b(6)-2

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

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

Mo. 11 *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	18									
15 Nov	[redacted]	start dry dressing Δ	10	[redacted]												
		qD to lower leg														
		wound														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW ® groin/® leg

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

MEDCOM - 23441

b(6)-2

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. 11 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	7	8	9	10	11	12	13	14	15	16	17	18	19
7NOV	[redacted]	Heplock IV	D													
			N													
7NOV	[redacted]	Ancef 1 gm IVPB	08													
		Q8°	16													
			24													
7NOV	[redacted]	Levaquin 500mg	X	X	X	X	X	X	X	X	X	X	X	X	X	X
		IVPB QD	10													
7NOV	[redacted]	Valium 5mg PO	08													
		Q8° x48°	16													
		then start	24													
7NOV	[redacted]	Valium 5mg PO QHS	22				D/C written 9 Nov 03									
7NOV	[redacted]	Valium 5mg PO QHS	22	X	X											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (L) Groin (R) Leg

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.
MEDCOM - 23442

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

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
7 NOV	[redacted]	Demerol 50mg IV	D/T													
		Q4° prn Breakthrough	D/I													
		pain	E/T													
7 NOV	[redacted]	Percocet ii PO	D/T	7NOV 1030	7NOV 2230	8NOV 1400	8NOV 2000	9NOV 0300	9NOV 1400	10NOV 0155	10NOV 2130	11NOV 0540	11NOV 1000	11NOV 1920	12NOV 1200	12NOV 2000
		Q4° prn pain	D/I	ii	ii	ii	ii	ii	[illegible]	ii	ii	ii PO	2 PO	ii	2	2 PO
			E/I				E									
7 NOV	[redacted]	Phenergan 25mg IV														
		Q 6° prn nausea														
7 NOV	[redacted]	Ambien 10mg PO	14NOV 2100													
		QHS prn insomnia	10mg													
7 NOV	[redacted]	Percoset ii PO q4° prn pain	13NOV 1640	13NOV 2015	14NOV 0100	14NOV 1115	14NOV 2015	15NOV 0500								
			2	ii		ii	ii	2								

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

MEDCOM - 23443

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

TRAUMA FLOWSHEET
The proponent is Dept of Surgery

0055

OTSG APPROVED *(Date)*
QI Appr 11 Jun 97

EMS REPORT

TIME: ______ ETA: ______ UNIT: ______

MED COM: [Y] [N]

M/E 30 yo ♂

P3Hx - AS Child sing to (L) side chest

ARRIVAL STATUS

TIME ______ IV x | ☐ O_2 ______ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☒ None ☐ Yes: ______

Allergies: ☐ UKN ☒ None ☐ Yes: ______

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake ______ hrs

LMP: ☐

LR (RAC)

PRIMARY SURVEY

AIRWAY

☒ Natural Patient ☒ [N]

☐ ETT ______ ☐ ______

☐ Secretions ______

BRETHING

☐ Labored ☒ Unlabored ☐ Absent

TRACHEA: ☒ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] >=< [R]

CIRCULATION

PULSE: ☐ Present ☐ Absent

BLEEDING: ☒ [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☒ Warn ☐ Cool ☐ Hot

☒ Pink ☐ Pale ☐ Cyanotic ☐ ______

☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E ______
V ______ 15
M ______

SPHINCTER TONE:
☒ WNL
☐ None

HEAD

PUPILS: ☒ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]
4-6

TM: ☒ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: ∅ [Y] [N]

Pain @ ______

JVD: [Y] [N]

HEART

RHYTHM: ☒ Regular ☐ ______

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☒ Bilat ☒ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☒ Soft ☐ Rigid ☐ Non-Tender

☐ Tender:

PELVIS

☐ Stable ☐ Unstable ☐ ______

Blood at meatus/vagina: [Y] [N]

Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound

GSW
GSW
GSW
GSW
lac
Shrapnel
open testes

VASCULAR ASSESSMENT

++ ++ ++ ++ + ++

++ Strong | + Palpable | D Dopler

RN ______ blw-2

PHYSICIAN ______

PREPARED BY *(Signature & Title)*

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC
ER

DATE
7 Nov 03

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

EPW # ______

blw-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700 MEDCOM - 23444

REQUIREMENT OF PRIVACY ACT ... IS COVERED BY DD FORM ...

VITAL SIGNS											
Rectal Temp:					NC @ 6 liters		GCS:				
TIME	BP	HR	RHY	RR	SAO2	FIO2	MODE	E	V	M	T
0056	123/74	93		18	97%						
0106	/	99			NC						
0109	138/76	92			100%						
0111	134/62	102		16	100%						
0126	132/66	97		24	100%						
0207	128/77	127	NSR	16	97						

GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
(4) - Spontaneous	(5) - Oriented	(6) Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

0055 pt arrived, by helicopter, [illegible]
0126 pt to CT c̄ RN
0200 CT of head chest, abd., + pelvis don[e]
Pt back to ER,
16 Fr Foley cath placed by Dr [redacted], [illegible]
0215 pt to OR c̄ CRNA

Staff note:
A&O x4 — and [illegible]. Good pulses distally x4
[illegible] groin GSW, Neuro [illegible]
[illegible] obvious open Fx (R) tib/fib,
ØABC issues

→ OR

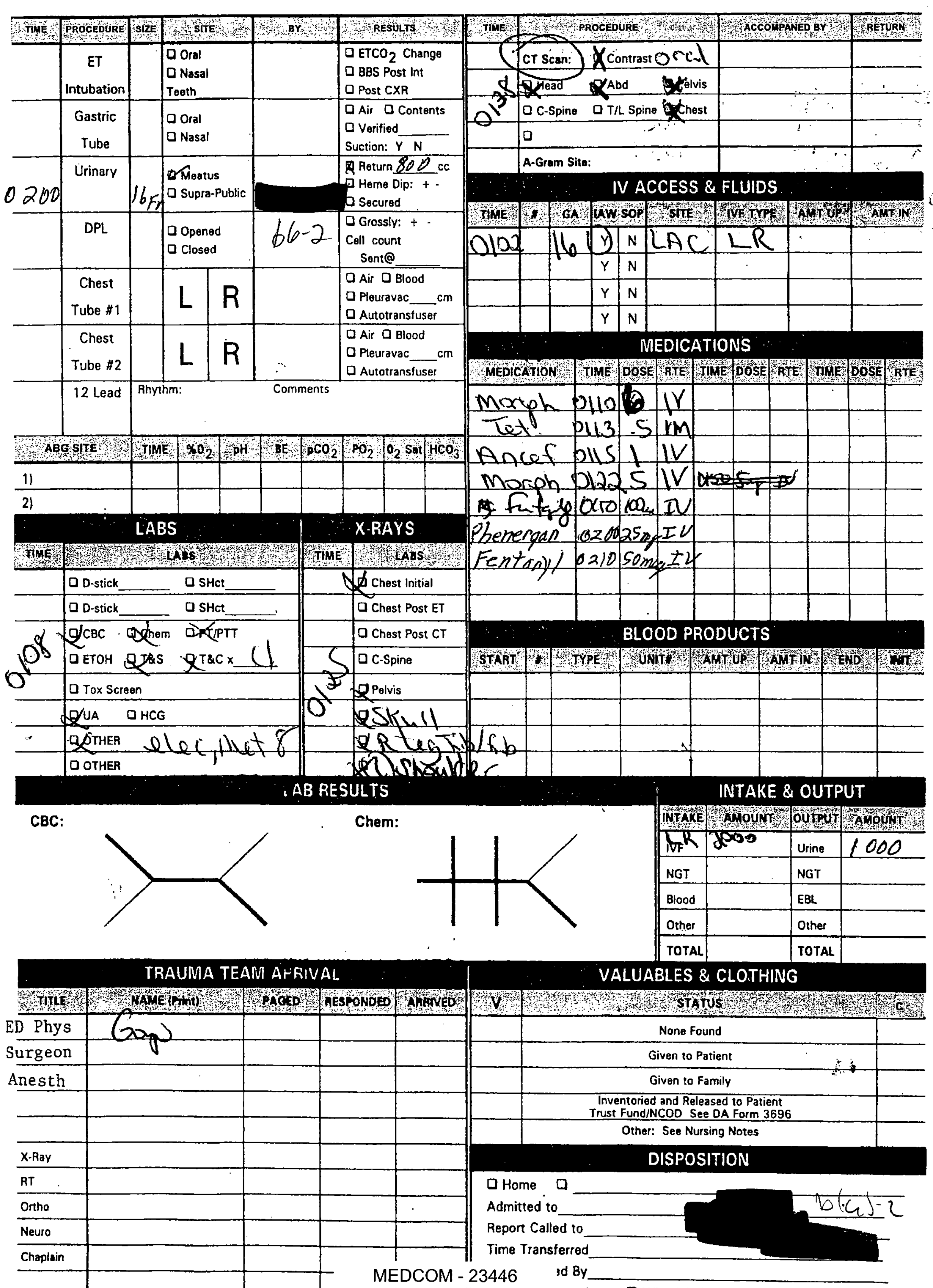
b(6)-2

[redacted] 0140

MEDCOM - 23445

ACLU-RDI 1681 p.5

DOD-037023



TIME	PROCEDURE	SIZE	SITE		BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth			☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal			☐ Air ☐ Contents ☐ Verified_______ Suction: Y N
0200	Urinary	16Fr	☒ Meatus ☐ Supra-Public		[redacted]	☒ Return 800 cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		b6-2	☐ Grossly: + - Cell count Sent@_______
	Chest Tube #1		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:			Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

TIME	PROCEDURE	ACCOMPANIED BY	RETURN
0138	CT Scan: ☒ Contrast Oral; ☒ Head ☒ Abd ☒ Pelvis; ☐ C-Spine ☐ T/L Spine ☒ Chest; ☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
0102		16	Ⓨ	N	LAC	LR		
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Morph	0110	6	IV						
Tet	0113	.5	IM						
Ancef	0115	1	IV						
Morph	0122	5	IV	~~[illegible]~~					
Fentanyl	0150	100	IV						
Phenergan	0200	25mg	IV						
Fentanyl	0210	50mg	IV						

LABS

TIME	LABS	
	☐ D-stick_______	☐ SHct_______
	☐ D-stick_______	☐ SHct_______
0108	☒ CBC ☒ Chem	☒ PT/PTT
	☐ ETOH ☒ T&S	☒ T&C x 4
	☐ Tox Screen	
	☒ UA ☐ HCG	
	☒ OTHER elec, Mat 8	
	☐ OTHER	

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
0125	☐ C-Spine
	☒ Pelvis
	☒ Skull
	☒ R Leg Tib/Fib
	☒ R Shoulder

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:

Chem:

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF LR	2000	Urine	1000
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	Gasp			
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _______

Admitted to [redacted] b(6)-2

Report Called to [redacted]

Time Transferred [redacted]

[...]ed By_______

MEDCOM - 23446

ACLU-RDI 1681 p.6

DOD-037024

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 NOV

Time In: 0355

Allergies: NKDA

Pre-op V/S: 120/54 99HR

Procedures: Scrotal/groin repair, head laceration/repair

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

OR Intake: Crystalloid 2300 Colloid

OR Output: UOP ____ EBL <50

Meds/Times: 5fent 150fent 25phen. B+

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

Airway: Nasal, (Oral), ETT, Trach, Other

Pre Op Meds

History

Time	0355	0400	0405	0410	0415	0420	0425	0430	0440	0450	0500	0510
SaO2	98	97	98	98	[illegible]	100	100	100	99	100	100	96
FiO2	RA	RA	RA	RA	5 [illegible]	10L	6L	6L	6L	2L	1L	RA
Methods					[illegible]	NRB	NRB	NRB	NRB	NC	NC	
RR	12	12	12	14	16	12	14	12	12	12	14	12
T	97 [illegible]			97 [illegible]			98			99.1		100.3 (?)

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

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	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	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	0	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.	5	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

(Continue on reverse)

PREPARED BY *(Signature & Title)*: [redacted] LTAN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 NOV 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

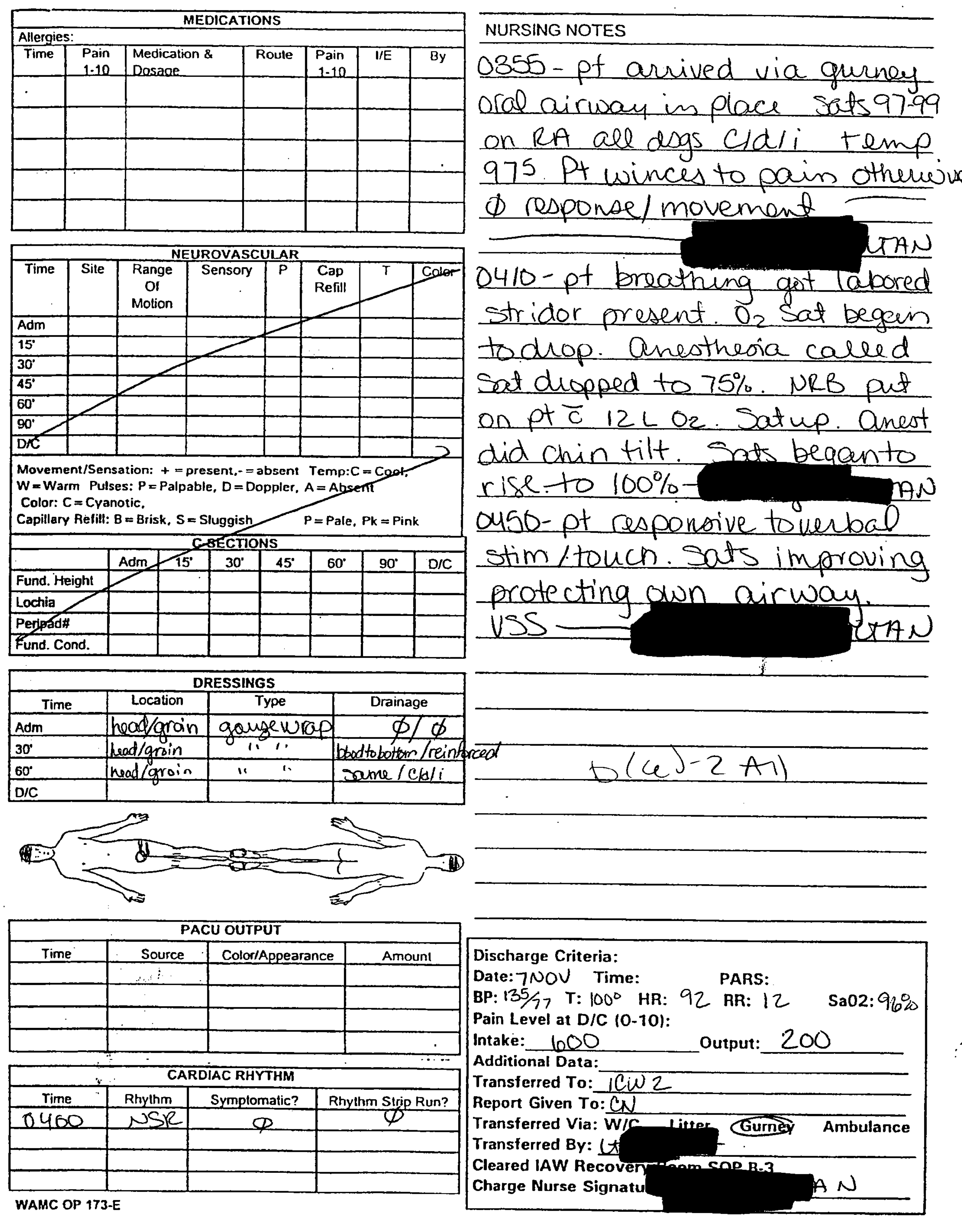
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

MEDCOM - 23447



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

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

NEUROVASCULAR

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	head/groin	gauze wrap	∅ / ∅
30'	head/groin	" "	blood to bottom / reinforced
60'	head/groin	" "	same / C/d/i
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0400	NSR	∅	∅

WAMC OP 173-E

NURSING NOTES

0355 - pt arrived via gurney oral airway in place Sats 97-99 on RA all dsgs C/d/i temp 97.5 Pt winces to pain otherwise ∅ response/movement — [redacted] TAN

0410 - pt breathing got labored stridor present. O_2 Sat began to drop. Anesthesia called Sat dropped to 75%. NRB put on pt c̄ 12 L O_2. Sat up. Anest did chin tilt. Sats began to rise to 100% — [redacted] AN

0450 - pt responsive to verbal stim/touch. Sats improving protecting own airway. VSS — [redacted] TAN

D(ω)-2 A1)

Discharge Criteria:
Date: 7 NOV Time: PARS:
BP: 135/77 T: 100° HR: 92 RR: 12 SaO2: 96%
Pain Level at D/C (0-10):
Intake: 600 Output: 200
Additional Data:
Transferred To: ICW 2
Report Given To: CN
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted] AN

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: 8NOV03 Anesthesia Type (Circle): (General) Spinal Epidural ~~IV Sedation~~ Nerve Block
Time In: 1206
Allergies: NKDA OR Intake: Crystalloid 2200 Colloid ...
Pre-op V/S: 123/62 101 OR Output: UOP 350 EBL 50
Procedures: IM nailing Meds/Times: 500mcg Fent
washout left groin JP drain levaquin + ancef 500 2gm

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

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1206	1211	1216	1221	1236
SaO2	99	100	100	100	100
FiO2					
Methods	RA	RA	RA	RA	RA
RR	12	12	14	16	12
T	98°				

Vital signs graph (240–20)

Time					
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	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	1	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.	9	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)

PR[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 08 NOV 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: 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

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

MEDCOM - 23449

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1220		2mg MSO4	IV			
1236		2mg MSO4	IV			
1241		2mg MSO4	IV			

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	W	PK

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 1206	R leg + groin	cast / Kerlex	0
30' 1236	R leg + groin	cast / Kerlex	0
60'			
D/C 1246	R leg + groin	cast / Kerlex	0

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1206	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p IM nailing + I+D of R groin. Pt SpO2 99% RA, pt c/o pain 2mg MSO4 given. 1236 pt still c/o pain 2 more mg MSO4 given. Report given to Lt [redacted] — [signature] [redacted]

b(6)-2

Discharge Criteria:

Date: 8 Nov Time: 1246 PARS: 9

BP: 132/79 T: 100.1 HR: 99 RR: 16 SaO2: 98

Pain Level at D/C (0-10): —

Intake: ______ Output: —

Additional Data: —

Transferred To: ICW

Report Given To: Lt [redacted] b(6)-2

Transferred Via: W/C Litter / Gurney Ambulance

Transferred By: [signature] [redacted]

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature: ______

MEDCOM - 23450

ACLU-RDI 1681 p.10

DOD-037028

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 15 NOV 03 Anesthesia Type (Circle) General Spinal Epidural LMA IV Sedation Nerve Block
Time in: 1010
Allergies: NKDA OR Intake: Crystalloid 600 Colloid —
Pre-op V/S: OR Output: UOP — EBL —
Procedures: Delayed primary closure Meds/Times:

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

Pre Op Meds History

Time	1010	1015	1020	1030	1045
SaO2					
FiO2					
Methods					
RR					
T					

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1010	LR	400	R Arm	[redacted]	600 b(6)-2

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 b(6)-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	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	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, ˇ = 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)

PREPARED BY [redacted] RN b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 15 NOV 03

PATIENT'S IDENTIFICATION (For typed or written entries give: 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

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

MEDCOM - 23451

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

NURSING NOTES

Pt to recovery room from OR s/p delayed primary closure (R) leg. Dsg to (R) lower leg intact, VSS. Will continue to monitor. [redacted] b(6)-2

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	FROM	+	+	B	W	PK
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	(R) leg	Kerlix	Ø
30'			
60'			
D/C			

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1010	SR	Ø	Ø

Discharge Criteria:
Date: 5 Nov 03 Time: 1045 PARS: 10
BP: 143/74 T: 96.2 HR: 82 RR: 17 Sa02: 100
Pain Level at D/C (0-10):
Intake: 200 Output: Ø
Additional Data:
Transferred To: ICW 1
Report Given To:
Transferred Vi[redacted]urney Ambulance
Transferred By: [redacted] b(6)-2
Cleared IAW Rec[redacted]
Charge Nurse Signature [redacted]

WAMC OP 173-E MEDCOM - 23452

ACLU-RDI 1681 p.12

DOD-037030

b(2)-2

Admission and [illegible]ing Information

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

1. Reporting MTF	2. MTF Location		
[redacted] b(2)-2	IZ		
3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(6)-4		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1968-06-01	35Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] b(6)-4
Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		01:00	
14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES		
17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee	
Direct from ER	ICW1	Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee	
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)	
TRF-OTH		2003-11-18	
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)	
AGG - FP ORTHOPEDICS		2003-11-07	
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission	
		2003-11-07	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P GSW L GROIN R LEG

878.2
834.9
890.0
880.00
873.0
998.89
E991.2

Procedure Narrative(s):

Cause of Injury Narrative:

MEDCOM - 23453

ACLU-RDI 1681 p.13

DOD-037031

9	10	11	12	13	14	1[illegible]				PAY GRADE 16	17	5. SEX 18

6. DATE OF BIRTH *(Y Y Y Y M M D D)* 19 20 21 22 23 24 25 26 | 7. AGE AT ADMISSION 27 28 29 | 8. RACE 30 | 9. ETHNIC BACKGROUND 31 | RELIGION

10. LENGTH OF SERVICE 32 33 34 | ETS | 11. FMP 35 36 | 12. SOCIAL SECURITY NUMBER 37 38 39 40 41 42 43 44 45

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 | WARD | NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

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

21. TYPE OF DISPOSITION 73 74 | 22. MTF TRANSFERRED TO 75 76 77 78 79 80 | 23. DATE OF DISPOSITION *(Y Y M M D D)* 81 82 83 84 85 86

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

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

FOR LOCAL USE

Dx: 8783, 82392, 8900, 8738, E9912

Pr: 613, 8345(2), 623, 7966, 7857, 8659

ADMITTING OFFICER *(Signature, as required)* | SIGNATURE OF ADMITTING CLERK 8703

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

Inj Trauma
450

MEDCOM - 23454

ACLU-RDI 1681 p.14

DOD-037032

To Camp

b(6)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

☐ Arson (I.P.C. 342)	☐ Burglary or Housebreaking (I.P.C. 428)
☐ Solicitation of Fornication/Prostitution (I.P.C. 399)	☐ Extortion/Communicating Threats (I.P.C. 430)
☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)	☐ Theft (I.P.C. 439)
☐ Murder (I.P.C. 405)	☐ Destruction of Property (I.P.C. 477)
☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)	☐ Obstructing a Public Highway/Place (I.P.C. 487)
☐ Maiming (I.P.C. 412)	☐ Discharging Firearm/Explosive in City/Town/Village (I.P.C. 495)
☐ Simple Assault (I.P.C. 415)	☐ Riot or Breach of Peace (I.P.C. 495(3))
☐ Kidnapping (I.P.C. 421)	☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: ESCAPING A RAID

☐ Violation of Curfew	☐ Trespass on Military Installation or Facility
☐ Illegal Possession of Weapon	☐ Photographing/Surveilling Military Installation or Facility
☐ Assault/Attack on Coalition Forces	☐ Obstructing Performance of Military Mission
☐ Theft of Coalition Force Property	☐ Other

Apprehending Unit: 1-34 AR [handwritten] | Location Grid:

Date of Incident (D/M/Y): 08/11/03 to / / | Time of Incident: 0300 hrs to hrs | Date of Report: (D/M/Y) / / | Time of Report: hrs

Detainee #	Key Connected Person: ☐ Victim ☐ Witness
Last Name:	Last Name:
First Name: Given Name:	First Name: Given Name:
Hair Color: Black / Scars/Tattoos/Deformities: b(6)-2	Hair Color: / Scars/Tattoos/Deformities:
Eye-Color: / Weight: lb / Height: in	Eye-Color: / Weight: lb / Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/Sect: / Sex: ☒ M ☐ F / Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	Ethn/Tribe/Sect: / Sex: ☐ M ☐ F / Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify)	☐ Passport ☐ Dr. license ☐ Other (specify)
Document #:	Document #:

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information Vehicle Number ____ of ____ Vehicle(s) Owner:

Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		

Contraband/Weapons in Vehicle:

☐ Property/Contraband ☐ Weapon Photo Taken of Suspect with Weapon/Contraband: Yes/ No

Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details: b(6)-2		Where Found:	Owner:

Name: 1-34 Armor | Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Last, First MI | Supervising Officer's Name (Print): Last, First MI

Signature:

MEDCOM - 23455

ACLU-RDI 1681 p.15

DOD-037033

Automated Facsimile

PATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted]	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	24Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]	b(6)-4	ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	03:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-13

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-08	[redacted] b(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-08	

31. Selected Administrative Data

Marital Status: DoB: 1979-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P VD R IF DPC OPEN MC FX VD BL LE

DX - PROV T I
81510 8628 1 449
81611 9354
8B20 8659
8910
E9919

815.10
894.1
E991.9

86.28
93.54
93.57
86.59

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	6	6

35. Total Days This Facility

b(6)-2

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0		0	0	0

Signature of Atte[redacted] [redacted]

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 23456[redacted]

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

29 yo Iraqi ♂ shot in raid resulting in (R) hand penetrating injury and BL LE shrapnel wounds. Presents for eval Tx. c/o BL LE wound pain & (R) hand pain.

PMHx: Ø
Meds: Ø
PSHx: Ø
All: ? PCN
Tolerated Ancef in E.D.

PHYSICAL EXAMINATION

WD ♂ in NAD
HEENT - WNL
Lungs - CTA
ABD - Benign
EXT. RUE: Penetrating entrance wound on dorsum of IF MC. Distal LT intact. intact Extension/Flexion. TTP @ metacarpal

RLE: Entrance wound on the anterior leg. No knee effusion. NTTP c FROM. DNVI.
LLE: Entrance wound on post. thigh, anterior leg. No effusion. Knee FROM. NTTP. DNVI.

Xray - (R) IF MC Fx.
shrapnel BL LE.

PROGRESS (Enter date of discharge and final diagnosis)

Imp: (R) IF Open MC Fx
BL LE Fragment wounds

Plan: R OR for I&D/ splint (R) IF MC Fx
I&D BL LE wounds

b(6)-2

SIGNATURE | DATE | IDENTIFICATION NO. | ORGANIZATION

PATIENT IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-105

b(6)-4

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
ØBNOVØ3	(152Ø) Assumed care of pt from ICU³ p̄ surgery via gurney in stable cond. VSS. Pt alert, speaking Arabic ██ Φ c/o pain. Drsgs to RUE and LLE CDI. Drsg to RLE c̄ sm. amount sero sang drainage on Ⓡ knee. IVFs SLd in IV in Ⓛ ac p̄ lunch. Φ S/Sx infiltration. Pt tol reg diet. Voiding s̄ difficulty. Elevated RUE on blankets. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. ██
9NOV03 @0050	assumed care of pt @ 1800. VSS. No c/o pain. Alert, speaks arabic; LS CTA; ⊕BS, tol reg diet well, IV HL'd; voids per urinal s̄ difficulty. RUE drsg CDI, ⊕CMS Ⓡ hand. RLE c̄ sm amnt yellow drainage noted, o/w CDI, ⊕CMS to Ⓡ foot, DP +2, equal (BIL). Ⓛ ac IV flushes well. 2 pt restraints on s̄ S/Sx skin/circulation compromise. Plan: IV abx as ordered, monitor neuros, monitor pain control. ██
9 Nov 03 1000	Assumed care @ 0600. VSS. A & O speaks some English. Able to make needs known. RUE c̄ splint c̄ acewrap. LUE AC c̄ HL patent. BLE shrapnel wound redressed. ~~R~~LE back of thigh wound c̄ small

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.

██

b(6)-2 All

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 - 23458

b(6)-2 Am

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) amount yellow drainage. Open wound wet-dry c̄ Kerlix wrap. Neurovascular intact. Pt medicated c̄ MSO4 2mg IVP for comfort during drsg Δs. Will continue monitoring & keeping RUE ↑ & Abx therapy as ordered. 2pt restraint s̄ compromise to circulation or skin. ———— MAG / 5on
09 Nov 03 1500	Pt sleeping c̄ RUE ↑. No acute distress. Will continue to monitor ———— MAG / 5on
09NOV@2325	Completed DSG Δ to shrapnel wounds. Placed dry 2x2 on superficial wounds. Ⓛ posterior upper thigh had 1"x2" open wound. Packed c̄ wet gauze + covered c̄ 4x4. ⊖ s/sx of infection to any wounds. VSS. ⊖ c/o pain at this time. Pt aware not to eat p̄ MN. Sign above bed. Infusing Ancef 1 gm as per order. Pt amb to BR x 1 c̄ steady gait. Pt has cast to Ⓡ wrist ⊕ cap refill. Pt able to wiggle fingers. To ~~Stat~~ start LR@100cc/hr p̄ MN. ————
10NOV03	(0915) Assumed care of pt @ 0900. Pt alert, speaking Arabic. VSS. Φ c/o pain. IV in Ⓛ ac dlcd d/t infiltration. 18g IV started in Ⓛ wrist. IVFs infusing s̄ s/sx infiltration. Drsg/splint to RUE CDI. Pt able to move fingers. Drsgs to BLE CDI. ⊕ pedal pulses equal bilat. Skin warm to touch. Pt able to move toes. Pt remains NPO for surgery. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. ————
	(1105) Pt to OR via gurney ————

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

b(6)-4

MEDCOM - 23459

ACLU-RDI 1681 p.19

DOD-037037

b(6)-2
All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11NOV03	(1200) Assumed care @ 0000. Pt alert, speaking Arabic.
	VSS. Ø c/o pain. Drsgs to BLEs ∆d. WTD drsgs
	applied to Ⓛ hip/thigh. Bacitracin applied to
	other wounds. Ø S/Sx infection. RUE placed in
	stocking elevation. Pt able to move fingers. Pt
	OOB to amb in hallway s̄ difficulty. Favors Ⓛ
	Leg. ↑ to chair. SL in Ⓛ ac flushes well s̄ S/Sx
	infection/infiltration. 2 point restraints in place s̄
	S/Sx complications. Will cont. to monitor [redacted]
12 NOV 03 -	VSS. Pt ⊖ c/o pain. A+O. Ⓡ Arm splint + elevated
0020	in sock. ⊕ brisk cap refill Ⓡ hand. Warm to touch. Pt completed
	IV ABX in early AM. ⊖ maintenance fluids. Tol PO well.
	urinating s̄ difficulty. Pt asleep in bed at this time.
	Will continue to monitor. ——— [redacted]
12NOV03	(1130) Assumed care @ 0000. Pt alert, speaking
	Arabic. VSS. Ø c/o pain. Pt OOB to amb in
	hallway. Steady gait. Drsgs to BLEs ∆d. Ø S/Sx
	infection. WTD drsgs applied to Ⓛ thigh. Bacitracin
	applied to other wounds. RUE in stocking
	elevation. Pt able to move all extremities s̄
	difficulty. SL in Ⓛ ac d/cd d/t infiltration –

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. KW1

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

MEDCOM - 23460

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Nov 03	ORTHO BRIEF OP NOTE
	Preop Dx - GSW (R) hand, 1R MC Fx, LE shrapnel wounds
	Postop Dx - Same
	Proc - I+D (R) hand, Dressing Δ's BL LE
	Surg - White Anesthesia - FETA MAJ Smith
	EBL - min Fluid 250cc UOP Ø Drain Ø
	Findings - clean wound (R) hand, DPC
	Clean wounds BL LE, dressings Δ's.
	Plan - Splint Δ in 2 days
	Continue daily dressing Δs.
	Expect D/C in 3-4 days. b(6)-2
	WHITE.
10NOV03	(1300) Pt returned to ward via gurney in stable
	cond. Ø C/o pain. Drsgs to BLE CDI. Pt able to
	move toes. Skin warm to touch. Splint to RUE CDI.
	Stocking elevation intact to RUE. Pt able to move
	fingers. IVFs infusing into IV in (L) wrist s̄ s/sx
	infiltration. 2 point restraints in place s̄ s/sx
	complications. Will cont. to monitor.
	(1640) IVFs s/Ld. Tol po well. Ø C/o pain. Will cont.
	to monitor. b(6)-2
10NOV@2340	Pt amb to BR x 2. Pt has mild limp when amb. Ø assistance needed.
	Δ'ed DSG to (L) thigh. WTD. (R) wrist in splint. (+) brisk cap
	refill. Pt able to move fingers. (R) wrist elevated in sock. New IV
	in (L) AC 20 Gauge. Flushes well + (+) blood return. D/c'ed IV
	fluid 2° tol PO well. Ø C/o pain.

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

b(6)-4

MEDCOM - 23461

ACLU-RDI 1681 p.21

DOD-037039

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12NOV03 (1130)	(cont) catheter intact. Pt tol reg diet well. Voiding s difficulty. 2 point restraints in place s s/sx complications. Will cont. to monitor. b(6)-[redacted]
12 NOV.03 1900	Pt A+Ox3, VSS, consumed 85% of diet, resting quietly, RUE elevated c stocking, pt able to move exts, (L) thigh dsg CDI, Ø c/o pain, voiding CYU s complications, dsg's to LE x2 CDI, 2 point restraint s any complications. b(6)-2 [redacted]
13 NOV 03 0800	- Assumed care pt. A+Ox3. VSS. Denies pain or discomfort Resting in bed. (R) hand in soft cast elevated c stocking intact Ø drainage noted. Ace wrapped. (L) lateral thigh wound wet + dry lightly packed 4x4 dsg minimal serous drainage. (B) LE shrapnel wounds scabbing over Ø s/s of infection. Will cont to monitor b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

b(6)-4 [redacted]

REGISTER NO.

WARD NO. ICW

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 - 23462

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 NOV 03	DISCHARGE SUMMARY
	Iraqi ♂ detainee with GSW to the right hand and shrapnel wounds to the legs. He has a GSW Index Finger metacarpal Fracture.
	Hospital Summary
	He underwent operative debridement of the hand and leg wounds x 2 with delay primary closure of the hand wound and radial gutter splinting.
	Discharge Diagnosis/TX.
	① Open Rt Hand Index Finger Metacarpal Fracture. Treated with I&D and radial gutter splint.
	DO NOT REMOVE THE SPLINT
	Follow-up in 10-14 days for splint removal, suture removal and short arm radial gutter cast application.
	② Bilateral lower extremity shrapnel wounds. Treated with I&D and wet to dry dressing changes.
	These require daily dressing changes with a wet to dry dressings on the left posterior thigh. b(6)-2
	[redacted] MAJ, MC ORTHO

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MIDDLE	SPONSOR'S ID NUMBER

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)*

1242

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, TREATING ORGANIZATION *(Sign each entry)*
8 Nov 03	ORTHO OP NOTE
	Preop Dx: (R) IF open MC Fx
	BL LE Shrapnel wounds
	Post op Dx: Same
	Procedure - I+D, splint RUE
	I+D BL LE
	Surg - [redacted] Anesthesia - [redacted]
	Fluids - 400cc EBL min
	Drain - Penrose (R) hand. b (x) - 2 AM
	Plan - Eval (R) hand in 48 hrs
	IV ABX x 48 hrs
	Possible repeat I+D in 2-3 days. [redacted]

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

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

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 - 23464

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.

1. AGE 29
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication)
☐ NKDA ☒ PCN ? ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) hand; B/L LE

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Shrapnel Wound
Tobacco ____ ppd X ___ yrs Body Piercing ✓ ____ Diabetes (Y) (N) ROM ↓ Extremities ASA/Motrin W 72hrs (Y) (N)
ETOH ____ Implants ✓ ____ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ✓ ____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: ∅

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	∅ Pt. verbalizes any specific anxiety. ∅ Pt. Exhibits relaxed body posture. -pt. Iraqi x language barrier	∅. Allow pt. to verbalize freely. ∅. Explain Or environment and answer questions regarding surgery. ∅. Offer comfort measures. (e.g. warm blanket. touch). ∅. Explain all nursing procedures before they are done. ∅. Remain with pt. Whenever possible. O. 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	✓ O Pt. will be able to breath without difficulty during immediate intraoperative phase.	∅. Offer to elevate head of litter or offer pillow. ∅. Observe pt. While awaiting surgery for signs of distress. ∅. Assist anesthesia during intubatior 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	✓ O Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	∅. Utilize pressure preventing devices on OR table and accessories. ∅. Check for proper positioning and support to maintain good body alignment. ∅. Pad pressure points. ∅. Place ESU ground pad on non compromised skin surface area. ∅. Keep prep fluids form pooling.

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

b(6)-4 [redacted] (SI)
[redacted] b(2)-2
8 NOV 03

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

DA FORM 5179. JUN 91 MEDCOM - 23465 Previous editions are obsolete. USAPA VI.0

ACLU-RDI 1681 p.25

DOD-037043

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	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	O Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. 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. O Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. ___ Potential Impairment of Mobility due to: ___ 1) Pain ___ 2) Intra operative Hazzards ___ ~~3) prosthesis~~ ___ 4) Positioning ___ 5) Transfer pt. To/form OR table E.2. ___ Potential Discomfort Due to: ___ 1) Length of Surgery ___ 2) Positioning ___ 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be 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. Bath towel. etc) for positioning.
F. Special Senses F.I. ___ 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 F.3. ___ Potential Injury due to Dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	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. Speak clearly and slowly. O Address pt. from Either side. O Validate pt.'s understanding of verbal communication. 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 INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[signature] [redacted] b(6)-2 CPT/AN   8 NOV 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [signature] [redacted] CPT/AN b(6)-2
DATE: 8 NOV 03 TIME: 0835

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [signature] [redacted] CPT/AN b(6)-2
DATE: 8 NOV 03 TIME: 0945

REVERS OF FORM 5179, JUN 91   USAPA VI.0

MEDCOM - 23466

ACLU-RDI 1681 p.26

DOD-037044

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop[onent ag]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERAT[ING RO]OM VIA litter BY litter

2. PATIENT IDENTI[FICATION, RE]CORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 8NOV03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 0840 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø concerns voiced

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained b(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta Scrub / Beta Paint
SITE: Ⓡ arm BY WHOM: [redacted]
SITE: B/L LE BY WHOM: [redacted]
COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES

scrub both legs c̄ Betadine; then debride + dress

LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet [XX] prep area b(6)-2

C = Correct I = Incorrect

10. COUNTS					Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X]	Yes	[ ]	No	/	/		[redacted]	[redacted]
Needle Sharp	[X]	Yes	[ ]	No	/	/			
Instrument	[ ]	Yes	[X]	No	/				
Other	[ ]	Yes	[X]	No	/	/	/	/	/

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

b(6)-4 [redacted] (SI)
[redacted]
8NOV03 b(2)-2

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

[X] ESU NO: Valleylab Force 40
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 73538 2005-08

[ ] 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):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 in Penrose	2.	3.
SITE	1. (R) hand	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x4 } legs
Kerlix }
Fluffs } (R) arm
Kerlix }
Splint }

19. ADDITIONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]

20. OPERATION(S) PERFORMED
I+D (R) arm / hand
I+D Bilateral LE

21. PATIENT TRANSFERRED TO
ICW3 (PACU) b(6)-2

TIME see DA7389

METHOD
Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN

MEDCOM - 23468

ACLU-RDI 1681 p.28

DOD-037046

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Stretcher BY anesthesia

2. PATIENT ... REVIEWED AND PROCEDURE VERIFIED BY ... CPT/AN b(6)-2

3. DATE 10 Nov 03 — TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM TIME 1103 — ... NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC ... b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT ...	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt arm BY WHOM: ...
SITE: BY WHOM: ...
COMMENTS: No pooling of fluids b(6)-2

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS — C = Correct I = Incorrect — Initial C ... b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[ ] Yes	[X] No					
Needle Sharp	[X] Yes	[X] No	/		C	...	...
Instrument	[ ] Yes	[X] No		/			
Other	[ ] Yes	[X] No	/		/		

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

... b(6)-4

... b(2)-2

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

[X] ESU NO: Force 4D R8E 10530S 40/40
GROUND PAD: BRAND Valleylab REm
LOT NO: 73538

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA ... IS OBSOLETE. — MEDCOM - 23469 — USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ Y ☐ NO IF YES NAME: ID NUMBER JFACTURER

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):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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

15. X-RAY IN OPERATING ROOM 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	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2's, 4x4's, Kerlix, Tape } B LE

Xeroform, Fluffs, Kerlix, Plaster splint, Ace } Rt. arm

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA Anesth. Type: General LMA

b(6)-2

20. OPERATION(S) PERFORMED

1. I & D w/ closure of Rt. hand wound
2. Clean & redress Bil. Lower ext. wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1201	Stretcher

22. [redacted] SIGNATURE [redacted] CPT/AN

MEDCOM - 23470

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1							
POST- DAY								
MONTH-YEAR NOV / DAY	8	9	10	11	12			
19 2003 / HOUR								

PULSE (O) / TEMP. F (•) / TEMP. C

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

(Centigrade Equivalents, for Reference only)

SPIRATION RECORD

BLOOD PRESSURE: 127/65, 124/72, 110/57, 111/63, 108/71, 108/61, 99/59, 118/65, 108/65; 124/69, 110, 107, 115/53, 111/64, 88; 119/66, 99.3, 109/..., 98.8, 99.1, 98.7

HEIGHT: WEIGHT →

O_2 Sat: 100(RA), 98% RA, 97% RA, 98(RA), 96%, 97(RA), 98(RA), 98%; 99(RA), 95(RA), 97% RA; 98(RA), 97(RA) 91 pulse, 97 P

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

REGISTER NO.

WARD NO. ICW 1

b(6)-4

VITAL SIGNS RECORDS

Medical Record

MEDCOM - 23471

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

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	TOTAL EBL
Propofol (mg)	150				250	min
Fent (mcg)	150 (100)					TOTAL URINE
SCH (mg)	120					0
Vec (mg)		4	2			
VOLAT AGENT Iso % del		1.3	1.3	0.9 X		
% 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

FLUIDS SUMMARY: CRYSTALLOID- 400cc; COLLOID- 0; BLOOD- 0

FLUIDS — LINE site: 18 (L) AC ☐ Warmed — LR 800 ——— (400) ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE - Not measured

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

BODY WEIGHT: 80 KG

HEMATOCRIT: 14/45

INITIAL DATA: BP- 124/76; HR- 115

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? 0830 TIME- Okay

TIME → 0830 45 0900 15 30 45 1000

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

Grid scale: 220 200 180 160 140 120 100 80 60 40 20

REMARKS — Code drugs with numbers, events with letters

0830 4. ckd Ent. Chart reviewed, To OR,

0840 Induction, ⊕ ventilation, ⊕ CO2, smooth Intubation, eyes taped, OG placed, stomach sxn, pt padded, arms < 90°

0915 Procedure started on (R) arm

0925 20mg IV

0935 Reversed c̄ Sug neostigmine 0.8 Robinul

0940 Pt extubated s̄ diff p̄ OP sxn, To PACU stable. Report to RN

VENTIL						
VT - ml	—	800	760	760	760	800
f - breaths/min	16	12	10	8	8	16
Peak inf pres / PEEP	—	18	16	16	16	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S

MONITORS/ACCESSORIES							
X BP/Auto Cuff	✓ ET CO2 (torr)	⊕	30	32	32	34	36
BP/oth	✓ FIO2 (Frac or %)	.58	.58	.58	.58	.58	.58
ART line	✓ SpO2 (%)	99	99	99	99	99	99
Steth- PC/ES	✓ ECG	ST	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site skin						
	✓ N-M Block (T/4)		4/4			4/4 c̄ 5	⊕ 50
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Sup → Π 60° → Sup

RECOVERY AT 0950 (PACU) ICU ____ (Specify) OTHER ____

CONDITION: Stable/Awake RESP- 20 SpO2- 98% BP- 125/69 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0840	0955

	Ready	Begin	End
PROC	0847	0900	0945

PROCEDURES and CPT Codes: I&D (B) Leg Wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — RSI ⊕ cricoid pressure, DL x 1 attempt c̄ MAC 4, #8 ETT, ⊕ BBS ⊕ EtCO2, smooth

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility — #[redacted] blk 4

SURGEON: [redacted]

ANESTHETISTS: [redacted] PT

PROCEDURE LOCATION: OR 2

DATE: 8 Nov 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 23472 COPY 3 - ANESTHESIA DEPARTMENT USAPA V1.00

ACLU-RDI 1681 p.32

DOD-037050

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

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

PROPOSED PROCEDURE: ____
SURGICAL SERVICE: ____
NPO SINCE: ____

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ø
( )
( )
( )
( )
( )

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

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

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
Ø

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharnyx MP I
Nares ____
CHEST: CTA
CARDIAC: RRR,
EXTREMITIES:
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

INFO[redacted]NSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and disc[redacted]egal guardian.
b(6)-2
Th[redacted]ems to understand and agrees. Questions answered.
Sig[redacted] Date: 8NOV03 Time: 0830 Hrs

POST-A[redacted]N AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b(6)4

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.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

PATIENT RECORD COPY

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

MEDCOM - 23473

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

(L) FEMUR
(R) TIB FIB
(R) HAND

AGE: 24 | SEX: M | SSN (Sponsor): 1242 EPW. | WARD/CLINIC: EMT | REGISTER

FILM NO.

PREGNANT
☐ YES

TELEPHONE

b(6)-2

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

GSW

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

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

STANDARD FORM 519-B
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-45.505

MEDCOM - 23474

b(6)-4

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

Knee series bilat
R-hand series

AGE | SEX: M | SSN: [redacted]

WARD/CLINIC: EXIT

REGISTER

FILM NO.

b(6)-2

PREGNANT ☐ YES

REQUESTED BY: [redacted]

TELEPHONE

SIGNATURE OF: [redacted]

DATE REQUESTED: 8 MAR

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

Shrapnel to R-hand + bilat knees

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)

[redacted]
b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — RADIOLOGY

STANDARD FORM 519-B
FPMR (41 CFR) 101-11.6

MEDCOM - 23475

Ward/Section: EMT | REQUESTING PHYSICIAN: b(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 | DATE 8NOV03 | TIME 0315 | SSN/PSEUDO SSN: b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

(Piccolo) ... 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
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

```
----------------------
i-STAT EC8+

Pt:[redacted]
Pt Name:___________

Glu________111 mg/dL
BUN_________10 mg/dL
Na_________138 mmol/L
K__________4.0 mmol/L
Cl_________106 mmol/L
TCO2________28 mmol/L
AnGap_______10 mmol/L
Hct_________43 %PCV
Hb*_________15 g/dL
  *via Hct
pH_______7.329
PCO2______50.7 mmHg
HCO3________27 mmol/L
BEecf________1 mmol/L

Sample Type_:

 08NOV03      03:53

Oper:[redacted] b(6)-2

Physician:_____________

Ser# 42015

Ver: JAM5046A
     CLEW A93
----------------------
```

```
======= PICCOLO =======
08/11/03            03:51
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #:       3154AA7
OPER #:[redacted]   DR #: 000
SERIAL #:b(6)-2 0000100494
.........................
ALB    4.4   3.3-5.5   G/DL
ALP    85*   26-84      U/L
ALT    94*   10-47      U/L
AMY    59    14-97      U/L
AST    55*   11-38      U/L
TBIL   0.9   0.2-1.6  MG/DL
GGT    33    5-65       U/L
TP     8.0   6.4-8.1   G/DL

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

REPORTED BY:	DATE:	LAB ID NO.:

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

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

LAST, FIRST, MI. [redacted] b(6)-4

DATE 8NOV03 TIME 0315 SSN/PSEUDO SSN: [redacted] b(6)-4

Urinalysis

Misc. Serology

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	N/A	RPR		Negative
	N/A	Mono		Negative
	Negative	Microbiology		
	Negative	Source		
	Negative	Gram Stain		
	N/A	Occ Bld		Negative
	Negative	H. pylori		Negative
	N/A	Micro Parasites		
	Negative	Malaria		
	0.2-1.0	O & P		
	Negative	Other		

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 04:09

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 15.2 sec.
Ratio = 1.2
Calculated INR = 1.43
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :04:08
Card Lot :080201
Operator : [redacted]
b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 04:14

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 31.5 sec.
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :04:10
Card Lot :100208
Operator : [redacted]
b(6)-2

ID: [redacted]
WB
08-11-03
04:06

			Patient Limits	
WBC	19.1 H	x10^3/uL	4.5	10.5
RBC	5.37	x10^6/uL	4.00	6.00
Hgb	14.6	g/dL	11.0	18.0
Hct	45.7	%	35.0	60.0
MCV	85.1	fL	80.0	99.9
MCH	27.2	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	282.	x10^3/uL	150.	450.
LY%	11.7 *L	%	20.5	51.1
LY#	2.2 *	x10^3/uL	1.2	3.4

ic Urinalysis

d Bank

SF 518 WITH REQUESTED

(MUST SU

OF BLOOD

CROSSMATCH

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

REMARKS:

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

MEDCOM - 23477

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	TOTAL EBL
Fentanyl 50μg/cc	100 50 50 50		<5
Norcuron 1mg/cc	7mg		TOTAL URINE
VOLAT AGENT Forane % del	1-3-2¼ — 1¼ — 1		
% e.t.			
AIR L/Min			
N2O L/Min			
O2 -3 L/Min	————		

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

FLUIDS — LINE site: RL - 280 — 200 — NS (250)

LOSSES — EST BLOOD LOSS / URINE -

FLUIDS - SUMMARY
CRYSTALLOID- 250
COLLOID-
BLOOD-

REMARKS (Code drugs with numbers, events with letters)

1. V/S Taken
2. Inducted c̄ Norcuron 7mg, Lidocaine 20mg, Diprivan 160mg, Anectine 100mg, #4 LMA
3. Procedure began
4. Procedure ended
5. O2 breathing well, suctioned to recovery

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: KG / LB
HEMATOCRIT:
INITIAL DATA: BP- 117/57, HR- 103, 98%
EQUIP CHECK OK?- Y N
PATIENT RECHECK
OK for PROCEDURE?
TIME-

TIME: 11⁰⁰ 15 30 45 12⁰⁰ 15

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		
f - breaths/min	19	20
Peak inf pres / PEEP		
MODE - S(pon), A(ssist), C(on)	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		44	47		
BP/oth	✓ FIO2 (Frac or %)		60%	58%		
ART line	✓ SpO2 (%)		100	99		
Steth- PC/ES	✓ ECG	ST	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ① ② ③ ④ ⑤

RECOVERY AT: PACU ICU ____ (Specify) OTHER
CONDITION: stable
RESP- 9 SpO2- 96
BP- 103/41 HR- 77

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1044	1108	1206
	Ready	**Begin**	**End**
PROC	1123	1131	1154

PROCEDURES and CPT Codes: I&D (R) hand c̄ closure • splint

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen c̄ LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4 LMA

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

SURGEONS: [redacted] b(6)-2
[redacted] CRNA

PROCEDURE LOCATION: OR
DATE: 10 Nov '03
PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 23478 — COPY 3 - ANESTHESIA DEPARTMENT — USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER: 8 Nov 03 TIME OF ORDER: 0815 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW 1 ORTHO DR [redacted] b(6)-2
2. Dx - (R) Index Finger Open metacarpal Fx, BL LE shrapnel wounds
3. Cond - Stable
4. Vitals - Q4°
5. All - ? PCN allergy - tolerated Ancef in ED
6. Act - Bedrest

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

7. IVF - LR @ 100cc/hr
8. NPO - on call to OR
9. Meds - Ancef 1gm IV Q8°
   MSO4 i-iv mg IV Q1° PRN
   Reglan 10mg IV Q6° PRN
   Benadryl 25-50mg IV Q6° PRN
10. b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 8 Nov 03 TIME OF ORDER: 0950 HOURS

1. Admit to ICW 1 ORTHO DR [redacted]
2. Dx - S/p I&D (R) IF Open MC Fx, I&D BL LE
3. Cond - Stable
4. Vitals - Q4° X3 then Q Shift
5. All - ? PCN - No Rxn to Ancef
6. Act - Elevate RUE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted [redacted] 8 Nov 03 1135 b(6)-2

DATE OF ORDER TIME OF ORDER HOURS

7. Wing - LR @ 100cc/hr HL IV when tolerating PO well.
8. Diet - advance as tolerated.
9. Meds - Ancef 1gm IV Q8°
   Reglan 10mg IV Q6° PRN
   Benadryl 25mg IV Q6° PRN
   MSO4 i-iv mg IV Q1° PRN

NURSING UNIT | ROOM NO. | BED NO.

24° / 0200 9NOV03 [illegible]

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

MEDCOM - 23479

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER: 9 Nov 03 TIME OF ORDER: 1130 HOURS

1. NPO p̄ MN
2. On call to OR in AM 10 Nov 03
3. Once NPO, start IVF LR @ 100 cc/hr.
4. Daily wet → dry dressing Δ's BL LE wounds

Thanks b(6)-2

NURSING UNIT: 1CW 1 ROOM NO.: 24° ✓ 10 NOV @ 0350 ... WHITE

LIST TIME ORDER NOTED AND SIGN: 9 Nov 03 1140

PATIENT IDENTIFICATION

DATE OF ORDER: 10 Nov 03 TIME OF ORDER: 12:00 HOURS

1. Admit to PACU → RW 1
2. Dx – S/P I+D, DPC (R) 1P Open MCFx
3. Cond – Stable
4. Vitals Q4° x3 then Q Shift
5. A/L – ? PRN
6. Act – Strict elevation RUE
7. Nursing – LR @ 100 cc/hr HL IV when tolerating PO well.
8. Diet advance as tolerated
9. Meds – Ancef 1gm IV Q8° x 3 doses
10. Percocet i-ii PO Q 4-6° PRN
    MSO4 i-iii mg IV Q1° PRN Breakthrough
    Phenergan 25 mg IV Q6° PRN
    Benadryl 25 mg IV Q6° PRN
    Tylenol 325-650 mg PO Q4-6° PRN
10. Daily dressing Δ's BL LE wounds
11.

b(6)-2 Noted 10 Nov 03 1255

b(6)-2

b(6)-2

NURSING UNIT 24° ... 11 NOV 03 @ 0135

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

MEDCOM - 23480

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 08	09	10	11	12	13	14	15
08 Nov03	[redacted]	Vitals q4° X3	10	[redacted]	/						
			14	[redacted]	/						
		then	18	[redacted]	/						
08	[redacted]	Vitals q shift	06 18	/	[redacted]						
			18 06	[redacted]							
08	[redacted]	Act: elevate RUE	06 18	[redacted]							
			18 06	[redacted]							
08	[redacted]	Diet: adv as tolerated	06 18	[redacted]	[redacted]	PRE-OP					
			18 06	[redacted]							
09	[redacted]	Daily W-D drsg	06 18	/	[redacted]						
		Δs BL LE wounds	18 06		[redacted]						
10 Nov03	[redacted]	Vitals q4° X3	12	—	/	[redacted]					
			16	—	/	[redacted]					
		then	20	—	/	[redacted]					
10	[redacted]	Vitals q shift	06 18	—	/	[redacted]	[redacted]	[redacted]			
			18 06	—	/	[redacted]	[redacted]	[redacted]			
10	[redacted]	Act - stocking elevation RUE	06 18	—	/	[redacted]	[redacted]	[redacted]			
			18 06	—	/	[redacted]	[redacted]	[redacted]			
10	[redacted]	Diet - adv as tol.	06 18	—	/	[redacted]	[redacted]	[redacted]			
			18 06	—	/	[redacted]	[redacted]	[redacted]			
10	[redacted]	Daily drsg Δs BLLE wounds	10	/	/	[redacted]	[redacted]	[redacted]			

ALLERGIES: [X] YES [ ] NO ? PCN

PRIMARY DIAGNOSIS: DPC S/P VD ® IF OPEN MCFX VD BL LE

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

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 11 Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
08 NOV03	[redacted]	Admit to ICW1 - ORTHO - Dr. White	08 NOV	—	—	[redacted]
08	[redacted]	NPO - on call to OR	08 NOV	—	—	[redacted]
9	[redacted]	NPO p MN	9 nov	2400	—	[redacted]
9	[redacted]	O/C to OR in A.M. 10 Nov 03	10 nov	O/C	—	[redacted]
10 Nov03	[redacted]	Admit to PACU → ICW1 - Cond: Stable	10	—	—	[redacted]

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

USAPA V1.00

MEDCOM - 23482

b(6)-2

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. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10
08 NOV 03	[redacted]	LR@100cc/hr · HLIV	08 18	[redacted]		
	-----	when tol. po well	18 06	[redacted]		
08	[redacted]	Ancef 1gm IV q8°	06	[redacted]		PRE-OP
	-----		14	[redacted]		
	-----		22	[redacted]		

ALLERGIES: ☒ YES ☐ NO
PCN
KEF IN ER

PRIMARY DIAGNOSIS: S/P VD ® IF OPEN MC FX
VD BL LE

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

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
	23	24	01	02	03	04	05	06

MEDCOM - 23483

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 11 Yr. [illegible]

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 Nov	[redacted]	Once NPO, Start IVF LR@100cc	10 Nov	2400		[redacted]
		b(6)-2 All				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED
08 Nov	[redacted]	Reglan 10mg IV q6° prn	D/T	
			D/I	
08	[redacted]	Benadryl 25mg IV q6° prn	D/T	
			D/I	[redacted]
08	[redacted]	MSO4 1-4 mg IV q1° prn	D/T	0915
			D/I	2mg [redacted]

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

MEDCOM - 23484

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10
08 NOV 03	- [redacted]	LR @ 100cc/hr · HL IV	08 18	[redacted]		
	-----	when tol. po well	18 04	[redacted]		
08	- [redacted]	Ancef 1gm IV q8°	06	[redacted] PRE-OP		
	-----		14	[redacted]		
	-----		22	[redacted]		

ALLERGIES: [X] YES [ ] NO
? PCN
TOL ANCEF IN ER

PRIMARY DIAGNOSIS:
S/P VD @ IF OPEN MC FX
VD BL LE

ADDITIONAL PAGES IN USE: [X] YES [ ] NO
PAGE NO. 1

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.
MEDCOM - 23485

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. Ø3

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 Nov	[redacted]	Once NPO, Start IVF LR@100cc	10 Nov	2400	—	[redacted]

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
Ø8 Nov	[redacted]	Reglan 10mg IV q6° prn	D/T
			D/I
Ø8	[redacted]	Benadryl 25mg IV q6° prn	D/T
			D/I
Ø8	[redacted]	MSO4 1-4mg IV q1° prn	D/T [redacted] 0915
			D/I 2mg [redacted]

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

MEDCOM - 23486

ACLU-RDI 1681 p.46

DOD-037064

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: 8NOV03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
Time In: 0955
Allergies: PCN OR Intake: Crystalloid 400 Colloid
Pre-op V/S: 124/76 115 OR Output: UOP — EBL MIN
Procedures: I+D B legs Meds/Times: 1gm Ancef 250mcg Fent 4 Zofran

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

Pre Op Meds History

Time	0955	1000	1005	1010	1025
SaO2	97	97	99	97	99
FiO2					
Methods	RA	RA	RA	RA	RA
RR	14	20	11	11	10
T	97.3				

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

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	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	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.	9	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

Time	Patient teaching done: Wound Care, Pain Management.
Pain (0-10)	T. C. & DB., Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

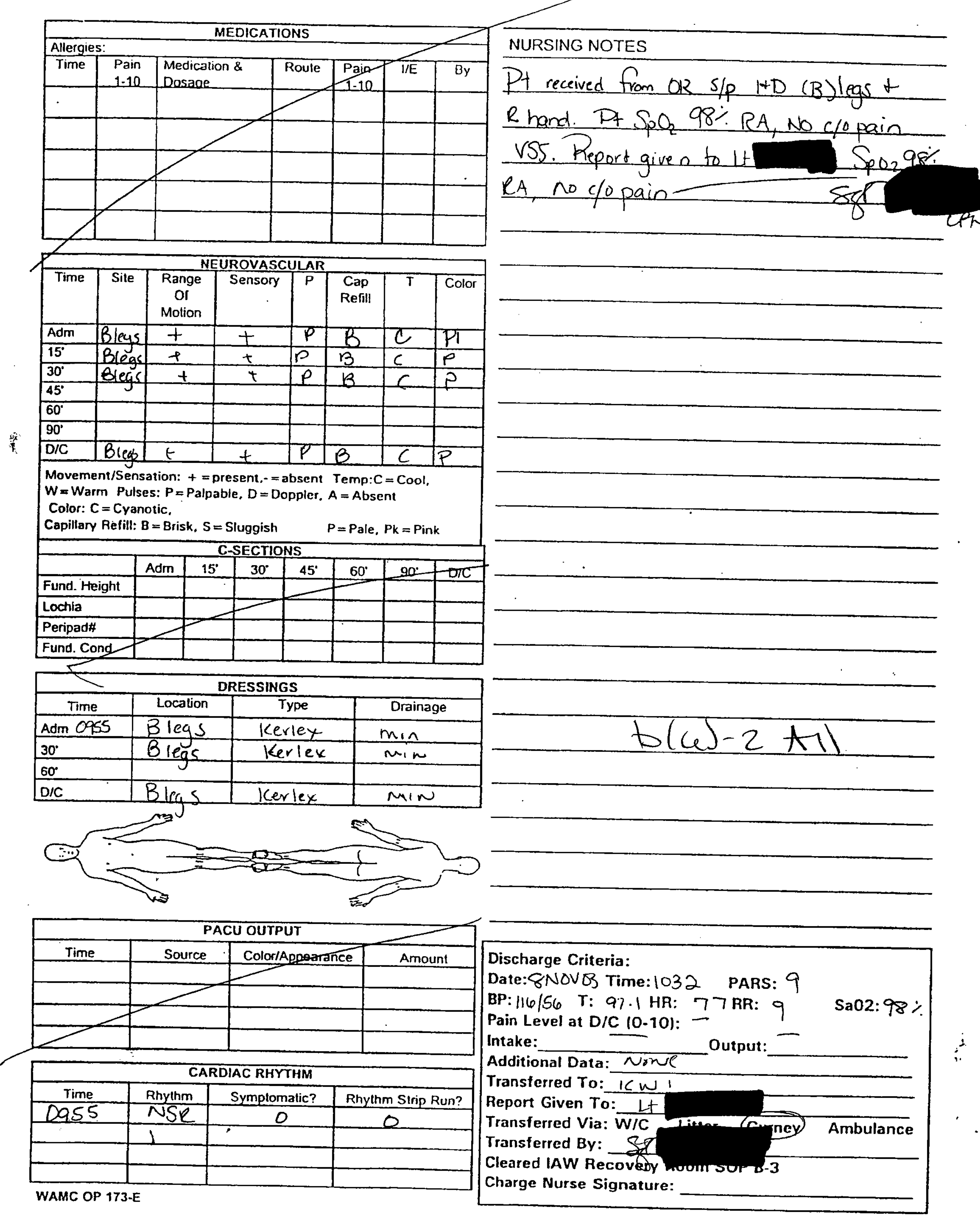
P[redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 8 NOV 03

PATIENT IDENTIFICATION (For typed or written entries give: 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

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



MEDICATIONS

Allergies:

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

NURSING NOTES

Pt received from OR s/p I+D (B) legs + R hand. Pt SpO_2 98% RA, No c/o pain VSS. Report given to Lt [redacted] SpO_2 98% RA, no c/o pain ——— Sgt [redacted]

b(6)-2 All

NEUROVASCULAR

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

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 0955	B legs	Kerlex	min
30'	B legs	Kerlex	min
60'			
D/C	B legs	Kerlex	min

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0955	NSR	0	0

WAMC OP 173-E

Discharge Criteria:

Date: 8 NOV 03 Time: 1032 PARS: 9

BP: 116/56 T: 97.1 HR: 77 RR: 9 Sa02: 98%

Pain Level at D/C (0-10): —

Intake: — Output: —

Additional Data: None

Transferred To: ICW 1

Report Given To: Lt [redacted]

Transferred Via: W/C Litter (Gurney) Ambulance

Transferred By: Sgt [redacted]

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature:

MEDCOM - 23488

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: 10 Nov 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1200
Allergies: NKDA OR Intake: Crystalloid 250 Colloid
Pre-op V/S: 117/57 103 OR Output: UOP ∅ EBL 5cc
Procedures: I+D (R) hand dressing change to legs Meds/Times: fentanyl

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1200	1215	1230	1245
SaO2	98	95	95	97
FiO2				
Methods	RA	RA	RA	RA
RR	15	12	12	16
T	96			

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

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1200	NS	250	DR	Dwards	250

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	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	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	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

(Continue on reverse)

[redacted] LPN b(6)-2 DEPARTMENT/SERVICE/CLINIC: PACU DATE: 10 Nov 03

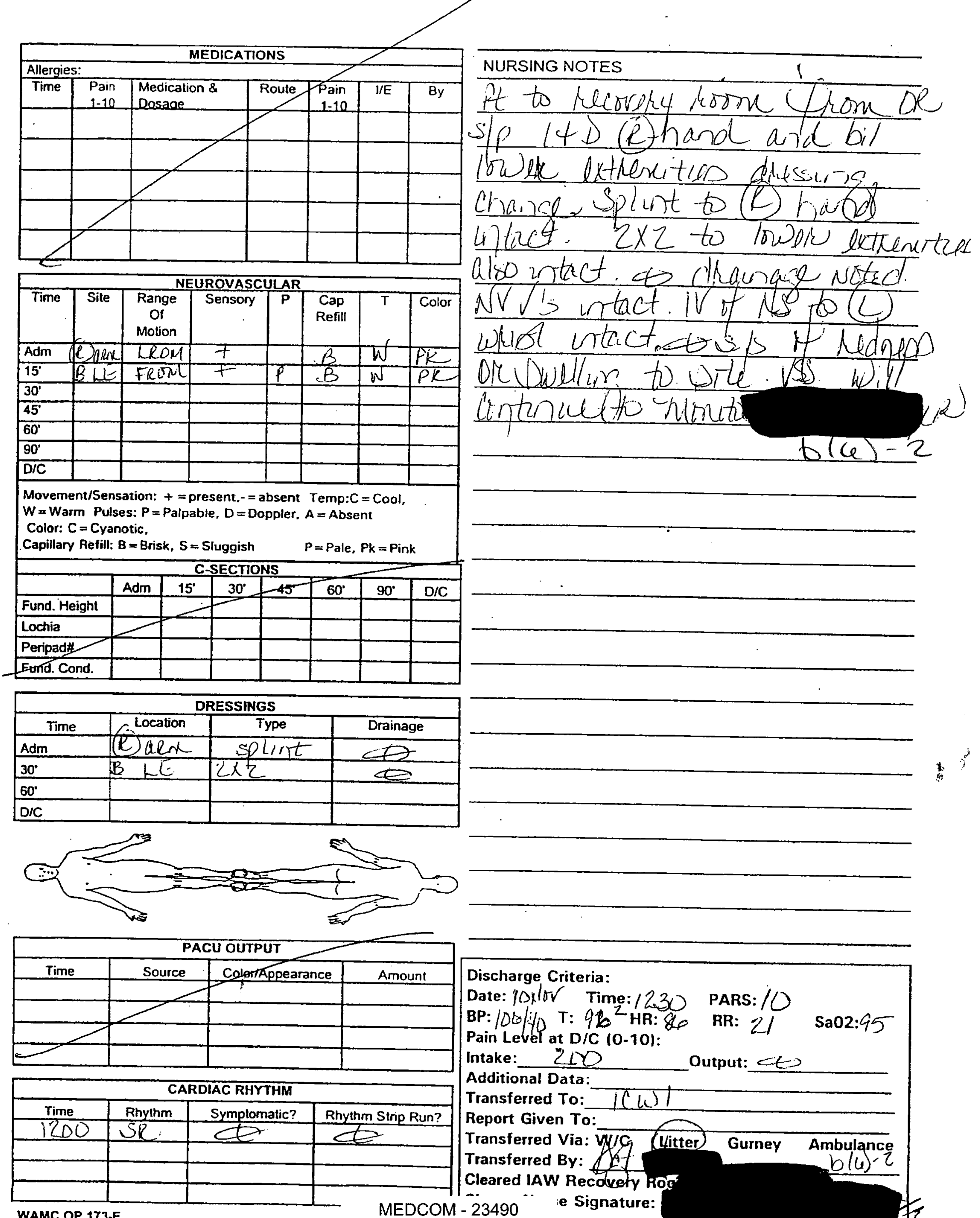
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

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

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

MEDCOM - 23489



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

NURSING NOTES

Pt to recovery room from OR s/p I&D (R) hand and bil lower extremities dressing change. Splint to (R) hand intact. 2X2 to lower extremities also intact. ⊘ drainage noted. NV √'s intact. IV of NS to (L) wrist intact. ⊘ s/p ... OR ... VSS. Will continue to monitor [redacted] b(6)-2

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) arm	LROM	+		B	W	PK
15'	B LE	FROM	+	P	B	W	PK
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	(R) arm	splint	⊘
30'	B LE	2X2	⊘
60'			
D/C			

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1200	SR	⊘	⊘

Discharge Criteria:
Date: 10/10/04 Time: 1230 PARS: 10
BP: 100/40 T: 98.2 HR: 86 RR: 21 Sa02: 95
Pain Level at D/C (0-10):
Intake: 200 Output: ⊘
Additional Data:
Transferred To: ICW1
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] b(6)-2
Cleared IAW Recovery Roo[redacted]
...e Signature: [redacted]

WAMC OP 173-E MEDCOM - 23490

ACLU-RDI 1681 p.50

DOD-037068

TIME	PROCEDURE	SIZE	SITE		BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth			☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal			☐ Air ☐ Contents ☐ Verified____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public			☐ Return____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed			☐ Grossly: + - Cell count Sent@____
	Chest Tube #1		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L	R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:			Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
AW	1		Y	N	® AC	SALINE	1L	
0326	2	18	Y	N	L AC	LR	1L	
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef	0315	1gm	IVP						
Tetanus	0326	.5	IM						
Fentanyl	0330	50	IVP						
Fentanyl	0410	75	IVP						
Fentanyl	0515	50	IVP						

2/F
hr

LABS

TIME	LABS
	☐ D-stick____ ☐ SHct____
	☐ D-stick____ ☐ SHct____
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x____
	☐ Tox Screen
	☒ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
0330	☒ L. femur
0330	☐ R. tib/fib
0330	☐ R. hand

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC: 19.1 / 14.6 / 45.7 / 282

PT/PTT 15.2/31.8

Chem: 138 | 106 | 10 ; 4.0 | 28 | ; 111

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ ____

Admitted to ____

Report Called to ____

Time Transferred ____

By ____

MEDCOM - 23491

VITAL SIGNS

~~Rectal~~ ORAL Temp: 97.9 SPO2 100 GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0310	130/73	51		10							
0315	136/73	114		20							
0326	137/60	130	SR	30	100%						
0352	122/60	117	SR	22	100%						
0425	128/62	130		19	99% RA						
0800	120/60	82		18	100%						
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

24 y/o Male brought in by Medics, pt. awake + alert. Shrapnel wounds noted to b/lat legs + Ⓡ hand. Skin cool + Dry. Movement to extremities b/l. PPP — [redacted] 20A

0350 pt. taken to surgery via litter, accompanied by RN + Medic [redacted]

0800 Pt in bed. Denies any pain or discomfort. Ortho with pt — [redacted]

b(6)-2

MEDCOM - 23492

ACLU-RDI 1681 p.52

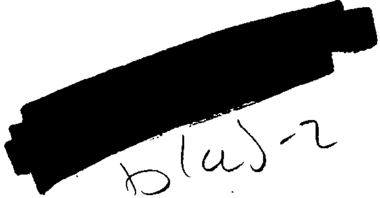
DOD-037070

24 y/o EPW. WAS RUNNING out of a house that U/S soldiers were RAIDING near RAMADI tonight. Arrived via medevac.
Pt AAOx3 in pain on Arrival
pt denies any pain Above waist except for R Hand. NO ABD/chest/Back/neck pain.
R B Leg pain.

Given IV, pain.

PMH – Ø
PSH – Ø
Fx – ?
All – NKDA
Meds – Ø

Ancef / Tetanus / Fentanyl / ortho consult.
2 x 2L IVF in ER.


b(6)-2

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: **TRAUMA FLOWSHEET** — The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME: ______ ETA: 0815 UNIT: #242

MED COM: [Y] [N]

ARRIVAL STATUS

TIME ______ ☐ IV x 1 ☐ 0_2 ______ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes: ______

Allergies: ☐ UKN ☐ None ☐ Yes: ______

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake ______ hrs

LMP: ______ ☐ ______

PRIMARY SURVEY

AIRWAY	BREATHING	CIRCULATION	
☒ Natural Patient [Y] [N] (Y marked)	☐ Labored ☒ Unlabored ☐ Absent	PULSE: ☒ Present ☐ Absent	SKIN: ☒ Warm ☐ Cool ☐ Hot
☐ ETT ____ ☐ ______	TRACHEA: ☒ Midline ☐ Deviated [L] [R]	BLEEDING: [Y] [N]	☐ Pink ☐ Pale ☐ Cyanotic ☐ ______
☐ Secretions ______	CHEST SYMMETRY: [L] = [R]	HEART TONES: ☐ Clear ☐ Muffled	☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY	HEAD	HEART	ABDOMEN
GCS: E ____	PUPILS: ☒ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]	RHYTHM: ☒ Regular ☐ ______	☒ Soft ☐ Rigid ☒ Non-Tender
V ____	TM: ☐ Clear ☐ Blood [L] [R]	PULSES: ☐ Central ☐ Peripheral	☐ Tender:
M ____	**NECK**	**LUNGS**	**PELVIS**
SPHINCTER TONE:	C-Spine Tenderness: [Y] [N]	BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear	☒ Stable ☐ Unstable ☐ ______
☐ WNL	Pain @ ______	Decreased [L] [R] Absent [L] [R]	Blood at meatus/vagina: [Y] [N]
☐ None	JVD: [Y] [N]	Wheezes [L] [R] Crackles [L] [R]	Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound

(L) femur fx

(R) tib fib fx

VASCULAR ASSESSMENT

++ ++ ++ ++

++ Strong | + Palpable | D Dopler

[redacted] (Signature & Title) b(6)-2

PHYSICIAN [redacted]

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: EMT

DATE: 8 NOV 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: 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

b(2)-2

1. Reporting MTF	2. MTF Location	Admission and Coding Information
	IZ	For use of this form, see AR 40-400; the proponent agency is OTSG

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
0015197	b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1979-01-01	24Y	X	9	

10. Length of Service		11. FMP	12. Social Security Number	
	ETS	99		

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		03:00	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
b(2)-2	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-13

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-11-08

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-11-08

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P VD R IF DPC OPEN MC FX VD BL LE

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer	Signature

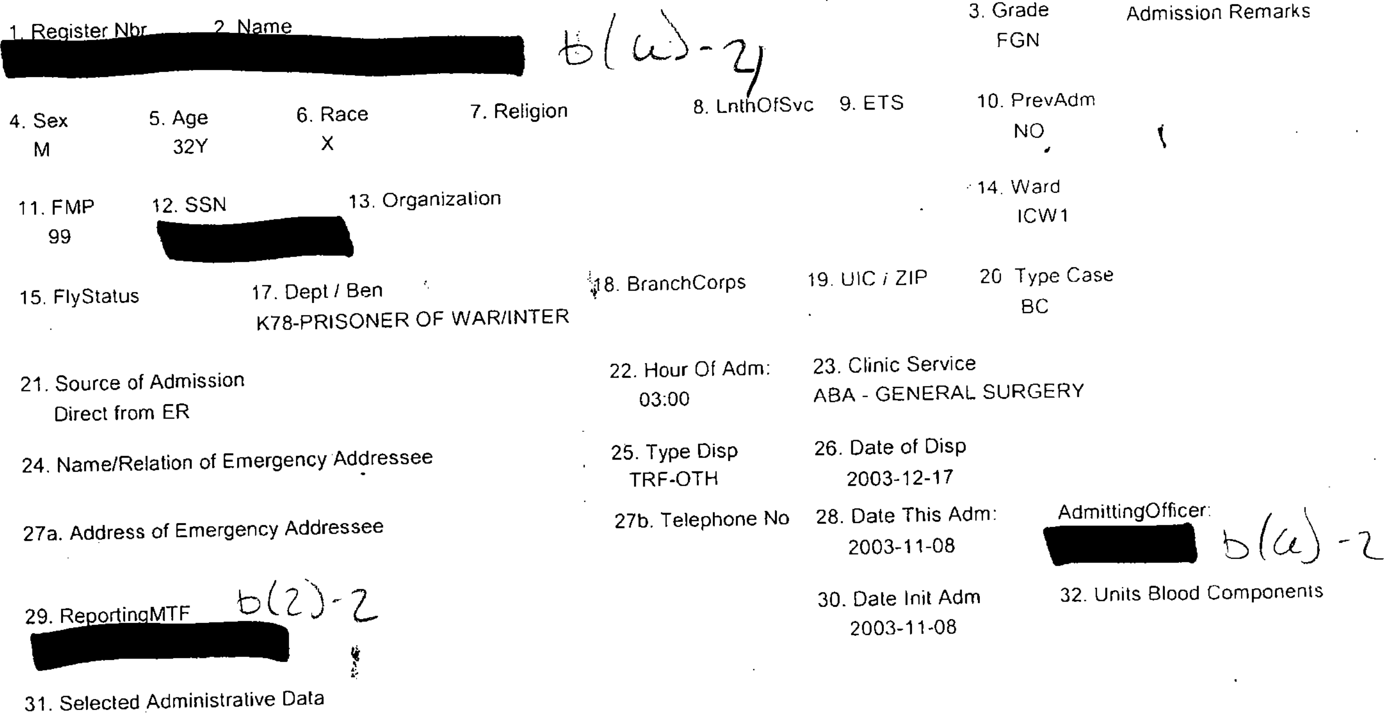
Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 23495

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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



1. Register Nbr 2. Name [redacted] b(6)-2
3. Grade: FGN
Admission Remarks

4. Sex: M
5. Age: 32Y
6. Race: X
7. Religion
8. LnthOfSvc
9. ETS
10. PrevAdm: NO

11. FMP: 99
12. SSN: [redacted]
13. Organization
14. Ward: ICW1

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

21. Source of Admission: Direct from ER
22. Hour Of Adm: 03:00
23. Clinic Service: ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee
25. Type Disp: TRF-OTH
26. Date of Disp: 2003-12-17

27a. Address of Emergency Addressee
27b. Telephone No
28. Date This Adm: 2003-11-08
AdmittingOfficer: [redacted] b(6)-2

29. ReportingMTF b(2)-2 [redacted]
30. Date Init Adm: 2003-11-08
32. Units Blood Components

31. Selected Administrative Data

Marital Status:
DoB: 1971-01-01
In/Out Patient: Inpatient
MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW L BUTTOCKS AND THIGHS

877.0 86.28
890.0 49.21
276.5 86.59
E991.2

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

[redacted] ...nding M... [redacted] ...er b(6)-2

Signature of PAD or Medical Records Officer [redacted] b(6)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

31 y/o Iraqi male c multiple GSW to the buttocks 1 hr ago and injuries to the thighs. Presented to the ED c hypotension and hemorrhage from a gluteal wound. Moving all ext and sensory intact.

∅ PMHx PSHx = ∅ NKDA

Labs 37.5 > 11.9 / 37.4 < 464
PT/T = 14.1/27.5 INR = 1.26
129 / 99 / 11 / 3.4 / 22 / 1.2 < 240

PHYSICAL EXAMINATION HR = 102 BP = 146/71 Sat = 100% on RA

HEENT = WNL
Lungs = CTA
CV: RRR (tachycardia)
Abd = soft; denies any pain; ∅ rebound
GU = WNL; No gross blood in urine
Ext = Palpable distal pulses; small medial wound to (R) thigh
Large medial wound to (L) thigh
Rectal = NBT = No gross blood; GSW to each gluteal area

CXR = WNL
Pelvis = ∅ fx
(L) femur = ∅ fx

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

A = GSW to buttocks + thighs
Plan = CT scan of Abd/Pelvis
Washout wounds; may need ex lap; proctoscopy

b(6)-2

SIGNATURE [redacted] | DATE 8 NOV 03 | 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

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08NOV03 0730	Recieved pt. from OR via litter. O2 @ 12L per rebreathable mask. Cordis to (R) SC intact & flushes well. IVF: NS c̄ 20MEQ KCL @ 125cc/hr infusing to site. PIV to (L) AC intact & flushes well. Drg noted to (B) thighs. Drsg also noted to buttock area c̄ packings. F/C to BS draining clear yellow urine. SpO2 100%. [signature] [redacted] b(6)-2

IBP TREND 11/08/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN
08:10	92	100	139 / 76	101
08:00	103	100	145 / 84	108
07:50	91	100	141 / 78	103
07:40	94	100	141 / 77	101
07:30	92	100	166 / 77	110
07:20	97	100	139 / 70	96
07:17	[illegible]	100	158 / [illegible]	

DATE	NOTES
0843	Nasal trumpet removed. Rebreathable mask replaced with NC ~~2L~~ O2 @ 2L per NC @ present time. SpO2 100% ∅ distress noted. Will continue to monitor pt. for S/SX of distress. [signature] [redacted] b(6)-2

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

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDCOM - 23498

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 NOV 03 0907	Brief Op Note
	Pre-Op Dx = GSW to bilat. buttocks + thighs
	Post-Op Dx = SAA
	Procedure = Flex-Sig / Anoscopy / Debridement + Washout /
	Indications = Mult. GSW
	Surgeon = [redacted] b(6)-2
	Anesthesia = GETA
	EBL = 300cc
	Fluids = 4 units PRBCs in EW prior to OR. Total of 6 units of crystalloid
	Specimens = None
	Drains = None
	Complications = None
	No evidence of rectal injury. All wounds washed out + debrided c̄ packing placed. Return to OR in 24 Hr.
	[redacted]
	Post Op Labs b(6)-2
	139 / 107 / 16 < 190 ; 4.1 / 22 / 0.9 ; 15.9 > 12.4 / 38.6 < 281
	7.337 / 41.6 / 114 / 22 / -4 / 98%
	[redacted]

MEDCOM - 23499

STANDARD FORM 509 (REV. 5/1999) BACK

ACLU-RDI 1681 p.59

DOD-037077

b(6)-2 Arl

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08NOV03	Pt's condition remains stable. VSS: B/P 115/73
0932	HR 105 RR 17 SpO2 100% on 2L O2 per NC. ⊖
	complaints of pain voiced @ present time. Pt's
	AM care completed @ this time. Scant amount
	of drainage noted to (B) thighs. Will continue
	to monitor pt. for any S/S of distress.
	Sgt [redacted]
1002	SpO2 100% RA. ⊖ respiratory distress noted @
	present time. Will monitor. [redacted]
1100	C/O pain. MSO4 4mg given for complaint of
	(Rt) thigh pain. Will continue to monitor
	pt. for S/S of distress. Sgt [redacted]
1115	Incentive spirometry done x 3. Pt able to get
	all 3 balls up c̄ ease. Will encourage
	pt to cough and do more incentive spirometry
	Sgt [redacted]
1149	Dsg reinforced to (B) thighs. Will continue
	to monitor. Sgt [redacted]
1230	⊖ complaints of pain @ present time. Pt.
	resting in bed c̄ eyes closed, easy to arouse.
	Will monitor. Sgt [redacted]

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

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

b(6)-4

EPW # [redacted]

PROGRESS NOTES
Medical Record

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MEDCOM - 23500

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08NOV03	⊖ complaints @ present time. Will cont. to
1402	monitor. Sgt [redacted]
1428	Pt. to be trasferred to ward. Sgt [redacted]
	b(6)-2

MEDCOM - 23501

STANDARD FORM 509 (REV. 5/1999) BACK

ACLU-RDI 1681 p.61

DOD-037079

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 NOV 03	- Assumed care pt sleep yet easily arousable
0700	A+O x 3 VSS Remains NPO except sips ē meds Medicated
	ē percocet ii tabs ē relief. Lungs clear HRRR
	Active BS. Multiple GSWs to Bilateral LE and buttocks
	ORDERS to Reinforce dsgs only. Burn pad placed
	underneith serous drainage to dsg not saturated
	reinforced as needed. Cont IV ABX Rx Will cont
	to monitor ——— b(6)-2 [redacted]
9NOV03	Brief Op Note
	Pre-op Dx = GSW to Thighs + Buttocks
	Postop Dx = SAA
	Surgeon = [illegible]
	Anesthesia = GETA
	Indication = GSW
	EBL = 100cc
	Fluids = 1 Liter
	Spec = Ø
	Drains = Ø
	Complications = Ø
	Healthy appearing tissue. Pulse lavage done.
	Dressings placed. Will return in 2 days
	for washout
	[redacted] b(6)-2

EPW

[redacted] b(6)-4

MEDCOM - 23502

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Pt transferred to ICW1 from ICU1 via litter in stable condition; All VSS, pt
	A&O speaking arabic; ⊕ CMS throughout, +2 PP, brisk cap ref; S1S2, LSCTA B
	⊕ BS, abd soft NTTP, FTG patent draining clear yellow urine; pt NPO for on call
	Sx in AM; dsgs to B upper thighs & buttocks CDI, scant drainage noted; R SC
	CL patent infusing D5½ NS c 20 Meq KCL s s/sx infection/infiltration; Restr
	in place, ⊕ circ, ⊖ skin breakdown, cont to monitor b(6)-2 [redacted]
8NOV03	VSS Alert Oriented. Aware of NPO status
2000	& scheduled for OR Tomorrow. R SC [redacted] IV
	patent & intact infus NS c 20MEq KCl/L @ 125
	Lungs clear. Abd soft, non-distended BS+
	Bil Thigh dsgs dry & intact. Buttock dsg
	reinforced due to soiled c moderate serosang
	drainage. Uses incentive spirometer properly @
	900-1200 cc/sec. Non productive cough. Peripheral
	pulses +2. +2 restraints in place will check
	frequently to ensure proper circulation & prevent
	damage to skin integrity [redacted] 2LT [illegible]
9NOV03	Reinforced dsg to ~~lt~~ thigh X2. Foley d/c'd
0545	@ 0545 hr. 500cc clear amber urine in drainage
	bag. Will report to oncoming shift
	b(6)-2 [redacted] 2LT

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	[SPONS]OR'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)*

[redacted] b(6)-4

REGISTER NO.

WARD NO. ICW1

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09NOV03 2200	~~A~~ [redacted] Assumed care Pt alert & Oriented. Resp 20 O_2SAT 92% c 2l NC. ~~[illegible]~~ Lying in bed HOB ↑30. Lungs clear. Assist pt OOB to chair. Tolerated Well. O_2SAT ↑ 96% RA. HR 140's Voiding clear amber urine 175cc @ this time. 18[illegible] Dr [redacted] present and was informed of Pt's condition. Received new order for 1 liter Bolus of NS NOW. Abd soft large non-distended Peripheral pulses +2. Temp 100. oral. BP 104/64 Drsg to Bilateral thighs + Buttocks reinforced d/t soiled c serosanguinous drainage. TEMP ↑10[illegible] @2100. Received Order for Tylenol 2 tabs PO NOW. VS @ 2200 Temp 100.3 - 116 - 18 112/57 O_2SAT 97% @2l NC Continues to use incentive Spirometer properly Q1 @ 1200cc/sec c non productive cough. Consumed 40% of Regular diet for dinner. Will continue to monitor closely ——— [redacted] RN
	b(6)-2

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

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EPW

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

MEDCOM - 23504

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03	Surgery POD#3 [illegible] washout + Debridement
	Afebrile
	Doing well
	Plan to OR for washout + partial wound
	closure tomorrow
	[redacted] b(6)-2
10 NOV 03 1300	Pt a/o, VSS, mild c/o pain (although falls asleep too quickly). Resp even & unlabored O2 sats @ 95% on 1L NC. Will attempt to wean off O2. HOB ↑ 30°. Foley reinserted due to bladder distention. Pt has not voided during this shift. ~~(since 0600)~~ ERROR [redacted] b(6)-2 Upon insertion voided 1400cc amber urine. Drsgs to bil ~~thighs~~ thighs & buttocks c̄ minimal drainage (reinforced). IS used hourly. Pt consumed 25% of lunch today. NS c̄ 20 mEq KCL infusing s̄ complication. ⊖ redness or edema @ site. Ⓡ SC IV. ⊕ peripheral pulses, brisk cap refill. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor. Plan: ambulate/OOB to chair, IV ancef, monitor drsgs, pain ctrl, mon. respiratory. Will monitor [redacted] 91WM6
	b(6)-2

MEDCOM - 23505

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ACLU-RDI 1681 p.65

DOD-037083

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11 NOV 03	Brief Op Note
1312	Pre-op Dx = Mult. GSW to thighs and buttocks
	Post-op Dx = SAA
	Surgeon = [redacted] b(6)-2
	Indications = Open wounds of buttocks and thighs and right hip
	Fluids = 2400cc
	EBL = minimal
	Drains = Penrose drains to each thigh and right buttock wound
	Specimens = ∅
	Complications = None
	Findings = Clean open wounds. drains placed + tissue approximated.
	[redacted] b(6)-2

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

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REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11NOV03 @0030	assumed care of pt @1800. VSS, O2@1.5LNC for sats 94-96. Pt is mouth-breather & sats ↓ to low 90s when sleeping. LS CTA, slightly tachycardic @110-115. ⊕BS, tol 25% of dinner, currently NPO for SX in AM. Ⓡ buttocks wound & (B/L) hip wounds drsgs reinforced D/T excessive sero-sanguinous drainage. Linen & pads Δd. Foley to gravity c̄ clear yellow urine. NS c̄ 20mEq KCL infusing, rate ↑@ MN to 150cc/hr. T@ MN ↑101°, Tylenol 1gm given, will monitor effect. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: monitor drsgs, monitor temp, monitor O2 sats, NPO for SX [redacted]
11NOV03 @0540	Pt's 0600 Tagamet dose held D/T pt NPO for SX [redacted] b(6)-2
11 NOV 03 0800	Assumed care pt. A&O x 3. VSS Remains NPO on call for surgery today. Lungs clear productive cough light green sputum. O2 SAT 90-93% RA. Mouth breather desats when sleep O2 @ 6s. Encouraged to deep breath and use IS. HRRR Active BS. Urinates per FTG as, light yellow Urine. Ⓛ subclavian CL intact patent NS c̄ 20 meq KCL @ 150cc/hr. Remains afebrile @ this time 99.4 Dressing c̄ serous drainage copious amt. dsg reinforced. Will cont to monitor ——— b(6)-2 [redacted]

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

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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. ICW #1

b(6)-4

[redacted]

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 NOV 03	Pt return from OR S/P I&D of bilateral lower extrem
1330	and (R) side of buttocks. VSS BP 141/86 HRRR tachy 110-125 bp
	Denies PAIN or discomfort. Dressings CDI Pts O2 SATS 80-
	92 on Room air when sleep. Snoring loud c mouth open. When
	awake encouraged to deep breath and use IS SPO2 rises to 95-
	98% O2 @ bs will notify MD. ——— b(6)-2 [redacted] 1LT/ANC
1430	- Pt place on 2L per NC O2 88-92% ø evidence of SOB or
	distress noted capillary refill brisk skin color WNL cough
	productive light green sputum otherwise lung CTA. Will cont to
	monitor ——— b(6)-2 [redacted] 1LT/ANC
11 NOV 03	Assumed care @1800 hrs reported of need to
1900	give Rel TX K(. Pt alert + Oriented, Temp 103.4 pt c/o
	HA. HR 134/min. Lungs clear Bilaterally. O2SAT
	96% on RA. Uses Incentive Spirometer properly @ 1200cc;
	non productive cough @ this time. Tylenol 1gm P.O given
	Voiding quantity sufficient yellow clear urine via
	foley. Peripheral pulses palpable. Capillary refill
	brisk to fingers & toes. Consumed 40% of regular
	diet for dinner. (L) SC triple lumen IV patent
	& intact infusing NS c 20mEq KCl/l @ 100cc/hr all ports
	patent & flushes without difficulty. [redacted] 2LT/AN b(6)-2

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

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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
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MEDCOM - 23508

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 NOV 03 2300	Temp 101.6 Will ~~continue~~ [redacted] give tylenol for fever. Hr 127/min O2 SAT 96% on 2L NC HOB ↑30°. Continues to use Incentive Spirometer properly @ 1200cc/sec. Drinking water q.s. Foley continues to drain clear yellow urine q.s. Resting with eyes closed. Will continue to monitor closely [redacted]
12 NOV 03 0400	Temp 99.7 - P 100 - 18 BP 100/60 O2 SAT 97% on 2L. Resting comfortable. Tylenol effective for fever. Will continue care as planned & report condition to next shift ——— [redacted] RN
12 NOV 03	Surgery POD #1 All dressings d/c'd. Wounds look good c sero-sanguinous drainage. Ø s/s infection. Will continue wound care [redacted]
12 NOV 03 0800	Assumed care pt. Sleep yet easily arousable A+O x3. VSS. Remains febrile @ this time. Lungs clear O2 titrated to keep greater than 95%, SATS 97% on RA IS and deep breathing encouraged. Pt. not as sluggish today. HOB elevated ō evidence of SOB or distress. HRRR Active BS Appetite has increased 75% of breakfast. Wound assessment: Bilateral posterior thigh c penrose drains intact wounds closed sutures intact. (L) thigh serous drainage copious amt. Wound to (R) buttock entrance and exit GSW sutures intact wounds closed penrose drain near anus. Burn pad to bed open to air pt positioned on (L) side to facilitate drainage. Cont IV ABX Tx. Will cont to monitor ——— [redacted] 91W

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 NOV 03	- Foley dc'd this am at 0800. At this time pt c/o
1430	pain to abdomin several attempts made to void per urinal
	states not able to. Positive distention noted. At this time
	in and out cath and 900cc dark yellow urine. Foley
	left in clamped to prevent bladder spasm 30 mins later
	foley unclamped 300 cc output. Pt was relieved of abd.
	pain Will cont to monitor —— b(6)-2 [redacted]
1630	- Foley dc'd per MD order. Cont to in and out cath
	if distention persist - Bladder training cont b(6)-2 [redacted]
1700	- 600 cc per urinal urine out put. —— [redacted]
12NOV03	Alert & Oriented Temp 100.6. Tylenol [illegible] P.O
2000	given O2 SAT 96% on RA. Lungs clear Bil
	Voiding amber clear urine without difficult
	QS. Consumed 80% of regular diet for dinner
	(L) SC IV patent & intact. Infusing NS c 20meq
	KCl/L @ 100cc/hr.) Other 2 port (R) SC triple lume pat
	& flushes without difficulty. Peripheral pulses
	palpable +2. Capillary refill brisk to fingers &
	toes. Drsg intact to ~~(R)~~ Bilateral thighs & buttocks
	Will continue care as planned. [redacted] 2LT AN ——
13NOV0500	Temp 97.1 No distress/discomfort voiced or noted [redacted] RN

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

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EPW
[redacted]
b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14NOV03	(1300) Assumed care @ 0000. Pt alert, speaking Arabic.
	VSS. Ø c/o pain. Drsgs to rectum / BLEs d/cd
	this am. Pt OOB to shower. Pt amb well c̄
	assist of walker. Penrose drains intact draining
	small amount of serosang drainage. Covered c̄
	Kerlix drsgs. Sutures to incisions intact. Ø s/sx
	infection @ wound sites. Pt ↑ to chair for 1°.
	Tol. well. Ⓛ SC TL flushes well s̄ s/sx infection/
	infiltration. Tol reg. diet well. Voiding s̄ difficulty
	⊕BM this am. 2 point restraints in place s̄
	s/sx complications. Will cont. to monitor [redacted]
	(1800) Pt OOB to amb in hallway c̄ walker.
	Tol. well. Ø c/o pain. b(6)-2 [redacted]
14 Nov 03	Assumed care @ 1800. Pt Alert & Speaking Arabic
	VSS ~~Pt complains of chest~~ ~~@ chest tube site~~
	Percocet Administered c̄ little effect. Penrose drain to
	Anus is CDI Draining Sero Sang Fluid. Drsg to
	Anus is [illegible]. ~~Rt~~ penrose to ~~[illegible]~~ posterior upper thigh
	Draining Sero Sang. Pt Ambulates c̄ Walker.
	Will continue to monitor b(6)-2 [redacted]

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

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[redacted] b(6)-4

REGISTER NO.

WARD NO. ICW

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15NOV03	Surgery Doing very well. All wounds healing. Some exudate at (L) gluteal wounds. Will continue to watch. B/D showers. Plan to place PIV and d/c central line [redacted] b(6)-2
15NOV03	(1745) Assumed care of [redacted]. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb in hallway c̄ walker. Pt showered before drsg Δs. Penrose drains intact draining sm. amount sero-sang drainage. Sutures intact. Central line d/c'd catheter intact. 18g IV started in (R) forearm. Flushes well s̄ s/sx infiltration. 2-point restraints in place s̄ s/sx complications. Will continue to monitor. b(6)-2 [redacted]
2100	assumed care of pt. @ 1800. Pt. alert speaking in arabic - VSS. Ø c/o pain @ this time. Pt. ambulated to shower well. conducted drsng Δ's c̄ small amount of drainage. sutures intact. applied 4x4's to wound, abd pad placed above + below drains. wrapped c̄ Kerlex. IV (R) FA patent, flushes well c̄ (-) s/sx inf. Two restraints in place. (-) skin breakdown. (+) circulation. Pt. resting in bed @ this time. will cont. to monitor [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16NOV03	(1030) Assumed care @ 0600. Pt alert, speaking Arabic.
	VSS. ⊖ c/o pain. Pt amb c̄ walker to shower s̄
	difficulty. Penrose drains intact to BLE/rectum draining
	sm. amount of sero-sang drainage. Gauze dsgs
	applied. Pt OOB in chair for 1°. Tol. well. Using IS
	correctly. Tol. reg diet well. Voiding s̄ difficulty. IVFs
	infusing into IV in ® forearm via dial-a-flow s̄ s/sx
	infection/infiltration. 2 point restraints in place s̄
	s/sx complications. Will cont. to monitor. - [redacted]
	(1750) Pt OOB to amb in hallway. Walked up and
	down hallway x 1 s̄ walker. Amb x 1 c̄ b(6)-2
	walker. ⊕BM. ⊖ c/o pain. Monitoring. [redacted]
17Nov03	Assumed care of Pt @ 1800. Pt A&O speaks
0100	small amount of english. Able to communicate
	needs. Pt Denies Pain. LS CTA. HRRR. ⊕BS x4
	quads. Drsg Δ to thigh and buttock @ 2200
	hours. Penrose to thigh ® intact e in place. Penrose
	~~to~~ Drain to Buttocks [redacted] intact and sutured to
	epidermis but out of wound. Dr [redacted]
	Notified. Dr [redacted] put penrose back into
	wound. Fluid infusing to IV in R Forearm. Will

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

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REGISTER NO.

WARD NO. ICW

[redacted]

b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16NOV03	(1030) Assumed care @ 0600. Pt alert, speaking Arabic.
	VSS. ⌀ c/o pain. Pt amb c̄ walker to shower s̄
	difficulty. Penrose drains intact to BLE/rectum draining
	sm. amount of sero-sang drainage. Gauze dsgs
	applied. Pt OOB in chair for 1°. Tol. well. Using IS
	correctly. Tol. reg diet well. Voiding s̄ difficulty. IVFs
	infusing into IV in Ⓛ forearm via dial-a-flow s̄ s/sx
	infection/infiltration. 2 point restraints in place s̄
	s/sx complications. Will cont. to monitor — [redacted]
	(1750) Pt OOB to amb in hallway. Walked up and
	down hallway x ī s̄ the walker. Amb x ī c̄
	walker. ⊕BM. ⌀ c/o pain. Monitoring [redacted]
17Nov03	Assumed care of Pt @ 1800. Pt A&O speaks
0100	small amount of english. Able to communicate
	needs. Pt Denies Pain. LS CTA. HRRR. ⊕BS x4
	quads Drsg Δ to thigh and buttock @ 2200
	hours. Penrose to thigh Ⓡ intact e inplace. Penrose
	~~[illegible]~~ Drain to Buttocks [redacted] intact and sutured to
	epidermis but out of wound. Dr [redacted]
	Notified D[redacted] put penrose back into
	wound. Fluid infusing to IV in R Forarm. Will

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

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

[redacted]

REGISTER NO. | WARD NO. ICW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			[redacted]

DATE	NOTES
17NOV03	continue to Monitor ——— [redacted] b(6)-2
Cont.	——— SPC 91WM6
17NOV03 @ 1600	Assumed care of pt @ 0600. VSS, A&O, Ø c/o pain. NS c 20KCl to (R) FA @ 100cc/h. DRSNG's to dorsal thighs & buttocks removed, pt to BR, (+) BM & took shower. Pt. ambulated c walker back to bed. MD assessed wounds. Penrose to buttocks removed, wound packed c damp ~~gauze~~ (NS) Kerlex, covered c gauze. Dry dressings applied to thighs, penrose intact. Ø signs of infection, moderate sero-sang drainage to (L) thigh & buttocks, scant drainage to (R) thigh wound. Pt. OOB to chair x 2 this shift. Pt. resting quietly in bed at this time, 2-point restraints Ø signs of skin breakdown. All other assessments WNC. Will cont. to monitor. ——— b(6)-2 [redacted] 2LT, ANC
~~17NOV03 2000~~	~~Assumed care of pt @ 1800 RR, A&O Ø c/o pain @ this time.~~

b(6)-4 [redacted]

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MEDCOM - 23515

ACLU-RDI 1681 p.75

DOD-037093

b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Nov 03	Assumed care @ 1800. VSS Pt Ambulated to BR
2000	For shower c̄ Assistance gait is steady ∅ dizziness
	[redacted] OOBTC For 30 min. Drsg to Buttocks Δ. Drsg
	to thigh (B) Δd. Tol PO well. Void c̄ [redacted] qs. Denies
	pain @ this time. Will cont to monitor.
	[redacted] 91WM6
18NOV03	(1430) Assumed care @ 0700. Pt alert, speaking
	Arabic. VSS. ∅ c/o pain. Pt OOB to shower
	this am. Amb well. Dsgs to BLE Δd. Penrose
	drains intact c̄ sm amount serosang drainage.
	wound to rectum Δd WTD. Sutures to BLE/rectum
	CDI. Pt OOB to chair. Tol. well. IVFs infusing into
	IV in (R) forearm s̄ s/sx infection/infiltration. Tol.
	reg. diet well. Voiding s̄ difficulty. 2-point
	restraints in place s̄ s/sx complications. Will
	cont. to monitor. [redacted]
18 NOV 03	VSS OOB → B/R for shower p̄ removing
2000	all drsg. Penrose to anal area
	not noted. Not noted in old drsg.
	Anal area had gauze packing. Will
	inform MD for clarification of need for anal packing.

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

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

(Continue)

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

REGISTER NO. | WARD NO.

b(6)-4

[redacted]

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Nov 03 2000	Assumed care @ 1800. VSS Pt Ambulated to BR For shower c̄ Assistance gait is steady c/o dizziness [redacted] OOBTC For 30 min. Drsg to Buttocks Δ. Drsg to thigh (B) Δd. Tol PO well. Void c/w [redacted] qs. Denies pain @ this time Will cont to monitor. [redacted] 91WM6
18NOV03	(1430) Assumed care @ 0700. Pt alert, speaking Arabic. VSS. ⌀ c/o pain. Pt OOB to shower this am. Amb well. Dsgs to BLE Δd. Penrose drains intact c̄ sm. amount serosang drainage. wound to rectum Δd WTD. Sutures to BLE/rectum CDI. Pt OOB to chair. Tol. well. IVFs infusing into IV in (R) forearm s̄ s/sx infection/infiltration. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
18 NOV 03 2000	VSS OOB → BR for shower p̄ removing all drsg. Penrose to anal area not noted. Not noted in old drsg. Anal area had gauze packing. Will inform MD for clarification of need for anal pack. (Continue)

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORD [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] [redacted]

PROGRESS NOTES
Medical Record

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MEDCOM - 23517

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continued)
18 NOV 03	Penrose to bilateral thigh posterior intact.
(2000)	Suture to incision on thighs bilaterally intact
	with incision edges well approximated.
	(R) FA IV patent & intact infusing NS c 20 mEq KCl
	@ 100 cc/hr. 2 pt Restraints applied without
	compromising circulation or skin integrity.
	Will continue care per planned [redacted] RN
19 NOV 03	General Surgery POD # 8 s/p wound closure b(6)-2
	Pt. doing very well. Wound on Right
	buttock open c 5 cm cavity. Drain out. Right
	hip and Left thigh wound / healing well / other
	drains in place. Will remove drains tomorrow
	Continue dressing Δ's to Right buttock wound
	[redacted]
	b(6)-2
19 NOV 03	(1125) Assumed care @ 0800. Pt alert, speaking
	Arabic. VSS. Φ c/o pain. Pt amb in hallway s̄
	difficulty. Pt showered prior to dsg Δs. Sutures
	to BLE intact. Penrose drains intact draining
	sm. amount sero-sang drainage. Gauze dsgs
	placed on BLE incisions. WTD dsg placed on
	[redacted] rectum. wound packed c̄ NS soaked gauze.
	IV in (L) forearm d/c'd per MD verbal order.
	Pt tol. reg diet well. Voiding s̄ difficulty. 2
	point restraints in place s̄ S/Sx complications.
	Will cont. to monitor. b(6)-2 [redacted] RN

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USAPA V1.0

b(6)-4 [redacted] MEDCOM - 23518

ACLU-RDI 1681 p.78

DOD-037096

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(6)-2
19 NOV 03	VSS. Consumed 80% of Regular diet for
1900	dinner. OOB → BR to shower. [redacted]
	removing drsg. Penrose intact to Bilat
	Posterior thigh incisions. Sutures intact.
b(6)-2	[redacted] area (R) Buttock with open cavity
	old packing removed prior to shower. All
	areas redress as ordered p̄ shower. +2
	restraints reapplied without compromising
	circulation or skin integrity. Will continue
	care as planned — [redacted] 2LT AN
20 NOV 03	POD #10
	Doing well. No new issues [redacted] b(6)-2
20 NOV 03 @ 1500	Assumed care of pt. @ 0600. VSS. A&O. Pt. OOB to
	shower this AM, ambulates s̄ assistance, steady gait. ⊕BM.
	Ø C/O pain, MD removed sutures from (R) buttocks & pulled
	penrose drains out 2-3 cm from bilat. thigh wounds, mod.
	sero-sang drainage from all wounds. W→D DRSNG Δ to buttocks
	wound, DRY DRSNG Δ to bilat. thigh wounds. Pt. in 2-point (cont.)

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. ICW

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 23519

ACLU-RDI 1681 p.79

DOD-037097

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20NOV (cont.)	restraints, Ø signs of skin breakdown. ~~All other~~ ERROR (MJ). Urinal
	at bedside, tea colored. All other assessments WNL. Will
	cont. to monitor. ——— b(6)-2 [redacted] 2LT, AN
20NOV03	USS ✗ Temp 100.° (orally) OOB → BR for shower
2000	prior to drsg Δ's. Penrose drains for
	(B) thighs draining sero-sanguinous fluids.
	(R) Buttock wound with pink moist tissue.
	Sutures to (B/L) Thigh incisions + (L) buttock
	incision intact with edges to incision well
	approximated. Percocet effective for pain
	management. Encourage pt to ↑ PO Fluid
	intake and C+DB. Lungs clear. Pulse ox
	97% on RA. Will monitor Temp. 2+ restraint
	in place without compromising circulation or
	skin integrity ——— [redacted] LTA
	b(6)-2

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USAPA V1.00

[redacted] b(6)-4
MEDCOM - 23520

ACLU-RDI 1681 p.80

DOD-037098

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 NOV 0800	- Assumed care of pt. A+O x3. VSS Denies having any pain or discomfort. Ambulated to bathroom shower taken. Dressing to (R) buttock Δ'd slightly pack. Wounds to Bilateral posterior thighs changed dry 4x4's pen rose drain to (L) thigh intact. Small amt of serous drainage sutures remain intact. Lungs clear HRRR active BS Urinating spontaneously Afebrile Will cont to monitr b(6)-1
22 NOV 03 0200	Assumed care @1800; VSS, pt A&O speaking arabic; Ø c/o pain; pt OOB, amb to BR for shower; dsg to wound just superior to anus Δ'd, packed W→D; dsgs to posterior thighs (B) Δ'd, penrose to (L) LE intact, sutures intact; pt voiding QS per urinal; Restraints in place, ⊕ circulation, Ø skin breakdown; Cont to monitor b(6)-2
22 NOV 03 0800	- Assumed care of pt sleep yet easily arousable Denies having pain or discomfort @ this time VSS Wound to Bilateral posterior thigh and buttocks. sutures remain intact 4x4 dry dsg and kerlix wrap Δ'd as needed. (R) buttock c̄ tunneling open to air slightly packed. Minimal serous drainage to wounds. Ambulates s̄ diff. Will cont to monitr b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

b(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 23521

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03	Surgery POD# 12 s/p closure of wounds. Doing very well. All drains removed. No evidence of infection. (R) buttock wound still open + getting BID dressing Δs. Will be here @ least 1-2 more weeks to heal.
23NOV03 @ 0440	Assumed care @ 1800; VSS, pt A+O speaking arabic; pain controlled ō percs; dsg Δd to wound superior to anus, packed W→D; minimal drainage noted; dsgs to posterior thighs (B) Δd, dry dsg placed, sutures intact; Pt to OOB to BR for shower; S/L patent, IV abx cont'd; Restraints in place (+) ... Ø skin break ↓; cont to monitor
23NOV03	(1420) NSG. - VSS. Pt amb to BR ō steady gait. Pt did own AM care. Δ DSGs. Sutures appopapproximated. (L) inner thigh sutures 1" not approximated. Minimal amt of serosang drainage. Cleaned area ō NS + placed dry dsg. (R) buttock packed ō NS soaked gauze. Wound appears pink c̄ small amt of yellow drainage. ...
23NOV.03 2000	VSS, A+Ox3, OOB → BR, had a shower, dsg's (B) LE Δ'd, Ø drainage noted, dsg on center of buttocks Δ'd, moderate amount sero sang drainage, Ø s/sx of infex, sutures CDI, pain controlled c̄ percs, Ø diff voiding. ... gw

MEDCOM - 23522

STANDARD FORM 509 (REV. 5/1999) BAC
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ACLU-RDI 1681 p.82

DOD-037100

b(6)-2
All

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MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
24NOV03	(1730) NSG. Pt ⊖ c/o pain. Amb to BR + did self AM care. Δ'ed DSGs
	to B/L inner thighs + buttocks. Sutures to thighs ⊖ signs of
	infections. buttocks WTD c̄ NS. + covered c̄ dry gauze. Pt tol
	PO meds + meals. Urinating clear yellow s̄ difficulty. [redacted]
25NOV03	assumed care of pt @ 1800. VSS. No c/o pain. LS
@0700	CTA, ⊕ BS, tol reg diet well, void per urinal qs.
	Pt ↑ AMB in hallway s̄ difficulty before P.M.
	shower. Buttocks ; b/l thigh drsg Δd. Buttocks
	wound WTD c̄ packing, ⊖ drainage noted. B/L thigh
	incisions c̄ sutures, covered c̄ dry 4x4s. 2pt
	restraints on s̄ s/sx of skin/circulation compromise
	Plan: monitor drsgs, enc AMB, OOB [redacted]
25NOV03	Surgery
0900	Doing very well. All wounds healing.
	Right gluteal/buttock wound still healing
	well / Likely here for 7-10 more days /
	[redacted]
25NOV03	(1310) NSG. VSS. c/o pain: Med c̄ ii perc + found adequate
	relief. Pt amb to BR + ward c̄ steady gait. Did own AM care.
	Completed DSG Δ to B/L inner thighs + Ⓡ buttock. →

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.

b(6)-4 [redacted]

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DOD-037101

b(6)-2 A1)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont') (R) buttock packed WTD c NS. Tol DSG Δ well. Sutures approximated. Scant amt drainage from ~~stures~~ sutures. Dr. spoke to pt c interpreter. Plans to D/C in 7-10 days. Wound healing. ⊖ signs of infection. Wound to (R) buttock pink c sm. amt of yellow area. Will monitor.
26NOV03 @0200	Assumed care of pt @1800. VSS, no c/o pain. Pt ↑ to BR for shower, drsgs to buttocks & thighs changed. (R) buttock wound packed c WTD drsg gauze, B/L thigh incisions covered c 4x4 dry drsgs. Sm amt serosanguinous drainage from thigh incisions noted, sutures intact. LSCTA, tol po well, void QS to urinal, AMB s difficulty. 2pt restraints on s S/Sx of skin/circulation compromise. Plan: cont drsg Δs, pain control, enc OOB.
26NOV03 @1600	Assumed care of pt. @0600. VSS. A&O, ⊘ c/o pain. Pt. OOB to BR for shower, WTD DSG Δ to (R) buttocks, wound beefy red, 6cm deep. Bilat. thigh wounds closed c sutures, scant serous drainage, dry DSG Δ to thigh wounds. Pt. ambulates well in hallway, steady gait. Pt. in 2-point restraints in bed, ⊘ signs of skin breakdown. All other assessments WNL. Will cont. to monitor pt.
27NOV03 @0100	assumed care of pt @1800. VSS. C/o pain @hs, percocet given c good relief noted. (B/L) thigh incisions c sutures, sm amt of serosanguinous drainage noted, dry drsgs applied p shower. (R) buttock wound WTD drsg Δd, ⊘ drainage. Pt ↑ AMB s difficulty. 2pt restraints on s S/Sx of skin/circulation compromise. Plan: cont drsg Δs, monitor drainage, enc OOB

MEDCOM - 23524

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USAPA V1.

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DOD-037102

b(6)-2 411

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27NOV03	Surgery
	No new issues. Healing (R) buttock wound
	1-2 more weeks [redacted]
27NOV03 1641	Assume care of PT @ 0600. A+O, VSS Ø c/o pain. Ambulate s̄ assistance. Took shower, Δ'ed drsg's to both inner thighs and (R) buttocks. Inner thighs sutures are intact, CDI, placed 4x4's wrapped in Kerlix. (R) buttocks WTD drsg, minimal drainage. In 2pt restraint s̄ skin breakdown. Will cont. to monitor. 91W SPC [redacted]
27Nov03 1700	I concur c̄ above assessment [redacted]
28Nov03 @ 0425	Assumed care @ 1800; VSS, A+O speaking arabic, pain controlled c̄ percs; pt amb to shower, s̄ assistance; dsg Δd to buttock, W→D, dry dsg placed over sutures to posterior (R) thigh sutures intact to posterior (R) thigh cont PO alax; Restraints in place, ⊕ circ, Ø skin breakdown, cont to monitor [redacted]

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

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

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

b(6)-4

[redacted]

PROGRESS NOTES
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MEDCOM - 23525

b(6)-2 A1

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27NOV03	Surgery
	No new issues. Healing (R) buttock wound
	1-2 more weeks
27NOV03	Assume care of PT @ 0600. A+O, VSS Ø c/o pain.
1641	Ambulate s̄ assistance. Took shower, Δ'ed drsg's
	to both inner thighs and (R) buttocks. Inner thighs
	sutures are intact, CDI, placed 4X4's wrapped in
	Kerlix. (R) buttocks WTD drsg, minimal drainage.
	In 2pt restraint s̄ skin breakdown. Will contn to
	monitor. 91W SPC
27 Nov 03	I concur c̄ above assessment.
1700	
28Nov03 @ 0425	Assumed care @ 1800; VSS, A+O speaking arabic, pain controlled c̄ percs; pt amb
	to shower s̄ assistance; dsg Δd to buttock, W→D, dry dsg placed over
	sutures to posterior (R) thigh sutures intact to posterior (R) thig
	cont PO alax; Restraints in place, ⊕ circ, ⊖ skin breakdown cont
	to monitor

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.

b(6)-4

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PROGRESS NOTES
Medical Record

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MEDCOM - 23526

ACLU-RDI 1681 p.86

DOD-037104

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28NOVØ3	Surgery No Δ's he is healing well [redacted]
28NOVØ3	(1700) Assumed care of pt ⓓ ØØØØ. Pt alert, speaking Arabic. VSS. Ø C/O pain. Pt amb to BR for a shower this am s̄ difficulty. WTD dsg to rectum Δd. Dry dsg placed on LLE. Sutures to incision on BLE CDI. Ø S/Sx infection. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor [redacted]
28Nov03@0400	Assumed care @ 1800; VSS, pt alert speaking arabic; Ø C/o pain, pt OOB to BR for shower, amb s̄ difficulty; W→D dsg to wound just superior to rectum Δ'; dry dsg to LLE; All sutures CDI Ø S/Sx infection; pt voids s̄ difficulty; Restraints in place Ⓟ circ. Ø skin breakdown; Cont to monitor [redacted]
29NOVØ3	(1310) Assumed care ⓓ ØØØØ. Pt alert, speaking Arabic, VSS. Ø C/O pain. Amb to BR for shower this am s̄ difficulty. Dry dsg applied to LLE. Sutures to BLE CDI. WTD dsg to rectum Δd. Wound pink and moist. Skin breakdown noted on Ⓛ buttock above rectum. Covered c̄ dry dsg. Tol reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor [redacted]
30Nov03@0325	Assumed care @ 1800; VSS, pt Alert speaking arabic, Ø C/o pain, pt OOB to shower; dsg to buttocks Δ'd W→D, dry dsg over Ⓛ LE, all sutures intact, Ø S/Sx infection, voids s̄ difficulty; Tol Reg diet; Restraints in place s̄ compromise [redacted]

MEDCOM - 23527

STANDARD FORM 509 (REV [redacted]) DAC
USAPA V1.

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
01Dec03	(1030) NSG:VSS. ⊖ c/o pain. Pt stated has not had B.M. in 2 days. Will discuss c̄ Dr [redacted] if wants to give anything. Pt Amb to BR c̄ steady gait. Did own AM care. WTD DSG placed on Ⓡ buttock. ⊖ signs of infection. Sutures on B/L inner thighs. scant amt of serosang drainage from Ⓛ thigh. ⊖ Signs of infection. [redacted]
1Dec03	2030 - VSS AND assumed care of pt. @ 1800. LS CTA Ⓑ, Resp. even unlabored. BS x4. pt. ambulated in hallway x 15mins + amb. to shower prior to dsg Δ. drsng Δ completed. packed buttock with WTD Gauze. ⊖ S/Sx infection. Sutures intact. cleaned sutures to Ⓛ thigh c̄ 1/2 NS + 1/2 peroxide. Pt. has ⊘ c/o pain @ this time. Voiding cyu per urinal. Pt. in bed @ this time c̄ two pt. restraints in place s̄ compromise to skin. will cont. to monitor pt [redacted]
2DEC03	Surgery No Changes Sutures Removed Will stay until wounds healed [redacted]

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ACLU-RDI 1681 p.88

DOD-037106

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30NOV03	(1300) NSG. VSS. ⊖ c/o pain. Voiding clear, yellow urine
	s̄ difficulty. DSG Δ completed. WTD DSG: Sutures
	intact ⊖ signs of infection. Pt amb to BR ⓘ steady gait.
	Did own AM care. Tol PO well. Consumed ~75% meal.
30NOV03	Surgery
	No new issues
	Wound Healing
	Will remove sutures
	b(6)-2
	(Cont) pt asleep at this time.
2315 -	VSS - A+O ⊖ c/o pain @ this time. LS CTAB
	Abd soft nontender BS x4. voiding c̄ per urinal. Pt. ambulated to shower
	completed drsng Δ. Packed buttock
	WTD. Removed sutures from Ⓡ
	thigh. Pt. tolerated well. Pt. resting
	@ this time c̄ two pt. restraints in
	place s̄ skin breakdown ⊕ circulation
	will cont. to monitor pt. b(6)-2
	Jenna Zabre assessment

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	(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.

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b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 All
unless noted diff.

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2 DEC 2003 @ 1330	Assumed care of pt @ 0600. VSS, A+O, C/O constipation.
	MD informed, pt. given M.O.M. 30cc PO & Colace 100mg PO BID @
	0900. Ø BM as of yet. Abdomen soft, non-distended, ⊕ BS
	all four quads. MD removed sutures to Ⓛ thigh this AM, assessed
	other wounds. Pt. OOB → shower, ambulates well s̄ assistance.
	DRY DSG applied to Ⓛ thigh, Ø drainage noted. Ⓡ thigh wound open to
	air, Ø drainage, edges well approximated. WTD DSG Δ to buttocks,
	4cm deep, 1-2 cm wide, 1-2 cm height. Small amount sero-sang drainage
	Pt. in 2-point restraints Ø signs of skin breakdown. All other
	assessments WNL. Will cont. to monitor. ——— [redacted] LT, AN
2 DEC 2003 @ 1600	Pt. given Dulcolax suppository pr rectum x1. Pt. reported small
	BM & some relief of constipation. Will cont. to monitor pt.
	——— [redacted] 2LT, AN
2145 -	Assumed care of pt. @ 1800. VSS - Pt ambulated
	to shower + in hallway x15 mins. Completed
	WTD dsg Δ to buttock. Packed c̄ 4x4's.
	Pt. tol. well c̄ Ø c/o pain. Incision to
	Ⓛ medial thigh cleaned c̄ ½ NS + ½ Peroxide
	Bacitracin applied to area + nerex applied. Pt
	in two pt. restraints s̄ compromise to skin.
	Will cont. to monitor pt ——— [redacted]

RELATIONSHIP TO SPONSOR: F
SPONSOR'S NAME: LAST: Emman Ealpre Osborne FIRST: MI: [redacted] 20—

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.

b(6)-4 b(6)-2
[redacted] (ERROR) [redacted]

EPW# [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 - 23530

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3DEC03@1700	Assumed care of pt. @0600. VSS. A&O. Ø c/o pain. WTD DSG Δ'd to Ⓡ buttocks, minimal sero-sang drainage, Ø S/Sx of INFX. Dry dsg. applied to Ⓛ thigh incision, scant sero-sang drainage, Ø S/Sx of infx. Pt. OOB to BR for shower, ambulates ̄s difficulty. Pt. in 2-point restraints, Ø S/Sx of skin breakdown or vascular compromise. All other assessments WNL [redacted] 2LT, AN b(6)-2
4Dec03@0400	Assumed care @1800; VSS, pt alert speaking arabic; pain controlled ̄c percs; pt OOB → BR for shower, amb ̄s difficulty; dsg to buttocks Δ'd WTD [redacted] dry dsg to L thigh ̄c bac. ointment; Ø S/Sx infection; pt tol Reg diet; voiding ̄s difficulty; Restraints in place ̄s compromise to skin/circ; Cont to monitor b(6)-2 [redacted]
4DEC03@1500	Assumed care of pt. @0600, VSS, A+O, Ø c/o pain, WTD DSG Δ this AM to Ⓡ buttocks, mod. serosang drainage to old DSG, Ø S/Sx of infx. Dry dsg Δ to Ⓡ thigh, scant serosa drainage, Ø S/Sx infx. Pt. OOB to shower this AM, ambulated in hallway 10 minutes, steady gait. Pt. in 2-point restraints, Ø S/Sx of skin breakdown, All other assessments WNL, will cont. to monitor. b(6)-2 [redacted] ..., AN
5DEC03	0130 - assumed care of pt. @1800. VSS - A+O. pt. ambulated to shower. dsg Δ completed. wound packed ̄c WTD gauze Ø S/S x inf. Pt. c/o pain. medicated ̄c ̈ii percs ⊕ relief. Bacitracin applied to Ⓛ LE incision + dry bandage. Ø S/S x inf. Pt. voiding qs per urinal ̄s difficulty. Pt in bed at this time ̄c two pt. restraints in place. Will cont. to monitor pt. b(6)-2 [redacted]

I concur with above assess. [signature]

[redacted] (Maj COR) M.D.
b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK USAPA V1.00

b(6)-2 AY

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06DEC03	(0915) Assumed care of pt @ 0600. Pt alert, speaking Arabic. VSS. Ø C/O pain. Pt OOB to shower this am. Amb s̄ difficulty. Rectal wound packed c̄ NS soaked gauze. Wound pink and moist s̄ S/Sx of infection. Skin breakdown noted on buttock above rectum. Dry dsg applied. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. — [redacted]
7DEC03 @0100	Assumed care of pt @ 1800. VSS. No C/O pain. Pt ↑ AMB to bed for shower, dsg Δ completed, wound healing to (R) buttock, beefy red / pink tissue noted, Pt ↑ AMB, tol reg diet well, voiding s̄ problems. 2 pt restraints no S/Sx of skin compromise. Plan: monitor dsg, monitor pain control, enc OOB c̄ AMB, enc po. — [redacted]
7DEC03@1517	Assumed care of pt. @ 0600. VSS. A&O. Ø C/O pain. Pt. OOB → shower, WTD DSG Δ to (R) buttocks, 3cm deep, mod. sero-sang drainage, Ø S/Sx of infx. Small amount of skin breakdown noted on (R) buttock, above (R) buttock wound, scant drainage, dry 2×2 applied. Pt. encouraged to Δ position in bed Q 1-2° on side. Pt. sitting in chair at this time. Pt. ambulated in hallway 3 times this shift, 10-20 minutes at a time. Pt. in 1-point restraints in chair, 2-point restraints in bed Ø S/Sx of skin breakdown. All other assessments WNL. [redacted] , AN

MEDCOM - 23532

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

ACLU-RDI 1681 p.92

DOD-037110

b(6)-2
A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5DEC03	Surgery No new issues. (R) gluteal wound healing To prison camp once healed All other wounds healed
05DEC03	(1210) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to shower this am. Amb well. Dsg Δd to rectum. Wound packed c NS soaked gauze. Dry dsg applied to skin breakdown above rectum on (L) buttock. Ø S/Sx infection. Incisions on BLE well healed. Tol. reg diet well. voiding s difficulty. 2 point restraints in place s S/Sx complications. Will cont. to monitor. [redacted] W2
6DEC03 @ 0245	assumed care of pt @ 1800. VSS. No c/o. Pt ↑ BR for shower, dsg WTD Δ'd, Ø drainage noted, healing red tissue noted. LS CTA, ⊕BS, tol reg diet well, voiding s difficulty. 2pt restraints on s S/Sx of skin / circulation compromise. Plan: monitor drsg, enc OOB, enc po intake, enc Amb. will monitor. [redacted] CPT

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. ICW1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20
USAP.

#[redacted]
b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8DEC03 0030	assumed care of pt @ 1800. VSS. No c/o pain.. Pt ↑ AMB to BR for shower, AMB x 30 minutes, Then returned to bed for drsg Δ. Buttocks wound healing, beefy red s̄ drainage, WTD drsg completed, using minimal amts of tape D/T skin shear around wound. All other assessments within normal limits.. 2pt restraints on S S/Sx of infection, ok in compliance. Plan - enc CDDB, enc position Δ, enc po, cont po Abx as ordered, pain control. [redacted]
	b(6)-2
8DEC03	Surgery Doing Very Well Right Gluteal Wound almost healed R/C to camp when completely healed [redacted] b(6)-2

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

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

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]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 DEC	VSS Alert Orient. OOB → BR for shower
0900	gluteal wound repacked as ordered. Tissue
	of wound pink & moist. Consumed 40% of
	Breakfast. Ø c/o pain or discomfort @ this
	time. 2 point restraints in place without
	compromising circulation or skin integrity.
	Will continue plan of care. [redacted]
8 Dec Ø3	VSS A&O. OOB To BR. BMx1 this PM. Void
	spontaneously s̄ difficulty. Tol PO well. Ambulates c̄
	steady gait. Dsg to Buttocks Δ'd, ~~[illegible]~~ Tissue in
	wound is pink moist granulated. No S/Sx of infection
	Pt Denies Pain @ this time. Tape to buttocks
	has caused skin to peel from Butto[redacted] Dry dsg
	covers .5 cm of open Abrasion to (R) [redacted] ttocks cheek
	Will cont to monitor. [redacted] 91WM
9DEC03 @1900	Assumed care of pt. @ 0600. VSS. A&O. Ø c/o pain, WTD DSG Δ
	to (R) buttocks, mod. sero-sang drainage to old DSG, wound
	improving, granulated tissue. Pt. OOB → shower this afternoon
	⊕ BM, ⊕ BS all 4 quads. Urinal @ bedside → C4U. BS clear
	bilat. Pt. in 2-point restraints, Ø S/Sx of infx. All other
	assessments WNL. [redacted] RCT AN
9Dec03	Assumed care of pt @ 1800. VSS A&O. OOB T BR Ambulated For
	30 minutes. Dsg to Buttoxs Δ'd. No S/Sx [redacted] fection. Pt Den
	ies pain @ this time. Pt consumed 10% of [redacted] this PM. LS
	CTA (B), ⊕ BS x4 quads. HRRR. Will cont [redacted] onitor.
	[redacted] Spc 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 23535

ACLU-RDI 1681 p.95

DOD-037113

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
10DEC03@	Assumed care of pt. @ 0600. VSS. A+O; Ø c/o pain.
1700	Pt. OOB → SHOWER, ambulated in hallway 30 min.
	Pt. OOB → chair @ this time. DSG Δ'd to buttocks, WTD,
	Ø S/Sx of infection, 3cm deep. Pt. tol. reg. diet well, ate
	100% breakfast & lunch. ⊕ BS all 4 quads. ⊕ BM in
	afternoon. Pt. in 2-point restraints Ø S/Sx ~~of infection~~ error
	of skin breakdown. All other assessments WNL. [redacted] 2LT, AN
10Dec03	Assumed care of Pt @1800. Temp 99°F(O) All other
	VSS. A&O. Pt Ambulated For 30 min. Showered and
	Drsg to Buttocks Δ'd. Cont Tagamet PO. Temp
	↓ 98.7 after Drsg Δ. Pt void CY [redacted] difficulty
	Will cont to monitor. [redacted]
11DEC03@1700.	Assumed care of pt. @ 0600. VSS, A+O, Ø c/o pain. Pt OOB
	to BR, ambulates well in hallway, steady gait. Pt. took
	shower & shaved face. WTD DSG Δ to buttocks p̄ shower.
	min. sero-sang drainage to old DSG, Wound 1-1.5cm
	deep, Ø S/Sx of infx. Pt. ate 50% of lunch & breakfast
	Pt. encouraged to eat more. ⊕ BS all 4 quads, urinal @
	bedside, CYU. Pt in 2-point restraints in bed,
	Ø S/Sx of skin breakdown. All other assessments WNL.
	Will cont. to monitor. [redacted] 2LT, AN

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.

[redacted] b(6)-4

b(6)-2 All

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11Dec03	Assumed care @ 1800. Pt VSS AFO Denies Pain @ this time. LS CTA (B) (+) BS x4 quads HRRR. Voids cvo qs s̄ difficulty. Drsg to Buttocks Δ'd. Wound appx cm deep. Will cont to monitor. —— Spc 91WM6
12 DEC03 1000	VSS. Pt OOB → Shower prior to Drg Δ. (R) Buttock c̄ <1cm x <1cm opening, wound pink + moist. Pack c̄ NS moist gauze loosely. Consumed 50% of Breakfast. Voiding without difficulty. 2point restraint in place without compromising circulation or skin integrity. Will continue care as planned
12 Dec03 1900	Surgery Awaiting wound closure. Pt. c̄ well-healing R buttocks wound, now ~1cm, with healthy granulation tissue. Anticipate closure and subsequent discharge home within a week. Otherwise without complaints. MA
12Dec03 2012	Assumed care @ 1800. VSS AFO. Denies pain. Pt ambulated 45min this PM. LS CTA (B), HRR (+) BS x4 quads. Drsg To Buttocks [illegible] Will cont to monitor. —— Spc 91WM

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 23537

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
13 DEC 03 0800	VSS Consumed 50% of Breakfast. Denies pain @ this time. Will have pt shower prior to dsg Δ to (R) Buttocks. Peripheral pulses +2. Voiding clear amber urine. 2 point restraints in place without compromising circulation or skin integrity. Will continue care as planned. [redacted] [illegible]
14 Dec 03	(0400) VSS. Ø C/O pain. Voids clear, yellow s̄ difficulty. Amb c̄ steady gait. Δ'ed DSG to (R) buttock + covered c̄ opsite. Wound appears to have Ø signs of infection. Tol po well. 2 restraints c̄ Ø signs of skin compromise. b(6)-2 [redacted]
14 DEC 03 0730	VSS A&O 50% of Breakfast Consumed. Ø C/O pain or discomfort [illegible] is noted. Will have pt shower prior to dsg Δ to (R) buttocks. Peripheral pulses palpable +2. OOB → BR (I) with MP supervision. 2 point restraints in place without compromising circulation or skin integrity. Will continue plan of care. b(6)-2 [redacted] [illegible]

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.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Dec03	(0135) VSS. ϕ c/o pain. Δ'ed DSG to Ⓡ buttock. WTD. Wound pink c̄ ϕ signs of infection. Placed 2x2 + covered c̄ opsite. Pt Amb to BR c̄ steady gait. Voids clear, yellow urine s̄ difficulty. BS CTA BS ⊕ x 4 quads. Will continue to monitor. [redacted] TIA
15Dec03 @0920	Assumed care @ 0600. VSS. No c/o pain. LSCTA, ⊕BS, tol reg diet well, void s̄ difficulty. Pt ↑ AMB to BR for shower s̄ difficulty. MD @ BS to see wound. Drsg Δ'd. No other issues. Pt restraints m s̄ S/Sx of skin/circulation compromise. Plan: enc po, enc OOB, monitor wounds. [redacted]
16Dec03	(0005) VSS. ϕ c/o pain. Amb to BR c̄ steady gait. Δ'ed DSG to buttocks. Wound pink c̄ ϕ signs of infection. Packed lightly c̄ 2x2 WTD. Pt to D/C to camp. Voids s̄ difficulty. [redacted]
16 Dec03 0820	Summary Pt s/p multiple GSW to thighs and buttocks on 8Nov03. His wounds were debrided on multiple occasions and then closed subsequently. One small wound on his right buttock was allowed to close on its own. Currently that wound is closed with ~1cm of skin defect. Given antibiotic ointment and encouraged to keep clean until skin covers the area. Will discharge to prison camp today. [redacted] MA

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16DEC03 @0915	Assumed care of pt @0600. VSS. no issues. awaiting D/C. Instructions given for drsg Δ. Pt ↑ ADLs ̄s difficulty. 2pt restraints on ̄s S/Sx of skin/circulation compromise. Plan: enc po, enc ambulation, await for D/C. [redacted]
16Dec03	(2320) VSS Ø C/O pain. Pt did own DSG Δ to Ⓡ buttock. Applied Bacitracin + 2x2. awaiting ride to camp 17 Dec. Will monitor. [redacted]
17 DEC 03 @ 1000	Assumed care of pt. @ 0600. Pt. OOB to shower. DSG to buttocks Δ'd, Ø S/Sx of infx. VSS, A+O, Ø C/O pain Pt. D/C'd to camp. [redacted] LT, AN
	b(6)-2 All 5

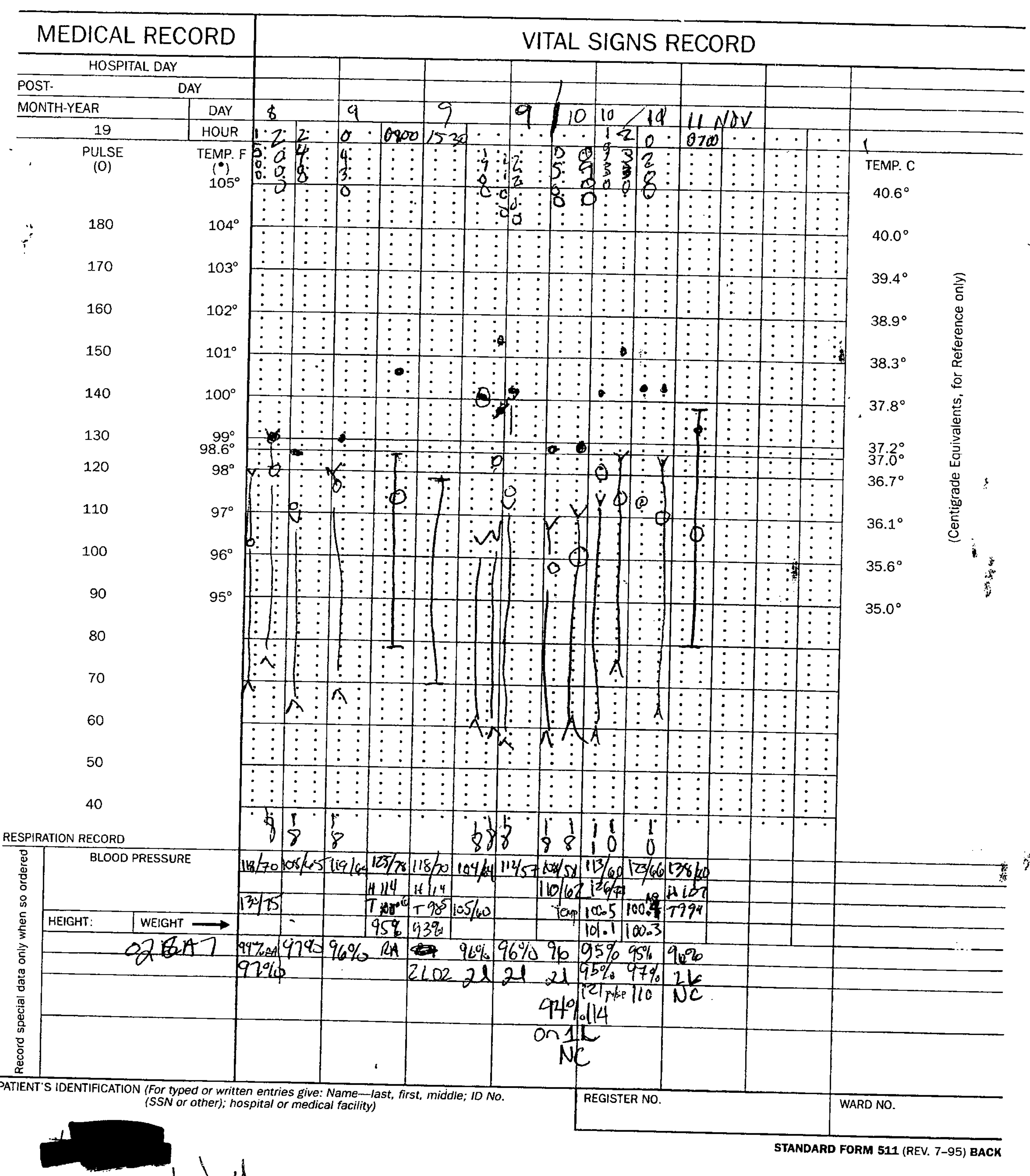
SPONSOR'S NAME				SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER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

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR 101-11.203

[redacted] b(6)-4

MEDCOM - 23540



b(6)-4

MEDCOM - 23541

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	11 NOV	11 NOV / 12	12	13	13	14	15	
19 / HOUR	1330 / 1830	2330 / 0400	0800 / 2000	0600 / 0800	1730 / 1930	2200 / 1606	0800 / 2000	

PULSE (O) / TEMP. F (•) / TEMP. C

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; 105° 40.6°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 22, 22, 16, 18, 18, 18, 20, 18, 18, 20

BLOOD PRESSURE	137/83 #124 T98.4	130/73		100/60	128/70 HR 105 T99.6		137/74 #104 T100.9	HR 108	132/69 100.7 P 109	132/57 129/67	117/60	123/68
HEIGHT: / WEIGHT →					96%							
O2 SAT	96 22	96 22	97% 22	2L NC	96% RA	96% RA		93%	98% (RA) 97% RA	97% (RA)	98% RA	
							pulse 114		100.9F Temp			

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)*

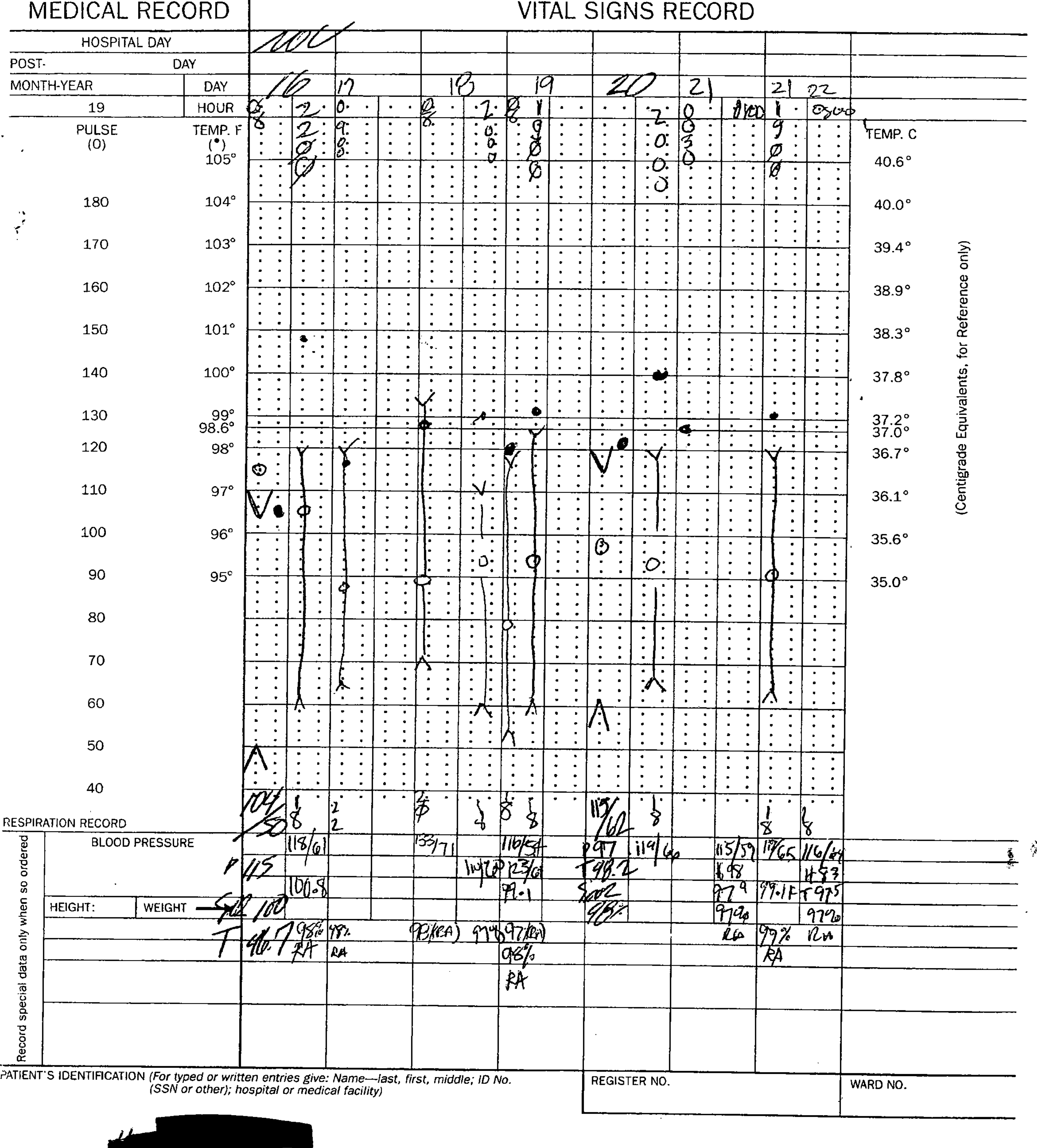
REGISTER NO. | WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

b(6)-4

MEDCOM - 23542

511-119 NSN 7540-00-634-4124



MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY / POST- DAY / MONTH-YEAR DAY / 19 HOUR

PULSE (O) / TEMP. F (•) / TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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.

b7(b)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 23543

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 22 23 24 25 26 27 28

19 2003 HOUR

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° 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

Record special data only when so ordered	22	23		24	25	26		27		28
BLOOD PRESSURE ①	115/64	116/61	115/59	114/60	106/58	104/51	118/63	107/58	128/62	124/61
②		81			97.2	96.8		99.1		
① TEMP	99.6	98.1	99.0	99.1	78	81	99.3	77	99.1	114/63
HEIGHT: WEIGHT ② TEMP										
① O2 Sat	96%	96%	98%	98%	97%	95%	98%	96%	96%	98% (RA)
SOURCE	RA	RA	RA	RA			RA		RA	97% RA
② O2 Sat SOURCE					114/62					
					86					

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

REGISTER NO.

WARD NO.

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 23544

MEDICAL RECORD	VITAL SIGNS RECORD

	29	30	1	1	2 Dec	3 Dec	4 Dec
HOSPITAL DAY							
POST- DAY							
MONTH-YEAR NOV .DAY	29	30	1	1	2 Dec	3 Dec	4 Dec
2003 HOUR							

PULSE (O) / TEMP. F (•) / TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

O2 SAT 98% 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**

MEDCOM - 23545

ACLU-RDI 1681 p.105

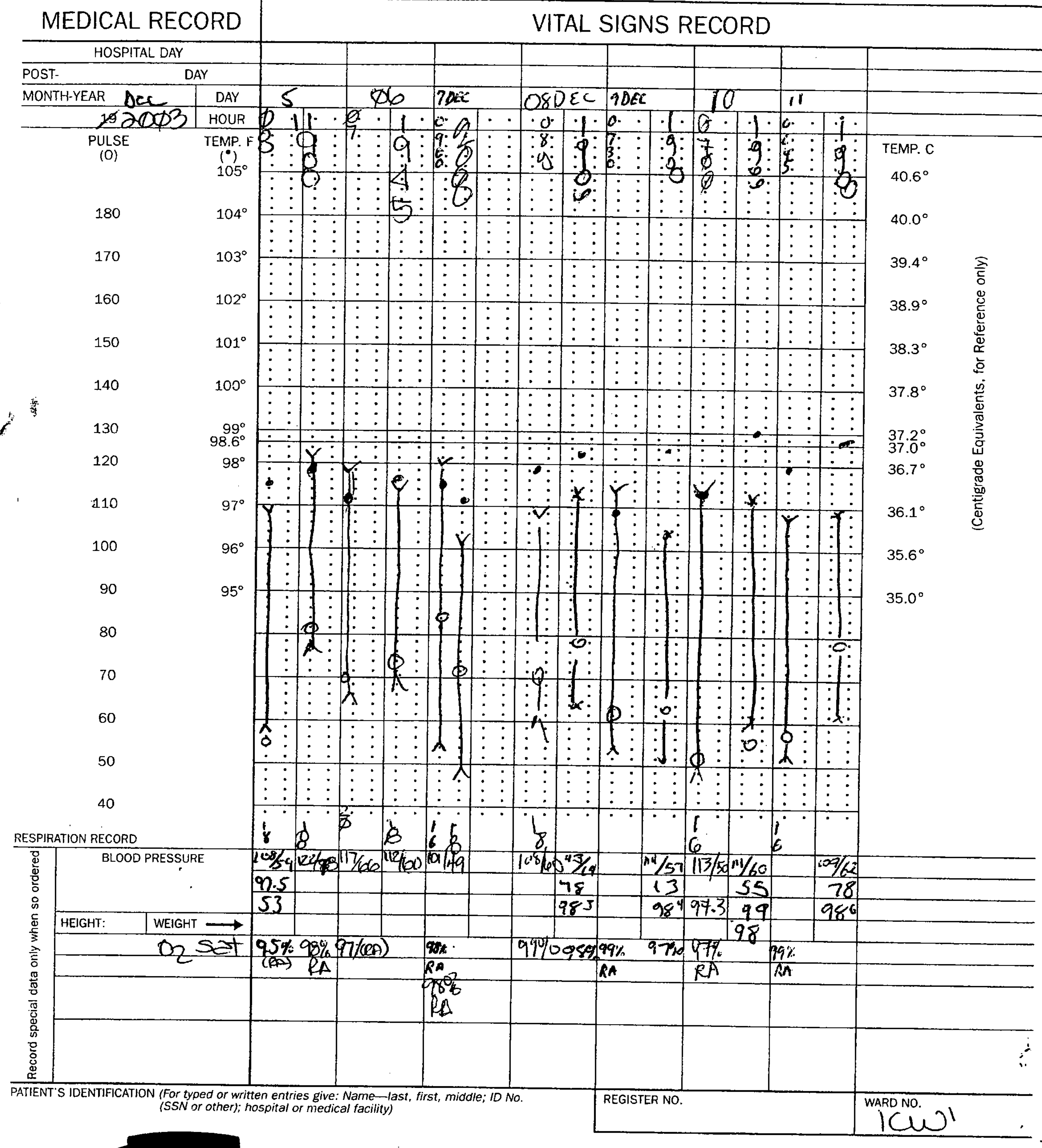
DOD-037123

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD



HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec 2003 | DAY 5 | 06 | 7DEC | 08DEC | 9DEC | 10 | 11

HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 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: 108/54, 122/48, 117/60, 112/60, 101/49, 108/60, 43/64, 114/57, 113/50, 111/60, 109/62

97.5, 53, 78, 98.3, 13, 98.4, 97.3, 55, 99, 98, 78, 98.6

Record special data only when so ordered

HEIGHT: | WEIGHT →

O2 Sat: 95% (RA), 98% RA, 97(RA), 98% RA 98% RA, 99% 98%, 99% RA, 97%, 97% RA, 99% 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. ICW

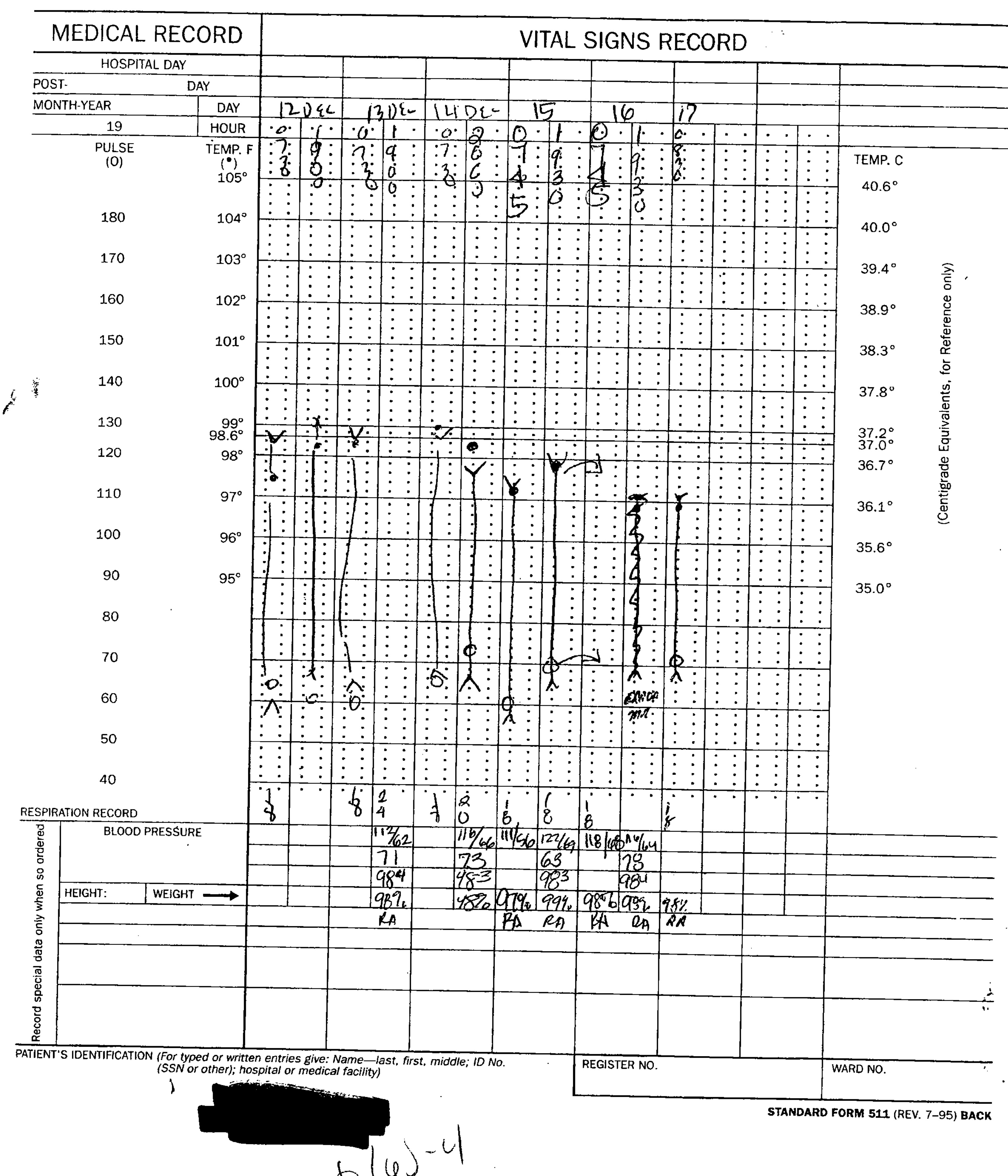
b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 23546



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 12 DEC 13 DEC 14 DEC 15 16 17

19 HOUR

PULSE (O) TEMP. F (•) TEMP. C

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

b(6)-4

MEDCOM - 23547

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency Is The Office of the Surgeon General.
1. AGE 31 HEIGHT: ? WEIGHT: ?	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) [X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD REACTION: 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I&D Buttock wounds (Thigh wounds & Hip wound)

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition______
Tobacco______ ppd X____ yrs Body Piercing______ Diabetes (Y) (N) ROM ______ ASA/Motrin W 72hrs (Y) (N)
ETOH ______ Implants______ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ______ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL _X_ potential for anxiety related to: _X_ 1) Surgical Procedure& Operating Room Environment _X_ 2) Separation Anxiety (Child) _X_ 3) Surgical Outcomes	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. Parents to stay with pt.
B. AERATION _X_ Potential for respiratory dysfunction due to: _X_ 1) Positioning _X_ 2) Effects of Anesthesia _X_ 3) Medical/Smoking History	O Pt. will be able to breath without difficulty during immediate intraoperative 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 _X_ Potential Impairment of Skin Integrity due to: _X_ 1) Intraoperative Immobility _X_ 2) ESU Pad Placement _X_ 3) Positional Aids _X_ 4) Prosthesis _X_ 5) Pooling of Prep Solutions	O Pt. will exhibit signs of impairment 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 form pooling.

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

[redacted] 16-4

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

DA FORM 5179, JUN 91 MEDCOM - 23548 Previous editions are obsolete. USAPA VI.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	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	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. 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. O Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. ✓ Potential Impairment of Mobility due to: ✓ 1) Pain ✓ 2) Intra operative Hazzards ✓ 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form OR table E.2. ✓ Potential Discomfort Due to: ✓ 1) Length of Surgery ✓ 2) Positioning ✓ 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be 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. Bath towel. etc) for positioning.
F. Special Senses F.I. ✓ 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 F.3.____ Potential Injury due to Dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	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. Speak clearly and slowly. O Address pt. from ______ side. O Validate pt.'s understanding of verbal communication. 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 INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 08 NOV 03 DATE

11. POSTOPERATIVE EVALUATION : SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 08 NOV 03 TIME: 0430

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 08 NOV 03 TIME: 0708

REVERS OF FORM 5179, JUN 91 USAPA VI.0

MEDCOM - 23549

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY EMT

2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b(6)-2

3. DATE 08 NOV 2003 TIME PATIENT ARRIVED IN SUITE 0434

4. PATIENT IN ROOM TIME 0434 NUMBER 2 cont #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: 31 y/o male.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS

Initial position Ⓡ side up, Pillow between legs & between arms. Patient then positioned supine ē both arms on arm boards @ <90°.

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

COMMENTS: legs Frog-legged to expose inner thighs.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint

SITE: Ⓡ hip/Buttocks BY WHOM: MAJ [redacted]

SITE: Bilateral thighs BY WHOM: CPT [redacted] b(6)-2

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES

Ⓛ Ⓡ

LEGEND X Ground Pad -- Safety Strap === Tourniquet N/A

b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

SCRUB: Initial count SPC [redacted] CIRCULATOR: CPT [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: R8B 102395

GROUND PAD: BRAND Valleylab LOT NO: 73538

☐ ESU NO:

GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23550

13. PROSTHESIS, IMPLANTS ☐ YE[S] ☐ NO IF YES NAME: ID NUMBE[R] [MAN]UFAC[TU]RER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Kerlix		
SITE	Buttocks / Thighs		

18. DRESSING/IMMOBILIZATION *(Specify)*

DBD + Tape

19. ADDITIONAL INFORMATION

Surgeon- Dr [redacted]
Anesthesia- CPT [redacted] CRNA

20. OPERATION(S) PERFORMED

Flexible sigmoidoscopy / I&D (R) hip wound / I&D Bilateral Buttocks / I&D Bilateral Thigh

21. PATIENT TRANSFERRED TO ~~PACU~~ ICU | TIME 0705 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] blood=2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 23551

ACLU-RDI 1681 p.111

DOD-037129

b(6)-2 unless noted diff.

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY Anesthesia

2. PATIENT IDENTIFIED, [redacted] REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 9Nov-03 — TIME PATIENT ARRIVED IN SUITE 1045

4. PATIENT IN ROOM TIME 1045 — NUMBER 2-2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS *(Specify)* PT on padded OR Bed. Head on foam doughnut for #1 POS. #1 Supine for 3 Tumor + Frog-legged for Thigh wash out. Arms <90°, ⓑ AP secured

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

to padded armboards c̄ safety straps, pillows under lateral side of knee, gel pad under Ankles. Rolled to Ⓛ lateral for 2nd part, pillow between legs (knees + ankles)

COMMENTS: LUE on padded armboard c̄ pillow on top + RUE on top of pillow arms secured. Bean Bag used. Correct Body Alignment Maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR By Dr [redacted] ☐ CLIP Ⓛ subclavian area

COMMENTS: no nicks or cuts noted. c̄ Beta Paint Prep

PREP SOLUTION *(Specify)* Betadine scrub + solution

SITE: Bilat Medial Thighs + groin BY WHOM: CPT [redacted]

SITE: Ⓡ hip + Buttock (as below) BY WHOM: CPT [redacted]

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES

pillow — pillow — pillow — prep.

LEGEND: X Ground Pad — Safety Strap — === Tourniquet

10. COUNTS — C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C		C	PFC [redacted]	CPT [redacted]
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;)*

#[redacted] b(6)-4

b(2)-2

9Nov-03 [redacted]

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

☒ ESU NO: RFB 102395

GROUND PAD: BRAND Valley Lab — LOT NO: 68706 Exp 2004-11

☐ ESU NO: ______

GROUND PAD: BRAND ______ LOT NO: ______

☐ BIPOLAR NO: ______

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 23552

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

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

0.9% NaCl - QS (>15,000cc)

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Kerlex NaCl	/	/
SITE	Buttock + Bilat Thigh wounds.	/	/

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlex Rolls, Kerlex Fluffs ABD pads, ACE to legs. Silk tape to Buttocks.

19. ADDITIONAL INFORMATION WC-IV

Surgeon: Dr [redacted]

anes: CPT [redacted] CRNA - Gen/Endo

Bovie pad site pre-op - CDI post-op CDI

b(6)-2 All

DA 5179 previously done

20. OPERATION(S) PERFORMED

Washout of gluteal wounds and thigh wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1310	Litter

22. REGISTERED [redacted] CPT/AN

MEDCOM - 23553 USAPA V1.00

ACLU-RDI 1681 p.113

DOD-037131

b(6)-2 A11

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Amb. BY anesth.

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

3. DATE 11 Nov 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM TIME 1054 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER *(Specify)* tired from amb. up stairs w/ crutches

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR INT.	Maj. [redacted] (1120-1254)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Bean bag for positioning Safety strap across legs Pillows between legs, axillary roll, pillow between arms in lat. position

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. leg BY WHOM: [redacted]
SITE: Lt. leg BY WHOM: [redacted]
Buttocks
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

C = Correct I = Incorrect Initial C [redacted]

					Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒	Yes	☐	No	/	/	C	[redacted]	[redacted]
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(6)-4

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

30/30

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23554

13. PROSTHESIS, IMPLANTS ☐ YE[S] ☑ NO IF YES NAME: ID NUMBER; [NUMB]ER

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):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICI[AN]

15. X-RA[Y] ... YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8" Penrose	1" Penrose	1" Penrose
SITE	Rt. thigh	Lt. Thigh	Rt. Buttocks

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, ABD's, Kerlix, Ace } Bilat. LE

Fluffs, ABD, 4x4, Tape } Buttocks

19. ADDITIONAL INFORMATION

Surg: Anesth: Sarafin, CRNA Anesth Type: General

6(u)-2 A1

Foley in place PTA

20. OPERATION(S) PERFORMED

1. I&D Rt. & Lt. Legs w/ closure of wounds
2. I&D Rt. Buttocks w/ closure of wounds

21. PATIENT TRANSFERRED TO PACU TIME 1323 METHOD Stretcher

22. REGISTERED NURSE SIGNATURE CPT/AN / MAJ AN

REVERSE OF DA FORM ..., OCT 87 MEDCOM - 23555 USAPA V1.00

ACLU-RDI 1681 p.115

DOD-037133

i-STAT EG8+

Pt: [redacted] b(6)-4

Pt Name:____________

Glu________190 mg/dL

BUN_________10 mg/dL

Na_________139 mmol/L

K__________4.1 mmol/L

Cl_________107 mmol/L

TCO2________22 mmol/L

AnGap_______15 mmol/L

Hct_________34 %PCV

Hb*_________12 g/dL

*via Hct

pH_______7.325

PCO2______39.2 mmHg

HCO3________20 mmol/L

BEecf_______-6 mmol/L

Sample Type_:

08NOV03 08:14

Oper: [redacted] b(6)-2

Physician:_____________

Ser# 42015

Ver: JAMS046A
CLEW A93

---

i-STAT EG6+

Pt: [redacted] b(6)-4

Pt Name:___________

Na_________139 mmol/L

K__________4.1 mmol/L

TCO2________24 mmol/L

Hct_________35 %PCV

Hb*_________12 g/dL

*via Hct

At 37C

pH_______7.337

PCO2______41.6 mmHg

PO2_________114 mmHg

HCO3________22 mmol/L

BEecf_______-4 mmol/L

sO2*________98 %

*calculated

At Patient Temp

pH_______7.334

PCO2______42.1 mmHg

PO2_________115 mmHg

Patient Temp: 99.0F

Sample Type_: ART

08NOV03 08:12

Oper: [redacted]

Physician: b(6)-2

Ser# 42011

Ver: JAMS046A
CLEW A93

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i-STAT CREA

Pt: [redacted] b(6)-4

Pt Name:___________

Crea_______0.9 mg/dL

Sample Type_:

08NOV03 08:19

Oper: [redacted] b(6)-2

Physician:_____________

Ser# 42011

Ver: JAMS046A
CLEW A93

*CBC Clotted

b(6)-2

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

Ward/Section: ICU I

REQUE[redacted]N:

LAST, FIRS[redacted] b(6)-4

DATE 8 JUN

TIME 0733

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

* (Hematology) CBC

TEST	RESULT	REF. RANGE
WB[C]		
RB[C]		
Hgb		
Hct		
MC[V]		
Plt		
Lym		
Seg		
Ban		
Lym		

ID: [redacted] 08-11-03
WB 08:52

				Patient Limits	
WBC	15.9	H	x10^3/uL	4.5	10.5
RBC	4.23		x10^6/uL	4.00	6.00
Hgb	12.4		g/dL	11.0	18.0
Hct	38.6		%	35.0	60.0
MCV	91.1		fL	80.0	99.9
MCH	29.2		pg	27.0	31.0
MCHC	32.1	L	g/dL	33.0	37.0
Plt	281.		x10^3/uL	150.	450.
LY%	9.4	*L	%	20.5	51.1
LY#	1.5	*	x10^3/uL	1.2	3.4

Atyp		Imm	
RBC Morph			

Test	Result	Ref. Range
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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Test	Result	Ref. Range
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Test	Result	Ref. Range
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 23557

b(6)-2

Ward/Section: EMT

REQUEST: [redacted]

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

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

DATE: 8 Nov 03 TIME: 0320

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

(Hematology) CBC

TEST	RESULT	REF. RANGE

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 03:20

Patient ID: [redacted] b(6)-2
Test Name :PT
Test Result:= 14.1 sec
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :03:18
Card Lot :080201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 03:22

Patient ID: 1243
Test Name. :APTT
Test Result:= 27.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time
Card Lot
Operator [redacted] b(6)-2

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	mod	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		

ID: [redacted] 08-11-03
WB 03:31

				Patient Limits	
WBC	37.5	H	x10^3/uL	4.5	10.5
RBC	4.01		x10^6/uL	4.00	6.00
Hgb	11.9		g/dL	11.0	18.0
Hct	37.4		%	35.0	60.0
MCV	93.3		fL	80.0	99.9
MCH	29.7		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	464.	H	x10^3/uL	150.	450.
LY%	11.9	*L	%	20.5	51.1
LY#	4.5	*	x10^3/uL	1.2	3.4

CSF

Cell Count	

Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

T+C 6 units

b(6)-2

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

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

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

DATE	TIME
[illegible]	[illegible]

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		

TEST: ALB, ALP, ALT, AMY, AST, TBIL, BUN, CA^{++}, CHOL, CRE, GLU, TP

TEST: GLU, BUN, CRE, CK, NA^{+}, K^{+}, CL^{-}, tCO_2, CL^{-}, tCO_2

(Piccolo) Metabolic Panel

RESULT	REF. RANGE
	73-118 mg/dl
	7-22 mg/dl
	8.0-10.3 mg/dl
	0.6-1.2 mg/dl
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

(Piccolo) Liver Panel Plus

======= PICCOLO =======
08/11/03 03:16
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 269 DR #: 000
SERIAL #: 0000100494

GLU	240*	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	711*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 3+, ICT 0

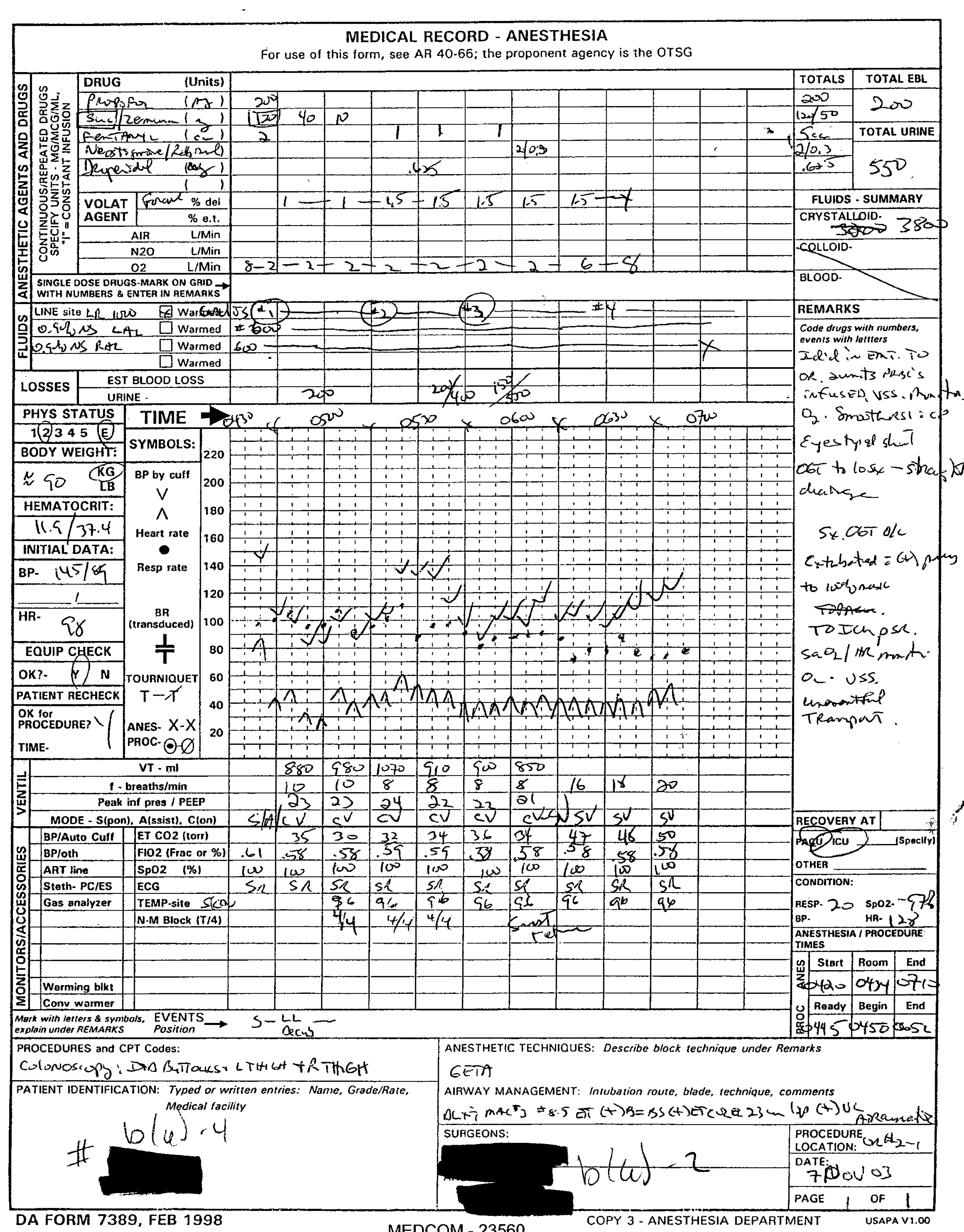
======= PICCOLO =======
08/11/03 09:10 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100684

ALB	3.1*	3.3-5.5	G/DL
ALP	89*	26-84	U/L
ALT	41	10-47	U/L
AMY	36	14-97	U/L
AST	42*	11-38	U/L
TBIL	1.0	0.2-1.6	MG/DL
GGT	51	5-65	U/L
TP	6.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 3+, ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:



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	TOTAL EBL
Propofol (mg)	200							200	200
Succ/Zemuron (mg)	120	40	10					120/50	
Fentanyl (cc)	2			1	1	1		5cc	TOTAL URINE
Neostigmine/Robinul (mg)						2/0.3		2/0.3	
Droperidol (mg)			.625					.625	550
( )									

VOLAT AGENT		
Forane % del	1 — 1 — 1.5 — 1.5 1.5 1.5 1.5	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	8—2 — 2 — 2 — 2 — 2 — 2 — 2 — 6 — 8	

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

FLUIDS - SUMMARY

CRYSTALLOID- ~~3800~~ 3800

COLLOID-

BLOOD-

FLUIDS

LINE site	Warmed	
LR 1000	☒ Warmed	#1 #2 #3 #4
0.9% NS LAC	☐ Warmed	#600
0.9% NS RAC	☐ Warmed	600
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE - 200 ... 200/400 150/550

REMARKS

Code drugs with numbers, events with letters

Id'd in EMT. To OR. 2 units PRBC's infused. VSS. Monitor. O2. Smooth RSI c cp. Eyes taped shut. OGT to LOSx – straight drainage.

Sx. OGT d/c. Extubated c (+) gag to 100% mask ~~[illegible]~~. To ICU post. SaO2/HR monitor. O2. VSS. Uneventful transport.

PHYS STATUS	
1 (2) 3 4 5 (E)	
BODY WEIGHT:	≈ 90 (KG) LB
HEMATOCRIT:	11.9/37.4
INITIAL DATA:	
BP-	145/89
HR-	98
EQUIP CHECK OK?-	(Y) N
PATIENT RECHECK OK for PROCEDURE?	✓
TIME-	

TIME → 0430 0500 0530 0600 0630 0700

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		880	980	1070	910	900	850		
f - breaths/min		10	10	8	8	8	8	16	18	20
Peak inf pres / PEEP		23	23	24	22	22	21		
MODE - S(pon), A(ssist), C(on)	S/A	CV	CV	CV	CV	CV	CV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		35	30	32	34	36	34	47	46	50
BP/oth	FIO2 (Frac or %)	.61	.58	.58	.59	.59	.58	.58	.58	.58	.58
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Scon			96	96	96	96	96	96	96	96
	N-M Block (T/4)			4/4	4/4	4/4		Sust Tet			
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS EVENTS Position → S— LL — Decub

RECOVERY AT (PACU) ICU ___ (Specify)

OTHER

CONDITION:

RESP- 20 SpO2- 97%

BP- HR- 128

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0420	0434	0713
	Ready	Begin	End
PROC	0445	0450	0652

PROCEDURES and CPT Codes:

Colonoscopy; D&D Buttocks, LT thigh + RT thigh

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

\# b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

DL x1 MAC 3 #8.5 ET (+)B=BS (+)ETCO2 @ 23cm lip (+)UL Atraumatic

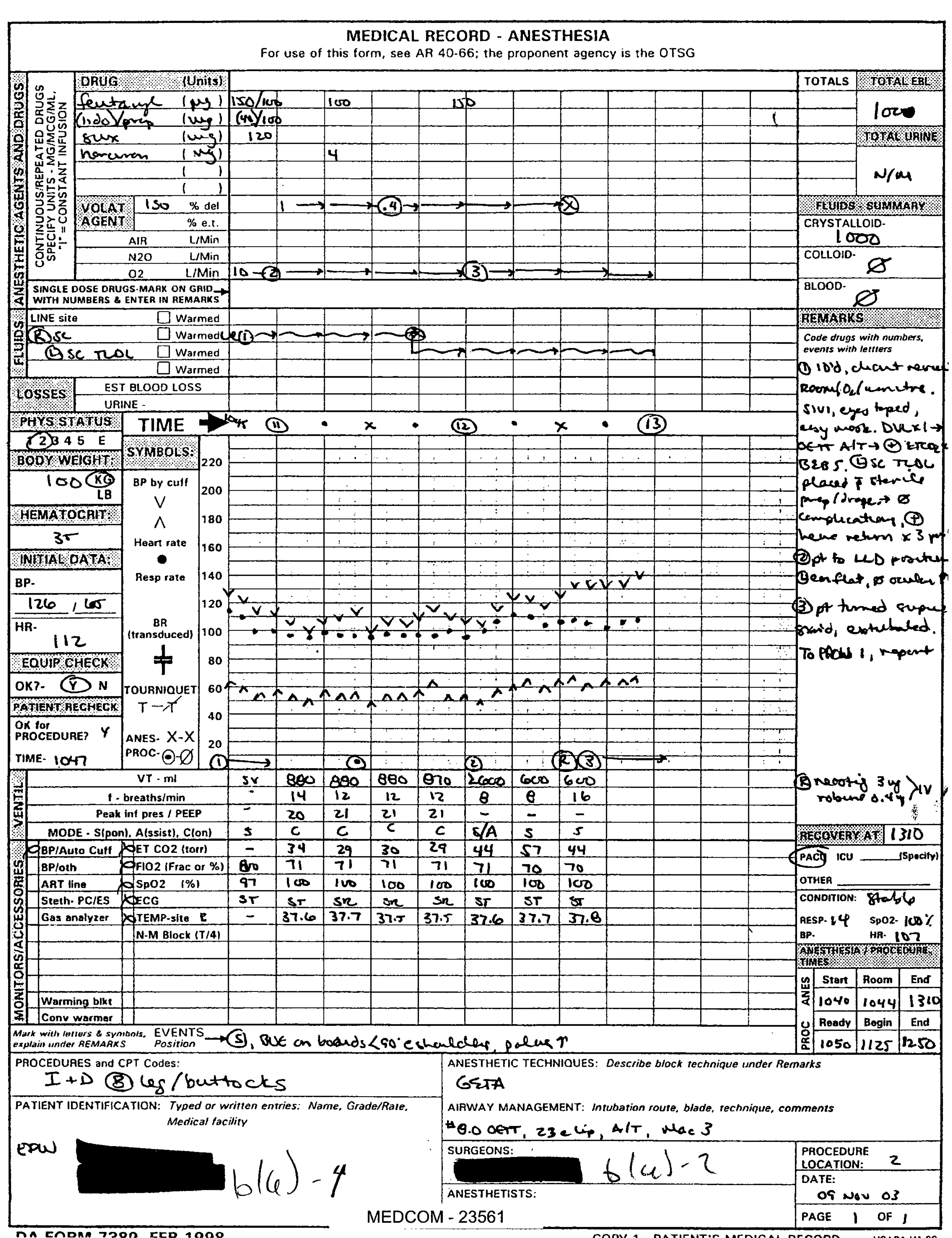
SURGEONS: b(6)-2

PROCEDURE LOCATION: OR #2-1

DATE: 7 NOV 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 23560 COPY 3 - ANESTHESIA DEPARTMENT USAPA V1.00



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)					
fentanyl (μg)	150/100	100		150	
lido/prop (mg)	(40)/100				
sux (mg)	120				
norcuron (mg)		4			
VOLAT AGENT 150 % del	1 →	→ (.4) →	→	→ (X)	
O2 L/Min	10 → (2) →	→	→ (3) →	→	→

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

TOTALS — TOTAL EBL: 100; TOTAL URINE: N/M

FLUIDS SUMMARY — CRYSTALLOID- 1000; COLLOID- Ø; BLOOD- Ø

FLUIDS — LINE site: (R) SC (Warmed) (1) →; (L) SC TLOL (Warmed)

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 100 (KG) LB

HEMATOCRIT: 35

INITIAL DATA: BP- 126 / 65; HR- 112

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1047

TIME: 1045 (11) • x • (12) • x • (13)

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

VENTIL								
VT - ml	SV	880	880	880	870	2600	600	600
f - breaths/min	-	14	12	12	12	8	8	16
Peak inf pres / PEEP	-	20	21	21	21	-	-	-
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S/A	S	S
ET CO2 (torr)	-	34	29	30	29	44	57	44
FIO2 (Frac or %)	80	71	71	71	71	71	70	70
SpO2 (%)	97	100	100	100	100	100	100	100
ECG	ST	ST	SR	SR	SR	ST	ST	ST
TEMP-site E	-	37.6	37.7	37.5	37.5	37.6	37.7	37.8
N-M Block (T/4)								

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

EVENTS Position → (S), BUE on boards <90° c shoulder, palms ↑

REMARKS — Code drugs with numbers, events with letters

(1) ID'd, chart reviewed. Room/O2/monitors. SIVI, eyes taped, easy mask. DVLx1 → OETT A/T → (+) ETCO2 BBBS. (L) SC TLOL placed ̅c sterile prep/drape → Ø complications, (+) blood return x 3 ports

(2) pt to LLD position (B) deflat, Ø ocular ↑

(3) pt turned supine, awake, extubated. To PACU 1, report

(R) neostig 3 mg, robinul 0.4 mg IV

RECOVERY AT 1310 — (PACU) ICU ____ (Specify); OTHER

CONDITION: stable; RESP- 14; SpO2- 100%; BP-; HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1040	1044	1310
	Ready	Begin	End
PROC	1050	1125	1250

PROCEDURES and CPT Codes: I+D (B) legs/buttocks

ANESTHETIC TECHNIQUES: GETA

AIRWAY MANAGEMENT: #8.0 OETT, 23 c lip, A/T, Mac 3

PATIENT IDENTIFICATION: EPW [redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETISTS:

PROCEDURE LOCATION: 2

DATE: 09 NOV 03

PAGE 1 OF 1

MEDCOM - 23561

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

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									200
Zemuron (mg)	20 40								1	1 [illegible]
Fentanyl (cc)	2 1									5cc
Morphine (mg)		4	6		2 2		2	2 2		20mg
( )										
( )										
VOLAT AGENT Forane % del	1.5	2	2.5	2.5	2	1.5	1.0	1.0		
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	8-2	2	4	4	4	4	4	4	8-10	

TOTAL EBL:

TOTAL URINE:

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

FLUIDS

LINE site LR 1000 [illegible] ☐ Warmed — #1 — #2 — #3

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS

URINE - 400

FLUIDS SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Ambulated w/assist. To OR#2. Monitors placed. Smooth IV induction. Eyes taped shut.

1255 Extubated c (+) pressure to 100% - mask.

PHYS STATUS 1 2 3 4 5 E

TIME 1100 — 1130 — 1200 — 1230 — 1300

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA:

BP- 131/75

HR- 130

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME-

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-∅

(Chart scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

VENTIL

VT - ml	900	1.0							
f - breaths/min	10	8	20	21	20	16	20	15	A
Peak inf pres / PEEP	22	24							
MODE - S(pon), A(ssist), C(on)	S/CV	CV	SV	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	28	31	39	37	39	40	39	39	33
BP/oth	FIO2 (Frac or %)	.81	.80	.81	.80	.81	.80	.81	.81	.80
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site SKIN		95	95	95	95	95	95	95	95
	N-M Block (T/4)	4/4	4/4	4/4				sust. tet		
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS EVENTS / Position → supine — L lat decub [illegible]

RECOVERY AT 1320

(PACU) ICU _____ (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- 135/63 HR- 111

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1052	1330

	Ready	Begin	End
PROC	1103	1112	1311

PROCEDURES and CPT Codes: LTR Washout / Partial closure of Thigh / Buttock wounds

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* OLT Miller #2 (+)VC (+)BBS (+)ETCO2 Atraumatic - easy; [illegible] #8.0

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

[redacted] b(a)-4

SURGEONS: [redacted] b(a)-2

ANESTHETISTS:

PROCEDURE LOCATION: OR #2

DATE: 11 Nov 03

PAGE 1 OF 1

MEDCOM - 23562

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 08NOV03 **Diagnosis:** GSW to Buttocks & thighs **HD:** ________ **POD:** ________

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	**Mobility**	No limitations	4
	Slightly limited	3		Slightly limited	(3)
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	4	**Nutrition**	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	(2)		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	(1)
Activity	Walks frequently	4	**Friction and Shear**	No apparent problem	3
	Walks occasionally	3		Potential problems	(2)
	Chairfast	2		Problems	1
	Bedfast	(1)			

Add the total score

Above 20 — Low Risk
Between 16 and 20 — Medium Risk
Between 11 and 15 — High Risk
Below 10 — Very High Risk

Total Score: 13

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes__ No__ Location: GSW to Buttocks + thighs
Procedure: Flex-Sigl Anoscopy / Debridment + wellac
Size:________ Drainage:________
Tubes:________ Pins:________ Appearance:________
Dressing change:________
Location:________
Size:________ Drainage:________
Tubes:________ Pins:________ Appearance:________
Dressing change:________

Burn wound (s): Yes__ No__ % BSA________ Partial________ Full________
Location:________ Size________
Appearance:________
Dressing change:________
Location:________ Size________
Appearance:________
Dressing change:________

Pressure Ulcer (s): Yes___ No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:________ Size:________
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough ________ Tunneling_____
Undermining_____ Odor_____ Purulent discharge_______ Eschar______ Exudates ________
Type of dressing change: Wet-to-dry_____ Comfeel dressing________ Carrasyn-V Gel______ Alginate________

Physician notified/consulted for wound debridement: Yes___No____ Date/time MD notified ________
CNS notified/consulted for Stage II and greater: Yes____No______
Nutrition Referral: Yes_______ No__________
Physical Therapy Referral: Yes_________ No_____________
Action taken:________
Date & Time________

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

PLAN OF CARE FO[illegible] KIN BREAKDOWN AND WOU[illegible] [illegible]AGEMENT

PROGR[illegible] NOTES

MEDICAL RECORD

Admission Date: 08NOV03 Diagnosis: GSW to Buttocks + thighs HD: ______ POD: ______

Date: 08NOV03 Time: 1022 RN Signature: ______

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: ______
Size: ______ Drainage: ______
Diabetic ulcer Tubes: ______ Pins: ______ Appearance: ______
Venous stasis ulcer Dressing change: ______
Other ______ Describe ______

Burn wound (s): % BSA ______ Partial ______ Full ______
Location: ______ Size ______
Appearance: ______
Dressing change: ______

Pressure Ulcer (s):
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: ______ Size: ______
Wound character: Pink ____ Moist ____ Dry ____ Granulation tissue ____ Yellow slough ______
Tunneling ____ Undermining ____ Odor ____ Purulent discharge ______ Eschar ______ Exudates ______

Refer to SOP for Dressing Change Instructions.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☐ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d
- ☐ qd

MD Signature and Date: ______

CNS Signature and Date: ______

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

MEDCOM - 23564

NSN 7540-01-185-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE | SEX | SSN (Sponsor)

WARD/CLINIC: ICW-1

REGISTER NO.

FILM NO. b(6)-4

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: Dr. b(6)-2

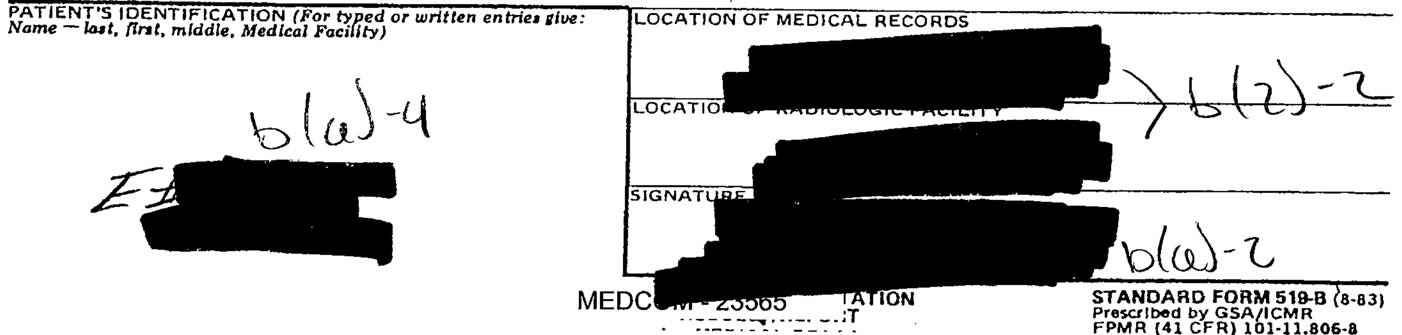
DATE REQUESTED

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

For CL placement

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)

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

b(2)-2

SIGNATURE

b(6)-2

MEDCOM - 23565 ATION

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

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

- [X] RED BLOOD CELLS (Crossmatch not performed)
- [ ] OTHER (Specify) ____________________
- [ ] THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED: ALANINE AMINOTRANSFERASE, CYTOMEGALOVIRUS TEST, HEPATITIS TESTS, RETROVIRUS TESTS, SYPHILIS SEROLOGY TEST

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE	DATE
[redacted] b(6)-2	8 Nov 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER	RECIPIENT ABO/Rh	INSPECTED AND ISSUED BY (Signature) / AT (Hour)	INDIVIDUAL ACCEPTING COMPONENTS
		[redacted] b(6)-2 / 0325	[redacted] MAJ AN / 8 Nov 03

UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
11 Nov [redacted]	O pos	[redacted]	[redacted]	8 Nov 03	8 Nov 03	10	NO
11 Nov [redacted]	O pos	[redacted]	[redacted]	8 Nov 03	8 Nov 03	10	NO
b(6)-4		b(6)-2					

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

1. Discontnue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. DO NOT disgard unit. Return Blood Bag, Filter Set and I.V. solution to the Blood Bank.

Description

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____________________

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.)

- [X] NO
- [ ] YES (SPECIFY) ____________________

PRE-TRANSFUSION

TEMP: 97.8 PULSE: 112 B/P: 144/72

SIGNATURE [redacted] b(6)-2 2LT AN

PREPARED BY [redacted] b(6)-2 2LT AN

WITNESS [redacted] CPT

DATE 8 Nov 03

PATIENT'S IDENTIFICATION (NAME- LAST, FIRST; SSN)

[redacted] b(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

MEDCOM - 23566

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

- [X] RED BLOOD CELLS (Crossmatch not performed)
- [ ] OTHER (Specify) ______________

- [ ] THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED:
  ALANINE AMINOTRANSFERASE — RETROVIRUS TESTS — CYTOMEGALOVIRUS TEST — SYPHILIS SEROLOGY TEST — HEPATITIS TESTS

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE [redacted] b(6)-2 — DATE 8 NOV 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER	RECIPIENT ABO/Rh	ISSUED BY (Signature)	INDIVIDUAL ACCEPTING COMPONENTS
		[redacted] b(6)-2 AT 0313	[redacted] 8 NOV 03

UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
11 NOV [redacted]	O pos	[redacted]	[redacted]	8 NOV 03	8 NOV 03	1U	NO
11 NOV [redacted]	O pos	UMATAN [redacted]	[redacted]	8 NOV 03	8 NOV 03	1U	NO
b(6)-4			b(6)-2				

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

1. Discontnue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. DO NOT disgard unit. Return Blood Bag, Filter Set and I.V. solution to the Blood Bank.

Description
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ______________

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.)
- [X] NO
- [ ] YES (SPECIFY) ______________

PRE-TRANSFUSION
TEMP: 97.8 PULSE: 128 B/P: 72/31

SIGNATURE [redacted] ABOVE b(6)-2

P[redacted] b(6)-2 — DATE 8 NOV 03

PATIENT IDENTIFICATION (NAME- LAST, FIRST; SSN)
[redacted] b(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

MEDCOM - 23567

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

NOTED 2 DEC 2003 @ 0900 LT, AN b(6)-2

DATE OF ORDER: 2 DEC 03 | TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. MOM x 1 30cc
2. Colace 100mg p.o. BID

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 2 DEC 03 @ | TIME OF ORDER: 1500 HOURS

1. DULCOLAX SUPP. PR x 1 NOW.

V.O. DR / LT, AN

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24°V 3 DEC @ 0800 LCTN

PATIENT IDENTIFICATION

b(6)-4

Noted 8 DEC 03 0830

b(6)-2

DATE OF ORDER: 8 Dec 03 | TIME OF ORDER: 0830 HOURS

1. VS QShift
2. Shower QD
3. D/C PO Cipro
4. DrsgDcontinue BID

V.O. Dr LTA

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

24V 09 DEC 03 0845

PATIENT IDENTIFICATION | DATE OF ORDER

Ø new orders 15 Dec 03 Ø5

b(6)-2

MEDCOM - 23568

ACLU-RDI 1681 p.128

DOD-037146

bLwS-2 All unless noted diff

Hlw-4

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

NURSING UNIT: ICU I | ROOM NO. | BED NO.: 1

DATE OF ORDER: 8NOV03 | TIME OF ORDER: 0700 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU from OR, Dr.
2. Dx: GSW to buttocks + thigh
3. Condition = stable
4. NKDA
5. Activity = Bedrest
6. Vitals = per routine
7. Incentive Spirometry 10x/hr while awake
8. Foley to gravity
9. I+O's
10. O2 per NC or Face Mask to keep Sat% ≥ 95%
11. (0730) CXR on arrival
12. Diet = NPO ̄x meds ̄c sips
13. IVF = NS ̄c 20 MEQ KCl/Liter @ 125cc/hr
14. Tagamet 300 mg IVPB q6°
15. Heparin SubQ 5000 Units BID
16. (0730) Ancef 1 gram IVPB q8°
17. MSO4 2mg-8mg IV q2° prn severe pain
18. Percocet i-ii p.o. q 4-6° prn pain
19. Re-enforce dressings prn
20. If soiled ̄c stool Δ outer dressing
21. (0730) CBC, Chem-7 and ABG on Arrival to ICU

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

MEDCOM - 23569

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 NOV 03 — TIME OF ORDER: 1250 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Return to Ward [redacted]
2. Dx = GSW to buttocks + thighs
3. Condition = stable
4. NKDA
5. Vitals q 8°
6. Activity = OOB to chair + ambulate
7. Incentive Spirometry 10x/hr
8. Diet = Advance to regular as tolerated
9. IVF = NS c̄ 20 MEQ KCl/Liter @ 75cc/h
10. Tagamet 400mg p.o. q6°
11. Heparin SubQ 5000 Units BID
12. Ancef 1 gram IVPB q 8°
13. MSO4 2-4mg IV q 2-4° prn severe pain
14. Percocet 1-11 p.o. q 4-6° prn
15. Re-enforce dressings as needed
16. If dressing soiled c̄ blood; change the outer dressing
17. Post-op CXR for Line Placement

PATIENT IDENTIFICATION

b(6)-4 b(6)-2 [redacted] 9 NOV 03 1300

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 10 NOV 03 — TIME OF ORDER: 0870 HOURS

1. Tylenol 1 gram p.o. q 4-6° prn pain

b(6)-4 noted b(6)-2 [redacted] 10 NOV @ 0830

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

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

MEDCOM - 23570

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4		11-9-03 / 2100 HOURS	
Noted 11/9-03 @2100		Tylenol ii po now	
		b(6)-2	
		b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER 10NOV03 / TIME OF ORDER 0904 HOURS	
	1	NPO ā 1N tonight	
	2	↑ IVF to 150cc/hr @ 1N tonight	
b(6)-4		b(6)-2	
NURSING UNIT 24° / ROOM NO. 0020 11NOV03 / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER _____ HOURS	
b(6)-4			
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER _____ HOURS	
b(6)-4			
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 23571

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 [redacted]

b(6)-2 Noted [redacted] 11 NOV 03 1640

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11NOV03 | TIME OF ORDER: 1628 HOURS | LIST TIME ORDER NOTED AND SIGN

1) CXR Now r/o PTX/pneumonia
2) Albuterol neb x1 now
3) Titrate O2 to Sat % ≥ 95

b(6)-2 [redacted]

PATIENT IDENTIFICATION: 24° V @ 0530 on 13 Nov

DATE OF ORDER: 13NOV03 | TIME OF ORDER: 1000 HOURS

1) May ambulate c crutches
2) OOB to chair TID
3) Once a day shower starting tomorrow AM

b(6)-2 [redacted]

NURSING UNIT: 24° V @ 0030 | ROOM NO. | BED NO. 14 Nurse [redacted]

PATIENT IDENTIFICATION: b(6)-2 Noted [redacted] 14 NOV 03 1250

DATE OF ORDER: 14NOV03 | TIME OF ORDER: ______ HOURS

1) Pt. needs to shower BID c Dressing Δ'. Be sure infected area is clean prior to dressing
2) Be sure to place a gauze (kerlix) above + below the drains so they are not touching the skin

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: b(6)-2 Noted [redacted] 15 NOV 03 1615

DATE OF ORDER: 15NOV03 | TIME OF ORDER: 1600 HOURS

1) Place PIV
2) Once PIV in, D/C central line

[redacted] 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 - 23572

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT: 1CW | ROOM NO. | BED NO.

DATE OF ORDER: 11NOV03 TIME OF ORDER: 1315 HOURS

LIST TIME ORDER NOTED AND

1) Return to Ward from RR Vs.
2) Dx: GSW to thigh & buttocks
3) Condition = stable
4) NKDA
5) Vitals = q6°
6) Activity = Bedrest
7) Foley to Gravity
8) DC Foley in AM
9) Diet = Regular
10) IVF = ~~[illegible]~~ NS c 20 mEq KCl per Liter @ 100cc/hr
11) Tagamet 400 mg p.o. q6°
12) Heparin SubQ 5000 units BID
13) Zosyn 3.375 grams IVPB q6°
14) Cipro 500 mg ~~IVPB~~ p.o. BID
15) MSO4 2-5 mg IV q2-4° prn and for dressing Δ's
16) Percocet i-ii p.o. q4-6°
17) BID Dressing Δ's and as often as needed if soaked. May change entire dressing
18) Tylenol 1 gram p.o. q6° prn temp ≥ 100.5

b(6)-2

b(6)-2

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

MEDCOM - 23573

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
b(6)-4

b(6)-2 Noted

DATE OF ORDER: 19 NOV 03 TIME OF ORDER: 0828 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Hep Lock IVF
2. D/C Zosyn

b(6)-2

NURSING UNIT: ICW1 ROOM NO.: 3 BED NO.: B

24° ✓ 21 Nov 0200

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

(NC)

1. ~~Pt. may ambulate to and from the bathroom~~
2. ~~q day dry dressing Δ to Right thigh donor site. Do Not pull off the Xeroform on the donor site ONLY from the edges~~
3. ~~q day dressing Δ to Right lower leg skin graft with Xeroform + dry dressing Xeroform only on the graft~~

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

b(6)-2

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

b(6)-2 noted

DATE OF ORDER: 30 NOV 03 TIME OF ORDER — HOURS

1. Remove all sutures except from Left Medial Thigh wound

b(6)-2

NURSING UNIT — ROOM NO. — BED NO.

24° ✓ 0300 2 DEC 03

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

MEDCOM - 23574

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. 11 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23
11/11		Vitals q 6°	06													
			12													
			18													
			24													
11/11		Activity: B Rest	06 / 18								D/C			SEE		
			18 / 06											BELOW		
11/11		Foley to gravity	06 / 18													
			18 / 06			D/C				12	NOV 03					
11/11		Diet: Regular	06 / 18													
			18 / 06													
11/11		BID Dressing Δs	10													
		and as often as	20													
		needed if soaked.														
		May Δ entire drsg.														
11/13		May ambulate c̄	06 / 18													
		crutches	18 / 06													
11/13		OOB to chair TID	06 / 18													
			18 / 06													
11/13		Once a day shower	06 / 18				SEE Δ BELOW									
		starting tomorrow	18 / 06													
		AM														
14 NOV 03		Pt needs to shower	10													
		BID c̄ drsg Δs. Be sure	22													
		gluteal area is clean														
		prior to dressing														
14		Be sure to place gauze (Kerlix)	10													
		above and below the drains so	22													
		they are not touching the skin														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thigh & buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

SPN # [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

MEDCOM - 23575

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

b(6)-2 Arl

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo Nov Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/11		Return to ward from OR Dr Ellison	11/11		1415	
11/11		Condition Stable	11/11	noted		
11/11		D/C Foley in AM	11/12	Done		
11 Nov 03		CXR now - r/o PTX/pneumonia	11 Nov 03	done		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
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----	----		
----	----		
----	----		
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MEDCOM - 23576

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. 11 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED													
				[redacted]	25	26	27	28	29	30	1	2	3	4	5	6	
11NOV	[redacted]	VS Q6°	6	[redacted]													
			12	[redacted]													
			18	[redacted]													
			24	[redacted]													
11NOV	[redacted]	Reg diet	6	[redacted]													
			18	[redacted]													
11NOV	[redacted]	OOBTC TID, AMB	6	[redacted]													
			18	[redacted]													
14NOV	[redacted]	Shower BID c̄ drsg	10	[redacted]													
		Δs. Be sure gluteal	22	[redacted]													
		area is clean prior	/														
		to drsg Δ.	/														
4DEC	[redacted]	N/O: BRADEN SCALE	06	/				[redacted]	/						/	[redacted]	
		Q7 DAYS	18	/				/	/						/	/	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

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

b(6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 11/12 Yr 2003

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30NO	[redacted]	Remove all sutures except from	30NOV			[redacted]
	----	left medial thigh wound.				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* — TIME/DATE COMPLETED													
----	----														
----	----														
----	----														
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MEDCOM - 23578

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. 12 Yr. 2003

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR							14	15	16	17	18	19
11 Nov 03	[redacted]	S 96°													
					D/C'd 8 DEC 03										
			18												
			24												
11	[redacted]	Reg diet	06 18												
			18 06												
11	[redacted]	OOBTC TID, Amb	06 18												
			18 06												
14 Nov 03	[redacted]	Shower BID c̄ dsg Δs	10		D/C 8 DEC 03										
		Be sure gluteal area is	22												
		clean prior to dsg Δ													
04 DEC	[redacted]	N/O: Braden scale q	06 18	/					/	W	/				/
		7D	18 06	/					/	V	/				/
8 DEC	[redacted]	VS @ Shift	06 18	/											
			18 06	/											
8 DEC	[redacted]	Shower QD	10	/											
8 DEC	[redacted]	Drsg Δ BID Be	10	/											
		sure gluteal area	22	/											
		is clean prior to													
		drsg Δ													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

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

MEDCOM - 23579

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 12 Yr 2003

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16	[redacted]	D/C to prison camp	16 Dec			

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

MEDCOM - 23580

b(6)-2

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. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12
08NOV	[redacted]	IVF: NS c̄ 20meq	06	[redacted]				
		KCL (Liter @ 125cc/hr)	18	[redacted]				
08NOV	[redacted]	Heparin Subq. 5000	10	[redacted]				
		units BID	22	[redacted]				
08NOV	[redacted]	Tagamet 300mg	06	/				
		IVPB Q6°	12	[redacted]				
			18	[redacted]				
			24					
08NOV	[redacted]	Ancef 1 gram IVPB	08	[redacted]				
		Q8°	16	[redacted]				
			24					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW to buttocks + thighs

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

PATIENT IDENTIFICATION:

EPW # [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

MEDCOM - 23581

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
08NOV		MSO4 2-8mg IV	08 Nov 03
		Q2° prn severe	1110 4mg
		pain	
08NOV		Percocet i-ii po	
		Q 4-6° prn pain	
		b(6)-2 All	

USAPA V1.00

MEDCOM - 23582

ACLU-RDI 1681 p.142

DOD-037160

b(6)-2

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. 11 Yr. Ø3

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED Ø8	Ø9	10	11
2300 Ø8 NOVØ3	[redacted]	IVF: NS c̄ 20mEq KCl/	Ø6				D/C'D
	-----	Liter @ 125cc/hr	18				
	-----		Ø6				
Ø8	[redacted]	Tagamet 400mg po	Ø6	/			
Ø9	-----	q6°	12	/			
	-----		18				
	-----		24				
Ø8	[redacted]	Heparin SubQ 5000	10	/			
	-----	units BID	22				
Ø8	[redacted]	Ancef 1gm IVPB	Ø8	/			
	-----	q8°	16				
	-----		24				
10	[redacted]	IVFs NS c̄ 20mEq KCL/L	6	/	/		
	-----	↑ to 150cc/hr	18	/	/		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW TO BUTTOCK/THIGHS

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.
MEDCOM - 23583

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/9	[redacted]	Tylenol ii P.O NOW	9 NOV	21W	21W	[redacted]
10	[redacted]	↑ IVF to 150cc @ MN tonight	10	2400	2400	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED					
08NOV	[redacted]	MSO4 2-8mg IV q2° prn severe pain	D/T	8NOV 1740	8NOV 2000	9NOV 0430		
			D/I	8mg	8mg	2mg		
08	[redacted]	Percocet i-ii po q4° prn pain	D/T	8NOV 1640	9NOV 0800	9NOV 1730	10NOV 1500	10NOV 2130
			D/I	ii	ii	ii	2	1PO
10NOV	[redacted]	Tylenol 1gm Q4-6°	D/T	11NOV 0005				
		PRN pain	D/I	1gm				

b(6)-2 A1

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

MEDCOM - 23584

b(6)-2

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. 11/12 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 NOV	[redacted]	Tagamet 400mg po	6														
	-----	Q6°	12														
	-----		18														
	-----		24														
11 NOV	[redacted]	Heparin SQ 5000units	10														
	-----	BID	22														
11 NOV	[redacted]	Cipro 500mg po BID	10														
	-----		22														
2 DEC	[redacted]	COLACE 100mg PO BID	10														
	-----		22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW - thighs/buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION: [redacted]

Rewritten

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23585

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		M.O.M. x 1 30cc	2DEC	0910	0910	
2DEC		Dulcolax supp PR x i now	2DEC	NOW	1600	
		b(6)-2 Ar1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
21/11		Rewritten: MSO4 2-5mg IV q2-4°	D/T													
		prn + for DSG Δ'S	D/I													
11/11		Percocet i-ii p.o.	D/T	25NOV 0700	21NOV 0900	26NOV 1300	27NOV 2215	28NOV 2200	4DEC 0100	4DEC 2030	6DEC 2000					
		q4-6	D/I	ii	ii	ii	ii	ii	ii	ii	ii					
11/11		Tylenol i gram p.o.	D/T													
		q 6° PRN temp ≥100⁵	D/I													

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

MEDCOM - 23586

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: 12 Yr: 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 09	10	11	12	[redacted]	[redacted]	[redacted]	[redacted]	17
11 Nov 03	[redacted]	Tagamet 400mg po	06	[redacted]								
	-----	q6°	12	[redacted]								
	-----		18	[redacted]								
	-----		24	[redacted]								
11	[redacted]	Heparin SQ 5000u	10	[redacted]								
	-----	BID	22	[redacted]								
3 Dec 03	[redacted]	Colace 100mg po	10	[redacted]								
	-----	BID	22	[redacted]								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to thighs/buttocks

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.

MEDCOM - 23587

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 12 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		blue) - 2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
11 NOV	[redacted]	MSO4 2.5mg IV q2-4° prn & for dsg Δs	D/T	
			D/I	
11	[redacted]	Percocet i-ii po q4-6° prn	D/T	
			D/I	
11	[redacted]	Tylenol i gram po q6° prn temp ≥ 100.5	D/T	
			D/I	

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

MEDCOM - 23588

ACLU-RDI 1681 p.148

DOD-037166

b(6)-2

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. 11 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
11/11	[redacted]	NS c̄ 20 meq KCl	06 18									D/C 19 NOV					
		per liter @ 100cc	18 06														
11/11	[redacted]	Tagamet 400mg	06														
		p.o. q 6°	12														
			18														
			24														
11/11	[redacted]	Heparin SQ 5000 U	10														
		BID	22														
11/11	[redacted]	Zosyn 3.375 grams	06														
		IVPB q 6°	12									D/C 19 NOV					
			18														
			24														
11/11	[redacted]	Cipro 500mg p.o.	10														
		BID	22														
11 Nov 03	[redacted]	titrate O2 to keep	06 18														
		sat % ≥95	18 06														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to thigh & buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: EPW # [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 1 FEB 79 4678 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 23589

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Nov		Yr. 03	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
11 NOV 03	[redacted]	Albuterol neb x 1 now	11 NOV 03	—	1930	[redacted]
15 NOV 03	[redacted]	Place PIV	15	—	1100	[redacted]
15	[redacted]	Once PIV in, d/c central line	15	—	1100	[redacted]
19 NOV	[redacted]	Heplock IVFs	19	—	—	[redacted]
19	[redacted]	D/c Zosyn	19	—		[redacted]
		b(6)-2 A1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED								
11/11	[redacted]	MSO4 2-5mg IV	Date	11 NOV	11 NOV						
			Time	1920	2340						
		$\bar{q}$ 2-4° prn and	Dose	5mg	5mg						
			[redacted]								
		for desig Δ's	I/E	E							
11/11	[redacted]	Percocet i-ii po	Date	12 NOV	13 NOV	14 NOV	19 NOV	20 NOV	22 NOV	22 NOV	23 NOV
			Time	2140	1600	0440	1215	2330	0600	2130	0700
		$\bar{q}$ 4-6°	Dose	2 tab	ii	ii	ii	i	ii	ii	ii
			[redacted]								
			I/E								
11/11	[redacted]	Tylenol i gram	Date	11 NOV	12 NOV	12 NOV	13 NOV	14 NOV	1 NOV		
			Time	1830	1010	2000	1930	2130	1530		
		p.o. $\bar{q}$ 6° prn temp	Dose	1gm	1gm	1gm	1gm	1gm	1gm		
			Init	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
		≥ 100.5	I/E	E	E						

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

MEDCOM - 23590

b(6)-2 A11

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		❑ Oral ❑ Nasal Teeth		❑ $ETCO_2$ Change ❑ BBS Post Int ❑ Post CXR
	Gastric Tube		❑ Oral ❑ Nasal		❑ Air ❑ Contents ❑ Verified ____ Suction: Y N
0310	Urinary	16fr	☑ Meatus ❑ Supra-Public	SGT [redacted]	☑ Return ____ cc ❑ Heme Dip: + - ❑ Secured
	DPL		❑ Opened ❑ Closed		❑ Grossly: + - Cell count Sent@ ____
	Chest Tube #1		L R		❑ Air ❑ Blood ❑ Pleuravac ____ cm ❑ Autotransfuser
	Chest Tube #2		L R		❑ Air ❑ Blood ❑ Pleuravac ____ cm ❑ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS	
	❑ D-stick ____	❑ SHct ____
	❑ D-stick ____	❑ SHct ____
0304	☑ CBC ☑ Chem	❑ PT/PTT
	❑ ETOH ❑ T&S	❑ T&C x ____
	❑ Tox Screen	
	❑ UA ❑ HCG	
0304	☑ OTHER T+C 6 units	
	❑ OTHER	

X-RAYS

TIME	LABS
0304	☑ Chest Initial
	❑ Chest Post ET
	❑ Chest Post CT
	❑ C-Spine
0304	☑ Pelvis
0304	☑ (L) femur
0304	☑ abdomen
	❑

TIME	PROCEDURE			ACCOMPANIED BY	RETURN
	CT Scan:	❑ Contrast			
	❑ Head	☑ Abd	☑ Pelvis		
	❑ C-Spine	❑ T/L Spine	❑ Chest		
	❑				
	A-Gram Site:				

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
			Y	N	(R) arm	LR		
central line			(Y)	N	(R) sub	LR		
0310		18ga	(Y)	N	(L) AC	NS		
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
fentynal	0329	100mg	IV						
O^2 Via NRM	0320	15L	NRB						
Ancef	0320	1gm	IV						
Tetanus	0325	.5ml	IV						
Fenly	0400	100g	IV						

b6-4

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT
0310		O Pos	[redacted]		1u		
0312		O Pos	[redacted]		1u		
0325		O Pos	[redacted]		1u		
0325		O Pos	[redacted]		1u		

LAB RESULTS

CBC:

Chem:

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]			
Surgeon	[redacted]			
Anesth	[redacted]			
X-Ray	[redacted]			
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

❑ Home ❑ ____

Admitted to ____

Report Called to ____

Time Transferred ____

[illegible]d By ____

Via: ❑ Stretcher ❑ Wheelchair

MEDCOM - 23591

VITAL SIGNS

Rectal Temp: GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0305	72/31	125	NSR	40							
0311	85/65	153	NSR		100						
0317	/	128	NSR		100						
0321	124/65	118	NSR	41	100						
0327	146/71	121	NSR	62	98						
0330	146/71	101	NSR	22	100						
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
(4) - Spontaneous	(5) - Oriented	(6) - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

MEDCOM - 23592

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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME: 03 04 ETA: 1 mgt UNIT:
MED COM: [Y] [N]

ARRIVAL STATUS

TIME 0304 ☑ IV x 1 ☐ O_2 ____ 1/min ☐ C-Spine Immob
Meds: ☐ UKN ☑ None ☐ Yes:
Allergies: ☐ UKN ☑ None ☐ Yes:
Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake ____ hrs
LMP: ____ ☐

PRIMARY SURVEY

AIRWAY	BREATHING	CIRCULATION	
☑ Natural Patient [Y][N]	☐ Labored ☑ Unlabored ☐ Absent	PULSE: ☑ Present ☐ Absent	SKIN: ☑ Warn ☐ Cool ☐ Hot
☐ ETT ____ ☐ ____	TRACHEA: ☐ Midline ☐ Deviated [L][R]	BLEEDING: [Y] [N] (Y marked)	☐ Pink ☐ Pale ☐ Cyanotic ☐ ____
☐ Secretions ____	CHEST SYMMETRY: [L] >=< [R]	HEART TONES: ☐ Clear ☐ Muffled	☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY	HEAD	HEART	ABDOMEN
GCS: E ____	PUPILS: ☑ Equal ☐ Fixed ☑ React ☐ Dilated [L][R]	RHYTHM: ☑ Regular ☐ ____	☑ Soft ☐ Rigid ☑ Non-Tender
15 V ____	TM: ☑ Clear ☐ Blood [L][R]	PULSES: ☑ Central ☑ Peripheral	☐ Tender:
M ____	**NECK**	**LUNGS**	**PELVIS**
SPHINCTER TONE: ☑ WNL	C-Spine Tenderness: ∅ [Y][N] (N marked)	BREATH SOUNDS: ☑ Bilat ☑ Equal ☑ Clear	☑ Stable ☐ Unstable ☐ ____
	Pain @ ____	Decreased [L][R] Absent [L][R]	Blood at meatus/vagina: [Y][N] (N marked)
☐ None	JVD: [Y][N] (N marked)	☑ Wheezes [L][R] Crackles [L][R]	Heme +/- Prostate: ☑ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound (circled)

GSW GSW

VASCULAR ASSESSMENT

++ Strong | Palpable | D Dopler

RN: [redacted]
PHYSICIAN: [redacted]

(Continue on reverse)

PREPARED BY *(Signature & Title)*: [redacted] b(6)-2
DEPARTMENT/SERVICE/CLINIC: FMT
DATE: 8 Nov 03

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

SJ [redacted]
31 y/o b(6)-4

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

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: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT b(6)-2

		TIME: 1200 INITIALS:	TIME: INITIALS:
NEURO	PUPILS	3mm PERL	
	SENSORIUM	alert	
	EXTREMITY MOVEMENT	limitation to (B) thighs	
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	~~HR 123~~ RR 16	
	BREATH SOUNDS	CTA	
	SECRETIONS	non productive cough noted	
	O2 SOURCE/FLOW/SAO2		
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	HR 123	
	CAPILLARY REFILL	+ ≤3sec refill	
	PULSES	(+) pulses	
	EDEMA	(-)	
GI	ABDOMEN	firm & nondistended	
	BOWEL SOUNDS	(+) Bowel sounds Q4 quadrant	
	BOWEL MOVEMENT	1 stool in OR this AM	
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	FC to BS	
	COLOR/CLARITY	pale yellow	
SKIN	COLOR	normal for race	
	INTEGRITY	GSW to buttock + (B) thighs	
		Dsg to thighs + buttock	
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis (R) SC	
	DRESSING CONDITION	Changed this AM	
	IV FLUID/RATE	D5 ē 20 MEQ KCL @ 125cc/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE

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

NAME: RANK: AGE:

UNIT: GENDER:

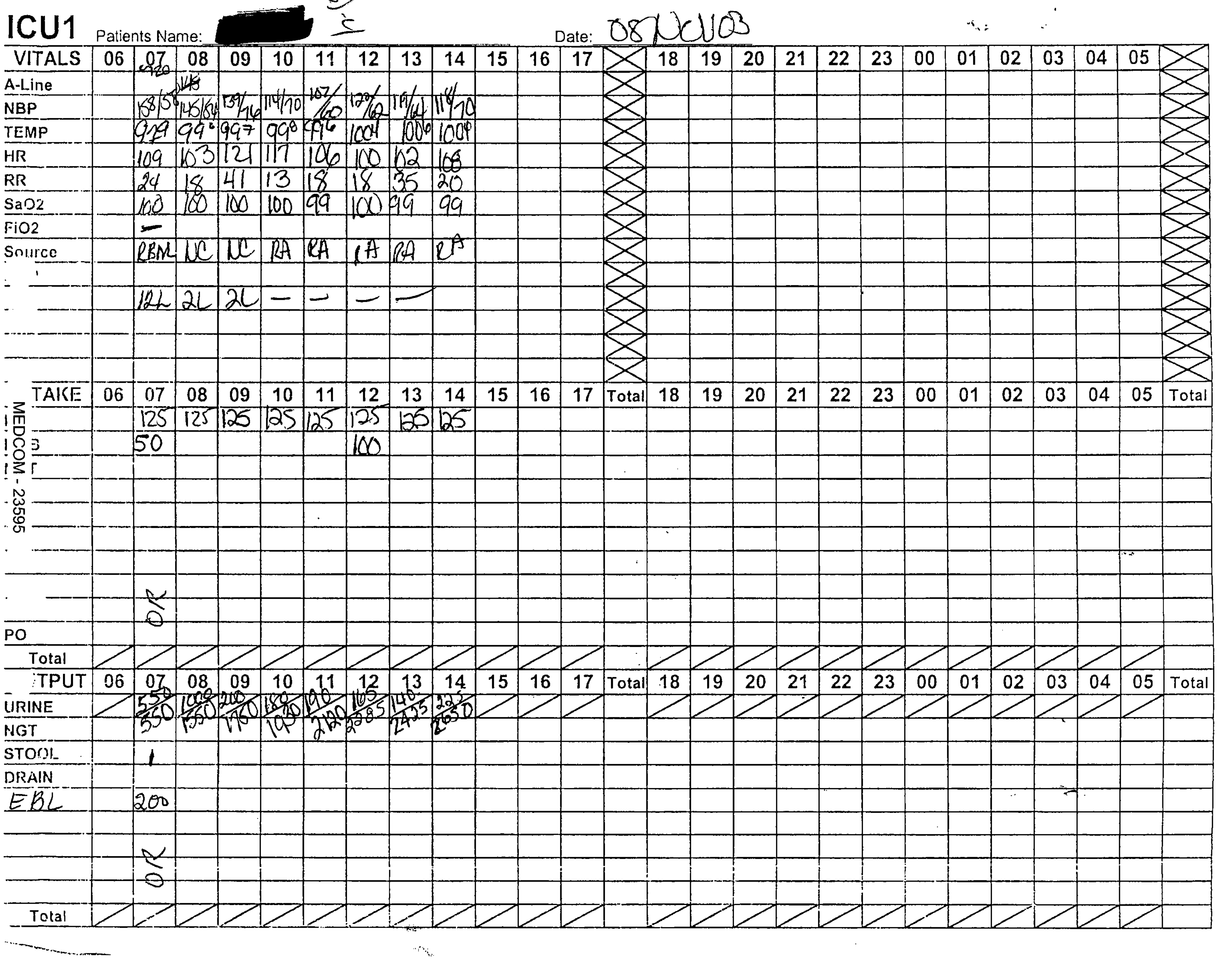
STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

MEDCOM - 23594

USAPPC V2.00



ICU1 Patients Name: [redacted] (b)(6)-4 Date: 08 Oct 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line		0720	1145																							
NBP		158/58	145/64	139/76	114/70	107/60	120/62	119/64	118/70																	
TEMP		979	99°	997	998	996	1004	1006	1009																	
HR		109	103	121	117	106	100	102	108																	
RR		24	18	41	13	18	18	35	20																	
SaO2		100	100	100	100	99	100	99	99																	
FiO2		—																								
Source		RBM	NC	NC	RA	RA	RA	RA	RA																	
		12L	2L	2L	—	—	—	—																		

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
		125	125	125	125	125	125	125	125																	
		50					100																			
		OR																								
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		550/550	1000/1550	200/1760	180/1930	190/2120	165/2285	140/2425	225/2650																	
NGT																										
STOOL		1																								
DRAIN																										
EBL		200																								
		OR																								
Total																										

MEDCOM - 23595

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

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

Date: 11/09/03
Time In: 1310
Allergies:
Pre-op V/S: 125 / 18 / 112
Procedures: I&D of both [illegible] legs & buttocks s/p GSW to thighs and buttocks

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 Colloid Ø
OR Output: UOP ______ EBL Ø
Meds/Times: Fentanyl 150 mcg. 1400 40 mg.

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

Pre Op Meds ______ History ______

Time	1310	1320	1325	1335	1350	1400	1412	1430
SaO2	100	97	98	98	96	97	93	95
FiO2	40	\	10L	[illegible]	[illegible]	[illegible]	\	\
Methods	RM	NC	FM	FM	FM	FM	RA	RA
BP (SBP plotted)	142	133	137	134	120	112	122	105
Pulse (plotted)	71	66	75	78	66	65	71	60
Hr	141	135	122	115	119	123	123	125
RR	14	12	10	12	16	16	15	16
T								

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

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1310	RL	250	TL(L) [illegible]	IV	250
1350	RL	1000	TL(L) [illegible]	IV	50

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	1	1	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.	9	9	10

Codes

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

V/S
X = A-line BP
ˆ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*: b(6)-2 ____ SWT

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/09/03

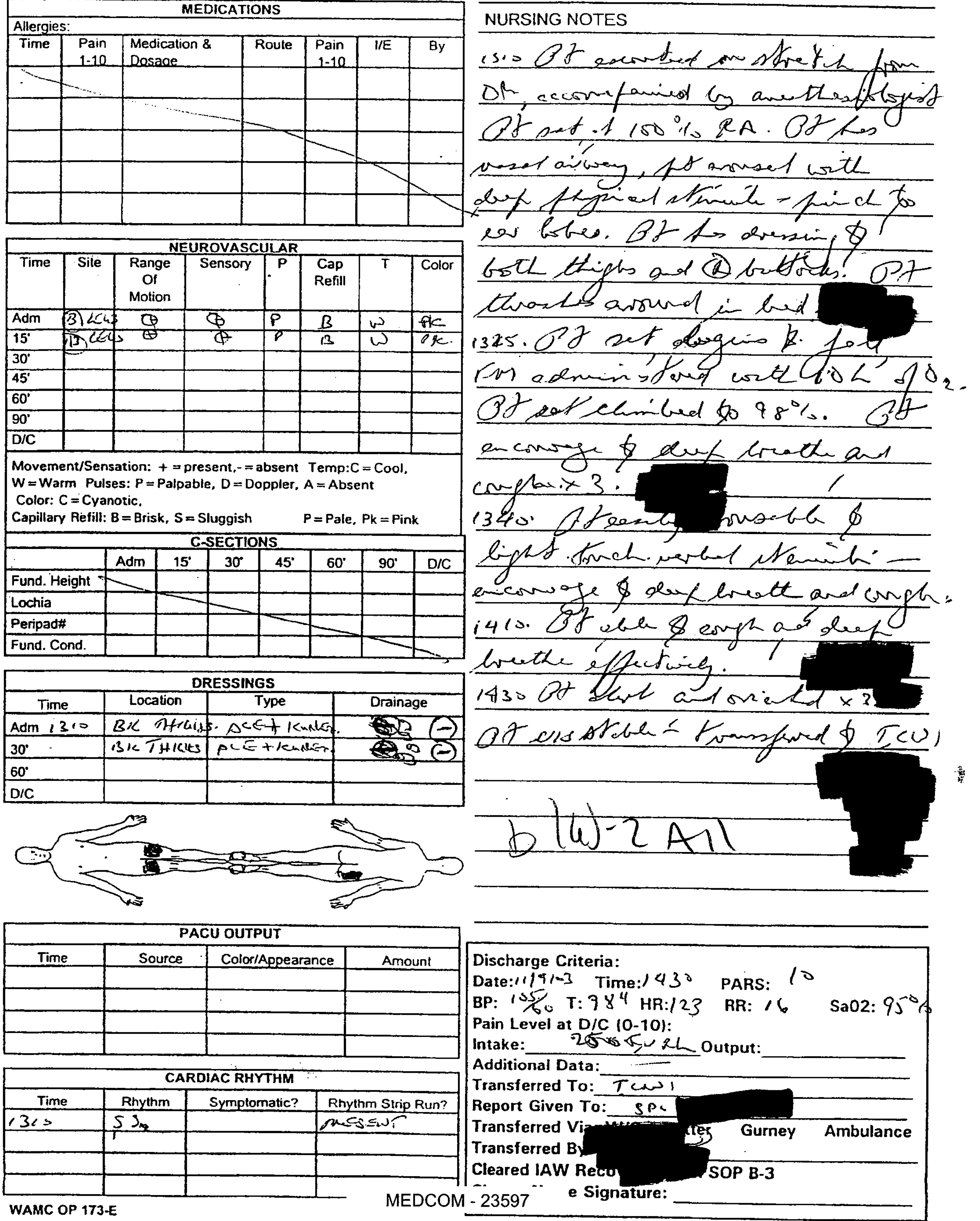
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade; hospital or medical facility)*

EPW ____ 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

MEDCOM - 23596



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	(B) LEGS	⊕	⊕	P	B	W	PK
15'	(B) LEGS	⊕	⊕	P	B	W	PK
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 1310	BK THIGHS	ACE + KERLIX	(−)
30'	BK THIGHS	ACE + KERLIX	(−)
60'			
D/C			

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1315	S Tach		PRESENT

WAMC OP 173-E

NURSING NOTES

1310 Pt escorted on stretcher from OR, accompanied by anesthesiologist. Pt sat. @ 100% RA. Pt has nasal airway, pt aroused with deep physical stimuli - pinch to ear lobes. Pt has dressing to both thighs and (R) buttocks. Pt thrashes around in bed [redacted]

1325. Pt sat dropping to [illegible] [illegible] administered with 10L of O_2. Pt sat climbed to 98%. Pt encourage to deep breathe and cough x3. [redacted]

1340. Pt easily [redacted] arousable to light touch, verbal stimuli - encourage to deep breathe and cough.

1410. Pt able to cough and deep breathe effectively. [redacted]

1430 Pt alert and oriented x3 [redacted]

Pt VSS stable, transferred to TCU

[redacted]

D/W-2 A11

Discharge Criteria:
Date: 11/9/03 Time: 1430 PARS: 10
BP: 135/60 T: 98.4 HR: 123 RR: 16 Sa02: 95%
Pain Level at D/C (0-10):
Intake: 2500 [illegible] Output:
Additional Data:
Transferred To: TCU
Report Given To: SPC [redacted]
Transferred Vi[redacted]ter Gurney Ambulance
Transferred By [redacted]
Cleared IAW Reco[redacted] SOP B-3
[illegible] e Signature:

MEDCOM - 23597

ACLU-RDI 1681 p.157

DOD-037175

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: 11 NOV 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1340

Allergies: NKDA OR Intake: Crystalloid 2400 Colloid

Pre-op V/S: 131/75 120 OR Output: UOP 400 EBL 20

Procedures: I+D w/ washout Meds/Times: MS04, fentanyl
b/l extremities Rectum

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1345	1347	1360	1355	1410
SaO2	98	88	96	94	93
FiO2		16	10		
Methods		A	M		
RR	14	18	22	22	22
T	37				

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1340	LR	600	L SC	OR	400

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	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	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.	6	8	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

(Continue on reverse)

PRE[redacted] LPN b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 11 Nov 03

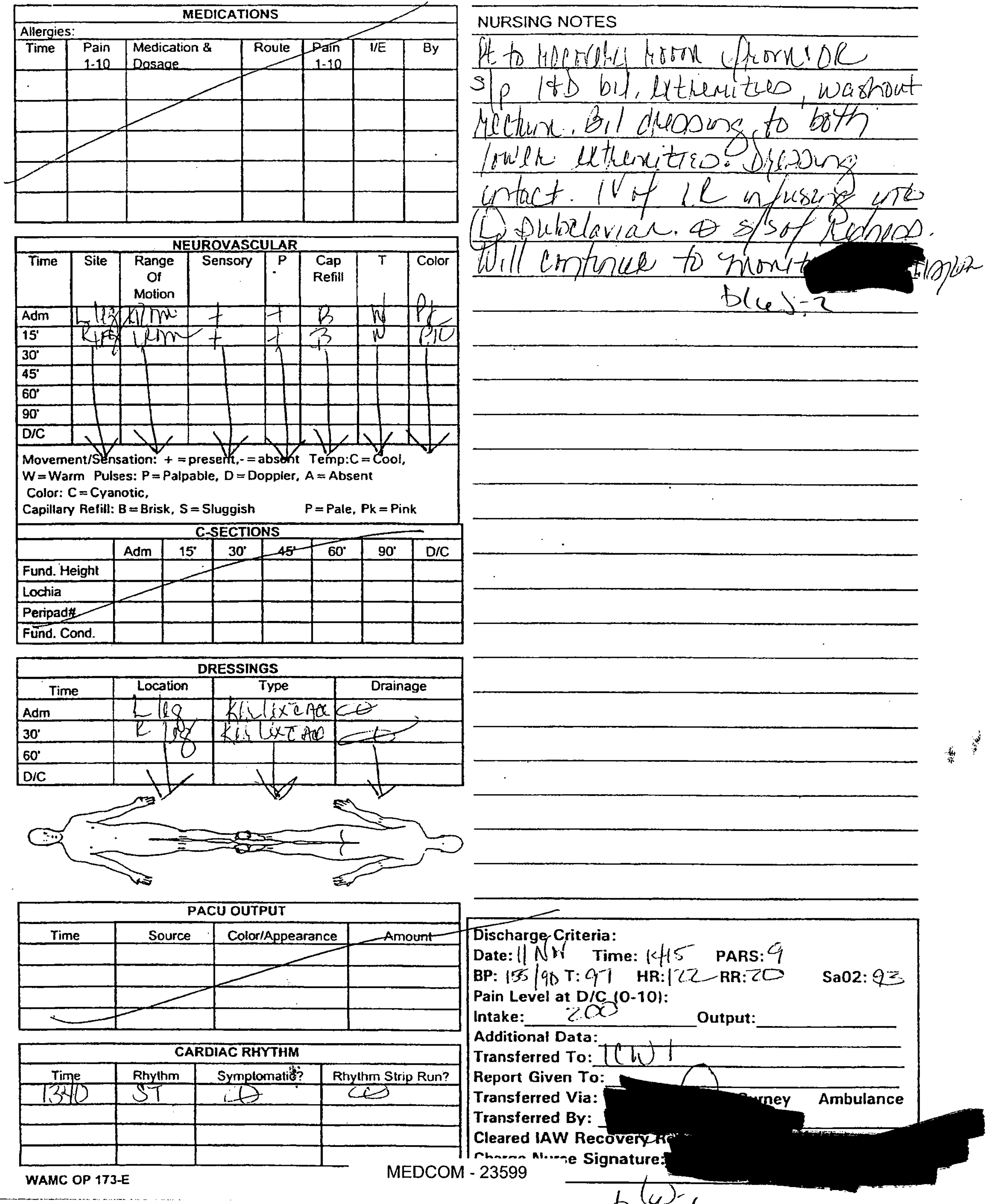
P[redacted] written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

#[redacted] b(6)-4

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

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

MEDCOM - 23598



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	L leg	ROM	+	+	B	W	Pk
15'	R leg	ROM	+	+	B	W	P/C
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	Kerlix/ace	⊖
30'	R leg	Kerlix/ace	⊖
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1340	ST	⊖	⊖

NURSING NOTES

Pt to recovery room from OR s/p I&D bil. extremities, washout [illegible]. Bil dressing to both lower extremities. Dressing intact. IV of LR infusing into (L) subclavian. ⊖ s/s of redness. Will continue to monitor. [illegible]

Discharge Criteria:
Date: 11 Nov Time: 1415 PARS: 9
BP: 155/90 T: 97 HR: 122 RR: 20 Sa02: 93
Pain Level at D/C (0-10):
Intake: 200 Output:
Additional Data:
Transferred To: ICW 1
Report Given To:
Transferred Via: ...rney Ambulance
Transferred By:
Cleared IAW Recovery R...
Charge Nurse Signature:

WAMC OP 173-E MEDCOM - 23599

ACLU-RDI 1681 p.159

DOD-037177

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM — ENEMY WIA

RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPN | RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M | NATIONALITY / NATIONALITÉ

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK ARRIÈRE

- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

GSW
(2) buttocks

4. LEVEL OF CONSCIOUSNESS NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- [ ] VERBAL RESPONSE / RÉPONSE VERBALE
- [ ] PAIN RESPONSE / RÉPONSE A LA DOULEUR
- [ ] UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT [ ] NO / NON [ ] YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE [ ] NO / NON [ ] YES / OUI | DOSE / DOSE | TIME / HEURE | 8. IV / IV 1000 | TIME / HEURE

9. TREATMENT OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

120, 112/70, 20
A - patent B 20, CTA (B)
C 112/70, 120 distal pulses +2
D A+O

10. DISPOSITION / DISPOSITION

- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ
- [ ] DECEASED / DÉCÉDÉ

TIME / HEURE: 0200

11. PROVIDER / UNIT / OFFICIER MÉDICAL [redacted]

DATE (YYMMDD): 11/18

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

blu) - 2

MEDCOM - 23600

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A					

2. MTF LOCATION (State or Country Code.)

7	8

3. REGISTER NUMBER

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial) b(6)-2

4. PAY GRADE

16	17

5. SEX

18
m

6. DATE OF BIRTH (YYYYMMDD)

19	20	21	22	23	24	25	26
1	9	7	1	0	1	0	1

7. AGE AT ADMISSION

27	28	29

8. RACE

30

9. ETHNIC BACKGROUND

31

RELIGION

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
0	0	0	0	0	1	2	4	3

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (YYYYMMDD)

81	82	83	84	85	86	87	88
2	0	0	3	1	2	1	7

24. CLINIC SVC - ADMITTING

89	90	91	92

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION (YYYYMMDD)

99	100	101	102	103	104	105	106
2	0	0	3	1	1	0	8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

107	108

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION (YYYYMMDD)

115	116	117	118	119	120	121	122

FOR LOCAL USE

Dx: 8770
8900
E9912

Pro: 8659 (2)
8628
8345
4524
4921
8801
9904 (2)
8962

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

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

MEDCOM - 23601

Admission and Coding Information

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

1. Reporting MTF b(2)-2 | 2. MTF Location: IZ

3. Register Number | Name (Last, First, MI) b(6)-4 | 4. Pay Grade: FGN | 5. Sex: M

6. DoB (YYYYMMDD): 1971-01-01 | 7. Age at Admission: 32Y | 8. Race: X | 9. Ethnicity: 9 | Religion

10. Length of Service: ETS | 11. FMP: 99 | 12. Social Security Number

Organization (Active Duty Only) | 13. Marital Status | Hour of Admission: 03:00 | Branch / Corps:

14. Flying Status | 15. Beneficiary Category: K78-PRISONER OF WAR/INTERNEES | 16. Zip Code of Residence:

17. Unit Location | 18. MOS | 19. Trauma: BC | Prev. Admission: NO

20. Source of Admission: Direct from ER | Ward: ICW1 | Name / Relationship of Emergency Addressee

Address of Emergency Addressee

Telephone Number of Emergency Addressee

Name and Location of Medical Treatment Facility: b(2)-2

21. Type of Disposition: TRF-OTH | 22. MTF Transferred To | 23. Date of Disposition (YYYYMMDD): 2003-12-17

24. Clinic Svc - Admitting: ABA - GENERAL SURGERY | 25. MTF Transferred From | 26. Date this Admission (YYYYMMDD): 2003-11-08

27. Location of Occurrence: IZ | 28. MTF of Initial Admission | 29. Date of Initial Admission: 2003-11-08

FOR LOCAL USE

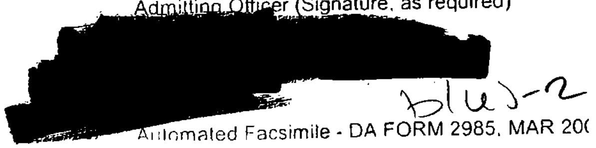
Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW L BUTTOCKS AND THIGHS

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required) | Signature of Admitting Clerk



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

Automated Facsimile - DA FORM 2985, MAR 200 | MEDCOM - 23602

'Automated Facsimile

...PATIENT TREATMENT RECO... ...COVER SHEET

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

Field	Value
1. Register Nbr	[redacted]
2. Name	[redacted] b(6)-4
3. Grade	FGN
4. Sex	M
5. Age	27Y
6. Race	X
7. Religion	
8. LnthOfSvc	
9. ETS	
10. PrevAdm	NO
11. FMP	20
12. SSN	[redacted]
13. Organization	
14. Ward	ICW1
15. FlyStatus	
17. Dept / Ben	K78-PRISONER OF WAR/INTER
18. BranchCorps	
19. UIC / ZIP	
20. Type Case	DIS
21. Source of Admission	Direct from ER
22. Hour Of Adm:	10:35
23. Clinic Service	ABD - NEUROSURGERY
24. Name/Relation of Emergency Addressee	
25. Type Disp	TRF-OTH
26. Date of Disp	2003-11-~~14~~ 13
27a. Address of Emergency Addressee	
27b. Telephone No	
28. Date This Adm:	2003-11-~~14~~ 8
AdmittingOfficer:	[redacted] b(6)-2
29. ReportingMTF	[redacted] b(2)-2
30. Date Init Adm	2003-11-~~14~~ 8
32. Units Blood Components	
Admission Remarks	

31. Selected Administrative Data

Marital Status:

DoB: 1976-08-19

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L FACAIL HEMOTOMA, L SHOULD SHRAPNEL,R HIP SHRAPNEL

873.41
880.10
890.0
877.0
E993

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	0	0

S[redacted] b(6)-2

Signature of PAD or Medical Records Officer [redacted] b(6)-2

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 23603

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

39 yo ♂ EPW S/P IED explosion and sustained shrapnel injuries to left cheek, left shoulder and right hip.

PMH
PSH
aller
meds
} denies

CV: RRR
Lungs: CTA (B)
Abd: soft NT ND (+) BS
Ext: (L) shoulder shrapnel wounds
(R) hip shrapnel wounds

Xrays
(+) shrapnel
- L face
- L shoulder

PHYSICAL EXAMINATION

HEENT A/O x3 mod distress
Perrl EOMI
(-) palpable facial/mand fx's
nares patent
TM's clear (B)
(+) trismus
(L) cheek hematoma (-) active bleeding
neck supple

CT scan
(+) shrapnel
(L) face c̄ free air + hematoma
(L) shoulder c̄ shrapnel

Consults
OMFS
Neuro sx
ortho

PROGRESS (Enter date of discharge and final diagnosis)

A/P S/P IED c̄ shrapnel wounds to (L) cheek, left shoulder + (R) hip
1. Admit for obs
2. consider evac of hematoma

SIG [redacted] b(6)-2 | DATE 8 NOV 03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT 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

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

MEDCOM - 23604

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 NOV 03 1506	VSS. AO. Received from [illegible] @ 1505 c PERRLA. HRR LSCTAB. BS(+)x4. c/o pain to (R) hip: DSG CDI to large laceration from injury & to (L) shoulder laceration. Severe weakness to (L) arm from shoulder to distal carpals. Weakened grip @ (L) hand. CMS intact. Severe hematoma to (L) mandible region. Cleared by MD & CT scan. Able to tolerate PO. Voiding bright yellow urine @ this time, BS. (+) pulses to extremities. Started IV AB per orders. Resting in bed. [redacted] b(6)-2
8 NOV 03 2200	VSS A&O, HRRR, LSCTA(B), (+)BS x4 quads. c/o pain. MSO4 administered. (R) side of face edematous due to shrapnel. (L) shoulder c puncture wound. Drsg D/I wound actively bleeding ~~when~~ when old Drsg removed. Drsg to (R) hip Δ. small puncture wound. W→D. (+) Pulses in all extremities. (L) hand weaker than ~~Left~~ Right. Skin warm e Dry to palpation. Cap refil [redacted]. Will continue to monitor — b(6)-2 [redacted] 91WM6
9 NOV 03 (1200)	Pt a/o, VSS, c/o pain earlier to (L) shoulder. 2 mg MSO4 given c noted relief. Drsgs D/I. to (L) shoulder & (R) hip. minimal drainage (bloody). Pt c/o pain to (L) hip, redness noted. Will notify MD. (L) side of face edematous. limited ROM to (L) arm/shoulder d/t pain. Pt NPO for OR today. NS @ 125cc/° to (R) AC s s/sx infection/infiltration. 2 pt restraints on s compromise to skin/circulation. Will monitor [redacted] 91WM6

[redacted] b(6)-4

MEDCOM - 23605

b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10NOV03 Q300	[redacted] Assumed care of Pt @ 1800. A&O, c/o Pain MSO4 administered. LSCTA (B) HRRR (+) BS x4 quads. Drsg to (L) Anterior Shoulder Δ'd. [redacted] No Drainage noted from wound. Drsg to (R) Hip Δ'd. moderate amount of Sero Sang Drainage to old Drsg noted. Will cont. to monitor. b(6)-2 [redacted] SPC 91W/M6
10 NOV (1200)	Pt a/o, VSS, c/o pain to (L) shoulder & arm. drsg (2x2) applied to shoulder c̄ scant amt drainage. (R) hip c̄ minimal bloody drainage (duoderm noted in wound) + no order to remove duoderm). Will discuss c̄ MD when avail. Pt c̄ c/o pain to (L) hip also (redness noted). ambulating to BR s̄ difficulty often. (B) cheeks appear edematous. (L) more than (R). Pt is NPO, d/T shrapnel in (L) cheek. Will notify MD of need for NPO re-eval. 2 pt restraints on while in bed s̄ compromise to skin/circulation. (R) AC IV infusing NS @ 125cc/° ⊖ edema or redness @ site. Will monitor [redacted] 91WM6 b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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. ICW#1

#[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 - 23606

MEDICAL RECORD | **PROGRE[SS N]OTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
11 Nov 03 @0107	Assumed care @1800. VSS. C/o pain to (R) buttocks & (L) cheek, MSO4 given c good relief noted. LSCTA, sats 98% on RA, 0 resp distress; (+) BS, tol regular clear liquids ~~well~~; voids per urinal s difficulty; ↑ amb s assistance. (R) buttocks wound, small c serosanguinous drainage, iodoform packing noted. (L) shoulder wound c sm amt serosang drng noted, dry dsg ~~[illegible]~~. New 20G IV to (L) AC, IVF's cont, can HL in AM. 2 pt restraints on s S/Sx of skin/circulation compromise. Pt ↑ amb to BR s difficulty. Plan: monitor pain, monitor dsgs, inc amb & po. Addendum: (L) jaw edematous, sm poss shrapnel wound OTA, 0 drainage, inside cheek edematous also, but 0 difficulties c breathing or swallowing, except pain c jaw movement. Will cont to monitor. [redacted]

b(6)-2

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

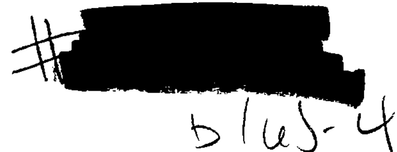
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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



b(6)-4

MEDCOM - 23607

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Nov 03	ORTHO CONSULT
	Called to eval (L) Shoulder Pain. Pt has shrapnel wound (@)
	(L) Posterior lateral deltoid region. Has h/o GSW to same shoulder
	from Iran-Iraq war. Previously shoulder was pain free c̄ full
	function.
	PE: Entrance wound post shoulder with slight swelling around
	wound. Minimal TTP in region of wound. Non-tender at
	anterior shoulder.
	FFlex 120 active, 180 passive
	ER 45 active 45 passive
	IR L_2 active
	Rot cuff 4/5 strength. (-) Drop Arm Test.
	Xray - AP Shoulder. Shrapnel at lateral margin of humerus.
	Imp: Deltoid muscle injury. No evid. of interarticular injury
	or rotator cuff tear.
	Plan: Encourage shoulder use and ROM. No intervention required.
	b(6)-2
	[redacted] , PANTEL
	ORTHO
	Addendum:
	Evaluated shrapnel wound (R) Buttock. Wound clean.
	Instructed nursing staff to do daily wet -> dry dressing Δ's
	[redacted]
	ORTHO

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11NOV03	(CONT) Voiding s difficulty. IV HL'd in (R) AC, flushes well. IV Abx cont. 2pt restraints MS S/SX of skin/circulation compromise. Plan: cont IV Abx, monitor drsgs, pain control.
12 NOV 03 1220	VSS. AO. [illegible] c/o HA this afternoon and provided [illegible]. Ambulated well to shower this AM and performed self care. DSG [illegible] to (R) hip WTD s difficulty or c/o pain. ∅ s/s infection to wound site. Moderate amount of [illegible] drainage noted. ∅ odor. IV started @ (R) AC region and HLIV. (L) shoulder wounds OTA. Voiding light yellow urine, [illegible]
12NOV03 @2215	assumed care of pt @1800. VSS. No c/o pain. (R) hip drsg AO serosang drainage noted on drsg, wound packed c moist 2x2, erythemic around wound entrance, can still palpate shrapnel (?) approx 2in away from wound toward groin. (L) shoulder wound OTA, (L) cheek wound OTA, both c old drainage noted. Tol mech soft diet s difficulties; void per urinal s difficulty. IV Abx cont. Plan: pain control, IV Abx, monitor drsg. 2pt restraints MS S/SX of skin/circulation compromise.
13 NOV 03 1230	VSS. AO. WTD DSG [illegible] s c/o pain. ∅ c/o HA, SOB or dizziness. Ambulated on own to [illegible]. Transported to EPW comp.

b(6)-2 A11

STANDARD FORM 509 (REV. 5/1999) E
USAPA

MEDCOM - 23609

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(6)-2
11 NOV 1330	Pt a/o, VSS, c/o pain to (L) shoulder, ~~medicated~~ ERROR Pt fell asleep before able to be medicated. Drs to (L) shoulder s'd, ø drainage, drsg to (R) hip c minimal sero-sang drainage (iodoform removed). repacked loosely c gauze (moist) & applied 4x4. IV HL'd, Tol PO fluids well. cont. clear liquid diet s difficulty. (L) cheek edema ↓ slightly. Pt able to move arm & shoulder (causes pain) with encouragement. voiding qs via urinal, had BM x1, ambulated x3 today. Ancef cont per orders. Will monitor b(6)-2 [redacted] 91WM6
11NOV03 @2230	assumed care of pt @1800. VSS. c/o pain, medicated c percocets c good relief noted. (L) shoulder wound OTA, limited ROM to (L) shoulder & arm. (R) buttocks wound approx 3.0cm x 3.0 cm, approx 3.5cm deep, packed c moist gauze; sm amt of drainage noted from old drsg. approx 3 inches from wound skin is erythemic & warm, small hard "knot" area felt. Will notify MD. (L) cheek shrapnel wound OTA, old drainage noted, ↓ edema noted, cont c/o pain c swallowing/opening mouth. Diet advanced to regular diet as tolerated. (CONT)
head — legs (R) side	

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID (SSN) [redacted] 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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

[redacted]
b(6)-4

MEDCOM - 23610

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Nov-03	ORTHO CONSULT
	Called to eval (L) Shoulder Pain. Pt has shrapnel wound @
	(L) Posterior lateral deltoid region. Has h/o GSW to same shoulder
	from Iran-Iraq war. Previously shoulder was pain free c̄ full
	function.
	PE: Entrance wound post shoulder with slight swelling around
	wound. Minimal TTP in region of wound. Non-tender at
	anterior shoulder.
	FFlex 120 active, 180 passive
	ER 45 active 45 passive
	IR L2 active
	Rot cuff 4/5 strength. (−) Drop Arm Test.
	Xray - AP Shoulder. Shrapnel at lateral margin of humerus.
	Imp: Deltoid muscle injury. No evid. of interarticular injury
	or rotator cuff tear.
	Plan: Encourage shoulder use and ROM. No intervention required
	ORTHO b(6)-2
	Addendum:
	Evaluated shrapnel wound (R) Buttock. Wound clean.
	Instructed nursing staff to do daily wet → dry dressing Δ's
	ORTHO

STANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1

MEDCOM - 23611

ACLU-RDI 1681 p.171

DOD-037189

MEDICAL RECORD | **PROGRESS NOTES**

AUTHOR[redacted] REPRODUCTION

DATE	NOTES
11/11/03	Neurosurgery
1830	Pt. continues to improve. Tolerated clear liquids.
	Notes decreased trismus and able to open mouth.
	Tongue is midline w/ projection & nasolabial fold
	mild flattening likely related to edema
	(L) angle of jaw edema decreased.
	Swelling progressively reduced over past 48°
	A/P Conservative management as long as remain
	AFEB & ↓ swelling.
	[redacted] b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	OMFS eval
8 NOV 03	Called to eval an 39 y/o Iraqi male
@ 1129	S/P IED c̄ shoulder shrapnel
	and left cheek shrapnel c̄
	left cheek hematoma.
	PMH:
	PSH: } Denies
	MEDS:
	Aller:
hematoma	HEENT: NC Perrl, EOMI
	∅ palpable facial steps or crepitus
	nares patent (B)
	TM's clear (B)
	max + mand stable c̄ trismus
	(L) cheek / angle hematoma
	Plain films shows a piece of shrapnel
	in soft tissue of left cheek.

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

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

REGISTER NO. | WARD NO.

b(6)-4

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

MEDCOM - 23613

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	CT scan:
	shows shrapnel in anterior
	left cheek.
	free air and hematoma collection
	in left cheek.
	∅ disruption of carotid vessels
	per CT scan.
	neurosurgery consult c̄ Dr. [redacted]
	recommends no neurosx tx
	@ this time and recommends
	delayed tx of hematoma once
	more solidified
A/P	S/P IED c̄ left facial shrapnel
	and hematoma
	① admit for observation + IV Abx.
	② will consider evacuation of
	hematoma @ later date.
	[redacted] MAJ/DC
	b(6)-2 OMFS

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 23614

ACLU-RDI 1681 p.174

DOD-037192

b(2)-c

NSN 7540-01-075-3786

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

LOG NUMBER: TR[redacted]

RECORDS MAINTAINED AT:

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS:

CITY: | STATE: | ZIP CODE:

ARRIVAL — DATE (Day, Month, Year): 8 NOV 03 | TIME: 1030

TRANSPORTATION TO FACILITY: Air

SEX: M

AGE: 39

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM: Pt.

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY:

CURRENT MEDICATIONS: Ancef - [illegible] - field

ALLEGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

HOW:

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

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

CHIEF COMPLAINT: shrapnel injuries / Fb's fragments — Ø past Med Hx

CATEGORY OF TREATMENT: ☐ EMERGENT ☒ URGENT ☐ NON-URGENT

TIME: 1025

INITIALS: [illegible]

VITAL SIGNS

TIME	1025	1040	1100		
BP	154/85	140/97	124/81		
PULSE	105	93	109		
RESP	19	20	18		
TEMP	98.7	98.8			
WT	100%	100%	98%		

LAB ORDERS: (CBC/DIFF) | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT | URINE C&S | (UA) MSCC/CATH | CHEM: 12 c lytes | BLOOD C&S X

X-RAY ORDERS: (CXR PA & LAT/PORTABLE) | ACUTE ABDOMEN | SINUS | ANKLE R/L — (L) [illegible] | C-SPINE | LS SPINE | HEAD CT

ORDERS

☒ PULSE OX 100% | ☒ MONITOR | ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1105	Morphine 5mg	[redacted]	b(6)-2		
1100	2L bolus LR	[redacted]			
1100	Td .5cc IM	[redacted]			

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 ☐ DETERIORATE

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN BY PROVIDER: [illegible]

TEST RESULTS

CBC		SMAC	
WBC	9.5	139 / 100 / 7	157
H/H	10.6 / 35.5	4.8 / 23 / 1.7	
PLT			
PT			
APTT		BHCG	ETOH	GLU

ABG/PULSE OX		
SUP 02	PH	PO2
PCO2	SAT	OTHER
U/A DIP		
U/A MICRO		

RADIOLOGY	Check if read by radiologist ☐
RESULTS	[crossed out]
EKG INTERPRETATION	

PROVIDER HISTORY/PHYSICAL

39 y/o M shrapnel injuries ∅ respiratory distress to Lt side of the face, Rt buttocks & Lt arm.

∅ CP/SOB

Ancef given PTA @ 0935 c/o (L) shoulder pain

PMH NL
PSH (L) arm

O: A&O x4 [illegible], VSS
Head: atraumatic, neck: supple, NT Face: ⊕ lg hematoma (L) face, ⊕ wound @ (L) mand angle, ∅ palpable [illegible]
[illegible]
Chest: CTA (B), full symmetric breaths
CV: RRR ∅ 4 b/t
Abd: ⊕ BS, NT Back: ⊕ shrapnel wound
Ext: ⊕ GSW post (L) shoulder ↓ ROM 2° pain, ∅ active bleed

Xray:
⊕ shrapnel (L) face
⊕ shrapnel (L) hip superficial

A/P (1) Admit Abx / obs / OMF c/s

CONSULT WITH	TIME	ACTION
OMF		
Surgery		

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted]

PROVIDER SIGNATURE A[redacted]

DIAGNOSIS (1) (L) face shrapnel c lg hematoma
(2) (L) shoulder shrapnel, stable
(3) (R) superficial hip soft tissue shrapnel

CODES b(6)-2

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

b(6)-2 [redacted]

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

MEDCOM - 23616

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD | PROGRESS NOTES

Admission Date: 11-8-03 Diagnosis: (L) Shoulder Shrapnel / Facial Hematoma / (R) Hip Shrapnel HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	Mobility	No limitations	4
	Slightly limited	3		Slightly limited	(3)
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	(4)	Nutrition	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	(1) (NPO X3days)
Activity	Walks frequently	(4)	Friction and Shear	No apparent problem	(3)
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Add the total score

Total Score (19)

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates HIGH RISK --Requires immediate Ulcer prevention program.

(Shrapnel)
Surgical wound (s): (Yes) No Location: (L) shoulder / (R) HIP Size: 2cm (each) Drainage: min. bloody
Tubes: Ø Appearance: red, healthy tissue.
Dressing change: dry drsg applied BID

Pressure Ulcer (s): Yes (No)
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:______ Size:______
Wound character: Pint______ Moist______ Dry______ Granulation tissue______ Yellow slough______
Odor______ Purulent discharge______ Eschar______ Exudates______

Type of dressing change: Wet-to-dry______ Comfeel dressing______ Carrasyn V-Gel______ Alginate______

Physician notified/consulted for wound debridement: Yes______ No______
CNS notified/consulted for Stage II and greater: Yes______ No______
Nutrition Referral: Yes______ No______
Physical Therapy Referral: Yes______ No______
Action Taken:______ Date & Time:______

REGISTER NO. | WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facilithy)

PROGRESS NOTES

Medical Record
STANDARD FORM 509

b(6)-4

#

MEDCOM - 23617

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 8 NOV 03 — DAY: 9, 9 NOV, 10, 11 NOV, 12 NOV 03, 13 NOV 03

19 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18, 22, 18, 20, 18

BLOOD PRESSURE: 124/76, 123/73, 124/75, 124/74, 116/69, 124/70, 129/70; 127/81

94, 75, 90

98%, Temp 98.5, 98.5, 96, 98

RA, 99%, 99%

97, 98%, 96%

122/74, O2 Sat (RA) 95%, (RA) 96%

98% (RA), Pulse 89, 81

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.

#[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 - 23618

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:44

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.0 sec.
Ratio = 1.1
Calculated INR = 1.25
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:42
Card Lot :080201
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:48

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:< 15 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:46
Card Lot :100208
Operator [redacted]
b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 10:50

Patient ID: [redacted]
Test Name :APTT
Test Result:= 19.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :10:48
Card Lot :100208
Operator [redacted]

ID: [redacted] 08-11-03
WB 10:36

			Patient Limits	
WBC	8.5	x10^3/uL	4.5	10.5
RBC	4.87	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	35.5	%	35.0	60.0
MCV	72.7 L	fL	80.0	99.9
MCH	21.7 L	pg	27.0	31.0
MCHC	29.9 L	g/dL	33.0	37.0
Plt	294.	x10^3/uL	150.	450.
LY%	19.2 L	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

ID: 001244 09-11-03
WB 06:06

			Patient Limits	
WBC	5.8	x10^3/uL	4.5	10.5
RBC	4.64	x10^6/uL	4.00	6.00
Hgb	10.2 L	g/dL	11.0	18.0
Hct	33.9 L	%	35.0	60.0
MCV	73.1 L	fL	80.0	99.9
MCH	22.0 L	pg	27.0	31.0
MCHC	30.1 L	g/dL	33.0	37.0
Plt	269.	x10^3/uL	150.	450.
LY%	34.8	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

i-STAT EG6+

Pt: [redacted]
Pt Name:___________

Na_________138 mmol/L
K__________4.3 mmol/L
TCO2________28 mmol/L
Hct_________37 %PCV
Hb*_________13 g/dL
*via Hct

At 37C
______ ...32
PCO2______47.0 mmHg
PO2_________31 mmHg
HCO3________26 mmol/L
BEecf________1 mmol/L
sO2*________55 %
*calculated

Sample Type_:

08NOV03 10:56

Oper: 0

Physician:_____________

Ser# 42011
Ver: JAMS046A
CLEW A93

Ward/Section: TCW 1	REQUESTING PHYSICIAN:	L[illegible]ORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE 9 Nov	TIME 0500	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative

(Hematology) Manual Differential				Urinalysis (cont.)			Microbiology (cont.)	
				pH		N/A	Micro Parasites	
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23620

b(6)-2

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

LAST, FIRST, MI. 1244 | DATE 8 Nov 03 | TIME 1030 | SSN: [redacted] b(6)-4

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

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative

```
======= PICCOLO =======
08/11/03            10:39
REFERENCE RANGE:
PATIENT #: [redacted]    MALE
METLYTE 8
DISC LOT #:           3151AA4
OPER #: [redacted]       DR #: 000
SERIAL #:          0000100494
..............................
GLU    157*   73-118   MG/DL
BUN    7      7-22     MG/DL
CRE    1.7*   0.6-1.2  MG/DL
CK     163    39-380   U/L
NA+    129    128-145  MMOL/L
K+     4.8*   3.3-4.7  MMOL/L
CL-    100    98-108   MMOL/L
tCO2   21     18-33    MMOL/L

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

b(6)-4 b(6)-2

NA - 138
CO2 - 28

CSF

Cell Count		
Directigen		Negati

Blood B (MUST SUBMIT SF 5

UNIT			

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

REMARKS:

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

MEDCOM - 23621

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

Ward/Section:	REQUESTING PHYSICIAN:	

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
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

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

scull series
~~C-spine~~
pelvis
Rt shoulder/Rt humerus
Rt hand
Rt arm

AGE | SEX | SSN (Sponsor) | WARD/CLINIC: EMT | REGISTER NO.

FILM NO.

b(6)-2

REQUESTED BY

PREGNANT: [ ] YES

TELEPHONE

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

39 y/o ♂ → shrapnel injuries

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
8 Nov 03		

RADIOLOGIC REPORT

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

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — RADIOLOGY

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

MEDCOM - 23623

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 NOV 03 TIME OF ORDER: @ 1239 HOURS

LIST TIME ORDER NOTED AND SIGN: b(6)-2

1. Admit to ICW 1 - Dr
2. Dx: Left facial hematoma
   Left shoulder shrapnel
   Right hip shrapnel
3. Cond: Stable
4. Vitals: Per Routine

PATIENT IDENTIFICATION

b(6)-2 Noted 08 NOV 03 1340

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

5. aller: NKDA
6. activ: Ad lib
7. Nurs: HOB ↑ 30°
8. Diet: Soft diet
9. IV: NS @ 125 cc/hr and heplock when taking PO
10. meds: Ancef 1gm IV q 8°
    MsO4 2-4 mg IV q 1° prn pain
    Tylenol 650 mg PO q 4° prn temp >101
11. Labs CBC in Am (9 NOV 03)
12. Dressing Δ's to Ⓛ Shoulder and Ⓡ Hip BID

b(6)-2

MD/DC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 08 NOV 03 TIME OF ORDER: 1620 HOURS

NPO

V.O. Dr

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ 0500 9 NOV 03

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

MEDCOM - 23624

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b(6)-4		10 NOV 03	1630 HOURS	
		V/O: Clear liquid diet		noted
		Dr. [redacted] / SPC [redacted]		[redacted]
		b(6)-2		10 NOV 03 1630
NURSING UNIT: ICW#1 / ROOM NO.: 24° / BED NO.: 0300 [redacted]				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ______ HOURS	
# [redacted]				
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ______ HOURS	
b(6)-4 [redacted]				
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ______ HOURS	
# [redacted]				
NURSING UNIT / ROOM NO. / BED NO.				

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

MEDCOM - 23625

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

noted

b(6)-2

NURSING UNIT: 1LW#1 | ROOM NO. | BED NO.

DATE OF ORDER: 11/11/03 | TIME OF ORDER: ______ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Advance diet as tolerated

PATIENT IDENTIFICATION

noted

NURSING UNIT: LCW#1 | ROOM NO.: 24?/2130 | BED NO.

DATE OF ORDER: 11NOV03 | TIME OF ORDER: 1845 HOURS

1. D/C Morphine b(6)-2
2. Vioxx 50mg po BID.
3. Percocet 1-4 po q4-6° prn severe pain

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER: ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER: ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 23626

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. 11 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED: 08	9	10	11	12	13	14
08 NOV	[redacted]	Vitals per routine	08 18							
			18 06							
08	[redacted]	Activ. - ad lib	08 18							
			18 06							
08	[redacted]	Nurs: HOB ↑ 30°	08 18							
			18 06							
08	[redacted]	Diet - soft diet	06 18	D/C 08NOV03						
			18 06							
08	[redacted]	Drsg chg to Ⓛ shoulder	10							
		and Ⓡ hip BID	22							
08	[redacted]	NPO	06 18			D/C'd				
			18 06							
10NOV	[redacted]	Clear liquid diet	06				D/C'd 11NOV03			
			18							
11NOV	[redacted]	ADV diet as tolerated	6							
			18							

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
① FACIAL HEMATOMA
② Ⓛ SHOULDER SHRAPNEL
③ Ⓡ HIP SHRAPNEL

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

b(6)-2 A1

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 11 Yr 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Ø8 NOV	[redacted]	Admit to ICW1 - Dr. Armandz	Ø8 NovØ3	—	—	[redacted]
Ø8	[redacted]	Cond. - stable	Ø8	—	—	[redacted]
Ø8	[redacted]	Labs: CBC in am	Ø9 NovØ3	Ø600		

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

USAPA V1.00

MEDCOM - 23628

b(6)-2

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12	13	14	15
03 NOV	[redacted]	NS @ 125cc/hr and	08								
	-----	HL when taking po	18								
08	[redacted]	Ancef 1 gm IV q8°	08								
	-----		16								
	-----		24								
11 NOV	[redacted]	Vioxx 50 mg po BID	10								
	-----		22								

ALLEPGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
1) FACIAL HEMATOMA
2) SHOULDER SHRAPNEL
3) HIP SHRAPNEL

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 1 FEB 79 4678 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.
MEDCOM - 23629

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. Ø3

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		d/c'd - 2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
Ø8 NOV	[redacted]	MSO4 2-4mg IV q1° prn pain	D/T	8 Nov 0900	8 Nov 1500	Ø8 NOV 1625	8 Nov 1930	8 Nov 2230	9 Nov 1800	9 Nov 1000	10 Nov 0155	9 Nov 1700	10 Nov 0230	10 Nov 0200	10 Nov 2130	11 Nov 0250
			D/I	4 [redacted]	4	4mg	4mg	4mg	2mg	2mg	2mg	4mg	4mg	2mg	2mg	2mg
Ø8	[redacted]	Tylenol 650mg po q4° prn temp >101	D/T	12 Nov 1200												
			D/I	650 [redacted]												
8	[redacted]	MSO4 2-4mg IV q1° prn pain	D/T	11 Nov 0940	D/C'd 11 NOV 03											
			D/I	2mg BR												
11	[redacted]	Percocet i-ii po Q4-6° prn severe pain	D/T	11 Nov 2050	12 Nov 2030											
			D/I	ii po [redacted]	ii po [redacted]											

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

MEDCOM - 23630

1. LAST NAME, FIRST NAME / NOM ET PRENOM: IRAQI PRISONER
RANK / GRADE: #1244
SSN: [redacted]
SPECIALTY CODE / SEM: b(6)-4
MALE / HOMME
FEMALE / FEMME
RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ELEMENT: A/T | AF/A | N/M | MC/M
BC / BC
NATIONALITY / NATIONALITÉ
NBI / BNC
DISEASE / MALADIE
PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE

- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

SHRAPNEL INJURIES
IED

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [x] ALERT / ALERTE
- [ ] VERBAL RESPONSE / REPONSE VERBALE
- [ ] PAIN RESPONSE / RÉPONSE À LA DOULEUR
- [ ] UNRESPONSIVE / SANS REPONSE

5. PULSE / POULS: 97 | TIME / HEURE: 0900
6. TOURNIQUET / GARROT: [x] NO / NON [ ] YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: [ ] NO / NON [x] YES / OUI | DOSE / DOSE: [illegible] | TIME / HEURE | 8. IV / IV. [illegible] | TIME / HEURE: 0855

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES DEM

[redacted] b(6)-4

BP 137/87
P 97
Pulse Ox
98 RA

10. DISPOSITION / DISPOSITION

- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [ ] EVACUATED / EVACUÉ
- [ ] DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A					

2. MTF LOCATION

7	8

(State or Country Code.)

3. REGISTER NUMBER

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial)

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH (YYYYMMDD)

19	20	21	22	23	24	25	26
1	9	7	6	0	8	1	9

7. AGE AT ADMISSION

27	28	29
2	7	Y

8. RACE

30

9. ETHNIC BACKGROUND

31

RELIGION

b(6)-4

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (YYYYMMDD)

81	82	83	84	85	86	87	88
2	0	0	3	1	1	1	3

24. CLINIC SVC - ADMITTING

89	90	91	92

25. MTF TRANSFERRED FROM

93	94	95	96	97	98

26. DATE THIS ADMISSION (YYYYMMDD)

99	100	101	102	103	104	105	106
2	0	0	3	1	1	0	8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

107	108

28. MTF OF INITIAL ADMISSION

109	110	111	112	113	114

29. DATE INITIAL ADMISSION (YYYYMMDD)

115	116	117	118	119	120	121	122

FOR LOCAL USE

Dx: 88010
8901
87351
920
E9919

Pr: 8703

Inj Trauma
443 1

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

MEDCOM - 23632

b(2)-2

Admission and Coding Information

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

1. Reporting MTF	2. MTF Location		
[redacted]	IZ		
3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(6)-4		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1976-08-19	27Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number
		20	[redacted]
Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		10:35	
14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES		
17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee	
Direct from ER	ICW1	Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee	
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)	
TRF-OTH		2003-11-14	
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)	
ABD - NEUROSURGERY		2003-11-14	
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission	
		2003-11-14	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L FACAIL HEMOTOMA, L SHOULD SHRAPNEL,R HIP SHRAPNEL

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitt[redacted] | S[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000 MEDCOM - 23633

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	b(6)-4					FGN	
4. Sex M	5. Age 27Y	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [redacted]	13. Organization				14. Ward ICW1	
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case DIS	
21. Source of Admission Direct from ER			22. Hour Of Adm: 10:35	23. Clinic Service -			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-11-11			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-11-08		AdmittingOfficer:	
29. ReportingMTF [redacted] b(2)-2				30. Date Init Adm 2003-11-08		32. Units Blood Components	

31. Selected Administrative Data

Marital Status: DoB: 1976-08-19

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

SHRAP INJURY L CHEST

877.0
876.0
875.0
E993

87.79
93.57

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
[redacted]	[redacted]

Automated Facsimile - DA FORM 3[redacted] b(6)-2

MEDCOM - 23634

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

S: 29yo male EPW, S/P IED injury to (L) chest c resultant superficial schrapnel injury to (L) chest. Ø other injuries.
ØMedHx / d — ØSurgHx (L) ORIF knee — Ø Tob

PHYSICAL EXAMINATION

BP-130/68 HR-93 RR-22 T-99.1

A+Ox4
HEENT - Clear
CV - RRR
Lungs - CTA (B)
Abd - benign

Ext - Ø injuries
Back/chest - superficial schrapnel to level T-11

PROGRESS (Enter date of discharge and final diagnosis)

A/P: Schrapnel injury to (L) chest
(1) Admit
b(6)-2 (2) Obs / Abx

SIGNATURE [redacted] | DATE 8 Nov 03 | IDENTIFICATION NO. | ORGANIZATION

[redacted] (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 NOV 03 1424	Assume care of PT @ 0600. C/O dizziness problem solved without meds. Δ ed drsg to (L) chest CDI and drsg to buttocks (R), CDI. Ambulate enough to exercise in hallway. Speaks good english. In 2pt restraint without any skin irratation. Will continue to monitor. — 9/WSPC [redacted]
1719	PT c/o not recieving enough food and juice. Nothing else major has occured. Will cont. to monitor. — 9/W SPC [redacted]
09 NOV 03 2000	VSS Alert & Oriented. OOB→AMB Ad lib. (L) chest wound 3cm ē scant amt of [illegible] drainage noted. Tissue to wound [illegible] red. Buttock ~~[illegible]~~ superficial wound to (R) buttock < 0.5cm Ø drainage noted left open to air. laceration < 0.5cm noted to [illegible] area. cleaned ē NS (sterile). Sterile drsg applied. Ø C/O pain. Consumed 80% of reg diet for dinner. Will continue care as planned. [redacted] 1 M
10 NOV 03 1410	Assume care of PT @ 0600. VSS, A+Ox3 Ambulate in hallway. Conducted personnal hygeine today. Ø C/O pain. Drsg Δ to (L) chest, area CDI ē minimal blood leakage. (R) buttocks CDI. In 2pt restraint without any skin irratation. Will cont. to monitor. — 9/WSPC [redacted]
	b(6)-2 A11

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

MEDCOM - 23636

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
08NOV03	(1515) Assumed care of pt from EMT in stable condition via gurney. Pt amb to bed. VSS. ∅ c/o pain. Drsg to Ⓛ side of chest c̄ sm. amount sero.sang. drainage. ∅ c/o SOB. Tol. reg diet well voiding s̄ difficulty. IVFs s/ld in IV in Ⓡ upper arm - ∅ s/sx infiltration. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted]
	(1615) Drsg to Ⓛ chest shrapnel wound c/d. ∅ s/sx infection monitoring. b(6)-2 [redacted]
~~08NOV 03~~	
08NOV03 2000	VSS. Alert & Oriented. OOB → AMB ①. Drg to Ⓛ chest & Ⓡ buttock dry & intact. Ⓡ upper arm saline lock patent & intact. Consumed 80% of Regular diet for dinner. Voids s̄ difficulty. Speaks some English. Peripheral pulses palpable +2. Lungs clear Bilaterally. 2+ restraints in place. Will check frequently to ensure circulation & prevent damage to skin integrity. [redacted] 2 47 b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10NOV.03	Pt A+Ox3, VSS, voices ø c/o pain or
2030	discomfort, dsg to Ⓛ chest + Ⓡ
	buttock d/i/d, ø s/sx of infex, tender
	around wound area, HL IV Ⓡ arm
	intact, ø s/sx of infex, 2 point restraint,
	ø complications. —— [redacted] gtw
	b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[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

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DAY	MONTH	YR.	TIME
8	Nov	03	1035

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

CURRENT MEDS. (tetanus immunization and other data) Ø

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES Ø

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX ♂ AGE 29

POSSIBLE THIRD PARTY PAYER? YES / NO

VITAL SIGNS

TIME	1040	
BP	130/68	129/
PULSE	93	85
RESP.	22	14
TEMP.	[illegible]	—
WT. (Child)		

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

TIME SEEN BY PROVIDER

29 y/o ♂ c L side IED

PMH Ø
PSH: L ACL knee
⊕ tob

O: A&Ox4 — NAD. VSS
HEENT: [illegible] atraumatic FACE [illegible]
Chest: CTA(B); [illegible] breaths equal
[illegible] [illegible] ⊕ L small shrapnel wound L axilla T-11 level
Abd: soft, ⊕BS, NT

CXR
⊕ [illegible] shrapnel soft tissue

A/P ① [illegible]

→ Admit [illegible] / Abx b(6)-2

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS	INITS.	TIME
CBC/UA/Chem 12		
lytes		
CXR/AMS/KUB		
Td .5cc IM	[redacted]	1145
Ancef 1g IV	[redacted]	1145

ASSESSMENT/DIAGNOSIS
Shrapnel L chest wall

DISPOSITION (Check all that apply)
HOME / FULL DUTY
QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
REFERRED TO (Indicate clinic)
EMERGENCY / TODAY / 72 HOURS / ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
X IMPROVED / UNCHANGED / DETERIORATED
TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications o[redacted]s and follow-up plans)

MEDCOM - 23639

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD | **PROGRESS NOTES**

Admission Date: 11-8-03 Diagnosis: Shrapnel Injury (L) Chest HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		Mobility	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4		Nutrition	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4		Friction and Shear	No apparent problem	3	
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score **Total Score**________

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates HIGH RISK –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location:______ Size:______ Drainage:______
Tubes:______ Appearance:______
Dressing change:______

Pressure Ulcer (s): Yes No
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:______ Size:______
Wound character: Pint____ Moist____ Dry____ Granulation tissue____ Yellow slough____
Odor____ Purulent discharge____ Eschar____ Exudates____

Type of dressing change: Wet-to-dry____ Comfeel dressing____ Carrasyn V-Gel____ Alginate____

Physician notified/consulted for wound debridement: Yes____ No____
CNS notified/consulted for Stage II and greater: Yes____ No____
Nutrition Referral: Yes____ No____
Physical Therapy Referral: Yes____ No____
Action Taken:______ Date & Time:______

REGISTER NO. | WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facilithy)

PROGRESS NOTES

Medical Record
STANDARD FORM 509