1

**5. PREOPERATIVE EMOTIONAL STATUS**

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

COMMENTS: pt sedated prior to arrival to OR ... ⊕ Smoker All= Acuzol

**6. NURSING PERSONNEL**

| | | | |
|---|---|---|---|
| ASSIGNED SCRUB | Spc (b)(6)-2 [redacted] 91D | RELIEF SCRUB | |
| ASSIGNED CIRCULATOR | Lt (b)(6)-2 [redacted] 66E | RELIEF CIRCULATOR | CPT C/AGG (break) |

**7. POSITION AND POSITIONAL AIDS** *(Specify)*

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

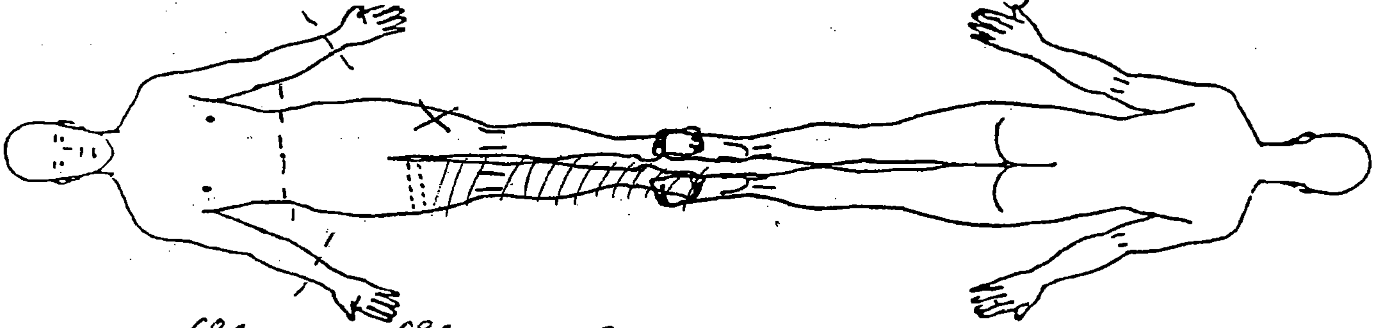
COMMENTS: Ⓡ hip bump; padded arm boards

**8. SKIN PREPARATION**

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: or (b)(6)-2 [redacted]; ∅ nicks / cuts

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Ⓡ leg-foot to TQ BY WHOM: Chase
SITE: BY WHOM:
COMMENTS: ∅ pooling or irritation

**9. LOCATION OF EXTERNAL DEVICES**



LEGEND X Ground Pad CSC -- Safety Strap CSC === Tourniquet CSC @ 275 for 121 min ///-prep

**10. COUNTS** C = Correct I = Incorrect

| | | | Other** | First Closing Count | Final Closing Count | SCRUB | CIRCULATOR |
|---|---|---|---|---|---|---|---|
| Sponge | ☒ Yes | ☐ No | C | C | C | (b)(6)-2 [redacted] | (b)(6)-2 [redacted] |
| Needle Sharp | ☒ Yes | ☐ No | C | C | C | | |
| Instrument | ☐ Yes | ☒ No | | | | | |
| Other | ☐ Yes | ☒ No | | | | | |

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

(b)(6)-4 [redacted]

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

☒ ESU NO: #1 cut/coag = 40/40
GROUND PAD: BRAND Valley lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

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

| MEDICATIONS.SOLUTION | DOSAGE | TIME | METHOD | PREPARED BY | GIVEN BY |
| --- | --- | --- | --- | --- | --- |
| | | | | | |

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
nss

| OTHER ORDERS | TIME | CARRIED OUT BY |
| --- | --- | --- |
| | | |

PHYSICIAN'S (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

| | 1. | 2. | 3. |
| --- | --- | --- | --- |
| TYPE/SIZE | 16 fr Foley | Hemovac 400 ml | |
| SITE | Bladder pt arrived c̄ in place | Right Knee | |

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix
Xeroform
Steri Strips
Benzoin

19. ADDITIONAL INFORMATION
Dr (b)(6)-2
Dr (b)(6)-2

Cpt (b)(6)-2, CRNA

20. OPERATION(S) PERFORMED
Ⓡ Knee I+D

21. PATIENT TRANSFERRED TO ICU TIME $14^{20}$ METHOD litter

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

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

511–119 NSN 7540–00–634–4124

# MEDICAL RECORD

## VITAL SIGNS RECORD

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HOSPITAL DAY | | | | | | | | | | | | | | |
| POST- DAY | | | | | | | | | | | | | | |
| MONTH-YEAR / DAY | 11Jun03 | | 12Jun03 | | 12Jun03 | | 13 Jun | | 14 Jun | | 15 Jun | | | |
| 19 / HOUR | 2008 | | 0414 | 6:15 | 2109 | | 0400? | 2100 | 6 | 2309 | 0600 | | | |
| RESPIRATION RECORD | | | | 26 / 19 | 2[illegible] | | 2[illegible] | | 22 / 20 | 2[illegible] | 20 | | | |
| BLOOD PRESSURE | 136/83? | | 127/65 | 122/67? | 121/63? | | 124/72 | 105/81 | 124/70 | 132/73 | 129/71? | | | |
| T | 100.4 | | 100.6 | 99.6 | 100.6 | | 100.5 | 94.0 | 99.4? | 98.1 | | | | |
| P | 104 | | 104 | 88 | 104 | | 101 | 93 | | 84 | 82 | | | |
| HEIGHT: / WEIGHT → | 99% | | 40%? | 78/48? | 84 | | 92/105? | 94% | 94% | 93% | 98% | | | |
| Resp | 20 | | 24 | | | | 28 | | | | | | | |

On the graph's left scales, PULSE (O) runs from 180 to 40, and TEMP. F (•) runs from 105° to 95°, with 98.6° marked. On the right, TEMP. C runs from 40.6° to 35.0° (Centigrade Equivalents, for Reference only).

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.

**VITAL SIGNS RECORDS**

Medical Record

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

Ward/Section: EMT | REQUESTING PHYSICIAN: (b)(6)-2

**LABORATORY RESULT FORM**
**(Subject to the Privacy Act of 1974)**

LAST, FIRST, MI: (b)(6)-4 | DATE: 11 | TIME: 1115 | SSN/PSEUDO SSN: (b)(6)-4

**Hematology/CBC**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| WBC | 13.6 | 4.8-10.8 x 10³ |
| RBC | 4.26 | 4.7-6.1 x 10⁹ |
| Hgb | 13.5 | 14-18 g/dl (M) 12-16 g/dl (F) |
| Hct | 41.4 | 42-52% (M) 37-47% (F) |
| MCV | 97.2 | 80-94 fl (M) 81-99 fl (F) |
| Plt | 221. | 130-500 x 10³ verified |
| Lymph % | 16.8* | 20.5-51.1% |

**Hematology Manual Differential**

| | | | |
|---|---|---|---|
| Segs | | Mono | |
| Bands | | Eos | |
| Lymph | | Baso | |
| Atyp | | Imm | |
| RBC Morph | | | |

| | | |
|---|---|---|
| Spun Hematocrit | | 42-52% (M) 37-47% (F) |
| Sed Rate | | |
| Other | | |

**Urinalysis**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| Color | Yellow | N/A |
| App | Cloudy | N/A |
| Glu | NEG | Negative |
| Bili | NEG | Negative |
| Ket | NEG | Negative |
| SG | 1.030 | N/A |
| Bld | NEG | Negative |
| pH | 5.0 | N/A |
| Prot | NEG | Negative |
| Urob | 0.2 | 0.2-1.0 |
| Nit | NEG | Negative |
| Leuk | NEG | Negative |
| HCG | | Negative |

**Serology**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| RPR | | Negative |
| Mono | | Negative |

**Microbiology**

| | | |
|---|---|---|
| Source | | |
| Gram Stain | | |
| Occ Bld | | Negative |
| H. pylori | | Negative |
| Micro Parasites | | |
| Malaria | | |
| O & P | | |
| Other | | |

**Miscellaneous Tests**

**CSF**

| | | |
|---|---|---|
| Cell Count | | |
| Directigen | | Negative |

**Blood Bank**

**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**

ABO/Rh:

**Coagulation Studies**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| PT | | 9.8-13.6 secs |
| APTT | | 21-34 secs |
| D dimer | | <20 ug/ml |
| FDP | | <10 ug/ml |

**Blood Products — MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**

| UNIT | TYPE | CROSSMATCH |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**REMARKS:**

**REPORTED BY:** (b)(6)-2 | **DATE:** 11 Jun 03 | **LAB ID NO.:**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| Na | | 138-146 mmol/L |
| K | | 3.5-4.9 mmol/L |
| Cl | | 98-109 mmol/L |
| pH | | 7.31-7.45 |
| PCO2 | | 35-45 mmHg (art)<br>41-51 mmHg (ven) |
| PO2 | | 80-105 mmHg (art)<br>N/A (ven) |
| TCO2 | | 23-27 mmol/L (art)<br>24-29 mmol/L (ven) |
| HCO3 | | 22-26 mmol/L (art)<br>23-28 mmol/L (ven) |
| sO2 | | 95-98% |
| BEecf | | (-2) – (+3) mmol/L |
| AnGap | | 10-20 mmol/L |
| Ca | | 1.12-1.32 mmol/L |
| BUN | | 8-26 mg/dl |
| GLU | | 70-105 mg/dl |
| Creat | | 0.7-1.5 mg/dl |
| Hct | | 38-51% PCV |
| Hgb | | 12-17 g/dl |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| Troponin-I | | |
| Drug of Abuse | | |
| | | |
| | | |
| | | |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| ALB | 4.0 | 3.5-5.5 g/dl |
| ALP | 45 | 26-84 u/l |
| ALT | 25 | 10-47 u/l |
| AMY | 9 * | 14-97 u/l |
| AST | 30 | 11-38 u/l |
| TBIL | 0.7 | 0.2-1.6 mg/dl |
| BUN | 16 | 7-22 mg/dl |
| $CA^{++}$ | 8.6 | 8.0-10.3mg/dl |
| CHOL | 157 | 100-200 mg/dl |
| CRE | 1.0 | 0.6-1.2 mg/dl |
| GLU | 115 | 73-118 mg/dl |
| TP | 7.5 | 6.4-8.1 g/dl |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| GLU | 108 | 73-118 mg/dl |
| BUN | 15 | 7-22 mg/dl |
| CRE | 0.6 | 0.6-1.2 mg/dl |
| CK | 132 | 39-380 u/l (M)<br>30-190 u/l (F) |
| $NA^{+}$ | 135 | 128-145 mmol/l |
| $K^{+}$ | 5.5 * | 3.3-4.7 mmol/l |
| $CL^{-}$ | 104 | 98-108 mmol/l |
| $tCO_2$ | 24 | 18-33 mmol/l |
| | | |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| GLU | | 73-118 mg/dl |
| BUN | | 7-22 mg/dl |
| $CA^{++}$ | | 8.0-10.3 mg/dl |
| CRE | | 0.6-1.2 mg/dl |
| $NA^{+}$ | | 128-145 mmol/l |
| $K^{+}$ | | 3.3-4.7 mmol/l |
| $CL^{-}$ | | 98-108 mmol/l |
| $tCO_2$ | | 18-33 mmol/l |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| ALB | | 3.3-5.5 g/dl |
| ALP | | 26-84 u/l |
| ALT | | 10-47 u/l |
| AMY | | 14-97 u/l |
| AST | | 11-38 u/l |
| TBIL | | 0.2-1.6 mg/dl |
| GGT | | 5-65 u/l |
| TP | | 6.4-8.1 g/dl |

| TEST | RESULT | REF. RANGE |
|---|---|---|
| $NA^{+}$ | | 128-145 mmol/l |
| $K^{+}$ | | 3.3-4.7 mmol/l |
| $CL^{-}$ | | 98-108 mmol/l |
| $tCO_2$ | | 18-33 mmol/l |

EMARKS:

| EPORTED BY: | DATE: | LAB ID NO.: |
|---|---|---|
| (b)(6)-2 | 11 Jun 03 | |

Ward/Section: ICU | REQU[...]G PHYSICIAN: Dr (b)(6)-2 (b)(6)-2

**L[...]RATORY RESULT FORM**
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4 (b)(6)-4 | DATE: 11 Jun | TIME: 0346 | SSN/PSEUDO SSN: (b)(6)-4

**(Hematology) CBC**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| WBC | 18.5 | 4.8-10.8 x 10³ |
| RBC | 3.75 | 4.7-6.1 x 10⁹ |
| Hgb | 10.3 | 14-18 g/dl (M)<br>12-16 g/dl (F) |
| Hct | 31.9 | 42-52% (M)<br>37-47% (F) |
| MCV | 85.1 | 80-94 fl (M)<br>81-99 fl (F) |
| Plt | 186 | 130-500 x 10³<br>verified |
| Lymph % | 11.7 | 20.5-51.1% |

**(Hematology) Manual Differential**

| | | | |
|---|---|---|---|
| Segs | | Mono | |
| Bands | | Eos | |
| Lymph | | Baso | |
| Atyp | | Imm | |
| RBC Morph | | | |

| | | |
|---|---|---|
| Spun Hematocrit | | 42-52% (M)<br>37-47% (F) |
| Sed Rate | | |
| Other | | |

**Urinalysis**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| Color | amber | N/A |
| App | clr | N/A |
| Glu | neg | Negative |
| Bili | large | Negative<br>Keto = large |
| Ket | mod | Negative<br>ace = mod |
| SG | 1.015 | N/A |
| Bld | neg | Negative |
| pH | 6.0 | N/A |
| Prot | neg | Negative |
| Urob | norm | 0.2-1.0 |
| Nit | neg | Negative |
| Leuk | neg | Negative |
| HCG | | Negative |

**Misc. Serology**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| RPR | | Negative |
| Mono | | Negative |

**Microbiology**

| | | |
|---|---|---|
| Source | | |
| Gram Stain | | |
| Occ Bld | | Negative |
| H. pylori | | Negative |
| Micro Parasites | | |
| Malaria | | |
| O & P | | |
| Other | | |

**Microscopic Urinalysis**

**CSF**

| | | |
|---|---|---|
| Cell Count | | |
| Directigen | | Negative |

**Blood Bank**

**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**

| | |
|---|---|
| ABO/Rh | |

**Coagulation Studies**

| TEST | RESULT | REF. RANGE |
|---|---|---|
| PT | 14.1 | 9.8-13.6 secs |
| APTT | 52.4 | 21-34 secs |
| D dimer | | <20 ug/ml |
| FDP | | <10 ug/ml |

**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EACH UNIT OF BLOOD REQUESTED)**

| UNIT | TYPE | CROSSMATCH |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**REMARKS:**

**REPORTED BY:** | **DATE:** | **LAB ID NO.:**

CP (b)(6)-2

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS, SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

| DRUG | (Units) | |
|---|---|---|
| Versed | (MG) | 2 |
| Fentanyl | (MCG) | (50) 50 (2) (100) 50 (100) |
| STP | (MG) | 125 / 75 |
| Sux | (MG) | 100 |
| Zofran | (MG) | 4 |
| MSO4 | (MG) | 3 3 4 |
| VOLAT. AGENT: Isoflurane | % del. | 2.6 2.3 2.5 1.7 1.3 1.2 1.0 1.0 |
| | % e.t. | 2.5 2.1 2.6 1.5 1.0 1.0 1.0 1.0 |
| AIR | L/Min | |
| N2O | L/Min | |
| O2 | L/Min | 8 2 2 2 2 2 2 2 2 2 |

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

FLUIDS — LINE site: NS ☐ Warmed — 900 — 1100 — (1200) — 1400

LOSSES — EST BLOOD LOSS; URINE – 125 ... 200

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG

HEMATOCRIT: 41.4

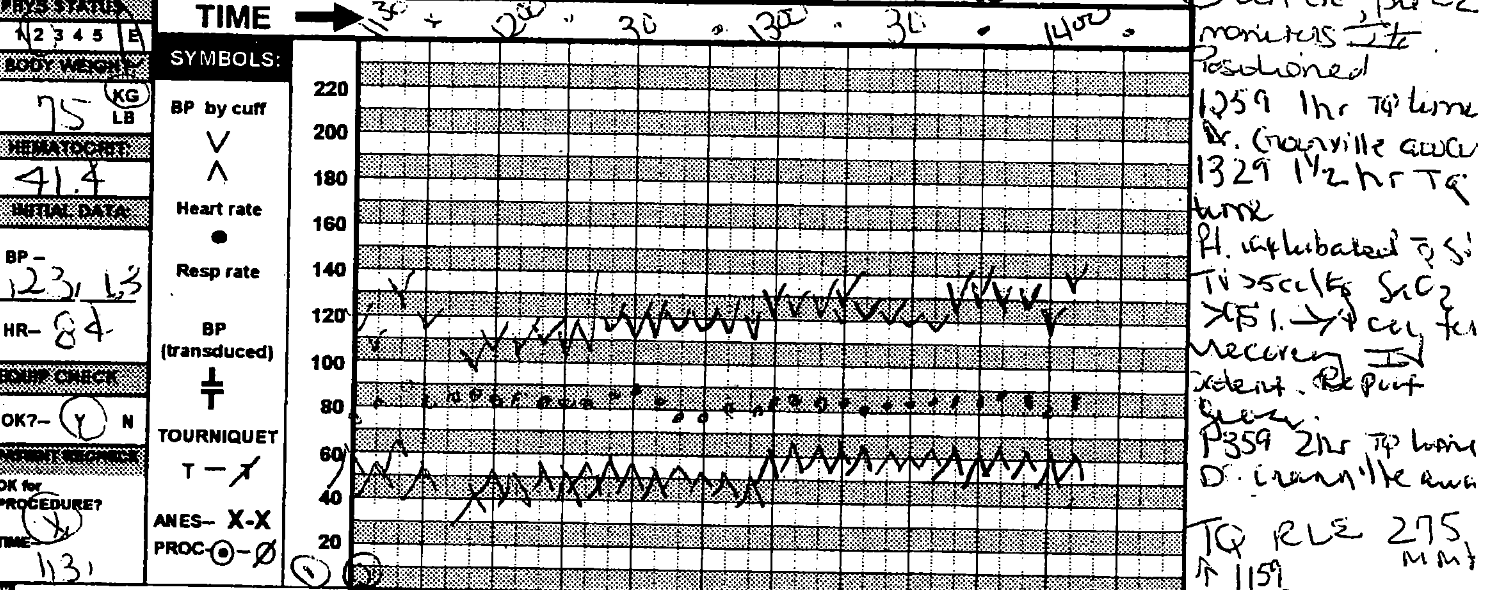
INITIAL DATA: BP – 123/63; HR – 84

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y); TIME – 1131

TIME: 1130 · 1200 · 30 · 1300 · 30 · 1400

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



| VENTILATION | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| VT – ml | 750 | | | | | | | | | | |
| f – breaths/min | 8 | 16 | 14 | 16 | 14 | 18 | 19 | 11 | 15 | 15 | |
| Peak inf pres / PEEP | 19 | | | | | | | | | | |
| MODE – S(pon), A(ssist), C(on) | S/C | A | S | S | A | A | S | S | S | S | S |

| MONITORS / ACCESSORIES | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BP/Auto Cuff | ET CO2 (torr) | | 34 | 58 | 56 | 48 | 50 | 61 | 57 | 59 | 61 | 55 |
| BP / other | FIO2 (Frac or %) | 9 | .92 | .92 | .9 | .92 | .92 | .9 | .9 | .9 | .9 | .9 |
| ART line | SpO2 (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Steth- PC/ES | ECG | SR | SR | SR | SR | SR | SR | SR | SR | SR | SR | SR |
| Gas analyzer | TEMP- site Skin | | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 |
| | N-M Block (T/4) | | | | | | | | | | | |
| Warming blkt | | | | | | | | | | | | |
| Conv warmer | | | | | | | | | | | | |

*Mark with letters & symbols, explain under REMARKS*

EVENTS — pressure 275 ... < 90°

Position — (2) roll under (R) hip

TOTALS: TOTAL IN: [illegible]; TOTAL URINE: 200

FLUIDS – SUMMARY: CRYSTALLOID – 1300; COLLOID – Ø; BLOOD – Ø

REMARKS — *Code drugs with numbers, events with letters*

(1) From ... → OR
(2) ... O2, pre O2, monitors ... positioned
1259 1hr TQ time Dr. Granville aware
1329 1½ hr TQ time
A. extubated ... S.
... SaO2 ... to recovery IV ... report given.
1359 2hr TQ time Dr. Granville aware

TQ RLE 275 MMHg
↑ 1159
↓ 1400
121 min

RECOVERY AT 1418 — PACU / ICU / OTHER (Specify); T 99.2

CONDITION: Sleeping

RESP – 14; SpO2 – 100; BP – 109/48; HR – 81

ANESTHESIA / PROCEDURE TIMES

| | Start | Room | End |
|---|---|---|---|
| ANES | 1105 | 1130 | 1422 |

| | Ready | Begin | End |
|---|---|---|---|
| PROC | 1145 | 1203 | 1410 |

PROCEDURES and CPT Codes: (R) knee debridement

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — GA

AIRWAY MANAGEMENT: *intubation route, blade, technique, comments* — ... 1 attempt CPT ... 1 attempt CRNA ... → ... 24cm (R) ...

PATIENT IDENTIFICATION— *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

SURGEON (b)(6)-2

ANESTHETIST (b)(6)-2

(b)(6)-2

CPT, AN
CRNA

PROCEDURE LOCATION: OR

DATE: 6/11/03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 6138

*U.S. GPO: 2002-729-180/40137

## PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 27 HRS DAYS MOS (YRS) SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Scope (R) knee SURGICAL SERVICE: ortho

ASA PHYSICAL STAUS 1 (2) 3 4 5 E
WEIGHT: 73 (KG)/LB HEIGHT: 68 IN.
ALLERGIES: [illegible]

### PREOPERATIVE ASSESSMENT

**HABITS:**
TOBACCO: 2 PPD
ETOH: 
DRUGS: denies

**CURRENT MEDICATIONS:**
( [ ] = ordered as premed)
[ ] NONE
[ ]
[ ]
[ ]
[ ]
[ ]

**PREMEDICATION:**
None Yes (@ ____ Hrs) /OC
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO

**LABORATORY STUDIES:**
HB/HCT: ____ / ____
U/A: ____
OTHER:

NPO 5pm 6/10/03

**PAST MEDICAL HISTORY/SYSTEMS REVIEW**

| System | Condition | N | Y |
|---|---|---|---|
| Cardiovascular: | Hypertension | N | Y |
| | Angina | N | Y |
| | MI | N | Y |
| | CVA | N | Y |
| | Other | N | Y |
| Pulmonary System: | Asthma | N | Y |
| | Bronchitis/URI | N | Y |
| | COPD | N | Y |
| | Other | N | Y |
| Renal System: | Acute/Chronic RF | N | Y |
| Gastrointestinal: | Hepatitis | N | Y |
| | Hiatal Hernia | N | Y |
| | PUD | N | Y |
| Endocrine System: | Diabetes | N | Y |
| | Steroids | N | Y |
| | Thyroid | N | Y |
| Neurological: | Seizures | N | Y |
| | Neuropathy | N | Y |
| | Other | N | Y |
| Gynecological: | Pregnancy | N | Y |
| Other Significant Hx: | | N | Y |
| | | N | Y |
| Familial HX | | | |

denies per interpreter

GSW to (R) knee

**PAST SURGICAL/ANESTHETIC HISTORY**
Penis
Hernia?

**PHYSICAL EXAMINATION**
BP 123/63 HR 87 RESP [illegible] 98.6
HEENT-Teeth loose (L) side
Trachea Midline
TMJ/Neck
Oropharynx
Nares
CHEST:
CARDIAC:
EXTREMITIES:
IV Access: #18G (L) AC
Ulnar Filling:
BACK:
OTHER:

ANESTHETIC PLAN: [ ] Local [ ] MAC – [ ] Regional (Specify): ____ [X] General: Mask (Intubation)

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. The patient/legal guardian seems to understand and agrees. Questions answered. d/w pt via interpreter. Questions answered

Signed: (b)(6)-2 CPT AN DATE: 6/11/03 TIME: 1102 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____ (b)(6)-2 CPT, AN CRNA

VITAL SIGNS: BP ____ HR ____ RESP ____ $SaO_2$

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level

SEE Anesthesia Record

REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE
[ ] NO ANESTHETIC COMPLICATIONS [ ] OTHER

(b)(6)-2

Signed: (b)(6)-2 MAJ, CRNA DATE: 12 June 03 TIME 0400 Hrs

PATIENT IDENTIFICATION: (Ward: ____ )

(b)(6)-4

WAMC Form 2300
1 Aug 92 (HSXC-SU)

MEDCOM - 6139

☆ U.S. GPO: 1994-628-533/00102

# CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

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

DATE OF ORDER: 6/11/03 | TIME OF ORDER: 1940 HOURS

1. Admit ICW
2. s/p GSW (R) Knee
3. Ancef 1g IVP q8
4. Hemovac to suction, record q8°
5. Percocet 1-2 tabs q4-6 prn pain
6. Regular diet
7. IVF NS @ 150 cc/hr

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN: 11JUN03 @ 1830 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

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

DATE OF ORDER | TIME OF ORDER HOURS

1. Morphine 2mg q15min up to 16mg in 4hrs prn pain
2. Foley

(b)(6)-2

(b)(6)-2

11 JUN03 @ 1830 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

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

DATE OF ORDER: 11JUN03 | TIME OF ORDER: 2030 HOURS

1. Clarification: MS04 2mg IVP q15mins up to 16mg q4° prn pain.

(b)(6)-2

11 JUN03 @ 1830

Q4° chart check 12JUN03 2003 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

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

DATE OF ORDER: 12 June 03 | TIME OF ORDER: 1510 HOURS

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

V.O. Dr. (b)(6)-2 1540

(b)(6)-2 1510

038

13 June 03 0330 (b)(6)-2 Q4°

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY B(b)(6)-2

14JUN03 Chart Check Q4° (b)(6)-2

15JUN03 @ 0100 Q4° Chart check (b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1994 ... 710

MEDCOM - 6140

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. JUN

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

| ORDER DATE | CLERK/ NURSE | RECURRING ACTIONS, FREQUENCY, TIME | HR | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 11JUN03 | (b)(6)-2 | Ancef 1 Gm IVP | 8 | / | (b)(6)-2 | | | | | | |
| | | Q8 | 16 | / | (b)(6)-2 | | | | | | |
| | | | 24 | (b)(6)-2 | | | | | | | |
| 11JUN03 | (b)(6)-2 | IVF: NS @ 150cc/hr | 6 | / | (b)(6)-2 | | | | | | |
| | | | 14 | / | (b)(6)-2 | | | | | | |
| | | | 22 | (b)(6)-2 | | | | | | | |

ALLERGIES: ☒ YES ☐ NO
Acuzol

PRIMARY DIAGNOSIS: (R) knee GSW

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

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

D 8 9 10 11 12 13 ...
E ... 10 17 ...
N 24 01 02 03 04 ...

| Verify by Initialing | | THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) | | | | Mo JUN Yr 2003 |
|---|---|---|---|---|---|---|
| Order Date | Clerk Nurse | SINGLE ACTIONS | Date to be Done | Time to be Done | Time Done | Initials |
| 11 JUN03 | (b)(6)-2 | Admit to ICW | 11 JUN03 | 1800 | 1800 | (b)(6)-2 |

| Order/ Expir Date | Clerk/ Nurse | PRN ACTION, FREQUENCY | INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 11 JUN03 | (b)(6)-2 | Percocet 1-2 tabs Q4-6h prn pain | 12 JUN03 0420 2 tabs | X (b)(6)-2 | 13 Jun 1150 Tl | 14 Jun 1500 (b)(6)-2 | | | | |
| 11 JUN03 | (b)(6)-2 | Morphine 2mg Q15min up to 16mg in 4hrs prn pain. IVP. | 11 JUN 2045 2mg | 3[illegible] JUN 2230 2mg (b)(6)-2 | 13 Jun [illegible]30 2mg (b)(6)-2 | 13 Jun 2200 2mg | 14 JUN 0140 2mg (b)(6)-2 | 14 JUN 2346 2mg (b)(6)- | MJ 0155 2mg (b)(6)-2 | 16 June 0015 2mg |

USAPA V1.00

MEDCOM - 6142

| 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. Jun Yr. 2003 |
|---|---|---|

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

| ORDER DATE | CLERK/ NURSE | RECURRING ACTIONS, FREQUENCY, TIME | HR | DATE COMPLETED 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11JUN03 | (b)(6)-2 | Hemovac to suction | 6 | / | (b)(6)-2 | | D/C Hemovac 12June03 (b)(6)-2 | | | | | | |
| | | record output | 14 | / | | | | | | | | | |
| | | Q8. | 22 | (b)(6)-2 | | | | | | | | | |
| 11JUN03 | (b)(6)-2 | Regular Diet | 06 | / | (b)(6)-2 | | | | | | | | |
| | | | 12 | / (b)(6)-2 | (b)(6)-2 | | | | | | | | |
| | | | 18 | (b)(6)-2 | | | | | | | | | |
| 11JUN03 | (b)(6)-2 | Foley care | 06 | / | (b)(6)-2 | | foley D/C (b)(6)-2 | | | | | | |
| | | | 14 | / | | | | | | | | | |
| | | | 22 | (b)(6)-2 | | | | | | | | | |
| 11JUN03 | (b)(6)-2 | VS Q8 | 06 | / | (b)(6)-2 | | | | | | | | |
| | | | 14 | / | (b)(6)-2 | | | | | | | | |
| | | | 22 | (b)(6)-2 | | | | | | | | | |
| 12June | (b)(6)-2 | NTO: W→D Drsg to (L) | 06 | / | (b)(6)-2 | | | | | | | | |
| | | lateral thigh BID | 18 | / | (b)(6)-2 | | | | | | | | |

ALLERGIES: [X] YES [ ] NO — Acuzol

PRIMARY DIAGNOSIS: (R) knee GSW

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 |

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 6 | Yr 2003 |
|---|---|---|---|---|---|---|
| Order Date | Clerk Nurse | SINGLE ACTIONS | Date to be Done | Time to be Done | Time Done | Initials |
| 12 | (b)(6)-2 | DC hemovac | 12 | | Done | (b)(6)-2 |
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| Order/ Expir Date | Clerk/ Nurse | PRN ACTION, FREQUENCY | INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
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USAPA V1.00

MEDCOM - 6144

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

Ⓡ Knee Debreed Bem — For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

OTSG APPROVED (Date)

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet 200

Date: 11 Jun 03
Time In: 1420
Allergies: ACUZOL
Pre-op V/S:
Procedures: Ⓡ Knee Debridement
SP GSW To Knee

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1300 NS Colloid
OR Output: UOP 200cc EBL Min
Meds/Times:

Drains: (Hemovac) NG JP T-tube Foley TLS

Airway: Nasal (Oral) removed ETT Trach Other

Pre Op Meds — History

| Time | 1415 | 1430 | 1445 | 1500 | 1530 | 1600 | 1700 |
|---|---|---|---|---|---|---|---|
| SaO2 | 98 | 98 | 98 | 98 | 98 | 98 | 97 |
| FiO2 | 100 | 50 | 50 | 50 | 50 | 50 | 35 |
| Methods | M | M | M | M | M | M | M |
| RR | 15 | 14 | 14 | 12 | 15 | 15 | 16 |
| T | 97.2 | 97.5 | 98 | 98 | 98 | 98 | 98 |

(Vital signs graph scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

| Time | 1415 | |
|---|---|---|
| Pain (0-10) | 0 | |
| LOS | | |

Pacu Intake

| Time | Solution | Amount | Site | By | Infused |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

X-rays: — Labs:

Post-Anesthesia Recovery score

| Criteria | ADM | 30" | D/C |
|---|---|---|---|
| Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities | 0 | 0 | |
| Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea | 2 | 2 | |
| Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op | 2 | 2 | |
| Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain | 1 | 1 | |
| Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic | 2 | 2 | |
| Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse | 2 | 2 | |
| TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C. | 7 | 7 | |

Codes

AIRWAY: A = Ambu; BB = Blow-by; M = Mask; FT = Face Tent; RA = RoomAir; NC = Nasal Cannula

V/S: X = A-line BP; ˇ = Cuff BP; • = Pulse

TEMP: S = Skin; O = Oral; A = Axillary; T = Tympanic; R = Rectal

LOS: C = Cervical; T = Thoracic; L = Lumbar; S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB, Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 11Jun1420

DEPARTMENT/SERVICE/CLINIC

DATE: 11 Jun 03

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

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

| MEDICATION | | | | | | |
|---|---|---|---|---|---|---|
| Allergies: | | | | | | |
| Time | Pain 1-10 | Medication & Dosage | Route | Pain 1-10 | I/E | By |
| 1500 | 4 | Morphine 2mg | IV | | | (b)(6)-2 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**NEUROVASCULAR**

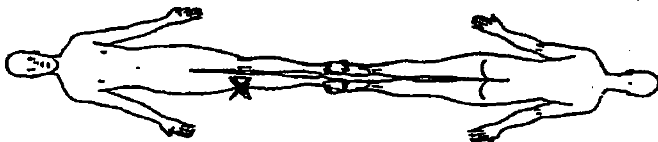
| Time 1445 | Site | Range Of Motion | Sensory | P | Cap Refill | T | Color |
|---|---|---|---|---|---|---|---|
| Adm | (R)LE | hip flexion | | P | <3 B | Cool | PK |
| 15' | (R)LE | knee immobilized | | P | <3 | C | PK |
| 30' | (R)LE | hip flexion | | P | B | C | PK |
| 45' | (R)LE | knee immobilized | | P | B | C | PK |
| 60' | (R)LE | | | P | B | C | PK |
| 90' | (R)LE | | | P | B | C | PK |
| D/C | | | | | | | |

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

| C-SECTIONS | Adm | 15' | 30' | 45' | 60' | 90' | D/C |
|---|---|---|---|---|---|---|---|
| Fund. Height | | | | | | | |
| Lochia | | | | | | | |
| Peripad# | | | | | | | |
| Fund. Cond. | | | | | | | |

**DRESSINGS**

| Time | Location | Type | Drainage |
|---|---|---|---|
| Adm | (R)LE | gauze/ACE | Hemovac |
| 30' | (R)LE | gauze/ACE | Hemovac |
| 60' | (R)LE | gauze/ACE | Hemovac |
| D/C | | | |



**PACU OUTPUT**

| Time | Source | Color/Appearance | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**CARDIAC RHYTHM**

| Time | Rhythm | Symptomatic? | Rhythm Strip Run? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

WAMC OP 173-E

**NURSING NOTES**

1415: Arrived on KU from OR via litter SP (R) Knee debridement. Pt has hemovac to wound. Dsg dry/intact c ACE wrap. (+) pulse, cap refill <3 sec. O2 @ 50% per Venturi Mask. (b)(6)-2

1445: Patient moaning in pain. [illegible] Given 2mg Morphine IVP. (b)(6)-2

1450: Pt has foley to gravity draining clear/yellow urine. NS infusing @ 150cc/hr into (L) arm. VSS, WNL. EPW restrained to litter @ wrist (+) pulse, ROM. (b)(6)-2

1600: UOP 125cc clear, amber urine VSS. (b)(6)-2

1610 O2 ↓ to 35% via VM SpO2 @ 97% (b)(6)-2

1700 UOP 125cc. VSS, WNL. Responsive to verbal command still sleepy able to follow commands. Pt meets criteria to transfer to ICW awaiting Transport. (b)(6)-2

Discharge Criteria:
Date: Time: PARS:
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10):
Intake:____ Output:____
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

# ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. M... ION (State or Country Code.)

3. REGISTER NUMBER: (b)(6)-2
NAME (Last, First, Middle Initial): (b)(6)-2
4. PAY GRADE:
5. SEX: M

6. DATE OF BIRTH (YYYYMMDD):
7. AGE AT ADMISSION:
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION: UNKNOWN

10. LENGTH OF SERVICE:
ETS: N/A
11. FMP: 9 9
12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only): N/A
13. MARITAL STATUS: U
HOUR OF ADMISSION: 1000
BRANCH / CORPS: N/A

14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 0
PREV. ADMISSION: YEAR: ; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0
WARD: ICU
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: 2 4
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (YYYYMMDD): 2 0 0 3 0 6 1 5

24. CLINIC SVC - ADMITTING: A E A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYYYMMDD): 2 0 0 3 0 6 1 1

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

FOR LOCAL USE
DX: GSW RIGHT KNEE

(b)(6)-2

(b)(6)-2 LTC, MC

SIGNATURE OF ADMITTING CLERK (b)(6)-2 (b)(6)-2 ...C, 91G10

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

# Admission a... oding Information

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

| | | | |
|---|---|---|---|
| 1. Reporting MTF (b)(3)-1 | 2. MTF Location (b)(3)-1 | | |
| 3. Register Number (b)(6)-4 | Name (Last, First, MI) (b)(6)-4 | 4. Pay Grade FGN | 5. Sex M |
| 6. DoB (YYYYMMDD) | 7. Age at Admission | 8. Race X | 9. Ethnicity Z | Religion MUSLIM |
| 10. Length of Service | ETS | 11. FMP 99 | 12. Social Security Number (b)(6)-4 |
| Organization (Active Duty Only) | 13. Marital Status | Hour of Admission 10:00 | Branch / Corps: |
| 14. Flying Status | 15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES | 16. Zip Code of Residence: | |
| 17. Unit Location IZ | 18. MOS | 19. Trauma DIS | Prev. Admission NO |
| 20. Source of Admission Direct from ER | Ward: ICU | Name / Relationship of Emergency Addressee | |
| | | Address of Emergency Addressee | |
| Name and Location of Medical Treatment Facility: (b)(3)-1 | | Telephone Number of Emergency Addressee | |
| 21. Type of Disposition TRF C-ACF | 22. MTF Transferred To | 23. Date of Disposition (YYYYMMDD) 2003-06-15 | |
| 24. Clinic Svc - Admitting AEA - ORTHOPEDICS | 25. MTF Transferred From | 26. Date this Admission (YYYYMMDD) 2003-06-11 | |
| 27. Location of Occurrence IZ | 28. MTF of Initial Admission | 29. Date of Initial Admission ~~2003-06-11~~ | |

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW to Leg

965.4 891

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 8912 Proc 8388
8628
E9912
E8498 Trauma 1
Inj 450

(b)(6)-2

Admitting Officer (Signature, as required) (b)(6)-2, LTC, MC

Signature of Admitting Clerk (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 6148