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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 Aug 03 TIME OF ORDER 0829 HOURS — LIST TIME ORDER NOTED AND SIGN

b(6)-2

1. Heplock IV ✓
2. Advance to regular diet
3. Colace 100 mg PO BID ✓
4. Percocet 1-2 PO q4° PRN pain ✓
5. [redacted]

Thump 0856 20 Aug

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 Aug 03 TIME OF ORDER 1355 HOURS

OK to transfer to 21 CSICU

b(6)-2

[redacted]

PATIENT IDENTIFICATION

b(6)-2 noted [redacted] 21Aug03 0946

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 Aug 03 TIME OF ORDER 0909 HOURS

DC Oxygen
V O2 sat q 1 hr
Transfer meds on chart
Transfer with IV heplocked

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 AUG 03 TIME OF ORDER [redacted] HOURS

1. Tx to ICU
   dx - (R) LL pneumonia
   cond Guarded
   Vitals Q1° & SAT ; I/O
   All - NKDA
   Act - OOB TID
   Nurse - Foley to Gravity

1850 KL

MB for

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Diet – NPO

IVF – ~~D5...~~ @ 125cc/hr

<u>Meds</u> – (1) Zosyn 3.375gm IV Q8° 1st Dose Now ✓

/ Lovenox 80 mg SQ (B)ID ✓

✓ Albuterol 0.5 cc in 2.5cc NS Q6° /

/ Atenolol 50 mg PO QD /

<u>LABS</u> CBC, Chem 8, Chem 12 QAM.

185° [redacted]

b(6)-2

[redacted]

21AUG03 2020

LR 500cc IV Bolus Now

[redacted] 21 AUG 03 2000

[redacted]

b(6)-2.

b(6)-2

[redacted]

8/22/03

KCl 40 meq – 500 cc NS. over 4 hrs

Hold maint during Run

then back to D5½ NS + 20 KCl @ 125 [redacted]

22 Aug 03 1515

b(6)-2

[redacted]

8/22/03 0940

CXR this Am and in Am

24° chart ✓ [redacted] ...ICIAN 22Aug03 @ 2145

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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	↓	ORDERS	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted]		DATE OF ORDER: 23 Aug 03 TIME OF ORDER: 0657 HOURS	
		Advance to Regular Diet	
		Repeat CBC ~~tok~~ 1400	
		[redacted]	
NURSING UNIT / ROOM NO. / BED NO.		b(6)-2	
PATIENT IDENTIFICATION		DATE OF ORDER: 23 Aug 03 TIME OF ORDER: 1411 HOURS	
		Please give 250cc bolus NS	noted [redacted] 08/23/03 2325
		[redacted]	b(6)-2
NURSING UNIT / ROOM NO. / BED NO.		24° [redacted] F/AN 08/23/03 2325	
PATIENT IDENTIFICATION		DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 1015 HOURS	
		1-IV to 75cc/hr	[redacted]
		b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
~~✓chart checks done~~ [redacted]		25 Aug 03 0330	
PATIENT IDENTIFICATION		DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 0530 HOURS	
		(1) morphine 2mg IVP now	
		b(6)-2	
		[redacted]	
~~Ø38~~		[redacted] M/AN	
NURSING UNIT / ROOM NO. / BED NO.			
24° ✓ done [redacted] 26 Aug 0200			

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE, T... ND SIGN EACH SET OF ORDERS. IF PRO... ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NU... IN COLUMN INDICATED BY ARROW BELO...

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4		DATE OF ORDER: 25 Aug 03 TIME OF ORDER: 0706 HOURS	
	(1)	CXR, Pelvic Xray today	
	(2)	Heplock IV	
		[redacted] b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER: 25 AUG 2003 TIME OF ORDER: 1240 HOURS	
		(1) Digoxin .25mg po QD 1300	noted [redacted]
		(2) DC IV fluids	
		~~(3) Nitro Sr... 10mcg/min~~ err	
		(3) Lasix 20mg IVP 1300	b(6)-2
		(4) Dulcolax suppository	
		[redacted]	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER: 25 Aug 03 TIME OF ORDER: 2000 HOURS	[redacted]
	(1)	Ambien 5mg PO c HS	noted [redacted] 25 Aug 03 2000
		[redacted]	b(6)-2
NURSING UNIT: 24° ✓ done [redacted]		BED NO.: [illegible] 26 Aug Ø200 [redacted]	
PATIENT IDENTIFICATION [redacted] b(6)-4 [redacted]		DATE OF ORDER: 26 Aug 03 [redacted] 1302 HOURS	[redacted]
		Start Dobutamine Drip @ 5mcg/kg/min	[redacted] 1734
		v.o. per Dr [redacted] / [redacted]	[redacted]
NURSING UNIT: 24° Chart [redacted] b(6)-2		[illegible] 1221 27 Aug 03	

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

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ACLU-RDI 1641 p.4

DOD-030833

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE AND SIGN EACH SET OF ORDERS. IF P... M ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM N... ER IN COLUMN INDICATED BY ARROW BE...

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	26 Aug 03	1600 ~~26 Aug 03~~ HOURS [redacted]	
X (1)	PCXR		
X (2)	ABG + VBG to determine baseline		
X (3)	Place on 100% NRB		
X (4)	ABG + VBG ē NRB		
X (5)	ABG + VBG 30 mins p Dobutamine started		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		____ HOURS	
X (6)	Hold today's Dose of Atenolol		
X (7)	D/C Dobutamine,		
X (8)	Switch pt back to NC		
X (9)	1L NS Bolus		
X (10)	ABG + VBG p NS bolus		
X (11)	V.O. per DR [redacted] 19...		[redacted] 44/ow

b(6)-2 A11

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	26 Aug 03	1700 HOURS	[redacted]
1	(1) transfuse 2 units g pRBC each over 1 hour		[redacted] 26 Aug 03 1736

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	26 Aug 03	2240 HOURS	Voted 26 Aug 03 @ 2250 via [redacted]
	(1) mon 30c p x1		[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU1	24 Chart	

[redacted] 26 Aug 03 1551

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
27 AUG 2003	0830 HOURS	
1 ① CBC & P		
b(6)-2 [redacted]		1091 27 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
27 Aug 03	1300 HOURS	
NPO except for sips of H2O v.o. per Dr. [redacted]		1400 27 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
27 Aug 03	1456 HOURS	b(6)-2
EKG Now v.o. per Dr.		27 Aug 03 1455
[redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	24 Chart	

DATE OF ORDER	TIME OF ORDER	
27 Aug 03	1500 HOURS	
① Initiate 2cc/hr IV ② b(6)-2		
27 Aug 03 1555 [redacted]		

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU1	24	

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
27 AUG 2003	1600 HOURS	

(1) NPO
(2) DC lovenox
(3) [redacted] NG tube → drainage 1000cc
(4) NG to CWS

b(6)-2 [redacted]

1616 27 Aug 03

Chart Check 0015 28 Aug [redacted] LT/AN

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
28 AUG 03	0830 HOURS	

0900 (1) NS wash 20 cc q 75 cc/hr
(2) Δ CBC to AM draw and [redacted]
(3) Vit K 10mg SQ QD x 3 days
0930 (4) Therapeutic Unit precs over 1 hr

Verbal 28 AUG 03 0855 [redacted] LT/AN

b(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
28 AUG 2003	1600 HOURS	

(1) DC NPO
1755 (2) D/C lovenox/NG

b(6)-2 [redacted]

Noted 28 AUG 03 1755 [redacted] LT/AN

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU1		

DATE OF ORDER	TIME OF ORDER	
28 Aug	2110 HOURS	

(1) Remove NG tube
V.O. Dr [redacted] LT/AN

b(6)-2 [redacted]

28 Aug 03 0023 [redacted] LT/AN

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DAT E AND SIGN EACH SET OF ORDERS. IF EM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM BER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU-1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 AUG 2003	0900 HOURS	
① DC Swan		
② Advance diet as tolerated		
③ OB & Chem		
④ KCL 40 meq po x1		[redacted] 29 Aug 03 0951
[redacted]		b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU1		

DATE OF ORDER	TIME OF ORDER	
29 AUG 03	1600 HOURS	
① Physical therapy consult		[redacted] 30 Aug 03 0934
[redacted]		b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU1		

DATE OF ORDER	TIME OF ORDER	
29 Aug 03	2015 HOURS	Noted 0020 on 30 Aug 03 [redacted]
① Tylenol T gm PO q6° PRN		
[redacted]		b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU1	24° Chart	

DATE OF ORDER	TIME OF ORDER	
30 AUG 03	0830 HOURS	
① Wean O2 as tolerated		
② OB & Chem, PT to wean O2		[redacted] 30 Aug 03 0934
[redacted]		[redacted] 30 Aug 03 0934

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER: 3 AUG 2003 TIME OF ORDER: 08[32] HOURS

LIST TIME ORDER NOTED AND SIGN: Noted 0840 [redacted]

1. D/C to CBC, met 8 QD
2. DC A-line
3. DC Foley
4. Ambulate with PT [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

DATE OF ORDER: 2 Sep 03 TIME OF ORDER: 08[20] HOURS

b(6)-2

1. Transfer to ICW Dr [redacted]
2. Diagnosis: eclampsia, pulmonary embolism
3. Condition: Stable
4. Vitals q shift with pulse ox
5. NKDA
6. Activity: ward privileges OOB to chair daily

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ↓ ↓ TIME OF ORDER ↓ ↓ HOURS

7. physical therapy consult daily
8. Nursing: IV to saline lock
9. Diet: regular
10. meds ① Prilosec 20mg po QD
② O2 2L NC
③ Atenolol 50mg po QD
④ Digoxin .125mg po QD

b(6)-2 Noted [redacted] 02SEP03 1235

NURSING UNIT

PATIENT IDENTIFICATION

DATE OF ORDER ↓ ↓ TIME OF ORDER ↓ HOURS

⑤ Colace 100mg po BID
⑥ Mobaline 2 tablespoons every 6° prn

11. Labs: CBC, met 8, M, W, F

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

2P/2300 2SEP03 [illegible]

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b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

DATE OF ORDER: 9/4 | TIME OF ORDER: 1030 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Ambulate daily

(2) Physical Therapy - daily

(3) Wound (abdominal) care:

Do not pack wound deep - gauze to keep skin from closing only

(4) Heparin 5000 units sq bid

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 Sept 03 | TIME OF ORDER: 0900 HOURS

(1) Wean Or to off

5 Sep 03 1800 RD 14 noted

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT: 3A | ROOM NO.: 3030 | BED NO.: 5 SEP 03

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 7 SEP 03 | TIME OF ORDER: 0315 HOURS

(1) Tylenol 325 mg tabs po + H q4 Tylenol prn

V.O. Dr [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

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.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICN #1 | ROOM NO. | BED NO.

DATE OF ORDER 9/10 | TIME OF ORDER 0800 | HOURS | LIST TIME ORDER NOTED AND SIGN

1. NSC 75/hr
2. Blood Cx
3. Urine Cx
4. UA
5. CXR

[redacted] b(6)-2

24: Chart [redacted] 0800

Noted [redacted] 1058 9/03

PATIENT IDENTIFICATION

[redacted] b(6)-2

DATE OF ORDER 9/12 | TIME OF ORDER | HOURS

1. Hip WBAT
   Change dressing qday

[redacted] b(6)-2

24: Chart [redacted] 1350 9/03 1300

Noted [redacted] 1350 9/03 1300

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICN 1 | ROOM NO. [redacted] | BED NO.

DATE OF ORDER 9/15 | TIME OF ORDER | HOURS

1. D/C Digoxin
2. D/C Heparin
3. D/C Coumadin
4. D/C to prison/custody
5. D/C IVF

[redacted] 9/15/03 1400

PATIENT IDENTIFICATION

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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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. 8 Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20
17/8	[redacted]	VS Q1°	06	[redacted]			
			18				
17/8	[redacted]	ACT: Bed Rest	06	[redacted]			
			18				
17/8	[redacted]	DIET: NPO	06				
			18	> D/C 17/8/03 0300			
17/8	[redacted]	CALL MD T>101.5,	06	[redacted]			
		SBP<180, U/O<30cc°	18				
17/8	[redacted]	ICS QS	06	[redacted]			
			18				
17/8	[redacted]	DIET: Clears	06	[redacted]			
			18				
17/8	[redacted]	Foley to GRAVITY	06	[redacted]			
			18				

ALLERGIES: ☐ YES ☐ NO
PKNDA

PRIMARY DIAGNOSIS: s/p SHRAPNEL WOUNDS: (L) iliac CREST fx, ex lap.

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17252

blw-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo AUG Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17/8	[redacted]	ADMIT ICU2	17/8	ASAP	0130	[redacted]
17/8		COND: STABLE	17/8	ASAP	0130	
17/8		MD ONCALL OR TONIGHT	17/8	ASAP	0130	

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

USAPA V1.00

MEDCOM - 17253

b(4)-2 AR

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 02 03 04 05 06 07 08 09 10 11 12 13 14 15
02 Sep 03	[redacted]	Vitals q shift c pulse ox	06 / 18	[redacted]
02	[redacted]	Act: ward privledges	06 / 18	
02	[redacted]	OOB to chair daily	06 / 18	
02/04	[redacted]	Physical therapy consult daily	10	
02	[redacted]	Diet: Regular	06 / 18	
02	[redacted]	CBC, met 8, M,W,F	05	
04	[redacted]	Ambulate daily	Pk / 18	
			18 / 06	
9/4	[redacted]	Wound (abdominal) care: DO not pack wound deep - gauze to keep skin from closing only.	Pk / 18 / 18 / 06	DIC 12 Sep 03
9/4				
12 Sep 03	[redacted]	Ship wound - △ drsg q day	06 / 18	[redacted]

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	Ex Lap, Pulmonary Embolism	PAGE NO:

PATIENT IDENTIFICATION:

#[redacted]

b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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D(e)-2 #11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 09 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
02 SEP03	[redacted]	Tx to ICW, condition - stable	02 SEP03	—		[redacted]
10 SEP03	[redacted]	Blood cx	10 SEP03	—		
10	[redacted]	Urine cx	10	—		
10	[redacted]	UA	10	—		
10	[redacted]	CXR	10	—		
9/15	[redacted]	D/C to prison custody	9/15			

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

USAPA V1.00

b(6)-2 A11

REMARKS

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17
2	[redacted]	VS QS o pulse ox	6	[redacted]	
			18		
2	[redacted]	ACT: ward privileges	6	[redacted]	
			18		
2	[redacted]	OOBTC daily. Ambulat daily	6	[redacted]	
			18		
2	[redacted]	Physical therapy consult daily	8	[redacted]	
			18		
2	[redacted]	Diet: Regular	6	[redacted]	
			18		
2	[redacted]	CBC, METS MWF	05	/	/ / / / / / / / / / / /
12	[redacted]	Drip wound - A dsg q day	08	[redacted]	
			X		

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Epilap, PE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17256

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
15 Sept	[redacted]	D/C to prison custody					
		blcd-2					

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

USAPA V1.00

(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. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28 29 30 31 1 2 3 4 5 6
28 Aug 03	[redacted]	Δ CBC to Gambraw + 1800	04	/ [redacted] Δ'd 31 Aug 03
			18	[redacted]
29 Aug 03	[redacted]	Advance Diet as tolerated (Regular)	07	[redacted]
			11	[redacted]
			17	[redacted]
29 Aug 03	[redacted]	OOB to Chair	06	[redacted] Δ'd 30 Aug 03
			18	[redacted] 0230
30 Aug 03	[redacted]	OOB to chair, PT to work with	06	/ [redacted]
			18	/ [redacted]
	[redacted]		X	
31 Aug 03	[redacted]	Ambulate with PT	06	/ / [redacted]
			18	[redacted]
31 Aug 03	[redacted]	Δ Hgb to CBC; Not 8 2D	04	/ / / [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap (Acy) @ Ileac Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17258

block-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29 Aug 03	[redacted]	OIC Swan	29 Aug 03		0900	[redacted]
30 Aug 03	[redacted]	Physical Therapy Consult	30 Aug		done	[redacted]
31 Aug	[redacted]	DC A. Leie	31 Aug 03			[redacted]
31 Aug	[redacted]	DC pkeg	31 Aug 03			[redacted]

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

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo: 8 Yr: 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 / 19 / 20
18 Aug	[redacted]	VS q4° x 48°, then Q 8°	05 / 13 / 21	[redacted]
18 Aug	[redacted]	NPO / clears in AM	06 / 11 / 17	[redacted] D/C see below
18 Aug	[redacted]	Foley to gravity drainage	05 / 1 / 21	[redacted]
18 Aug	[redacted]	Incentive spirometer Q1° WA.	05 / 13 / 21	[redacted]
18 Aug	[redacted]	OOB TID	05 / 13 / 21	[redacted]
20 Aug	[redacted]	Reg Diet	05 / 12 / 17	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

BLW-2 A11

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
NON-MEDICATION

Mo ____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18Aug	[redacted]	Transfer to ICW				
8/18	[redacted]	CXR, PA/LAT tonight ? ty			DONE	
8/18	[redacted]	Please get Rythm strip for eval			DONE	
8/18	[redacted]	Send CBC, chem 8			DONE	
8/18	[redacted]	ABG tonight			DONE	
8/18	[redacted]	Lopressor 5mg IVP now	8/18	2ª	2225	[redacted]
8/18	[redacted]	Lasix 20mg IVP now	8/18		2200	[redacted]
8/18	[redacted]	1L NS c 40mg KCl @ 125cc/hr	8/18	2345	2345	[redacted]
21Aug	[redacted]	D/C O2 v O2 Sat in 1 hr	21Aug	1000	1000	[redacted]
21Aug	[redacted]	Transfer c meds on chart	21Aug			
21Aug	[redacted]	Transfer c IV heplocked	21Aug		1000	[redacted]

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

USAPA V1.00

b(4)-2 A 11

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 26	27	28	29	30	31	1	2
26 Aug 03	[redacted]	Start Dobutamine Drip @ 5mcg/kg/min	06	[redacted]							
			18			DC'd [redacted] 26 Aug 03 1550					
27 Aug 03	[redacted]	Prilosec 20 mg PO QD	10	[redacted]							
28 AUG 03	[redacted]	NS @ 20 KCl @ 75cc/hr	06	[redacted]							
			18								
28 AUG 03	[redacted]	Vit K+ 10mEq SQ QD x 3 days	10	[redacted]							
30 Aug 03	[redacted]	Wean O2 as tolerated	06	[redacted]							
			18								

ALLERGIES: ☐ YES ☐ NO

NKDA.

PRIMARY DIAGNOSIS:

S/P EX Lap, (R) Iliac Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

[redacted] b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 17262

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26Aug03	[redacted]	Transfuse 2 units of PRBCs	26Aug03	#1	2018	[redacted]
		each over 1 hour	26Aug03	#2	2114	
26 Aug03	[redacted]	MOM 30cc X1	26Aug03	Stat	2242	
28 Aug03		Transfuse 1 unit PRBC over 1°	28Aug03		0958	
29Aug03	[redacted]	KCl 40meq PO x1	29Aug03		1015	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED	
29 Aug03	[redacted]	Tylenol 1GM po Q6° PRN	2024 1Aug	31Aug03 0800 [redacted]

USAPA V1.00

MEDCOM - 17263

ACLU-RDI 1641 p.23

DOD-030852

b(6)-2 All WHITE

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. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27 28 29 30 31 1 2 3
21 Aug	[redacted]	~~KVO~~ T25 cc	07	
22 Aug	[redacted]	D5 1/2NS+20KCL @ 125	19	DC 8/22/03
21 Aug	[redacted]	Lovenox 80mg SQ	20	recurfly, see below
2		bid	22	
21 Aug	[redacted]	Zosyn 3.375 gm IV	14	
		q 8°	22	recurfly & see below
			06	
21 aug	[redacted]	Albatrol 0.5 cc in 2.5 cc NS q 6°	06	
			12	
			18	D/C 28 Aug 03
			24	
21 aug	[redacted]	Atrol 150 mg po q day	10	
24 Aug	[redacted]	D5 1/2 NS + 20 KCL @ 75 cc/hr	06	A
			14	DC — A/C
			22	
25 Aug	[redacted]	H.L. IV (Flush q 8)	06	D/C
			18	
25 Aug	[redacted]	Zosyn 3.375 gm IV q 8°	06	
			14	
			22	
25 Aug	[redacted]	Aspirin 0.25 mg qd (P.O.)	10	
28 Aug	[redacted]	Lovenox 80 mg SQ bid	10	DC'd 27 Aug 03
	copied 25 Aug		22	

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/p Exp. Lap (Neg.), ® iliac Fx, ® LL Pneumonia

ADDITIONAL PAGES IN USE? ☒ YES ☐ NO — PAGE NO. 1

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 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

blood · 2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 2003
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/21/ [redacted]	LR 500cc Bolus x1 now		NIGHT	2020	[redacted]
22 Aug [redacted]	40mg KCl IVPB am 4°-	done			[redacted]
[redacted]	Hold IV Maint dry am				
23 Aug [redacted]	Please give 250cc NS bolus	23 Aug 03	1411	done	
25 Aug [redacted]	MS04 2mg IVP now	25 Aug	0536	0536	[redacted]
25 Aug [redacted]	Lasix IVP	25 Aug	1300	done	
25 Aug [redacted]	Calculex suppository	25 Aug	26 Aug 03	0710	
25 Aug [redacted]	DC IV Fluids	25 Aug	0700	done	
25 Aug [redacted]	5mg PO @ HS Ambien	25 Aug	2200	now	
26 Aug [redacted]	Place on 100% NRB	26 Aug 03		1400	
26 Aug [redacted]	Hold today's dose of Atenolol	26 Aug 03		1400	
26 Aug [redacted]	Switch pt back to NC	26 Aug 03		~~1400~~	
26 Aug [redacted]	1LNS Bolus	26 Aug 03		1605	

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

USAPA V1.00

b(4)-3 All GREEN

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. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27 28 29 30 31 1 2 3
21 Aug	[redacted]	Condition guarded	07	[redacted]
			19	
21 Aug	[redacted]	Vitals q 1° ē sat	07	
			19	
21 Aug	[redacted]	I + O q hr.	07	
			17	
21 Aug	[redacted]	OOB T 10	07	Δ d/c 27 Aug 03
			19	
21 Aug	[redacted]	Foley to gravity	07	D/C'd 31 Aug 03
			19	
21 Aug	[redacted]	~~Appa CLD~~ Reg	07	[redacted]
			19	
21 Aug	[redacted]	CBC, Chem 8, Chem 12 q am	04	[redacted] d/d 31 Aug 03
23 Aug 03	[redacted]	Regular Diet	07	[redacted] Δ d/c 27 Aug 03 1403 hrs
			11	
			17	
25 Aug 03	[redacted]	~~Digoxin .25 mg p.o~~ QD	~~10~~	
27 Aug 03	[redacted]	CBC Q8°	04	[redacted] Δ'd 28 Aug 03
			12	
			20	
27 Aug 03	[redacted]	NPO except for sips of H2O	06	[redacted] D/C'd @ 28 Aug 03
			18	
27 Aug 03	[redacted]	NG to LIS	06	[redacted] Δ'd 28 Aug 03
			18	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Exp. Lap (neg.), R iliac Fx
R LL Pneumonia

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

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

4 pg 17 Aug 03 182

MEDCOM - 17266

b(6)-2 A11

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 2003
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
21 Aug [redacted]	Transfer to ICU	21 Aug	-	Done	[redacted]
22 Aug [redacted]	CXR in AM 0400	23 Aug	0400	0500	[redacted]
23 Aug [redacted]	CBC 1400	23 Aug	1400	1420	[redacted]
25 Aug [redacted]	CXR + pelvis X ray	25 Aug	0830	0830	[redacted]
26 Aug 03 [redacted]	PCXR	26 Aug 03		1230	[redacted]
26 Aug 03 [redacted]	ABG + VBG to determine baseline	26 Aug 03		1335	[redacted]
26 Aug 03 [redacted]	ABG + VBG on NRB	26 Aug 03		1442	[redacted]
26 Aug 03 [redacted]	ABG + VBG 30 mins p Dobutamine	26 Aug 03		1544	[redacted]
26 Aug 03 [redacted]	ABG + VBG p NS Bolus	26 Aug 03		1644	[redacted]
27 Aug 03 [redacted]	EKG Now	27 Aug 03		1510	[redacted]
27 Aug [redacted]	NG Tube → Lavage 6000cc	27 Aug 03		1645	[redacted]
28 Aug [redacted]	Clamp NGT	28 Aug 03		1755	[redacted]
28 Aug [redacted]	D/C NG Tube	28 Aug 03		2110	[redacted]

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

USAPA V1.00

b(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 02 03 4 5 6 7 8 9 10 11 12 13 14 15
02 Sep 03	[redacted]	N to SL (flush q shift)	06	[redacted] D/C 19 Sep 03
			18	
02	[redacted]	Prilosec 20mg po QD	10	[redacted]
02	[redacted]	O2 2L NC	06	[redacted] D/C'd 58 02
~~02~~	[redacted]	~~Atenolol 50mg p PRN~~	18	[redacted]
02	[redacted]	Atenolol 50mg po QD	10	[redacted]
02	[redacted]	Digoxin .125mg po QD	10	[redacted]
02	[redacted]	Coreg 12.5mg po BID	10	[redacted]
			22	
04	[redacted]	Heparin 5000u SQ	10	[redacted]
	[redacted]	BID	22	[redacted]
[redacted]			06	[redacted]
			18	[redacted]
			HR	16 17 18
2 Sep	[redacted]	Prilosec 20mg po QD	10	[redacted]
			X	
2 Sep	[redacted]	~~Digoxin~~ Atenolol 50mg po QD	10	[redacted]
			X	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Ex GAP, Pulmonary Embolism

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

PATIENT IDENTIFICATION:
#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 17268

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5sep03	[redacted]	Wean O2 to off	5sep03			[redacted]
5sep	[redacted]	D/C IVF				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED															
05SEP03		maalox 2tbsp q6° prn																
7	[redacted]	Tylenol 325mg + Hydr q4 prn	7sep 0830	6sep 1900	9sep 1545	10sep 0610								S1				
		b(6)-2	[redacted]															

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

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

Mo. 8 Yr 05

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18/19/2021
18 Aug 20 Aug	[redacted]	LR @ 125 cc/hr. HL IV	05	✓ [redacted]
			13	[redacted]
			21	
18 Aug	[redacted]	Ancef 1gm q 8°	08	✓ [redacted]
			16	✓
			24	
8/18	[redacted]	Albuterol tx Q4° overnight, then PRN -	00	X ✓ [redacted]
			04	X ✓
			08	X ✓
			12	X ✓ ✓
			16	X ✓ ✓
			20	[redacted] ✓
18 Aug	[redacted]	Wean O2 to keep sat 92%	5	X [redacted]
			15	X
			21	[redacted]
		~~Lopressor 5mg IVP~~		
8-18	[redacted]	Lovenox 40mg SQ QD - 1st dose tonight	21	[redacted]
19 Aug	[redacted]	Atenolol 50mg PO QD	17	✓ [redacted]
19 Aug	[redacted]	Colace 100mg PO QD	10	✓ ✓ [redacted]
			22	✓

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap

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 4678, 1 FEB 79 | EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. | USAPA V1.00

MEDCOM - 17270

PRN Meds

18 Aug AVM	MSO4 2-6mg q2° PRN Give MSO4 for Breakthrough pain 19 Aug 1400 4mg IVP AVM
18 Aug AVM ~~20 Aug~~	Phenergan 12.5mg IVP q6° PRN 20 Aug 12.5mg IVP ~~pt~~ 0012 AOS
20 Aug KL	Albuterol tx PRN
19 Aug 03 AVM	Percocet 1-2 PO q4° PRN pain

ONE TIME ORDERS

8·20·0000 Mylanta 30cc PO x Now [redacted] AOS

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. 8 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20
17/8	[redacted]	Ancef 1gm Q8	08	[redacted]			
			16	[redacted]			
			24	[redacted]			
17/8	[redacted]	LR @ 150cc/HR	06	[redacted]			
			18	[redacted]			

ALLERGIES: ☐ YES ☒ NO
KNDA

PRIMARY DIAGNOSIS:
S/P SMR apnel wound (R) iliac crest washout/3x ± an exlap

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00
MEDCOM - 17272

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/a)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
17/8	[redacted]	MSO4 2-6 mg	0130 18 Aug 03	18 Aug												
		IVP Q1-2hr prn	5mg IV JK	3mg AM	2118 1430											
17/8	[redacted]	Zofran 4mg IVP	18 Aug 1600													
		Q6hr prn	[redacted]													

USAPA V1.00

EPW [redacted] b(6)-4

25AUG03

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 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0800	INITIALS		INITIALS	1800	INITIALS
NEURO	PUPILS	PERRLA			-	PERRLA	[redacted]
	SENSORIUM	Alert, verbalizes needs			-	A+O x3, expresses needs appropriately	
					-	MAE	
RESPIRATORY	RESPIRATORY PATTERN	Regular labored E			-	deep, rapid, labored	
	BREATH SOUNDS	increased asthmy			-	OTA bilaterally E	
	SECRETIONS	FIO_2 3LN sat 98%			-	diminished bases	
					-	Ø cough	
					-	4LNC 97%	
SKIN	COLOR	jaundiced			-	normal for race	
	INTEGRITY	abdominal incision D+I			-	ab incision, staple intact	
		(L) iliac dressing D+I				min redness & swelling	
IV SITE	LOCATION	(R) forearm AC - A.L.				good approximation, Ø drainage	
	CONDITION	intact, Ø S+S of infection				or odor	
					-	(R) AC patent Ø S/S of infxn	
GASTRO	ABDOMEN	Hypoactive BS all			-	BS present x 4 quad	
	BOWEL SOUNDS	4 quadrants			-	round, large	
		& BM					
GU	URINE:	foley clear yellow			-	foley dark yellow	
	COLOR/CLARITY	urine @ S					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR E PVC / ST W/100			-	NSR/ST E occ PVC	
		rate 98-100.			-	S1S2	
		JVD (R). Upper			-	+1 pulses x 4 ext	
		LE edema. Abd			-	Upper & lower Ext edema	
		distended.				+2	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

[redacted] (Signature & Title) CPT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 25AUG03

[redacted] IFICATION (For typed or written entries give: Name—last, first, mi[redacted]: date; hospital or medical facility)

EPW [redacted]
b(6)-4

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

EPW [redacted] b(6)-4 25 Aug 03

PAGE 20

DATE 25 AUG 03 | BP EXP. (AP/LAT) (R) ILIAC FX (R) L. PNEUMONIA | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff	117/76	116/71	120/82	111/68	186/70	119/76	118/81	112/79	117/80	113/80	107/79	120/75	105/72	110/68	110/74	109/69	105/75
Temperature	97.7			98.2			97.9				97.5				98.°		
Pulse	103	98	102	102	99	99	100	104	106	106	102	95	96	96	98	102	103
Respiratory Rate	26	27	28	10	29	26	25	31	21	21	29	25	32	34	36	34	26
SpO2	94	94	94	94	95	97	95	93	93	93	94	94	93	97	98	96	96
FIO2	3L	3L	3L	3L	3L	3L	3L	3L	3L	2L	2L	2L	2L	4L	4L	4L	4L
														POCs	POCs	POCs	POCs

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVF:	75	Off																
P.O.			150			150			300		150		100					350
														ONS				
TOTALS										1430	1500	1515	1600	1700				

OUTPUT

URINE	HOUR / TOTAL	100/100	100/200	70/270	70/340	75/415	70/480	50/530	50/580	585	525/525	200/725	200/925	120/1045	100	60	50	80
	SP GR																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

Vinay 20 mg IVP

EPW [redacted] b(6)-4

b(6)-4

EPW [redacted] 25 Aug 03

POST-OP DAY

VITAL SIGNS	22	23	00	01	02	03	04	05
	109	109		105	92	93	91	95
	72	68		60	60	68	68	61
		98.3					98.9	
	102	95	101	81	104	112	109	111
	28	30	30	20	18	20	19	19
	96	99	98	99	99	98	96	97
	4L	4L	4L	4L	4L	4L	4L	4L
								DBS

INTAKE	22	23	00	01	02	03	04	05	8° T
	LRV abx		abx			lab		abx	

OUTPUT	120	110	100	100	80	120	100	120

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_iO_2										
	TV										
	RATE										
	PEEP										
ARTERIAL BLOOD GASES	A pH										
	A PCO_2										
	A pO_2										
	B HCO_3										
	SAT										
	G BASE										

LABORATORY	TIME										
	GLUCOSE										
	Na/K										
	Cl/CO_2										
	BUN/Cr										
	WBC/PLATELET										
	Hct/Hgb										

ACTIVITIES DAILY LIVING	TIME										
	MOUTH CARE										
	BATH										
	SKIN CARE										
	FOLEY CARE										
	TRACH CARE										
	ROM EXERCISES										

TURN	TIME										
SUCTION											

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	
BALANCE			

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

MEDCOM - 17276

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 b(6)-2

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [redacted] b(6)-2	INITIALS	2300	INITIAL [redacted]
NEURO		PUPILS	PERRLA			PERL	
		SENSORIUM	A+Ox3			Alert + Oriented able to communicate needs	
RESPIRATORY		RESPIRATORY PATTERN	Tachypneic, labored			Labored. RR	
		BREATH SOUNDS	Coarse + diminished in LLL otherwise CTA			Coarse to LLL.	
		SECRETIONS	None			LA	
SKIN		COLOR	Normal for Race			normal for race	
		INTEGRITY	Mid-line Abdominal Incision Staples Intact			Abd wound intact c staples	
IV SITE		LOCATION	@AC			@ AC	
		CONDITION	Ø S/S of infection			Clean	
GASTRO		ABDOMEN	Soft, Nontender			BOH - distended hypoactive bowel sounds	
		BOWEL SOUNDS	Hypoactive				
GU		URINE:	Foley to Gravity			9FC to BS	
		COLOR/CLARITY	Dark Yellow			Clean urine to drainage bag	
CARDIOVASCULAR		CARDIAC RHYTHM	ST 3 ectopy			~~ST~~ ectopy	
			Cap refill 2-3 secs			Good Cap Refill	
			Ø JVD			Edema +0 ↑ +1	
			Edema BUE + BLE			Dependent Edema	
			Skin cool to touch			Skin cool to touch	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SVA - Fractional; SAT - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] SP/AV

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 26 Aug 03

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

EPW [redacted] b(6)-4

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

DATE 26 Aug 03 | DX | HOSPITAL DAY 108/8

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line								91/60		111/64	101/59	98/60	103/61	110/64	[illegible]	[illegible]	[illegible]	
BP Cuff	92/69	104/66	111/60	103/60	98/58	89/59	101/60	117/75		111/67	97/58	90/60	102/55	105/61	100/64	102/64	96/55	
Temperature	97.2				97.5			98.1		98	98.5	97.8				97.3		
Pulse	119	118	117	116	115	118	117	117		110	121	125	104	93	115	83	110	
Respiratory Rate	37	37	32	29	30	32	34	38		38	34	33	29	27	39	35	28	
MAP	77	79	80	75	68	71	86	86		80	73	71	74	74	78	78	71	
SaO2	96	97	98	97	99	98	96	97		98	100	96	98	99	96	97	96	
O2	4L	4L	4L	4L	4L	4L	4L	4L		100%	100%	4L	4L	4L	4L	4L	4L	
Mode	NC	NC	NC	NC	NC	NC	NC	NC		NRB	NRB	NC	NC	NC	NC	NC	NC	
PA								57/23		53/15	54/15	60/18	30/20	46/17	39/18	55/18	48/16	
PCWP								27		22/13								
C.O								3.4		4.1	3.3							
Mean PA								35		31	32	35	31	30	34	32	32	
CVP													13					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°
IVPB	50								50	50								
Dobutamine											30							
~~RX~~ NS												1000						
Aline, PA line								6	6	6	6	6	6	6				
PO	240		240			240			720	240		240						48
TOTALS									776									100

OUTPUT

	HOUR / TOTAL	100	111	70	90	95	95	91	90	742	94	40	90	55	55	120	80	80	54
URINE	SP GR																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	22	23	24	01	02	03	04	05
ART	105/66	109/67	107/64	109/60	111/64	140/63	98/64	134/69
NIBP	117/56	109/60	90/8	105/66	97/53	92/59	105/60	105/55
Temp	98.6			98				98
HR	107	108	105	102	104	101	98	111
RR	29	25	32	29	27	26	26	25
M	82	78	71	81	71	70	78	73
SpO2	98	95	96	95	96	97	96	96
	4L	4L	4L	4L	4L	4L	4L	4L
	NC	NC	NC	NC	NC	NC	NC	NC
PA	50/16	55/21	35/16	34/19	33/16	34/16	44/16	64/20
MPA	33	34	31	31	31	35	30	33

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

INTAKE	22	23	24	01	02	03	04	05	8°T
IVPB	50								
PO	100				120				180
	110								

OUTPUT									
	90	110	60	60	65	55	80	60	585
	XI				XI				X2

ACTIVITIES DAILY LIVING	TIME	0000								
	MOUTH CARE									
	BATH	✓								
	SKIN CARE	✓								
	FOLEY CARE	✓								
	TRACH CARE	/								
	ROM EXERCISES	per self								

TURN	TIME									
SUCTION										

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

[redacted]

b(e) - 2

EPW# [redacted] b(6)-4

20 Aug 03

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 b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0715	INITIALS [redacted]		INITIALS	1900	INI [redacted]
NEURO	PUPILS	PERRLA				PERRLA 3mm Brisk	
	SENSORIUM	A+O×3				A+Ox3	
						Follows Simple Commands	
						Able to move extremities	
RESPIRATORY	RESPIRATORY PATTERN	Regular, Less labored				RRR	
	BREATH SOUNDS	CTA				CTA Ⓑ	
	SECRETIONS	None				Ø	
						4L NC SaO2 >96%	
SKIN	COLOR	Normal for Race				Normal for Race	
	INTEGRITY	Incision Mid-Abd				Mid Abd Dsg CDI	
		& LLQ				LLQ dsg CDI	
I V SITE	LOCATION	Ⓡ IJ Cordis c Swan				Ⓡ IJ Cordis c Swan Ganz	
	CONDITION	Swan 47cm @ Hub				2 proximal ports patent	
		Cordis, Proximal Ports				Ⓡ Radial A-Line	
		x 2 all patent to				Monitoring PA	
		flush. Ø S/S of					
		infection					
GASTRO	ABDOMEN	Soft, Nontender				Soft Round Nontender	
	BOWEL SOUNDS	Hypoactive				⊕	
		Ø N/V					
GU	URINE:	Foley to bagvity				Foley to Gravity	
	COLOR/CLARITY	Dark yellow				Dark yellow, clear	
CARDIOVASCULAR	CARDIAC RHYTHM	ST c occasional				SR c multifocal PVC	
		PVC, Ø JVD				& unifocal PAC	
		Cap Refill < 3 secs				Generalized edema c	
		Edema +3 BUE +				+3 pitting to extremities	
		BLE				Cap Refill < 3 sec	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC: ICU | DATE: 20 Aug 03

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

EPW# [redacted] b(6)-4

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

#[redacted] b(6)-9

DATE 8/9 AUG 03 — DX — HOSPITAL DAY

VITALS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial Line	106/65	100/61	102/65	125/67	94/69	98/57	114/62	106/65		98/59	104/59	114/68	116/68	105/65	112/67	123/73	89/47	
	BP Cuff	109/66			111/61	92/56	96/64	92/62	105/66		90/59	104/63	96/50	102/61	105/63	104/64	103/62	111/69	
	Temperature	98.8				98.1					97.5				98.0			97.9	
	Pulse	90	95	101	101	99	95	85	81		81	87	76	80	78	77	78	77	
	Respiratory Rate	28	32	33	24	21	23	21	21		22	26	26	19	23	17	31	20	
	MAP	72	75	74	82	65	72	76	77		71	71	81	81	79	80	80	90	
	SaO2	95	97	97	99	100	98	98	97		98	94	97	97	99	97	98	98	
	O2	4L	4L	4L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	
	mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	PA	48/17	45/14	45/12	46/13	53/15	48/16	40/16	50/15		44/14	46/14	49/15	4/14	44/13	35/13	36/13	34/16	
	PCWP		13												13				
	CO																		
	mean AA	29	28	26	27	30	29	27	27		27	26	27	26	25	25	26	14	
	CVP																		

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
	IVPB		50							50	50								50
	PO	240	118		80			236	60	734		80					60	60	200
																			250
	TOTALS									784									250

OUTPUT		HOUR / TOTAL	60	70	70	60	80	135	90	130	695	80/80	100/180	106/286	86/366	100/466	90/556	100/656	80/736	936
	URINE	10 gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC		(+)																
	EMESIS			Large Black Tarry Stool					Large Black Tarry Stool					Large Black Tarry Stool						
	STOOL																Sm. for Stool			
	DRAINS																			
	TOTALS																			

POST-OP DAY

VITAL SIGNS	00	01	02	03	04	05
	124/72	129/65	125/66	124/64	121/63	118/70	121/64
	110/60	107/52	113/62	104/60	104/59	100/68	102/59
			98		99		
	78	72	77	78	77	77	80
	16	18	18	19	21	18	20
	80	70	80	76	95	80	81
	98	100	96	97	98	98	100
	4L	4L	4L	4L	4L	4L	4L
	NC	NC	NC	NC	NC	NC	NC
	34/13	47/12	43/12	39/13	37/13	40/13	42/15
	13				12		
	27	26	26	26	26	26	27

INTAKE								
								8° T
	50							
	120							

OUTPUT								
	95/95	90/105	80/45	80/45	80/45	50		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	0340	0340								
		MODE	ABG	ABG								
		F_iO_2										
		TV										
		RATE										
		PEEP										
	A	pH	7.447	7.544								
	A	PCO_2	21.3	28.2								
	A	pO_2	66	21								
	B	HCO_3	23	24								
	B	SAT	97	44								
	G	BASE	2	2								

LABORATORY DATA	TIME	26 Aug 1954	27 Aug 0352	1200	2010						
	GLUCOSE	~~147~~ 96	143								
	Na/K		134/3.5								
	Cl/CO_2		102/21								
	BUN/Cr	53/1.3	47/1.3								
	WBC/PLATELET	37.1/109		53.7/108	31.8/99						
	Hct/Hgb	28.4/8.6		26.7/8.1	25.1/7.8						

ACTIVITIES OF DAILY LIVING	TIME	0715			TURN	TIME 0715	0808			
	MOUTH CARE									
	BATH	X				1900	2000	2200		
	SKIN CARE	X								
	FOLEY CARE	X			SUCTION					
	TRACH CARE									
	ROM EXERCISES	X								

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	784	Urine: 695
PO	250	736
TOTAL		TOTAL

BALANCE _____

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0615	INITIALS [redacted] b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm PERRLA			3mm PERRLA	
	SENSORIUM	Alert, able to follow simple commands, oriented to person			A+O x 3 able to follow commands	
RESPIRATORY	RESPIRATORY PATTERN	NL Oz via NC, labored			4L NC SATS @ 99%	
	BREATH SOUNDS	~~Clear throughout~~			Labored breathing, diminished @ BS.	
	SECRETIONS	@ noted @ this time diminished BSS throughout				
SKIN	COLOR	WNL for race			NFR, incision to midline abd. staples c/d/I	
	INTEGRITY	midline abd incision staples, 40 dressing				
IV SITE	LOCATION	@ RIJ cordis sheath			@ RIJ cordis & swan, @ Flank NS @ 20 cc/hr infusing through prox port. A line to @ radial @ Flank @ Groin	
	CONDITION	Swan 47cm @ hub, 2 proximal ports patent + flush easily, @ radial A-line, @ PIV c 0% S of infection				
GASTRO	ABDOMEN	soft, round, nontender			BS x 4 quad, hypoactive soft, round nontender	
	BOWEL SOUNDS	(+) hyperactive @ naso NGT to LIS Brown drainage noted			NG tube to @ Nare clamped PF NPO	
GU	URINE: COLOR/CLARITY	Foley to gravity draining clear yellow urine			Foley to gravity clear yellow urine c sediment	
CARDIOVASCULAR	CARDIAC RHYTHM	SR c complet + multifocal PVCs, +3 palpable pulses in all 4 ext, Cap refill < 3 sec, generalized edema throughout			multifocal PVCs @ pulses x 4 extremities, cap refill < 3 sec generalized edema throughout	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; Fx - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 28 AUG 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

DATE 28 AUG 03 — DX — HOSPITAL DAY

VITALS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line	135/68	131/65	116/100	124/63	134/71	139/77	124/65	134/76	135/73	127/71	137/70	143/76	147/85	150/85	153/88	162/87	
BP Cuff	113/67	116/66	100/70	102/65	109/71	112/63	118/62	129/70	116/68	119/70	131/74	131/75	131/70	131/76	132/80	126/80	
Temperature	97.4	97.7	97.9	98.4	97.0	97.9	97.9	98.0	98.0	99.5	97.7	98.0	97.9				
Pulse	116	80	76	78	75	76	71	71	69	72	69	67	69	68	74	69	
Respiratory Rate	20	22	18	15	8	14	11	14	12	18	23	19	19	17	14	20	
MAP	85	85	82	80	82	78	84	92	86	88	95	95	94	98	94	88	
SaO2	98%	96%	100%	99%	100%	99%	99%	97%	98%	98%	98%	99%	98%	97%	99%	99	
O2	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	
mode	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	N3	
PCWP	13							13				13					
mean PA	27	27	27	26	27	27	27	26	26	26	26	26	25	26	27	28	

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVPB	50								50	50								
MIVF				75	75	75	75	75	375	75	75	75	75	75	75	75	75	
Blood					350				350									
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
URINE		38/38	75/113	60/173	65/238	95/333	48/381	42/423	70/493	493	60/553	55/608	320/928	60/1028	40/1068	209/1277	80/1357	86/1443	1443
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL								KT											
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

22	23	24	01	02	03	04	05	
160/88	149/86	158/87	157/84	154/84	147/85	166/91	167/90	
138/85	125/84	133/85	140/80	137/83	121/78	120/72	123/80	
98.7	98.5	98.7	97.7	97.5	96.8	97.9		
70	71	72	59	73	69	77	75	
23	23	21	22	22	17	16	20	
103	99	103	108	101	97	93	98	
99%	97	97%	97	96	97	96	97	
4L	4L	4L	4L	4L	4L	4L	4L	
NC	NC	NC	NC	NC	NC	NC	NC	
29	32	24	23	24	24	24	26	

INTAKE

22	23	24	01	02	03	04	05	8° T
80								
75	75	75	75	75	75	75	75	

OUTPUT

90/70	80	88	76	74	60	84	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
A		pH									
		PCO_2									
		pO_2									
B		HCO_3									
		SAT									
G		BASE									

LABORATORY DATA

TIME	0437								
GLUCOSE	120								
Na/K	123/3.?								
Cl/CO_2	103/19								
BUN/Cr	32/0.9								
WBC/PLATELET	25/104								
Hct/Hgb	25.4/7.9								

ACTIVITIES OF DAILY LIVING

TIME				TURN / SUCTION	TIME				
MOUTH CARE									
BATH									
SKIN CARE									
FOLEY CARE									
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV	________	Urine:	________
po	________		________
	________		________
TOTAL	________	TOTAL	________

BALANCE ________

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

MEDCOM - 17285

M. AL RECORD-SUPPLEMENTAL MEDICAL

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [redacted] b(6)-2	INITIALS	1900	INITIALS
NEURO		PUPLIS	PERRLA			Perl	
		SENSORIUM	A+O×3, Follows Commands			Alert & Oriented. Able to commicate needs, follows all commands	
RESPIRATORY		RESPIRATION PATTERN	Regular + Unlabored			IQ & unlabored	
		BREATH SOUNDS	Crackles RML otherwise CTA in all other lobes			Ø Alterations	
		SECRETIONS	Ø secretions				
SKIN		COLOR	Normal for Race			Normal for race	
		INTEGRITY	Incision Mid-line Abdomen, UQ			incision to mid-abd.	
IV SITE		LOCATION	®IJ Swan			® Radial A-line &	
		CONDITION	- Øs/s of infection			Ø s/s of infection	
			®Radial Aline - Øs/s of infection				
GASTRO		ABDOMEN	Soft, Nontender			Slightly distended.	
		BOWEL SOUNDS	Hypoactive Ø N/V			Hypoactive Bowel sounds	
GU		URINE	Foley to Gravity			4FC-UOBS - amber	
		COLOR/CLARITY	Dark Golden Color			color urine noted to foley.	
CARDIOVASCULAR		CARDIACRHYTHM	NSR, Ø ectopy noted @this time			Ø Ectopy. HR 69	
			Cap refill < 3 secs			Good Capillary Refill	
			Edema +3 BUE & BLE			+ pulse to all extremities Edema noted to extremities	

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY *(Sign)* [redacted] aff/fn

DEPARTMENT/SERVICE/CINC ICU 1

DATE 29 Aug 03

PATIENT'S INDICATIONS *(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)*
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17286

DATE 29 Aug 03 | DX S/P Ex [redacted] p, R clavicular Fx | HOSPITAL DAY

	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITALSIGNS	BP Arterial line							161/86	137/92		152/88	165/81	148/83	158/86	142/85	140/75	140/83	139/88	
	BP Cuff							150/84	132/78		129/84	127/84	129/87	139/86	121/77	135/81	131/80	110/77	
	Temperature								97.2						97.7				
	Pulse							68	71		72	67	65	70	65	61	61	65	
	Respiratory Rate							18	21		16	19	17	18	19	19	19	23	
	MAP							107	115		105	109	100	106	102	95	100	104	
	SaO2							97	98		97	97	98	98	97	98	98	99	
	O2							4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	
	Mode							NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	PAP							39/17	36/15		37/16	DC'd							
	Mean PA							27	29		24								

	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
INTAKE	NS ε 20 KCl							75	75	150	75	75	75	75	75	75	75	75	600
	IVPB							50	~~200~~ 50	50							50		50
	PO								478	478					900		240		740
	TOTALS									678									1390
OUTPUT	URINE HOUR / TOTAL							100	100	200	100	30	30	46	20	18	3	3	250
	URINE SP gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG PH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
ABP	152/97	145/94	148/93	151/92	144/85	144/82	140/86	150/88	
NBP	147/96	126/83	127/86	130/85	118/78	119/79	120/82	121/80	
T	97⁷			97⁵		98			
HR	65	65	65	58	109	106	68	72	
R	23	24	25	22	26	16	15	22	
MAP	113	108	100	104	103	98	103	105	
Sats	96	95	99	97	98	99	96	96	
O_2	4L	4L	4L	4L	4L	4L	4L	4L	
Mode	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE / OUTPUT

	16	17	18	19	20	21	22	23	8°T
INTAKE	75	75	75	75	75	75	75	75	600
							50		50
		480		120		120			720
									(1370)
OUTPUT	5	3	500/500	15/576	75/650	50/730	100/800	100/900	(900)
Stool				x11					(x2)

RESPIRATORY DATA

	TIME								
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

	TIME								
TIME	0456								
GLUCOSE	97								
Na/K	139/3.4								
Cl/CO_2	104/22								
BUN/Cr	33/1.1								
WBC/PLATELET	9/84								
Hct/Hgb	30.7/9.4								

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATCH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN / SUCTION — TIME

24° I&O TOTALS

WT Yesterday ________ wt Today ________

INTAKE: IV ________ Po ________ TOTAL ________

OUTPUT: Urine: ________ ________ TOTAL ________

BALANCE ________

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

b(6)-4

EPW #[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL [redacted]A

30AUG03

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 8Mar 89

INITIAL SHIFT ASSESSMENT

			INITIALS		INITIALS		INITIALS
NEURO	TIME	0710	[redacted]	b(6)-2			
	PUPLIS	PERRLA				PERRL	
	SENSORIUM	A+Ox3				A+Ox3 able to follow simple commands.	
RESPIRATORY	RESPIRATION PATTERN	Regular + Unlabored				RR+L. CTA Bilat symetrical rise + fall of chest. No use of accessory muscles	
	BREATH SOUNDS	CTA, Diminished Bases					
	SECRETIONS	None					
SKIN	COLOR	Normal for race				NFR Incision	
	INTEGRITY	MiD-line Abd & LLQ				Midline to abd stg II	
		Incisions Stage II Decub - @Buttock				Decub to buttock, Skin tear @ Flank	
IV SITE	LOCATION	@ IJ Cordis				@ IJ cordis	
	CONDITION	Patent & S/S of infection				(+) Flush @ S/S of infection @ redness A-line @ flush, Zeroed @ S/S of infection	
		@ Radial Aline					
		Intact & S/S of infection					
GASTRO	ABDOMEN	Soft, Nontender				Soft, round, nontender.	
	BOWEL SOUNDS	Hypoactive				Hypoactive BS x4 quad.	
		@ N/V					
GU	URINE	Foley to Gravity				Foley to gravity minimal amount (30cc/hr) clear yellow urine	
	COLOR/CLARITY	Yellow					
		Purulent Drainage noted on penis					
CARDIOVASCULAR	CARDIACRHYTHM	SR & occasional PVCs				SR & occasional PVCs. <3 sec Cap refill.	
		Cap Refill <3secs					
		@ JVD, Edema 2 DP/PT					

LEGEND

Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; F_IO_2- Bicarbonate; ICP - Intracranial Pressure; PCO_2- PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAI - Saturation; TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CINC ICU I

DATE 30AUG03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW #[redacted] b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

EPW #[redacted] b(6)-4

DATE 30AUG03 DX SP EX [redacted] P. @ iliac, FX HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	148/41	135/86	128/75	141/88	154/85	129/84	150/85	168/96		133/78	143/87	140/86	146/90	139/83	143/88	153/91	123/71	
BP Cuff	117/81	130/84	117/72	119/76	130/81	154/83	123/83				127/77	123/77	113/85	118/82				
Temperature	98[1]			96		97.4				98[C]				98[1]				
Pulse	70	65	102	59	62	67	74	70		74	75	71	69	77	69	70	76	
Respiratory Rate	21	15	15	13	21	21	18	27		19	14	16	15	20	13	27	21	
MAP	109	101	89	98	104	114	107	115		93	102	101	102	96	105	109	86	
Sats	96	98	98	98	100	98	97	98		97	96	96	93	91	97	93	96	
O2	4L	4L	4L	4L	4L	4L	4L	4L		2L	2L	2L	RA	RA	RA	RA	2L	
MODE	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC					NC	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS c 20KCl	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
IVPB							50		50							50		50
PO				120		120			240	360			180			240		780
TOTALS									890									1430

OUTPUT

		HOUR / TOTAL	100 / 100	100 / 1000	75 / 1075	50 / 1125	100 / 1225	75 / 1300	100 / 1400	150 / 1550	1550	50	60	70	105	55	66	65	75	546
URINE		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GU/AC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	133/83	165/96	144/88	154/91	147/91	151/92	159/91	134/82
	98¹							
	72	71	75	75	73	70	75	76
	24	24	24	21	18	16	23	21
	97	118	106	109	108	107	110	97
	97	99	93	97	96	97	96	96
	22	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC	NC	NC	NC

INTAKE

	16	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	
		240	450						

OUTPUT

	45	40	35	40	38	50	68	100

RESPIRATORY

	TIME											
	MODE											
	F_1O_2											
	TV											
	RATE											
	PEEP											
A	pH											
A	PCO_2											
B	pO_2											
B	HCO_3											
G	SAT											
G	BASE											

LABORATORY

	TIME	0352	1720									
	CLUCOSE	100										
	Na/K	135/4.5										
	Cl/CO_2	105/24										
	BUN/Cr	25/0.6										
	WBC/PLATELET	14.3/88	16.8/112									
	Hct/Hgb	23.5/9.0	31.9/9.8									

ACTIVITIES

	TIME											
	MOUTH CARE											
	BATCH											
	SKIN CARE											
	FOLEY CARE											
	TRACH CARE											
	ROM EXERCISES											

DAILY LIVING

TURN

SUCTION

TIME

24 HR TOTALS

NURSE'S SIGNATURE

INITIALS

WT Yesterday _____ wt Today _____

INTAKE OUTPUT

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

[redacted]

MEDCOM - 17291

MEDI[redacted]ECORD-SUPPLEMENTAL MEDICAL DA[redacted]on General

For use of this form see, [redacted]40-66; the proponent agency is The Office of The [redacted]

OTSG APPROVED (Date) QA Appr 8Mar 89 b(6)-2

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

		TIME	0800	INTILAS		INTILAS	1830	INTILA[redacted]
NEURO	PUPLIS		PERRA				PERRA	
	SENSORIUM		Alert Verbalizes need appropriately				Alert, speaks in broken english as appropriate	
RESPIRATORY	RESPIRATION PATTERN		RRR SOB ē ↑ activity 4o CPM				RRR	
	BREATH SOUNDS		B				CTA, slight ↓ (R) base	
	SECRETIONS						Ø	
SKIN	COLOR		WNL Rare				WNL	
	INTEGRITY		abd, Ø flank dressing D+I				abd dsg CDI	
IV SITE	LOCATION		(R) SC cordis				(R) IJ cordis ~~flow~~	
	CONDITION		D+I ∃ infection				Patent Ø s/s of infx	
GASTRO	ABDOMEN		Distended but non tender				Round nontender	
	BOWEL SOUNDS		Normal BS all quadrants				(+) bowel sound x4 quadrants	
GU	URINE		DC foley 0900				Ø voiding via urinal	
	COLOR/CLARITY		put out 700 cc 2 hours from foley				Clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM		NSR ē rare PVC rate ↓ 80-90's generalized edema upper flow ext.				NSR, rate 70-80's, cap refill <3 sec	

LEGEND: Cr - Creatinine; F_IO - Fraction of inspired O_2; F_IO_2 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

b(6)-2

PREPARED BY (Signature & Title) [redacted] RN

DEPARTMENT/SERVICE/CINC

DATE 3 FEB 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 17292

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	0	2	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	152/86	148/86	136/77				130/74	126/69										
BP Cuff	143/80	149/86		123/75	114/72	131/78	113/73			117/73	125/83	141/79	131/71	140/65	146/71	165/73		
Temperature	98°		98.5		98.1	98.1	98			98.2			98.4			98.2		
Pulse	70	72	75	75	74	71	67	69		57	57	66	70	68	72	75		
Respiratory Rate	11	16	18	17	15	18	16	12		18	30	37	24	20	22	24		
O2 SAT	96	97%	97	94	97	97	98	98		97	95	95	94	95	99	94		
Source	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC		
	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS c 20 meq KCl	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
IVPB							50		50									
P.O.											150						150	300
TOTALS										D/C'd								

OUTPUT

	HOUR / TOTAL	20	100 / 120	100 / 220	200 / 420	150 / 570	200 / 770	250 / 1020			250 / 1000					300 / 1400		200 / 1600	1600
URINE	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
		1143							
	145/88	79	131/77	140/65	135/74	134/73	130/80	120/80	
T	98.0	99.8		98.6	98.6		98.2	98.3	
A	67	74	76	82	73	75	75	80	
L	29	26	23	23	21	17	23	22	
	96	94	94	93	94	94	95		
S	NC	NC	NC	NC	NC	NC	NC	NC	
	2L	2L	2L	1L	1L	1L	1L	1L	

INTAKE

	16	17	18	19	20	21	22	23	8°T
I	75	75	75	75	75	75	75	75	600 600
							50		50 50
N		150					50		200

OUTPUT

O			350/180				475/1335		2335

RESPIRATORY

	TIME									
	MODE									
	F_iO_2									
DIABETIC	TV									
	RATE									
	PEEP									
	A: pH									
	B: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

LABORATORY

	TIME									
	CLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING

	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN

TIME						

SUCTION

24^180 TOTALS

NURSE'S SIGNATURE

INITIALS

[redacted]

b(6)-2

WT Yesterday

wt Today

INTAKE		OUTPUT	
IV	1900	Urine:	4050 ~~2335~~
Po	500		4050
TOTAL	2400	TOTAL	~~2335~~
		BALANCE	~~-65~~ 1650

MEDCOM - 17294

M[redacted]L RECORD-SUPPLEMENTAL MEDICAL[redacted]
For use of this form see, AR 40-66; the proponent agency is The Office of [redacted]urgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)*
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

Section	Item	TIME	INTILAS	0730	INTILAS	1900	INTILAS
NEURO	PUPLIS			PERRLA.	[redacted]	3mm PERRL	[redacted]
	SENSORIUM			Oriented, alert.		Awake & follows	
				MAE purposefully		simple commands	
				c̄ Limited ROM 2°			
				Contractures —			
RESPIRATORY	RESPIRATION PATTERN			O_2 1L N/C c̄ SATS		RRR, on O_2	
	BREATH SOUNDS			95%. BS c̄ END		NC @ 1L c̄ O_2 sat	
	SECRETIONS			Exp. Rhonchi +		≥ 95%. lung fields	
				↓↓ Bases Esp on		coarse.	
				(R). Mouth Breath			
				occ. c̄ exercise.			
SKIN	COLOR			membrane pink.		NFR	
	INTEGRITY			Stage (2) decub			
				coccyx — (R) Buttock			
IV SITE	LOCATION			(R) cocdis c̄ NS c̄		(L) hand c̄ NS c̄ 20mg	
	CONDITION			20K @ 75°. Site		KCL @ 75cc/hr	
				intact s̄ noted			
				edema, erythema.			
GASTRO	ABDOMEN			Obese, soft c̄		F, ST, ND, + BS x 4	
	BOWEL SOUNDS			(+) BS in (4) Quads		quads, good appetite	
				Non-Tender c̄ tarry			
				Black stools. —			
GU	URINE			Voids spontaneous		to urinal QS	
	COLOR/CLARITY			to urinal. —		clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM			SR c̄ HR 80's. (A)		NSR, S_1S_2 normal	
				Irregular.		no ectopy, murmurs	
				Periph edema 3-4+		noted on auscultation.	
				Cap refill < 3 Sec.			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive and Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

b(6)-2

(Continue on reverse)

[redacted] 9WMGM3

DEPARTMENT/SERVICE/CINC: ICU #1

DATE 1 Sept 03

[redacted]S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

HUD [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☒ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 4700, 1 MAY78
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17295

DATE 1 Sept 03 | DX S/P Ex [redacted] p Rt Iliac FX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff	114/80	135/85	129/83	123/81	130/84	124/82	134/83	135/98		120/76	136/76	123/44	125/81	135/76	X	X	X	
	Temperature	98.3		98.4		98.4			98		X	X	X	X	X				
	Pulse	74	74	72	72	83	73	69	78		78	92	80	76	71	67	71	69	
	Respiratory Rate	12	18	17	22	21	23	15	16		14	15	16	17	15	22	26	28	
	SpO2	95	95	95	97	95	95	95	98		95	96	97	97	97	96	96	97	
	Source	NC	NC	NC	NC	NC	NC	NC	NC										
		1L	1L	1L	1L	1L	1L	1L	1L										

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS c 20 mEq KCl	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
	IVPB							50		50							50		50
	P.O.								480	480									480
	TOTALS																		

OUTPUT																				
	URINE	HOUR / TOTAL	450		450 900	550 1450	525 1975	450 2425		NM (-9)	240	550		575				400	1602
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL									Lg Black										
	DRAINS																			
	TOTALS																			

POST-OP DAY 26

VITAL SIGNS

	14	17	18	19	20	21	22	23	
BP	X			132/78	130/71	126/74	117/73	130/75	
T		99			99.3	99.5			
P	66	62		75	76	72	72	77	
RR	15			22	15	17	19	25	
SpO2	95	96		96	96	97	96	96	

INTAKE

	14	17	18	19	20	21	22	23	8°T
IV	75	75	75	75	75	75	75	75	

OUTPUT

			475		500		350	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_IO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

TIME	
CLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME		
MOUTH CARE		
BATCH		
SKIN CARE		
FOLEY CARE		
TRACH CARE		
ROM EXERCISES		
Chair	07	1930

TURN SUCTION

TIME
0700

24°180 TOTALS

WT Yesterday ____ wt Today ____

INTAKE	OUTPUT
IV 1900	Urine: ____
Po 500	____
TOTAL 2400	TOTAL ____

BALANCE ____

NURSE'S SIGNATURE | INITIALS

D(65-7

[redacted]

M[redacted]AL RECORD-SUPPLEMENTAL MEDICAL

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 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS		INTILAS
NEURO	PUPLIS						
	SENSORIUM						
RESPIRATORY	RESPIRATION PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
G U	URINE						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM						

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC

DATE 02 SEP 93

PATIENT'S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

[redacted] b(4)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17298

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	148/73	129/73	137/79	134/78	125/76	120/77	134/79	132/76										
Temperature	98.9									98.3								
Pulse	76	73	74	74	70	72	69	73										
Respiratory Rate	22	22	22	16	20	24	18	21										
O_2 SAT	95	93	95	95	94	97	95	97										
Source	NC	NC	NC	NC	NC	NC	NC	NC										
	2L	2L	2L	2L	2L	2L												

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	76	75	75	75	75	75	75	75										
TOTALS																		

OUTPUT

	HOUR / TOTAL	300		400			300		400										
URINE	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

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: 17AUG03 Anesthesia Type (Circle) (General) Spinal Epidural IV Sedation Nerve Block

Time In:

Allergies: NKDA OR Intake: Crystalloid 1600 cc Colloid Hespan 500 cc

Pre-op V/S: 127/67 OR Output: UOP 450 EBL 100

Procedures: I&D shrapnel wounds (L) flank | ex lap Meds/Times: anectine | 250 fent vec - reversed @ end 40 Esmolol - HTN

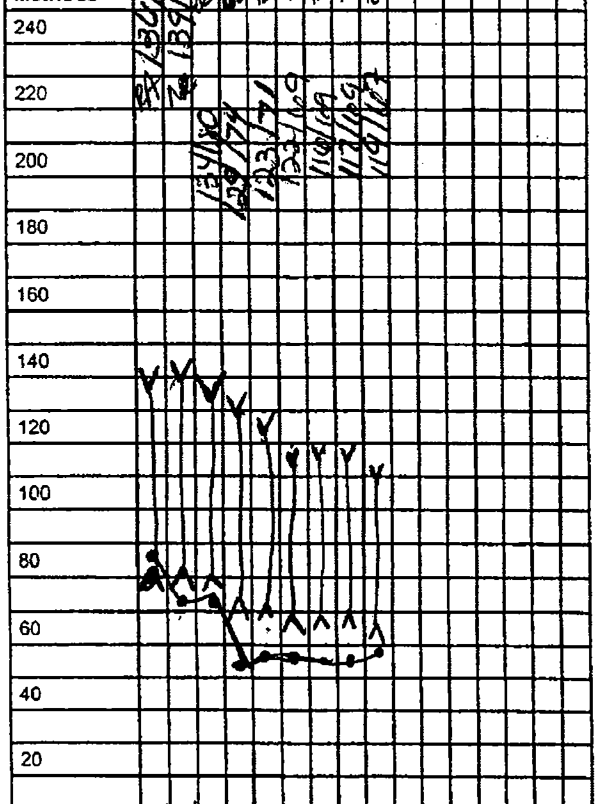
X Iliac crest (L)

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	0845	0912	0925	0940	0955	1010	1025	1040	1055	D/C ICU 2				
SaO2	95	100	100	100	100	100	100	100	100					
FiO2			FM	FM	FM	FM	FM	m	m					
Methods					4L	4L	4L	4L	4L					



RR	24	21	22	22	20	20	20			
T	96		99		98					
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	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	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	11	11

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU 2 | DATE 17/8/03

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

[redacted] 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

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	(D)HP	+	+	P	++	W	Pk
15'	|	+	+	P	++	W	Pk
30'	|	+	+	P	++	W	Pk
45'	|	+	+	P	++	W	Pk
60'	|	+	+	P	++	W	
90'	|	+	+	P	++	W	Pk
D/C	(D)HP	+	+	P	++	W	

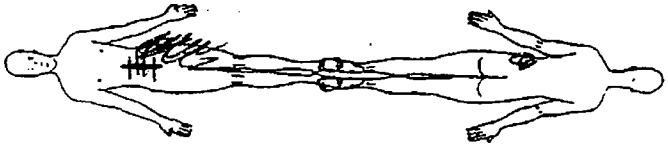
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ABD (D)HP	Dsngs	++
30'	ABD (D)HP	|	++
60'	ABD (D)HP	|	++
D/C	ABD (D)HP	DSNG	++



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0600	Foley	Yellow	400 cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0400	SB	ϕ	ϕ

WAMC OP 173-E

NURSING NOTES

Received pt p surgery. He was able to articulate (he was cold and in a pn. as well as how his wound was to the MD. Pt SPO2 ~95% RA. Placed on 6LFM that SPO2 ~ 100%. while sleeping. Pt able to take deep breaths c encouragement. SB but ϕ symptomatic. Dsngs intact. c serosang. drainage noted through silk tape. (D)hip dsng has Penrose drng tubing. Pt currently sleeping c FM on + SPO2 ~95% 4LFM. —CPT [redacted] Uneventful recovery. Pt cont to sleep c SPO2 100% c 4L FM. Dsngs intact——

CPT [redacted]

Discharge Criteria:
Date: 18/6 Time: 0600 PARS: 11
BP: 119/67 T: HR: 58 RR: 20 Sa02: 100%
Pain Level at D/C (0-10):
Intake: ϕ Output: —
Additional Data: ϕ
Transferred To: Remained @ ICU 2
Report Given To: N-A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/a
Cleared IAW Recovery Room SOP
Charge Nurse Signature: CPT [redacted]

F (3) A

21 AUG 03

ICU Flowsheet — Patient Name: E PW [redacted] — 1330 / Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature																			97.7			97.9				
Pulse																			88	87	86	88	83	83	81	
~~B/P A-Line~~																										
MAP																										
B/P Cuff																			99/58		100/61	102/69	109/68	106/63	97/67	
Respirations																			35		32	36	32	30	20	
Sa02																			99%	100%	100	99	99	97	98	
~~100% NRB~~																					12 L	10L	10	10	10	
SOURCE																					NRB	NRB	NRB	NRB	NRB	
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF																										
LR																			1000	125	125	125	125	125	125	1750
~~LR~~ 1 Bolus																							500		500	1000
IVPB																				50						50
PO intake																			Ø							
O.R. IN																										
Totals																										~~2850~~ 2850
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly																			~~50~~ 50	75/15	~~75~~ 75	30/105	30/135	30/165	30/195	195
NG Tube																			Ø							
Drains #1																			Ø							
#2																			Ø							
#3																			Ø							
Emesis/Stool																										
O.R. OUT																										
Totals																										

J96

24 hour input	
24 hour output	
24 hour balance	

M `AL RECORD-SUPPLEMENTAL MEDI ATA
For use of th see AR 40-66; the proponent agency is the Office Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(4)-2	Time: 2050 Initals [redacted] b(4)-2
NEURO	Pupils	2R	PERRL, 3mm Alert.
	Sensorium	A/O	Moves all extremities. Sensation
	LOC / GCS		intact. Swallows ⊖ difficulty.
CARDIAC	Cardiac Rhythm	SR ⊂ ectopy	SR ⊂ frequent PVC's. Radial/
	PRI: / QRS:		Pedal pulses 3+. Cap refill
	Pulse Strength	2+	<4 sec. 2+ Anasarca. ⊖ CP
	Cap Refil / JVD		cool extremities.
	Edema	1+	
	Chest Pain	⊘	
RESP	Respiratory Pattern	equal use/full	Even, Regular, unlabored.
	Breath Sounds	CTA↑	Clear all lung fields, ↓ RLL.
	Secretions	⊘	Strong cough ⊘ secretions.
	Cough	⊘	
SKIN	Color	NFR	WNL cool extremities. Dry.
	Integrity	COF	2cm pink skin, open to ® buttock/hip.
	Backside	2cm skin tear to b.l/buttocks	Petroleum gauze ⊂ tegaderm over.
IV	Access Devices	PIV x1	IV ® AC infusing D5½NS ⊂
	Location	®AC	20 KCl @ 125 cc°. Dressing intact.
	Condition	COF	
GI	Abdomen	soft	Slightly distended. Incision
	Bowel Sounds	⊕	ML abdomen ⊂ staples intact. ⊘
	Stoma/Ostomy	⊘	drainage. Tolerates meals. ⊘ BM
			ABS x4. Nontender.
GU	Device	foley	Foley replaced. Foley to DD.
	Color / Clarity	yellow, clear	Clear yellow urine adequate.

(Continue on reverse)

PREP [redacted] b(4)-2 DEPARTMENT/SERVICE/CLINIC b(2)-2 DATE
ICU #1, [redacted] 23 Aug 05

PATIENT'S IDENTIFICATION (For type[redacted]tries give: Name – last, first, middle; grade; date; hospital o[redacted]acility)
NAME: EPW #[redacted] RANK: AGE:
UNIT: b(4)-4 GENDER: M
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

USAPPC V2.00

F-139

ICU Flowsheet

Patient Name: EPW # [redacted]

Date: 08/23/2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	96.8 (A)				96.8 (A)					96.7							98.7							97.8 (A)		
Pulse	69	69	69	73	70	69	76	73	71	72	73	74		71	77	76	78	76	62	74	72	71	75	73	71	
B/P A-Line																										
MAP	81	90	86	94	85	94	94	91	94	91	96	80		95	94			90	87	97	91	90	85	90	85	
B/P Cuff	96/69	115/74	110/71	116/77	108/72	119/77	113/83	115/72	119/76	114/71	120/83	139/76		129/74	121/77	110/66	117/71	119/76	105/67	130/73	124/75	113/73	109/70	117/68	109/70	
Respirations	20	21	24	25	21	21	23	15	20	20	18	18										24	16	24	19	
Sa02	98	96	93%	93%	97%	94%	93%	95%	95	99	95	94		100	95	96	95	97	97	96	96	95	95	97	96	
FiO2	4L	4L	2L	2L	2L	1L	—	1L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Mode	NC	NC	NC	NC	NC	NC	RA	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF	125	125	125	125	125	125	125	125	125	125	125	125	1500	125	125	125	125	125	125	125	125	125	125	125	125	1500
				50							50		100			125 NS	125 bolus		500 NS			50				800
PO intake	120		180		210	120	150		1000		240	240	2260			400				400					120	920
O.R. IN																										
Totals													3880													3220
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	100/100	100/200	100/300	100/400	125/525	100/625	75/700	100/800	30/830	30/860	22/882	110/992	1022	70/70	30/100	25/125	30/155	34/189	20/209	15/224	15/239	300/539	100/639	110/749	65/814	814+
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													1022													814+

24 hour input	7700
24 hour output	1836+
24 hour balance	+5864

b(a)-2

INITIAL SHIFT ASSESSMENT

		Time: 06 Initals: [redacted]	Time: 1..3 Initals: [redacted]
NEURO	Pupils	PERRLA	PERL, Alert and communicative needs 5 difficult.
	Sensorium	Appear drowsy but easily	
	LOC / GCS	arousable. Able to verbalize	
		needs	
CARDIAC	Cardiac Rhythm	Rare PVC, noted gallop	Pulse strong. Good cap.
	PRI: / QRS:	rhythm. Mild JVD (R)	refill. Generalized edema
	Pulse Strength	strong	noted to LV+1 (B) extremities
	Cap Refil / JVD	<3 sec / @ JVD	
	Edema	generalized edema 1E H+	
	Chest Pain	generalized CP (R) chest	
RESP	Respiratory Pattern	Labored @ 2L NC sat 96-98%.	2L O2 via NC Sat 95%.
	Breath Sounds	(L) CTA c diminished BS (R) base	Diminished sounds (R) base
	Secretions	@ exchange	
	Cough	@	
SKIN	Color	appear jaundice	normal for race.
	Integrity	Abd staples intact	Staples intact to abd.
	Backside		
IV	Access Devices	(R) arm D&I PIV	(L) arm PIV D5 1/2 NS +20 KCl
	Location	LR 125 cc/hr	@ 75 cc/hr. PIV patent +
	Condition		intact 5 swelling/redness to
			area.
GI	Abdomen	distended but soft staples	Staples intact to abd. Slight
	Bowel Sounds	open to air. BS hypoactive	distention noted.
	Stoma/Ostomy	both quadrants	BS hypoactive.
GU	Device	foley to gravity, yellow	F/C to BS c dark yellow
	Color / Clarity	amber colored urine	urine draining

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted] b(2)-2

DATE

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

NAME: EPW [redacted] b(a)-4 RANK: AGE:

UNIT: ICU 1 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

LSAPPC V2.00

PT'S NAME: EPW [redacted] Dust 4

ID#:

DATE: 24 Aug 03

25Aug03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP	125/81	134/80	127/75	120/82	126/82	116/79	118/76	125/84	123/80	110/71	116/78	113/79	120/82	115/77	124/75	130/75	119/79	120/84	123/82	123/84	127/80	112/77	137/80	117/76
TEMP	98.0			98.2			98.3			98.0		95.7		97.1		97.6			97.9	98.1		97.1		
PULSE	75	75	77	73	72	72	76	80	93	81	89	93	94	102	101	102	102	102	103	103	105	106	102	103
RESP	18	24	18	21	20	15	21	18	26	21	20	29	28	32	32	29	26	27	32	31	34	34	30	26
SP02	98	98	98	96	97	96	96	94	94	96	96	95	94	95	94	96	94	95	94	95	94	93	98	95
FIO2	2L	2L	2L	2L	2L	2L	2L	RA	RA	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
INPUT																								
IV D5.5 2/3	125	125	125	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
PO	100	50		150			150			150		50		150		150			150	50				
NGT	—																							
O.R. IN	—																							
SUB TOTAL																							1459	
TOTAL																								
UT																								
URINE	100	100	150	100	100	90	100	75	80	90	100	150	80	100	60	100	70	45	60	46	46	120	140	
NGT																							970	
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

AL RECORD-SUPPLEMENTAL MED ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: 1945 Initals: [redacted]
NEURO	Pupils	2-R/2R	PERRL 3mm, Alert. Speaks little english. Moves all extremities. Sensation intact.
	Sensorium	Alert,	
	LOC / GCS		
CARDIAC	Cardiac Rhythm	SR c ectopy	SR c frequent PVC's. Asymptomatic. Radial/pedal pulses 3+. Cap refill < 3 sec. Cool BLE. 2+ edema BLE.
	PRI: / QRS:		
	Pulse Strength	2+	
	Cap Refil / JVD	< 3 sec (+)	
	Edema	2(+) LE	
	Chest Pain		
RESP	Respiratory Pattern	equal/useffull	Equal, even, unlabored. Mouth breather. 4L o2 per NC sats >96%. Clear all lung fields. ↓ in bases. Ø cough.
	Breath Sounds	CTA / diminshed LL (b)	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	NPR	WNL. Warm, dry, intact c cool BLE. Incision Midline c staples intact. Ødrainage. Ø s/s infection.
	Integrity	intact	
	Backside	intact	
IV	Access Devices	PIV (R) AC	IV (R) AC infusing D5 1/2NS c 20KCl @125cc/h. (L) AC SL. Dressing intact.
	Location		
	Condition	CDI	
GI	Abdomen	flat	Soft, nondistended. Nontender. Active bowel sounds x4. ØBM. Swallow tho problems
	Bowel Sounds	(+)	
	Stoma/Ostomy	NA	
GU	Device	foley	Foley to DD. Secured to (L) leg. Clear yellow urine.
	Color / Clarity	yellow / clear.	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC b(2)-2
ICU #1, [redacted]

DATE
22 Aug 03

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

[redacted] b(6)-4

USAPPC V2.00

MEDCOM - 17307

22 ACG 03

ICU Flowsheet **Patient Name:** **Date:** 8/22/2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	96.7 AV						96.4 AV		95.6							95.?						97.9 (A)				
Pulse	84	80	81	82	78	77	78	79	80	80	83	80		75	78	69	67	67	67	71	67	68	67	71	68	
B/P A-Line																										
MAP										82	86	90		102		82		84	92	76		88	83	89	93	
B/P Cuff	99/50	90/69	105/93	112/62	100/69	99/67	119/50	1nt/93	100/64	105/67	106/74	108/79		135/70	89/77	109/75	107/73	110/72	103/81	109/83	107/74	101/76	105/69	113/75	116/75	
Respirations	30	28	28	32	30	24	28	30	20	21	22	22		23	26	26	21	20	23	19	10	24	22	24	21	
Sao2	99	98	100	100	100	100	100	100	100	100	98	99		98	97	95	99	98	97	95	96	97%	95%	95%	99%	
3 2	10L	8L	8L	10L	10L	10L	10L	10L	10L	10L	8L	6L		6L	6L	4L	6L	6L	6L	6L	4L	4L	4L	4L	4L	
Source	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	SM	SM		SM	SM	SM	SM	SM	SM	SM	NC	NC	NC	NC	NC	
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF	125	125	125	125	125	125	NS	125	125	125	50	50	1350	125	125	125	125	125	125	125	125	125	125	125	125	1500
IVPB									KCL →		75	75	150	75	100 (20mg)					50 (Lasix)						225
Bolus																										
											200 Lactated	30	200			300				200						
PO intake																						90	90	60	120	860
O.R. IN																										
Totals													1700													2585
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	70/90	55/145	50/195	100/295	80/375	80/455	50/505	70/575	50/625	100/725	125/850	125/975	975	125/125	50/175	50/225	100/325	150/475	75/550	100/650	100/750	100/850	100/950	100/1050	75/1125	1125
NG Tube																										
s #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													975													1125

24 hour input	4285
24 hour output	2100
24 hour balance	+2185

[redacted] b(4)-4

PATIENT'S CLEARANCE RECORD

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

b(6)-4

#[redacted]

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE: 15 SEP 08

TIME OF DISCHARGE: @1300

SIGNATURE OF WARD OFFICER: b(6)-2 [redacted]

ACTIVITY CLEARANCE

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

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

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE

DA FORM 4029, MAR 73 ...CES DA FORM 6-258, 1 DEC 59, WHICH WILL BE ...SED

USAPPC V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A
2. LOCATION (State or Country Code.):
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): EPW, [redacted]
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): [redacted]
7. AGE AT ADMISSION: 55Y
8. RACE: 2
9. ETHNIC BACKGROUND: 9
RELIGION: UNK b(6)-4
10. LENGTH OF SERVICE:
ETS: NA
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only): NA
13. MARITAL STATUS: 2
HOUR OF ADMISSION: 0147
BRANCH / CORPS: N/A
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K78
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code): IZ
18. MOS:
19. TRAUMA:
PREV. ADMISSION: YEAR: ; 2 NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: O b(2)-2
WARD: ICU1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK
21. TYPE OF DISPOSITION: 50
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 030915
24. CLINIC SVC - ADMITTING: ASAA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 030818
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

I&D (L) HIP WOUND

DX: 80851, 86813, 5789, 4486, 27509

PX: 7969, 8608, 5411, 8964

E991.9

b(6)-2

[redacted] (Signature, as required)

Pt: [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FORM 2005 MAR 80

MEDCOM - 17310

IN[illegible]ENT TREATMENT RECORD COVER [illegible]EET

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

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

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

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

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	2320	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	05	23AUG03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	—	16 aug 03	DR [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

b(6)-2

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (R) leg Shrapnal wound

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

36. [redacted]

a. [illegible] R DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
b(6)-2				

SIGNAT[illegible]	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
DR [redacted]	

DA FORM [illegible]

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDCOM - 17311

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

28YO Iraqi male s/p Blast injury
@ EPW camp c/o (R) knee pain

All	PMH	DSH	TOB	Meds
PCN	Ø	Ø	Ø	Ø

PHYSICAL EXAMINATION

88 107/63 99% SAT

NCAT OP clr TM clr

Neck NT, NL AROM

Chest CBTA

Back NT ©Deformity

Abd NDNT NABS Soft

Ext wnl

Ext ① Puncture ② upper Arm
③ (L) Volar wrist puncture
④ (R) Ant knee LAC over patella
⑤ (R) Foot LAC Dorsal

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

A/D 28 yo c surface shrapnel wounds
to OR for washout.

b(6)-2

SIGN [redacted]	DATE 16AUG03	IDENTIFICATION NO.	ORGANIZATION
PATI [redacted] (*Typed or written entries give Name last, first, ...ile; grade; date; hospital or medical facility*)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

[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

[redacted]

MEDCOM - 17312

MEDICAL RECORD	PROGRESS NOTES

DATE	
17 Aug 03 @ 0839	Received pt resting in bed, VSS, LSCTAB HRR, pulses equal + strong, IV access (L) ac/fa patent & intact. BS (+), NPO, drsg intact to (R) leg. Alert, speaks some english. Pt. to OR this am returned by no neg Δ'S. New drsg C/D/I. transfer self w/ minimal assist from litter to bed. Able to wiggle toes, foot warm, cap refill brisk. unable to assess pulse due to drsg. Small amt emesis x1 after transfer, basin @ BS, Foley patent + intact draining clr yellow urine. Will cont to monitor [redacted]
17 Aug 03 1730	Ø significant Δs from day shift. Neuro [redacted] intact. Ace drsg to RLE C,D,+I. RLE [redacted] complaints voiced. Repositioned for dinner. PIV patent/benign c prescribed flds running VSS/Afb [redacted]
2000	Continue c̄ reassessment. [redacted]
18 Aug 03	Pt received sleeping, awoke easily to physical stimuli, alert, s/s noted c̄ peripheral pulses, lungs CTA bilat, (+) bowel sounds, drsg to (R) LE C/D/I c̄ able to wiggle toes. Cont. to monitor [redacted]

b(6)-2

(Continue on reverse side)

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

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

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

PROGRESS NOTES

DATE	
18 Aug 03 1730	Pt. currently sitting in NAD. ∅ Sign. Do non days assessment. R LE dsg C, D, + I. Neurovasc status intact. Pt is NPO for another trip to O.R. VSS/Afeb ∅ complaints voiced [redacted] Sgt/LPN
PIV to LVE patent + benign	b(6)-2
18 AUG 03 2145	Ortho Op Note
	Pre-Op Dx ō Open (R) patella fx
	(2) Open (R) 5th MT fx
	Post-Op Dx Same
	Procedure - (1) I + D (R) patella
	(2) I + D (R) 5th MT
	Surgeon [illegible]
	[illegible]
	[illegible] - [illegible] 900 cc 200 [illegible]
	Findings - Wounds clean, irrigated with pulse lavage. Closed in layers [illegible] staples.
	Plan - IV antibiotics x 72 hours, then [illegible]
	[redacted]
	b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	b(2)-2 ORTHO DISCHARGE SUMMARY - [redacted]
24AUG03	PT INJURED IN MORTAR SHELLING 17AUG03 SUSTAINED WOUND OVER (R) PATELLA AND OPEN FRACTURE OF (R) 5TH METATARSAL. I+D X2 BONES, AND WOUNDS CLOSED CAST APPLIED TO (R) FOOT.
	PLAN (1) CRUTCHES, NO WEIGHT BEAR ON INJURED
	(2) NO DRESSING TO (R) KNEE.
	(3) CIPROFLOXACIN 500MG P.O. BID. X 7DAYS
	(4) PERCOCET TABS, 1-2 P.O. Q 4-6 HRS PRN #20
	(5) NEEDS TO RETURN FOR CAST CHANGE, SUTURE REMOVAL, IN 5-7 DAYS.
	b(6)-2 [redacted]
	COL MC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

MEDCOM - 17315

DATE	NOTES
24 Aug 03	PT/ORTHO NOTE Pt c Ⓡ 5th metatarsal fx needs crutch training. Pt supine in bed. (I) sit ⇔ stand. Walked approx 1000 ft c crutches. Pt did not bear weight because of pain but instructed to do so in future. Placed pt back in bed. [redacted] SPC 9LWP1 b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03 0247	J55. A0. B5 @ x4. PERRLA. DSG to (R) knee & foot c DP. 15 c AB @ pulses to (R) foot. Cool to touch CR sluggish +3 sec. JSQ 135 cc/hr. Restg in bed — [redacted] b(6)-2
17 AUG 03 0730	Ortho Op Note Pre Op Dx (1) Soft tissue wound (R) knee (2) Open (R) 5th MT fx Post Op Dx (1) Open (R) patella fx (2) Open (R) 5th MT fx Procedure (1) I+D (R) open patella fx (2) I+D (R) 5th MT fx Surgeon - [redacted] b(6)-2 Anesth - 100 cc's Findings - soft tissue wound over (R) knee extended through into joint space. Foreign body found there. (R) 5th MT fracture with some bleeding. Pocket. Plan - NWB Ambulate and Cryotherapy. Repeat I+D in 48 hours, with wound closure

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b(6)-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPON [redacted]	

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

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

MEDCOM - 17317

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug 0030	Care assumed @ 0010, transferred from ICU2. VSS, Pt is alert and aware c/o slight pain in rle. Lungs CTA, bs@. Pt c HL in @ FA, to be replaced when tolerating PO. Cost on RECDI, patient c@ cap refill and able to wiggle toes. Pt ~~S c/o~~ S complaints at this time, will continue to monitor. b(6)-2 [redacted] qumc
19Aug03	0620 - Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS@, pulses palpable x 3. IV to @ arm LR @ 125cc/o. @ leg c splint & ace wrap, @ sensation, able to wiggle toes, skin warm to touch. Voicing @ complaints at this time. Will cont. to monitor [redacted] Board
19Aug03 1400	Assumed pt care @ 1300. Pt AAOX3. VSS. lungs CTA, abd firm round nontender nondistented. BS @x4. @ leg c splint & ace wrap. Pt able to wiggle toes. <3sec cap refill. LLE c @ pulse. BUE c @ pulses. HL to @ FA flushes S dsg, @ S/Sx of infection noted. @ c/o pain voiced @ this time. Will cont to monitor b(6)-2 [redacted] 9lwmc
19Aug03 1915	pt c/o unable to void. will notify MD for straight cath order b(6)-2 [redacted] 9lwmc

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

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

ePW [redacted]
b(6)-4

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

MEDCOM - 17318

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03 1930	Told pt if unable to void, he will get a foley. pt voided 800 cc amber color urine. B foley voided. [redacted] 9/WM6
19Aug03 2203	Recd c/o pt @ 21:00. Restraints x2 to D wrist. Awake and alert in bed. VS wnl per flow sheet. Skin W/D/I. LCA(B) HRR S1S2. BS(+)x4. HL(P) F/A patent upon flushing IV pt c/o pain and site erythematous. New IV initiated (P) F/A. (P) leg splint & ace wrap dsg C/D/I. (+) NVVs to (P) digits. c/o pain to (P) knee. ii Percocet given will mon. [redacted] PRN/AWO
20Aug03	Addendum: Heat packs applied to (P) AC will mon [redacted]
20Aug03	1245: Pt alert + oriented x3 ambulating on crutches to use commode. Hct BMM x1. VSS, lungs CTA, BS(+), pulses (+)x3. Splint & ace wrap to (P) leg, (+) sensation, able to wiggle toes, skin warm to touch. HL to (P) forearm infusing antibiotics. Voicing no complaints. Will cont to monitor [redacted]
8/20/03	[redacted] b(6)-2 A11 No complications pt will continue D/C tx as ordered
20Aug03 1430	pt care assumed @ 1300. pt AAOX3. VSS. lungs CTA abd. soft BS(+)x4. (P) leg & splint & ace wrap. (+) sensation, pt able to wiggle toes. UE & BUE & full ROM (+) pulses. HL to (P) FA flushes & dsg (+) redness/swelling noted. (+) c/o pain voiced. Will cont to monitor. [redacted] 9/WM6

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	(cont) S1S2, ⊕ pulses x4; LS CTA Ⓑ, equal & unlabored; ⊕ BS x4, abd soft
	non-tender, pt voiding QS, clear yellow urine via urinal; SL patent
	Ø c/o pain/discomfort @ this time; cont to monitor — [redacted]
	@0700 — I concur c above assessment. — [redacted]
22AUG03	0800 VSS A&O x3 Speaks English fluently
	Ⓛ hand SL patent & intact. Lungs clear. BS ⊕
	x4 quad. Abd large soft non-distended
	Ⓡ Lower leg splinted. Moves Ⓡ toes freely
	Ⓡ toes capillary refill < 3 sec. Urinary clear
	amber urine. Tolerates Regular diet. Restraints
	removed and reapplied. Will check restraints
	frequently. Will continue to monitor [redacted]
22Aug03 @ 2100	Assumed care @ 1900 p̄ receiving report from dayshift; All
	VSS; NV ✓ WNL ⊕ movement & sensation in affected leg; S1S2, LS
	CTA Ⓑ; ⊕ BS x4; soft splint to Ⓡ LE intact; HL patent; Ø c/o pain
	or discomfort @ this time; cont to monitor — [redacted]
	@2300 — I concur c above assessment [redacted]
23 Aug03	1000 VSS Alert & Oriented. Ⓛ hand Saline lock patent
	and intact. AM care done. Moves Ⓡ toes freely
	has sensation to Ⓡ Foot / toes c capillary refill
	< 3 sec. Denies pain, numbness or tingling to
	Ⓡ Lower extremity. Started PO cipro last evening.
	Restraints removed and reapplied. will check restraints
	frequently. Will continue to monitor [redacted]
23Aug03 @ 2000	Assumed care @ 1900; All VSS; ⊕ movement & sensation in affected; pt
	neurologically intact; ortho tech. came in & placed a hard cast; S1S2, LS CTA
	Ⓑ; ⊕ BS x4; SL in Ⓛ wrist patent & intact; Ø c/o pain or discomfort
	@ this time; cont to monitor — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM [redacted]

MEDCOM - 17320

ACLU-RDI 1641 p.80

DOD-030909

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Aug03	Rec'd cb pt @ 2130. Pt awake and alert. c/o pain to
22:15	® leg. ii Percocet given. Restraint x1 ® wrist. Skin W/D/I
	PERRLA OWNL. LCA®. HRRS, SR. BS ⊕ x4, ⊕PP®, ⊕NV√
	to ® digits WNL. Will cont. to mon. [redacted]
0223	Pt c/o pain to ® leg ii Percocet given [redacted]
21Aug03	assumed care @ 0500 - VSS - no % pain
0840	@ this time - cap refill <2sec in ® toes,
	pt. can wiggle toes, split cast in place - b(6)-2
	SL patent [redacted] CPT AN
21Aug03	Received pt via litter for A/E. Pt A&O x 3.
1500	® FA SL infiltrated. IV site Del to ® hand
	SC. x1 attempt. Warm compress placed
	upon ® FA IV site. Lungs clear. BS ⊕ x 4 quad
	Abd soft, non-distended. Urine. Regular
	diet. Denies pain or discomfort ® leg
	Splint with ace wrap dry + intact. Wiggles
	® toes freely. Capillary refill < 3sec to ® toes.
	Pt. has sensation to all ® toes, + extremity
	+ checked frequently. Will continue to monitor.
	[redacted] CPT AN
	Assumed care of pt @ 1900 p receiving report from dayshift
	All VSS, pt A&O x3, Neuro √ WNL; ii perc given for pain c good relief

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. ICW2

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
ST[illegible]DARD FORM 600 (REV. 6-97)
[illegible]d by GSA/ICMR
(41 CFR) 201-9.202-1

MEDCOM - 17321

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24Aug03 0900	VSS Pt Alert & Oriented. Speaks fluent English. Moves (R) toes freely with full sensation and capillary refill < 3sec. (R) Toes warm to touch & pink in color. Pt ambulated c crutches with assistance / guidance of Physical Therapist. Continue on PO. Cipro & tolerated well. Voids clear amber urine without difficulty. Restraints removed & reapplied with check restraints frequently. Will continue to monitor [redacted] b(6)-2 CTA. Pt informed of Transfer to EPW camp today. D/C RX filled. Awaiting Transfer. [redacted] b(6)-2 CTA
24Aug03@1995	Assumed care of pt @ 1800; A&O x 3, VSS, pt A&O x3, speaks fluent english; NVI intact, (+) movement & sensation; S1,S2, (+) pulses x4 c brisk cap Ref; LS CTA (A); (+) BS x4; pt awaiting transfer to EPW camp; Restraints intact c complications; Cont monitor [redacted] b(6)-2
25Aug03	(1055) Assumed care of pt @ 0600 c report from night shift. Pt alert, speaking small amount of English. VSS. Pt medicated this am c IV Perc for pain c good relief. (R) LE in cast elevated on blanket. Drsg to (R) knee CDI.

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

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29AUG03	(cont) Pt able to move toes on (R) foot. Cap refill <2secs Voiding 5 difficulty. Tol. reg diet well. 2 point restraint in place. Will continue to monitor. [redacted] DAN
	(1345) Pt stable for d/c to EPW camp. Amb c crutches - escorted by MPs. Record taken to PAD. [redacted] DAN
	b(6)-2 All

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY: SMH

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 16 Aug 07 | TIME: 2320

TRANSPORTATION TO FACILITY: MEDEVAC

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

CURRENT MEDICATIONS: None

ALLERGIES: Penicillain

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1117

INITIALS: SJ

VITAL SIGNS

TIME	1117					
BP	107/63					
PULSE	77					
RESP	18					
TEMP						
WT						

LAB ORDERS

☒ CBC/DIFF	ABG	☒ PT/PTT	BHCG/URINE/BLOOD/QUANT		
☒ URINE C&S	UA MSCC/CATH		CHEM: 17		
BLOOD C&S X			X electrolytes		

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Foley catheter				
2340	Ancef 1g				
1118 SJ	Tetanus (SJ) 2340	SJ			
	Morphine 3				

DISPOSITION: HOME ☐ FULL DUTY ☐

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: IMPROVED ☐ UNCHANGED ☐ 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

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY Check if read by radiologist ☐
	H/H			SUP 02	PH	PO2	RESULTS
	PLT			PCO2	SAT	OTHER	
PT			U/A	DIP			EKG INTERPRETATION
APTT	BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

See HEP

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] b(6)-2

DIAGNOSIS

Frm Wound (R) knee / foot

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

ER case

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): PCN 3. PREVIOUS SURGERY [ ] NO [X] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE: I+D (R) knee, (R) foot

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ?
Jewelry removed: yes/no Family waiting: yes/no
N/A

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	◊ Pt. verbalizes any specific anxiety. ◊ Pt. exhibits relaxed body posture.	◊ 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. ◊ Maintain family interface.
B. AERATION Potential for respiratory dysfunction due to sedation; positioning; injury	◊ PT. will be able to breathe without difficulty during immediate intra-operative phase.	◊ Offer to elevate head of litter or offer pillow. ◊ Observe pt. while awaiting surgery for signs of distress ◊ Assist anesthesia during intubation and extubation
C. INTEGUMENT Potential impairment of skin integuity due to bovie pad; position; fluid shift	◊ PT. will not 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 from pooling.

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

[redacted] blw-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; ~~previous surgery~~	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation Iraqi F.3. Potential injury due to dentures. ___	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 17Aug03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: eli

Drsg: dli

Breathing: ØSOB

b(6)-2

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

DATE: 17Aug03 TIME: 0610 b(6)-2

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

DATE: 17Aug03 TIME: 0740

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAO. .RA DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA wheeled litter BY Anesthesia

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

3. DATE 17 Aug 03 — TIME PATIENT ARRIVED IN SUITE 0630

4. PATIENT IN ROOM TIME 0630 — NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: PCN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (0700-EOC)

7. POSITION AND POSITIONAL AIDS (Specify)

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

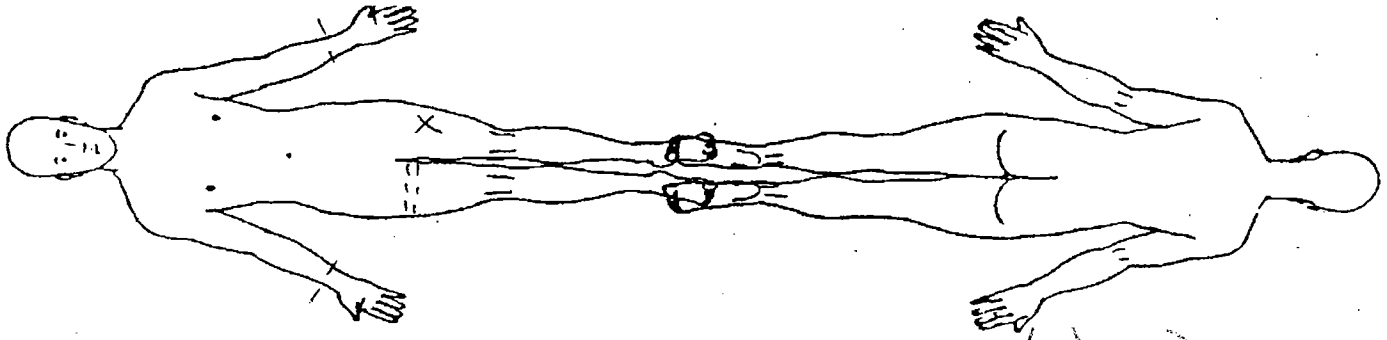
COMMENTS: proper body alignment maintained, arms at less than 90° on padded armboards, head resting on foam donut, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Betal Beta
SITE: (R) Leg — BY WHOM: [redacted]
SITE: *see — BY WHOM: b(6)-2
COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect Initial: [redacted]

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

SCRUB [redacted] NA — CIRCULATOR [redacted] NA

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: VL Force 2 # 3 (000417)
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 68936 2005-03

☐ 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 V1.01

MEDCOM - 17328

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 YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs, Kerlix, Ace wrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op _____ Bovie Settings: 30/30 Coag/Cut
Tourniquet Site intact pre-op ✓: post-op _____

Ancef 1gm Tetnus in ER

20. OPERATION(S) PERFORMED
I+D ® knee, ® foot

21. PATIENT TRANSFERRED TO ICU 3 b(6)-2 TIME see D17389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] AN

REVERSE OF DA FORM 3179-1, OCT [illegible]

MEDICAL RECORD — **INTRAO[illegible]A [illegible]OCUMENT** b(a)-2

For use of this form, see AR 40-66, the propon[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY anesthesia

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

3. DATE 18 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN [illegible] TIME 2018 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(a)-2	RELIEF SCRUB	b(a)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	maj [redacted] (2000-2030)

7. POSITION AND POSITIONAL AIDS (Specify)

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

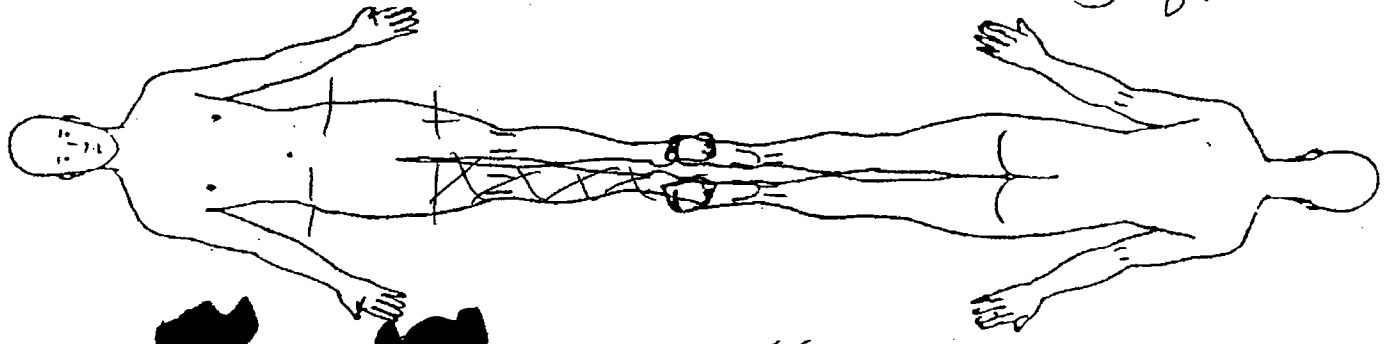
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: R leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X G[redacted]d -- Safe[redacted]nap === Tourniquet XXX-prep

C = Correct I = Incorrect

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

SCRUB b(a)-2 [redacted] CIRCULATOR b(a)-2 [redacted] CPT

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

H[redacted] b(a)-2

[redacted] b(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO
CUT 30 COAG 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 V1.01

MEDCOM - 17330

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

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wrap
- splint

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

Bovie Pad site intact pre-op N/A; post-op N/A Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op N/A: post-op N/A

20. OPERATION(S) PERFORMED
I&D (R) knee and foot

21. PATIENT TRANSFERRED TO ICU2 TIME 2145 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN

REVERSE OF DA FORM 5179-1, OCT 87 b(6)-2 MEDCOM - 17331 USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 19 2003 | DAY 17 18 | HOUR

PULSE (O) | TEMP. F (°)

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

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] / ICN 1

b(6)-2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17332

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY 19

MONTH-YEAR Aug 03 DAY 20

19 HOUR 0700

PULSE (0) | 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)

EPW [redacted]

b(6)-2

REGISTER NO.

WARD NO. 3CW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17333

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]	DATE 16 Aug	TIME 1123	SSN/PSEUDO SSN: [redacted]

(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 (ar 41-51 mmHg (ven
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

b(6)-4

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
16/08/03 23:59
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.5	3.3-5.5	G/DL
ALP	79	26-84	U/L
ALT	55*	10-47	U/L
AMY	43	14-97	U/L
AST	<5*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	23*	7-22	MG/DL
CA++	9.6	8.0-10.3	MG/DL
CHOL	151	100-200	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
GLU	153*	73-118	MG/DL
TP	8.1	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
16/08/03 23:57
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	153*	73-118	MG/DL
BUN	20	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	124	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.0*	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: FMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 11 May	TIME 1137	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
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 10^3 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	Dark Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Small	Negative
Ket	Small	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Large	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	-	Negative
HCG		Negative

POC Protein - Bill → Ketones

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

55 H - Large . 3+ mucus
1170 - Neg
Acetest - Small
WBC - 10-20
RBC - 1-3

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.9	9.8-13.6 secs
APTT	28.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

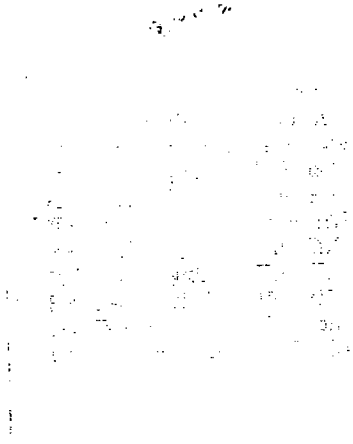
Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 11 May 03	**LAB ID NO.:**

b(6)-2



PRE-ANESTHETIC ASSESSME ND PLAN OF CARE

AGE: 28 Days Mos Yrs (circled) GENDER: (X) Male ( ) Female ALLERGIES: PCN

P S: 1 2 3 4 5 (E) WT:_____Kg/Lb HT:_____In.

PROPOSED PROCEDURE: Open R Patella Fx; R Foot Fx

SURGICAL SERVICE: Ortho

NPO SINCE:_____

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury / (shrapnel wounds (R) leg)

HABITS:

Tobacco:_____

EtOH:_____

Drugs: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ancef 1gm

( ) MSO4 5mg EMT

( ) Tetnus

( )

( )

( )

PREMEDICATIONS:

None / Yes @ _____Hrs

LABORATORY STUDIES:

129 | 97 | 20 / 153

3.0 | 17 | 1.6

14.4 | 17.3 / 51.6 | 304

Other:_____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	Foley - Cloudy yellow
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

Speaks English

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

99%

BP: 107/63 HR: 88 RR:___ T:___

Pain (0/10 Scale):_____

Airway Exam:

Dentition: Intact

Trachea_____

TMJ/C-spine_____

Oropharynx: MP II-III

Chest:

Lungs: CTA

Heart_____

IV Access: 16g (L) Arm

Ulnar Filling:_____

Back:_____

Other:_____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional:_____ (X) General: Intubation / Mask-LMA Notes:_____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signe [redacted] b(6)-2 CRNA CRT Date: 16 Aug 03 Time: 2340

PATIENT IDENTIFICATION:

[redacted] b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed:_____Date:_____Time:_____

Nursing Unit: EMT

28TH COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD
MEDCOM - 17337

28 yo.

MEDICAL RECORD - ANESTH

(his form, see AR 40-66; the proponent agenc... OTSG

allergic to PCN

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

DRUG (Units)						TOTALS
Fentanyl (mcg)	50 ~	<150>	50			250 mcg
Midazolam (mg)	2					
Lidocaine (mg)	50					
Propofol (mg)	200					
Sux (mg)	100					
MSO4 (mg)		4	2	2	2	10 mg
VOLAT AGENT ISO % del		1.5 ~	1.2	1.2	1.2	
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	10 ~	2	2	2	6	

TOTAL EBL: Min

TOTAL URINE: 100

FLUIDS SUMMARY

CRYSTALLOID: LR 1000

COLLOID-

BLOOD-

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

LINE site 16G (L) AC [X] Warmed ... #1

[ ] Warmed

[ ] Warmed

[ ] Warmed

LOSSES: EST BLOOD LOSS

URINE - 200

REMARKS

Code drugs with numbers, events with letters

1) Pre-op assessment
2) Room, monitors, induced, eyelids taped
3) OG + soft bite block

0730
Spont resp
Opened eyes
Extubated
Suctioned
To ICU

SYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: 51.6

INITIAL DATA: 117/63, 88

EQUIP CHECK: Y (Y) N

PATIENT RECHECK for PROCEDURE? JR 0600

TIME → 0630 · 0700 · 30 · 0800

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

(Vital signs chart, scale 20–220: BP approx. 120/70 to 100/60; HR approx. 100 to 80)

VT - ml	—	900	860	860	200
f - breaths/min	—	8	8	7	13
Peak inf pres / PEEP		23	23	23	
MODE - S(pon), A(ssist), C(on)	S ~ C	C	C	C	S
ET CO2 (torr)	38	30	29	30	46
FIO2 (Frac or %)	0.88	0.88	0.89	.88	.88
SpO2 (%)	100	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP-site Sk	34°C		34°C	34	
N-M Block (T/4)				4/4 ST	
BS		+	+		

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

Warming blkt / warmer: X1 blanket →

Letters & symbols, REMARKS: EVENTS ①②③ 0— ; Position: arms <90° abducted c padded

RECOVERY AT: PACU ICU (Specify) ✓ OTHER STAB

CONDITION:

RESP 12, SpO2 95%

BP 120/80, HR 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0615	0630	0800
	Ready	Begin	End
PROC	0640	0700	0730

PROCEDURES and CPT Codes: (R) knee / I+D (R) foot

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DLx1 Miller 3 grade 1 view, 8.0 ETT styletted, 8ml air cuff. + BBS + sust ETCO2

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

[redacted]

b(6)-4

SURGEONS:

[redacted]

MAJ/CRNA

PROCEDURE LOCATION: 2

DATE: 17 Aug 03

PAGE 1 OF

DA FORM 7389, FEB 1998 MEDCOM - 17338 [redacted] PATIENT'S MEDICAL RECORD USAPA V1.00

b(6)-2

2840 -Fred 48, Cipro 48

#: PCN

MEDICAL RECORD - ANESTH[ESIA]

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
Versed ( )	1 2							5
Fentanyl ( )	50/100/50		50					250
Propofol ( )	200			40/40/40/40/40				400
Lidocaine ( )	100	100						200
VOLAT AGENT: ISO % del / % e.t.	x/2.0/1.0/1.0/1.0/0.4/x/x/x							
AIR L/Min								
N2O L/Min								
O2 L/Min	8/2/3/3/3/3/3/2/2							

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

TOTAL EBL: MIN

TOTAL URINE: 200

FLUIDS SUMMARY
CRYSTALLOID- 900
COLLOID- Ø
BLOOD- Ø

FLUIDS
LINE site: 18 Ⓛ A/C
- [ ] Warmed
- [x] Warmed — LR1 —— 500 —— 500; LR2 ——
- [ ] Warmed
- [ ] Warmed

LOSSES
EST BLOOD LOSS
URINE - 200

TIME ➔ 2015 2030 A 2100 Y 2130

18mg labetalol

PHYS STATUS: ①2 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: 51.6

INITIAL DATA:
BP- 107/63
HR- 88

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y)
TIME- 1630

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	210	220	200	230	240	200
f - breaths/min	22	10	17	15	17	11
Peak inf pres / PEEP	/	/	/	/	/	/
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	43	52	52	50	51	51
BP/oth	✓FIO2 (Frac or %)	.63	.63	.63	.63	.63	.69
ART line	✓SpO2 (%)	99	99	99	99	99	99
Steth- PC/ES	✓ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	✓TEMP-site	Avail					
	✓N-M Block (T/4)	Avail					
Warming blkt							
Conv warmer							

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

REMARKS
Code drugs with numbers, events with letters

2000 pt ID, chart reviewed, Ø change from Preop HR.
2018 RM, O2, monitors
2028 LMA #4 placed
2138 pt c LMA removed
2142 RPT TO [redacted] RN

RECOVERY AT: 2140
PACU ICU ✓ (Specify)
OTHER
CONDITION:
RESP- 15 SpO2- 97
BP- 124/82 HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2000	2018	2145
	Ready	Begin	End
PROC	2035	2046	2135

PROCEDURES and CPT Codes: I&D Ⓡ leg + foot

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA c LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #4 LMA placed atraumatically x 1 attempt, soft BB in place

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

[redacted] b(6)-4
ICU 1

[redacted] b(6)-2

ANESTHE[redacted] CA CRNA

PROCEDURE LOCATION:
DATE: 18 AUG 03
PAGE 1 OF 1

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

MEDCOM - 17339

ACLU-RDI 1641 p.99

DOD-030928

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]

[redacted] 8/16/24

NURSING UNIT | ROOM NO. [redacted] BED NO.

DATE OF ORDER: 17 Aug 03 | TIME OF ORDER: 0100 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to ward
2. Dx: (R) leg injury
3. Condition stable
4. IVF LR @ 125 cc/hr
5. NPO
6. Elevate (R) foot
7. Ancef 2gm q8°

DATE OF ORDER | TIME OF ORDER | HOURS

MSO4 2-6mg IVP q 2° PRN pain
Phenergan 12.5mg IVP q 6° PRN nausea

8. Foley to gravity drainage
9. On call for OR
10. Allergy: PCN — b(6)-2
11. D. [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER: 17AUG03 | TIME OF ORDER: 0[redacted] HOURS

1. Resume previous orders
2. Regular diet
3. IV LR at 125cc/hr Hep Lock when taking PO well
4. Tylenol 650mg PO Q 4-6hrs PRN
5. Percocet 1-2 PO Q 4-6 hrs PRN
6. MSO4 2-6mg IVP Q 2 hrs PRN

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

7. Phenergan 25mg IVP or PO Q6hrs PRN
8. Ancef 1 Gm IVPB Q 8hrs
9. Ciprofloxacin 400mg IVPB Q12hrs

[redacted]

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° 2000 transfer [redacted]

DA FORM 4256, 1 APR 79 | REPLACES EDIT[redacted]UL 77, WHICH MAY BE USED.

b(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990—409-924

"USE BALL POINT PEN—PRESS FIRMLY | NO CARBON PAPER REQUIRED"

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]

DATE OF ORDER: 18AUG03 TIME OF ORDER: 2130 HOURS

LIST TIME ORDER NOTED AND SIGN: [redacted] 0840

b(6)-2

1. Resume previous orders
2. Regular ~~diet~~ diet
3. LR at 125cc/hr saline lock when tolerating PO well
4. D/C Foley

b(6)-2 [redacted]

NURSING UNIT: 24/S ROOM NO.: 0040 19AUG03 BED NO.: [illegible]

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

DATE OF ORDER: 8/22/03 TIME OF ORDER: 1400 HOURS

Noted 22AUG03 [redacted] b(6)-2

- D/C IV Ancef
- D/C IV Cipro
- Heplock IV
- Start Cipro 500mg PO BID

b(6)-2 [redacted]

NURSING UNIT: 24 ROOM NO.: 2300 22AUG03 BED NO.: [redacted]

b(6)-2 Noted [redacted] 8/24/03

PATIENT IDENTIFICATION:

DATE OF ORDER: 8/24/03 TIME OF ORDER: 0840 HOURS

1. Discharge today after PT, to EPW.
2. Cipro 500 mg P.O. BID
3. Percocet 1-2 P.O. q 4-6 hrs prn

b(6)-2

b(6)-2 [redacted]

NURSING UNIT: ICW 1 ROOM NO.: 24 8/24/03 2340 BED NO.: [redacted]

PATIENT IDENTIFICATION:

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT: ROOM NO.: BED NO.:

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

MEDCOM - 17341

b(6)-2 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. 8 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: Aug 17	18	19	20	21	22	23	24	25	26	27
17	[redacted]	LR@125cc/hr	5	[redacted]										
	[redacted]	HL Duren taking po well												
17	[redacted]	Ancef 2gm q8° IV	8	X										
			16	X										
			24	D/C										
17	[redacted]	Ancef 1 gm q 8° IVPB	06	/										
			14	/										
			22	/										
17	[redacted]	Ciprofloxacin 400mg IVPB q12°	10	/										
			22	/										
17	[redacted]	Ancef 1 gm q8° IVPB	08	[redacted]										
			16											
			24											
17	[redacted]	Cipro 400mg IVPB Q12	12							SW				
			24											
22Aug03	[redacted]	Heplock IV N	07							D/C				
			19											
22Aug	[redacted]	Start Cipro 500mg P.O BID	10											
			22											

D/C 17 Aug 03 0900

D/C 22 Aug 03

ALLERGIES: [X] YES [ ] NO PCN

PRIMARY DIAGNOSIS: (R) Lt shrapnel injury

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17342

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	*Mo* Aug *Yr* 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY		*INITIAL PROPER COLUMN FOLLOWING COMPLETION* — TIME/DATE COMPLETED						
17 / 20	[redacted]	MSO4 2-4mg IVP Q2° prn pain	D/T							
			D/I							
17	[redacted]	Phenergan 12.5mg IVP Q6° PRN	D/T	D/C'd 17 Aug 03 0900						
			D/I							
17	[redacted]	Phenergan 25mg	Date							
			Time							
		IVP or P.O. q6 prn	Dose							
			Init							
17 / 22	[redacted]	Percocet 1-2 po	Date	19 Aug	19 Aug	20 Aug	20 Aug	21 Aug	22 Aug	25 AUG
			Time	0950	2216	2219	0800	2100	2145	0155
		q 4° prn pain	Dose	ii	ii PO	ii PO	ii PO	II po	ii	ii
			Int	[redacted]						
			I/E							
		Tylenol 650mg P.O. q 4-6° prn								

V1.00

USAPA V1.00

b(6)-2 All

CLINICAL RECORD

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

Mo. 8 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16 17 18 19 20 21 22 23 24 25
17	[redacted]	NPO	5	X
			17	X D/C 17 Aug 03
17	[redacted]	Elevate (R) foot	5	[redacted]
			17	
17	[redacted]	Foley to gravity	5	[redacted] D/C
			P	
17	[redacted]	Regular Diet	25/17	/
			17/05	/

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: ~~GHE~~ (R) leg shrapnel injury

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

GREEN SHEET

MEDCOM - 17344

b(6)-2A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17	[redacted]	Admit to ward, Stable				
17	[redacted]	O/C to OR, [redacted]				
18	[redacted]	D/C Coley	18Aug	0800	1230	[redacted]
24	[redacted]	D/C today per P.T.	8/24			

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

USAPA V1 00

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**

DTSG APPROVED *(Date)*

Date: 17

Time In: 0735

Allergies: PCN

Pre-op V/S: 167/63 ; 88

Procedures: (R) [illegible] foot I&D

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

OR Intake: Crystalloid 1000 Colloid

OR Output: UOP 100 EBL

Meds/Times:

Drains
Hemovac
NG
JP
T-tube
(Foley)
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	0735	0800	0815	0830
SaO2	93	94	95	94
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V		V	V
100				
80				
60				
40				
20				
RR	17	20	16	20
T	98.6		98	98
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	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2		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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	12		

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)* [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE 17 Aug 2003

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

[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

NEUROVASCULAR

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

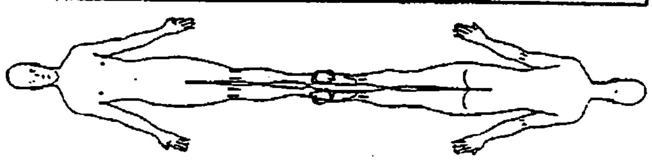
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0735 pt adm awake, [illegible] sleepy but arousable
complete [illegible] occlusive dressing to (L)
leg from above knee to toe c ace wrap
foley to gravity drain, peripheral IV 16G [illegible]
c IV fluid NS infusing c difficulty palpating
pedal pulse on [illegible] + good pulse ox
on R leg via toe breath sounds CTA all fields
heart sounds S1S2 present c NSR skin color
WNL no pain @ operative site complaint
of H/A PERL. [redacted]
0840 [illegible] [redacted]

b(6)-2 All

Discharge Criteria:
Date: 17 Aug 03 Time: 0845 PARS: 12
BP: 125/65 T: 96.7 HR: 92 RR: 20 Sa02: 94
Pain Level at D/C (0-10):
Intake: 120 Output: ~~[illegible]~~ 100 cc
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP R-3
Charge Nurse Signature: [redacted] [illegible]

MEDCOM - 17347

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)*

ASA II
90Kg

Date: 18 AUG
Time In: 2140
Allergies: PCN
Pre-op V/S: 107/63 98
Procedures: (R) (Leg I&D)

Anesthesia Type (Circle)): **General** Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 900 LR Colloid
OR Output: UOP 200 Fth EBL MIN
Meds/Times:

250 Fent
184 5 versed
Propofol

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	2140	2145	2150	2210	2230	2320	2330								
SaO2	99	98	98	100	98	100	99								
FiO2	RA	RA	RA	RA	RA	RA	RA								
Methods															
240															
220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RR	16	20	18	20	20	18	22								
T	99			98			96								

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	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	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.	8	9	9

Codes

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

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

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

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

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

(Continue on reverse)

PRE[redacted]

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

DEPARTMENT/SERVICE/CLINIC: PACU #2

DATE: 18 AUG 03

PATIENT'[redacted] written entries give: first, midd[redacted]al facility) Name — last,

[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

b(6)-2 A11

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	LLE	TOES	+	UTA	BR	COOL	NL
15'							
30'	LLE	TOES	+	UTA	BR	COOL	NL
45'							
60'	LLE	TOES	+	UTA	BR	COOL	NL
90'							
D/C							

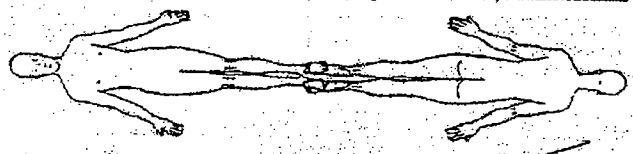
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	BULKY DSG	Ø
30'			
60'			
D/C	LLE	BULKY DSG	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

2330 D/C FOLEY DTV @ 0530.
VSS. TO TRANSFER TO ICU [redacted]

[redacted]

Discharge Criteria:
Date: 18 AUG 03 Time: 2330 PARS: 9
BP: 128/86 T: 96.9 HR: 88 RR: 20 Sa02: 100% RA
Pain Level at D/C (0-10): 8
Intake: Ø Output: 300
Additional Data: Ø
Transferred To: ICU [redacted]
Report Given To: SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re[redacted] Room SOP B-3
Charge Nurse Sig[redacted]

b(6)-2

PATIENT'S CLEARANCE RECORD

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

#[redacted] b(6)-4

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE	TIME OF DISCHARGE
25AUG03	1345

SIGNATURE OF WARD OFFICER

[redacted] b(6)-2

ACTIVITY CLEARANCE

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

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

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. MTF LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	C	1	D	C		I	Z	

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

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

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
			—	9	9	[redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / [illegible]
—	46	2320	— b(6)-4
	Z		

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			K	7	K78									

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	NO
									9		☒

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU#2	UNK
O		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b(6)-2		UNK

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
0	5							0	3	0	8	2	3

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							0	3	0	8	1	6

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

FOR LOCAL USE

Dx: (R) leg Shrapnal wound

932.1
935.35
980.03
941.02
E993

17 Aug 03
79.69
79.61
18 Aug 03
86.28
86.59
93.50

Dx: 81510
8221
E9919

Px: 7963
7966

[redacted] (Signature, as required) b(6)-2

SIGNATURE OF ADMITTING CLERK

DA FORM 80 [illegible]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]	2. NAME (Last, First, MI) EPW # [redacted] b(6)-9				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 30	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION —			14. WARD TCW2
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN K70	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE NBE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct FROM ER			22. HOURS OF ADMISSION 0130	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 17Aug03		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk			27b. TELEPHONE NO. unk	28. DATE OF THIS ADMISSION 17 Aug 03		ADMITTING OFFICER DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (2) Leg (1) heal fragment

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
		b(6)-2			

SIGNATURE OF ATTENDING MEDICAL OFFICER DR [redacted]

SIGNATURE OF [redacted] RECORDS OFFICER

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

MEDCOM - 17352

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

EPW s/p Fragment (L) lower leg
(L) skull

PHYSICAL EXAMINATION

y.o. = CTA (D)
♀ = AAR
ATTD: BG

(L) Lower Extr palpable distal
mild wounds
Head (L) 2 small wounds.

X-ray = Skull
Ø Fx

8.4 / 4.7 250

15/34 (125 / 101 / 19 (111

PT/PTT 40

(L) tib Frag ×1
away from
bone. Ø Fx.

PROGRESS (Enter date of discharge and final diagnosis)

- Fragment wounds
  - Head (L) side
  - (L) lower Extr

Admit
- Abx
- pain control
- DSG Δ / clean

SIGNATURE OF PHYSICI[redacted] DATE 17 Aug | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIF[redacted] (For subsequent entries give Name last, first, middle initial; date; hospital or medical facility) | REGISTER NO. | WARD NO.

b(6)-2

[redacted]

b(6)-4

ICU I

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

[redacted]

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL

DATE	NOTES
17Aug03 0200	Rec'd Pt from E.R. via litter. Pt in NAD. A+O, coherent / cooperative. NAE, lungs CTA, abd. soft NT/ND (+) BS, dsg to LLE C, D, + I. PIV to RFA H/L'd.
155 / Afeb	Restraints placed. ∅ complaints voiced. Comfort measures given. Adm process c Pt. teaching done needs reinforcement / translator - [redacted] Sgt LPN.
0215	- I concur c above assessment [redacted]
17Aug03 0330	Dsg taken ↓ by M.D. - wnds irrigated / cleansed. Superficial wnds to (L) foot beefy red / clean. dry dsg placed / physician. Dsg Δ tol. well [redacted] Sgt / LPN
17Aug03 @ 0700	- Assumed care AX Ox3. ∅ c/o pain or discomfort @ this time. lungs CTA HRRR S1 S2 present Active BS. Dressing to LLE intact CDI. Wound care done will cont to monitor [redacted]
17Aug	D/C Surg Amb / tol (L) leg PO / AF / pain ↓ Frag wound blunt trauma to (L) Hand b(6)-2 Cont Abx D/C spw chg [redacted] / wyn
17Aug03 1000	I concur c above shift assessment. Pt prepared for D/C to EPW Camp. Transportation pending. Will Continue monitoring. Neurovasc. / intact [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

/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] EPW

b(6)-4

ICW I

PROGRESS NOTES
Medical Record

STANDARD FORM 50

Prescribed by GSA/ICMR FPMR

MEDCOM - 17354

ACLU-RDI 1641 p.114

DOD-030943

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
17 Aug 03	D/C to EPW Camp escorted by MP. Med.
1350	record & Radiology films to PA [redacted]

b(6)-2

:DICAL RECORD

AUTHORIZED FOR LOCAL RI

PROGRESS NOTES

DATE	NOTES
17 Aug	DC Summary Admitted p EPW camp Blast. Had 4 (E) sided Lead blast trauma → pain. 2 frag wound x2 small ⊘bleeding 2. (E) Lower ext. Frag wounds. X-rays ⊘Fx (+)Frag. (A) Frag / blast trauma (P) ⊘Fx / pain control RTD EPW camp [redacted] b(6)-2

NSHIP TO SPONSOR

LAST	SPONSOR'S NAME FIRST	MI	SPONSOR'S ID N (SSN or Other)
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F

MEDCOM - 17356

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATM [redacted]

RECORDS MAINTAINED A [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

AGE: 30

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

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

ARRIVAL

DATE (Day, Month, Year): 16/08/03 | TIME: 1115

TRANSPORTATION TO FACILITY: Medevac

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: denies

ALLERGIES: NKDA

CHIEF COMPLAINT: Lt GSW

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2315			
BP	143/82			
PULSE	89			
RESP	18			
TEMP	98.9			
WT				

LAB ORDERS

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

X-RAY ORDERS

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

XR 4 Lft ib req 2315 XAP and Lateral Skull

☐ PULSE OX 95%

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2315	Ancef 1 GM IV	2328			
2315	Morphine 4mg IV	[redacted]			
2315	Tetanus 0.5mg IM	b(6)-2			
0050	5mg MSO4 IV				

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)

EPW [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

TEST RESULTS

CBC: WBC; H/H; PLT — SMAC — PT — APTT — BHCG — ETOH — GLU

ABG/PULSE OX: SUP 02 | PH | PO2 | PCO2 | SAT | OTHER

U/A: DIP; MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL GSW to left foot Good Pulse distal to injury. 7V infusing A150 c/o pain left temporal lobe

See H&P

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE A[redacted] b(6)-2

DIAGNOSIS

CODES

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

b(6)-4 [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

511–119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 17 Aug

19 | HOUR: 0700

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18

BLOOD PRESSURE: 124/68

HEIGHT: 72

WEIGHT: 198

RA

Record special data only when so ordered

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

[redacted] EPW

b(ce)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17359

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

(Hematology) CBC

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W			Mono		
RI			Eos		
Hg			Baso		
Hc			Imm		
MC					
Plt					
Ly					
(					
Segs					
Bands					
Lymph					
Atyp					
RBC Morph					
Spun Hematocrit		42-52% (M) 37-47% (F)			
Sed Rate					
Other					

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	15.2	9.8-13.6 secs
APTT	34.4	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 17 Aug 03 **LAB ID NO.:**

b(6)-2

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

LAST, FIRST, MI: [redacted] b(6)-1 | DATE: 16Aug03 | TIME: 2338 | 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		
[illegible]	[illegible]	

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l

======= PICCOLO =======
16/08/03 23:42
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.8	3.3-5.5	G/DL
ALP	55	26-84	U/L
ALT	51*	10-47	U/L
AMY	60	14-97	U/L
AST	41*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	8	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	159	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	110	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
16/08/03 23:44
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	111	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	135	39-380	U/L
NA+	125*	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 2+, ICT 0

REMARKS:

REPORTED BY: [redacted] b(6)-7 | DATE: 17 Aug 03 | LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 17 Aug TIME OF ORDER 0130 HOURS LIST TIME ORDER NOTED AND SIGN

Admit Ward
Dx = Frag wound (L) head (L) leg
Cond = stable
VS = per protocol
ALL = NKDA
Act = SPW restraint
Nursing = Dsg Δ q 6° ; clean wound

NURSING UNIT | ROOM NO. | BED NO.

ICW

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER TIME OF ORDER HOURS

Diet = Reg
Labs = Ø
IV = Heplock / saline lock p̄ IVBAG
Meds = Keflex 250 mg QID po
Percocet ii po q 4° PRN pain
Motrin 800 g i po q 8° PRN

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE [redacted] TIME OF ORDER HOURS

b(6)-2

- Bath patient
- Cleanse legs wounds b(6)-2
(L) LE - sterile dsg

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 17 Aug TIME OF ORDER HOURS b(6)-2

D/C SPW 17 Aug

[redacted]

[redacted]

b(6)-2

17 Aug 03
1020

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 1986—409-824

"USE BALL POINT PEN - PRESS FIRMLY | NO CARBON PAPER REQUIRED"

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. ___ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	DATE COMPLETED 17
17	[redacted]	VS = PROTOCOL	5	X	[redacted]
			17	[redacted]	
17	[redacted]	EPW RESTRAINT	5	X	[redacted]
			17	[redacted]	
17	[redacted]	Drsg Δ Q60, clean wound,	6	X	[redacted]
			12	X	[redacted]
			18	X	
			24	[redacted]	
17	[redacted]	Diet: regular	5	X	[redacted]
			17	[redacted]	
		b(a)-2			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: ① head ② leg fragwound ③

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: [redacted] b(a)-4

EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

USAPA V1.00

[redacted]

MEDCOM - 17363

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing		SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Order Date	Clerk Nurse					
17	[redacted]	admit IAW #1, Stubbe	17 Aug 2003	[redacted]		
17	[redacted]	D/C EPW Camp	17 Aug			

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

USAPA V1.00

MEDCOM - 17364

b(e)-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. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
17	[redacted]	IV: SL		1617
			5	X [redacted]
17	[redacted]	KEFLEX 250MG	17	N
		+ PO QID	6	X [redacted]
			12	X
			18	X
			24	X

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: (L) heel (L) leg FRACTURED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: [redacted] b(e)-4

EPW

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

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

MEDCOM - 17365

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----					

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED
17	[redacted]	Percocet 1+PO Q4° PRN PAIN	D/1
-----	-----	blw 2	D/1
17	[redacted]	Motrin 800mg+po Q8° prn	D/1
-----	-----		D/1
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	Ø 3 Ø	Z	Z	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	Ø13Ø	b(6)-2

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N D	K T E	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I Z		9	YEAR [ ] NO [X]

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø b(2)-2	ICW2 b(2)-2	unk
[redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 Ø		Ø 3 Ø 8 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		Ø 3 Ø 8 1 7

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

FOR LOCAL USE

Dx: (2) heal (2) leg fragment

Dx: 891D
E998

Px: 8086
8302

873.8
891.3
E993

ADMITTING OFFICER (Signature, as required): DR. [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

b(6)-2

DA FORM 2985, MAR 89

USAPPCV1.0

MEDCOM - 17367

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	EPW# [redacted] b(6)-4		EPW	
4. SEX: M	5. AGE: 28	6. RACE: —	7. RELIGION: —	SVC: —	8. ETS: —	10. PREVIOUS ADMISSION: NO.
11. FMP: —	12. SSN: [redacted]	13. ORGANIZATION: b(6)-4				14. WARD: ICW2
15. FLYING STATUS: —	16. FATIGUE/ DSG: —	17. DEPT./ BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP: —		20. TYPE CASE: WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0130	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
unk	50	26aug03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
unk	unk	14aug03	DR. [redacted] b(6)-2

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

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: multiple Shrapnel wounds

874.9
822.1
823.90
825.1
E 991.2
E 991.9

06.09
79.69
79.66

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	9	9

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(6)-2				

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted]

MEDCOM - 17368

DA FORM 3[redacted]

EDITION OF 1 AUG 79 IS OBSOLETE

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] [illegible] wound (R) [illegible]
[illegible] (R) [illegible] and (L) knee and (L)
Foot C/o (L) foot (L) [illegible]
No [illegible]
C/o (R) [illegible]
[illegible] ∅
PSH ∅

PHYSICAL EXAMINATION

Lung CTA wound [illegible] (R) [illegible]
[illegible]
[illegible] NT. [illegible] exam [illegible]

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

[illegible] [illegible] [illegible] [illegible] and [illegible] [illegible]
[illegible]
[illegible] [illegible] c̄ [illegible] [illegible]
[redacted] Wound [illegible] [illegible] [illegible]

b(6)-2

DATE	IDENTIFICATION NO.	ORGANIZATION
8/1/2/03		

[redacted] ritten entries give Name last, first, date; hospital or medical facility)

REGISTER NO.	WARD NO.
	ICU2

EPW [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

MEDICAL RECORD | PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
8/17/03	Brief op note
	Pre-op Dx: R supraclavicular wound
	Post-op Dx: Same
	Procedure: R supraclavicular Explore
	Surgeon: Matsumoto
	Assist: Mulley
	Findings: grazing wound R clavicle
	No fracture. Soft tissue
	Complications: Ø
	[redacted] b(6)-2
8/17/03 0840	Ortho Op Note
	Pre-Op Dx: ① Open (L) knee joint
	② fragment wounds (L) leg
	Post-Op Dx: ① Open (L) knee intraarticular
	fracture, MFC.
	② Open (L) tibia fracture
	③ Open (L) calcaneus
	Procedure: ① I+D (L) knee with arthrotomy
	② I+D (L) tibia fx, ③ I+D (L) calcaneus

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.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 17370
509-114

DATE	NOTES
	Surgeon - [redacted]
	Findings - Surgical wound site (L) knee joint lodged in (L) upper Surgical wound edge of (L) tibia. Surgical debris removed. [redacted] IED's, shrapnel. Purse in (L) knee. wounds left open to drain. Open knee skin closed loosely, but effectively left open
	PLAN: IED in 48 hours
	[redacted] b(6)-2

Progress Note

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02 1700 17 Aug 03	Nursing Note: Pt. is A+Ox3. Pupils Perrla. Lungs clear; Active BS x4; Palpable pulse x4 extremities. Cap refill < 3secs. x4 extremities. IV (R) AC infusing @ LR @ 150cc/hr. HL to (L) AC; Pt. received 1 gram of Ancef in the O.R. @ 2400. Foley to gravity @ clear red yellow urine. Shrapnel injuries to chest X 5, @ no or minimal drainage; shrapnel to (R) leg @ drainage noted on dsg. dsg (L) foot @ drainage noted to (L) ankle area. NO injuries to back. Pt. is NPO for O.R. ~~will continue~~ Neuro vascular checks all normal. b(6) CPT [redacted]
03 18 Aug 03 0405	Nursing Note: Neuro checks normal. CPT FROM pt returned from OR via litter. pt awake, not fully awake and aware of surrounding from anesthesia. S/P (L) leg debridment under general anesthesia. Received 900 ccs of crystalloid in OR. Minimal blood loss. placed pt on ICU monitor BP 144/62, HR 116 RR 25 SaO2 97% in RA. Pupils - 2mm PERL.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b(6) [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONS [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.

A [redacted] b(6) - 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03	moves all extremities. limited ROM to (L) leg.
0905.	skin warm and dry. small lacerations noted (R) shoulder, abd. and (R) index finger. (L) leg drsg secure & dry. Ace wrap intact. (R) neck drsg dry & intact. (R) antecubital PIV intact, site free of infection. LR @ 150cc/hr via dial-a-flow. Lungs - poor inspiratory effort. No resp distress noted. Lungs - equal expansion. Lungs - CTA bilaterally. Heart S1 S2 Ø murmers. Ø peripheral edema noted. Capillary refill < 2 sec. Radial pulses strong @ 3+. Abd. flat, non-tender. Active bowel sounds x 4 quad. Dorsalis pedal pulses strong & equal. Foley intact & draining minimal yellow color
~~1000~~ 0950	urine. pt nauseated. Vomited approximately 50ccs brown liquid c blood tinged drainage.
1000	pt resting c eyes closed. no signs of agitation or restless noted. continue to monitor for nausea b(6)-2 [redacted]
1010	Ancef given @ 1010 - Scheduled for OR?? pt @ Surgery SGT [redacted] 91WM6
1200	noted c/o throat pain [illegible] ma c exudate (-) lymphadenopathy noted SGT [redacted] b(6)-2
1800	RECEIVED REPORT FROM DAY SHIFT SGT [redacted] PT IS CURRENTLY AWAKE AND ALERT c PUPILS 3MM BRISK BILATERALLY FOLLOWS SIMPLE COMMANDS. MAE (B) UE c EQUAL STRENGTH (B) LE ABLE TO WIGGLE TOES c DIFFICULTY. (L) LE LIMITED ROM 2° TO ITD. RESP

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-60?

MEDCOM - 17373

Progress Notes

24 Aug 03 1730: Assumed care @ 1400. T-98.6°F P- R-16 BP-117/55 SpO_2-100%
Lung sounds clear. Abd. soft & nondistended. BSx4. Lac to (R) clavicle - sutures CD+I. ACE wrap to (L) leg CD+I. No c/o pain or discomfort. NC-WNL. Will continue to monitor. [redacted]

25 Aug 03 0030 assumed care @ 2200 - no c/o pain @ this time - encouraged pt. to ambulate c crutches during day - ace wrap CDI on (L) leg, neurov's WNL in (L) foot - reported limited ROM in (L) knee, told pt. to exercise that knee, stated understanding - [redacted] CR, AN
BP 116/57
P 62
T 99.1
R 16
SpO_2 98
b(6)-2

0400 BP 118/54 R-14 HR 58 T-98.2 [redacted] b(6)-2

25 Aug 1200 Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Pt. s IV access. Ace wrap to (L) LE CDI, (+) sensation, full ROM of digits, cap refill < 3 sec. DSG D/I to (R) ant thigh, wound s s/s of infection. Sutures to incision on (R) clavicle intact, site approximated well s s/s of infection. AM care completed. Pt up to ambulate x1. Pt. s complaints @ this time. Will continue to monitor. [redacted] /AN
b(6)-2

25 Aug 03 1625: Assumed care @ 1400, T-98.8 P-64 R-12 BP 118/45 SpO_2-99%
A&Ox3, Denies pain or discomfort @ this time. Ambulates c crutches. Sutures above (R) clavicle intact. Dressing to (L) lower extremity CD+I. Will continue to monitor. [redacted]
b(6)-2 [redacted] AN

25 Aug 03 2200 - PT VS are P-78, BP 116/72, T-98.5, R-18, SpO_2-97 - SPC [redacted] 91W

26 Aug 03 0400 PT Vital Signs taken BP 110/56 P 59 T 98.4 R 12 ~~SpO2~~ SpO2 100 SPC [redacted] 91W10

1120 - Pt A&Ox3, VSS, lungs CTA, BS ⊕x4, pulses ⊕x4 ~~[illegible]~~ Sutures intact to (L) knee & Ankle, ø s/s of infx. Sutures intact to (R) upper chest, some redness noted but ø drainage. Voiding ø complaints at this time - Will cont to monitor - [redacted]
b(6)-2

EPW [redacted] b(6)-4

ICW2

26 Aug 03 1500: Assumed care @ 1400. T- 96.9°F P- 75 R-16 BP- 102/74 SpO2-98% Denies pain or discomfort @ this time, HR-reg. Lung sounds clear bilat. Abd. soft, non distended, BSx4, Sutures to Ⓡ clavicle CD+I. Sutures to medial portion of Ⓛ knee intact, Sutures to Ⓛ Foot/ankle intact, Ambulates c crutches, Will continue to monitor. [redacted]

2200 98.8
P-66
R-24
99%
139/89
Ø

26Aug03 assumed care @ 2200 - VSS no c/o 2345 pain @ this time - wound edges well approximated, sutures removed, steri strips on Ⓡ clavicle, Ⓛ knee, Ⓛ foot/ankle - ambulating 5 crutches, limited ROM in Ⓛ knee - awaiting transport to EPW camp, meds @ bedside, DC Summary in chart [redacted]

27 AUG 03 [illegible] P 54, BP 111/54, BR 99, T 96.5 [redacted]

26 Aug03 0913 Pt awake/alert & complaints @ this time. HR Reg, Lung sands clear bilat, bowel sounds (+) x 4 quads. Horizontal incision to Ⓡ clavical approximated well c steri strips intact. Ⓛ LE pedal pulse palpable (+) sensation, cap refill < 3 sec, limited ROM of knee, steri strip to ankle intact. D/c summary & order in place, meds @ bedside. Pt. awaiting [redacted] EPW camp. Will continue to monitor. [redacted]

27 Aug 03 1643. Assumed care @ 1400. T-98.7 P-76 R-16 BP 115/70 SpO2-100% D/C'd to EPW camp @ 1545 c discharge summary + meds [redacted]

bled-2
All

BS 98
97.2 20
115/57

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0500	VSS. Pt denies pain. MSO4 effective for pain. Ø Void ⓒ this time. Will continue to monitor. [redacted]
13Aug03 0600	Pt resting comfortably in bed. NO complaints [redacted]. Respirations even and unlabored. BBS CTA. Palpable pulses Ⓑ. NO edema noted. Abd soft NT, ND ⓒ active bowel sounds. NF LRC 150/hr infusing freely. Drsg to ⒷLE. ~~Incision~~ CDI Ace bandage to Ⓛ LE CDI No distress noted [redacted]
18Aug03 1400	Pt resting in bed. No complaints voiced. NPO. [redacted] discussed plan of care ⓒ pt. VSS. Drsg D&I to [redacted] sites. Will cont. to monitor [redacted]
	b(6)-2
18 AUG 03 1743	Ortho Op Note
	Pre Op Dx - ① Open fx Ⓛ knee ABG
	② Open Ⓛ tibia fx
	③ Open Ⓛ calcaneus
	Post Op Dx - Same
	Procedure I&D wounds
	Surgeon [illegible]
	EBL - MIN Fluids - 1 LR
	Findings - wounds clean. All irrigated and bone curetted. Closed in layers.
	Plan: IV antibiotics x 72 hours. b(6)-2
	[redacted]

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

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AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	20 BPM EVEN UNLABORED BBS CTA SaO2 99% ON ROOM AIR CW S1,S2 (+) HR 60-70s NSR ø ECTOPY PULSES 2+ RADIAL 2+ DP BILATERALLY. CAP REFILL BRISK THROUGHOUT. GI BS(+)x4 QUADS ø TENDERNESS PT NPO TO ADVANCE AS TOLERATED GU FOLEY C CLEAR YELLOW URINE >40cc/HR. SKIN SCATTERED SHRAPNEL WOUNDS THROUGHOUT. STITCHES TO (R) CHEST NEAR CLAVICLE APPROX 3" WELL APPROXIMATED ø DRAINAGE NOTED; 1.5" INCISION LOWER ABD WELL APPROXIMATED ø DRAINAGE NOTED; LLE WRAPPED S/P I&D NO DRAINAGE NOTED @ THIS TIME. LINES 18G PIV TO (R) AC C LR @ 150cc/HR. NO S/S OF INFECTION DUE INTACT / PATENT. WILL CONTINUE TO MONITOR [redacted]
2000	VSS. PT WANTS TO TRY TO EAT. PT GIVEN [redacted] 240cc ANS CRACKERS. PT TOLERATED WELL W/ DIFFICULTY / WILL MONITOR FOR EPISODES OF N/V. [redacted] b(6)-2
2100	FOLEY D/C'D. DTV @ [redacted] INFORMED OF DTV. WILL MONITOR [redacted]
2200	VSS. PT [redacted] ø PAIN. WILL CONTINUE TO MONITOR THROUGHOUT SHIFT [redacted]
18 AUG 05 0200	VSS. Pt received [redacted] for pain to LLE. LLE on blankets. NV done C 2+ pulse DP and Brisk Cap Refill. Pt able to wiggle toes and lift leg upwards. Will continue to monitor. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	RECORDS MAINTAINED AT

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

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

EPW # [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03 2030	Assumed care of pt @ 1800. VSS, afebrile. lung sounds clear bilaterally, apex to base. RR equal + unlabored. O_2 Sat 98% RA. Radial pulses strong + equal to palpation. (R) Pedal pulse strong + palpable. Unable to assess (L) pulse due to bandage. Cap Refill to all extremities < 3sec. PERRLA 3mm. Mucous membranes moist. Pt to start Reg diet when fully awake. BS active x 4 Quad Soft, non-distended, non-tender. Pt has Complete ROM to BUE + RLE. Pt can wiggle toes to LLE c movement from hip. Pt has Kerlix + ace wrap dressing to LLE mid thigh to toes, CDI. Pt has 2x2 dressing to (R) hip, small amt of drainage. Pt has multiple small schrapnell wounds pt has Stitches, le, to (R) collar bone, open to air, Ø drainage, slightly red. Pt also has 1" cut c 2 stitches to LUQ. Pt has IV. to (R) ac. Pt has 18G IV to (L) ac c LR @ 125cc/hr. Will continue to monitor for Δ's SPC [redacted] 9 WWL
PT AUG 03 0004	Q6° VS: 125/70, HR 68, RR 18, O_2 Sat 100% RA, temp 98.7 - SPC [redacted]
19 Aug 03 0600	Received report from Outgoing shift VS 120/62 T 97.2 HR 60 R 14 SaO_2 99 RA. Pt Resting c eyes closed easily roused A + O x 3 speaks English denies pain @ this time pt semi fowlers position HOB ↑ 75° R-lung unlabored CS CTA Color good ABD soft NT (+) BN (+) nights BS hypoactive x 4 Capefil Brisk x 4 Skin warm to touch. Dsg (L) leg CDI NVI Sutures (R) collarbone intact noted ecchymosis NT

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

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

EPW # [redacted]

51 (a)-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

125/-

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03 0600	cont. numerous sm scraped wounds on body (-) drainage will cont to monitor SGT [redacted] 91W M6
19Aug03 WSC 0930 1000	bed bath given, pt washed c assist, hygiene care given pt shaved face given. C/o pain given Percocet II tabs po for (D) leg pain NAD. SGT [redacted] 91WM6
19Aug03 1130	—
19Aug03 1738	Pt transferred from ICU, in stable cond. PERRLA. Lungs CTA bilat, (-) resp distress. BSR. Abd soft, non-tender, bowel sounds active x4 quads. Incision to (R) flank area. Sutures intact, open to air. Dsg to (R) thigh CDI. Ace wrap from (R) toes to Mid-thigh. Strong pulses and brisk cap refill to bilat LE. No complaints — [redacted] 91W/AN
2040	Care assumed @ 2000. VSS, AOX3, c/o pain only when he moves his lle. Lungs CTA, b/s (+). Pt c incision to (R) chest/shoulder, sutures CTA CDI. Dsg to (R) thigh CDI. Dsg c Ace wrap to lle, CDI, pt able to wiggle toes on (L) foot, slight edema noted. No complaints at this time, will continue to monitor. — [redacted] 91WM6
	blw - 24

STANDARD FORM 600 (REV. 6-97) BACK

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Aug03 0600	Pt. awake & alert c̄ HOB @ 45°. HR Regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. Sutures intact to horizontal incision on (R) side of neck, site s̄ s/s of infection. Dsg to (R) upper thigh CDI. Ace wrap to (L) LE CDI, full ROM in digits, (+) sensation, <3 sec cap refill, digits cool to the touch. HL in (L) FA s̄ s/s of infection. VSS. Pt. s̄ complaints @ this time. Will continue to monitor. [redacted] /AN
	b(6)-2
20Aug03	[illegible] Staff
	No complaints. Afeb VSS, Dsg clean & dry. Dsg D tomorrow.
	[redacted]
	b(6)-2
20aug03 1330	Pt awake and alert. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender bowel sounds active x4 quads. Incision to (R) clavicle CDI, sutures open to air. Dsg to (R) thigh CDI. Ace wrap c̄ dsg to (L) leg from toes to AKA. Strong pulses and brisk cap refill to bilat LE. Ø complaints b(6)-2 [redacted] /AN
1400	Neurovascular check grossly intact. PERRLA. Pt awake and alert. Strong

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. 1CW2

EPW [redacted]

b(6)-4

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

MEDCOM - 17380

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	pulses and brisk cap refill to
	all 4 extremities. Bilaterally equal
	strength to upper and lower extrem.
	[redacted]
20 Aug 2020	Care assumed @ 2100. VSS, AOx3, no c/o pain. Lungs CTA,
	BS ⊕ x4, unable to assess pulse on LLE. Dsg on LLE CDI, pt
	able to wiggle toes and c ⊕ cap refill. Wound on chest c staples
	CDI Ø S/S infection. Pt c 2x2 on thigh and calf of ® leg,
	dsg's Δ'd, wounds c minimal drainage and no S/S infection.
	HL on LFA flushes well. Will continue to monitor. [redacted]
21 Aug 03 0830	assumed care @ 0500 - VSS - no c/o pain @
	this time - dsg CDI on multiple schrapnel
	wounds - neuro V'S WNL, PERRLA, answered
	orientation questions appropriately c interpreter
	SL patent - Sutures intact on ® clavicle
	[redacted]
21 Aug 03 1530	Received pt via litter from air evac. VSS. PERRL. Lungs
	CTA ®. Ø resp. distress. GI ⊕ BS x 4 quads. Pt voids per
	urinal. MAE. Neurovascular WNL. Multiple healing shrapnel
	wounds. Dsg to ® lateral shin & ® thigh CDI. Ace wrap
	to LLE. Sutures to ® collar CDI. Erythema to area.
	HL Ⓛ FA. Aneg c pain infusing NPC. Denies pain.
	Will monitor for status Δ's. [redacted]
22 Aug 0733	RVS BP 128/84, HR 60, T 97.9, HR 60, SpO2 9[redacted]
22 Aug 03 1130	Pt. awake & alert in bed s complaints @ this time. VSS. HR Regular, Lung
	sounds clear bilat, bowel sounds (+) x 4 quads. Sutures to ® side of neck
	intact s s/s of infection, and well approximated. HL in Ⓛ FA flushed well c 5cc NS
	Multiple shrapnel wounds to ® LE redressed s s/s of infection. Ace wrap to Ⓛ LE intact

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 17381

ACLU-RDI 1641 p.141

DOD-030970

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year) 16 Mar | TIME 2340

TRANSPORTATION TO FACILITY Medevac

SEX M | AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN (Date)
IS THIS AN INJURY?	X		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 GSW / Mortar

CATEGORY OF TREATMENT

☐ EMERGENT ☐ URGENT ☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2345				
BP	125/58				
PULSE	91				
RESP	20				
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	.5 TETANUS				
	5 morphine				
	1gm Ancef				
	Foley to gravity				

DISPOSITION ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ 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

TEST RESULTS

CBC	WBC 17.5	SMAC	138 / 105 / 9
	H/H 13/39		7.2 / 39 / 127
	PLT 280		1.5
PT 15.2			
APTT 240	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 CXR - Eshrpnel - [illegible]	
EKG INTERPRETATION	

PROVIDER HISTORY/PHYSICAL

♂ EPW Iraqi S/P [illegible]
Arrived via Aerovac as part of MASSCAL

G: WD, WN, NAD, [illegible] @ [illegible] [illegible] well
H: NC/AT [illegible] Sympathetic [illegible]
[illegible]
L: [illegible]
Chest: [illegible] shrapnel over [illegible]
Fort [illegible]

(A/P) to OR after other surgeries..

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b(6)-2

PROVIDER SIGNATURE AND STAMP

[redacted]

CODES

DIAGNOSIS

Shrapnel to to chest wall

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

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

MEDCOM - 17383

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21AUG03	2145		VSS, A+O x3, speaks English, ϕ c/o pain @ this time, Wounds to (R) LE dsg CDI, (R) thigh c 2x2 CDI, Wound to (R) upper chest / (R) clavicular area c sutures approximated CDI. IV to (L) FA patent, continuing IV antibiotics routinely, will continue to monitor. No other remarkable assessment findings. [redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-2

NURSING NOTES

Medical Record

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

MEDCOM - 17384

510-112-

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes) b(6)-2 A11

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20Aug03	1130		full rom of digits, cap refill <3sec, (+) sensation. Pt. S other abnormalities noted from assessment. Will continue to monitor. [redacted] RT/AW
		1954 20 03	
		2003	Pt. care assumed @ 1500. VSS. HR Reg, lungs CTA, BS (+) X 4. Dsg to (R) leg CDI. NV checks to (R) V ext. WNL. Pt. c/o pain to (R) leg when weight bearing. Pt. has ø pain when resting in bed. Sutures to neck line OTA, CDI. Incision slightly [redacted] reddened ø purulent drainage skin cool, dry. will cont. to moniter [redacted]
22 Aug 03		2315	pt care assumed @ 2300. pt resting quietly easily arouses to verbal stimuli. VSS. Sutures to area above clavicle on (R) side intact OTA free of sx of infection. lungs CTA, abd soft nontender BS(+)X4 quads. LLE c ace wrap from thigh to toes CDI. pt able to wiggle toes. RLE c (+) pulse. BUE c (+) pulses. CTA c HL flushes well. (-) redness/swelling noted. Dsng to (R) index finger CDI. 4 pumo V's WNL. (-) c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted]
23 Aug 0734			RVS BP 117/52, HR 64, T 99.0, RR 18, SPO2 99% [redacted]
	1215		Pt alert & oriented OOB x 2 utilizing crutches. P.T. in with pt [redacted] lungs CTA. b(6)

(Continue on reverse side)

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

EPW [redacted]

b(6)-4

REGISTER NO. [redacted]

NURSING NOTES

Medical Record

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

MEDCOM - 17385

b(4)-2 A11

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			BSO, pulses @ x4. Incision intact to (R) upper chest, ø s/s of infx. Ace wrap to (L) leg, @ sensation, able to wiggle toes, skin warm to touch. Voicing ø complaints. Will cont to monitor [redacted]
		1720	Pt. care assumed @ 1500. HR Reg 1 lungs CTA, BS@ X4. @ LE dsng CDI ē pulse 2+, br isk caprefill, @ sensation. Pt. c/o ↓ pain. Pt. ambulated ē crutches, able to bear some weight on @ LE. will cont. to moniter. [redacted]
23Aug03		2330	Pt awake and alert. Lungs CTA bilat ↓ resp distress. NSR. Abd soft, non-tender bowel sounds active x4 quads. Incision to (R) clavicular area reddened ↑ minimal swelling. Sutures intact open to air. Drsg to R leg CDI. Ace wrap to (L) leg CDI, pt wants to bend (L) knee. Strong pulses & brisk cap refill to bilat LE. ø complaints [redacted]
24Aug03	0743		PT VS BP 116/64, HR 65, T 98.7, RR 16, SpO2 98%
	1110		BP 115/57, HR 86, T 98.3, RR 16, SaO2 100% [redacted]
		1239	VSS, lungs CTA, BSO x4, pulses @ x4, A+O x3, Incision to (R) clavicle area ø drainage noted. Sutures intact. Splint & ace wrap intact to (L) leg. Ambulated x2 [redacted] Will cont to monitor

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

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MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:
HEIGHT: See H&P
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication):
NKDA

3. PREVIOUS SURGERY [ ] NO [X] YES (type): UNKNOWN
See H&P

4. PROPOSED SURGICAL PROCEDURE:
(R) Neck Exploration I & D (L) Knee / Foot

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no
See H&P

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of 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 from pooling.

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

[redacted]
b(6)-4

DA FORM 5179, JUN 01 Previous editions are obsolete. USAPA V1.01

MEDCOM - 17387

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. 4 o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	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 neeessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ ANC 17 Aug 03 DATE

11. [redacted] ATION: Pt awake. VSS. No complaints verbalized Dsgs dry & intact. Bovie pad site intact.

D(a)-2

12. PREOPERTIVE [redacted] (Signature and Ti[redacted] CRNA

DATE: 17 Aug 03 TIME: 0830

13. PREOPERTIVE [redacted] BY (Signature and T[redacted] CRNA

DATE: 17 Aug 03 TIME: 0855

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

b(4)-2 A11

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Anesthesia [redacted]
2. PATIENT VERIFIED [redacted] REVIEWED AND PROCEDURE CPT/Dx
3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0825
4. PATIENT I[redacted] TIME 0725 NUMBER 1 - 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] / Maj [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

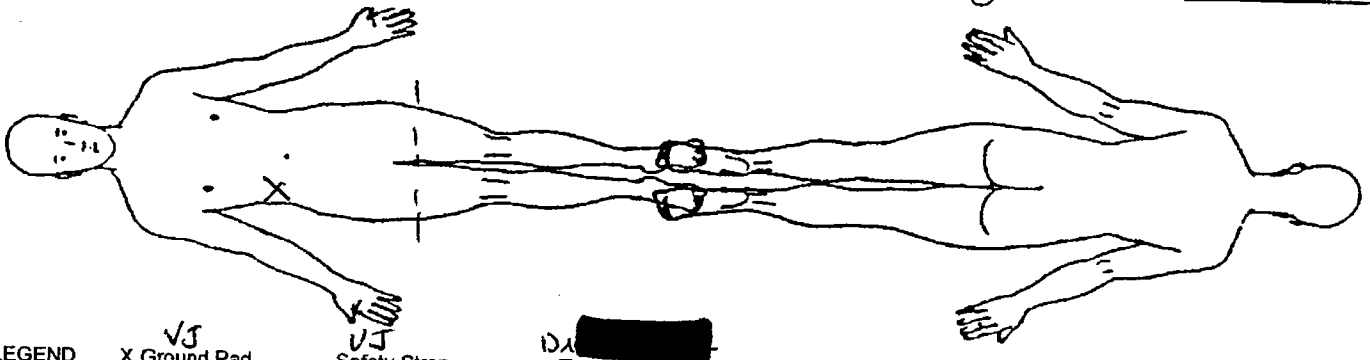
COMMENTS: Arms tucked @ sides. Roll under back

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Betadine
SITE: Incl. chest-abd. BY WHOM: CPT [redacted]
SITE: (L) knee to foot BY WHOM: MAJ [redacted]
COMMENTS: ϕ pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad VJ – Safety Strap VJ === Tourniquet [redacted]

@ 0808 @ 275mmHg ↓ @ 0829 = total time 21 min

10. COUNTS (C = Correct I = Incorrect)

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

Initial SCRUB [redacted] / CPT [redacted] CIRCULATOR [redacted]

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

[redacted]

b(4)-4

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

cut 30 coag 30

☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-[illegible] OCT[illegible] REPLACES DA FORM [illegible] OBSOLETE. MEDCOM - 17389 USAPA V1.01

13. PROSTHESIS, LANT ☐ ES ☒ NO IF YES NAME: ID NUMBER; M JFAC. 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):
NS

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8 dsg / tape
Fluffs, Kerlix/ace wrap

19. ADDITIONAL INFORMATION
WC I
Surgeons [redacted] Anesthesia: General Anesthesia Type:

Bovie Pad site intact pre-op VS ; post-op ~~change~~ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op VS : post-op ~~change~~

b (6) -2 'All

20. OPERATION(S) PERFORMED
I; D (L) knee and foot; (R) neck wound exploration

21. PATIENT TRANSFERRED TO Ft Sam TIME 0855 METHOD Litter

22. REGISTER [redacted]

REVERSE OF [redacted]

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

b(a)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Wheeled litter BY MAJ [redacted] /CPT [redacted]

2. PATIENT IDENTIFIED [redacted] VERIFIED BY CPT [redacted] AND PROCEDURE b(a)-2

3. DATE 18AUG03 TIME PATIENT ARRIVED IN SUITE 1555

4. PATIENT IN ROOM TIME 1555 NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(a)-2	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed. Head on folded towel, Arms Extended to sides < 90° in CAP, secured to padded armboards & safety straps. LLE prepped into sterile field.

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

COMMENTS: Proper Body Alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

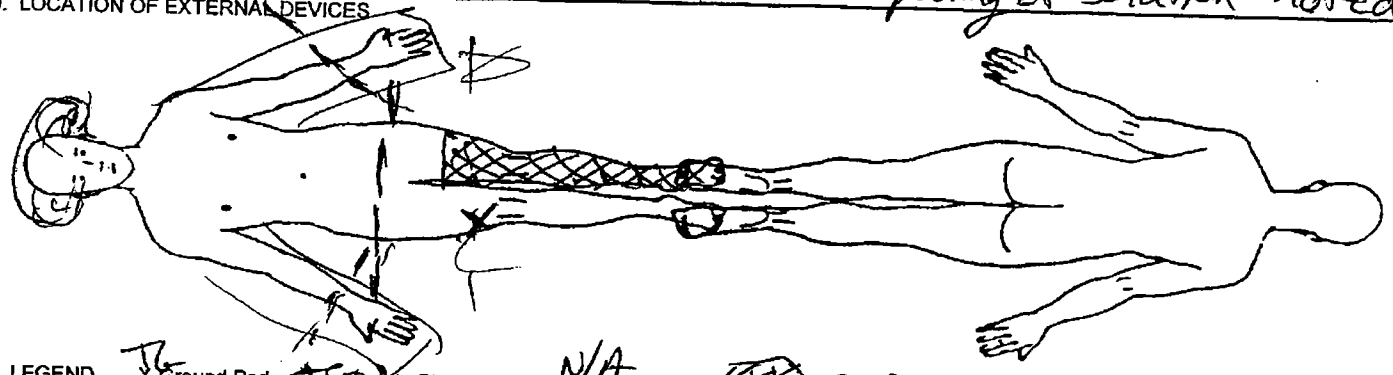
PREP SOLUTION (Specify) Betadine / Betadine b(a)-2

SITE: LLE BY WHOM: CPT [redacted]

SITE: (as below)

COMMENTS: no pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad Safety Strap N/A Tourniquet prep

C = Correct I = Incorrect

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

SCRUB	CIRCULATOR
SPC [redacted] 91D	CPT [redacted] RN

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

[redacted]

b(a)-4

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

☒ ESU NO: 3 SN 000417

GROUND PAD: BRAND Valleylab Polyhesive II REM

LOT NO: 68936/2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 88, WHICH IS OBSOLETE.

MEDCOM - 17391

USAPA V1.01

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 - QS.

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	18. DRESSING/IMMOBILIZATION *(Specify)* Kerlex Fluffs, Kerlex Roll, ACE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC II
Surgeons: Dr. [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: GEN/LMA
5(es) - 2 MAJ [redacted] CRNA

Bovie Pad site intact pre-op CT; post-op CT Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A post-op ____

DA Form 5179 previously done

20. OPERATION(S) PERFORMED
I+D (L) Foot, Heel, + Knee

21. PATIENT TRANSFERRED TO ICU 2 TIME 1725 METHOD Wheeled litter

22. REGISTERED NURSE SIGNATURE

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

Aug 19 HOUR

17

8:00 12:00

2 4 6 8 10

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°
120	98°	37.0°
		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.

[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 - 17393

1-119

MEDICAL RECORD

NSN 7540-00-634-41

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 19

DAY 10 20 21 21 aug 23

HOUR

PULSE (O) | TEMP. F (°) | TEMP. C (Centigrade Equivalents, for Reference only)

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°

120 98° 37.0°

110 97° 36.7°

100 96° 36.1°

90 95° 35.6°

80 35.0°

70

60

50

40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] b(6)-4

REGISTER NO.

WARD NO. CW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17394

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO 18 HOURS | TOTAL HOURS COVERED | DATE 17 Aug

INTAKE

~~ORAL~~ Urine O/P

TIME	TYPE	AMOUNT	ACCUM TOTAL
02	~~45~~ Urine	950	950
03		100	1050
04		100	1150
05		120	1270
06	Urine	100	1370
07			
08	Surgery		
09			
10			
11			

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
02	1000	LR @ 150			

~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
06			
07			
08			

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72

MEDCOM - 17395

*U.S.GPO:1998-404-613/30343

Ward/Section: ENT	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] bla)-4	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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/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

======= PICCOLO =======
17/08/03 00:29
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 bla)-4
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: bla)-2 [redacted]

GLU	134*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	280	39-380	U/L
NA+	126*	128-145	MMOL
K+	3.1*	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	20	18-33	MMOL

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

---
i-STAT CREA
Pt: [redacted]
Pt Name:_____

Crea_____1.5 mg/dL

Sample Type_:

---
i-STAT 6+
Pt: [redacted]
Pt Name:_____

Glu_____127 mg/dL
BUN_____9 mg/dL
Na_____138 mmol/L
K_____3.2 mmol/L
Cl_____105 mmol
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

Sample Type_:

17AUG03 00:56

bla)-2

REPORTED BY: [redacted]	DATE: 8-17-03	LAB ID NO.:

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

LAST, FIRST, MI. b(6)-4 [redacted]	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
H		
M		
P		
L		

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	15.2	9.8-13.6 secs
APTT	24.0	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.:

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)								
phenergan (mg)	12.5							
MSO4 (mg)	<10>							
propofol (mg)	100/60							
SUX (mg)	100							
( )								
( )								
VOLAT AGENT I50 % del		1.5	1.5	2.0	1.5	1.0 X		
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	6	1	1	1	1	2	6	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	(1)(2)							

FLUIDS

LINE site 16g RAC ☐ Warmed	LR 1000				#2	700		
18g LAC ☐ Warmed	hep lock							
☐ Warmed								
☐ Warmed								

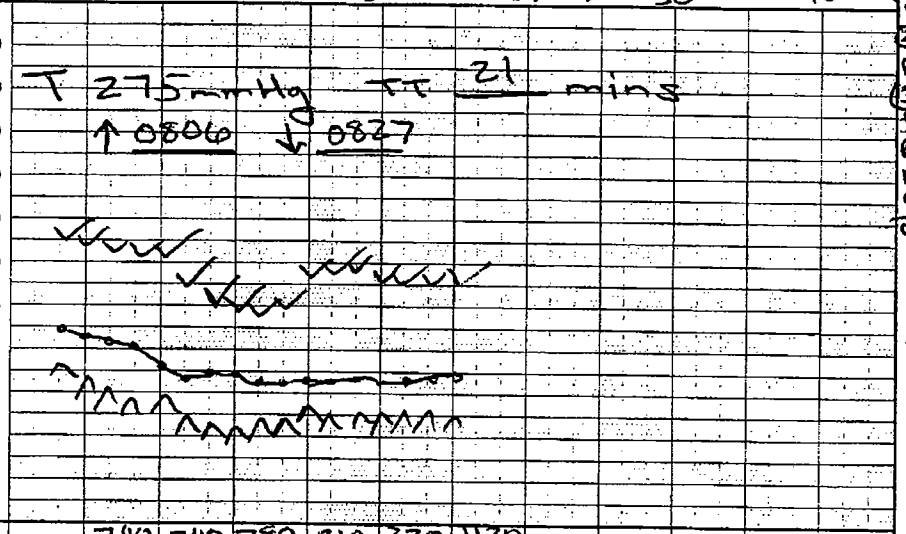
LOSSES

EST BLOOD LOSS								
URINE -	Foley				200			

PHYS STATUS (1 2 3 4 5 E) — **BODY WEIGHT** 75 (KG / LB) — **HEMATOCRIT** — **INITIAL DATA** BP- 130/72, HR- 92 — **EQUIP CHECK** OK?- (Y) N — **PATIENT RECHECK** OK for PROCEDURE? TIME- 0715

SYMBOLS: BP by cuff V ^ — Heart rate ● — Resp rate — BR (transduced) ╪ — TOURNIQUET T—T — ANES- X-X PROC- ⊙-∅

TIME → 0730 → 0800 → 0830 → 0900 → 0930 → 1000



VENTIL

VT - ml			740	740	780	210	320	420
f - breaths/min			10	10	9	20	18	18
Peak inf pres / PEEP			17	17	20	—	—	—
MODE - S(pon), A(ssist), C(on)		5	C	C	C	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	34	31	31	32	38	
BP/oth	✓ PIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.7
ART line	✓ SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR	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 → Arms tucked

TOTALS — TOTAL EBL 10 min — TOTAL URINE 200

FLUIDS SUMMARY — CRYSTALLOID- 900 — COLLOID- Ø — BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

P+S chart+✓. OK to proceed. (1) To room via litter, SOC mons applied, preO2. (2) Smooth IV RSI 3 I ccp. (3) Suctioned & extubated. Post-extub L spasm. easily relieved CPP. To ICU stable

RECOVERY AT — PACU (ICU) 2 (Specify) — OTHER

CONDITION: RESP- 24 SpO2- 100 BP- 144/62 HR- 124

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0725	0900
PROC	Ready	Begin	End
	0735	0754	0840

PROCEDURES and CPT Codes: Rt neck exploration; Arthrotomy x 3D Lt knee; I&D Lt Foot/ankle; I&D Rt thigh

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

[redacted] b(6)-4

20 yo Iraqi EPW

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, DL x 1 ⊖ trauma, ⊕ ETCO2 BSFB. 8.0 ETT secured 23cm @ teeth. [redacted]

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2 MAJ, CRNA

PROCEDURE LOCATION: 1-1

DATE: 8-17-03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 17398 — PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

160

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

DRUG	(Units)													
Versed	(mg)	3/2		2 5										
Fent	(µg)	50												
Ketamine	(mg)	100												
propofol	(mg)	100												
Lido	(mg)	25												
MSO4	(mg)			(5 X 5)										
VOLAT AGENT	Forane del	1.5	1.5	2.0	1.5	1.5								
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	10	2	2	2	2								

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

FLUIDS

LINE site LR	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

TOTALS

TOTAL EBL	TOTAL URINE
5m6	mL
	—
10m6	

FLUIDS - SUMMARY

CRYSTALLOID- LR : 1000

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1555 in OR, monitors applied.
1600 #5 Prosea/LMA placed one attempt ⊕BS, ⊕ETCO2
1730 Spont Resp prosea/cuff
Spont Resp to PACU mask O2
Report given

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 85 KG LB est

HEMATOCRIT

INITIAL DATA

BP- 113/55

HR- 72

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 1530

TIME 1600 x 30 x 17 x 30 x 18

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	810	500	290	30	30	SV 2012	
f - breaths/min	9	7	19	19	18		
Peak inf pres / PEEP	17	15	—	—	—		
MODE - S(pon), A(ssist), C(on)	S-CV	CV	SV	SV	SV	SV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	44	46	46	44	48	46
BP/oth	FIO2 (Frac or %)	.81	.81	80	80	81	.83
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site SK/in			35			
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS Position → o-1 arms ≤ 90° abducted

RECOVERY AT ICU2

PACU ICU _____ (Spacify)

OTHER Spont Resp Report given

CONDITION: T98.3

RESP- 22 SpO2- 100

BP- 143/64 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1555	1830
PROC	Ready	Begin	End
	1605	1620	1706

PROCEDURES and CPT Codes: IeD(L) foot

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA c Prosea/LMA #5

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

[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #5 prosea/LMA placed one attempt, secured c tape b(2)-2

SURGEON [redacted] b(6)-2

ANES [redacted] RNA

PROCEDURE LOCATION: [redacted]

DATE: 8/13/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 17399 — COPY 1 - PA — T'S MEDICAL RECORD — USAPA V1.00

PRE-ANESTHETIC ASSESSMENT AND PLAN OF CARE

AGE: 28 Days Mos (Yrs) GENDER: (✓) Male ( ) Female P S: (1) 2 3 4 5 (E)

ALLERGIES: NKDA WT: 75 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: Zone I neck exploration

SURGICAL SERVICE: GS / CT

NPO SINCE: 2400

PREOP DX / MECHANISM OF INJURY: S/p Blast Injury

HABITS:

Tobacco: Ø
EtOH: Ø
Drugs: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) None
( )
( )
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ______ Hrs
None

LABORATORY STUDIES:

Other:

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	Schrapnel wounds
Familial Hx	N	Y	

Pt. speaks english (Pt distressed during admission)

SURGICAL HISTORY

PHYSICAL EXAMINATION

BP: 125/58 HR: 69 RR: 12 T: ____

Pain (0/10 Scale): ____

Airway Exam:
Dentition intact
Trachea Midline
TMJ/C-spine ____
Oropharynx MP 1

Chest:
Lungs CTA (B) =
Heart RRR Ø m

IV Access: 18G Ⓛ arm

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ________ (✓) General: (Intubation) / Mask-LMA Notes: ________

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] Date: 8-17-03 Time: 0007

PATIENT IDENTIFICATION: [redacted]

[redacted]

b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: ________ Date: ________ Time: ________

Nursing Unit: ICW2

MEDCOM - 17400   28TH COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

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 [redacted]		17 Aug 03	0100 HOURS	
		1) Admit ICW #2		
		2) Dx [redacted] Shrapnel Wnd		
		3) [illegible] new [illegible] Check		
		4) Activity Bedrest		b(6)-2 [redacted]
NURSING UNIT / ROOM NO. / BED NO.		5) Diet NPO		
		7) IV LR at 150cc/h		
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		8) Pending OR [illegible] hours		
		9) Ancef 1g IV q8°		
		10) MSO4 [illegible] 2-8mg IV q1° prn		
		11) Call MD T>101°, SBP>180 <90		
		Chng [illegible] shft		
NURSING UNIT / ROOM NO. / BED NO.		[redacted]		
PATIENT IDENTIFICATION		DATE OF ORDER	HOURS	
NOTED 17 AUG 03 [illegible] [redacted]		NO VS Q6° c NV✓ TO LLE		[redacted]
NURSING UNIT / ROOM NO. / BED NO.		b(6)-2		
PATIENT IDENTIFICATION		DATE OF ORDER 18 AUG 03	TIME OF ORDER 1700 HOURS	18 Aug 03 [redacted] 1800
		✓① RESUME PREVIOUS ORDERS		
		✓② PERCOCET 1-2 P.O. Q 4-6 HRS PRN		
		✓③ REGULAR DIET		
		④ TYLENOL 650 mg P.O. Q 4 HRS PRN		
NURSING UNIT / ROOM NO. / BED NO.		⑤ [illegible] [illegible] HEP LOCK [illegible] P.O. WNL		[redacted] b(6)-2

NOTED [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE: 1980—409-824

"USE BALL POINT PEN—PRESS FIRMLY / NO CARBON PAPER REQUIRED"

MEDCOM - 17401

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
#EPW [redacted] b(6)-4		17AUG05 ______ HOURS	
	1)	To [illegible]	
	2)	Dx [illegible]	
		[illegible]	
		[illegible]	
	3)	[illegible]	
NURSING UNIT / ROOM NO. / BED NO.	4)	[illegible] Q1° X 4 [illegible] Q4°	
		[illegible]	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER	
	5)	Activity Bedrest HOURS	
	6)	Diet [illegible]	
		when alert [illegible]	
	7)	IV LR at 125cc/L	
		[illegible]	
	8)	MEDS	
NURSING UNIT / ROOM NO. / BED NO.		MSO4 2-8mg IV Q1-2° [illegible]	
		or	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER	
noted 20AUG05 [illegible] [redacted] b(6)-2		✓ Percocet 2 po Q4° HOURS	
		[illegible] IV Q1° [illegible]	
		[illegible] IV Q8°	
	9)	labs CBC Chem [illegible]	
	10)	Call MD T>101.5, SBP >180	
NURSING UNIT / ROOM NO. / BED NO.		<90, UOP<30cc/L	
PATIENT IDENTIFICATION		DATE OF ORDER [redacted] HOURS	
		b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 17402

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: 24 VS | ROOM NO.: 2250 | BED NO.: 19 Aug 03 Perfect

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 1720 HOURS | LIST TIME ORDER NOTED AND SIGN

Transfer to ICW 2

Continue all previous orders

VO Dr. [redacted]

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT: ICW | ROOM NO.: 240 chart ✓ | BED NO.: 14 [redacted]

DATE OF ORDER: 8/22/03 | TIME OF ORDER: 1420 HOURS

✓ - D/c Ancef

✓ - Keflex 500mg PO QID

✓ PT for ambulation training today

✓ - Heplock IV

noted 22 Aug 03 1420

b(6)-2

[redacted]

903

DATE OF ORDER: 24 Aug 03 | TIME OF ORDER: 1200 HOURS

① CBC, Diff, LFT's ASAP

b(6)-2

[redacted]

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT: ICW | ROOM NO.: 5 | BED NO.: 13

DATE OF ORDER: 25 Aug 03 1540 | TIME OF ORDER: HOURS

D/C Q4 vitals, Δ to q shift.

Dressing Δ to @ LE q day.

V.O. from Dr. [redacted]

noted 25 Aug 03 1545

[redacted]

b(6)-2

b(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted] b(6)-4

DATE OF ORDER 26 AUG 03 TIME OF ORDER 1650 HOURS

LIST TIME ORDER NOTED AND SIGN

Noted 26 Aug03 1710 b(6)-2 [redacted]

1. DIAZEPAM 5 mg PO QHS PRN
2. KEFLEX 250 mg P.O. QID X 10 DAYS
3. MOTRIN 800 mg TID PRN #30

NURSING UNIT | ROOM NO. | BED NO.

24 WARD 5 27 Aug 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER b(6)-2 HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256

MEDCOM - 17404

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]

NURSING UNIT | ROOM NO. | BED NO.

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

XR - Lateral (L) Ankle
Lateral (L) Knee

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

b(a)-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. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21
17 Aug 03	[redacted]	Vitals q8h with neuro vascular checks	06	[redacted]					
			18	[redacted]					
17 Aug 03	[redacted]	Activity bed rest	06	[redacted]					
			18	[redacted]					
[redacted]									
17 Aug	[redacted]	Q6° VS T N V (J) TD	06	[redacted]					
		LLE.	18	[redacted]					
18 Aug	[redacted]	Regular diet	06	[redacted]					
			18	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: multiple Shrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(a)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17406

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 8 Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(17 Aug 03)	[redacted]	admit to ICU #2	(17 Aug 03)	ASAP	0145	[redacted]
17 Aug 03)	[redacted]	Pending OR	17 Aug 03)	ASAP		
	-----	XR - Lateral (L) [illegible]			VOID	
18 Aug	[redacted]	~~Resume~~ Lateral (L) Knee			VOID	[redacted]
18 Aug	[redacted]	Resume previous orders	18 Aug	Now	1735	[redacted]

	-----	b(e)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
17 Aug	[redacted]	Call MD for T > 101.1,	
-----	-----	SBP > 180 < 90, change	
-----	-----	in neurovascular status	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

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. 8 Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	DATE COMPLETED (HR)
Copied	[redacted]	Activity - BR	[redacted]
Copied	[redacted]	Neuro Q shift 25 Aug 03	[redacted]
Copied	[redacted]	Log Roll	[redacted]
Copied	[redacted]	Call MD T>101.5 BP>180	[redacted]
25	[redacted]	Dressing Δ to [redacted] Q day	[redacted]
25	[redacted]	Vitals QS	[redacted]

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS:

Lung Contusion Diagonal wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-9

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES.

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

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

MEDCOM - 17408

b(6)-2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		CBC, Chem 8 [illegible]				
22Aug		PT for crutch training today	22Aug today			DCd 27Aug03 1545
28Aug		D/C to FLW camp c Keflex x 7 days				

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

USAPA V1.00

b(a)-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. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16 17 18 19 20 21 22 23 24 25
[redacted]				
17 Aug 03	[redacted]	Cefuroxime 1 GM IV	06	[redacted]
		q8h	08	D/C'd 20 Aug 1100
2			14	
18 Aug	[redacted]	IV LR @ 125/hr	06	Rewritten
		Heplock when tolerating	18	See below
		PO well		
19 Aug	[redacted]	Heplock IV	05	
			13 AW	D/C 23 Aug
			21 PP	
20 Aug 03	[redacted]	Keflex 500mg po QID	06	
			12	D/C'd 27 Aug 1545 [redacted]
			18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: multiple shrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

b(a)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED — USAPA V1.00

MEDCOM - 17410

blw-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing — Mo. 8 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		~~Pen~~ error				
27Aug	[redacted]	D/c to EPW camp	27Aug	ASAP	DC'd 27Aug03 1545	[redacted]
		blw-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
17Aug03	[redacted]	MSO4 2-8mg IV q1h PRN	4mg IVP 0200 18Aug [illegible]; D/C 18Aug03 [redacted] SD [illegible]
18Aug	[redacted]	Percocet 1-2 PO q 4-6° prn	TTPO 2100 [illegible]; 19Aug 1000 TTPO; 19Aug 1600 TTPO [redacted]; 19Aug 2330 TTPO; 20Aug 1400 TTPO [redacted]; 21Aug03 0030 TT [redacted]
18Aug	[redacted]	Tylenol 650mg PO q 4° prn	
17Aug 03	[redacted]	MSO4 2-8MG IVP Q1HR PRN	6mg IVP 2130 18Aug [illegible]
20Aug	[redacted]	Zofran 4mg IV q6° PRN	

D/C'd 27Aug03 1545 [redacted]

USAPA V1.00

MEDCOM - 17411

Patients Name: EPW# [redacted] Date: 19AUG03

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	~~120~~						118																			
NBP	~~62~~						64																			
TEMP	97*						98.8																			
HR	60						66																			
RR	14						16																			
SaO2	99						100																			
FiO2	~~0~~						RA																			
Source	~~0~~						-																			
MAP	-						-																			

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	Tot
IVF LR	125																									
IVPB																										
NGT																										
P .al	125																									

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	~~0~~			500			450																			
NGT	-																									
STOOL	~~0~~																									
DRAIN	-																									
Total																										

MEDCOM - 17412

DOD-031001

ACLU-RDI 1641 p.172

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: 17 Aug 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block ASA I

Time In: 0905

Allergies: NKDA OR Intake: Crystalloid 900 Colloid

Pre-op V/S: 139/72 92 OR Output: UOP 200 EBL min.

Procedures: I+D (L) leg (L) thigh Meds/Times:

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

Pre Op Meds History

Time	[illegible]
SaO2	[illegible]
FiO2	[illegible]
Methods	
240	
220	
200	
180	
160	
140	
120	^
100	
80	
60	✓
40	
20	
RR	20
T	98.7
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		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1		
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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.			

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): b(6)-2 SGT [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 17 Aug 03

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

EPW # [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

ICU1

Patients Name: # [redacted] (PW

Date: 17AUG03

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			S																							
NBP	102/70	132/70		196/62	128/68	124/72	126/66	122/58	118/62	120/58	118/64	130/84		118/60				119/60				112/52				
TEMP	99	99	U	98.4			98.4			99				100.5	100.5			100.0				99.0				
HR	70	90	R	98	102	100	98	92	96	88	92	88		79				70				68				
RR	20	22		18	16	22	24	20	18	22	24	18		22				20				22				
SaO2	100	100	G	100	100	100	99	100	100	99	99	98		99				99				100				
O2	∅	∅		∅	∅	∅	∅	∅	∅									RA				RA				
Source			E																							
MAP																										
			R																							
			Y																							

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	Tota
IVF	150	150	900	150	150	150	150	150	150	150	150	150		150	150	150	150	150	150							
IVPB	100										100									50						
NGT																										
P																										
al																										

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	80	110		120	80	70	110	100	80	80	90	110		210			150									
NGT																	NC									
SOL																	FOLEY									
DRAIN																										
Total																										

143/64 22 100 75 98 8

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: 18 Aug 03
Time In: 1735
Allergies: NKDA
Pre-op V/S: 143/85 72
Procedures: IV D2W @ 75 (22 100)

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 5 EBL 5.0
Meds/Times: 3 versed 10 mg MSO4 Fent 100mcg

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

Pre Op Meds

History

Time	1735	1740	1745	1800	1815	1830
SaO2	100	100	100	96	100	
FiO2	8L			8L	8L	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	22		15	20	15	
T	98.8					

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	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1	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
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	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.	7	8	9	

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)

b(6)-2 [redacted] CPT

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 18 Aug 03

PATIENT [redacted] (For typed or written entries, give: first, middle, last name; hospital or medical facility)

b(6)-4 [redacted]

Name - last

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

2

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg			+		W	P
15'	"			"		"	"
30'	"			"		"	"
45'	"			"		"	"
60'	"			"		"	"
90'							
D/C	"			"		"	"

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg		CDI
30'			
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1735 Arrived from OR
Extremity drowsy Respirations even and unlabored Capnetic
43 sec. No distress no c/o pain
N/V [redacted]

b(6)-2

Discharge Criteria:
Date: 18AUG03 Time: 1845 PARS: 9
BP: 126/63 T: 99.3 HR: 83 RR: 15 SaO2: 98 RA
Pain Level at D/C (0-10): 0
Intake: _____ Output: _____
Additional Data: _____
Transferred To: ICU 2
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SPC [redacted] 91WM6
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: b(6)-2

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	028	2	2	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	ADMISSION	BRANCH / CORPS
	2	0130	b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K10	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
IZ		9		X

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

N[redacted]	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
b(2)-2	unk	unk

21. TYPE OF DISPOSITION	MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030826

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AFAA		030810

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

FOR LOCAL USE

DX: multi shrapnel wounds

DX: 8910 8922 8920

PX: 7166x2 8365x2 8302x2

b(6)-2

ADMITTING OFFICER (Signature as required)

[redacted]

OF ADMITTING CLERK

[redacted]

DA FORM 2985, MAR

MEDCOM - 17417

USAPPCV1.0

[redacted]

IN[illegible]ENT TREATMENT RECORD COVER [illegible]EET

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

REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
	UNK - EPW [redacted]			EPW	
4. SEX / 5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M. / 24Y	X	MUSLIM	—	—	NO.
11. FMP	12. SSN		13. ORGANIZATION		14. WARD
99	[redacted]		— b(6)-4		ICW1
15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO.		K78	—	—	WIA.

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from the ER.	0130.	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	D/C TO CAMP.	18 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	17 AUG 03.	

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE [redacted]

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

MORTAR ROUND BLAST INSIDE EPW CAMP.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Shrapnel Wounds / Partial TOE Amputation.

873.41
892.0
890.0
895.0
893.0
891.0
E979

84.11
86.28
86.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

SIGNATURE OF ATTENDING MEDICAL O[redacted] SIGNATU[redacted] MEDICAL RECORDS OFFICER

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 yo Iraqi male s/p Blast @ EPW camp

c/o (B) leg pain !

Last meal 2000

All Ø meds Ø PMH - Ø PSH Ø

PHYSICAL EXAMINATION

102 123/ 98% SAT

small lac (L) cheek

Neck NT ⊖ Deformity NL AROM

BACK - NT ⊖ injury

Chest - CBTA

Abd ND soft NT

rectal Heme ⊖ NL TONE

GU WNL

Vasc 2+ PP throughout

Ext (1) penetration over (R) Lat Greater Troch

(2) wound (L) Lat inguinal crease

(3) Peppering (R) Ant thig

(4) rt Foot wound c ST Defect

⊖ near Amp (L) 2nd + 3rd toes

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

A/P (1) (B) low ext wound

(2) Traumatic Amp (R) toes

(3) Hip penetrat r/o Pelvic injury.

b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	[illegible]		

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

REGISTER NO.	WARD NO.
	ICW 1

EPW [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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 AUG 03 0217	VSS. AOx3. (+) Pulses. PERRLA. BS(+)x4. DSG's to (R) foot @ (L) cheek CDI. LSCTAB. S1S2. FTG [illegible] light [illegible] [illegible] quantify sufficient. Denies pain @ this time. NPO after MN. Rests comfortably in bed. [redacted] b(6)-2
17 AUG 03 0930	Brief Op Note
	PreOpDx: Shrapnel wounds (B) LE
	PostOpDx: Same
	Procedure: I&D of wounds, completion partial toe amputation (L) 2nd toe
	Surgeon: [redacted]
	EBL: ∅
	Fluids: 1000cc
	Findings: multiple soft tissue shrapnel wounds (B) LE, partial amputation (L) 2nd toe
	Cx: ∅
	Post Op Plan: Abx, dressing Δ's [redacted] b(6)-2
17 Aug 03 @1000	OMFS Brief procedure note
	Closure of left cheek laceration c̄ 5.0 prolene suture s̄ complications in OR.
	b(6)-2 [redacted] MAJ/DC OMFS

STANDARD FORM 509 (REV. 5/1999) B
USAPA

MEDCOM - 17420

DATE	NOTES
7 Aug 03 1621	Received pt resting in bed, USS, A+Ox3 LSCTAB, MRL, BSE X4, ABD SNT, pulses equal + strong. Drsg intact. Pt to OR, recovery then back to ICU with no shift. Pt returned w/ LSCTAB, USS, A+Ox3, BSE, abd SNT. Drsg on RLE c/d/i, LLE noted to have some serosang drainage, drsg intact. Toes warm, cap refill good, able to wiggle toes. IV patent + intact. med x2 w/ 2mg MSO4 per orders. Will cont to monitor. [redacted] b(6)-2
17 AUG 03 1930	USS. c/o BLE foot pain & given 2mg MSO4. DSG's CDI. Voids light amber urine. Quantity sufficient. Minimal PO intake this PM. Belly is soft. [redacted]
18 Aug 03 0545	Pt received awake & alert c/o pain, given MSO4 2mg IV, x1, x2 noted c bilat UEs @ peripheral pulses, bilat LE c drsg LLE c dried bloody drainage otherwise CDI c good capillary refill, warm to touch & able to wiggle toes, drsg to @ thigh CDI, drsg to @ inner thigh CDI, lungs CTA bilat, @ bowel sounds, cont to monitor. [redacted] b(6)-2
18 Aug 03 0940	Pt received 2mg IVP MSO4 for c/o pain. Will monitor for effect. [redacted]
18 Aug 03 1115	Pt resting in bed. S complaints. [redacted] b(6)-2
18 Aug 03 1336	Pt transferred to ICU #2 via litter. Report given to CPT(P) [redacted] b(6)-2

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

EPW [redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03	D/C Summary This Iraqi male sustained shrapnel wound to both leg and a ruptured left 2nd toe amputation on 8/16/03. His wound are clean and should continue to remain clean & dry. Oral antibiotics should be continued. Weight bearing as tolerated [redacted] b(6)-2

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Aug03 1500	assumed care when pt. transferred from ICU 1 @ 1430 - VSS, T 100.8 - 9/10 pain in feet, given 650mg PO tylenol - NS @ 125cc/hr infusing into (L) AC IV - lungs CTA (B) - (+) BS - restrained (R) wrist, (L) Ankle - (L) foot c Kerlix & ace wrap, small amount of drainage near 4th toe, (+) sensation, (+) movement, neuro V's WNL - (R) foot c Kerlix & ace wrap CDI, (+) movement, (+) sensation, neuro V's WNL - pt. speaks limited english and understands english - pt. has dc orders for 19 Aug 03 b(6)-2 [redacted] RTAW
18Aug03 2000	daily dsg Δ done @ 1700 - (L) thigh wound dressed, (L) foot 2nd toe packed c iodoform, Kerlix placed over 3 other schrapnel wounds then ace wrap, (R) thigh wound loosely packed, other schrapnel wounds on (R) thigh covered c 2x2 & Kerlix, (R) foot 2nd toe sutures intact and 3rd toe suture intact dsg placed on toes, Kerlix & ace wrap - Sutures on (L) foot and lower (R) thigh intact and dressed b(6)-2 [redacted] CRTAW
19 Aug 0100	Care assumed @ 2100. VSS, pt A&Ox3, 1 tab percocet given for pain @ 2115 Lung sounds CTA, bs x4 quads

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. ICU2

EPW [redacted]
b(6)-4

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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 0100	HL @ lac intact, IV ABX @ 2200. Dsgs on (L)le and dsg on (R) foot all CDI. Pt can wiggle toes and has (+) sensation on both feet. Has d/c orders for 19 Aug, with summary, will continue to monitor. [redacted] Assume
19Aug03 0605	Assume pt. care @ 0500. Pt asleep easy to awake. A+O x 3. VSS. HR reg. Lungs CTA. Abd Soft BS x 4. HL (+) AC (+) flush 5 redness/infiltrate. Dsg to (L) shin CD+I. DSG's to (L) + (R) foot CD+I (+) sensation to toes. C/o pain percocet given @ 0600. Pt has DISCharge orders/summary meds @ pharmacy. Will cont. to monitor [redacted]
19Aug03 1500	Pt stable. Dsg A's done this am. Pt not ambulatory at this time. To be returned to EPW camp. Meds and Xrays at bedside. Discharge instructions & PMD. To be escorted by MP. [redacted] b(6)-2 All
1545	Pt discharged to EPW Camp I MP escort. Meds and D/c instructions I pt. [redacted] b(6)-2 All

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

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

REGISTER NO. | WARD NO.

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

MEDCOM - 17424

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted] b(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 16 Aug 03 | TIME: 1142 PM

TRANSPORTATION TO FACILITY

SEX: M

AGE: 24

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Shrapnel wound

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1143

INITIALS: ST

VITAL SIGNS

TIME	1143				
BP	123/45				
PULSE	91				
RESP	18				
TEMP	99.3				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2347	2 gms ANCEF	DR. [redacted]	CPT [redacted]	2350	
2347	MSO4 10 ml IM	DR	CPT	2350	b(6)-2
2347	0.5 ml IM TETANUS	DR.	CPT	2350	
0005	4 mg SOM	DR.	CPT	0005	

DISPOSITION
☐ HOME ☐ FULL DUTY

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

PATIENT/DISCHARGE INSTRUCTIONS

MODIFIED DUTY UNTIL

RETURN TO DUTY

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

MEDCOM - 17425

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN BY PROVIDER: 23:50

TEST RESULTS

CBC	WBC 19.8; H/H 13.1/40.9; PLT 374
PT	19.1
APTT	33.0
SMAC	132 / 161 / 17 / 142 ; 3.4 / 17
BHCG	
ETOH	
GLU	
ABG/PULSE OX	SUP 02 / PH / PO2 / PCO2 / SAT / OTHER
U/A	DIP / MICRO
RADIOLOGY	Check if read by radiologist ☐
RESULTS	Feet (+) 2, 5 toe Fx (L); (+) shrapnel (R) femur ∅ Fx; ∅ pelvic Fx
EKG INTERPRETATION	(+) shrapnel (R) foot c ? Fx 5th toe

PROVIDER HISTORY/PHYSICAL

S: 24 y.o. ♂ c/o s/p shrapnel wounds feet (B) (R) leg, (R) thigh, (+) lac. (L) cheek - face 60% rectal ... Back: clear

O: VSS afebrile
Gen: WDWN 24 y.o. ♂, A+O x3, (+) speaks English, (+) mod. distress 2° pain
CV: CTA (B) HEENT (+) superficial lac. (L) cheek U/S by Dr. [illegible] ∅ free fluid chest + liver, spleen (R) ... to surgery (1) toe amputation
RRR
ABD soft, NT, ND ∅ masses
Ext: (+) partial amputation 2nd toe (L) foot c 2+ DP pulse
(+) lac 5th toe (R) foot
(+) 3/4 cm avulsion dorsum (R) foot, (+) lac. 5th toe (R) foot
(+) 34 cm avulsion ... (+) 2 fragment wounds (L) femur, (+) 1 fragment
(+) multiple fragment wounds (L) SAW c (+) 2 ... (L) ... wounds c (+) partial amputation 2nd, 3rd toes, (+) (R) lower ... shrapnel wounds
... wound (L) hip A: ... (+)(R) hip injury ? partial pelvis

CONSULT WITH	TIME	ACTION
ortho	12:00	wounds examined
surg	12:00	U/S done, wounds examined

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
[redacted] / [redacted]

CODES
b(6)-2

DIAGNOSIS
- partial toe amputation (L) (+) facial lac - superficial
- shrapnel wounds (B) leg
- (R) hip h/o shrapnel wound

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

[redacted]
b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 24 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [X] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D 1 (L) toe amputation

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL — Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION — Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT — Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of 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 from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] b(6)-4
ICW,

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; ~~shock; previous surgery~~	o ✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o ✓ Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	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. speaks some english	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. b(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT MN 17 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bone Site:

Drug:

Breathing:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] CPT IAN	[redacted] CPT MN
DATE: 17 Aug 03 TIME: 0810 b(6)-2	DATE: 17 Aug 03 TIME: b(6)-2

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

MEDICAL RECORD — INTRAOPERA DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 17 Aug 13 TIME PATIENT ARRIVED IN SUITE 0855

4. PATIENT IN ROOM TIME 0855 NUMBER 2-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	b(a) - 2 A 11
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained, arms extended at less than 90° on padded armboards, position approved by surgeon and Anesthesia

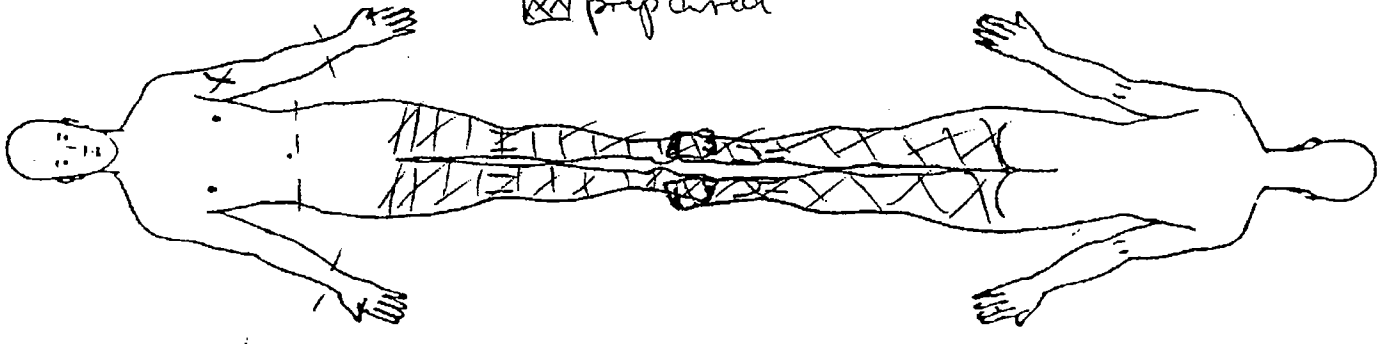
8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betal Betal
SITE: (R) Leg BY WHOM [redacted]
SITE: (L) Leg BY WHOM [redacted]
#See 9
COMMENTS: no pooling or skin s's noted

9. LOCATION OF EXTERNAL DEVICES

☒ prep area



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

10. COUNTS		C = Correct I = Incorrect Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☒ No	NA	NA	NA	NA	NA
Other	☐ Yes ☒ No					

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

[redacted]
ICW,

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

☒ ESU NO: VL Force 2 #3 (00047)
GROUND PAD: BRAND VL Reem Physiave II
LOT NO: 68936 2015-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPL ...S D MEDCOM - 17429 H IS OBSOLE... USAPA V1.01

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

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 [redacted]

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs, Kerlix, Acewrap, 4x8's, Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1/2 in Iodoform	1/2 in Iodoform	
SITE	(R) foot (R) thigh	(L) right calf	

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General
b(6)-2
30/35
Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op —: post-op— N/A

20. OPERATION(S) PERFORMED
I+D multiple shrapnel wounds (R) leg + (L) leg + bil feet Amputation 2nd toe (L) foot, Repair facial laceration

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	See DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT IAN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

b(6)-2

MEDCOM - 17430

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug DAY 17 18 19

~~19~~ 2003 HOUR

PULSE (0)	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

121/72 132/68 130/60 127/78

125

99.6

HEIGHT: WEIGHT →

98 98 98 98

130/72

107

94.1

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. ICW1/2

[redacted] ICW1

b(a)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17431

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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**

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: CMT | REQUESTING PHYSICIAN: | DATE: 16 Aug 03 | TIME: 2310 | SSN/PSEUDO SSN: [redacted] b(6)-4

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
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 10^3 verified
RDW		20.5-51.1%

(Hematology) Manual Differential

Bands		Mono	
Lymph		Eos	
Atyp		Baso	
RBC Morph		Imm	

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	19.5	9.8-13.6 secs
APTT	33.0	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	CLR	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	Trace	Negative
SG	1.030	N/A
Bld	mod	Negative
pH	5.0	N/A
Prot	Trace	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Acetyl amazi
WBC - 1-3
RBC - 8-10
mucus - mod

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(4)-2

REPORTED BY: [redacted] DATE: 17 Aug 03 LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, M: [redacted] b(6)-4	DATE: 16 Aug 03	TIME: 2350
SSN/PSEUDO SSN: #[redacted] b(6)-4		

(Hematology) CBC			Urinalysis			Misc. Serology		
	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		4.8-10.8 x 10^3	Color	yellow	N/A	RPR		Negative
			App	CLR	N/A	Mono		Negative
			Glu	neg	Negative	**Microbiology**		
			Bili	neg	Negative	Source		
			Ket	Tr	Negative	Gram Stain		
			SG	1.030	N/A	Occ Bld		Negative
			Bld	mod	Negative	H. pylori		Negative
			pH	5.0	N/A	Micro Parasites		
			Prot	Trace	Negative	Malaria		
			Urob	norm	0.2-1.0	O & P		
			Nit	neg	Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative	AU KS+ 3m211 WBC - 1-3 RBC - 8-10 mic - mod		

			CSF			Blood Bank	
Spun Hematocrit		42-52% (M) 37-47% (F)					
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	19.5	9.8-13.6 secs			
APTT	33.0	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted] b(6)-1	**DATE:** 17 Aug 03	**LAB ID NO.:**

Ward/Section: EMT	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 16 AUG 03	TIME 2350
		SSN/PSEUDO SSN: [redacted] b(6)-2

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.4 mg/dL

Sample Type_:

17AUG03 01:00

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

** PRINT CANCELLED **

Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

NGE	TEST	RESULT	REF. RANGE
ol/L	ALB		3.5-5.5 g/dl
I/L	ALP		26-84 u/l
I/L	ALT		10-47 u/l

======= PICCOLO =======
17/08/03 00:32
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	142*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	17*	13-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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.:

NKDA Procedure st [illegible]

24yo

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 (UG)	050						250UG	min
Diprivan (MG)	150							TOTAL URINE
Dex (MG)	100							
( )								
NSO4 (MG)	2 2 6 4 (2)		4 (2)				30MG	100
( )								
VOLAT AGENT [illegible] % del	2.0 - 2.0	2 - 2 - 2 X						FLUIDS - SUMMARY
% e.t.								CRYSTALLOID- LR 1000
AIR L/Min								
N2O L/Min								COLLOID- NS
O2 L/Min	6 - 2 - 2 - 2 - 2 - 2 - 6							
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	↓ induction							BLOOD-

FLUIDS

LINE site		
18 (L) A/C	☐ Warmed	NS
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES EST BLOOD LOSS / URINE -

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

BODY WEIGHT: 70 KG

HEMATOCRIT: 40.9

INITIAL DATA: BP- 123/75 HR- 104

EQUIP CHECK OK?- Y N (Y circled)

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 0910

TIME → 0900 x 30 x (1000) x 30 x (1100)

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

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

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

0845 - Pt • 1O [illegible] IV in place → Reg done [illegible]

0855 - Dr [illegible] Montas - induction & intubation

1055 - Spont resp opened eyes - Suctioned & extubated to ICU

VENTIL

VT - ml	140	130	160	150	230	240
f - breaths/min	13	13	18	14	10	10
Peak inf pres / PEEP						
MODE - S(pon), A(ssist), C(ont) SV	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	47	47	47	37	32	30	
BP/oth	FIO2 (Frac or %)	.90	.93	.92	.90	.87	.90	.90
ART line	SpO2 (%)	100	100	100	100	100	99	97
Steth PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS
Gas analyzer CO2	TEMP-site Skin		34	34	33	35	X	
	N-M Block (T/4)	4/4 [illegible]						
Warming blkt		wool blanket/head wrap						
Conv warmer								

Mark with letters & symbols, explain under REMARKS

EVENTS Position → supine arms <90° abducted / padded

RECOVERY AT: PACU ICU (Specify) OTHER (ICU circled) Stable

CONDITION: 98

RESP- 14 SpO2- 98 BP- 128/63 HR- 140

ANESTHESIA / PROCEDURE TIMES:

	Start	Room	End
ANES	0845	0855	1110
	Ready	Begin	End
PROC	0910	0930	1040

PROCEDURES and CPT Codes: D & D Amputation (L) TOE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA - #8 oral ET taped 22 cm teeth → #2 [redacted] Eyes taped

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — ODTT (L) return [illegible] Preox - RSI - DL x1 Gr I view. ETT easily passed. BBS+ EtCO2 + Atraumatic. Teeth intact

PATIENT IDENTIFICATION: Typed or written [redacted] Name, Grade/Rate Medical facility [redacted]

b(6)-2

SURGEONS: [redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: #2

DATE: 17 AUG 03

PAGE 1 OF 1

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

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ACLU-RDI 1641 p.196

DOD-031025

PRE-ANESTHETIC ASSESSME ND PLAN OF CARE

AGE: 24 Days Mos (Yrs) GENDER: (X) Male ( ) Female P S: (1) 2 3 4 5 (E)
ALLERGIES: NKDA WT: 70 Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: I&D b/l, loss / Ex lap
SURGICAL SERVICE: Ortho/Gen
NPO SINCE: 2000

PREOP DX / MECHANISM OF INJURY: s/p Blast Injury (shrapnel Injury b/l legs / pelvis)

HABITS:

Tobacco: ~~0~~
EtOH: ~~0~~
Drugs: ~~0~~

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Tetnus
( ) Ancef → EMT
( ) MSO4 1mg
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ________ Hrs

LABORATORY STUDIES:

409

Other: ____________

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	(N)	Y	
Angina	(N)	Y	
MI	(N)	Y	
CVA	(N)	Y	
Other	(N)	Y	
Pulmonary:			
Asthma	(N)	Y	
URI	(N)	Y	
COPD	(N)	Y	
Other	(N)	Y	
Renal System:			
ARF/CRF	N	Y	Foley cath
Other	N	Y	
Gastrointestinal:			
Hepatitis	(N)	Y	
Hiatal Hernia	(N)	Y	
GERD/PUD	(N)	Y	
Endocrine:			
Diabetes	(N)	Y	
Steroids	(N)	Y	
Thyroid	(N)	Y	
Neurological:			
Seizures	(N)	Y	
Neuropathy	(N)	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY

PHYSICAL EXAMINATION

BP: 123/45 HR: 104 RR: 20 T: 96 Ax

Pain (0/10 Scale): ________

Airway Exam:
Dentition Intact
Trachea ________
TMJ/C-spine ________
Oropharynx ________

Chest:
Lungs ________
Heart ________

IV Access: 18g (L) AC

Ulnar Filling: ________

Back: ________

Other: ________

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ________ (X) General (Intubation) / Mask-LMA Notes: ________

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Sig[redacted]KWA Date: 2345 Time: 16 Aug 03

PATIENT IDENTIFICATION:

[redacted] b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: ________ Date: ________ Time: ________

Nursing Unit: EMT

MEDCOM - 17437 ...RT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

ACLU-RDI 1641 p.197

DOD-031026

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NUMBER

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 01:30 HOURS | LIST TIME, ROOM, NOTES AND INITIALS

8/17 Admit ICU - I / surgery

Shrapnel wounds / partial toe amputations

Stable condition

Vitals as per routine

NKDA

Bedrest

Diet - NPO

PATIENT IDENTIFICATION

[redacted] b(6)-4

noted

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 01:30 HOURS

8/17 IVF NS @ 125 cc/HR

Meds

2 ug MgSO4 q 01 PRN pain

Lasix 20 mg Phenergan 12.5 q6 PRN nausea

PCA, chart & tube pain

Other

- Pt to OR today for toe amputation

PATIENT IDENTIFICATION

[redacted] b(6)-2

NURSING UNIT | ROOM | BED NO.

27°/2000 Max wgt

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

8/17 - Foley to Gravity

- Resume pre op orders/meds

- D/C foley

- Ancef 1gm IVPB q8°

- Daily Dressing D's, Irrig

- Regular Diet

PATIENT IDENTIFICATION

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 0900 HOURS

8/15-3

- D/C to EPW camp tomorrow

- Re-consult

- D/C drsgs & remove packing prn to D/C

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4		Trnsfr ICW2 [redacted] b(6)-4	[redacted] 18 Aug 03 1336
NURSING UNIT: ICW2 / ROOM NO.: / BED NO.: 7			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
[redacted] EPW		18 Aug 03 1600 HOURS Taken by [redacted]	[redacted] noted 2000
		(1) HL IVF b(6)-2	
		(2) Tylenol 650mg mg PO q4-6° prn pain	
		(3) Percocet 1-2 tabs PO q4-6° prn severe pain	
		Dc'd Dr. [redacted]	
NURSING UNIT: ICW2 / ROOM NO.: 24 V/S / BED NO.: 7		19Aug0100 [redacted] b(6)-2	

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
NURSING UNIT / ROOM NO. / BED NO.			

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"USE BALL POINT PEN—PRESS FIRMLY—NO CARBON PAPER REQUIRED"

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. 8 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16 17 18 19
17	[redacted]	VS: ROUTINE	5	X [redacted]
			17	[redacted]
17	[redacted]	BR	5	X [redacted]
			17	[redacted]
[redacted]	[redacted]	Foley to gravity	5	X [redacted] D/C
			17	[redacted] D/C 19 Aug 03
17	[redacted]	Daily dressing Δ's, Daily	10	✓ ✓ [redacted]
17	[redacted]	Diet regular	06	✓ ✓ [redacted]
			12	✓ ✓
			17	✓ [redacted]

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: shrapnel wounds/partial toe amp

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17440