AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05 Oct 03	arrived care at 0615, VS A+ [illegible], all care complete
	pt ambulated to BR, pin care complete with H_2O_2 and
	sterile water, wounds around pins reddish pink
	with minimal drainage after ambulating, pins open to
	air, pt ambulated ∅ difficulty, sat in chair [redacted]
05 Oct 03	1330 I concur c̄ above assessment. Tolerating crutch
	ambulation well. Pt c̄ 2 pt restraints s̄ compromise
	to skin integrity & circulation b(6)-2 [redacted]
05 Oct 03	VSS. AO OOB to crutch walk for 30 min and tolerated
2035	well. Performed own pin care s̄ difficulty. No s/s
	infection to pin sites. Voiding light amber, in
	quantity sufficient. [redacted]
	b(6)-2
06 OCT 03	ORTHO
0700	[illegible]
	AFVSS
	Stiff knee - 0-30°
	to OR tomorrow, manipulation under anesthesia.
	[redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) b(6)-2

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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 19041

ACLU-RDI 1650 p.1

DOD-032615

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06 OCT 03 0522	Pt Awake A&O. LS CTA (B) ~~2~~ S_1 S_2 present, (+) BS x4 quads. Ex Fix on (L) LE. CTA. (+) pulses in all [redacted] tremities. Pt NPO ō midnight. On call to OR To[redacted]w. Will cont to Monitor. ——— b(6)-2 [redacted] SPC 91W mb
6 OCT 03	2100: VSS, Ø c/o pain @ present time, A+Ox3, pt. did pin care on his own after setting up supplies for him, ex fix in place c̄ small exudate from pin insertion sites. (L) LE ↑, edema noted. Neurovascularly intact 2+ pedal pulse (L) foot. IV Hl to (R) FA flushed & patent, continuing Ancef around the clock, will be NPO p̄ MN & initiating maintenance fluids @ that time (LR @ 100cc/°). Ø other remarkable finding. x2 restraints when in bed, continue to monitor. [redacted] RN
07 OCT 03 0810	Pt Returned from OR via litter. P/O Ex Fix adjustment. Gauze Dsg c̄ small ~~amt~~ Bloody show on middle pin. Pt c/o Pain controlled c̄ MSO4. (L) LE Elevated. Will continue to monitor. [redacted] 91WM b(6)-2
8 OCT 03 0118	VSS. Performed self pin care and wrapped pins. Ø S/S of infection. Amb c̄ AB ... and voiding light yellow urine quantity sufficient. ——— [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 19042

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
070403 0811	ORTHO prop DX: Stiff (L) knee S/P Fem fx. post-op DX: same manipulation under anesthesia, clean pin sites. pre-op ROM 0-30, post-op ROM 0-50° Dermal Q Comp to RR Stable

[redacted] b(6)-2

[redacted] b(6)-4

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

UNIT./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

MEDCOM - 19043

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 OCTOBER 1000	Received pt resting in bed, VSS, tol RD, HL in ⓡ fa, patent, flushes easily. Amb w/ crutches steered thru dm. SWGS. Self care of pen sites w/ H2O2 half strength, minimal serous drainage on old dressings. amb indep w/ crutches. X ray request for AP & LAT of ⓛ femur. Ex fix to ⓛ femur intact. IV to ⓛ hand (S) d/c'ed. ø other remarkable assessments @ this time Restraints per GPW protocol, ø dsm breakdown noted. Will cont to monitor pt. [redacted] 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.

C [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
08OCT03	D/C Summary This is a 35 y.o. Iraqi male s/p GSW (L) femur with open femur fracture. Wound is closed (POD) c external fixator in place. Pin sites are clean and X-ray demonstrates callous formation at fracture. Pt is ambulatory with crutches. Pin sites should be cleaned twice a day and oral antibiotics twice a day can be taken by mouth (Keflex 500mg BID). Routine follow up for X-ray in 2 weeks c Dr. [redacted] b(6)-2 [redacted] 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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 19045

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER [redacted]
		RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 11 Sep 03 | TIME: 1221

TRANSPORTATION TO FACILITY: AIR

SEX: M

AGE: 35

DUTY/LOCAL PHONE		HOME PHONE	
AREA CODE	NUMBER	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 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: NKA

CHIEF COMPLAINT: SP GSW

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 INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1220

INITIALS: b(6)-2 [redacted]

VITAL SIGNS					
TIME	1220				
BP	113/63				
PULSE	101				
RESP	16				
TEMP	101.6				
WT					

LAB ORDERS								
☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	X-RAY ORDERS	☐ CXR PA & LAT/PORTABLE	☐ C-SPINE
URINE C&S	UA MSCC/CATH		CHEM: ~~Met 8~~		☐ ACUTE ABDOMEN	☐ LS SPINE
BLOOD C&S X			T+S		☐ SINUS	☐ HEAD CT
					☐ ANKLE R/L	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	CXR, ☒ Tylenol				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

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)*

[redacted]

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)
USAPA V1.00

MEDCOM - 19046

NSN 7540-01-075-3786

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 02	PH	PO2	RESULTS		
	PLT			PCO2	SAT	OTHER			
PT				U/A	DIP		EKG INTERPRETATION		
APTT	BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

See Admission Paperwork

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] b(6)-4

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

510-112

TEP.

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2145 10SEP03			PT CARE TRANSFERRED => PH VIA LITTER.
			I+D @ (R) TIBIA/EXFIX @ (R) FEMUR FX.
-VS @ 2145-			A+OX3 PER TRANSLATOR. Ø SOB Ø NAUSEA
B/P 126/68			NTD. SMALL AMT. BLOODY DRAINAGE NTD
PR 75			@ EXFIX SITE/TIBIA DRSG. Ø ODOR NTD
RR 18			CURRENTLY RESTING SUPINE NAD. IV @
O2 97% ON RA			(R) ~~FA~~ INFUSING LR @ 120cc/hr. SITE Ø[illegible]
TMP 98.8° FORAL			[redacted] b(6)-2
VS @ 0145-		1030	2mg MSO4 IVP & 5cc LR FLUSH [redacted]
B/P 130/72			* MED NOTE => ANCEF @ 8 X 6 DOSES
P 77			1ST DOSE @ 1730L [redacted] b(6)-2
R 16			
O2 97% ON RA			
TMP 99.1° FORAL			
11SEP03	0130	~~0130~~ AM	ANCEF 1g IVPB [redacted]
	0200		VOID => 510cc CLR. YEL. URINE Ø DYSURIA
VS @ 0545-			NTD. Ø GROSS BLD. NTD [redacted] b(6)-2
B/P 130/73			
P 73	0230		2mg MSO4 IVP & 5cc LR FLUSH
R 18			
O2 98% ON RA	0230		PT ASLEEP NAD [redacted]
TMP 101.3 FORAL	0310		VOID #2 => 800cc CLR. YEL. URINE Ø DYSURIA [redacted] b(6)-2
	0440		VOID #3 => 650cc CLR. YEL. URINE Ø DYSURIA NTD
	0545		PT FEBRILE @ 101.3° FORAL TYL 325mg PO
			[redacted] SGT. [redacted]
	0600		~~DRSG~~ SMALL AMT. BLOODY DRAINAGE NTD [redacted] b(6)-2
			@ EXFIX SITE. [redacted]
	0600		BAG #1 LR @ 120cc/hr. SITE Ø[illegible] [redacted]
	0745		PT DENIES BREAKTHROUGH PAIN [redacted]

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

[redacted]

IRAQI EPW

b(6)-4

-3.5.105 AIR

(Continued on reverse side)

REGISTER NO.

WARD NO.

BACK

NURSING NOTES

Medical Record

MEDCOM - 19048

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 SEP 03		0830	VOID ⇒ CLR. YEL. URINE 900cc Ø DYSURIA
			Ø BLOOD NTD [redacted] EPW
		0845	2mg MSO4 IVP c 50cc NS FLUSH [redacted] EPW
		0930	1g ANCEF IVPB * AWAITING GROUND EVAC
			⇒ [redacted] [redacted] EPW b(2)-2 b(2)-2

*U.S. Government Printing Office: 1995 — 387-722/20011

STANDARD FORM 510 (REV. 7-91) BACK

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 35
HEIGHT:
WEIGHT: 61 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex Fix (L) femur

4. PROPOSED SURGICAL PROCEDURE:
I&D (R) tibia, I&D (L) femur, Adjust Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco (Y) ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ↓ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ex Fix L Femur Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: MSO4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g., warm blanket, touch). Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

EPW # [redacted] blw-4

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOME	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or wraps. If none, check with doctor. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ ~~Place and take down legs from stirrups with slow bilateral motion.~~ ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available f transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier: Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed where he/she is and what is happenin ✓ Inform pt. in which direction to m and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of ve communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] RN b(6)-2 All 11SEP03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & (Y)(N)
BREATHING EASY (Y)(N)

12. PREOPERATIVE EVALUATION (Signature and [redacted] PREPARED BY [redacted] RN
DATE: 11SEP03 TIME: 1520

13. POSTOPERATIVE [redacted] PREPARED BY (Signature and Title [redacted] RN
DATE: 11SEP03 TIME: 1745

MEDICAL RECORD — **INTRAOPER: :UMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY ATLS

2. PATIENT IDENTIFIED, RECORD [redacted] OCEDURE
VERIFIED BY Spc [redacted] b(6)-2

3. DATE 10 Sept 03 TIME PATIENT ARRIVED IN SUITE 1810 HRS

4. PATIENT IN ROOM
TIME 1810 HR NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Spc [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

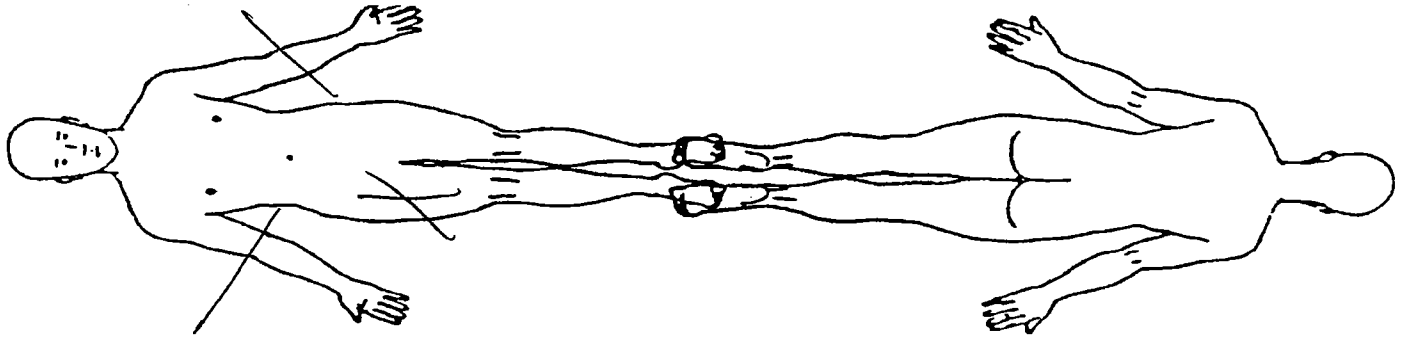
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine b(6)-2
SITE: LLE BY WHOM: Spc [redacted]
SITE: RLE BY WHOM: Dr [redacted]

COMMENTS:

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	5K	10	10
Needle Sharp	☐ Yes ☐ No	8	8	8
Instrument Blade	☐ Yes ☐ No	2	2	2
Other Rayex	☐ Yes ☐ No	9	9	9

SCRUB Spc [redacted] b(6)-2 CIRCULATOR Spc [redacted]

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

LOG# [redacted]
SSAN# Iraqi DV EPW b(6)-4
NAME:

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

☐ ESU NO: Cut to / Coag to
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS [X] YES [ ] NO — IF YES NAME: ID NUMBER; MAN

RE Lt femur external fixator

Cat No. [redacted] i-150
Ultra X External Fixator
NSN [redacted]
LOT CODE: [redacted]

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 [X] YES [ ] NO, TYPE(S):
1000cc NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE Dr [redacted] b(6)-2

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	18. DRESSING/IMMOBILIZATION (Specify) RLE Kerlix Roll & Ace Wrap Dressing LLE Kerlix Roll & Ace Wrap Dressing

17. TUBES, DRAINS/PACKING YES [ ] NO [ ]

	1.	2.	3.
TYPE/SIZE	1 Lg Penrose	2.	3.
SITE	1. RLE	2.	3.

19. ADDITIONAL INFORMATION

Assisted by Dr [redacted] b(6)-2
Attempted Foley placement per myself and Dr [redacted] made + placed due to resistance.

IN 1810 Hrs
CUT 1845 Hrs
CLOSE 1718 Hrs
OUT 1945

Bovie Tip 1 First Cut 1 Last Cut 1

b(6)-4
LOG # [redacted]
SSAN# [redacted] Imaging & ESPN
NAME:

20. OPERATION(S) PERFORMED

I + D to 6 SW + RLE
External fixator placement to Lt femur fx

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU b(6)-2	1945	Walker

22. REGISTERED NURSE SIGNATURE Spc [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 19053 USAPA V1.01

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT 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 IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] b(6)-2

3. DATE 11 Sep 03 TIME PATIENT ARRIVED IN SUITE 1540

4. PATIENT IN ROOM TIME 1540 NUMBER 2-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA, NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table

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

COMMENTS:

8. SKIN PREPARATION

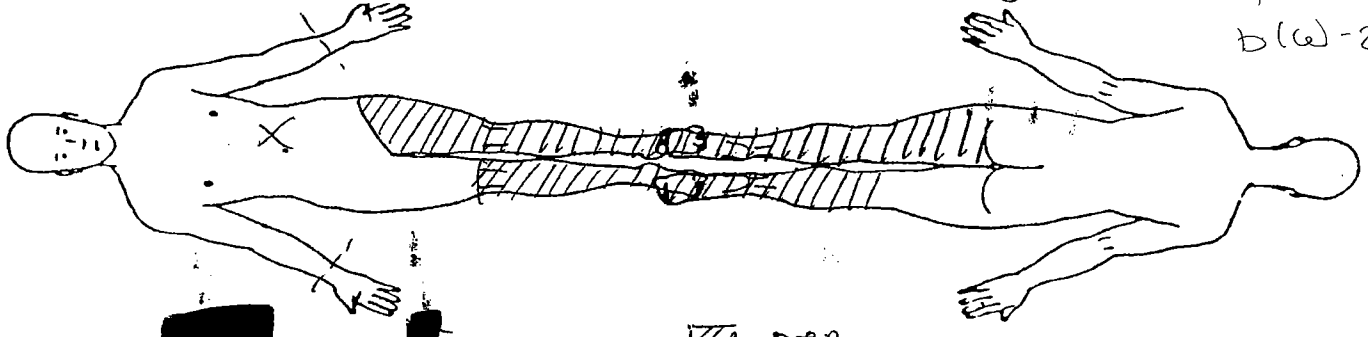
HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP (R) calf

COMMENTS: NO nicks or cuts noted

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Left leg BY WHOM: 1LT [redacted]
SITE: Right leg BY WHOM: CPT [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet ▨ - prep

Initial: SPC SSIGS 1LT Malachi

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

C = Correct I = Incorrect

SCRUB b(6)-2 SPC [redacted]

CIRCULATOR b(6)-2 1LT [redacted]

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

EPW # [redacted] b(6)-4

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

☒ ESU NO: VL Force 40
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 089310 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19054

13. PROSTHESIS, IMPLANTS [X] YES [ ] NO — IF YES NAME: ID NUMBER; MANUFACTURER

Hoffman II Ex Fix Load # 0425101
5023-5-150 x1
5018-6-180 x2
4920-1-010 x5
4920-2-020 x2
4920-2-140 x 4
5029-8-840 x 2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE [redacted] MD CPT [redacted]

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] C-Arm IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION (Specify)
Fluffs
Kerlix
ACE

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. (R) leg x (L) thigh	2.	3.

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: GETA

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut 30/30, 45/45.
Tourniquet Site intact pre-op N/A; post-op_____
Tourniquet Time: Up____ Down N/A

b(6)-2 All

DA5179 initiated.

20. OPERATION(S) PERFORMED
IxD (R) tibia
IxD (L) femur
Modification Ex Fix (L) femur

1. PATIENT TRANSFERRED TO PACU — TIME See DA7389 — METHOD Liter O2

REGISTERED NURSE SIGNATURE [redacted] RN [redacted] CPT MSC

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

b(4)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

DAPAM 40-01

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY MAJ [redacted] MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PRE[redacted]ED BY MAJ [redacted]

3. DATE 14 Sept 03 TIME PATIENT ARRIVED/IN SUITE 1232

[redacted]ATIENT IN ROOM TIME 1232 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: PCN NKA ED

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(4)-2	RELIEF SCRUB	1310 SPC [redacted] b(4)-2
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

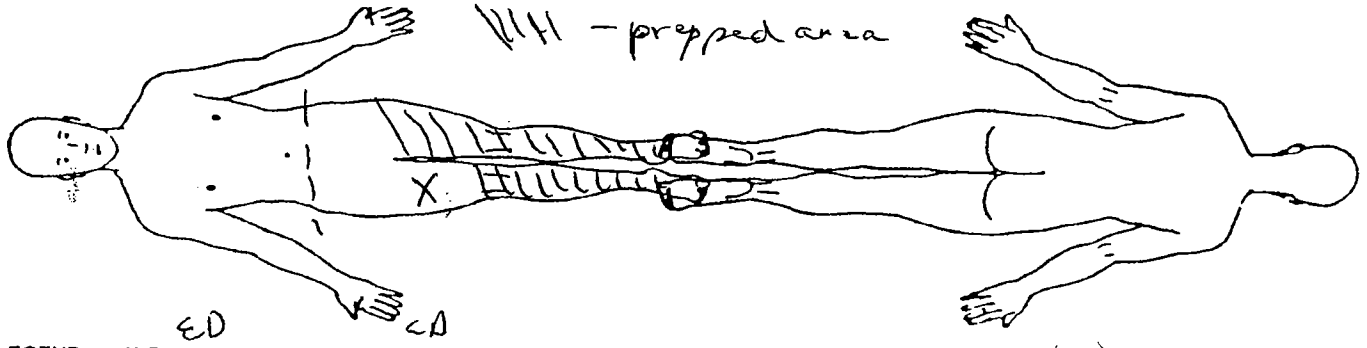
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine Scrub & Solution
SITE: Left leg BY WHOM: MAJ [redacted]
SITE: Right leg BY WHOM: CPT [redacted]
COMMENTS: No pooling of solution b(4)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(4)-2

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SPC [redacted] SPC	MAJ [redacted] MAJ
Needle Sharp	☑ Yes ☐ No		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;)

ED
[redacted] b(4)-4

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

☑ ESU NO: R8B 102395
GROUND PAD: BRAND Valley Lab
LOT NO: 68245 Exp 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19056

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): NS.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIG [redacted] b(4)-2

15. X-RAY IN OPE[redacted] IF YES, SITE
YES ☐ NO ☑

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	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Lt thigh ABD 4x8 Kerlix
Rt calf 4x8's Kerlix

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] b(4)-2 Anesthesia: MAJ [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op NA; post-op ____
Tourniquet Time: Up NA Down ____

20. OPERATION(S) PERFORMED
I&D Rt ~~thigh~~ calf, I&D Left thigh & adjustment of ex-fix

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1350	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 14 Sep 03
b(4)-2

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 19057

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

For use of this form, see AR 40-407, the propo[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA letter BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CRT/AN

3. DATE 7OCT03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0745 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

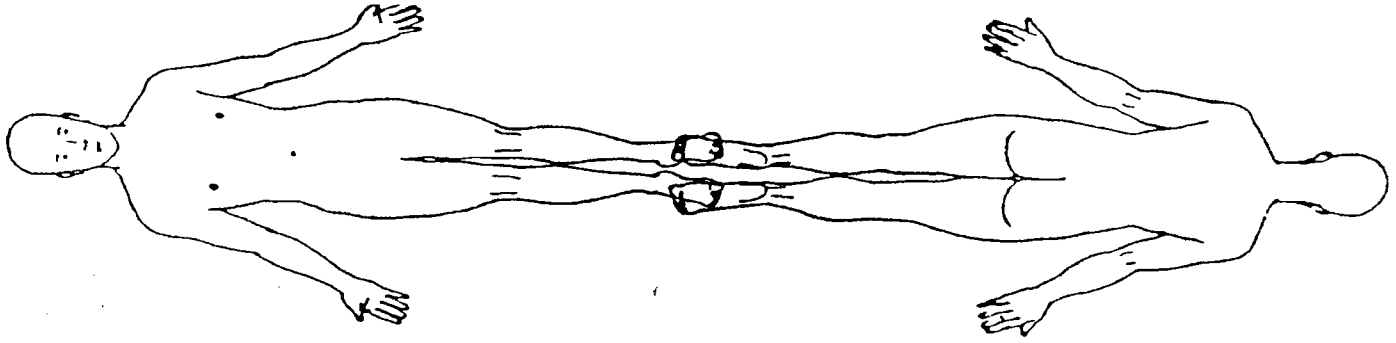
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify)
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No					
Needle Sharp	☐ Yes ☐ No					
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;)

#[redacted] b(4)

7OCT23

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ 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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S S[redacted] b(6)-2

15. X-RAY [redacted] IF YES, SITE
YES ☐ NO ☒

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	

18. DRESSING/IMMOBILIZATION *(Specify)*
Ilerlix around pins

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
(L) knee exam under anesthesia

21. PATIENT TRANSFERRED TO ICW b(6)-2 TIME 0820 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 8_

USAPA V1.00

MEDCOM - 19059

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS
TO ____ HOURS

TOTAL HOURS COVERED

DATE 11Sep03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1Sep 2100	120 H20		120
			14Sep

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1000	NS@100			
1800	1800-0600				
0600	1000	LR@100			950

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(a)-4

MEDCOM - 19060

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
Sep 2100	400	400cc			
2300	150	550cc			
0500	600	1150cc			
0570	300	1450cc			
Sep 400cc 00-0800	400cc				
2080	100	500cc			
300 dyu	420	920cc			
200 dyu	600	1320			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0800	700cc	urine meal yellow	700
14th Sep		1800 - 0600	
2300	400	mod. yellow	400
0200	800		1200
0530	400	(dyu)	1600

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted]
b(4)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- DAY

MONTH-YEAR: Sep 03 — DAY: 12 Sept 03 | 13 Sept 03 | 14 Sept | 15 Sept 03 | 16 Sept | 17 Sep

HOUR: 19

PULSE (O) / TEMP. F (°) / TEMP. C

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° / 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

BLOOD PRESSURE

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)*

[redacted] b(6)-4

REGISTER NO.

WARD NO. TCW #1

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19062

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	18 Sept	19 Sep 03	20 Sep	21 Sep	22 Sept	23 Sept	23 Sep 03
19 / HOUR	[illegible]	[illegible]	0210	0739	1830	0830	1845
RESPIRATION RECORD	18	18	18		18		122/44
BLOOD PRESSURE	120/85 103.9 95	133/57 122/70	133/68 99 98.9 100% RA	124/77 98%	115/57 83 97.4 99% RA	111/56 101 98.9	110/58 121 100% R-18 98.7	P 79 R 15 O2 99% RA

PULSE (O): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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)

Record special data only when so ordered

HEIGHT: | WEIGHT →

O2 SAT 97% RA | 97% RA

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.

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

[redacted]

b(6)-4

MEDCOM - 19063

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY			26 Sep 03	27 Sep 03	28	29 Sep 03	
MONTH-YEAR / DAY	27 Sep 03	25 Sep / 26 Sept		1030	Sep		
19 / HOUR		0900 / 1840 / 0038	1840		0700		

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° / 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: 16; 18

BLOOD PRESSURE: 119/62; 122/68; 117/60 ©95; 112/57 92; ©98; 96.7; ©99%; 99%; 117/67; 112/67; 101/57; 116/64; 103/49; 120/62; 98.2; 111; T 98.3; 114/62; H 92; 97.3; H 96

HEIGHT: WEIGHT →

O2 sat: 100% (RA); 99% (RA); 98% (RA); ©; 98% RA; 99% (RA); 98.2 RA; 98.1; 99%; 99%; 112/64; 97.5; 98; 99%

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)* | REGISTER NO. | WARD NO.

#[redacted]

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

MEDCOM - 19064

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 30 Sept 03 | 1 Oct 03 | 2 Oct | 3 Oct 03 | 4 Oct | 5 Oct 03 | 6 Oct 03 | 7 Oct 03

MONTH-YEAR / DAY

19 / HOUR: 1900 | 0400 | 1900 | 0645 | 1830 | 0645 | 0645 | 1900

PULSE (O) | TEMP. F (°) | TEMP. C

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° / 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

BLOOD PRESSURE

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)*

REGISTER NO.

WARD NO.

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

[redacted] b(4)-4

MEDCOM - 19065

ACLU-RDI 1650 p.25

DOD-032639

b(4)-2

Ward/Section: [redacted] | REQUESTING PHYSICIAN: [redacted]

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

LAST [redacted] | DATE 11 Sept 07 | TIME 1230 | SSN/PSEUDO SSN: [redacted]

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

[redacted]ology) CBC

Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

Mis[redacted]

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] | DATE: 11 Sep 07 | LAB ID NO.:

b(4)-7

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

i-STAT

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) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	~~RESULT~~	~~REF. RANGE~~

======= PICCOLO =======
11/09/03 13:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

GLU	101	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	8.3	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	136	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

GSW to leg

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia) Smoker

Age 35 **DAYS MOS YRS** **Sex** (/) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: adjust ex-fix/washout
SURGICAL SERVICE: (ORTHO)
NPO SINCE: 10 Sept 23

ASA Physical State 1 2 3 4 5 E
WT: 60 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) N/A
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: 13.2 PS 10/14.2 3/11.2 10
U/A: ____
OTHER: ____

11 Sept 23
11.0 / 4.6 / 33.8 / 258

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	____
Angina	N	Y	____
MI	N	Y	____
CVA	N	Y	____
Other	N	Y	____
Pulmonary System:			
Asthma	N	Y	____
Bronchitis/URI	N	Y	____
COPD	N	Y	____
Other	N	Y	____
Renal System:			
Acute/Chronic RF	N	Y	____
Gastrointestinal:			
Hepatitis	N	Y	____
Hiatal Hernia	N	Y	____
PUD/GERD	N	Y	____
Endocrine System:			
Diabetes	N	Y	____
Steriods	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	N	Y	____

ASSESSMENT
PAST SURGICAL/ANESTHETIC
N/A

PHYSICAL EXAMINATION
BP 163/100 HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth (Intact)
Trachea Midline
TMJ/Neck FROM
Oropharnyx Cl-2, 3/6 PM
Nares ____
CHEST: BBS+/CTA
CARDIAC: S1S2 RRR
EXTREMITIES: (2) A/C #18
IV Access: (2) A/C #18
Ulnar Filling: OK
BACK: OK
OTHER: ____

NPO Since 10 Sept

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. Vessel translator

The patient/legal guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] Date: 11 Sept 23 Time: 1400 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
b(6)-2
Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

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

ICW 1

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS
MEDCOM - 19068
PATIENT RECORD COPY
Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

NKDA   Procedure/Site verified

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)								TOTALS
Fentanyl (UG)	250	250						500
Lidocaine (MG)	40							40
Propofol (MG)	150							150
Vec (MG)	(10)	10 10	2					22
( )								
( )								
VOLAT AGENT Iso % del		1.7	1.7	1.7	1.5	1.5	1.5	
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	6	2	2	2	2	2	2 2.6	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → Induction

TOTAL EBL: MIN

TOTAL URINE: —

FLUIDS SUMMARY
CRYSTALLOID- NS-500
COLLOID-
BLOOD-

FLUIDS
LINE site #18 (L) AC ☑ Warmed — NS →
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE -

Smoker

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

BODY WEIGHT: 61 (KG)

HEMATOCRIT:

INITIAL DATA:
BP- 115/63
HR- 90's

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? (+)
TIME- 1530

TIME → 1550 (1600) x 30 x (1700) x 30 x (1800) x 30 x

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

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20 (BP plotted ~100–120 systolic / ~40–50 diastolic; HR ~80)

VENTIL

VT - ml		860	840	760	770	770	720	400
f - breaths/min		10	10	8	8	8	8	4
Peak inf pres / PEEP		20	20	21	21	21	21	
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	CV	CV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		31	31	40	35	35	36	30
BP/oth	FIO2 (Frac or %)	.96	.96	.94	.94	.85	.85	.85	.75
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS
Gas analyzer	TEMP-site	Skin		35	35	35	35	35	
O2	N-M Block (T/4)		4/4	0/4	0/4	0/4	0/4	1/4	4/4 ST+
Warming blkt		Blanket/sheets →							
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → arms <90° abducted/padded

REMARKS
Code drugs with numbers, events with letters
1530 - Pt. c 10 - IVs in place, Chart ✓, headphones
1545 - In room, monitors on, Induction, Anesthesia ...
1730 - Reversal, 5 ...
1745 - ... 80 ... Opened eyes, spont resp, Extubated

RECOVERY AT 98.6
(PACU) ICU ____ (Specify)
OTHER Stable
CONDITION:
RESP- 26   SpO2- 99%
BP-   HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1550	1545	17...
	Ready	Begin	End
PROC	1555	1611	1735

PROCEDURES and CPT Codes:
Washout - I&D - Adjust Ex-fix (L) forearm

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA - #7 oral, #3 Mac, taped 22 in teeth, Eyes taped, OGT ↓ E+, retain: Soft bite block

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
ICW I
b(6)-4
[redacted]

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Recovery, DL x1, GR 2 view, ETT easily passed. BBS+ CO2+, At ... Test OK

SURGEONS: [redacted] b(6)-7

PROCEDURE LOCATION: #23
DATE: 11 Sept 03
PAGE 1 OF

MEDCOM - 19069 [redacted]

DA FORM 7389, FEB 1998

ACLU-RDI 1650 p.29

DOD-032643

– agree c̄ previous anesthesia (pre-op) 11Sept03

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Phenergan	(mg)	25	25
MSO4	(mg)	4 <6> <5> <8>	20
Lidocaine	(mg)	100	100
Propofol	(mg)	200 20	
	( )		
	( )		
VOLAT AGENT Iso	% del	2.0 2.0 2.0 2.5	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 2 2 2 10	

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

TOTAL IN: <50

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– Ø

BLOOD– Ø

FLUIDS

LINE site		
18 L OA	☐ Warmed	D5LR
18 (L) A	☒ Warmed	LR #1 ———
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE –

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 61 (KG) LB

HEMATOCRIT: —

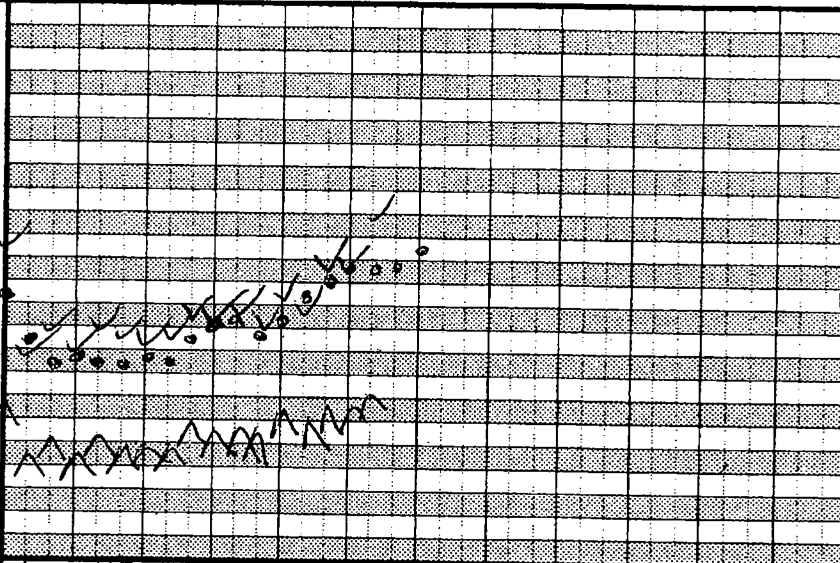
INITIAL DATA: BP – 106/56; HR – 96

EQUIP CHECK OK?– (Y) N

PATIENT RECHECK OK for PROCEDURE? [initials]; TIME– 1130

TIME → 1230 . 1300 . 30 . 1400

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T –; ANES– X-X; PROC ⊙-Ø



REMARKS– Code drugs with numbers, events with letters

voided pre-op

(1) Pre-op assessment. Phenergan + MSO4 IV. NPO verified

(2) Room monitors. O2 induced. eyelids taped closed. 18G PIV started (L) A other PIV D/C'd

(3) Head tilt, chin lift OA + NP 30FR tube placed (R) nare.

(4) OA + NP tube removed, responsive to PACU. Report to RN

(5) Demerol 10mg IV for P.O. shivering.

VENTILATION / MONITORS

VT – ml	+	400	380	670	400	400	
f – breaths/min	+	24	22	20	25	25	
Peak inf pres / PEEP	+	—	—	—	—	—	
MODE– S(pon), A(ssist), C(on)	S~C	S	S	S	S	S	
ET CO2 (torr)	+	40	40	49	62		
FIO2 (Frac or %)	.82	.82	.82	.79	.78	.78	
SpO2 (%)	100	100	100	100	100	100	
ECG	SR	SR	SR	SR	SR	SR	
TEMP- site axil							
N-M Block (T/4)							

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer

Warming blkt: X 1 WOOL Blanket ——> ———

Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4); Position —

RECOVERY AT 1350 (PACU) ICU ____ (Specify)

OTHER T-101.4

CONDITION: Stable, responsive

RESP– 20 SpO2– 100

BP– 108 HR– 106

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1215	1225	1402

	Ready	Begin	End
PROC	1235	1255	1336

PROCEDURES and CPT Codes: I+D (L) femur, (R) calf wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — LMA #4 reinforced – not seated. Mask easily 90mm OA placed + BBS + Sust ETCO2

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

EPW # [redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA

[redacted] MAJ ... MEDICAL ... ANESTHESIA

PROCEDURE LOCATION 2 (2)

DATE 14 Sept 03

PAGE 1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 19070

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)						TOTALS
Versed	( )	2	2	2	2	2	10
Fent 50	( )	2	2	2			6 mg
	( )						
VOLAT. AGENT	% del / % e.t.						
AIR	L/Min						
N2O	L/Min						
O2 / NC	L/Min	3 — 3					

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

FLUIDS — LINE site: LR — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed — 1 KL

LOSSES — EST BLOOD LOSS: 100 — URINE –

TOTAL EBL: 100
TOTAL URINE: 0

FLUIDS SUMMARY
CRYSTALLOID– 1800
COLLOID– 0
BLOOD– 0

REMARKS — Code drugs with numbers, events with letters

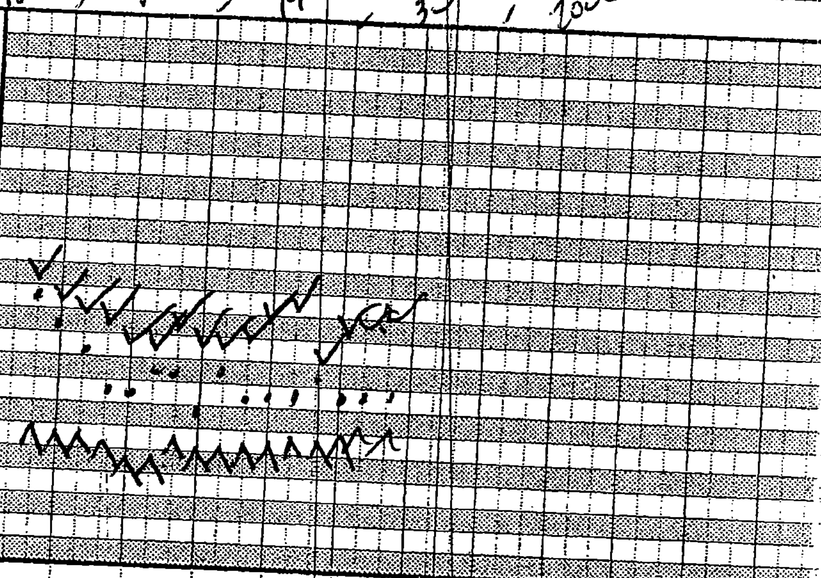
35 yo ♂ GSW (R) LE
NKDA
A+O x3
PMH: ∅

SAB: sitting, midline L3-4 BPx3, local 2cc 1% lidocaine 18G introducer, 24G sprotte, DPx1, freeflow CSF, Heme, ⊖ paresthesia, 12 mg 0.75% marcaine ē 8.25% glucose.

PHYS STATUS: 1 (2) 3 4 5 (E)
BODY WEIGHT: 70 (KG) LB
HEMATOCRIT:
INITIAL DATA: BP 124/59 — HR– 119
EQUIP CHECK: OK?– (Y) N
PATIENT RECHECK — OK for PROCEDURE? TIME– 1800

TIME ➔ 1800 / 30 / 1900 / 30 / 2000

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



VT – ml					
f – breaths/min	22	16	16	16	16
Peak insp pres / PEEP					
MODE – S(pon), A(ssist), C(on)	S	S	S	S	S
ET CO2 (torr)					
FiO2 (Frac of %)					
SpO2 (%)	98	100	100	100	100
ECG	ST	SR	SR	SR	SR
TEMP- site skin	37	37	36		36
N-M Block (T/4)					

MONITORS: ✓ BP/Auto Cuff — BP / oth — ART line — Steth- PC/ES — Gas analyzer — Warming blkt — Conv warmer

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → ∠ →

RECOVERY AT 1931 — PACU ICU ____ (Specify) — OTHER — CONDITION: — RESP– 20 SpO2– 98% RA — BP– 125/61 HR– 72

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1800	1810	1948
	Ready	Begin	End
PROC	1825	1845	1933

PROCEDURES and CPT Codes: Debridement, GSW (R) LE. Application External Fixator (R) Femur.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — SAB ē IVS

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted]

b(6)-4

b(6)-2

[redacted]

[signature] CRNA

MEDICAL RECORD / ANESTHESIA

PROCEDURE 680 FST
LOCATION 82nd
DATE 19 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 19071

ACLU-RDI 1650 p.31

DOD-032645

ASA II 7ob.
NKA
61 kg

Hx Rx Fx L mm MPC II 3FB M→H : [illegible] UsCTA [redacted]
Dr [redacted] Man. pulation Under Anes. GETA . os: Kefzol [redacted] 10/7/03

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)				TOTALS
Propofol (mg)	200	100		300
Lidocaine ( )	100			
Versed ( )	2.5			2.5
Fentanyl ( )	100	150		
Succinylcholine ( )	80			
Narcan (mg)		.04	.04	
VOLAT AGENT Forane % del	2.0	X	X	
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	8	8	8	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	①②③			

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site		
18g ② wrist	☐ Warmed	LR 1 —
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS — ; URINE -

REMARKS
Code drugs with numbers, events with letters
① PT ID IN
② RM - O2 - MON.
③ IND/INT.
④ PT c̄ purposeful mvmt - ext - [illegible]
⑤ OOR to RR
⑥ RPT

PHYS STATUS: 1 ② 3 4 5 E
BODY WEIGHT: 61 KG / LB
HEMATOCRIT: —
INITIAL DATA:
BP- 110 / 56
HR- 98
EQUIP CHECK
OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE? ✓
TIME- 0741

TIME → 0745 0800

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENTIL

VT - ml	850	800	500
f - breaths/min	6	6	14
Peak inf pres / PEEP	/	/	
MODE - S(pon), A(ssist), C(on)	SV - CV -	CV -	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	52	51	62
BP/oth	✓ FIO2 (Frac or %)	.73	.73	.73
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	✓ TEMP-site	Avail		
	✓ N-M Block (T/4)	4/4	0/4	4/4
Warming blkt				
Conv warmer				

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

RECOVERY AT 0820
PACU ICU ______ (Specify)
OTHER
CONDITION: [illegible]
RESP- 16 SpO2- 100
BP- HR- 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	~~0740~~ 0735	0826
	Ready	**Begin**	**End**
PROC	0742	0745	0756

PROCEDURES and CPT Codes:
EUA

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI c̄ DL x1 grade I view #8.0 ETT to 23 Lip #9 OA in — [illegible]

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] Ward 13B
b(6)-4

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: 1-1
DATE: 7 OCT 03
PAGE 1 OF

ANESTHETIST: [redacted] CPT CRNA

DA FORM 7389, FEB 1998 MEDCOM - 19072 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

Doctor's Orders—Post-OP

126th OP 4256

Nurse Complete	Dr.'s Select	
	☑	DATE: TIME:
	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
	☑	2. Diagnosis: [illegible]
	☑	3. Condition: ☐ Critical ☐ Guarded ☑ Stable ☐ VSI ☐ SI
	☑	4. Allergies: See SF 558
	☑	5. Vitals: ☑ Unit SOP ☐ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < ___ or > ___, RR < ___ or > ___, or Temp > ___
	☑	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
	☑	a. Propaq monitor w/ Pulse-ox
	☑	b. O_2 to maintain SAT's above 94%
	☐	c. ~~Maintain Vent~~ settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
	☐	d. ☑ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
	☐	e. ~~I's & O's~~
	☐	c. ~~Suction NT ETT PRN~~
	☐	d. ~~CT to ☐ H_2O seal~~ or ☐ Suction at _____
	☐	8. Diet: ☐ NPO ☑ Clear fluids as tolerated ☒ Other: ADAT
	☐	9. IV: ☐ NS or ☑ LR TRA 125 cc/hr until to OR ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ____ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
	☐	10. ~~BLOOD~~: ☐ T&S or ☐ T&C _____ units ☐ Transfuse _____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
	☐	a. ~~Tobramycin 300mg~~ IV Q12hrs X
	☐	b. ~~Clindamycin 600mg~~ IV
	☑	c. Cefazolin 1 gram IV 2 gm x 1 dose 1st dose @ 1730 hrs
	☐	d. Phenergan 12-25mg Titrate ☑ IV ☐ IM Q4hrs PRN nausea/vomiting
	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
	☐	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
	☐	i. Robinul 0.1mg IV X 1
	☐	j. ~~Zantac 50 mg~~ ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
	☐	k. Tetanus Immune Globulin
	☐	~~l. Toradol ☐ IV 30mg or ☐ IM 60 mg~~
	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		[redacted]
		Signature: [redacted]

LOG#

PT NAME: [redacted]

PT SSAN#: [redacted]

10JAN03

MEDCOM - 19073

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

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sept 03 | TIME OF ORDER: 1240 | HOURS | LIST TIME ORDER NOTED AND SIGN

Demaal 0.5 IV
x2 prn Shivers
MSO4 1-2 mg prn pain
upto 30 mg/24h b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

[redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

☆ U.S. GO MEDCOM - 19074 710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

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

DATE OF ORDER: 4 Sept 03 TIME OF ORDER: _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU 1
2. Dx: GSW (B) LE
3. Condition - stable
4. Vitals - per floor routine
5. Allergies - NKDA

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

6. Activity - Bedrest
7. Nursing notify MD for temp > 100.4, BP > 160/90 or < 90/50 RR > 25 or < 10 HR > 130 or < 50

b(6)-4

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

8. Diet - NPO
9. IVF - 125cc/hr CL
10. CABG ϕ
11. Meds - MSO4 2-4 mg IVP q 3-4 hr prn

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

[redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION b(6)-4

EPW # [redacted]

noted & transcribed 11Sep03 2102 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

- Admit to Floor / Hergate / ortho
- S/p I/D (R) leg, I/D (L) Fem + ex fix
- Stable
- Vitals / I&O's Routine
- NKDA
- ADAT to Reg.
- LR @ 100cc/h until tol po
- MSO4 1-3mg iv 20 min prn
- Percocet 1-II po q4° prn
- Tylenol 650mg po / PR q6° prn
- Phenergan 12.5mg IV q6° prn
- Lovenox 30mg SQ BID start AM 9/12
- Ancef 1g IV q8° x 6 doses post op — 8 16 24
- Zantac 150mg po bid
- PT consult: WBAT (R) LE, TTWB LLE, ROM (L) knee
- Routine call orders. b(6)-2

[redacted]

3rd Chart [redacted] b(6)-2 RN 11Sep03 2102 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

13Sep03 0710 OK

- OOB to chair BID at least.
- D/C Zantac

b(6)-2 [redacted]

b(6)-2 Noted [redacted] 13Sep03 1450

NURSING UNIT | ROOM NO. | BED NO.

3rd / 2135 13Sep03 [redacted]

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

☆ U.S.G MEDCOM - 19076 3-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

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

14Sept03 [illegible]
NPO
LR @ 100cc/
plan OR today for [redacted] I/D.
[redacted]
b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-2 [redacted]

DATE OF ORDER — TIME OF ORDER — HOURS

14Sept03
- Readmit to Floor S/P repeat I/D.
- Resume prep orders
ADAT to Reg
LR @ 100cc/° until tol po b(6)-2
AP/LAT (L) Femur [illegible]
[redacted]

NURSING UNIT | ROO[redacted] | BED [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 9-14-03 — TIME OF OR[redacted] 1400 HOURS

[redacted]

(1) Demerol 10mg IV PR[redacted] 9/14 1015
Post-op shivering max dose
25mg IV

[redacted] CRNA/MA ?
b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

DATE OF ORDER — TIME OF ORDER — HOURS

15Sept03 0830 b(6)-2
~~NPO p MN for OR tomorrow~~ eve
~~LR @ 100cc/° p MN~~ eve
Keflin? 1g IV q8° x3 [redacted] Team [redacted]
[redacted]
vitals q shift b(6)-2
D/C I/O's

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE [illegible]

MEDCOM - 19077

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 TIME ORDER NOTED AND SIGN

17 Sept 03 1918 — pin care BID c ½ str H2O2 - may leave pins & dressing. b(6)-2 — noted

V/O Dr [redacted]

may leave @ ankle actv [redacted] OTA. 2000. 17 Sep

NURSING UNIT | ROOM NO. | BED NO.

ICU — 0030 — 1 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER | TIME (HOURS)

[redacted]

21 Sept 03 0847 — Colace 1 po bid.

4/21/ 0813

NURSING UNIT | ROOM NO. | BED NO.

ICU

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER | TIME OF ORDER (HOURS)

25 Sept 03 0925 — D/C Lovenox. b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICU — 240 chart — 2345 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

27 Sept 03 0930 — Keppra 1g IV q8

b(6)-2

Noted [redacted] 2750 0925

NURSING UNIT | ROOM | BED NO.

[redacted] 9/29/03

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

MEDCOM - 19078

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 [redacted] b(6)-4

29 Sept 03 0922

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

AP/LAT (L) Femur today.

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ICW | 24° | 39 Sept 03 @ 2245

9/29/03 0923

PATIENT IDENTIFICATION

Noted + transcribed 10 Oct 03 1910 [redacted] b(6)-2

DATE OF ORDER | TIME OF ORDER ____ HOURS

- NPO p MN
- LR @ 100cc/' p MN.
- plan OR tomorrow for manipulation knee

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

2A | [redacted] | 14 | 10 Oct 03 1910

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted] 10 Oct 03 1000

DATE OF ORDER | TIME OF ORDER ____ HOURS

10-8-03 | 1600

- XR AP + LAT @ femur
- DC pt to EPW comp. b(6)-2 [redacted]

SGCT

NURSING UNIT | BED NO.

10 Oct 03 1000

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 19079

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 TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				07 OCT 03 0800 Readmit to Floor Regular diet LR @ 100cc/hr until tolerating PO Resume prep orders/meds XRAYS AP/LAT @ Femur today	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER / HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER / HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

b(6)-2 All

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. 9 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 21 22 23 24
9/11	[redacted]	Vitals per P/R	06	
		Routine	18	
			18	
9/11	[redacted]	Activity – Bedrest	06	
			06	
			18	
			18	
9/11	[redacted]	Nursing: notify MD	06	
		for temp >100.4	18	
		B/P >160/90 or <90/50	18	
		RR >25 or <~~8~~ 10	/	See rewritten order below)
9/11	[redacted]	Diet NPO	/	
			06	
9/11	[redacted]	Nursing: notify MD	18	
		for temp >100.4	18	
		B/P >160/90 or <90/50	06	
		RR >25 or <10	/	
		HR >130 or <50	/	
			/	
9/11	[redacted]	Vitals/I&O Foley	18	
			18	
			06	
			06	
			18	
			18	
			06	
9/15	[redacted]	OOB to chair BID &	06	
		least	18	
14	[redacted]	~~NPO~~ ADAT to	06	
		No	18	
9/15	[redacted]	Vitals q shift	06	
			18	
			06	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW BLE S/P I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

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

MEDCOM - 19081

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sept Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/11	[redacted]	Admit to ICU, Stable	9/11	—		[redacted]
9/11	[redacted]	Labs @	9/11	noted		[redacted]
11Sep	[redacted]	Admit to floor/Hugate/Ortho	11Sep03	—		[redacted]
11Sep	[redacted]	Stable	11Sep03	—		[redacted]
11Sep	[redacted]	PT consult: WBAT @ LE,	11Sep03	—		[redacted]
	-----	FTNWBLLE, ROM @ knee				
11Sep	[redacted]	Routine call orders	11Sep03	—		[redacted]
14	[redacted]	Plan OR today for repeat I+D				
14	[redacted]	NPO				
14	[redacted]	Readmit to floor, resume prep				
	-----	orders, ADAT to regular				
14	[redacted]	AP/LAT @ bemis in AM	PostOp			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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USAPA V1.00

b(6)-2 A11

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. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19 20 21 22 23 24 25 26 27 28 29 30 1
13Sep	[redacted]	OOB to chair BID @ least.	06 18	[redacted]
14Sep	[redacted]	Regular diet	06 18	[redacted]
15Sep	[redacted]	VS q shift	06 18	[redacted]
17Sep	[redacted]	pin care BID c 1/2 Sterile H2O2 may leave pins 5 dr sg./may leave (R) ankle sutures open to air.	10 20 / / /	[redacted]

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: GSW (B)LE — 5pI+D (L) thigh ex-fix.

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

PATIENT IDENTIFICATION:

[redacted] 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

MEDCOM - 19083

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
9/09	[redacted]	AP & LAT (L) Femur	[redacted]				

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

USAPA V1.00

b(6)-2 A11

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 0 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9
13 Sep	[redacted]	OOB to chair BID (at least) (recopied)	06	[redacted]							
			18								
14 Sep	[redacted]	Reg diet (recopied)	06	[redacted]							
			18								
15 Sep	[redacted]	VS q shift (recopied)	06	[redacted]							
			18								
17 Sep	[redacted]	pin care BID c. 1/2 sterile H_2O_2. May leave pins & dsg. May leave (R) ankle sutures open to air (recopied)	10	[redacted]							
			22								

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
R SW (R) LE S/P I&D (L) thigh exfix

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

PATIENT IDENTIFICATION:
[redacted] 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

D(a)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Oct	[redacted]	NPO p MN	7Oct03	0001		[redacted]
6Oct	[redacted]	Plan OR tomorrow for manipulation	7Oct03			
	----	OR knee				
06 Oct03	[redacted]	XR AP & LAT @ femur	06 Oct03			
06	[redacted]	D/C pt to EAW camp				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
----	----															
----	----															
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USAPA V1.00

b(6)-2 A11

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. 09 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11 12 13 14 15 16 17 18 19 20 21 22 23 24
9/11	[redacted]	LR@100cc until	6	X [redacted] D/C
		~~TOL - PO - to~~ PO	18	
11sep	[redacted]	Lovenox 30mg SQ	10	X [redacted]
		BID (START 9/12)	22	X
11sep	[redacted]	Zantac 150mg PO BID.	10	X [redacted] > D/C 13SEP03
			22	
11sep	[redacted]	Kefzol (Ancef) 1gm IVQ8X6 doses post-op.	08	X [redacted]
			16	
			24	X
15Sept	[redacted]	Kefzol (Ancef) 1gm q 8° x3 doses	08	[redacted] > auto d/c
			16	
			24	
9/21	[redacted]	Place T po bid	10	[redacted]
			22	
9/11	[redacted]	HL when tol PO	9/e 18	[redacted]
			18-06	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW (B) LE S/P I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted]

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

MEDCOM - 19087

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
13 SEP03	[redacted]	D/C Zantac	13 SEP03	———	———	[redacted]

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 SEP03	[redacted]	MSO4 1-3 mg IV q20min PRN	D/T	I	11Sep 2030	11Sep 2130	11Sep 2300	12Sep 0320	12Sep 0400	12Sep 0440	12SEP 0905	13Sep 2215	15 0045	15 0530		
-----	-----				2mg	2mg	2mg	2.5	2.5	3mg	3mg	3mg	3mg	3mg		
			[redacted]													
11 Sep	[redacted]	Percocet i - ii PO Q4 PRN	D/T	13SEP 1510	15Sep 2315	16Sep 1115	16Sep 1545	16Sep 2140	17Sep 08[illegible]	17Sep 2200	18Sep 1010	18Sep 1933	18Sep 1500	19SEP 1030	19SEP 1635	19 2320
-----	-----		D/I	ii KPS	ii	ii	ii	ii	[illegible]	ii	ii	2	2	ii	ii	ii
					[redacted]											
11 Sep	[redacted]	Tylenol 650mg PO/PR q6 PRN	12Sep 000[illegible]	17SEP 1905												
-----	-----		650	ii [redacted]												
11 SEP03	[redacted]	Phenergan 12.5mg IV q6 PRN														
-----	-----															
11 SEP	[redacted]	Percocet i - ii PO	D/T	21Sep 0530	21Sep 1730	21Sep 2200	22 0210	9/22 1040	9/22 1615	9/22/03 2030		23SEP 0915	23SEP 1235	23SEP 1945	03 /	24SEP 1005
-----	-----	Q4 PRN	D/T	ii BR	2mg [illegible]	BR ii	BR ii	gp ii	gp ii	RD ii		KPS ii	KPS ii	ii RD	/	ii KPS
11 Sep	[redacted]	Percocet i - ii	D/I	24 2330												
-----	-----	PO Q4 PRN	D/T	ii [redacted]												
-----	-----															

USAPA V1.00

MEDCOM - 19088

b(6)-2 All

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 09 Yr 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26 27 28 29 30 1 2 3 4 5 6 7 8
11 Sep 03	[redacted]	Lovenox 30mg SQ BID (start 9/12)	10	02 < D/Ced 25 Sept 03
			22	
21 Sep 03	[redacted]	Colace 1 po BID	10	[redacted]
			22	
11 Sep 03	[redacted]	HL when tol po (flush q shift)	06	
			18	
27 Sep 03	[redacted]	Kefzol 1gm IV q8°	06	//
			14	//
			22	//
6 Oct 03	[redacted]	LR @ 100cc/° p MN	06	[redacted]
			18	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW BLE S/P I/D

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

PATIENT IDENTIFICATION:
[redacted]
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

MEDCOM - 19089

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 All				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED												
11SEP03	[redacted]	MSO4 1-3mg IV q20 min prn	D/T	7OCT 0920												
			D/I	3mg												
11SEP03	[redacted]	Percocet i-ii po q4° prn	D/T	24SEP 1615	25Sep 1515	25Sep 2110	26Sep03 1915		27Sep 1655	28Sep 2005	29Sep 2330	1Oct 0220	1Oct03 2230	2Oct03 2200	3Oct03 2202	5OCT 0224
			D/I	ii KPB	ii	ii [redacted]	ii		2	2	ii	i	ii	ii	ii	2
11SEP03	[redacted]	Tylenol 650mg PO/PR q6° prn	D/T	25Sep 1000	27SEP 1055											
			D/I	650	650mg [redacted]											
11SEP03	[redacted]	Phenergan 12.5mg IV q6° prn	D/T	7OCT 12.5mg												
			D/I	0920												
1Sep03	[redacted]	Percocet i-ii po q4° PRN	D/T	7OCT 0920												
			D/I	ii [redacted]												

USAPA V1.00

MEDCOM - 19090

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9/11 Anesthesia Type (Circle): General Spinal Epidural
Time In: 1750 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 1500 NS Colloid
Pre-op V/S: 115/63 90 OR Output: UOP 0 EBL MIN
Procedures: Ex Fix to left femur Meds/Times: Ancef 1gm 1545

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

Pre Op Meds History

Time	1750	1755	1800	1815
SaO2	99	98	99	95
FiO2	RA			
Methods	GW	RA	RA	RA

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RR	21	20	20	14
T	98.4			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1830	NAcLR	400	L2 FA		

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	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes

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

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

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

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

Time	
Pain (0-10)	
LOS	

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)

[redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC: PACU DATE: 11 Sep 03

PAT[redacted]ve: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1800	—	Demerol 12.5	IV	—	—	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R leg	+	+	P	B	W	PK
15'	R leg	+	+	P	B	W	PK
30'	R leg	+	+	P	B	W	PK
45'							
60'							
90'							
D/C	R leg	+	+	P	B	—	PK

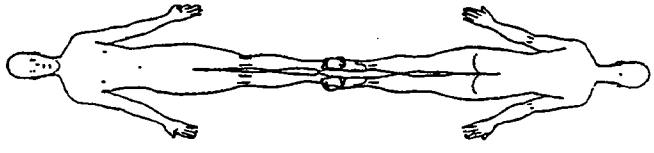
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ex fix left leg	Kerlex	MIN
30'	ex fix R leg	Kerlex	MIN
60'			
D/C	ex fix L leg	Kerlex	MIN



PACU OUTPUT

Time	Source	Color/Appearance	Amount
Ø			

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1850	TSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Received pt from OR. Sats 69%. Put pt on 10L FM sats ↑ 100%. Took pt off of O2. Pt sats 98% RA 12.5mg Demerol given for Shivering

b(w)-2 A11

Discharge Criteria:
Date: 1/Sep 03 Time: 1820 PARS: 10
BP: 134 T: HR: 86 RR: 14 Sa02: 94
Pain Level at D/C (0-10):
Intake: _____ Output: Ø
Additional Data: _____
Transferred To: ICW #1
Report Given To: _____
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: SgT [redacted]
Cleared IAW Recovery Ro[redacted]
Charge Nurse Signatur[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

MC88

OTSG APPROVED (Date) 6/1/03

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

Date: ______ Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1353

Allergies: NKDA OR Intake: Crystalloid 600 Colloid ______

Pre-op V/S: 106/54, 96 OR Output: UOP Ø EBL 150

Procedures: ______ Meds/Times: [illegible]

[illegible]

Pre Op Meds ______ History ______

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

Time	1355	1400	1405	1415	1425	1430	1440
SaO2	98	100	100	100	100	95	95
FiO2	2L	2L	[illegible]	[illegible]	RA	RA	RA
Methods	[illegible]	[illegible]	[illegible]	[illegible]			
RR	10	20	12	10	8	12	14
T	10[illegible]						

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Time	1355
Pain (0-10)	
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	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	9

Codes

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

V/S: X = A-line BP, ˅ = 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 X2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED BY [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: [illegible]/ICU

DATE: 14 SEP 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1420	—	[illegible]	IV	—		[redacted]

NURSING NOTES

(B) LE 70D w/ (+) 3+ pulses to (B) extremities. Cap (B). [illegible] [illegible] [illegible] of [illegible]. [redacted] 1420

1420: Pt continues to be [illegible] sedated, VSS. Sats 95-100% on room air. Will continue to monitor. [illegible] to take a deep breath. [redacted] 1420 [redacted]

Pt 1440: [illegible] [illegible]. [illegible] [illegible] [illegible]. Will [illegible] to 1440

b(6)-2 All

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(B) LE	—	+	P	<3	W	nml
15'							
30'							
45'							
60'							
90'							
D/C							

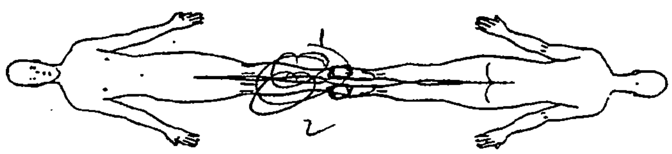
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) LE / (R) [illegible]	Gauze	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 9/1/02 **Time:** 1440 **PARS:** 9
BP: 109/62 **T:** 101 **HR:** 95 **RR:** 12 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 100 cc **Output:** Ø
Additional Data:
Transferred To: ICW2
Report Given To: [illegible]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] 1470

WAMC OP 173-E

MEDCOM - 19094

ACLU-RDI 1650 p.54

DOD-032668

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 7 OCT 03
Time In: 0820
Allergies: NKDA
Pre-op V/S: 116/76 98
Procedures: knee manipulation

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 0 EBL
Meds/Times: Fentanyl ; versed (MARCAN)

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	0820	0845	0915	0945
SaO2	100	100	100	
FiO2				
Methods	RA	RA	RA	
240				
220				
200				
180				
160				
140				
120				
	V	V	V	V
100				
80				
60				
40				
20				
RR	17	14	13	
T	95			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0820	LR	200	L hand	OR	200

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	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes

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

V/S
X = A-line BP
" = 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: [redacted] b(a)-2 LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 Oct 03

PATIENT'S [illegible] entries give: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] b(a)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 19095

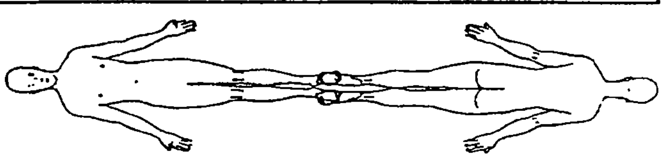
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) leg	ext fix	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0820	SR	Ø	Ø

NURSING NOTES

Pt to recovery room from OR via litter s/p (L) knee manipulation, ext fix intact. IV of LR infusing into (L) hand. Ø s/s of redness or swelling. VSS. Will continue to monitor [redacted]
0820 ICW#1 — [redacted]

b(6)-2 All

Discharge Criteria:
Date: 7 Oct **Time:** 0845 **PARS:** 9
BP: 113/68 **T:** 95.7 **HR:** 93 **RR:** 17 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: 100 **Output:** Ø
Additional Data:
Transferred To: ICW#1
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted]ey **Ambulance**
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
[redacted]se Signature: [redacted]

WAMC OP 173-E

MEDCOM - 19096

ACLU-RDI 1650 p.56

DOD-032670

[redacted]

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.	A
10 Sept 03 1700	[redacted]	
3. NAME [redacted]	4. DATE OF BIRTH b(6)-4	
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] b(2)-2		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.	B
10 Sept 03 1700	[redacted]	
3. NAME [redacted]	4. DATE OF BIRTH b(6)-2	
5. RANK		
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] b(2)-2		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. [redacted]	C
10 Sept 03 1700	[redacted]	
[redacted]	4. DATE OF BIRTH b(6)-2	
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE [redacted] b(2)-2		
10. [redacted]		

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED

[redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	ZZ	[redacted]	[redacted] b(6)-2	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted] Z	32Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
Z	Z	~~99~~ 80	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1410	b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø5		031008

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030911

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

FOR LOCAL USE

DX: (1) GSW (B) LE

(2) S/P I+D (L) THIGH EX-FIX (open (L) Femur fx)

[redacted] b(6)-2

ADMITTING OFFICER (Signature) [redacted] CPT

SIGNATURE OF ADMITTING [redacted]

DA FORM [redacted]

MEDCOM - 19098

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME [redacted] b(6)-2			3. GRADE CIV	ADMISSION REMARKS
4. SEX m	5. AGE 40Y	6. RACE X	7. RELIGION Unk	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION b(6)-2			14. WARD ICW2
15. FLYING STATUS —	16. RATING/ OSG —	17. DEPT./ BEN —	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct (EE)				22. HOURS OF ADMISSION 0824	23. CLINIC SERVICE general surgery	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION O/C HOME	26. DATE OF DISPOSITION 19Sept03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 15Sept 03	ADMITTING OFFICER [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]					30. DATE OF INTIAL ADMISSION 15Sept 03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED [redacted] b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

grade II liver laceration

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
0	0	0	0	5	5

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
0	0 b(6)-2	0	0	5	5

SIGNATURE OF ATT[redacted]

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

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

[redacted] b(6)-4

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE	TIME OF DISCHARGE
19Sep03	1000

SIGNATURE OF WARD OFFICER

[redacted] MAJ/AN b(6)-2

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	[redacted] b(6)-2
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR
19Sep 03	[redacted] b(6)-2

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

15 Aug 1315

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 y/o Iraqi civilian struck by frag from IED ~ 15 M away ~ 0700, brought to EMT, rec'd tet tox ER
Med ō allergies Sh
PMH:

PHYSICAL EXAMINATION

PE: 120/70 90 afeb R 20
HEENT ⊖, poor dentition
chest - clear b/l cx RRR s/ⓜ
abd - generally soft by tense recti ō resp'n, c/o pain ō palpation RUQ
BS+
back - slight Ⓡ CVA tenderness
pelvis - stable
extr - move all

PROGRESS (Enter date of discharge and final diagnosis)

Hct 47 WBC 19 130 | 104 / 3.7 | 26 glu 129 cr 1.2 alb 3.3 AST 77 ALT 83 (10-47) amyl 98
plt 205
U/A 1030 SG trace blood

CXR - frag Ⓡ thoracoabd
CT - tract from entry wound, thru Ⓡ lobe liver, into SQ post. Bilat.. ablated, ō evident hemo, ō free air or fluid in abd, admit for obs + AB's

SIGNATURE [redacted] /C DATE 15 Aug

b(6)-2

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.

[redacted] b(6)-4

[redacted]

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45 505
OCTOBER 1975
USAPPC V1 00

MEDCOM - 19101

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Sep '03	Discharge Note Admit 18 Sep - Dict 19 Sep Dx - grade III liver lac (R) lobe liver Follow-up 1 week 26 Sep ER Pt a 40 y/o M injured ~0700 18 Sep arrived ER 1300. Exam revealed stable Pt c wound Anterior Axilla line (R) side ~ 7th IS. Pt had moderate pain in (R) lower anterior chest and (R) UQ CXR (-) Lot 47 WBC 19 'lyte + pH-T's normal CT abdomen revealed a posterior pair of fragments from anterior thru lateral (R) lobe into soft tissues - subcutaneous - posteriorly (not able to palpate frag) Pt received gent 400 mg daily + Ancef 1gm q8h x 48hrs then switched to po cipro 500 mg po q12h. His WBC progressively decreased to 9.1 - 9.2 by 3rd day. He has remained afebrile throughout his course. His bilirubin increased to 3 on the 16th and has remained there but his GGT remain normal, ALT ~ 58-60. A repeat CT on the evening of the 16th revealed no change in tract - there was ~~not~~ no extracapsular blood, no free blood in abdominal cavity. The patient is eating well and has minimal pain and c/o →

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)*

[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ambulatory. He is discharged to be followed up in 1 week, and will continue ciprofloxacin 500 mg po q 12h for 6 more days - ~~total~~ 10 days AB;
	[redacted] MD LIC
	[redacted] LIC
	b(a)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15Sept03	pt arrived via Medevac, ? injury / incident per
@0825	interpreter. Arrived AxOx3, grunting
	& holding (R) side. Pt c small 1/2 inch
	shrapnel wound to (R) rib area, lungs CTA
4L	O_2 placed immediately & on full monitor
	pt stable, see VSS for VS. [redacted]
@0830	labs drawn & sent. pt to have [redacted]
	done. Fast exam - limited (-). No other
	injuries noted. 50mcg fentanyl given for pain.
@0900	pt calm, lying flat, talking c interpreter
	Anaf 1 GM complete administered. Td
	shot given IM on (R) deltoid. waiting for
	CT [redacted] SCAN [redacted]
@0910	pt transferred to CT Scan, O_2 [redacted]
	pt 97% RA, appear in no apparent
	distress [redacted]
@1000	pt back from CT Scan, tolerated [redacted]
@1145	pt waiting for transfer to Iraqi hosp [redacted]
	arranged by PAO. pt grunting & holding [redacted]
	(R) side, 50mcg fentanyl given [redacted]
@1205	pt lying flat in NAD, VSS
@1205	Iraqi ambulance here for transfer [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MA[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	[redacted]

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.

[redacted] b(6)-4

Iraqi Civilian

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

b(6)-2
All

MEDCOM - 19104

b(2)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
@1405	pt arrived back @ [redacted] p Iraqi
	hospital refused patient. ~~Am~~ pt placed back
	in EMT, pt alert, VSS ~ see 558. 1200cc clear,
	yellow urine in foley. 2, 18g IV still in place in
	each AC. PAD notified, admission [redacted]
	initiated ———

b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
☆ U.S. GPO:1998-432-786/75236

MEDCOM - 19105

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Sep 03	S) 40 year old male Iraqi civilian s/p IED injury to
	(R) lower anterior chest wall w/ complaint of
	localized abd pain mild (R) scapular pain
∅ímmy	
∅ρικ	O) mild pain, A O x 3 BP 122/70, HR 86
NKDA	mmm 99% RA, 16
∅mes	∅ cervical, midline
	CTAB. (R) BS
	RRR pulm
	soft, ND TTP w/ small entrance wound
	∅ Back injury
	M 6x. (+)IAFD
	small abrasion (R) RA CXR. ∅ FRAir
	∅PTX
	~~∅ hemothorax~~
	A/P (R) RUQ peritoneal penetrating injury
	Mod 4mg IV L
	wagon 3g IV —
	wound cleaned & dressing
	TO CSH.
	[redacted] b(6)-2
	[redacted] MAJ, MC

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.

[redacted]

[redacted] 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 - 19106

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug '03	0900
	40 y/o ♂ c IED in ~2h ago, brought to EMT, c/o pain (R) lower ant chest/(R) upper ant abd
	Med ō all ō PMH (-)
	PE: 122/70 80 97%
	HEENT (-), poor dentition
	neck (-)
	chest - bil BS
	cv - RRR
	abd - generally soft, tender rectus c rebd'n extreme worst ~ 6th IS AAl
	pelv - stable
	extr - move all
	CXR - (R) lower thorax abd
	P - CT [redacted] b(6)-2
18 Aug 1000	Frag entered ~ 7th IS, AAh, passed thru (R) lobe liver, + is lodged in patient SQ; ō free fluid or free air; atelectasis lower bilateral
	Hct 45 WBC 19.4 a. 1.2 amylase 98
	130/104 BR 1.5 ALT 83 (10-47)
	3.7/26 ALP 49 nl
	alb 3.3
	A - gr II lives bx b(6)-2
	P - transfer to Aegis Hosp for cont'd [redacted] antibiotics MD LTC

STANDARD FORM 600 (REV. 6-97) BACK

[redacted] b(6)-4

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15SEP03	SURGERY
0750	40 y/o ♂ c hx of Improvised Explosive Device shrapnel injury to RUQ abdomen / (R) low chest. Pt. c/o pain RUQ. No dyspnea / SOB. No other injuries to 2° survey. CXR obtained (upright AP) s evidence of HTX / PTX, SpO_2 98% ORA, phonating, mentating well.
	SBP 120-130, HR 88.
	Local wound exploration @ bedside shows ½ cm entrance wound @ 8 cm inferior to (R) nipple.
	Foley placed. DRE (-). 8 guage IV x 2.
A:	RUQ penetrating abdominal wound. Pt's VS stable for transport.
P:	Transfer to CSH, possible ex lap.

b(6)-2

[redacted]

CPT MC M.D.

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.

[redacted]

[redacted] 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 - 19108

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Sep	0700
	S- ↓ pain
	O- afeb
	BS clear
	abd (+) BS
	ten tender RUQ
	hct 44 WBC 12.6 plt 200 132/100 9 1,2
	CXR-nl 44/22
	A- stable
	P- reg diet DC foley if stable dischg c AD's 17 Sep
16 Sep 1930	IV DC'd, switch to po TB's
	Tolerated diet well
17 Sep	1100
	chest clear, 1+/4 pain RUQ, abd soft
	WBC 9.3 Hb 14.5 plt 188
	BR 3.0 Alk T 18 amyl 15 ALT 68 ALPS,
	A- likely resolving hematoma c nl ALT, but c lo grade
	Temp p beg afeb, will watch 24 h

b(6)-2 All

[redacted]

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

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

MEDCOM - 19109

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Sep	2100
	CT ō [illegible], ō air in tract ō fluid in Morrison's pouch,
	minimal (R) pleural effusion
	P- cont obs re √ lab
	[redacted] b(6)-2
18 Sep	0630
	S- feels better
	O- ↓ BS present bil, slightly ↓ (R) base laterally afeb
	abd soft, minimal RUQ pain
	diet [illegible]
	Hct 48 WBC 9.1 plt 211 cr 1.2 BR 3.5↑ AST 26
	ALT 58↓ ALP 51
	A- stable GGT 20
	P- obs x 48h +
	[redacted] b(6)-2

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT** *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: IRAQI CIV

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 15 Sep 03 | TIME: 0824

TRANSPORTATION TO FACILITY: MEDEVAC

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
40	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?			WHERE		TETANUS
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: Shrapnel (R) chest

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0824

IN: [redacted] b(6)-2

VITAL SIGNS

TIME	0824	0847	0935	1200	1155	1400
BP	124/77	125/59	110/57	114/55	120/55	112/69
PULSE	79	77	74	76	78	80
RESP	18	22	18	20	18	20
TEMP	97.8 (A)					
WT	98%	99%	98%	97% RA	98%	94%

LAB ORDERS

- X CBC/DIFF | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT
- URINE C&S | UA MSCC/CATH | X CHEM: 12 C lytes
- X BLOOD C&S X ~~2units~~ T&S

X-RAY ORDERS

- CXR PA & LAT/PORTABLE | C-SPINE
- ACUTE ABDOMEN | LS SPINE
- SINUS | HEAD CT
- ANKLE R/L | ~~X~~ KUB ~~X~~ CT Scan - Abdomen

ORDERS

X PULSE OX 94% X MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	50mcg Fentanyl IV	[redacted]	@0840		75mcg Fentanyl IVPB @ 1145 for pain
	1GM Ancef IV IM	@0836	@0858		
	60mg Fentanyl IV		@1012		

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

TIME OF RELEASE

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)

IRAQI CIV

[redacted] 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)
USAPA V1.00

MEDCOM - 19111

NSN 7540-01-075-3786

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

TEST RESULTS

LFT's - mild ↑

CBC: WBC 19; H/H 15/47; PLT 205

SMAC: 130 | 104 | 16; 3.7 | 26 | 1.2; 129

PT

APTT | BHCG | ETOH | GLU

ABG/PULSE OX: SUP O2 | PH | PO2; PCO2 | SAT | OTHER

UA: DIP (2+); MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS: CXR: ⊖ PTX or HTX

EKG INTERPRETATION: CTAB - Grade 2 liver laceration

PROVIDER HISTORY/PHYSICAL

pt arrived 4x0x3 per interpreter, c/o Ⓡ rib/abdominal pn. ? shrapnel to Ⓡ rib, no other injuries noted. pt arrived c foley in place, 2 IVs in Ⓛ/Ⓡ AC c 1500cc fluid in. Lungs CTAB

3. Alert, NAD, GSC = 15

HEENT - ⊖ apparent injuries.

Neck ⊖ injuries

Lungs - CTAB

Abd - soft, non-distended, min. tender

Chest Ⓡ shrapnel wound c 3-4mm ant. axilla line @ T7 Ⓡ side

Extrem ⊖ injury Back ⊖ ext wound.

FAST exam - limited; unable to visualize Ⓡ kidney well; Ⓛ side ⊖ fluid/injury.

P:

Transfer to Role 2 hospital for observation

CONSULT WITH	TIME	ACTION

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

MAJ MC

AND STAMP FM/Specialty [redacted] (b)(2)-2

DIAGNOSIS

A: shrapnel wound as detailed above pt stable

CODES

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

[redacted] IRAQI CIV

b(6)-4

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 1

TRANSFER

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

Time 1455 To ICW#2 From EMT ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time 48 hrs Physician ______ Anesthesia (Specify): ______

Procedure/Diagnosis Liver lac (level II) B/P 112/61 P 80 R 20 T 97.9 98% RA

LOC AAOx3. No English Neurovascular checks ______

Dressing/cast RUQ entrance wound. Tubes IV, Foley

Intake (IV, po) ______ Output (EBL, other) ______ Voided ☒ No ☐ Yes Amount: N/A

Medication [illegible] early AM.

Other S/P IED explosion. Labs OK. Tetanus

Report From CPT [redacted] 14 Sept b(6)-2 Received By LT [redacted] b(6)-2

VITAL SIGNS

TIME:	1600	2000	0400													
BP ARTERIAL LINE																
BP CUFF	100/60	116/64	48/68													
TEMPERATURE	99.5	97.9	99.0													
PULSE	68	108	76													
RESPIRATORY RATE	18	18	16													
OXYGEN (L/%)																
PULSE OXIMETER	98%	96	96													
O_2 METHOD	RA	RA														

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:	1500	2000	2230						
PAIN INTENSITY (0–10)	2	1	5, 3						
MED ADMINISTERED (Y/N)	N		Y						
RELIEF ACCEPTABLE (Y/N)			Y						
MSO4 5mg			5mg						

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	N/A	NA
*Falls prevention protocol	↓	↓
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA
TODAY'S WEIGHT: ↓
WEIGHT CHANGE:

*Per hospital policy.

OTHER

TIME:	1500							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)	↓							

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

PATIENT IDENTIFICATION
[redacted] b(6)-4

DIAGNOSIS: Liver lac
DRG: ______ ADMISSION DATE: 15 Sept 03
LOS: ______ EXPECTED RELEASE: ______
CASE MANAGER: ______
PRIMARY CARE MANAGER: ______
ISOLATION REQUIRED (Specify): ______

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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. D(e)-2

	TIME: 1800 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	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.	☑	☑	☐
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)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
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.	☑ ~~X~~ TTP @ liver lac site.	☐ pain ~ palpation @ liver lac site	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley to gravity ~ clear yellow urine.	☐ Foley to gravity ~ clear yellow urine	☐
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.	☐ OOB ~ assist	☐ OOB ~ assist 2° to pain	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ ~~X~~ liver lac.	☑ Dsg to (R) UQ CD (to liver lac puncture site	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ 5/10 pain MS04 for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: AW	TIME: INITIALS:
IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: assessed	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK	IV Site #1:
IV Site #2:	IV Site #2: (L) AC / OK	IV Site #2:
Comments: LR @ 100 cc/hr.	Comments: LR @ 100 cc/hr to (R) AC; (L) AC HL	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: LSO	TIME: 1500	2230					
COLOR	MA	NA					
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	E	2230
ID band visible/legible	AS	AW
Orient to environment prn	AS	AW
Side rails (2/4) up	N/A	NA
Bed position low		
Call light within reach		
Review & post lab results	AS	AW
Notify MD abnormal labs	AS	AW
Incontinent urine/stool	NA	NA
Linen change prn		
Turn/reposition q2h		
ROM q2h if immobile		
Antiembolic hose	✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: CC
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME:	INITIALS:	TIME: 2230	INITIALS: [redacted]
CONTENT:		CONTENT:		CONTENT: - Pain management - Fluids via IV - Encourage PO fluids	
☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	b(6)-2 SIGNATURE	SHIFT
CIV [redacted] b(6)-4	[redacted]	/OTAN	F
		AW/AN	22-06

MEDCOM - 19115

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1400	® upper flank over lac	Dsg CDI	Dsg Δd 2° Blood soaked bandage
	2230	® UQ	Dsg CDI	assessed

SECTION IV - NOTES

1500: Pt. tx to ward from EMT via litter c unknown allergies. IV to ® AC c LR @ 100cc/hr. IV to ⓛ AC HL. Foley to gravity draining clear yellow urine. Pt. stable. Will cont. to monitor [redacted]

15 Sep 03 2230 Pt sleeping, easily arousable c verbal stimuli. C/O pain to abd ®LQ/®UQ c palpation. Given Mscl for pain. Will cont to monitor [redacted]

b(6)-2 All

MEDCOM FORM 689-R (TEST) (MC), MAR 99

Page 4 of 4 pages

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16Sep03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 0 | HOSPITAL DAY: 2

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☒ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia *(Specify)*: _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From [redacted] Received By _____

VITAL SIGNS

TIME:	1000	1650	2000	0400												
BP ARTERIAL LINE	/	/		/												
BP CUFF	107/57	114/60	110/80	123/66												
TEMPERATURE	97.9	99.4	98.9	99.5												
PULSE	71	67	83	71												
RESPIRATORY RATE	16	16	16	18												
OXYGEN (L/%)	/	/		/												
PULSE OXIMETER	96	98	98%	95												
O_2 METHOD	RA	RA	RA													

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:	1600	2000	2330							
PAIN INTENSITY (10 / 5 / 0)	0	A								
MED ADMINISTERED (Y/N)	N		N							
RELIEF ACCEPTABLE (Y/N)	N/A		NA							

OTHER

TIME:	1600	2330								
FINGER STICK GLUCOSE	N/A	NA								
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	900	1600	2230
*Skin breakdown prevention	☐	N/A	[redacted]
*Falls prevention protocol	NO		
*Restraint protocol	NO		
*Seizure precautions	NO		
*Isolation precautions	NO		

YESTERDAY'S WEIGHT: N/

TODAY'S WEIGHT: ND

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] blw-2

DIAGNOSIS: Liver lac

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

ARE MANAGER: _____

MEDCOM - 19117

ISOLATION REQUIRED (S...

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(a)-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☑	☑
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)*	☐	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
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.	☐ upper LQ tenderness to deep palpation	☐ RUQ TTP, dsng from liver lac CDI	☐ Pt rebound pain to RUQ & LLQ palpation
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley D/C	☑	☑ Foley D/C voiding to urinal
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.	☐	☐ X RUQ liver lac, dsng CDI	☐ Dsg to RUQ puncture site CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☑	☑

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

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided: ✓	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: R AC 18G	IV Site #1: CVL OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: IVF @ 75cc/hr	Comments: ø IV access

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1600	1600	2230			
COLOR	N	N/A	NA			
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	E	2230
ID band visible/legible	[redacted]	
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

Review & post lab results			[redacted]
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		[redacted]
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile	[redacted]		
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: CLEAR FLUIDS	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 100%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED: WELL	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☒ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST (AMBULATE) BSC BRP CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST (AMBULATE) BSC BRP CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1800 INITIALS: [redacted]	TIME: 2230 INITIALS [redacted]
CONTENT: TO EAT [redacted] TO ASK FOR PAIN MED IF NEEDED	CONTENT: -pain management -ambulate & assist	CONTENT: -Pain management -Ambulate & assist -call for assistance
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ (Patient)/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted] b(4)-1

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]		1600-2
	UT/AN	E
	UT/AN	2230

SECTION III - INTERVENTIONS & TEACHING (Cont.)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		RPC BELOW THORACIC CAVITY		PSG. W/D DRY
	1600	RUQ	DrsngCDI	assessed
	2230	RUQ	Dsg CDI	assessed

SECTION IV - NOTES

1100 Pt advised to ambulate. Pt had foley D/C. IV reduced to 75cc/hr. Pt encouraged to eat & assess tolerance for food, & ambulate as tolerated PO fluids. Pt D/C [illegible] removed [illegible] day by MD. [illegible] 91WM6
1345 Pt ate clear liquid diet, tolerated diet well. [illegible] Pt asleep most of the time. Pt voided [illegible] and [illegible] ambulated to bathroom — [redacted] [illegible]
16Sep03 2230 Pt awake and alert. [redacted] except palpation to Ⓡ UQ & Ⓡ LQ. Tolera[redacted]g clear liquids. Will do labs in am and continue to monitor — [redacted] LT/AN

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 3

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	0800	1200	2000	2400											
BP ARTERIAL LINE	/	/														
BP CUFF	123/60	/	114/69	125/76	111/68											
TEMPERATURE	99.5	99.6	98.5	97.9	98.8											
PULSE	71	/	79	92	74											
RESPIRATORY RATE	18	/	16	18	16											
OXYGEN (L/%)	Ø	/		-												
PULSE OXIMETER	95	/	96	96	96											
O2 METHOD	RA	/	RA	RA												

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:	0600	2000	2230						
PAIN INTENSITY (10 / 5 / 0)		X							
MED ADMINISTERED (Y/N)	N		N						
RELIEF ACCEPTABLE (Y/N)	N/A		NA						

OTHER

TIME:	0600	1500	2230						
FINGER STICK GLUCOSE	N/A	N/A	NA						
INSULIN (Y/N)	N/A								

SPECIAL NEEDS

TIME:	0600	1500	2230
*Skin breakdown prevention	N/A	N/A	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

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

Civ # [redacted] b(a)-4

DIAGNOSIS: grade II liver lac

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

CARE MANAGER: _____

MEDCOM - 19121

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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 0600 INITIALS [redacted]	TIME [redacted]	TIME: 2220 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ language barrier	☐	☑ b(6)-2 All
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑ RUQ dsg CDI	☐ RUQ puncture to liver	☐ Dsg to (R) UQ puncture site
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
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.	☑	☑	☐ (R) UQ puncture site affecting liver, dsg CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/o sm amt of pain to liver puncture	☐ moved to RUQ 2° shrapnel	☐ C/o pain to palpation and ambulation
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: _____ INITIALS: _____	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: ~~0 access~~
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0600	E	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up		X	NA
Bed position low			
Call light within reach			
Review & post lab results			[redacted]
Notify MD abnormal labs			
Incontinent urine/stool			NA
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

	0700-1500	1500-2300	2300-0700
TIME:	0600	1400	2230
INITIALS:	[redacted]	[redacted]	[redacted]
CONTENT:	- Call for assist		- Call for assistance - Ambulate c assist
	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ # [redacted] b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted]	D
	CTR/AN	E
	CIV/AN	N

MEDCOM - 19123

ACLU-RDI 1650 p.83

DOD-032697

SECTION III - INTERVENTIONS & TEACHING (cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0845	RUQ	sm wound dry-no drainage	Dsg Δ
	1400	RUQ	Drsng CDI	assessed
	2200	(R) UQ	Dsg CDI	assessed

SECTION IV - NOTES

17Sept03 0855 Dr. [redacted] into see pt this am. Labs reviewed BIL elevated. Pt encouraged to ambulate and eat. Labs to be drawn tomorrow. [redacted]
17Sept03 2230 Pt sleeping, easily arousable to verbal stimuli. 0/10 pain. Will monitor [redacted]

b(6)-2

MEDCOM FORM 689-R (TEST) (MC) , MAR 99

MEDCOM - 19124

Page 4 of 4 pages

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 0 | HOSPITAL DAY: 4

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	1500	1900	1200	1:00	2000	2400	0100	0400						
BP ARTERIAL LINE															
BP CUFF		150/76			116/70				106/61						
TEMPERATURE	97.9			98.8	99.1	99.5	98	100.4/61	100.0						
PULSE					92				71						
RESPIRATORY RATE				16	16	18		20	20						
OXYGEN (L/%)															
PULSE OXIMETER					96%				97%						
O2 METHOD					RA				4						

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:	1400	2000	0100					
PAIN INTENSITY (10 / 5 / 0)	X	X	X					
MED ADMINISTERED (Y/N)	N		N					
RELIEF ACCEPTABLE (Y/N)	Y		N/A					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0800	1400	0100
*Skin breakdown prevention	[redacted]	NA	N/A
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: NA

WEIGHT CHANGE: No

*Per hospital policy.

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

PATIENT IDENTIFICATION

CU# [redacted] b(a)-4

DIAGNOSIS: Grade II liver lac

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

CASE MANAGER: [redacted] b(a)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0500 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 0100 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☐ PT DSG DONE SITE closed. SLIGHT ABD DISCOMFT.	☐ Dsg to (R) flank/UQ is CDI wound has no drainage noted.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
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.	☐	☐ fx able wound	☐ (R) flank/UQ wound - dsg CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ SLIGHT PAIN FROM SID SHRAPNEL WOUND	☐ See pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 1200 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 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: No IV.	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2: No Access	IV Site #2:
Comments: PT on PO MSDS	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 0700	1				
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION (R) SIDE	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1400	2200
ID band visible/legible	☐	[redacted]	[redacted]
Orient to environment prn	☐	[redacted]	[redacted]
Side rails (2/4) up	[redacted]	[redacted]	[redacted]
Bed position low	[redacted]	[redacted]	[redacted]
Call light within reach	[redacted]	[redacted]	[redacted]

OTHER

Review & post lab results	☐	MA	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		[redacted]
Turn/reposition q2h			[redacted]
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	REGULAR	REGULAR	Regular
PERCENT CONSUMED:	75 %	50 %	75%
HOW TOLERATED:			OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	~~BEDREST~~, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1400	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: 1. ENCOURAGE TO HYDRATE SELF 2. ENCOURAGE TO AMBULATE - TOWARDS RECOVERY.		CONTENT: - Staff orientation - Call for help - Pain management		CONTENT:	
☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

CIV# [redacted]
b(6)-4

INITIALS	b(6)-7 SIGNATURE	SHIFT
[redacted]		
	IG, AN	14-22
	MATAR	BNS

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
0800	Ⓛ SIDE	~~ESCHAR~~ SCAB.	DRESSING APPLIED - D
01 00	Ⓡ Side	covered	dsg CDI

SECTION IV - NOTES

Pt wound area at Ⓡ side of upper abdomen has 2x2cm scab area closed and site maintained clean. Pt able to tolerated food, encourage more Po fluids and ambulate. Pt on Pt meds. [redacted]

1400 → Assumed pt care.

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

DATE: 18 19Sept03 | SECTION I - PATIENT ASSESSMENT | PATIENT ACUITY LEVEL: III | POST-OP DAY: 0 | HOSPITAL DAY: 5

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____

Procedure/Diagnosis _____ Anesthesia (*Specify*): _____

LOC _____ B/P _____ P _____ R _____ T _____

Dressing/cast _____ Neurovascular checks _____

Intake (IV, po) _____ Output (EBL, other) _____ Tubes _____

Medication _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	0800														
BP ARTERIAL LINE		/														
BP CUFF	116/61	/														
TEMPERATURE	100.0	98.9														
PULSE	71	/														
RESPIRATORY RATE	20	/														
OXYGEN (L/%)	0	/														
PULSE OXIMETER	97%	/														
O2 METHOD	RA	/														

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:	0400									
PAIN INTENSITY (10 / 5 / 0)										
MED ADMINISTERED (Y/N)	N									
RELIEF ACCEPTABLE (Y/N)	N/A									

TIME:	0400									
FINGER STICK GLUCOSE	N/A									
INSULIN (Y/N)	/									

SPECIAL NEEDS

TIME:	0400									
*Skin breakdown prevention	N/A									
*Falls prevention protocol										
*Restraint protocol										
*Seizure precautions										
*Isolation precautions										

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] b(6), 2

DIAGNOSIS: Grade II liver lac,

DRG: _____

LOS: _____ ADMISSION DATE: 15Sept03

CASE MANAGER: _____ EXPECTED RELEASE: _____

PRIMARY CARE MANAGER: [redacted] b(6)-4

DCOM FORM 689-R (TEST) (MCHO) MAR 00 MEDCOM - 19129 (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF [illegible]

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. b(a)-2

	TIME: 0600 INITIALS: [redacted]	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.	☑ lang barrier	☐	☐
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)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
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.	☑	☐	☐
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.	☐ Sm normal RUQ	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

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

TIME: _____ INITIALS: _____	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:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 0600					
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0600			
ID band visible/legible	[redacted]			
Orient to environment pm	[redacted]			
Side rails (2/4) up				
Bed position low				
Call light within reach				

OTHER

Review & post lab results	[redacted]			
Notify MD abnormal labs	[redacted]			
Incontinent urine/stool				
Linen change pm				
Turn/reposition q2h				
ROM q2h if immobile				
Antiembolic hose				

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST (AMBULATE) BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - DSG Δ - pain management - Discharge teaching by MD	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	b(6)-2 SIGNATURE	SHIFT
KW	[redacted] r/Nurse	D

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CONTD

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
0945	RHD	sm wound healing well	DSG A

SECTION IV - NOTES

19Sept03 0945 Pt being Discharged th. am.
c Cipro. Follow up + 1 week [redacted]

to (e)-2 #11

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep 15 DAY

2003 HOUR

15 16 17 18 19

PULSE (0) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 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

BLOOD PRESSURE

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)*

C [redacted] b(6)-4

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19133

b(6)-2

Ward/Section: FMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 15 Sep 03	TIME 0837
		SSN/PSEUDO SSN: [redacted] b(6)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
		15-09-03 08:51 Patient Limits
WBC	19.4 H	x10^3/uL 4.5 10.5
RBC	5.18	x10^6/uL 4.00 6.00
Hgb	15.1	g/dL 11.0 18.0
Hct	47.4	% 35.0 60.0
MCV	91.5	fL 80.0 99.9
MCH	29.1	pg 27.0 31.0
MCHC	31.8 L	g/dL 33.0 37.0
Plt	205.	x10^3/uL 150. 450.
LY%	9.4 *L	% 20.5 51.1
LY#	1.8 *	x10^3/uL 1.2 3.4
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	Hazy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		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

RBC - 0-3 Calcium oxalate
WBC - 0-1 Crystals - many
EP: - 0-2 SSA - Trace

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 Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 9-15-03

LAB ID NO.:

ER

REQUESTING PHYSICIAN: [redacted] b(6)-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-2

DATE: 15 [illegible]

TIME: [illegible]845

SSN/PSEUDO SSN: [redacted] b(6)-4

i-STAT

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) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST | RESULT | REF.

======= PICCOLO =======
15/09/03 08:48
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	83*	10-47	U/L
AMY	98*	14-97	U/L
AST	77*	11-38	U/L
TBIL	1.5	0.2-1.6	MG/DL
BUN	15	7-22	MG/DL
CA++	8.7	8.0-10.3	MG/DL
CHOL	179	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	137*	73-118	MG/DL
TP	7.0	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST | RESULT | REF. RANGE

,U
IN
E
73-118 mg/dl

======= PICCOLO =======
15/09/03 08:48
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	129*	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	120	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 0

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 9-15-03

LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4	DATE: 15 Sep 03	TIME: 1800	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted]		15-09-03
WB		18:31
		Patient Limits
WBC	16.2 H	x10^3/uL 4.5 10.5
RBC	5.09	x10^6/uL 4.00 6.00
Hgb	15.1	g/dL 11.0 18.0
Hct	46.8	% 35.0 60.0
MCV	91.9	fL 80.0 99.9
MCH	29.6	pg 27.0 31.0
MCHC	32.2 L	g/dL 33.0 37.0
Plt	207.	x10^3/uL 150. 450.
LY%	10.4 *L	% 20.5 51.1
LY#	1.7 *	x10^3/uL 1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		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		

Macroscopic Urinalysis

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 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 15 Sep 03	LAB ID NO.:

Ward/Section: 1CW2	REQUESTING PHYSICAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI: CIV [redacted] b(6)-4	DATE: 16Sep	TIME: 0500	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted] WB		16-09-03 04:59 Patient Limits
WBC	12.6 H	x10^3/uL 4.5 10.5
RBC	4.86	x10^6/uL 4.00 6.00
Hgb	14.1	g/dL 11.0 18.0
Hct	44.4	% 35.0 60.0
MCV	91.4	fL 80.0 99.9
MCH	29.1	pg 27.0 31.0
MCHC	31.9 L	g/dL 33.0 37.0
Plt	200.	x10^3/uL 150. 450.
LY%	15.5 *L	% 20.5 51.1
LY#	1.9 *	x10^3/uL 1.2 3.4
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Mono		
Eos		
Baso		
Imm		

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

Urinalysis

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

CSF

Cell Count		
Directigen		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		

Macroscopic Urinalysis

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 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: CBC, Met Panel, LFT's

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2

REQUESTING PHYSICAN: [redacted] b(6)-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST M: CIV [redacted] b(6)-4

DATE: [illegible]

TIME: [illegible]500

SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RA
Na		138-146 mm
K		3.5-4.9 mm
CI		98-109 mm
pH		7.31-7.45
PCO2		35-45 mm 41-51 mm
PO2		80-105 mm N/A (ven)
TCO2		23-27 mm 24-29 mm
HCO3		22-26 mm 23-28 mm
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mm
Ca		1.12-1.32
BUN		8-26 mg/
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

PICCOLO

16/09/03 04:57

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(6)-4

MEILYTE 8

DISC LOT #: b(6)-2 3151AA4

OPER #: [redacted] b(6) DR #: 000

SERIAL #: [redacted]

GLU	100	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	112	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 1+

(Piccolo) Metabolic Panel

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/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
GLU		73-118 mg/d
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M 30-190 /l (F
NA+		128-145 mm
K+		3.3-4.7 mm
CL-		98-108 mm
tCO2		18-33 mm

PICCOLO

16/09/03 04:57

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(6)-4

LIVER PANEL PLUS

DISC LOT #: 3154AA7

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-[redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	81*	10-47	U/L
AMY	63	14-97	U/L
AST	58*	11-38	U/L
TBIL	3.1*	0.2-1.6	MG/DL
GGT	17	5-65	U/L
TP	6.5	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 1+

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
ICU2	[redacted] b(6)-2	

LAST, FIRST, MI.	DATE	TIME	SSN/PEEUDO SSN:
Curlean # [redacted] b(6)-4	17 Sep	0500	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	ID [redacted]	17-09-03
RE	WB	05:01
H		Patient Limits
H	WBC 9.3 * x10^3/uL	4.5 10.5
	RBC 4.99 x10^6/uL	4.00 6.00
M	Hgb 14.5 g/dL	11.0 18.0
	Hct 45.3 %	35.0 60.0
I	MCV 90.9 fL	80.0 99.9
	MCH 29.1 pg	27.0 31.0
J	MCHC 32.0 L g/dL	33.0 37.0
	Plt 188. x10^3/uL	150. 450.
	LYZ 23.1 * %	20.5 51.1
	LY# 2.2 * x10^3/uL	1.2 3.4
Segs		
Bands	Eos	
Lymph	Baso	
Atyp	Imm	
RBC Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		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	

Macroscopic Urinalysis

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 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: CBC & LFT's

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW2	REQUESTING PHYSICAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST MI: CW [redacted] b(6)-4	DATE: 17 Sep / TIME: 0500	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		130-250 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metly

TEST	RESULT	REF. RANGE
GLU		7
BUN		7-
CRE		0.6-
CK		39-3 30-1
NA^+		128-1
K^+		3.3-4.7
CL^-		98-108
tCO2		18-33 mn

(Piccolo) Metabolic Panel

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/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

Panel Plus

		REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		4-97 u/l
		38 u/l
		1.6 mg/dl
		u/l
		g/dl

======= PICCOLO =======
17/09/03 05:10
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-1 [redacted]

ALB	3.4	3.3-5.5	G/DL	
ALP	51	26-84	U/L	
ALT	68*	10-47	U/L	
AMY	55	14-97	U/L	
AST	43*	11-38	U/L	
TBIL	3.0*	0.2-1.6	MG/DL	
GGT	18	5-65	U/L	
TP	6.8	6.4-8.1	G/DL	

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 1+

REMARKS: CBC & LFT's

REPORTED BY:	DATE:	LAB ID NC

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
1cw2	[redacted] b(6)-2	

LAST, FIRST MI:		DATE	TIME		SSN/PEEUDO SSN:
CIV [redacted] b(6)-4		18Sep	0500		

(i-STAT)

ID: [redacted]			18-09-03	
WB			05:22	
			Patient Limits	
WBC	9.1	x10^3/uL	4.5	10.5
RBC	5.21	x10^6/uL	4.00	6.00
Hgb	15.5	g/dL	11.0	18.0
Hct	47.8	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	211.	x10^3/uL	150.	450.
LY%	24.0	%	20.5	51.1
LY#	2.2	x10^3/uL	1.2	3.4

TEST	RESULT	REF. RANGE
HCO3		22-26 mmol/L (23-28 mmol/L)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/
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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
18/09/03 05:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: b(6)-2 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	14	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 1+

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
[illegible]		7-22 mg/dl

======= PICCOLO =======
18/09/03 05:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	51	26-84	U/L
ALT	58*	10-47	U/L
AMY	58	14-97	U/L
AST	26	11-38	U/L
TBIL	3.3*	0.2-1.6	MG/DL
GGT	20	5-65	U/L
TP	7.4	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 1+

REMARKS:
CBC, LFT's, Lytes

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CT abdomen					
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted] b(6)-2				TELEPHONE/PAGE NO.
	S[redacted]ESTOR				DATE REQUESTED 15 Jul 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Surgical RUQ. Please include lower lobe of (R) lung field.

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

1) Location Liver AP

2) bullet fragment (R) post soft tissue back

3) [redacted]

4) (B) Location ATCX

b(6)-2 [redacted] MD

[redacted] b(6)-4

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

#[redacted] b(6)-4

LOCATION OF [redacted]

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 19142

7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: ABD CT

AGE: | SEX: M | SSN (Sponsor): CIV # [redacted] b(6)-4 | WARD/CLINIC: ICU #2

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☐ NO

REQUESTED BY (Pri[redacted]): Dr [redacted] b(6)-2

TELEPHONE/PAGE NO.:

SIGNATURE OF REQUESTOR:

DATE REQUESTED: 9-17-03

PECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*: Liver lac

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

(1) No sig A (R) Liver lac.

(2) Small (R) SS AT LX

(3) Small (R) effusion

b(6)-2 [redacted] b(2)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

CIV # [redacted] b(6)-4

LOCATION OF MEDICAL RECORDS:

LOCATION OF RADIOLOGIC FACILITY:

SIGNATURE:

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 19143

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sp	WARD/CLINIC	REGISTER NO.
Portable CXR	40	M	C [redacted] b(6)-4	1cW2	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTER [redacted] b(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR AWalker				DATE REQUESTED 16 Sep

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

liver laceration

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
CIV [redacted] b(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 19144

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

[redacted]

b(6)-4

DATE OF ORDER: 15 Sep 1330 — TIME OF ORDER: ______ HOURS — LIST TIME ORDER NOTED AND SIGN

Admit EPW ward [redacted]
Cond fair
Diet - clear liq
Act - OOB 1310 may ambulate c assist
VS - q4h
Dx - grade II liver lac 2° IED

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER — TIME OF ORDER ______ HOURS

IV LR1000 at 150 cc/h
[redacted] 1gm IVPB q8h
[illegible] 400mg IV q am
CBC at 1800 today
CBC, lytes am 16 Sep also LFT's
portable CXR 16 Sep
MS 2-6 mg IV q 1-2h prn pain

NURSING UNIT | ROOM | BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER — TIME OF ORDER [redacted]

Foley to grav drain
call MD if UO <60cc
for any 2 consecutive h [redacted]

b(6)-2

remove field IV's, + place new IV [redacted]

NURSING UNIT | ROOM NO. | BED NO.

15 Sep 03 0530 [redacted] for 040 Chart

PATIENT IDENTIFICATION

DATE OF ORDER: 16 Sep 0700 — TIME OF ORDER ______ HOURS

DC foley
Reg diet
ambulate [illegible]
↓ IV to 75 cc/hr [redacted]

16 Sep 03 0715 [redacted]

b(6)-2

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 19145

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

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

PATIENT IDENTIFICATION

b(6)-4

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

17Sep03 0030

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

16 Sep 1930 ____ HOURS

(1) DC IV + IV ABs

(2) ciprofloxacin 500 mg po q 12h x 10 d

(3) CBC, LFT's am 17 Sep

b(6)-2

MJ/AW

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

17 Sep 03 0830 ____ HOURS

(1) CBC, LFT's am 18 Sep

(2) ambulate ad lib

b(6)-2

Noted 17Sep03 0835

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

17Aug03 0830 ____ HOURS

Dressing Δ q day

Vitals routine c temp q 4°

VO Dr [redacted] MAJ/AW

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

16 Sep 1730 ____ HOURS

Abd CT - reevaluate

b(6)-2

DA FORM 1 APR 79 4256

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

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 [redacted] b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted] | b(6)-2 | [redacted]

DATE OF ORDER 17 Sep 2045 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

(1) add lytes to am 18 Sep labs

(2) Percocet 1-2 po q 4 prn pain

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICU2 | 7 | A 240 [redacted]

DATE OF ORDER 18 Sep 0700 TIME OF ORDER _____ HOURS

(1) Temp q 4h

(2) BP, pulse 1X/24 hrs

(3) encourage fluids

(4) CBC w diff, lytes 19 Sep am

b(6)-2 [redacted]

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 Sep 0915 TIME OF ORDER _____ HOURS

(1) diet pt

(2) follow-up 1 week MONDAY 26 Sep in EMT

b(6)-2 [redacted]

Noted 19Sep0940 [redacted] b(6)-7

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

[redacted]

b(e)-2 A11

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. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17
9-15	[redacted]	LR 1000cc @ 180 cc/hr	D	X [redacted]
			E	
9-16		↓IV to 75cc/hr	N	
9-15	[redacted]	Ancef 1gm IVPB q8h	08	[redacted] D/C'd
			16	
			24	
9-15	[redacted]	Gent 400 mg IV Q am.	0	[redacted] D/C 1650
9-16	[redacted]	Cipro 500mg PO Q 12h	10	X [redacted]
			22	X
		A&S		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Grade IV liver lac 2° TBI

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

PATIENT IDENTIFICATION:

CIV # [redacted] b(e)-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

MEDCOM - 19148

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 9 Yr 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----					

	-----	b(we)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED															
9-15 9-18	[redacted]	MS 2-6mg IV	1540 0300	1650														
-----	-----	Q 1-2h prn pain	5mg PRN	DWR	[redacted]													
-----	-----																	
9-17	[redacted]	Percocet 1-2PO	9-17 2117															
-----	-----	Q4° PRN	11 PO															
-----	-----		[redacted]															
-----	-----																	
-----	-----																	
-----	-----																	
-----	-----																	
-----	-----																	
-----	-----																	
-----	-----																	

b(6)-2 A11

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. ___ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17
9-15	[redacted]	CL Diet	7	/	N	
			11	/		
			17	[redacted]	D/C 16Sep03	
9-15	[redacted]	Act: OOB BID, may ambulate, assist	08	X	[redacted]	
			20	[redacted]		
9-16	[redacted]	Ambulate in hall	D		[redacted]	
9-15	[redacted]	VS Q4°	00	X	[redacted]	
			04	X		
			08	X		
			12	X		
			16	[redacted]	D/C 16Sep03	
			20	[redacted]		
9-15	[redacted]	foley to gravity drain	D	X	[redacted]	
			E	[redacted]		
			N	[redacted]	D/C 16Sep03	
9-16	[redacted]	Regular Diet	08	[redacted]	[redacted]	
			12	/		
			18	[redacted]		
9-17	[redacted]	Ambulate in halls	D	/	/	[redacted]
			E	/	/	
			N	/	/	
9-17	[redacted]	Dressing Δ q day	10	/	/	
9-17	[redacted]	Vitals routine c temp q 4°	D	/	/	
			E	/	/	
			N	/	/	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Grade II liver lac 2° IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

Civ # [redacted]

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

b(6)-2 A(1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9-15	[redacted]	Admit to FPW ward	9-15	1500	1501	[redacted]
	----	Cond. Fair				
9-15	[redacted]	CBC @ 1800 today	9-15	1800		
9-15	[redacted]	CBC, lytes, LFTs 16 Sept AM	9-16	0400		
9-15	[redacted]	Portable CXR 16 Sep	9-16			
9-15	[redacted]	Remove field IVs and place	DONE			
	----	Inew				
9-16	[redacted]	D/C foley	9/16	9/16	7:38	[redacted]
	----	Due to void 6° p D/C foley	9/16	9/16	7	[redacted]
9-16	[redacted]	CBC, LFTS am 17 Sept	9/17	0400	0430	[redacted]
9-17	[redacted]	CBC, LFTS in am 18 Sep	9/18	0400	0500	[redacted]
9-17	[redacted]	CT ABD	9-17	ASAP		[redacted]
9-17	[redacted]	Add lytes to a.m. Sept 18 labs	9-18	0400	0500	[redacted]
9/18	[redacted]	DRAW CBC, LFT's, LYTES. 9/19/03	9/19.	0400		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED														
9-15	[redacted]	Call MD if UO															
----	----	< 60 cc for any															
----	----	2 consecutive															
----	----	hrs.															
----	----																
----	----																
----	----																
----	----																
----	----																
----	----																

b(6)-2 A11

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. 7 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23
16 Sep	[redacted]	Regular diet	08	[redacted]					
			12						
			18						
16 Sep	[redacted]	Ambulate in halls	D						
			E						
			N						
16 Sep	[redacted]	Dsg Δ QDay	10						
16 Sep	[redacted]	VS QS ± temp	D	[redacted]					
		Q4	E						
			N						
16 Sep	[redacted]	Encourage PO fluids	D	[redacted]					
			E						
			N						
18	[redacted]	BP, pulse QD 04	04	[redacted]					
		Temps Q4 08	08						
		12	12						
		16	16						
			20						
			24						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Grade II brain AC

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Civ # [redacted] 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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo ____ Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 Sep	[redacted]	CBC, LFT's, Lytes in AM	19 Sep	0430	0500	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
18 Sep	[redacted]	Call MD if UO	
		< 60cc for any	
		consecutive 2 hrs	

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	40	X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0824	b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 6	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICW2	

NAME [redacted] — ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE b(2)-2

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
05		030919

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
ABAA		030915

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

FOR LOCAL USE

grade II liver laceration 2° IED

Dx: 864.15

E991.9

88.19
87.44
88.01
99.29

ADMITTING OFFICER (Signature, as required) [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

b(6)-2

DA FORM 3985 MAR 89

MEDCOM - 19154

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
[redacted]	[redacted] b(4)-4		CIV	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	ETS	10. PREVIOUS ADMISSION
M	22y	X	MUSLIM	—	—	NO
11. FMP	12. SSN	13. ORGANIZATION			14. WARD
~~99~~ 30	[redacted]	— b(4)-4			ICW2
15. FLYING STATUS	16. DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—		~~K76~~ K98			DNBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From ER.	1228	Opthamology

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION	ADMITTING OFFICER
UNK	D/C HOME	29 Sep 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	
UNK		15 Sep 03	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: ① ~~Retinal Hemorrhage OS~~ / Ruptured Globe OS
② Endophthalmitis OS
③ 2MC Fractures (L)
④ Multiple Facial Lacerations

Px: 76.71, 86.09, 87.44, 88.27, 88.22, 87.03

Dx: 871.0, 360.00, 802.4, 873.40, 823.30, E991.9

35. Total Days This Facility					
a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	15	15

36. Total Days All Facilites b(4)-2 All					
a. ABSENT SICK DAYS	b. OTHER DAYS	c. [redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	[redacted]	[redacted]	15	15

SIGNATURE OF ATTENDING MEDICAL OFF[redacted]

MEDCOM - 19155

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22 yo Kurdish soldier involved in car bomb explosion ~10 Sep 03. Pt seen @ Kurdish hospital & transferred to [redacted] to R/O orbital floor fx. Pt was dx'd c retinal hemorrhage, and (L) 2mc fx. Pt sent to the [redacted] b(2)-2 for CT scan. Eval by OPHTHALMOLOGY & ORIF of (L) 2mc fx.

PMH: ϕ
PSH: ϕ
All: NKDA
Meds:

VS: BP 144/66
P 101
@1111 R 18
T 99.5

HT 165 cm
WT 78 kg.

PHYSICAL EXAMINATION WD Kurdish male in NAD

HEENT: NC - multiple facial lacs closed @ Kurdish hospital wounds poorly cared for
(B) Periorbital Ecchymosis
edema
OU c subconjunctival hematoma
OS pupil oval & NR c chemosis
OD pupil reactive +slow
EOM - limited upgaze - IR
(+) Pain on palpation of face
Left ear TM perforation & Pinna wound c dried Blood
(-) TM clear
Maxilla & mandible stable c repeatable occlusion
nasal bores stable

CV: RRR
Lungs: CTA (B)
Abd: SOFT NT/NT (+) BS
Chest: Sup. Shrapnel wounds

mult lacs dried crusted blood & silk suture

EXT: R forearm c lacs sutured
3rd digit c injury
legs c superficial shrapnel wounds

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

A/P S/P carbombing ~5 days ago. Pt sent to Kurdish Hosp. & 21st CSH and no apparent wound care given. Suspected (L) 2mc fx c entrapment of IR.
) CT scan face (2) OPHTHAL CONSULT (3) ORIF (L) 2mc (4) ORTHO Eval

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
b(6)-2 [redacted] MD	15 Sep 03		

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

REGISTER NO.	WARD NO

[redacted] b(6)-2

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 19156

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
#769	Kurdish soldier (b)(2)-2 saved vs soldiers p carbomb. sent to [redacted] x 5 days c ZMC fx seen by optom – rehna fleat, entraped + force duchins
	Evac to [redacted] limbal entrance @ 7o'clock c ins encarceation. — repair 9/15
9/17	repair ZMC fx- assisted OMF removing eye from fx site
	pending → PPVit IOFB removal b(6)-2 [redacted] 6014 LTC,

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.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMS Brief OP NOTE

17Sep03 @1256 Pre-Op Dx: Left 2mc fx non healing facial wounds

Post op dx: Same

Procedure: ORIF (L) 2mc fx, foreign body rem Orbital floor exploration I&D + closure of facial wound

2 plates + screws

Surg: [redacted]

Assist: [redacted]

Anesth: GETA

EBL: 100cc

U/O 300cc

fluids 2000cc LR

Comp: 0

findings: comminuted (L) 2mc fx foreign body in (L) side of nasal bone lateral orbital foreign body. Poorly closed facial wounds & hematoma

Cond: Stable extubated & transferred to recovery Surgeon: [redacted] MAJ/DE

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER
	LAST	FIRST	MI	(SSN or Other)
		b(4)-2		

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.
# [redacted] b(4)-4		

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/18/03	
#769.	Ophth Note
	POD #1 S/P ZMC c entrapment repair
	Va - HM
	segmf chemosis, ↓ STS periorbital
	EOM improved c [redacted] sig. pain
	DFE: segmf heme, retinals
	Imp retained IOFB
	Plan CPM add Med 60mg PO qD+ Zantac 150 bid [redacted] b(a) - 2
18Sep03	OMFS POD #1 Ancy #2 #3
	S/P (L) ZMC. FX ORIF c orbital floor exploration.
	Pt c clo pain this am controlled c pain meds.
	L eye. Periorbital edema c chemosis present

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.

#[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	facial wounds closed 1° c no active bleeding. granulating Right chin and left ear wounds. no signs of infx. intra oral wounds closed 1°.
	A/P S/P c/R of (L) 2mc fx.
	(1) Continue current wound care
	(2) OPHTH tx per Dr [redacted] b(6)-2
19 Sep 03 @0905	OMS POD#2 Ancef #4 Pt sitting in chair c c/o pain facial edema + Left eye edema d/ing. wounds closed 1° c no s/s of infx and bleeding.
	A/P S/P c/R of (L) 2mc fx
	(1) awaiting eval c Ophthro [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/19/03	Optho Svc
1018	
	S: pt to clinic c 6o headache
	O: Va - CF → LP
	Ext: extensive STS - improved from yesterday able to open eye
	SLE: Conj: sig chemosis cornea clear Ac ~ 1+ cell & flare iris dilated lens cl.
	Vit: @ blood/cells poor view
	Bscan: layed blood in retreats retina flat
	Imp: S/p ruptured globe, ZMC fx repair
	Plan: CAM, steroids initiated, awaiting retina eval.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) [redacted] b(a)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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.

[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	OMFS PN POD #7
24 Sep 03 @0900	Pt S/P ORIF Rt ⓛ 2mc fx doing well this am. Wounds healing well and closed 1°. Abrasions well granulated. Will remove remaining sutures. Continue Bactracin to face. Awaiting Appt ⊂ Iraqi OPHTH. b(6)-2 [redacted]
25 Sep 03 @0840	OMFS PN POD #8 pt doing well - wounds healing well d/s/s ointment. Continue bactracin awaiting appt ⊂ iraqi OPHTH. [redacted] b(6)-2
27 Sept	Pt seen in conjunction ⊂ Iraqi retinal specialist agreed ⊂ current mgmt. pt to be sent to Iraqi hospital for vitrectomy. coordination already started [redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR (LAST / MI) [redacted]	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FAC [redacted]	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)*

[redacted]

b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

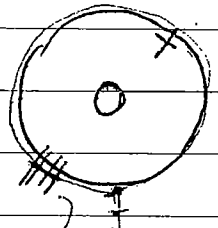
MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, T… ING ORGANIZATION *(Sign each entry)*

9/15/03
1920

Ophth Op Note

pre-op dx: ruptured globe c IOFB, globe entrapment
postop dx SAA
proc. repair of limbal rupture site OS
globe exploration OS
forced duction test OS
findings



limbal rupture c uvea incarceration

compl ø
EBL min
anes: GETA
fluids: 1400 cc

[redacted] b(6)-2

60 ± LTC

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.)* [redacted] 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

MEDCOM - 19163

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9-15-03	ORTHO
	22 y/o Kurdish male involved in car bombing 5 days ago sustaining multiple soft tissue wounds. XR reports [illegible] demonstrate no fx's. (L) UE has volar forearm [illegible] sutured c silk. (R) UE c open wound volar aspect [illegible]. No evidence of infection. [illegible] FDS/FDP, [illegible] sensory [illegible] 2+ pulses. (L) UE AT. (B) LE c no joint effusion. FROM c 2+ DP/PT. Superficial shrapnel wounds (R) + (L) knee, ant tibia (R) leg.
	Imp: Multiple soft tissue wounds (B) UE (B) LE c no clinical evidence of infection. NV compromise, [illegible] fx.
	Plan - Local wound care.
	b(6)-2 [redacted]
	b(2)-8
9/15/03 1340	22 y/o Kurdish male involved in a car bombing 5 days ago, eval c [redacted] sent here for eye exam to clear eye 6 repair of ZMC fracture.
	Va - unobtainable - can't communicate c pt.
	ROTS: restricted in all directions of gaze P 4/6 +2 tr APD

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

MEDCOM - 19164

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	SLE: 4L swollen, ? small healing lac center (L) lid right above lashes
	Conj: sig chemosis inf temp
	Cornea clear x ? small rupture ~1-2mm @ limbus 7 o'clock
	A/C 1+ cell
	iris ~3/4 dilated (+) mont (trau)
	DFE: poor view 2° to vit heme
	B scan: vit heme ? IOFB metallic inf retina
	CT scan (+) IOFB inf retina & ? sub conj f-b nasal conj anterior to globe
	Imp (1) comminuted ZMC fx c ? entrapment
	(2) ? globe limbal intraoc wound @ 7 o'cl. OS
	(3) by CT metallic f-b adj to globe infr. nasal
	(4) per CT metallic IOPB inf retina OS
	Plan (1) will discuss c OMF plan as globe exploration to determine status of limbus @ 7 o'clock & to explore to assure f-b infranasal not into globe then determine timecourse for fx repair.
	(5) metallic IOFB - will need to coordinate c local airlift for removal - ASAP.

b(6)-2 [redacted]

[redacted] 600 (REV. 6-97) BACK
U.S. GPO: 1999 422-786/75236

[redacted] ons vec

MEDCOM - 19165

b(2)-2

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS [redacted] b(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 15 SEPT 03 | TIME 1111

TRANSPORTATION TO FACILITY BIRD

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE 22	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: ~~NKDA~~ PO Benicar

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?	/		09/10/03
INJURY/SAFETY FORMS			WHERE
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: here for opthamology evaluation

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME 1111

INITIALS [redacted] b(6)-2

VITAL SIGNS

TIME	1111	1139			
BP	144/66	124/60			
PULSE	101	100			
RESP	18	18			
TEMP	99.5	99.1			
WT					

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	

ORDERS

☒ PULSE OX 98 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

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

TIME OF RELEASE

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)*

[redacted] 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)
USAPA V1.00

MEDCOM - 19166

NSN 7540-01-075-3786

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				UA	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

Seen by Dr. [redacted] / Dr [redacted]
For primary.
See opthalmology / oral surg note

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] b(6)-2

DIAGNOSIS
1) Orbital fx (L) orbit.
OS retinal hemorrhage

CODES

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 0 | HOSPITAL DAY: 1

TRANSFER

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

Time 1250 To ICW2 From EMT ☐ AMBULATORY ☐ CRUTCHES ☑ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician Dr [redacted] Anesthesia (Specify): _____

Procedure/Diagnosis Retinal bleed, maxillar fx, shrapnel R+L knee B/P 144/66 P 101 R 18 T 99.5

LOC A+O x3, speaks Kurdish Neurovascular checks N/A

Dressing/cast dress (R) leg + (L) arm Tubes NS (L) AC

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☒ No ☐ Yes Amount: _____

Medication _____ b(1)-2 b(2)-2

Other car bomb, saved americans CT → Dr [redacted] → ICW2, Transfer from [redacted]

Report From LT Fiske Received By MAJ [redacted]

VITAL SIGNS

TIME:	2000	0400								
BP ARTERIAL LINE										
BP CUFF	120/62	119/58								
TEMPERATURE	98.9	99.7								
PULSE	94	71								
RESPIRATORY RATE	14	20								
OXYGEN (L/%)										
PULSE OXIMETER	100	100%								
O2 METHOD	RA									

(1.5) 7 hole curved plate

(1.5) 7 hole curved plate

(1.5) Six screws

4 hole straight plate

(2.0) under eye

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:	1445	2330								
PAIN INTENSITY (10 / 5 / 0)	5									
MED ADMINISTERED (Y/N)	N	Y								
RELIEF ACCEPTABLE (Y/N)	N	Y								
mSO4 Percocet		4 mg IV								

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	1445	2300
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted]

Kurdish

DIAGNOSIS: Retinal bleed, maxilla fx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

D(ed)-2

	TIME: 1445 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]	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.	☐ (R) eye WNL. (L) eye swollen shut. When opened manually, sclera reddened & conjunctiva extremely swollen.	☐ (L) eye covered (R) eye swollen lids	☐
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)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
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.	☐ NPO for OR	☐ tol. regular diet - small amount	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Ør void	☐	☐
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.	☐ Maxillary fx & (R)/(L) knee wounds. Swelling noted to (L) side of face.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Multiple abrasions & sutures to face (primarily (L) side). [illegible] dry at this time, Drsgs to	☐ multiple abrasions to (L) side of face, IV Sites x2	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain. Awaiting med orders	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ speaks no English. Understands some arabic	☐ understands Some arabic no english	☐

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

TIME: [redacted] 1445 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency √ q 8 hr:	IV patency √ q 8 hr:	IV patency √ q hr:
IV site care provided:	IV site care provided: Flushed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / OK	IV Site #1: (L) AC / OK	IV Site #1:
IV Site #2:	IV Site #2: (R) FA / OK	IV Site #2:
Comments: NS@75cc/hr	Comments: SL'd x2	Comments:

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

MEDCOM - 19169

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: [redacted] TIME: 1445						
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	M					
PASSIVE FLEXION	D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME: 1445 2300		
ID band visible/legible	[redacted]	[redacted]
Orient to environment prn	[redacted]	N/A
Side rails (2/4) up	[redacted]	
Bed position low	[redacted]	
Call light within reach	[redacted]	

OTHER

Review & post lab results	[redacted]	
Notify MD abnormal labs		
Incontinent urine/stool		
Linen change prn	[redacted]	
Turn/reposition q2h		
ROM q2h if immobile		
Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: NPO
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1445 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - Staff orientation - Call for help - On call to OR	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted]

b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	14-22
	[redacted] AN	N
	b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0230	dsg to (L) eye	covered	CDI

SECTION IV - NOTES

1400 → ~~error~~ error cs 1445 → Pt arrived w/c ~~litter~~ error cs w/c to ward. Ambulated from w/c to bed & assist. IV @ TKO. NKDA. NPO for OR. [redacted]

1530 → Pt to OR via litter & anesthesia. [redacted]

2000 → Pt returned from OR via litter. Pt ambulated from litter to bed & [redacted]

2005 → Pt has large pressure dsg to OS. Ø drng noted. Pt's nurse [redacted] bed. Pt fell asleep almost instantly. IV Fluids continue. Pt is due to void. [redacted]

bled - 2
AM

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 0 | HOSPITAL DAY: 2

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400														
BP ARTERIAL LINE	—	—															
BP CUFF	112/53	110/52	111/46														
TEMPERATURE	98.3	98.5	99.3														
PULSE	72	76	72														
RESPIRATORY RATE	18	16	20														
OXYGEN (L/%)	a	—															
PULSE OXIMETER	94%	100%	99%														
O2 METHOD	RA	RA	RA														

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:	0645	1233	1800	2300	2400	0400											
PAIN INTENSITY (10 / 5 / 0)	X	X			PRS												
MED ADMINISTERED (Y/N)	Y	Y	N	N	Y	N											
RELIEF ACCEPTABLE (Y/N)	N	Y	NA	NA	Y	N											
percocet					IV												

OTHER

TIME:	1500																
FINGER STICK GLUCOSE	NA																
INSULIN (Y/N)	↓																

SPECIAL NEEDS

TIME:	1500	2300
*Skin breakdown prevention	N/A	N/A
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

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

CIV [redacted] b(6)-4

Kurdish

DIAGNOSIS: retinal bleed, maxilla fx, Schrapnel R&L knee

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

MEDCOM - 19172 CE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(6) - 2 ATH

	TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: ABB	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ (E) eye covered c DRSG -> CDI (B) PERRLA/EOMI ↓ 40 HL;	☐ OS edematous, erythema to sclera, pupil reactive to light -language barrier.	☐ (L) eye covered c DSG
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ multiple scars	☐ Sutures to OS lid, multiple abrasions to neck, face, chest, RUE.	☐ multiple abrasions on face, neck (B) arm
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ medicated c percocet, MSIV (P) effect	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: flushed.	IV site care provided: assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL	Comments: SL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1300	F	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	/	N/A	N/A
Bed position low	/		
Call light within reach	/		
Review & post lab results	/		
Notify MD abnormal labs	/		
Incontinent urine/stool	/		
Linen change prn	[redacted]		[redacted]
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: ETHNIC / ROS	TYPE: B. ETHNIC	TYPE:
PERCENT CONSUMED: 20%	PERCENT CONSUMED: 50%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: COB & shoes for safety and & asst. pain control	CONTENT: - pain control	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C1V [redacted] b(6)-d

b(6)-2 [redacted]

SIGNATURE	SHIFT
[redacted]	
[redacted]	E
[redacted]	N

SECTION III - INTERVENTIONS & TEACHING

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
1500	① OS ② RUE	① Sutures CDI, OTA, edema, tearing ② Dsng CDI	① assessed. dsng Δ'd ② Dsng reinforced
23 00	① OS ② RUE	① Covered ② Covered	① CDI ② CDI

b(6)-2

SECTION IV - NOTES

1500: IV to (R) hand ø patent and D/c'd — [redacted] TAN

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17Sept03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: Ø | HOSPITAL DAY: 3

TRANSFER

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

Time ______ To ______ From ______ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician ______ Anesthesia (Specify): ______

Procedure/Diagnosis ______ B/P ______ P ______ R ______ T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

Intake (IV, po) ______ Output (EBL, other) ______ Voided ☐ No ☐ Yes Amount: ______

Medication ______

Other ______

Report From ______ Received By ______

VITAL SIGNS

TIME:	1600	2000	0400
BP ARTERIAL LINE			
BP CUFF	126/66	130/54	121/58
TEMPERATURE	98	99.8	99.7
PULSE	90	79	78
RESPIRATORY RATE	16	16	20
OXYGEN (L/%)		—	—
PULSE OXIMETER	98%	99%	98%
O2 METHOD		RA	

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:	1600	2000	2100
PAIN INTENSITY (10 / 5 / 0)	[circled near 10]	X [near 3]	• [near 8]
MED ADMINISTERED (Y/N)	Y		Y
RELIEF ACCEPTABLE (Y/N)	Y		Y

SPECIAL NEEDS

TIME:	1410	1600	2400
*Skin breakdown prevention	O	NA	NA
*Falls prevention protocol	NA	↓	↓
*Restraint protocol	NA	↓	↓
*Seizure precautions	NA	↓	↓
*Isolation precautions	NA	↓	↓

YESTERDAY'S WEIGHT: ______

TODAY'S WEIGHT: ______

WEIGHT CHANGE: ______

*Per hospital policy.

OTHER

TIME:	
FINGER STICK GLUCOSE	
INSULIN (Y/N)	

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

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

Kurdish soldier

[redacted]

DIAGNOSIS: retinal bleed, maxilla fx, R/L knee Schrapnel
DRG: ORIF of L [illegible] Fx. [illegible]
ADMISSION DATE: 15Sept03
LOS: ______ EXPECTED RELEASE: ______
CASE MANAGER: ______ b(6)-2
E MANAGER: [redacted]
ISOLATION REQUIRED (Specify):

MEDCOM - 19176

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (2) EYES OPENING CLOSED DUE TO TRAUMA, S/P SURGERY	☐ OS swollen shut, No ↓ function to OD noted,	☐ OS swollen shut
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)*	☐	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
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.	☐ HAS FOLEY FROM OR. TO BE D/C.	☑ Foley D/C'd	☑
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.	☐ KNEE	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (R) HAND	☐ Sutures to (R) orbit/ulcer, (R) face (L) forehead intact, wounds to (R) chin (L) eyebrow, chest & (R) arm, D&G (R) arm D & I	☐ Sutures to (L) area under eye. Sutures to (L) side of forehead. abrasions to chin. (R) arm dressing CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ NO PAIN AT THIS TIME.	☐ Screaming in agony upon return from OR, crying. MS/4 4mg IVP given	☐ C/O pain @ 2230 given IV percocet
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
IV patency ✓ q ___ hr: 18	IV patency ✓ q 6 hr:	IV patency ✓ q 8 hr:
IV site care provided: CB	IV site care provided:	IV site care provided:
IV tubing changed: ☐ IV (2) ARM	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) ARM. / Good	IV Site #1: (L) FA / OK	IV Site #1: LFA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: BT ASSUMED FROM OR. S/P ORIF OF LEFT 2MC 1- FRACTURE, CLOSURE OF LACERATION.	Comments:	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1400					
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA (4) SLIGHT (1) PAST.	2 1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1400	1600	2400
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	NA	NA	
Bed position low	[redacted]		
Call light within reach	NA		

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	No		
Linen change prn	[redacted]		
Turn/reposition q2h	NA	NA	
ROM q2h if immobile	NA		
Antiembolic hose	NA		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: MOO	TYPE:	TYPE: CI liq
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: (1) NOT TO BEND DOWN FROM ONE WAIST (2) NO STRAINING (3) NO TOUCHING OF (4) EYE & BARE HANDS	CONTENT: Plan of Care Pain control	CONTENT:
☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4 [redacted]

INITIALS	SIGNATURE	SHIFT
b(6)-2 [redacted]		6-2
[redacted]	2LT, AN	2
[redacted]	[redacted]	N

MEDCOM - 19178

SECTION III - INTERVENTIONS & TEACHING

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	(L) EYE (L) SIDE OF FACE	INDSWSED RED.	EYE DROPS OPEN, SUTURED
	(R) ARM	SLIGHTLY EDEMATOUS	DRESSING
2100	(L) eye (R) eye (R) arm	OS swollen shut sutures under eye OD c̄ bruising to eye lid (R) arm drsg CDI	assessed
			b(6)-2 All

SECTION IV - NOTES

0800 PT had complete bath, oral care and meds given as ordered.
PT prep for OR [redacted]
1415 PT returned from [redacted] PACU. PT has foley and IV
fluids. Facial wounds cleaned and (L) eye attended to
by surgeons. PT transferred to bed. PT resting comfortably.
Later in shift foley to be removed — [redacted]
1600: Awake and alert. c/o pain in OS. 4mg MSO4 IV given.
Cleaned face & applied bacitracin. Will continue to monitor [redacted]
18 Sep 03 0030 pt c/o tightness to face, bacitracin applied as ordered. Will
cont to monitor [redacted] 91WM6

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 1 | HOSPITAL DAY: 4

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1600	2000	0400													
BP ARTERIAL LINE																
BP CUFF	104/58	104/60	125/56													
TEMPERATURE	98.8	100	97.2													
PULSE	79	84	100													
RESPIRATORY RATE	16	18	22													
OXYGEN (L/%)																
PULSE OXIMETER	99%	98%	100%													
O2 METHOD	RA	RA														

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:	2300	0830	0930	1400	2000				
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	Y	Y	Y	N					
RELIEF ACCEPTABLE (Y/N)	Y	Y	Y	Y					

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	0700	1400	2300
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol			
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: NA

WEIGHT CHANGE: NA

*Per hospital policy.

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

PATIENT IDENTIFICATION

Giv[redacted] b(a)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxilla fx, supraorbital lac

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

CASE MANAGER: _____

MEDCOM - 19180

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) GCS 15-IMPAIRED SIP SURGERY.	☐ (L) eye is extremely edematous. Ø vision noted R/T that eye. Only opens by manual manipulation, & significant pain. (L) WNL	☐ OD Dressing Shut, opens only for med.
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
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.	☑	☑	☑
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.	☐ (R) ARM TRAUMATIZED, IBAS DRESSING DUE TO SWOLLENESS.	☐ (L) arm bandaged. Neurovascularly intact & no c/o pain. Sling CDI.	☐ (R) forearm & dressing CDI
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ IBAS WOUND FROM MINOR FRACTURES	☐ Abrasions & sutures to face, especially (L) side,	☐ Sutured under OD intact OTA, sutures to (L) side of forehead, bacitracin applied to face
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ REQUESTED PAIN MED IV FOR COMFORT.	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr: 12	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided: flushed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) hand	IV Site #1: (L) hand / OK	IV Site #1: (L) hand / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL (flushed well)	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (2) LT E. TIME: 1200 ~~1400~~

COLOR	W
CAPILLARY REFILL	2
TEMPERATURE	W
EDEMA	2
SENSATION	S
MOTION	~~P~~
PASSIVE FLEXION	P/D
PERIPHERAL PULSE	2

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0800	1400	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Regular
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: ok
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	~~☒~~ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	~~BEDREST~~ AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
CONTENT: 1. NO TO BEND FROM WAIST 2. NO CRANK TURNING OF HEAD	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: pain management call for help
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
b(6)-2	[redacted]	6-2
	[redacted] LCPL	14-22
	[redacted]	N

MEDCOM - 19182

SECTION III - INTERVENTIONS & TEACHING (cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2300	(A) EYE (B) SIDE OF FACE	PALE, EDEMATOUS.	1. EYE DROPS 2. CLEANSED W/ H2O + PSN AND BACITRACIN APPLIED.
		(C) HAND.	NORMAL, SMALL CUTS.	3 DRSG
	2300	(B)		

SECTION IV - NOTES

BT medicated for pain IV and given AB therapy via IV and optht. gtts in (A) eye. advised. [redacted] BT & taught ADLS, (C) hand cleansed and dressing applied. BT encouraged with PO fluids, and rest advised — [redacted] q 1 hrs

1400 → Pt exc assumed [redacted] SAN

b(6) - 2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 19 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 2 | HOSPITAL DAY: 5

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000															
BP ARTERIAL LINE																		
BP CUFF	128/86	127/61	103/41															
TEMPERATURE	97.2	98.6	97.5															
PULSE	100	79	67															
RESPIRATORY RATE	22	20	16															
OXYGEN (L/%)	0																	
PULSE OXIMETER	100%	98	100															
O2 METHOD	RA		RA															

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:	0600	1400	2000	2330														
PAIN INTENSITY (10 / 5 / 0)																		
MED ADMINISTERED (Y/N)	Y	N		N														
RELIEF ACCEPTABLE (Y/N)	Y	Y		NA														

OTHER

TIME:	0600																	
FINGER STICK GLUCOSE	N/A																	
INSULIN (Y/N)	N/A																	

SPECIAL NEEDS

TIME:	0600	1400	2330
*Skin breakdown prevention	N/A	NA	N/A
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N

TODAY'S WEIGHT: _____

WEIGHT CHANGE: A

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] 5(ce)-4

Kurdish Soldier

DIAGNOSIS: retinal bleed, Maxillofx, Schrapnel R/L Knee

DRG: _____ ADMISSION DATE: 15Sept03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(4)-2

	TIME: 0600 INITIALS: KW	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Language barrier	☐ Eye extremely swollen, can be opened by pt however. No visual Δs to Rt eye	☐ Lt eye edematous and echymotic Pt can open own eye
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ RUE & multiple shaped wounds. Facial wounds	☐ Multiple lacerations to face and RUE dsg. RUE CDI. Facial lacs covered & bacitracin. Some serosang drainage	☐ multi lacs to face and Rt E. Bacitracin to face & RUE. Old drainage
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 5/10 percocet given	☐ See pg 1 dsg noted, MD aware	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: assess/flush	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: (L) FA / OK	IV Site #1: (L) Ft / OK	IV Site #1: (L) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: HL (flushed)	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE	TIME: 0600	1400	2230			
COLOR	P		P			
CAPILLARY REFILL	2		2			
TEMPERATURE	W		W			
EDEMA	0		0			
SENSATION	S		S			
MOTION	M		M			
PASSIVE FLEXION	0		0			
PERIPHERAL PULSE	2		2			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0600	1400	2230
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: ok	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: - Encourage pt to ambulate - call for assist - pain management	CONTENT: - Staff orientation - Call for help - Ambulation	CONTENT: - Call for assistance. - Encouraged ambulation - Reviewed
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted]
Kurdish Soldier

INITIALS	SIGNATURE	SHIFT
[redacted]	b(6)-2	D
	USAF	14-22
	LT/MC	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
[illegible]	RUE	multiple shrapnel wounds 5mm in size no drainage	cleaned wounds c̄ sterile water - dsg of kerlix
1400	(L) ~~side of~~ eye/face, (L) eye	sutures intact	Cleaned and bacitracin applied
2230	(L) eye, face	sutures intact, shrapnel wound @ c̄ bacitracin	bacitracin applied

SECTION IV - NOTES

19 Sept03 0900 pt going to appointment c̄ Dr.
[redacted]
1400 → Assumed pt. care. [redacted] 91WM
1820 New IV started by order of LT Vanfossen 20 GA to back of [redacted]
(L) wrist. PRN Adapter in place. PFC [redacted] 91W10
19 Sep03 2230 (Ø) c/o pain. Pupils reactive to light. (L) pupil sluggish. Eye edematous and echymotic but ↓ from yesterday. Gtts to eye. Will monitor [redacted]

b(6)-2 All

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

MEDCOM - 19187

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 20Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 3 | HOSPITAL DAY: 6

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0460 (21Sep03)													
BP ARTERIAL LINE	/		/	/													
BP CUFF	111/60	116/56	116/76	111/68													
TEMPERATURE	99.1	97.9	97.9	97.6													
PULSE	79	62	60	68													
RESPIRATORY RATE	18	18	16	16													
OXYGEN (L/%)	/	/	/														
PULSE OXIMETER	99	99	96	99													
O2 METHOD		RA	RA														

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:	1400	2000	2230														
PAIN INTENSITY (10 / 5 / 0)																	
MED ADMINISTERED (Y/N)	N		Y														
RELIEF ACCEPTABLE (Y/N)	Y		NA														

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)			NA														

SPECIAL NEEDS

TIME:	2	1400	2230
*Skin breakdown prevention	Y	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: NA

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ[redacted] to (w)-2

[redacted]

Burdick Soldier

DIAGNOSIS: retinal bleed, maxilla fx, Shragnal fx

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

MEDCOM - 19188 EQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(6)-2

	TIME: INITIALS:	TIME: MOD INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ Ⓛ EYE INJURY ~~RESPON FOREIGN~~ BODY	☐ Ⓛ eye swelling markedly ↓ from yesterday. Pt concerned about eye surgery - [illegible] No good assessment at site [illegible] 2° language barrier	☐ Ⓛ eye edematous & ecchymotic, able to open, contusion, pupil responding slowly, not completely round, pupil @ Ⓛ edge
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ SIDE OF Ⓛ FACE SUTURED.	☐ Sutures to Ⓛ side of face c̄ abrasions continue. Bacitracin continues	☐ sutures to Ⓛ side of face intact abrasions c̄ bacitracin
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

	Column 1	Column 2	Column 3
TIME	0800	1400	2230
INITIALS	[redacted]	[redacted]	[redacted]
IV patency ✓ q __ hr	12	8	
IV site care provided			
IV tubing changed			
IV Site #1 (Location / Condition)		Ⓡ hand / OK	Ⓡ hand / OK
IV Site #2 (Location / Condition)			
Comments	RECEIVED ON CBR [illegible]	HL (flushed)	heplocked

MEDCOM - 19189

ACLU-RDI 1650 p.149

DOD-032763

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) Knee	TIME: 0700	1400					
COLOR	N						
CAPILLARY REFILL	1						
TEMPERATURE	W						
EDEMA	2						
SENSATION	S						
MOTION	D						
PASSIVE FLEXION	D						
PERIPHERAL PULSE	2						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

OTHER

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 30%	PERCENT CONSUMED: 100%	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED: well	HOW TOLERATED: ok
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1400	INITIALS: [redacted]	TIME: 2230	INITIALS: [redacted]
CONTENT: 1. TO REPORT CHANGES IN MENTAL STATUS 2. DSC FOR PAIN MEDS		CONTENT: - Staff orientation - Call for assistance - Pain management - Encouraged Ambulation		CONTENT: Staff orientation Call for assistance Pain management	
☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

Civ [redacted] b(4)
Kurdish Soldier

INITIALS	SIGNATURE	SHIFT
[redacted]	b(6)-2	6-2
[redacted]	[redacted]	14-22

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	(L) EYE.	SWOLLEN, RED	EYE DROPS
	(L) SIDE OF FACE	SWOLLEN MODERATELY	BACITRACIN
2230	(L) eye	Sclera reddened, swollen, ecchymotic	- gtts given
	(L) side of face	Swollen, sutures intact	- bacitracin to sutures

SECTION IV - NOTES

1330 Pt alert and oriented. Unable to assess level of sight. Pt concern about his eye. Care given, face cleansed with water and hydrogen peroxide mixture. Eye drops given then bacitracin applied to suture site.

1400 Pt ate Kurdish lunch. Pt deeply concern about when he is going home. Pt seen by MD and pt condition reiterated to him through interpreter that he has to undergo more surgery before he is stabilised. Pt resting quietly in bed able to open (L) eye.

~~1400~~

1900 → Assumed pt care. [redacted] RN

20Sep03 2230 Pt awake and alert, ø c/o pain. Pt able to open (L) eye on his own although still reddened and ecchymotic. Unable to assess visual Δ's to eye due to language barrier. Will continue to administer gtts and monitor pain management [redacted]

b(6)-2 All;

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 4 | HOSPITAL DAY: 7

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 22 Sep 03 Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0400												
BP ARTERIAL LINE																
BP CUFF	111/49	104/64	113/63	117/60												
TEMPERATURE	97.6	97.7	97.5	97.6												
PULSE	69	71	80	81												
RESPIRATORY RATE	16	16	16	16												
OXYGEN (L/%)	RA	RA	RA	RA												
PULSE OXIMETER	99	98%	98%	99												
O2 METHOD	RA	RA	RA	RA												

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:	0600	1400	2000	2230												
PAIN INTENSITY (10 / 5 / 0)	0	X	0	X												
MED ADMINISTERED (Y/N)	N	N	NA	N												
RELIEF ACCEPTABLE (Y/N)	N/A	Y		NA												

OTHER

TIME:	0600															
FINGER STICK GLUCOSE	N/A															
INSULIN (Y/N)	N/A		NA													

SPECIAL NEEDS

TIME:	0600	1400	2230
*Skin breakdown prevention	N/A	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

CIV [redacted] b(4)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxilla fx, shrapnel ®

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(4)-2

PRIMARY CARE MANAGER: [redacted]

MEDCOM - 19192 IUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

bleb - 2

	TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Ⓡ pupil slow reaction to light & round. Sclera red	☐ Ⓡ pupil appears clear but non-reactive. Slight discharge to circle at 7-o'clock position. Skin to Ⓡ pupil eye reddened but no active bleb	☐ OD Sclera red OS reactive to light.
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ wounds to face & drainage	☐ wounds to Ⓡ eye w/ sm dainty Bacitracin applied. Also, IV site	☐ Sutures to Ⓛ orbit of face intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Assess/flush	IV site care provided:	IV site care provided:
IV tubing changed: Ⓛ FA OK	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1:	IV Site #1: Ⓛ wrist OK	IV Site #1: Ⓛ wrist OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: HL (flushed)	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0600	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED: 30%	PERCENT CONSUMED: 50%
HOW TOLERATED: Well	HOW TOLERATED: well	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: - call for assist - inform nurse of dizziness, nausea	CONTENT: -Staff orientation -Call for help -pain management	CONTENT: pain management call for assistance
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

[redacted]

Kurdish soldier

INITIALS	SIGNATURE	SHIFT
b(6)-2	[redacted] SPC/9thMPG	D
		14-22
	[redacted] 9thMPG	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0800	wounds to face	sutures OTA, intact no drainage	bacitracin applied

SECTION IV - NOTES

21 Sept 0360 Pt up to shower S difficulty. Wounds cleaned bacitracin applied. Pt rested @ this time

1400 → Assumed pt care.

1415 → Pt ambulatory to opthamology clinic

1435 → Pt returned from opthamology clinic S difficulty

[redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 5 | HOSPITAL DAY: 8

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 23 Sep Received By _____

VITAL SIGNS

TIME:		1200	2000	0400													
BP ARTERIAL LINE		✓	✓	✓													
BP CUFF	114/55	114/46	110/61	114/72													
TEMPERATURE	97.7	98.6	98.4	96.4													
PULSE	66	83	81	69													
RESPIRATORY RATE	20	18	18	16													
OXYGEN (L/%)		✓	✓	✓													
PULSE OXIMETER	99	100	99%	90													
O2 METHOD	RA	RA	RA														

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:	1200	1400	2000	2230	0200				
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X	X				
MED ADMINISTERED (Y/N)		Y	N/A	N	Y				
RELIEF ACCEPTABLE (Y/N)		Y		NA	Y				
Percout		T							

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	0800	1400	2230
*Skin breakdown prevention	B	M	NA
*Falls prevention protocol	NS		
*Restraint protocol	NS		
*Seizure precautions	NS		
*Isolation precautions	NS		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: NA

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

[redacted] b(4)-21

Kurdish soldier

DIAGNOSIS: Retinal bleed, maxilla fx, lac nasal @ R knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

MEDCOM - 19196 ADDITIONAL REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☐ (L) eye pupil @ 5mm. Non reactive. Unable to perform accurate assessment. Pt states pt loses light & see shadows.	☐ (L) eye pupil at 5mm, responds slightly and sluggish to light. Pt vision blurry to (L) eye
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)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
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.	✓	✓	✓
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.	✓	☐ Pt c/o (R) shoulder pain, Percocet given for pain	✓
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ IV site's sutures x three. MD says sutures will come out tomorrow	☐ Multi shrapnel wounds to chest and bilat UE.
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ see p1	✓
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	✓	✓

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

TIME: 0800 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr: prn
IV site care provided:	IV site care provided:	IV site care provided: site d/c
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (L) hand / OK	IV Site #1: (L) hand / I
IV Site #2:	IV Site #2:	IV Site #2: (R) wrist / OK
Comments: Pt on IV and Bolus	Comments: HL (flushed)	Comments: HL between meds

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) Eye	TIME: 1200					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1200	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	REGULAR		Regular
PERCENT CONSUMED:	75%		OK 75%
HOW TOLERATED:	WELL		OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1400	INITIALS: [redacted]	TIME: 2230	INITIALS: [redacted]
CONTENT: 1. NOT TO TOUCH EYE WITH FINGERS 2. NOT TO BEND FROM WAIST		CONTENT: -Staff orientation -Call for help -Pain management		CONTENT: Staff orientation Call for assistance Pain management Eye gets	
☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

Civ [redacted] b(6)-6

INITIALS	b(6)-2 SIGNATURE	SHIFT
	[redacted]	6-2
	LP, AN	14-22
	LP, AN	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	Ⓛ EYE ; CHEEK	~~PINKISH~~ SWOLLEN x 1	EYE DROPS SUTURES INTACT. BACITRACIN ~~CREAM~~
2230	Ⓛ eye & cheek	Ⓛ eye reddened, swollen Ⓛ cheek swollen, sutures intact	eye gtts q2° Bacitracin to face

SECTION IV - NOTES

1200 Patient alert and oriented x3. able to voice concerns. Pt had eye drops, ate meal. Had visit from DOD rep. Pt passed American liaison. Pt in no distress. Resting quietly [redacted]

1400 → Assumed pt care. [redacted]

22 Sep 03 2230 Pt awake and alert, ∅ c/o [redacted]. Gtts continue to Ⓛ eye, bacitracin to Ⓛ cheek. New IV to Ⓡ wri[redacted]

b(6)-2

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 6 | HOSPITAL DAY: 9

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1100	2000	0400														
BP ARTERIAL LINE																	
BP CUFF	118/70	109/70	109/61														
TEMPERATURE	97	97.8	97.3														
PULSE	84	88	76														
RESPIRATORY RATE	20	18	16														
OXYGEN (L/%)																	
PULSE OXIMETER	99	99	99														
O2 METHOD	RA	RA															

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:	1600	2000								
PAIN INTENSITY (10 / 5 / 0)	0	1								
MED ADMINISTERED (Y/N)	Y									
RELIEF ACCEPTABLE (Y/N)										

OTHER

TIME:	1600									
FINGER STICK GLUCOSE	N/A									
INSULIN (Y/N)	N									

SPECIAL NEEDS

TIME:	0600	1600	2000
*Skin breakdown prevention	[redacted]	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] 5(a)-2

[redacted]

Kurdish Soldier

DIAGNOSIS: Retinal bleed, maxilla fx, shrapnel ® knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(6)-2

	TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (1) EYE SWELLING POOR VISION COOPERATIVE.	☐ OS BV, erythema pupil ø reactive to light	☐ OS swollen erythema to OU ø reaction to light
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ (2) FACE LACE-SUTURED SITE.	☐ Laceration (1) cheek sutures OTA	☐ (1) cheek sutures intact
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑ ø c/o pain. asked for Ambien 10mg Ambien given 2230
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ CONCERN ABOUT FAMILY	☑	☐

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

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
IV patency ✓ q ___ hr: IVL	IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: assessed	IV site care provided: flushed
IV tubing changed:	IV tubing changed: flushed	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (R) FA / OK	IV Site #1: RFA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: RO IN IVL DUE? MMS	Comments: HL	Comments: HL

CW [redacted] b(6)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (C) EYE O FACE TIME:	0600	E					
COLOR	N	MA					
CAPILLARY REFILL	1						
TEMPERATURE	W						
EDEMA	2						
SENSATION	S						
MOTION ↑ HAND	M						
PASSIVE FLEXION ↑ HAND	D						
PERIPHERAL PULSE	2						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0600	E	N
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h	[redacted]		
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REGULAR.	TYPE: REGULAR.	TYPE: REG.
PERCENT CONSUMED: 60%	PERCENT CONSUMED: 80%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
CONTENT: 1. HOW TO COMMUNICATE USING ABILITY BY GESTURES. 2. TO MONITOR AND REPORT CHANGES IN VIS.	CONTENT: Pain management	CONTENT: Pain management call for assistance
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4 Kurdish Soldier	b(6)-2		6-2
		[redacted] AMAN	E
		QUINN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	(L) EYE (L) SIDE OF FACE	SWOLLEN - REDNESS SWOLLEN	EYE DROPS SUTURES
	(L) eye (L) side face.	swollen, erythema sutures CDI	eye drops.
2200	OS (L) Cheek	Swollen erythema sutures CDI	assessed

SECTION IV - NOTES

0800 Pt in bed, aware of treatment plan. That is need for eye drops and keep area around eye and facial laceration site clean. Pt had visit from DOD personnel. Pt able to phone family. [redacted] 91WN4
1100 Pt feels more comfortable or mostly bonding with other persons including Iraqi friends and patients. Pt keeps Kurdish food. Eye drops applied to (L) eye, pt showing more outgoing [illegible] 91WM6.
Pt ate lunch 100% [redacted] b(6)-2

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

Civ [redacted] b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 7 | HOSPITAL DAY: 10

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 25Sep Received By _____

VITAL SIGNS

TIME:	0956	2000	0400													
BP ARTERIAL LINE																
BP CUFF	117/59	140/56	102/58													
TEMPERATURE	97.1	97.5	97.3													
PULSE	72	98	68													
RESPIRATORY RATE	20	20	16													
OXYGEN (L/%)																
PULSE OXIMETER	98	98	99													
O_2 METHOD	RA	RA														

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:	1540	2000	2320	0030												
PAIN INTENSITY (10 / 5 / 0)	5	5	5	10												
MED ADMINISTERED (Y/N)	Y		N	Y												
RELIEF ACCEPTABLE (Y/N)	Y		NA	Y												

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME: 0900 1540 2320

*Skin breakdown prevention [redacted]

*Falls prevention protocol

*Restraint protocol

*Seizure precautions

*Isolation precautions

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

CIV [redacted] b(6)-4

[redacted]

Kurdish soldier

DIAGNOSIS: Retinal Bleed, maxilla fx, Trauma (R) knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(4)-2

	TIME: 07 00 INITIA[redacted]	TIME: 1540 INITIALS[redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) EYE = IMPAIRED VISION, PUPIL 5MM (R) EYE PUPIL 3 M.	☐ ↓ vision to OS, Pain to OU.	☐ ↓ vision to (L) eye
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ (L) SIDE OF FACE LAC, SUTURES INTACT.	☐ Lacerations to (L) face sutures intact. Bacitracin applied.	☐ lacerations to (L) side of face sutures removed.. CDI. Bacitracin applied
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ c/o pain in OU & (R) shoulder. Percocet PO given.	☐ Percocet for pain to face
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0630 INITIALS[redacted]	TIME: 1540 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr: IVL	IV patency ✓ q 8 hr:	IV patency ✓ q 8 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: (R) FA / OK	IV Site #1: (R) FA / I
IV Site #2:	IV Site #2:	IV Site #2: (L) wrist / OK
Comments: IVL R FA IVPB MORS	Comments:	Comments: (R) FA IV removed, new IV placed to (L) wrist

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0700					
COLOR	N					
CAPILLARY REFILL Blanch	1					
TEMPERATURE	W					
EDEMA	2					
SENSATION	S					
MOTION ↑ / HEAD	P					
PASSIVE FLEXION ↑ / HEAD	D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0700	1540	2030
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h	NA	NA	
ROM q2h if immobile	NA		
Antiembolic hose	NA		

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular		
PERCENT CONSUMED:	100		
HOW TOLERATED:	100%		
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1540 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: 1. TO KEEP ARTICLES + CLOTHES AWAY FROM (L) EYE. 2. TO REST (L) EYE	CONTENT: Plan of care.	CONTENT: Call for assistance + Pain management + Gtts to (L) eye + New IV
☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C [redacted] b(6)-4	[redacted]	[redacted] b(6)-2	6 2 2206

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

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
1.	(L) EYE.	SWOLLEN + 2, PINKISH-RED.	EYE DROPS
2.	(L) SIDE OF FACE	BACITRACIN OINT.	SUTURES.
1540	(L) face	sutures intact	bacitracin applied.
2230	(L) eye (L) side of face	sclera red, eyelids still swollen Sutures removed, CDI	gtts q2° Bacitracin applied

SECTION IV - NOTES

0900 Pt perform ADLs. face cleansed and eye drops administered, scabs and sutures coated with bacitracin. MD removed sutures from face, pt tolerated procedure well. Pt (R) eye pupil 3MM, (L) eye pupil 5MM. Pt said, "I have see." [redacted]

1100. Pt seen by MD [redacted] for pain in (R) scapula x-rays orders completed - no bone defect noted. [redacted]

1540: Alert. c/o pain in OU + (R) shoulder. Percocet II PO given. Will continue to monitor. [redacted]

24 Sep 03 2230 Pt awake and alert, Ø C/O pain at this time. Sutures removed from (L) side of face, wound healing well, edges well approximated. Bacitracin applied. Gtts continue to (L) eye. [redacted]

b(6)-2 All

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sep 03 | PATIENT ACUITY LEVEL : II | POST-OP DAY: 8 | HOSPITAL DAY: 11

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400
BP ARTERIAL LINE	—		
BP CUFF	122/60	100/60	121/52
TEMPERATURE	97.6	99.1	98.2
PULSE	79	84	91
RESPIRATORY RATE	18	18	
OXYGEN (L/%)	—		
PULSE OXIMETER	100	99	100
O_2 METHOD	RA	RA	

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:	0800	1200	1400	2000
PAIN INTENSITY (10 / 5 / 0)	4	X	X	
MED ADMINISTERED (Y/N)	Y	Y	N	Y
RELIEF ACCEPTABLE (Y/N)	N		Y	

OTHER

TIME:				
FINGER STICK GLUCOSE				
INSULIN (Y/N)				

SPECIAL NEEDS

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

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

[redacted] b(6)-4

Kurdish Soldier

DIAGNOSIS: Retinal bleed, Maxillofacial fx, Shrapnel wounds

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted] b(6)-2

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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.

b(4)-2

	TIME: 0830 INITIALS: [redacted]	TIME: 1460 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ Sclera redden OU (R) eye 4-5mm (L) eye 3 mm ↓ vision in OU	☐ (R) eye sclera continues to be reddened. (R) eye PERRLA. (L) eye does not constrict.	☐ Sclera OU red
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ Multiple scars to face bacitracin ointment applied	☐ Multiple lacerations & abrasions to face, Dental = bruised	☐ Several abrasions to face
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MEDICATION Percocet providing (+) effect	☐ see pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0830 INITIALS: [redacted]	TIME: 1460 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided: flushed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) RA / OK	IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2: #	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL (flushed)	Comments: HL

Civ [redacted] b(4)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0830	1400	2300
ID band visible/legible	[redacted]	[redacted]	[redacted]
Orient to environment prn	[redacted]	[redacted]	[redacted]
Side rails (2/4) up	—	[redacted]	
Bed position low	—		
Call light within reach	—		
Review & post lab results	—	[redacted]	
Notify MD abnormal labs	—		
Incontinent urine/stool	—		
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

b(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: ok
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
CONTENT: Pain Control Translator end lib	CONTENT: -Call for help -Pain mgmt -Staff orientation	CONTENT: Pain management
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ [redacted] Verbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION	INITIALS	SHIFT
CIV [redacted] b(6)-2 Kurdish Soldier	[redacted]	1
		14-22
		N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1400 → Assumed ft care. [redacted] dw

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 26 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 9 | HOSPITAL DAY: 12

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0400
BP ARTERIAL LINE				
BP CUFF	121/52	117/48	104/57	110/53
TEMPERATURE	98.2	98.3	96.5	97.3
PULSE	91	82	72	86
RESPIRATORY RATE	16	18	16	16
OXYGEN (L/%)	0	/	—	
PULSE OXIMETER	100	100	100%	98
O_2 METHOD	RA	RA	RA	

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:	0700	1200	1600	2000	2330
PAIN INTENSITY (10 / 5 / 0)			X		
MED ADMINISTERED (Y/N)	N		Y	N	N
RELIEF ACCEPTABLE (Y/N)	N/A		Y	NA	NA
Percocet			11		

OTHER

TIME:	0700
FINGER STICK GLUCOSE	N/A
INSULIN (Y/N)	N/A

SPECIAL NEEDS

TIME:	0700	1400	2230
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: Retinal bleed, Maxilla fx, Shrapnel @ knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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* [redacted] [illegible]

	TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) pupil unreactive to light around sclera of (R) + (L) eye red. Pt able to see light (L) eye	☐ (L) pupil remains dilated. Pt claims to see lights & shadows, (R) eye has some redness & blood to lateral side of eye	☐ Eyes red (R) + (L). over dilated pupil. Responds minimally to light. Blurred vision and ↓ vision (L) eye
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑	☑	☑
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.	☐ multiple wounds to face and (L) arm no s/s infection	☐ multiple wounds to (L) face. Most sutures removed covering c̄ Bacitracin ointment. ∅ s/s infection. Also IV.	☐ multiple shrapnel wounds to (L) face. Sutures removed, healing well
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

	TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency √ q __ hr:		8	8
IV site care provided:	flush process		
IV tubing changed:	(L) FA OK		
IV Site #1 (LOCATION / CONDITION):		(L) FA / OK	(L) FA / OK
IV Site #2 (LOCATION / CONDITION):			
Comments:	HL'd	HL (flushed)	HL, flushed

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0700	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg	Reg	Regular
PERCENT CONSUMED:			75%
HOW TOLERATED:			OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: / INITIALS:	0700 [redacted]	1400 [redacted]	2223 [redacted]
CONTENT:	-call for assist	-Staff available - Call for help - Pain management	Call for assistance Eye gets Vary
	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C&C [redacted] b(6)-4 b(6)-2	[redacted]	[redacted]	D 14-22 22 OK

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

26Sept03 0740 Pt amb S difficulty. showered this am. yw c/o pain on discomfort. Will see Iraqi Dr. today. [redacted] SPC/9/WM6

26Sep03 0830 - IV DC @ 0815. New IV started @ 0825 hrs. 20 GA to back of (R) hand. PRN in place and flushed c NS. [redacted] PFC 9/W10

1400 → Assumed pt care. Pt seen by Iraqi retinal specialist. PAD [redacted] for surgery at Iraqi hospital for retinal surgery. [redacted] SPC

26Sep03 2230 Pt sleeping, easily arousable c verbal stimuli. Ø complaints @ this time. Will continue to monitor [redacted] U/SPC

b(e)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 27 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 10 | HOSPITAL DAY: 13

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0415													
BP ARTERIAL LINE		—	—	—													
BP CUFF	116/53	102/62	111/66	104/57													
TEMPERATURE	97.3	98.4	98.3	97.4													
PULSE	86	94	95	91													
RESPIRATORY RATE	16	18	16	16													
OXYGEN (L/%)	/	/	—	—													
PULSE OXIMETER	98	98%	99%	99													
O2 METHOD	RA	RA	RA	RA													

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

PAIN

TIME:	0640	1400	2000	2230													
PAIN INTENSITY (10 / 5 / 0)	0	0	0	0													
MED ADMINISTERED (Y/N)	N	N	N	N													
RELIEF ACCEPTABLE (Y/N)	N/A	Y	NA	NA													

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)																	

SPECIAL NEEDS

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

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

Civ [redacted] b(6)-4

Kurdish soldier

DIAGNOSIS: retinal bleed, maxillary & zygomatic fx (L)

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

MEDCOM - 19216

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Language barrier (L) pupil unreactive to light & round. (R) seems to react. (R) pupil reactive & round	☑ Keeps (L) pupil remains dilated unresponsive to light. States unable to see small amounts of light. (R) pupil PERRLA.	☐ (L) pupil remains dilated & minimally responsive to light. Pt states he can see the light. (R) pupil normal
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ Congestion noted to RUL on exhale. No cough noted	☑	☑
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.	☑	☑	☑
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.	☐ Full ROM to (R) shoulder & elbow. Some amt of pain	☐ Combines to c/o small amounts of (R) shoulder pain. ROM limited by this pain	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Facial wounds healing well (R) arm stinging wounds healing OTA	☐ Facial lacerations healing well. Ø S/S infection. Ø sutures remaining	☐ Facial wounds healing well. (R) arm healing
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Flush	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: (R) FA / OK	IV Site #1: (R) hand / OK	IV Site #1: (R) hand / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL (Flushed).	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME: 0600 [illegible] 2220	
ID band visible/legible	[redacted]
Orient to environment prn	
Side rails (2/4) up	
Bed position low	
Call light within reach	

OTHER

Review & post lab results	
Notify MD abnormal labs	
Incontinent urine/stool	
Linen change prn	
Turn/reposition q2h	
ROM q2h if immobile	
Antiembolic hose	

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg	Reg	Regular
PERCENT CONSUMED:			75%
HOW TOLERATED:			OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: · Call for assist · Pain plan of care	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: + Staff orientation + Call for assistance + Pain management + Eye gates
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C [redacted] b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted] SM/9mm	0
	[redacted]	14-22
	[redacted]	22-0

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

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1600	(L) eye	pupil not round unreactive to light sclera red	Stk q 2°
	2230	(L) eye	Sclera red; pupil not responsive not round	gets q 2°

SECTION IV - NOTES

27 Sept 03 0700 Pt seen by Iraqi doctor yesterday. Arrangements are being made for pt to go to Iraqi hospital for surgery. [redacted] RN/MC

1400 → Assumed pt care. [redacted] RN

27 Sep 03 2230 Pt sleeping, easily arousable to verbal stimuli. Ø c/o pain at this time. Eye gtts continue q 2°. Will continue to monitor [redacted] RN

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: N | HOSPITAL DAY: 4

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	/	/														
BP CUFF	127/70	139/75	130/70													
TEMPERATURE	97.6	98.9	98.4													
PULSE	90	99	96													
RESPIRATORY RATE	16	16	18													
OXYGEN (L/%)	/	/														
PULSE OXIMETER	97%	99	99%													
O2 METHOD	RA		RA													

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:	0900	1400	2330	0400						
PAIN INTENSITY (10 / 5 / 0)										
MED ADMINISTERED (Y/N)	N	N	N							
RELIEF ACCEPTABLE (Y/N)		Y	NA							

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)	N/A									

SPECIAL NEEDS

TIME:	1400	2330
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxillary fx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-7

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ talks a little English (L) pupil unresponsive (R) pupil responsive & reactive to stimulation	☐ (L) pupil dilated to 6mm unresponsive (R) pupil PERRLA.	☐ (L) pupil dilated unresponsive (R) pupil PERRLA, appropriately responsive
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)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
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.	☑ b(w)-2 A11	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
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.	☐ Some small bruises & abrasions noted to arms & face	☐ Multiple abrasions to face. Bacitracin applied	☐ Small diagonal wounds to face healing well
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 3/10 no pain meds given	☐ see pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

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

TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 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: (R) wrist / OK	IV Site #1: (R) wrist / OK	IV Site #1: (R) wrist / OK
IV Site #2: * /	IV Site #2: /	IV Site #2: /
Comments: HL IV antibiotics	Comments: HL (flushed)	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0900	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			OFF
Bed position low			
Call light within reach			
Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Regular
PERCENT CONSUMED:	75%	75%	75%
HOW TOLERATED:	well	OK	OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	CONTENT:	
		- Pain Control - Ambulation	☐ Patient/Family Verbalizes Understanding
1400	[redacted]	- Staff orientation - Call for help - Pain management	☒ Patient/Family Verbalizes Understanding
2230	[redacted]	Call for assistance Pain management Eye gtts	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ [redacted] b(6)-4	b(6)-2	[redacted]	1D
			14-22
			22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

MOO → Assumed pt care [redacted] MSTW
28 Sep 03 2230 Pt awake and alert, ambulating in hallways w/ assistance. Ø complaints. [redacted] CT/MT

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 12 | HOSPITAL DAY: 15

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200																
BP ARTERIAL LINE	✓	—																
BP CUFF	134/70	114/66																
TEMPERATURE	98.6	98.2																
PULSE	96	69																
RESPIRATORY RATE	16	18																
OXYGEN (L/%)	✓	✓																
PULSE OXIMETER	99	100%																
O2 METHOD	RA	RA																

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:	0830	1200	1450															
PAIN INTENSITY (10 / 5 / 0)	X	X	X															
MED ADMINISTERED (Y/N)	N	N	N															
RELIEF ACCEPTABLE (Y/N)	NA	NA	Y															

OTHER

TIME:																		
FINGER STICK GLUCOSE																		
INSULIN (Y/N)																		

SPECIAL NEEDS

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

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

Civ [redacted] b(4)-4

[redacted]

Kurdish soldier

DIAGNOSIS: Retinal blood, maxillofx, shrapnel @ knee

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(4)-3

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	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.	☐ - OS pupil nonreactive to light - OS sclera red - pt stated that he sees red when light shined into OS	☐ OS pupil remains non-reactive to light & dilated. sclera of ® eye reddened. States he can see some light.	☐
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)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
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.	☑ b(6)-7 A11	☑	☐
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.	☐ - Scars below OS & on ® side of face - dime size open wound to upper ® chest	☐ multiple abrasions to © hand. Bandaged	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 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: NO IV access	IV Site #1: NO IV Access	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0830	1400					
ID band visible/legible	[redacted]						
Orient to environment prn							
Side rails (2/4) up							
Bed position low							
Call light within reach							

OTHER

Review & post lab results	[redacted]						
Notify MD abnormal labs							
Incontinent urine/stool	[redacted]						
Linen change prn							
Turn/reposition q2h							
ROM q2h if immobile							
Antiembolic hose							

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 100%	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) (AMBULATE) BSC (BRP) CHAIR	BEDREST (AMBULATE) BSC BRP CHAIR	BEDREST AMBULATE BSC BRP CHAIR
	☒ SELF ☐ ASSIST	☒ SELF ☐ ASSIST	☐ SELF ☐ ASSIST
	# TIMES/SHIFT	# TIMES/SHIFT	# TIMES/SHIFT

TEACHING

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Call for assistance	CONTENT: - Staff orientation b(4)-2 - Call for help - Pain management	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4 [redacted]	[redacted] b(4)-2	[redacted] DT/AN	06-14
		LT/AN	14-22

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0830	Ⓡ upper chest	red, moist & sml amt of serous drainage	bacitracin & dry 2x2 placed over wound

SECTION IV - NOTES

1400 -> Assumed pt care. [redacted]

1615 -> Pt ambulated upon DC (actually, transfer to Iraqi hospital). Eye meds provided. X-rays sent & pt patient. Pt transferred to Iraqi hospital via Iraqi ambulance. Transfer [redacted] provided.

b(4)-2

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 22y/o HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKOA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

left eye exploration

5. ADDITIONAL INFORMATION: Last PO: Thurs am Medical Hx: ∅ Implants: ∅ Medications: ∅
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impair-ment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted]
b(a) - 4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o ~~Place and take down legs from stirrups with slow bilateral motion~~ [redacted] o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. none	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MJ AN 15 Sept 03 DATE

11. POSTOPERATIVE EVALUATION: b(6)-2

Bowie Site: N/A
Drsg: clean
Breathing: SOB

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title
[redacted] MJ AN	[redacted]
DATE: 15 Sept 03 TIME: 1600	DATE: 15 Sept 03 TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

b(6)-2

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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: Gurney BY: LTC [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: LTC [redacted] b(6)-2

3. DATE: 17 Sep. 03 TIME PATIENT IN SUITE: 0800

4. PATIENT IN ROOM TIME: 0800 NUMBER: 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	b(6)-2 CPT [redacted] - 0950 - 1010; CPT [redacted] - 1100 - 1130

7. POSITION AND POSITIONAL AIDS (Specify) pillow under knees; arms tucked to sides c fingers free

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

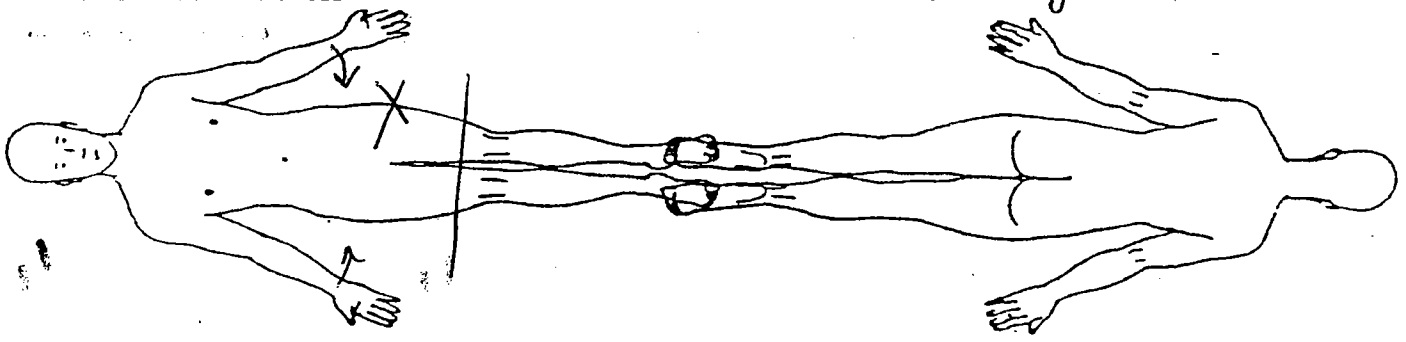
COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify) Betadine scrub/paint
SITE: face/neck Lt ear BY WHOM: LTC [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS		C = Correct I = Incorrect: Initial Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	V	C	C
Needle Sharp	☒ Yes ☐ No	V	C	C
Instrument	☐ Yes ☒ No	/	/	/
Other	☐ Yes ☒ No	/	/	/

SCRUB	CIRCULATOR
Spc. [redacted]	LTC [redacted]
/	/

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

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
cut: 35 coag: 35
☒ ESU NO: R8B10239S Valleylab Force 40
GROUND PAD: BRAND Polyhesive REM II
LOT NO: 68245
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 19230

3. PROSTHESIS, IMPLANTS [X] YES [ ] IF YES NAME: ID NUMBER; MAN ER KLS Martin Plating
.5 Curved 7 hole plate x1 2.0 7mm Screw x1 Modular Osteosynthesis Syst. Mod. 15 System
5 curved 7 hole plate x1 2.0(E) 7mm Screw x2 KLS Plating
& Six screws (See screws listed) 4-hole plate x1 1.5 5mm screws X14
~~curved 7 hole plate x~~ 2.0 5mm Screw x1

4. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
% xylo. c 1:100,000 epi	40*	intraop	local inj	[redacted]	Dr. [redacted]
Bacitracin oint	qs	post op	topical		" b(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN [redacted] b(6)-2

5. X-RAY [redacted] ROOM IF YES, SITE
YES [ ] NO [X]

6. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

7. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

18. DRESSING/IMMOBILIZATION *(Specify)*
kerlix fluffs roll } Rt. hand/arm
"
Bacitracin to face

19. ADDITIONAL INFORMATION
Surgeons: Drs. [redacted], & [redacted]
Anesth: LTC [redacted], CRNA b(6)-2
DA 5179 in chart
Teeth Brushed c Chlorhexidine Gluconate oral rinse preoperatively

20. OPERATION(S) PERFORMED
Repair (ORIF) of (Lt) 2 MC fx; wash out & change of dsg. Rt. hand/arm

21. PATIENT TRANSFERRED TO b(6)-2 PACU | TIME 1250 | METHOD via Gurney

22. REGISTERED [redacted] SIGNATURE LTC, AN [redacted]

[redacted] OF DA FORM 5179-R, [redacted] MEDCOM - 19231 [redacted] USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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 IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ AN

3. DATE 15 Sept 03 TIME PATIENT ARRIVED IN SUITE 1600

4. PATIENT IN ROOM TIME 1600 b(6)-2 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	CPT [redacted] 1810-1840 EOC

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

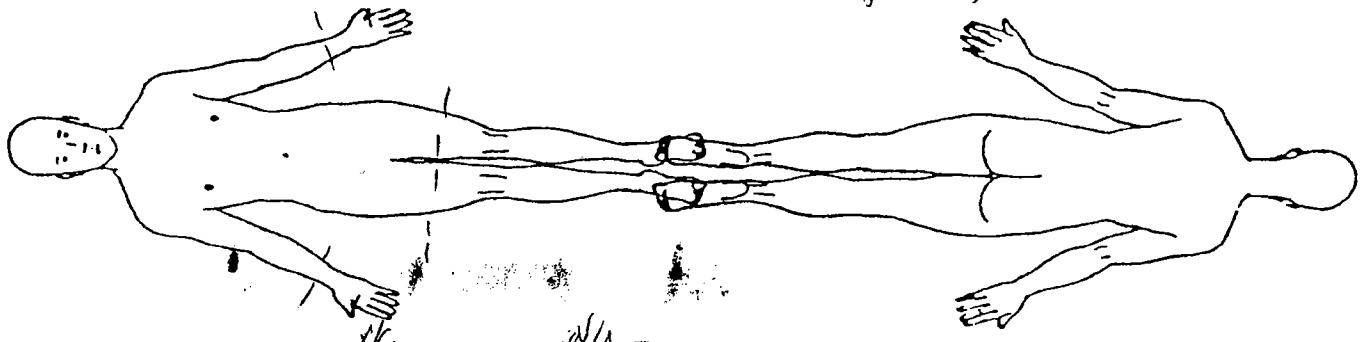
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine Solution
SITE: (L) Eye BY WHOM: MAJ [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: Ø, packing

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap N/A === Tourniquet

C = Correct I = Incorrect Initial !

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

SCRUB [redacted] b(6)-2 CIRCULATOR [redacted]

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

[redacted] b(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ 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
Mitchol-E	QS	Intraop	gtts	[redacted]	Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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	18. DRESSING/IMMOBILIZATION *(Specify)* eye pad fox shield

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC I
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op [redacted]; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op [redacted] post-op_____
Tourniquet Time: Up [redacted] Down_____

D (ce) - 2 A11

20. OPERATION(S) PERFORMED
Left eye exploration, Repair of Ruptured Globe

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	see DA 3328	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN [redacted] CPT AN

R[redacted] FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 19233

ACLU-RDI 1650 p.193

DOD-032807

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- DAY: DOS

MONTH-YEAR: 15 | DAY: 16 17 18 19 20 21 22

19 | HOUR

PULSE (0) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 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

BLOOD PRESSURE

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)*

C [redacted]

REGISTER NO.

WARD NO. ICU2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19234

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep 05 | DAY | HOUR

23 24 25 26 27 28 29

PULSE (O) | TEMP. F (°)

105° 104° 103° 102° 101° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 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

BLOOD PRESSURE

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)*

REGISTER NO.

WARD NO. 1CW2

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

CIV [redacted] b1a)-4

MEDCOM - 19235

99.1
14/00
88
1670
16

Ward/Section: | REQUESTING PHYSICIAN: | CHEMISTRY RESULT FORM (Subject to the Privacy Act ...)

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 09 | TIME 1157 | SSN/PSEUDO [redacted]

i-STAT

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO2		
PO2		
TCO2		
HCO3		
sO2		
BEecf		
AnGap		
Ca		
BUN		
GLU		
Creat		
Hct		
Hgb		
TE		
Tropx		
Drug Abu		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

======= PICCOLO =======
15/09/03 12:45
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]
.....

ALB	3.5	3.3-5.5	G/DL
ALP	60	26-84	U/L
ALT	22	10-47	U/L
AMY	59	14-97	U/L
AST	37	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CHOL	137	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	7.8	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	73-118 mg/dl
	7-22 mg/dl
	0.6-1.2 mg/dl
	39-380 u/l (M) 30-190 u/l (F)
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

Piccolo) Methyte 8

i-STAT EC8+
Pt: [redacted] b(6)-4
Pt Name:_____

Glu_____95 mg/dL
BUN_____12 mg/dL
Na_____141 mmol/L
K_____4.3 mmol/L
Cl_____109 mmol/L
TCO2_____27 mmol/L
AnGap_____10 mmol/L
Hct_____35 %PCV
Hb*_____12 g/dL
*via Hct
PH_____7.345
PCO2_____47.7 mmHg
HCO3_____26 mmol/L
BEecf_____0 mmol/L

Sample Type_:
15SEP03 12:46
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

REMARKS:

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

Ward/Section: EMT | REQUESTING PHYSICIAN: [redacted] b(6)-2 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 15SEP03 | TIME: 1245 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	ID [redacted]	
RI	WB	
Hg		
H	WBC 11.3 H x10^3/uL	
	RBC 4.00 L x10^6/uL	4
M	Hgb 11.9 g/dL	11
	Hct 37.2 %	35
	MCV 93.1 fL	8
PI	MCH 29.8 pg	27
	MCHC 32.0 L g/dL	33
L	Plt 409. x10^3/uL	15
	LY% 13.7 wL %	2
	LY# 1.5 * x10^3/uL	
	tial	
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		

Mono			
Eos			
Baso			
Imm			

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

Urinalysis

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

CSF

Cell Count		
Directigen		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

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 Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Jolacco

NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)	Doses	TOTALS
Medazolam (mg)	2	2
Fentanyl (mcg)	50 50 50 50 50 50 50 50	400
Lidocaine (mg)	100	
Propofol (mg)	150	
Sux (mg)	80	
Rocuronium (mg)	5 50 20 10 20 20 20	
VOLAT AGENT Iso % del	1.5 1.5 1.0 1.4 1.2 1.2 1.2 1.2 1.2 1.0 0.8	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	10 ~ 2 ~ 2 ~ 2 ~ 2 2 2 2 2 2 2	

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

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS — SUMMARY
CRYSTALLOID– 1600
COLLOID– Ø
BLOOD– Ø

FLUIDS
LINE site 18 (R) HD ☐ Warmed — NS #1 (400) — 200 [Arietlgn IPB] 400
16 (L) A ☒ Warmed — LR #1 — 400 — 800 / #2
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS Ø
URINE – Ø — min

PHYS STATUS 1 (2) 3 4 5 E

TIME → 1600 . 30 . 1700 . 30 . 1800 . 30 .

BODY WEIGHT: 76 (KG) LB

HEMATOCRIT: 37.2

INITIAL DATA: BP – 127/54 HR – 95

EQUIP CHECK OK?– (Y) N

PATIENT RECHECK OK for PROCEDURE? JA TIME– 1600

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T — ⊥; ANES– X-X; PROC– ⊙–Ø

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Breaking lung CAVA

VENTILATION

VT – ml	—	740	740	740	810	760	750	780	770	750	180	470
f – breaths/min	—	10	7	7	7	8	8	8	8	8	10	11
Peak inf pres / PEEP	—	17	17	17	18	18	18	19	19	19	14	—
MODE– S(pon), A(ssist), C(on)	S ~	S-C	—C	~C	C	C	C	C	C	C	S	S

MONITORS / ACCESSORIES
BP/Auto Cuff ✓; BP / oth; ART line ✓; Steth- PC/ES ✓; Gas analyzer

ET CO2 (torr)		46	35	32	34	33	33	33	33	33	48	45
FiO2 (Frac or %)	0.6	0.6	0.6	0.6	0.5	0.47	0.47	0.47	0.48	0.48	0.48	.47
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	SR ~	SR ~	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site			98.3 oral									
N-M Block (T/4)	4/4			4/4	2/4	4/4	1/4	4/4	2/4	4/4 c sust tet		

Warming blkt x1 sheet →
Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4)
Position → O-Hand 90°

REMARKS— Code drugs with numbers, events with letters
(1) Pre-op assessment c the interpreter questions answered NPO status verified
(2) Room, monitors PIV x 2 attempts Dr [redacted] induced eyelids taped Soft bite block No fasciculations obser
(3) Reglan 10mg IV
(4) Neostigmine 3mg & robinul 0.4 mg IV

RECOVERY AT 1915
PACU / ICU ______ (Specify)
OTHER T – 99.9 Ax
CONDITION: Stable, respon
RESP– 17 SpO2– 98
BP– 119/51 HR– 64

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1530	1600	1920
	Ready	Begin	End
PROC	1620	1655	1910

PROCEDURES and CPT Codes
Orbital Exploration & Repair ruptured Lt globe

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA — Modified RSI Cricoid pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 MAC 4 Grade 1 view 8.0 styletted OETT 22cm @ lip Teeth + BBS sust ETCO2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
CIV [redacted]
b(6)-4

SURGEO[redacted]
b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION 1

DATE 15 Sept 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 19238

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

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units): Fentanyl (400) (mg) ( ) ( ) ( ) ( )

VOLAT AGENT: ISO % del 0.8 % e.t.

AIR L/Min

N2O L/Min

O2 L/Min 2.0

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

FLUIDS — LINE site: 18(R) HO Warmed (R #2); 16(L) A Warmed (R #1); Warmed; Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: See KG LB

HEMATOCRIT:

INITIAL DATA: BP 99 / HR 71

COMP CHECK: OK? Y N

PATIENT CHECK: OK for PROCEDURE? TIME

TIME → 1400 . 30 . 2000

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

220 200 180 160 140 120 100 80 60 40 20

VENTILATION: VT – ml 650; f – breaths/min 12; Peak inf pres / PEEP —; MODE– S(pon), A(ssist), C(on) C

MONITORS: BP/Auto Cuff; BP / oth; ART line; Steth– PC/ES; Gas analyzer; Warming blkt x1 sheet; Conv warmer

ET CO2 (torr) 47; FIO2 (Frac or %) .48; SpO2 (%) 100; ECG SR; TEMP– site Oral; N-M Block (T/4)

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → (5) (6)

TOTALS — TOTAL MIN See; TOTAL HRS 99

FLUIDS – SUMMARY: CRYSTALLOID– ; COLLOID– #1; BLOOD–

REMARKS – Code drugs with numbers, events with letters

(5) SO RR 8>4<30 BP TV > 4mL/kg, responsive OP Suctioned Extubated 5 Complications

(6) To Holter & To PACU. Report to RN

RECOVERY AT: PACU ICU (Specify) OTHER See; CONDITION: ; RESP– 99 SpO2– ; BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	#	1	
PROC	Ready	Begin	End

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation/route, blade, technique, comments 99 #1

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

CIV # [redacted] b(6)-4

SURGEONS: b(6)-2

[redacted] ETISTS CRNA/MA

PROCEDURE LOCATION 1

DATE 15 Sept 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 19239

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

NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Unit)		TOTALS
Vec	(MG)		
fentanyl	(UG) (10)		
MSO4	(MG) (10)	2 3 5	20
( )			
Propofol	(ml)	10/10/10	
( )			
VOLAT AGENT: 150	% del	1.5-1.5-1.5-1.2-1.2 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	2-2-2-2-2-8	

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

TOTAL EBL

TOTAL URINE

FLUIDS — SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

FLUIDS — LINE site: Rg LA ☐ Warmed LR (1100) ☐ Warmed ☐ Warmed ☐ Warmed

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

LOSSES — EST BLOOD LOSS; URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

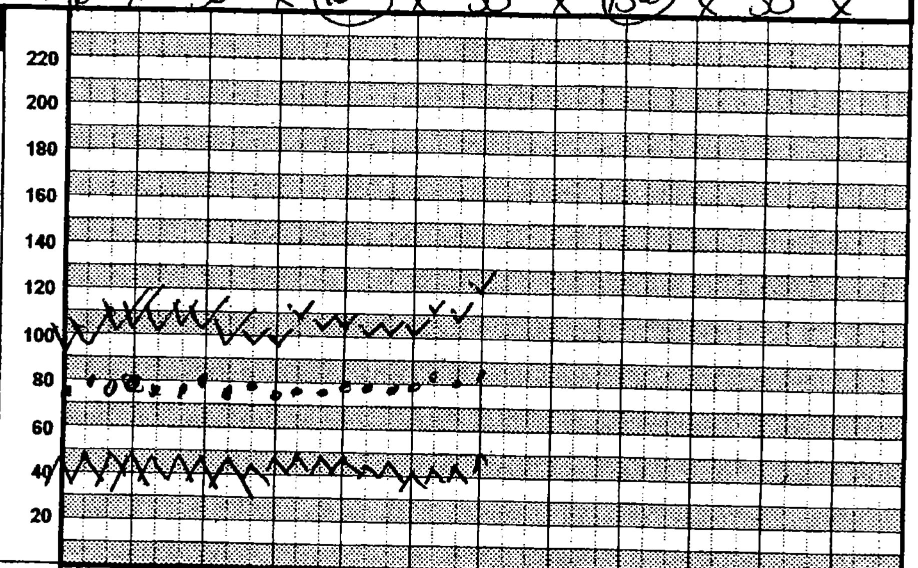
INITIAL DATA: BP – 108/39; HR – 69

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? (P) TIME – 0740

TIME → 10 X 30 X (1200) X 30 X (1300) X 30 X

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



VENTILATION / MONITORS & ACCESSORIES

VT – ml	760	830	830	640	400	540	610
f – breaths/min	8	8	8	5	8	11	7
Peak inf pres / PEEP	20	20	20	18			
MODE– S(pon), A(ssist), C(on)	CV	CV	CV	C	S	S	S
✓ ET CO2 (torr)	33	34	34	42	47	45	47
✓ FiO2 (Frac or %)	.72	.72	.72	.73	.7	.7	.7
✓ SpO2 (%)	100	100	100	100	100	100	100
✓ ECG	ST	ST	ST	SR	SR	SR	
✓ TEMP site Ax	36.5	36.6	36.6	36.6	36.5	36.0	
✓ N-M Block (T/4)			4/4				

✓ BP/Auto Cuff; BP / oth; ART line; Steth– PC/ES; Gas analyzer; Warming blkt; Conv warmer

RECOVERY AT — PACU ICU ____ (Specify) OTHER ____ CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	**Begin**	**End**
PROC			1245

Mark with letters & symbols, explain under REMARKS — EVENTS: ✓ —; Position → arms tucked padded

PROCEDURES and CPT Codes: ORIF (L) zygoma fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — see pg 1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* →

SURGEONS: [redacted]

ANESTHETISTS: [redacted] cont ... B(6)-2

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

CIV [redacted] B(6)-4

[redacted]

11032

PROCEDURE LOCATION 2-2

DATE 17 Sept 03

PAGE 2 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 19240

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