ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1-6): A 1 1 D 1
2. MTF LOCATION (State or Country Code.) (7-8): I Z

3. REGISTER NUMBER (9-15): [redacted]

NAME (Last, First, Middle Initial): (b)(6)-4 UNK

4. PAY GRADE (16-17):

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19-26):

7. AGE AT ADMISSION (27-29): 2 6 y

8. RACE (30): Z

9. ETHNIC BACKGROUND (31): 9

RELIGION: UNK

10. LENGTH OF SERVICE (32-34):

ETS: UNK

11. FMP (35-36): 9 9

12. SOCIAL SECURITY NUMBER (37-45): [redacted]

ORGANIZATION (Active Duty Only): NA

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 1340

BRANCH / CORPS: (b)(6)-4 NA

14. FLYING STATUS (47-49): N

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

16. ZIP CODE OF RESIDENCE (53-61):

17. UNIT LOCATION (State or Country Code) (62-63): I Z

18. MOS (64-70):

19. TRAUMA (71):

PREV. ADMISSION: YEAR — [✓] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2

21. TYPE OF DISPOSITION (73-74): 2 4

22. MTF TRANSFERRED TO (75-80):

23. DATE OF DISPOSITION (Y Y M M D D) (81-86): 0 3 1 0 0 5

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

25. MTF TRANSFERRED FROM (91-96):

26. DATE THIS ADMISSION (Y Y M M D D) (97-102): 0 3 1 0 0 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103-104):

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

29. DATE INITIAL ADMISSION (Y Y M M D D) (111-116): 0 3 1 0 0 3

FOR LOCAL USE

DX: NASAL FX

Dx 8020
E8859
Proc 217[redacted] (b)(6)-2
Trauma 9
Inj 231

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

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

DA FORM 3585 MAR 89

MEDCOM - 20841

ABU GHARAIB MEDICAL TRANSFER REQUEST FORM

DATE OF REQUEST: 02 OCT 03

REQUESTOR: SFC [redacted] (b)(6)-2 / LTC [redacted] (b)(6)-2

ISN #: ____________________

COMPOUND: #4

PRIORITY: ASAP

LITTER / AMBULATORY (CIRCLE) — AMBULATORY circled

DESCRIPTION OF INJURIES: Possible detached retina

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

* Requesting ophthalmological evaluation

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 2

DATE OF TRANSFER: ____________________

TIME OF TRANSFER: ____________________

DESTINATION: ____________________

POC AT DESTINATION: ____________________

ANTICIPATED LENGTH OF TRANSFER: ____________________

EQUIPMENT REQUESTS: ____________________

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

(b)(6)-2

Dear Dr. [redacted]

Good morning (R) EYE

a case of a posteriorly dislocated cataractous lens with Traumatic iridodialysis & ↑ IOP poorly controlled on antiglaucoma measures.

Your opinion about consideration of PPV.

Thanks

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

(b)(6)-2

Dear Dr [redacted]

The patient with traumatic iridodialysis (4-6) and (9-11) Posterior dislocation of cataractous lens, vitritis and high IOP

The retina, optic disc & macula seems normal

I think he can benifit from Trabeculectomy + Vitrectomy + Scleral fixed IOL (Putting an AC IOL is not favourable.).

Scleral fixation IOL is not available.

Best regards [redacted], (b)(6)-4

[redacted] 10. 2003.

MEDCOM - 20843

ACLU-RDI 1659 p.3

DOD-034417

please clear [illegible]

In awaiting for surgery on Wensday

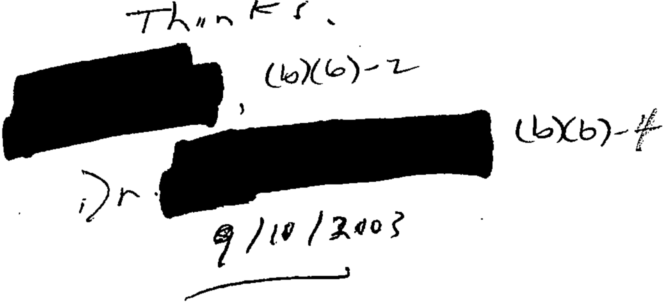
15/10/03 put him on

1. Timoptic
2. alphagan
3. atropine
4. ~~[illegible]~~ Dexamethasone
5. Diamox tabs
6. Antibiotic - steroid ointment

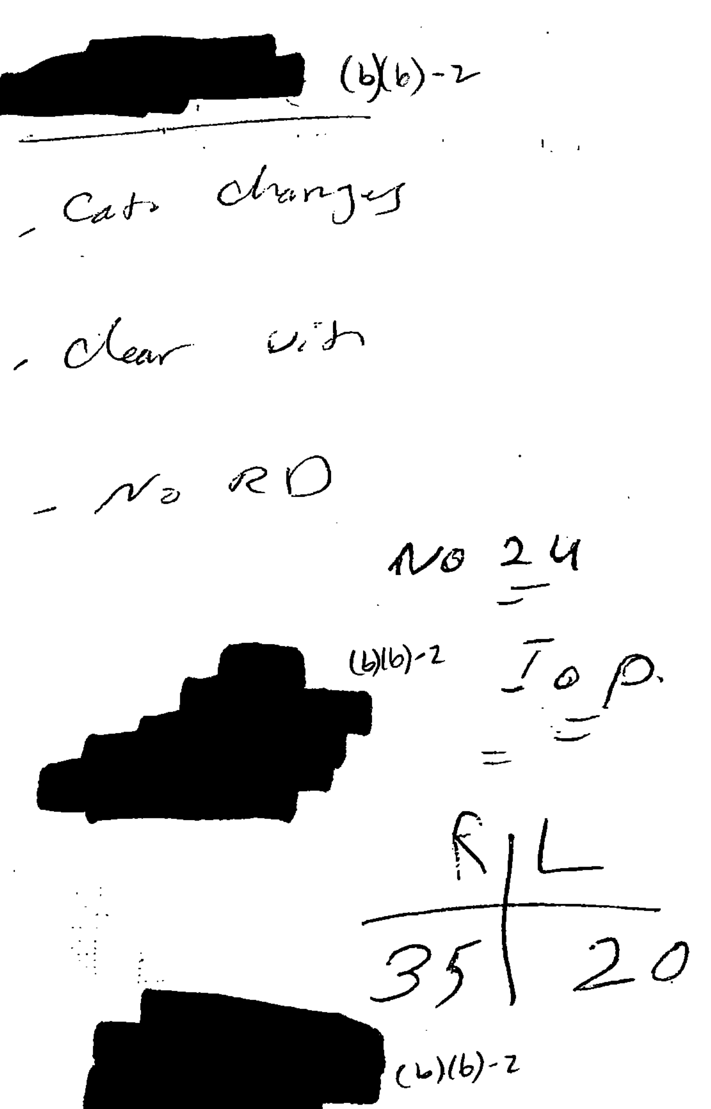
} Topical

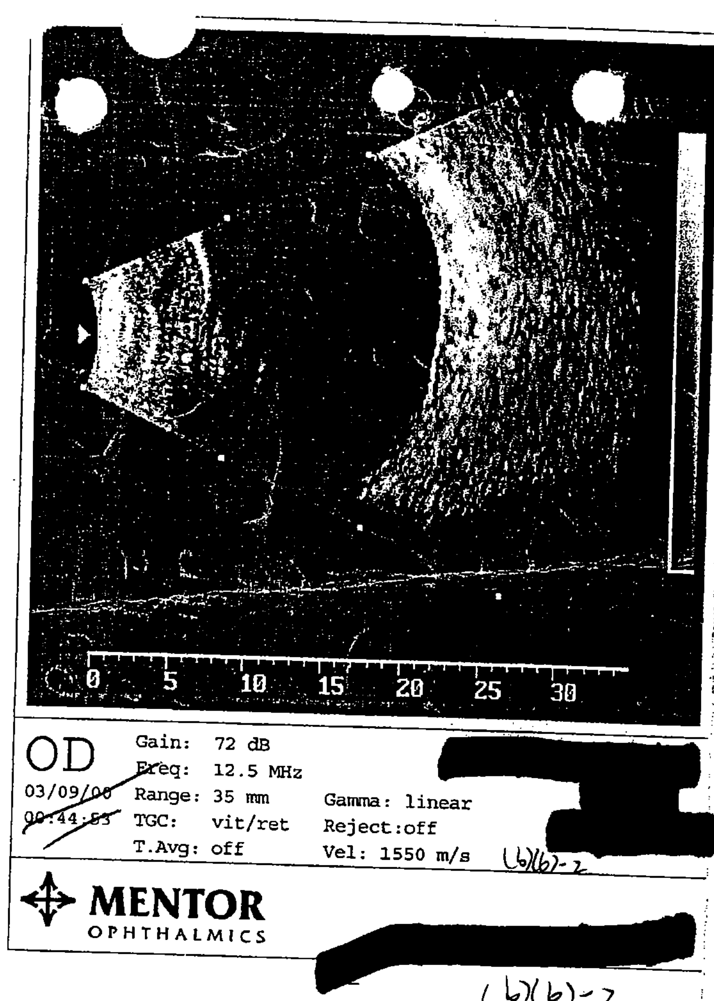
& follow him up regarding his rise in IOP.

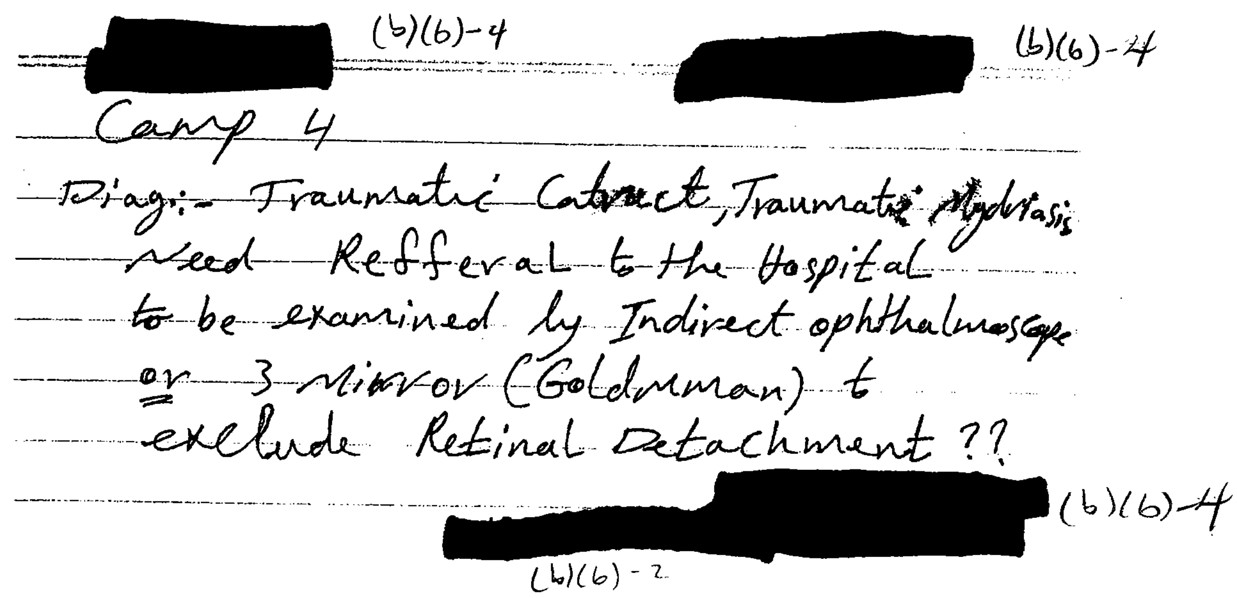
Thanks.



MEDCOM - 20844






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

Camp 4

Diag:- Traumatic Catract, Traumatic Mydriasis
Need Refferal to the Hospital
to be examined by Indirect ophthalmoscope
or 3 Mirror (Goldmman) to
exclude Retinal Detachment ??

(b)(6)-4
(b)(6)-2

MEDCOM - 20845

ACLU-RDI 1659 p.5

DOD-034419

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF	9.	10. PREVIOUS ADMISSION
M	unk	Z	unk	N/A	N/A	No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	N/A	ICW 1

15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78	N/A		NB1

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
Unk	50	10 Oct 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	Unk	3 Oct 03	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)(6)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Phacoanaphylactic Glaucoma

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
Ø	Ø	Ø	Ø	8	8

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
Ø	Ø	Ø	Ø	8	8

SIGNATURE OF ATTENDING PHYSICIAN	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
[redacted] Dr. [redacted] (b)(6)-2	For [redacted] (b)(6)-2

DA FORM [redacted] (b)(6)-2 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 20846

ACLU-RDI 1659 p.6

DOD-034420

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

see SF600

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 20847

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(b)(6)-4
	# [redacted] is an Iraqi patient who presented with
	an one month history of blunt trauma to his
	right eye. Exam revealled a white eye 2+ cell
	in anterior chamber, large iridodialysis 8-11 o'clock
	lens subluxed onto inferior retina, +2 vit cells &
	pigment. corneal edema
	Pt placed on Timoptic, Alphagan & Xalatan
	& 80mg Prednisone (1mg/kg). following day IOP
	decreased to 18 edema of cornea started resolving
	Over next 24 hours IOP slowly increased back
	up to 50's. Added oral Diamox / Trusopt IOP
	now in 40's.
	Ddx Diagnosis: ? Aphakic Glaucoma.
	$\bar{p}$ traumatic TM failure
	vs. Phacoanaphylactic (doubt - not enough inflammation)
	Plan: referral for trabeculectomy or filtration
	device placement together with lens removal.
	(b)(6)-2
	[redacted] LTC

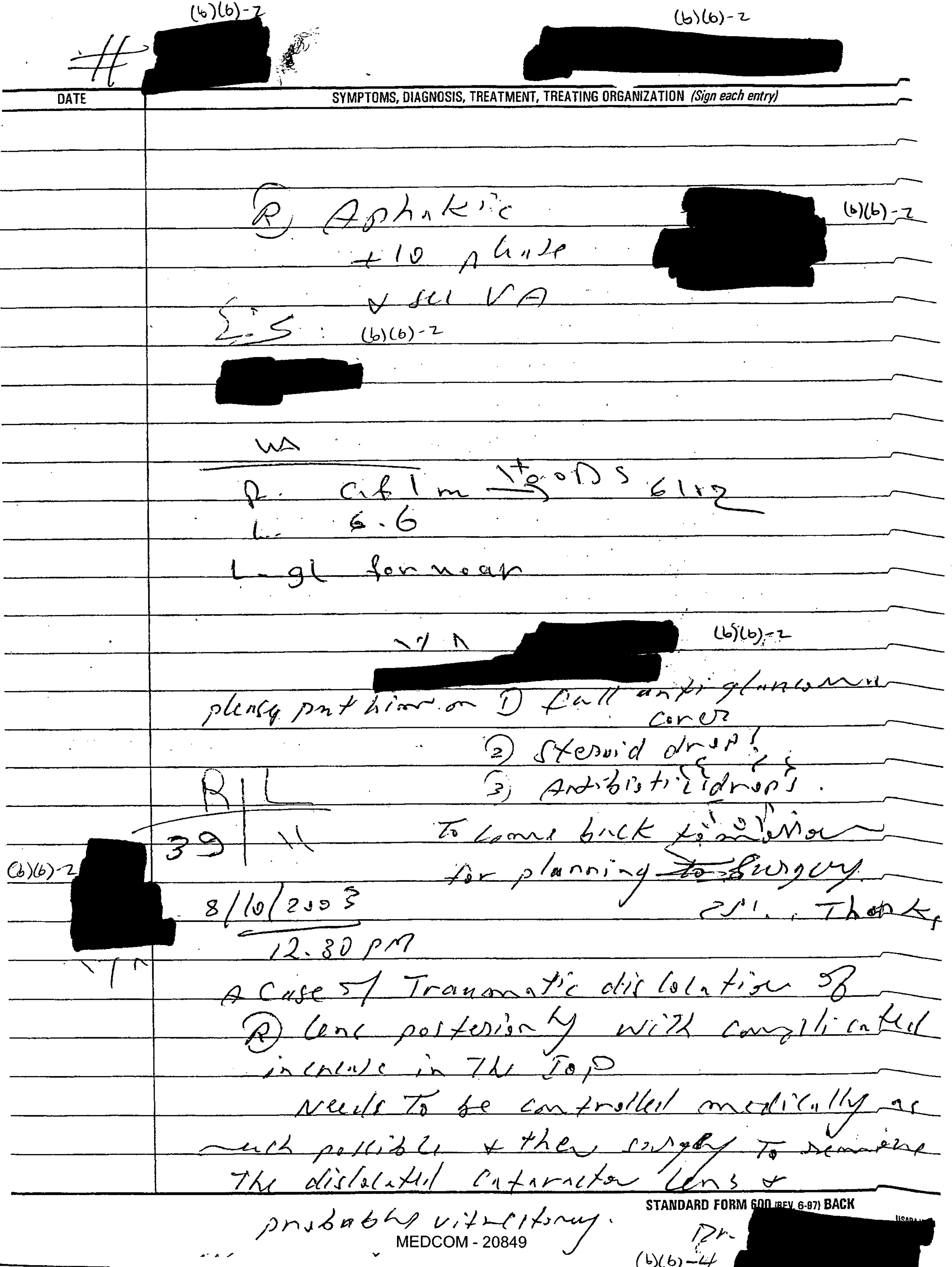
HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
		(b)(6)-2	

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

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

REGISTER NO.	WARD NO.

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



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

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

(R) Aphakic
+10 [illegible]
[illegible] VA
[illegible] : (b)(6)-2

(b)(6)-2

VA

R. [illegible] 6.6
L. 6.6

L-gl for near

(b)(6)-2

please put him on 1) full antiglaucoma cover
2) steroid drops
3) Antibiotic drops.

R | L
39 | 11

To come back [illegible] for planning surgery.
[illegible] Thanks

(b)(6)-2

8/10/2003
12.30 PM

A case of Traumatic dislocation of (R) lens posteriorly with complicated increase in the IOP
Needs to be controlled medically as much possible + then surgery to remove the dislocated cataractous lens + probably vitrectomy.

Dr. (b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 20849

ACLU-RDI 1659 p.9

DOD-034423

MEDICAL RECORD

CHRONOLOGICAL RECORD OF ME[illegible] CARE

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02OCT03	S- Pt. was refered + transfered to Iraqi Clinic from Compound for evaluation opth.
	O- Pt. appears to have a film covering his eyes.
	A. R/o Retinal detachment r/o glaucoma.
	PLAN - This Referal is from [redacted] (b)(2)-2
	The attached is referral from Iraqi [redacted] (b)(6)-2 (b)(6)-2
3 OCT 03	Accident in Basra - during demonstration states he was hit by plasma shot by US. now vision clouded OD only.
OD.	iridodialysis; microcystic corneal edema; pigmented vitreous in A/C; 1052 Ta 68 / 18

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

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

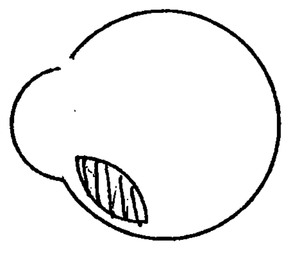
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

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

Comp 4

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

MEDCOM - 20850



DFE: lens sublux & is sitting on retina inferiorly

vit: +2 cells/+3 pigment.

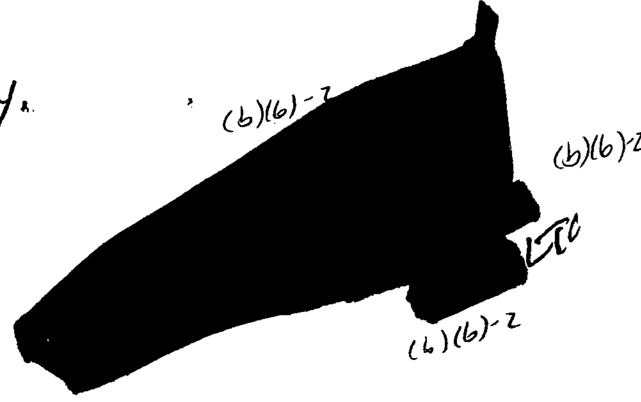
Disc - 0.4x0.4

macula - poor view cannot R/O CME

v/p - ∅ RD @ present

Imp: Severe blunt trauma to OD
 c̄ traumatic mydriasis
 " iridodialysis
 c̄ lens rupture & subluxation c̄ ↑↑IOP/inflammation
 2° corneal edema from ↑IOP.

Plan: Admit to hospital
 Prednisone 80mg per day
 Timoptic/alphagan / Xalatan qhs
 bid bid
 Coordinate for P.P lensectomy.



ACLU-RDI 1659 p.11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Oct 03 1200	- Assumed care of pt. A+O x3. Transfer from EMT ambulatory Dx. Blunt trauma to Ⓡ eye. Redness noted pupil dialated non reactive to light. Ø photosensitivity noted. Lungs clear. HRRR. Active BS x 4 quads. Ø c/o pain or discomfort. Will cont to monitor — [redacted] (b)(6)-2
1500	One time eye drop order given 5 min interval. Redness of Ⓡ eye clearing up. States having improvement of eye sight. Will cont to monitor — [redacted] (b)(6)-
3Oct03	1900 = VSS, A+Ox3, resting in bed comfortably, Ø s/s irritation to Ⓡ eye, continuing eye gtts around the clock OD, no remarkable problems c̄ vision @ this time. Continue to monitor for any acute Δ's. [redacted] (b)(6)-2
4 Oct 03	0615 VSS, A+Ox3, pt has Ø c/o pain @ this time, pt given drops as per orders, Ø c/o vision or eye pain. restraints x2 in place Ø skin breakdown Ⓟ circulation [redacted] (b)(6)-
	(1705) I concur c̄ above assessment. [redacted] (b)(6)-2
4 OCT 03 2205	VSS. AO. Provided eye drop to Ⓡ eye. No c/o pain. Systems stable @ this time. [illegible] sufficient. [redacted] (b)(6)-2

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

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

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

[redacted] (b)(6)-4

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW	[redacted]		

DATE	NOTES
5Oct03	0615 assumed care of pt, pt A+Ox3, VSS, pt has ∅ c/o pain at this time, pt voiding in BR under own power without difficulty, pt receiving eye drops as per order, all care complete, restraints x2 in place ⊕ circulation. Will continue to monitor SPC [redacted] (b)(6)-2
5Oct03 1200	I concur c above. Pt resting quietly in bed. No acute distress. Will continue eye drops & po meds. Pt denies pain @ this time. [redacted] (b)(6)-2
5OCT03 2041	VSS. A&Ox3 to Ambulate s̄ difficulty and emptied own urine. Light yellow quantity sufficient. ∅ s/s infection or skin breakdown. [redacted] (b)(6)-2
06OCT03 0625	Pt Awake A&O x3. LSCTA Ⓑ S1 S2 present. ⊕ BS x4 quads. [redacted] (b)(6)-2 Pt has No c/o at this time. ⊕ Pulses in all extremities [redacted] (b)(6)-2 2 point restraints. Will cont. to monitor [redacted] (b)(6)-2 SGT 91WM6
6Oct03	1930: VSS, A+Ox3, ∅ c/o pain, ∅ vision problems upon assessment, ∅ s/s irritation/redness to Ⓡ eye. Continuing eye gtts around the clock, x2 restraints when in bed, ⊖ skin breakdown noted. Ambulates PRN to use BR/exercise in hall s̄ difficulty. Continue to monitor. (b)(6)-2 [redacted]
6Oct03	2030: Dr [redacted] (b)(6)-2 here, stated pt's eye pressure ↑, order to give Aphagan gtts i x ii q5mins apart & Timoptic i gtts x ii 5 mins apart administered. Pt's Ⓡ eye appears greenish colored

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

MEDCOM - 20853

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/6/03	S: Pt denies pain, Eye quiet
	O: 4/c wm Ta 58
	Conj SInj
	K ⊕ microcystic edema
	A/c grossly quiet, ⊕ vit in A/c ø cornea touch
	iris dilated
	A/P ① ↑ IOP s̄ significant inflammation ~~? steroid response~~ [redacted] (b)(6)-2
	~~though not on steroids when he presented with ↑IOP~~ [redacted] (b)(6)-2
	Aphakic Glaucoma. vs. p̄ traumatic TM failure
	Plan: Diamox 250mg po qid.
	Timoptic, Xalatan, Alphagan q5min x iii
	↓ Pred to 40mg po qD [redacted] (b)(6)-2
	to see civilian ophth tomorrow
	for surg consultation to [redacted] (b)(6)-2
	remove lens / filter surgery (b)(6)-2 [redacted], LTC

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

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES

…THORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
6Oct03	2030 - continued - Will continue to monitor for acute s's. ——— (b)(6)-2 [redacted] /SN
Ø7Oct Ø3	Pt Awake A&O x3. LS CTA (B) ⊕ BS x4 quads. $S_1 S_2$ present Pt voiding spontaneously qs c/o. Pt Denies pain OD gtts continue. Will continue to monitor. ——— (b)(6)-2 [redacted] SPC 91WM6
8Oct03 0125	VSS. OD appears slightly reddened, round & reactive, tracks well. Cont c OD gtts Tx. Voiding light yellow urine, quantity sufficient. ——— (b)(6)-2 [redacted] RN ———
8Oct03 1036	Received pt resting in bed, VSS, tol PO, OOB and amb independently. ⊕BM, SVGS. Am shower provided. Compliant w/ care. OD slightly reddened this am, pupil round & reactive. Will cont gtts per MAR and PO meds per MAR. Ø complaints of pain @ this time. Restraints per CPW protocol, Ø skin breakdown noted, will cont to monitor pt. Ø other remarkable assessments @ this time. [redacted] 2LT AN (b)(6)-2
8Oct03 2000	VSS. AO. OD round & reactive c slight redness. Tracks well. Ø c/o pain @ this time. Ambulated x1 on ward s difficulty. Voiding light yellow urine QS. (b)(6)-2 [redacted] RN ———

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)

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 20855

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(1930) 9 OCT 03	Pt a/o, VSS, ∅ complaints @ this time. OD c̄ some redness, round & reactive. eye gtts cont. voiding adeq. qty, amb x1 s̄ difficulty. 2 pt restraints on s̄ compromise to skin or circulation. (NPO p̄ MN). will monitor. (b)(6)-2 [redacted] 91WM6
10 OCT 1200	Received pt resting in bed, VSS, a&ox3, pt upset @ NPO status this am. MD then cancelled surgery @ Iraqi hospital & pt was able to eat, food provided & situation explained, pt cont to be upset, and refused food @ first (did eat a small amt later. Pt gtts for OD cont and meds cont, OD slightly red, pt is slated for d/c to Iraqi hosp w/ surgery pending. ∅ other remarkable assessments @ this time, restraints per EPW protocol, ∅ breakdown noted. Will cont to monitor. [redacted] (b)(6)-2
10 OCT 03 1945	Pt A+Ox3, VSS, LS CTA (B), ⊕ BSx4, S_1 S_2 present, voiding well, eye drops treatment cont, ∅ c/o pain or discomfort, pending d/c to iraqi hospital tomorrow, 2 pt restraint, ∅ skin breakdown or poor circulation noted. [redacted] (b)(6)-2 91W (b)(6)-2

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

[redacted] (b)(6)-4

MEDCOM - 20856

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/10/03	Pt admitted for sig ↑IOP's, sig blunt trauma c̄ 2° Iridodialysis, sphincter tears, lens subluxation & prob TM dysfunction
	pt placed on maximum medical therapy. Sent to Iraqi hospital for surgery. Twice returned c̄ request to place pt on glaucoma Rx (pt already on). Rx x 1½ wks prior to consult
	~~Surgery postponed until Wed - Needs glaucoma surgery ASAP~~
	D/C back to prison hospital awaiting surgery
	Zantac 150mg po bid.
	Meds ~~Cosopt Tgtts OD bid~~ [redacted] (b)(6)-2
	alphagan Tgtts OD bid — space gtts 5 minutes apart.
	Xalatan Tgtts OD qhs
	Diamox 250mg i tab po qid
	Pred Acetate Tgtts O[redacted] TID (b)(6)-2
	D/C ~~Ocuflox Tgtts OD qid~~ [redacted] (b)(6)-2
(b)(6)-2	Prednisone [redacted] po qD (b)(6)-2
D/C	[redacted] ~~Atropine Tgtts OD BID~~
	~~Pt NPO p̄ midnight on Tuesday 14 Oct 03~~
	~~Wednesday 15~~
PT NOW REFUSES SURGERY	~~On Tuesday an [redacted] Oct 03 pt to be transported to Al-Hatham hospital for eye surgery. Post op care @ Ibn Sina hospital~~ [redacted] (b)(2)-2
	[redacted] (b)(6)-2
	~~POC is undersigned.~~
REFUSES SURGERY	~~coordinate c̄ S5 for time of surgery~~ [redacted] (b)(6)-2
	~~please send medical paperwork c̄ patient~~ [redacted] (b)(6)-4 (b)(6)-2 [redacted] LTC
	OVER
	~~* Pt will require steroid taper after surgery (po Prednisone)*~~

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

MEDCOM - 20857

TAPER PREDNISONE OVER ↑ MONTH
DECREASE TO 20MG PREDNISONE × ↑ WK
15 MG "
10 MG "
5 MG " THEN D/C [redacted] (b)(6)-2
D/C ZANTAC WITH PREDNISONE

PRED ACETATE
~~↑ TAB PO TID × ↑ WK~~ [redacted] (b)(6)-2
BID × ↑ WK
qD × ↑ WK
THEN D/C

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/11/03	Pt on MMT for glaucoma to include Cosopt, αgan, Xalatan & oral Diamox. anti-inflammatory - topical steroids/oral Pred.
	Pt has been sent to Civilian hospital x 2 for glaucoma surgery, both times returned: request add'l medical therapy.
	Pt notified w/o surgery he will go blind. Pt still desires d/c to prison to facilitate his released. As pt is painfree I am unsure he appreciates the risk, but as he is aphakic (functionally blind) the difference may be academic. Civ. hospital nor I have IOL's for placement. CTL not avail either.
	(b)(6)-27
Ta < 55	Dr [redacted] to come today. Will explain situation again. It is possible that our lack of supplies (surgical) + ∅ glaucoma specialist & similar pblms in Civilian sector may result in no real options available for patient [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.)*

[redacted] hospital

(b)(6)-4

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/11/03	TALKED c̄ IRAQI DOCTOR -- PT SCHEDULED
	FOR SURG WED, PLAN ~~[illegible]~~ GLAUCOMA &
	RETINAL SURGERY
	(b)(6)-2
	(b)(6)-2
10/13/03	TALKED c̄ PT YESTERDAY
	PT DESIRES D/C → NO SURGERY
	UNDERSTANDS HE MAY GO BLIND
	STILL WANTS D/C
	WILL TAPER OFF MEDS

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
11 Oct 03	0900 VSS Alert & Oriented. (b)(6)-2 Escorted (b)(6)-2 down stair to Optham clinic by MP'S. (b)(6)-2 consumed Regular diet. OOB → BR ad lib. Continue on multi eye gtts. Awaiting d/c to prison hospital. (b)(6)-2
11 OCT. 03 1945	Pt A+Ox3, VSS, LS CTA(B), ⊕BSx4, cont gtts therapy, voiding well, awaiting d/c to EPW Camp. ∅ c/o pain or discomfort 2 pt restraint s s/sx of complications. (b)(6)-2 (b)(6)-2
12 Oct 03 0800	VSS Alert & Oriented. Denies HA, blurred vision or dizziness @ this time. Tolerating regular diet. OOB ad lib. Awaiting d/c to prison hospital. No acute care needed. Continue Multi eye gtts to OD (b)(6)-2

See translation

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

Translation Bates page Medcom 20861:

I refused to have surgery for the right eye. 10/12/2003

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 OCT 03 1830	Pt A+O x3, VSS, ø c/o pain or discomfort, LS CTA (B), ⊕ BS x4, abd soft flat non tender, cont eye drops treatment, 2 pt restraint s̄ complications. (b)(6)-2 91W
13 OCT 03	(1400) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. Cont. OD gtts as ordered. Pt OOB to BR for personal hygiene. Amb well. ø c/o dizziness/N/V. Tol. reg diet well. Voiding s̄ diff. ⊕ BM. 2 point restraints in place s̄ s/sx complications. Awaiting trans. to Iraqi hospital. (b)(6)-2
13 OCT 03 1915	Pt A+O x3, VSS, LS CTA (B) ⊕ BS x4, S_1 S_2 present, abd soft flat non tender, denies pain or discomfort, cont. eye tx, 2 pt restraint in place s̄ complications, conducted personal hygiene, OOB → BR. (b)(6)-2 91W (b)(6)-2
14 OCT 03	(1320) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain cont OD gtts as ordered. Pt amb well. ø c/o dizziness/N/V. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. (b)(6)-2
	(1745) Pt refusing OD gtts, d/t not being d/c'd today. monitoring. (b)(6)-2
(1900)	Pt alert, VSS, ø c/o pain, still refusing eye gtts. tol dinner well. LCTAB, ⊕ BS x4, HRRR, amb & voiding s̄ difficulty. Restraints on while in bed (cont)

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

MEDCOM - 20862

*

MEDICAL RECORD | PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
10/13/03	PT ADMITTED FOR ↑ IOP c̄ BLUNT TRAUMA
	HAS BEEN MEDICALLY MANAGED. WAS SCHEDULED
	FOR SURGERY. NOW REFUSES SURGERY DESIRES
	HEARING IN PRISON UNDERSTANDS REFUSAL WILL RESULT IN
	BLINDNESS OD.
	MEDS: PREDNISONE 20MG PO qD x 1 WK
	15 "
	10 "
	5 MG PO qD x 1 WK
	THEN D/C
	ZANTAC 150MG PO BID - D/C WITH PREDNISONE
	PRED. ACETATE 1 GTT OD BID x 3 DAYS
	1 GTTS OD qD x 3 DAYS ⇒ THEN D/C
	DIAMOX 250MG 1 TAB PO QID
	XALATAN 1 GTTS OD qHS
	ALPHAGAN 1 GTTS OD BID
	PT TO F/U HERE IN 4-6 WKS.

(b)(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

(b)(6)-2

CTC

(b)(6)-2

REGISTER NO.

WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

10/13/03 PT c̄ HI EYE PRES p̄ BLUNT TRAUMA. NEEDS GLAUCOMA SURGERY. PT NOW DESIRES SURGERY WILL REINSTITUTE PREVIOUS MEDS AND CONTINUE COORD. c̄ S5 (DISREGARD PREVIOUS NOTE).

PLAN:

PREDNISONE 40MG PO qD.
OCUFLOX i GTTS OD QID
PRED ACETATE i GTTS OD QID
ATROPINE i GTTS OD qD
COSOPT i GTTS OD BID
XALATAN i GTTS OD qHS
ALPHAGAN i GTTS OD BID
DIAMOX 250MG i TAB PO BID
ZANTAC 150MG PO BID

• DROPS SPACED 5 MINUTES APART.

(*) TO EL-HATHAM EYE HOSPITAL WEDNESDAY BEFORE 0900 FOR EYE SURGERY. 10/15

(*) NPO p̄ MIDNIGHT TUESDAY 10/14.

WILL TAPER MEDS p̄ OP. PT WILL RETURN T. IBN SINA HOSPITAL POST-OP. MAY REQUIRE POST-OP EVAL @ EL HATHAM HOSPITAL FOR SELECTIVE SUTURE REMOVAL WITH LASER IN IMMEDIATE p̄ OP PERIOD.

(b)(6)-2

(b)(6)-4

(REV. 5/1999) BACK

(b)(6)-2

(b)(6)-2 LTC

MEDCOM - 20864

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
14OCT	s̄ compromise to skin or circulation. Will mon-
(1900)	itor. (b)(6)-2 [redacted] 91WM
(2100)	Pt tells Dr. (b)(6)-2 [redacted] (thru translator)
	that he does not want surgery, & states
	that he just wants to go back to camp
	tomorrow. Pt refuses all eye gtts, be-
	cause he says they're no good without the
	surgery. Importance of gtts explained, pt
	still refuses. Will monitor [redacted] 91WM
15OCT03	(0925) Assumed care of pt @ 0800 p̄ report from night (b)(6)-2
	shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt
	amb well. Pt cont to refuse OD gtts. Will take po
	meds. Tol. reg diet well. Voiding s̄ difficulty.
	2 point restraints in place s̄ s/sx complications. (b)(6)-2
	Awaiting trans. to EPW camp. monitoring. [redacted]
	(1440) Pt D/C to EPW camp - ambulatory - escorted by
	MPs. (b)(6)-2 [redacted]

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

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

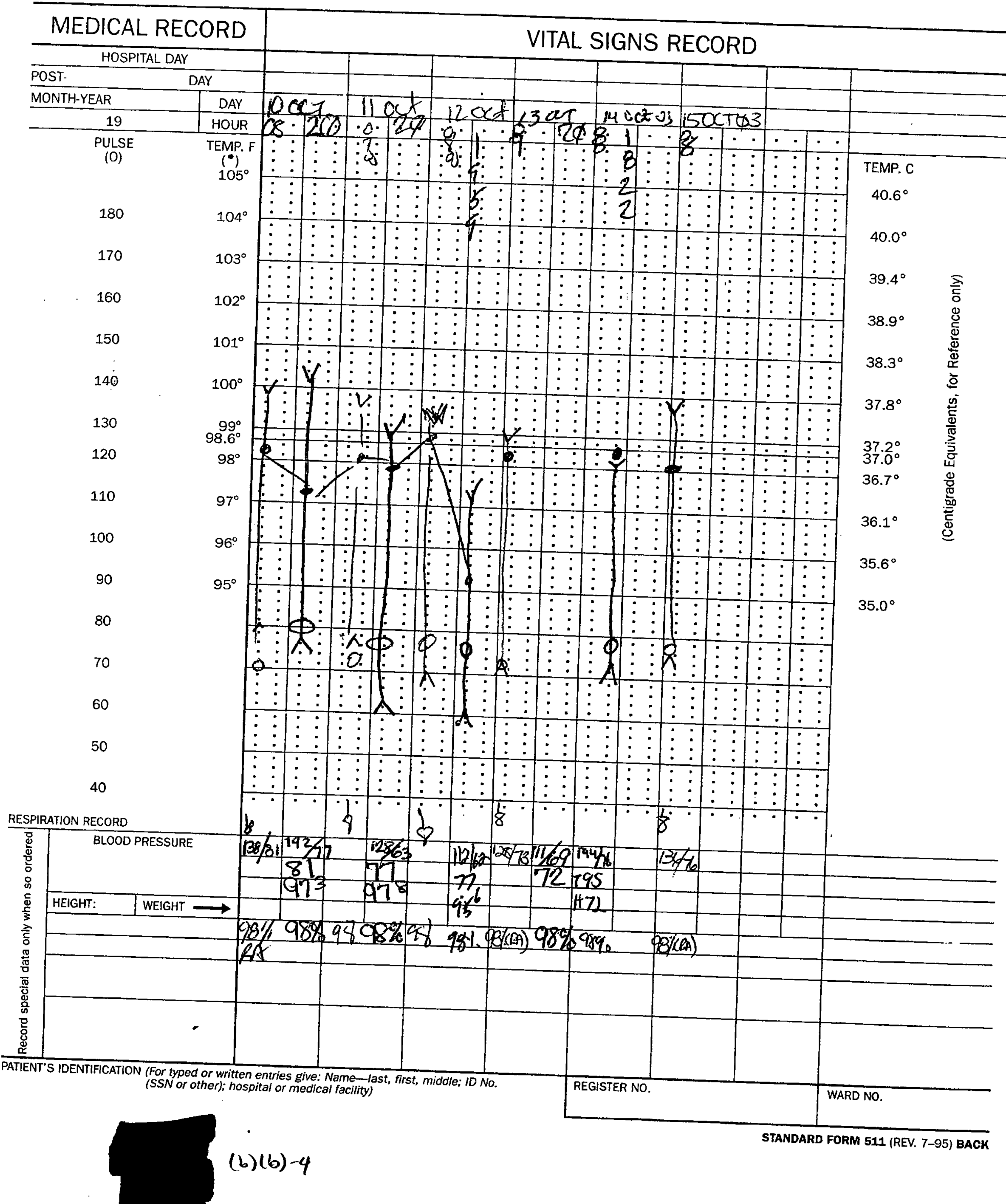
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 20865


MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 10 OCT 11 Oct 12 Oct 13 OCT 14 OCT 03 15 OCT 03

19 HOUR 08 2000 0 24 08 16 09 1200 08 20 08

PULSE (O) TEMP. F (•) TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD 18 19 16 18 18

BLOOD PRESSURE 138/81 142/77 128/63 112/60 126/73 111/69 194/76 134/76

81 77 77 72 95

97.3 97.8 97.6 71

HEIGHT: WEIGHT →

98% RA 98% 97% 98% 98% 98% 98% (RA) 98% 98% 98% (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)

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

(b)(6)-4

MEDCOM - 20866

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 3 OCT | 4 OCT | 5 OCT | 6 OCT | 7 OCT 03 | 8 OCT | 9 OCT 03

19 HOUR: 1200 | 1830 | 0615 | 0615 | 1905 | 18 | 01

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 142/76 | 137/81 | 134/82 | 135/82 | 140/88 | 144/77 | 145/88 | 119/66 | 137/83 | 137/63 | 137/64 | 136/82

HEIGHT: WEIGHT →

Record special data only when so ordered: H76 T97.8 96% RA | O2 98% RA | P 63 T97.7 SpO2 95% | 83 95.7 96.1 | P 63 T98.0 SpO2 97 | 71 96.3 97% O2 98% RA | 76 96.5 96.1 | 98% RA | 95% RA | 77 96.8 98% | 97.0 RA 97% (RA)

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

REGISTER NO.

WARD NO.

(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 - 20867

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

Admit to ICW1
Dx: Phacoanaphylactic glaucoma 2° to (b)(6)-2 Blunt trauma
Condition stable
Vitals routine
ALL: NKDA
Diet Regular

PATIENT IDENTIFICATION (b)(6)-4

noted 30 Oct @ 1520 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

Activity: per SOP
Meds:
Prednisone 80mg po qDay
Zantac 150mg po bid
Pred Acetate 1 gtts OD q2°
Muro 128 oint OD qid
Timoptic 1 gtts OD bid

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

Alphagan 1 gtts OD bid
Xalatan 1 gtts OD qhs
Atropine 1 gtts OD bid

awaiting surgery (b)(6)-2
Hatham hospital (b)(6)-2

(b)(6)-2 LTC

PATIENT IDENTIFICATION

noted 30 Oct @ 1520 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

240 (b)(6)-2 LT/AD

DATE OF ORDER | TIME OF ORDER ____ HOURS

Timoptic 1 gtts OD q5min x II
Alphagan 1 gtts OD q5min x II
Xalatan 1 gtts OD q5min x II
(b)(6)-2

(b)(6)-2

30 Oct 03 1900 (b)(6)-2 LTC

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

MEDCOM - 20868

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/4/03	Ophth Svc
	IOP - 68 on admission
	treated c̄ Pred 80mg/day
	Timoptic/Alphagan/Xalatan q5min x 2
	this am IOP = 18
	A/C 1+ cell
	+2 vit cell c̄ pigment
	eye white, ⌀ corneal edema
	Imp: prob phacoanaphylactic though eye is not as hot as I would expect - much better today
	Plan CPM
	awaiting surgical removal
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

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

PROGRESS NOTES
Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 10/6/03 TIME OF ORDER 2012 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Decrease Prednisone to 40mg po qday.
2. Diamox 250mg i tab po qid.
3. Timoptic q5min x II
   Alphagan i gtts OD q5min x II

6 Oct 03 2030

NURSING UNIT | ROOM NO. 1 | BED NO.

PATIENT IDENTIFICATION (b)(6)-2

(b)(6)-2

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

i gtts OD q5min x II

D/C Xalatan

Add Trusopt i gtts OD tid (b)(6)-2

(b)(6)-2

NURSING UNIT 2CV | ROOM NO. 1 | BED NO.

6 Oct 03 2030

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER 10/13/03 TIME OF ORDER 0715 HOURS

Prednisone 20mg po qD

D/C Ocuflox

D/C Atropine

Pred Acetate i gtts OD BID

D/C Cosopt

D/C to Prison (b)(6)-2

Hospital (b)(6)-2

Noted (b)(6)-2 13 Oct 03 0720

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/3/03 TIME OF ORDER 0835 HOURS

1. Pt Now Desires Surgery
2. Increase Prednisone to 40mg po qD
   Restart Ocuflox i gtt OD QID
   Atropine i gtts OD qD
   Cosopt i gtts OD BID
   Pred Acetate i gtts OD QID
   D/C to Prison Hospital

Noted (b)(6)-2

(b)(6)-2

NURSING UNIT ICW | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 REPLACES EDITION ... WHICH MAY BE ... (b)(6)-2

MEDCOM - 20870

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

\#

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

√ D/c timoptic, trusopt
√ start cosopt i gtts OD bid
√ Continue alphagan i gtts OD bid
√ Xalatan i gtts OD qhs
√ Continue Diamox 250mg i tab po qid
Ocuflox i gtts OD qid
√ Pred Acetate i gtts OD qid
√ NPO p midnight

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

Noted

PATIENT IDENTIFICATION

DATE OF ORDER

(b)(6)-2

(b)(6)-2

24° √

(b)(6)-2

9OCT @ 2300

D/c Muro 128

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 20871

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 (b)(6)-2 11/11 10OCT		10/10/03	0821 HOURS	
		Resume Reg diet		
		D/C to prison hospital today c̄ bedside glts		
		(b)(6)-2		(b)(6)-2
NURSING UNIT: JAC · ROOM NO.: 0230 11OCT03 · BED NO.: (b)(6)-2				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT · ROOM NO. · BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT · ROOM NO. · BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT · ROOM NO. · BED NO.				

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

MEDCOM - 20872

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. Oct *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED: 3	4	5	6	7	8	9	10	11	12	13	14	15
10/3/03	[redacted]	Condition: stable	06													
		(b)(6)-2	18													
10/3/03	[redacted]	Vitals routine	06													
		(b)(6)-2	18													
10/3/03	[redacted]	Diet regular	06													
		(b)(6)-2	18													
3Oct03	[redacted]	Activity: per SOP	06													
		(b)(6)-2	18													

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Blunt trauma
Phacoanaphylachi glaucoma

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3Oct03	[redacted]	Admit to ICU #1, Condition Stable 3Oct03				[redacted] (b)(6)-2
08 Oct03	[redacted]	NPO p midnight	09 Oct03	0001	noted	[redacted] (b)(6)-2
10 Oct	[redacted]	Reg diet [illegible]	10 Oct	done		
10 Oct	[redacted]	D/C to prison hospital today w/	10 OCT	—	—	
	----	bedside drops	—		—	
13 Oct03	[redacted]	D/C to prison hosp	15	—	—	[redacted] (b)(6)-2

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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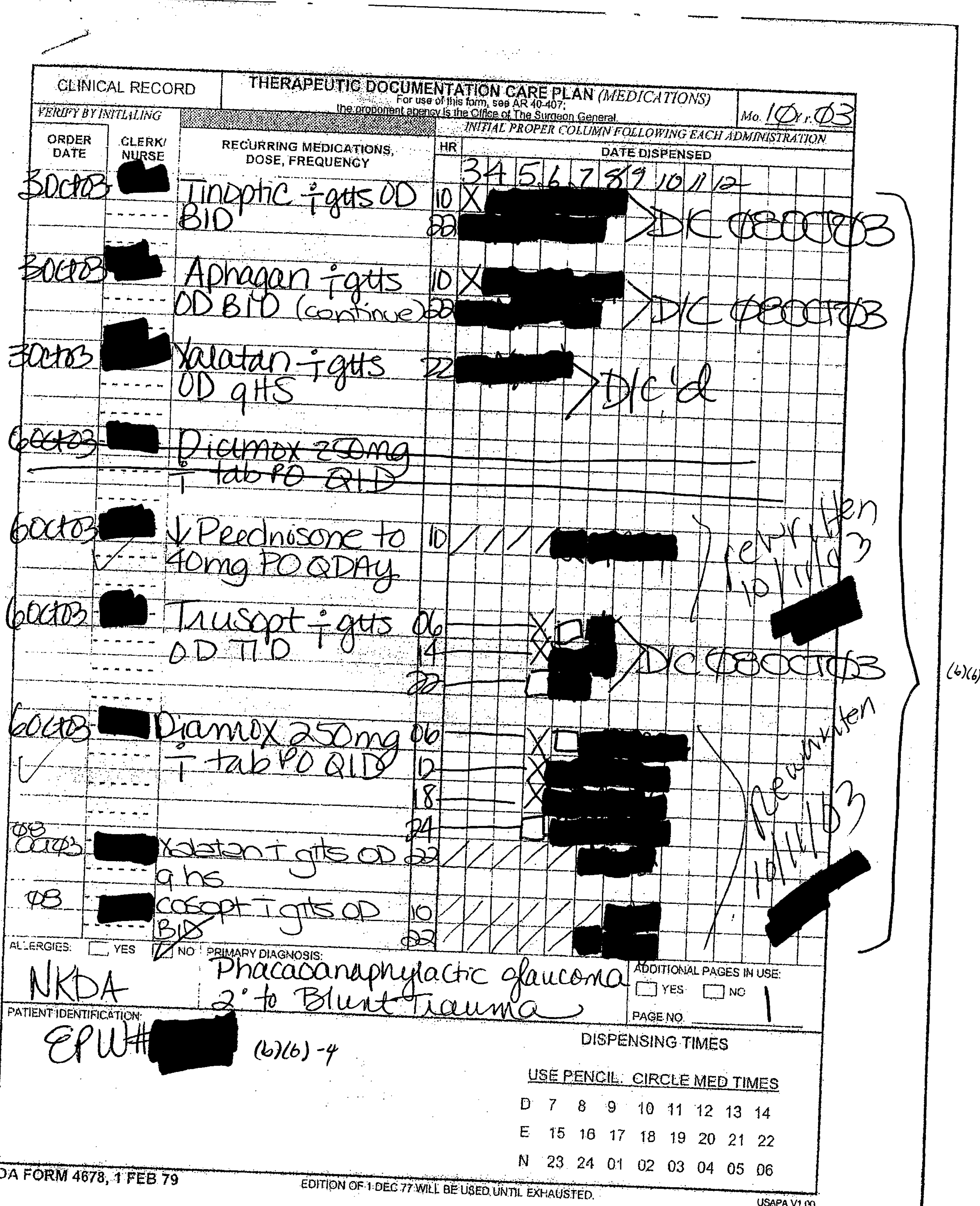
MEDCOM - 20874

USAPA V1.00



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. 10 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 3 4 5 6 7 8 9 10 11 12
3Oct03	[redacted]	Timoptic i gtts OD BID	10 / 22	X [redacted] D/C 08Oct03
3Oct03	[redacted]	Aphagan i gtts OD BID (continue)	10 / 22	X [redacted] D/C 08Oct03
3Oct03	[redacted]	Xalatan i gtts OD qHS	22	[redacted] D/C'd
~~6Oct03~~	[redacted]	~~Diamox 250mg i tab PO QID~~		
6Oct03	[redacted] ✓	↓ Prednisone to 40mg PO QDAY	10	/ / / / [redacted] rewritten 10/11/03 [redacted]
6Oct03	[redacted]	Trusopt i gtts OD TID	06 / 14 / 22	X [redacted] D/C 08Oct03
6Oct03 ✓	[redacted]	Diamox 250mg i tab PO QID	06 / 12 / 18 / 24	X [redacted] rewritten 10/11/03 [redacted]
08Oct03	[redacted]	Xalatan i gtts OD qhs	22	[redacted]
08	[redacted]	Cosopt i gtts OD BID	10 / 22	[redacted]

(b)(6)-4

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Phacoanaphylactic glaucoma 2° to Blunt Trauma

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

MEDCOM - 20875

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. Oct Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	Notes
10/3/03	[redacted]	Atropine ī gtts OD BID	10	X								Rewritten 10/11/03
			22									
3Oct03	[redacted]	Prednisone 80mg PO QDAY	10	X								D/C'd
3Oct03	[redacted]	Zantac 150mg po BID	10	X								Rewritten 10/11/03
			22									
3Oct03	[redacted]	Pred Acetate ī gtts OD Q2°	02	X								D/C 08Oct03
			04	X								
			06	X								
			08	X								
			10	X								
			12	X								
			14	X								
			16									
			18									
			20									
			22									
			24									
3Oct03	[redacted]	Muro 128 oint OD qid	08	X								D/C 10/11/03
			12	X								
			18									
			24									

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blunt trauma Placoanaphylactic glaucoma

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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 - 20876

Verify by Initialing	THE...APEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo._____ Yr. _____	
Order Date	Clerk/ Nurse	(b)(6)-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
6Oct03	[redacted]	Timoptic Q5min x ii	6Oct03	2030		[redacted]	(b)(6)-2
6Oct03	[redacted]	Aphagan i gtts OD q5min x ii	6Oct03	2045		[redacted]	(b)(6)-2
	(b)(6)-2						

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

USAPA V1.00

MEDCOM - 20877

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 Oct Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4
10/3/03	[redacted] (b)(6)-2	Prednisone 80mg po q day	06	✓	
10/3/03	[redacted] (b)(6)-2	Zantac 150 mg po BID	10	✓	
			22		
10/3/03	[redacted] (b)(6)-2	Pred Acetate i gtts OD q2°	06	✓	
			08	✓	
			10	✓	
			12	✓	
		(b)(6)-2	14	[redacted]	
			16		
			18		
		(b)(6)-2	20	[redacted]	
		(b)(6)-2	22	[redacted]	
		(b)(6)-2	24	[redacted]	
			02		
	(b)(6)-2		04		
10/3/03	[redacted]	Muro 128 oint OD qid	06	✓	
			12	✓	
			18		
	(b)(6)-2		24		
10/3/03	[redacted] (b)(6)-2	Timoptic i gtts OD BID	10	✓	
			22		
10/3/03	[redacted] (b)(6)-2	Alphagan i gtts OD BID	10	✓	
			22		
10/3/03	[redacted]	Xalatan i gtts OD QHS	22		

Rewritten

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blunt trauma Phacoanaphylactic glaucoma

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
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 - 20878

THERAPEUTIC DOCUMENTATION CARE PLAN

(MEDICATIONS)

Verify by Initialing

Mo. Oct *Yr.* 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES (b)(6)-2	Date to be Given	Time to be Given	Time Given	Initials
10/3/03	[redacted]	Timoptic i gtts OD q 5 min x ii	10/3/03		1500	[redacted] (b)(6)-2
10/3/03	[redacted]	(b)(6)-2 Alphagan i gtts OD q 5 min x ii	10/3/03		1500	[redacted] (b)(6)-2
10/3/03	[redacted] (b)(6)-2	Xalatan i gtts OD q 5 min x ii	10/3/03		1500	[redacted] (b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													

USAPA V1.00

MEDCOM - 20879

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12	13	14	15
08 OCT 03		Alphagon i gtts OD	10	/							
		BID	22								
08		Pred Acetate i gtts	06	/				see △ below			
		OD qid	12	/							
			18								
			24								
08		Ocuflex i gtts OD	06	/				D/C 13OCT03			
		qid	12	/							
			18								
			24								
10/10/03 recopied		Atropine i gtt OD	10	/	/	/					
		BID	22	/	/	/					
10/11/03 recopied		Zantac 150mg PO	10	/	/	/					
		BID	22	/	/	/					
10/11/03 recopied		↓ Prednisone to 40mg	10	/	/	/		see △ below			
		PO QDay	X								
10/11/03 recopied		Diamox 250 mg	06	/	/	/					
		i tab PO QID	12	/	/	/					
			18	/	/	/					
			24	/	/						
10/11/03 recopied		Valantan i gtt OD	22								
		QHS	X								
10/11/03 recopied		Cosopt i gtt OD	10	/	/	/		D/C 13OCT03			
		BID	22	/	/	/					
13 OCT 03		Prednisone 20mg po qD	10	D/C 13OCT03							
13		Pred Acetate i gtts OD	10	△ed 13OCT03							
		BID	22								

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 20880

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16
10/13	[redacted]	Increase prednisone to 40mg po q D	10	[redacted]			
10/13	[redacted]	Restart Ocuflox i gtt OD QID	06	/ [redacted]			
			12	[redacted]			
			18	[redacted]			
			24	[redacted]			
10/13	[redacted]	Atropine i gtts OD q D	10	[redacted]			
10/13	[redacted]	Cosopt i gtts OD BID	08	[redacted]			
			20	[redacted]			
10/13	[redacted]	Pred Acetate i gtts OD QID	06	/ [redacted]			
			12	[redacted]			
			18	[redacted]			
			24	[redacted]			
06 OCT 03	[redacted]	Trusopt i gtts OD TID	06	/ [redacted]			
			14	[redacted]			
			22	[redacted]			
08 OCT 03	[redacted]	Alphagan i gtts OD BID	10	[redacted]			
			22	[redacted]			
11 OCT 03	[redacted]	Zantac 150mg PO BID	10	[redacted]			
			22	[redacted]			
11	[redacted]	Diamox 250mg i tab PO QID	06	/ [redacted]			
			12	[redacted]			
			18	[redacted]			
			24	[redacted]			
11	[redacted]	Xalantan i gtts OD qHS	22	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Blunt Trauma OD

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 3

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

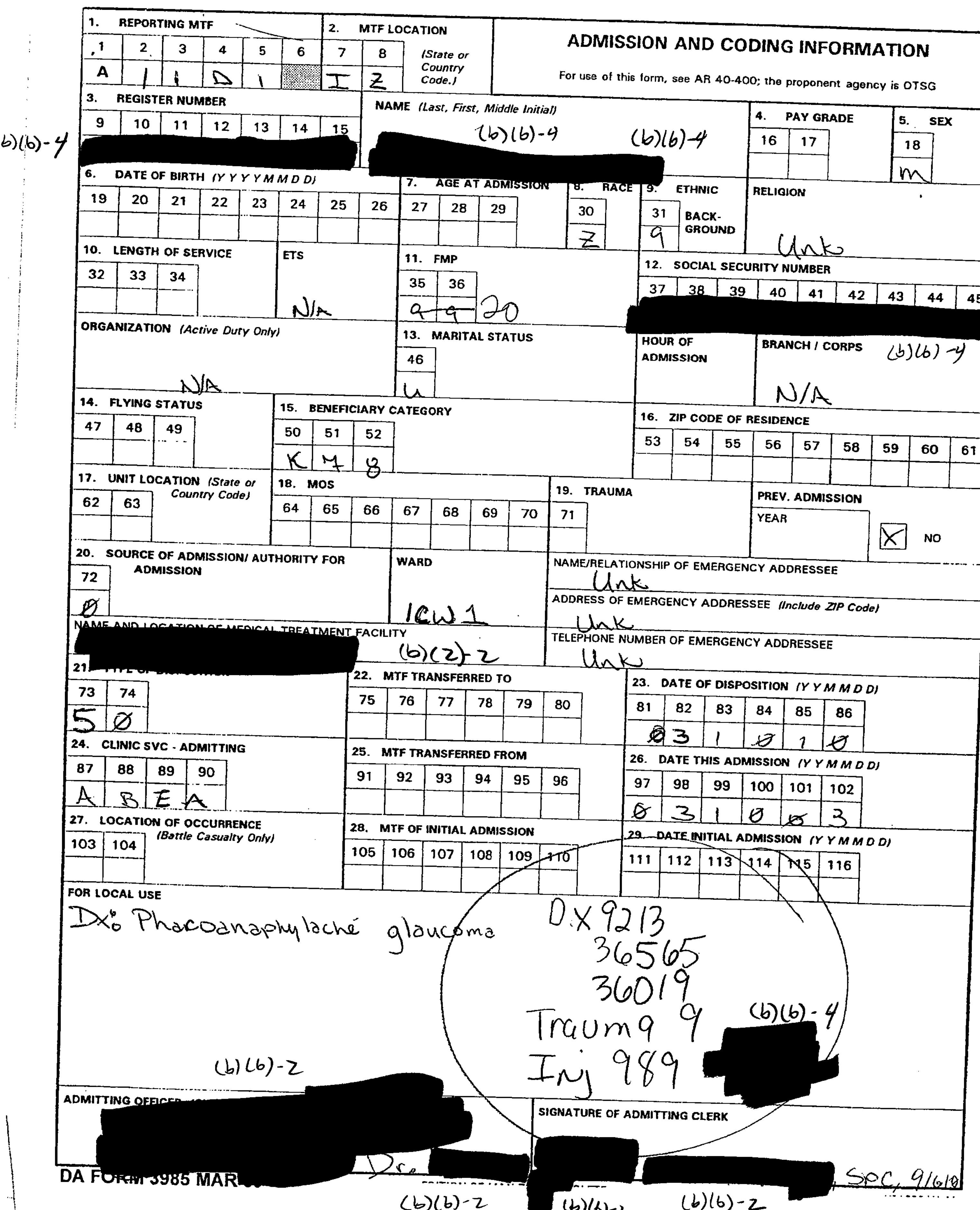
DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 20881



ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A 1 1 D 1
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: [redacted] (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (YYYYMMDD):
7. AGE AT ADMISSION:
8. RACE: Z
9. ETHNIC BACKGROUND: 9
RELIGION: Unk
10. LENGTH OF SERVICE:
ETS: N/A
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only): N/A
13. MARITAL STATUS: U
HOUR OF ADMISSION:
BRANCH / CORPS: (b)(6)-4 N/A
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA:
PREV. ADMISSION YEAR: [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø
WARD: ICW1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: Unk
21. TYPE OF DISPOSITION: 5 Ø
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (YYMMDD): Ø3 1Ø 1Ø
24. CLINIC SVC - ADMITTING: A B E A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYMMDD): Ø3 1Ø Ø3
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (YYMMDD):

FOR LOCAL USE

Dx: Phacoanaphylacté glaucoma

DX 9213
36565
36019
Trauma 9
Inj 989

(b)(6)-4

(b)(6)-2

ADMITTING OFFICER: [redacted] Dr. [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted] SPC, 9/6/10

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

DA FORM 3985 MAR

MEDCOM - 20882

(b)(6)-4

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	20Y	X	ISLAMIC			NO

11. FMP	12. SSN	13. Organization	14. Ward
~~96~~ 20		(b)(6)-4	ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	12:06	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-15

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-03	(b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(2)-2	2003-10-03	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: INJURED BY US SOLDIERS WHILE ATTEMPTING MURDER

34. Diagnosis / Operations and Special Procedures:

GSW ABDOMEN

Dx: 863.30
863.44
V44.3
E991.9

Proc:
46.52
87.41
88.01

E991.2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	12	12

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	12	12

Signature of Attending Medical Officer (b)(6)-2 (b)(6)-2

Automated Facsimile - DA FORM 3647, May 79 (b)(6)-2

MEDCOM - 20883

Referral Notes: Age : 20 y.   العنوان: الشعلة الشيخ علي

address : [redacted]   م ٢١٠ ز ٢٨ د ١٠

(b)(6)-4   see translation

Dear Sir

This young man, presented to our hospital with a bullet ? or shell ? in Lt lower abdomen.

Laparatomy finding :

1. Small bowel perforation (through & through) 80 cm from Doudenojejunal junction. Resection & end to end anastomosis in two layers.

2. through & through inj. to Sigmoid Colon, ~~being~~ brought as Loop colostomy.

he now have :

- N-G tube.
- 2 tube drains.
- urine (Foley's Catheter)

& till Now he didn't pass Flatus or stool.

he was put on :

- cefotaxim inj. : 1g X 3 I.V
- Flagyl : 500 mg X 3 I.V infusion
- G/S : 7 units/24.

(b)(6)-4 [redacted] KCl 60 meq / 24 h.

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

chief of Resident doctor.

3. 10. 03.

MEDCOM - 20884

ACLU-RDI 1659 p.45

DOD-034459

Translation Bates page Medcom 20884:

Address: [redacted] – 20 years- [redacted]

DEPARTMENT OF THE ARMY
12th Military Police Detachment (CID)
United States Army Criminal Investigation Command
Victory Camp, Iraq
APO AE 09335

CIRC-ABE

10 October 2003

MEMORANDUM FOR ALL PERSONNEL CONCERNED

SUBJECT: Request for Prisoner Hold

(b)(6)-4, (b)(6)-5, (b)(7)(c)-5 (b)(6)-4, (b)(6)-5 (b)(7)(c)-5 (b)(6)-4, (b)(6)-5 (b)(7)(c)-5

1. The 12th MP Detachment (CID) request that Mr. [redacted] (Pt. #[redacted]) and Mr. [redacted] (Pt. #[redacted]) be held at the Abu Ghraib Prison facility until further notice. Both personnel are suspected of murdering a U.S. soldier in downtown Baghdad on 1 Oct 03. Mr. [redacted] and Mr. [redacted] were both detained due to them having gunshot wounds and matching the description of the shooter. Investigation is continuing to gather evidence for the prosecution of the individuals above for murder.

(b)(6)-4 (b)(6)-5 (b)(7)(c)-5

(b)(6)-4, (b)(6)-5 (b)(7)(c)-5

2. Point of contact is the undersigned at DNVT [redacted] or [redacted]

(b)(6)-1 (b)(6)-1

//Original Signed//
[redacted] (b)(6)-1
CW2, MP
Special Agent-in-Charge

FOR OFFICIAL USE ONLY

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

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

[ ] Offense against Coalition Forces [check one] If "Other" then describe:

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

Apprehending Unit:

Location Grid: [redacted]

Date of Incident: (D/M/Y) 3 /10 /03 to / /

Time of Incident: 1432 hrs to hrs

Date of Report: (D/M/Y) / /

Time of Report: hrs

Detainee	Key Connected Person: [ ] Victim [ ] Witness
Detainee #: (b)(6)-4	
Last Name: [redacted]	Last Name:
First Name: [redacted] Given Name: (b)(6)-4	First Name: Given Name:
Hair Color: BLK	Hair Color:
Scars/Tattoos/Deformities:	Scars/Tattoos/Deformities:
Eye-Color: BRN Weight: lb Height: in	Eye-Color: Weight: lb Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/Sect:	Ethn/Tribe/Sect:
Sex: [X] M [ ] F	Sex: [ ] M [ ] F
Phone#:	Phone#:
DOB D/M/Y:	DOB D/M/Y:
[ ] Mobile [ ] Regular	[ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify)	[ ] Passport [ ] Dr. license [ ] Other (specify)
Document #:	Document #:

Total Number of Persons Involved 2 (list names/identifying info on reverse under "Additional Helpful Information")

[X] Vehicle Information Vehicle Number ___ of ___ Vehicle(s) Owner:

Make: [redacted]	Color: [redacted]	VIN:
Model: (b)(6)-4	Type: (b)(6)-4	Plate No. / Number of People in Vehicle:
Year: [redacted] (b)(6)-4	Names of People in Vehicle: UNK	

Contraband/Weapons in Vehicle:

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

Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer/ (Print): [redacted] (b)(6)-1
Signature:	Signature: [redacted] (b)(6)-1
Email:	Email:
Unit Phone: Date: / /	Unit Phone: Date: / /

MEDCOM - 20886

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? Positively Identified as Killing SPC [redacted] by Surviving Soldier, SPC [redacted]
(b)(6)-4, (b)(6)-2 (b)(6)-4, (b)(6)-2
At 011930-012000 Shot 2 US Soldiers in Akhadra area and was wounded and fled.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses
SPC [redacted] [redacted]
(b)(6)-4, (b)(6)-2 (b)(2)-2
Unk Soldiers [redacted] who transfered from Al Yarmuk hospital.

WO1 [redacted], [redacted] (b)(2)-2
(b)(6)-4, (b)(6)-2

How was this person traveling (car, bus, on foot)? Unk

Who was with this person? Unk

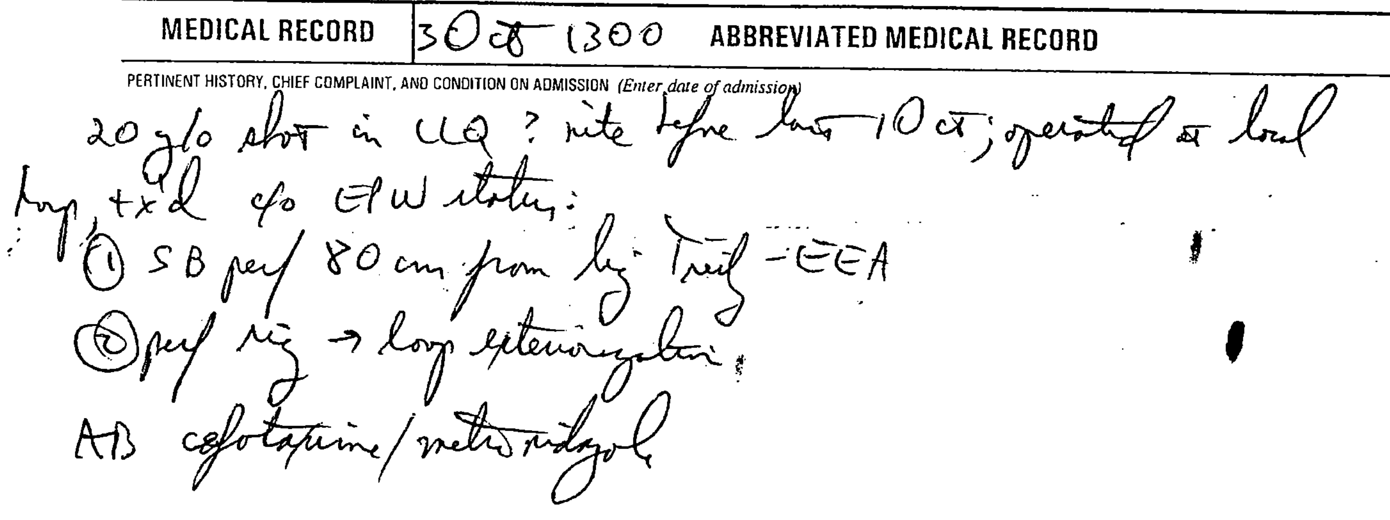
What weapons was this person carrying? Unk

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

(b)(2)-2
Additional Helpful Information: See [redacted] Commander for additional Info. (b)(6)-2
CALL [redacted] TOC IMMEDIATELY for ASSISTANCE
[redacted] (b)(6)-2



MEDICAL RECORD | 30 Oct 1300 | ABBREVIATED MEDICAL RECORD

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

20 y/o shot in LLQ ? nite before last 10 Oct; operated at local hosp, tx'd c/o EPW status:

① SB perf 80 cm from lig Treitz - EEA

② perf sig → loop exteriorization

AB cefotaxime/metronidazole

PHYSICAL EXAMINATION

WD ♂ NAD

HEENT ⊖

chest clear

cor - ⊘ M

abd

red rubber drain

loop ostomy

entry wound

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

trach - OK

20 y/o ~ 2 days postop for recovery

① SB EEA

② loop ostomy

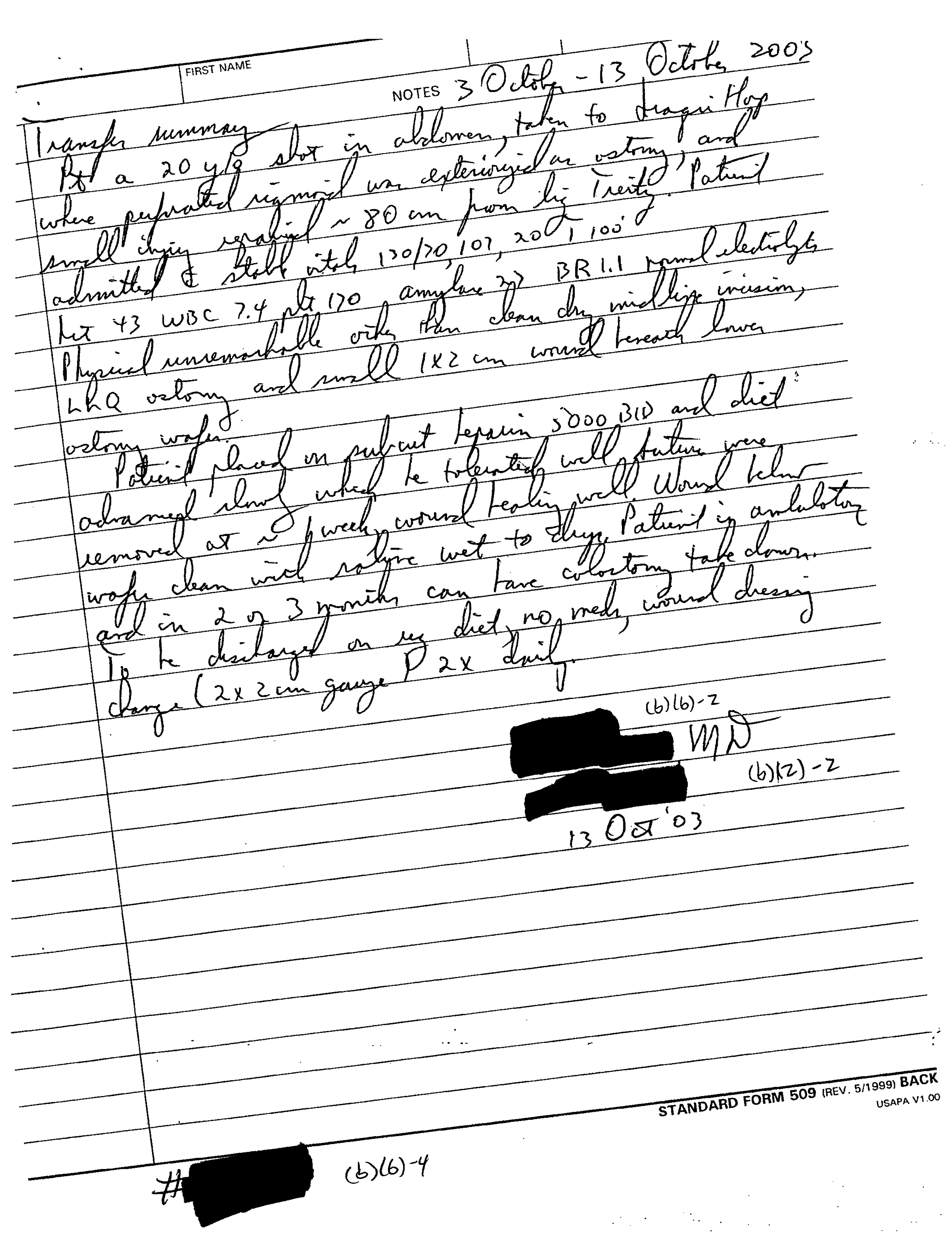
(b)(6)-2

SIGNATURE | DATE 30 Oct | IDENTIFICATION NO. | ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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



FIRST NAME

NOTES 3 October - 13 October 2003

Transfer summary
Pt a 20 y/o shot in abdomen, taken to Dragon Hosp
where perforated sigmoid was exteriorized as ostomy, and
small injury repaired ~ 80 cm from lig Treitz. Patient
admitted & stable vitals 130/70, 107, 20, 100°
hct 43 WBC 7.4 plt 170 amylase 22 BR 1.1 normal electrolytes
Physical unremarkable other than clean dry midline incision,
LLQ ostomy and small 1x2 cm wound beneath lower
ostomy wafer.

Patient placed on subcut heparin 5000 BID and diet
advanced slowly which he tolerated well. Sutures were
removed at ~ 1 week, wound healing well. Wound below
wafer clean with saline wet to dry. Patient is ambulatory
and in 2 or 3 months can have colostomy take down.
To be discharged on reg diet, no meds, wound dressing
change (2x2 cm gauze) 2x daily.

(b)(6)-2
MD
(b)(2)-2
13 Oct '03

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

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30Oct03 1745	Received pt from [illegible] in stable condition. VSS, NPO, NG to gravity, foley to gravity, wound drains x2 to LLQ, colostomy (loop) to RQ, ø BS, ø gas/flatus from colostomy. Midline abd incision. Gauze drsg [illegible] and incision. Output: NG 250cc green bile; Foley 700cc clr yellow urine; wound drains 100cc total sang. Pt is NPO. IS [redacted] (b)(6)-2 given to pt + taught, demonstrated use, able to raise dark blue ball [illegible] 50% of the time. LS rhonchi throughout, enc CDB. HRR. ø colostomy output at this time, stoma red in color. Pt able to reposition self + transfered self from litter to bed w/o assist. IV to Ⓡ AC patent + intact infusing D5½NS + 20 meq of K w/o apparent problem. IV access to Ⓛ wrist, HL, flushes well. Restraints per EPW protocol, ø breakdown noted. Other unremarkable assessments. Will con[redacted] (b)(6)-[illegible]
30Oct03 @ 2300	Assumed care @ 1800, T: 101.0°, pt NPO, no meds given; pt A[redacted] c/o pain or discomfort @ this time; NGT to gravity draining g[redacted] bile; FTG

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

MEDCOM - 20890

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) draining QS, clear yellow urine; 2 wound drains to RLQ
	draining small amt of dark, reddish fluid; colostomy bag intact, ⊖ stool,
	⊖ flatus, ⊕ BSx4 quads; midline dsg CDI; IS & CDB exercises encouraged,
	pt consistently inhaling 900-1200 cc/sec per IS; pt freely moving all
	extremities, N intact; PIV to Ⓡ AC patent & infusing D5½ NS c̄ 20 mEq KCL
	@ 125 cc/hr S/Sx infection/infiltration; Restraints in place, ⊕ circ ⊖ skin break
	↓; cont to monitor ——— [redacted] (b)(6)-2
4 Oct 03	Temp 100.8. Alert & Oriented. NG to gravity drain
0[redacted] (b)(6)-2	c̄ minimal green drainage. Lungs with Rhonchi
1000	through fields Bilaterally. Uses incentive spirometer
	properly @ 900 cc/sec. Has wet non productive
	cough. Will continue to [redacted] (b)(6)-2 encouraged on his
	IS usage. Peripheral pulses +2. Abd soft
	tender to touch. ⊕ BS heard @ this time. Abd.
	non-distended. Colostomy stoma pink & moist.
	⊘ output @ this time. Foley to gravity draining
	clear yellow urine. OOB ambulated down hallway
	accompany by CID agent. Pt ambulated c̄
	steady gait. Ⓡ AC IV patent & intact infusing
	D5½ NS c̄ 20 mEq KCl/L @ 125 cc/hr. Will continue
	care as planned. Ⓛ LQ drsg dry & intact ———
	(b)(6)-2 (b)(6)-2 [redacted] 2LT [illegible]
4 Oct 03	With Dr [redacted] assistance Abd drains, foley
1400	and NG tubes were d/c. Pt will remain
	NPO. No c/o pain or discomfort noted or
	voiced @ this time. Continues to use IS (b)(6)-
	with productive cough noted with cloudy sputum. [redacted] 2LT

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

MEDCOM - 20891

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4oct@2315	Assumed care @1800; T: 100.5°, HOB↑, IS use enc. CDB exercises enc.; Temp retaken; 99.8°; pt A&O, NV intact, ⊖ c/o pain or discomfort (b)(6)-2 @this time; S1S2, LS Ronchi throughout (B); IS use encouraged, pt able @ consistently @ 900-1200 cc/sec, CDB, pt ↑amb in Hall x1 for 10min, Tol well s̄ assistance; pt has productive cough, putting out, clear-white colored mucous; abd soft & ⊖ TTP; ⊕ BS x4 quads, colostomy intact, ⊖ stool, ⊖ flatus @ this time; ostomy site, Red, beefy & moist, FT draining QS, clear yellow urine; PIV patent & intact infusing D5½NS c̄ 20 mEq KCl s̄ S/Sx infection/infiltration; Restraints in place, ⊕ circulation ⊖ skin break. Will (b)(6)-2 Cont to monitor
5 Oct 03 0930	VSS. Alert & Oriented. Peripheral pulses palpable. Lung sound with scatter rhonchi throughout but better than yesterday. O2 SAT 98% RA. IS used properly @ 1200 cc/sec Has productive cough c̄ cloudy mucous. Will continue to Encourage C&DB. Ambulated to BR with steady gait. will ambulate time down hallway in front of room. Diet advanced to clear liquid per Dr. (b)(6)-2 BS hypoactive ⊘ gas/flatus noted in Colostomy bag. Dr. [redacted] aware. No drainage

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

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

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

EPW # [redacted]

(b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	(Continued) NOTES
5Oct03	Need to Abd drsg to old drainage tube sites.
0900	Voiding amber clear urine. Tolerating
	PO c̄ clear liquid. (L) FA IV patent & infusing
	infusing D5½ NS c̄ 20mEq KCl @ 125cchr.
	Will continue care as planned (b)(6)-2 [redacted] 91WM
5OCT.03	Pt A+Ox3, VSS, ø c/o pain or discomfort @
1945	this time, IS @ bedside, encouraged use
	⊕ BS, colostomy bag intact, midline abd inci-
	sion sutures intact, incision appears good s̄
	s/sx of infex, IV (L) FA patent infusing D5½
	NS c̄ 20 mEq KCL @ 125cc/hr. ø s/sx of
	infex on pts of restraint. (b)(6)-2 [redacted] 91W
ø6OCTø3	(1645) Assumed care of pt ā [illegible] p̄ report from night
	shift. Pt alert, speaking Arabic. VSS. φ c/o pain.
	Pt OOB this am to BR for personal hygiene. Amb
	well. Colostomy bag Δd this am d/t leakage from
	old bag. wet→dry abd drsgs Δd - φ s/sx infection
	ā sites. IVFs SLd in IV in (R) forearm. Pt adv. to
	reg diet - tol. well. voiding s̄ difficulty. 2 point
	restraints in place s̄ s/sx complications. will continue
	to monitor. (b)(6)-2 [redacted]
6OCT.03	Pt A+Ox3, VSS, medicated for pain c̄ 4mg
	MSO4, colostomy bag intact, midline abd
	incision sutures intact, abd dsg CDI, SL IV
	(R) FA intact, ø s/sx of infex or infiltration, voiding
	well, LS CTA (B), ⊕ BS x4, ø skin breakdown or poor
	circulation on pts of restraint. (b)(6)-2 [redacted] 91W

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Ø7OCTØ3	(1635) Assumed care of pt ② ØØØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4 X1. Wet→dry drsgs to abd Δd this am. Colostomy bag intact c̄ loose brown stool, emptied by pt this am. Pt amb well. Tol reg diet. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted] MAW
7OCT.Ø3 2ØØØ	Pt A+OX3, VSS, colostomy intact, dsg on abd CDI, tol PO well, voiding s̄ diff, ⊕BS x4, pain controlled c̄ percs, 2 pts restraint in place, Ø s/sx of poor circulation or skin breakdown. (b)(6)-2 [redacted] (b)(6)-2
Ø8OCTØ3	(1645) Assumed care of pt ② ØØØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt assisting c̄ colostomy care. Bag Δd today d/t leaking from old bag. Stool loose brown. Drsgs to abd Δd - Ø s/sx infection. Pt OOB to BR this shift for personal hygiene. Amb well. Tol po well. Voiding s̄ diff. 2-point restraints in place s̄ s/sx complications. Monitoring (b)(6)-2 [redacted]

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

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

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

[redacted] (b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8Oct03 1900	= VSS, ∅ c/o pain, A+O x3, sutures to midline abdomen approximated, ∅ drainage noted, colostomy attached & intact putting out light brown semi solid stool, 2 2x2's vertically dressed to (R) abd quad CDI. OOB to chair s̄ difficulty. x2 restraints when in bed, continue to monitor, ⊖ skin breakdown.
	(b)(6)-2 [redacted]
9Oct03 0900	VSS alert & O riented. OOB → BR ad lib. Colostomy stoma pink & moist. Midline abdominal incision dsg dry & intact will change later this shift. Lungs clear. BS (+) x 4 quad. Tolerating regular diet. Will continue care as planned [redacted] (b)(6)-2
10Oct03 2025	VSS. AO. Ad lib S.N.T. BS⊕x4. Tolerating PO well. Colostomy putting out light brown liquid stool. Sutures OTA. 2x2 DSG's CDI. All other systems WNL.
	[redacted] (b)(6)-2
∅OCT∅3	(1605) Assumed care of pt ∅ ∅∅∅∅ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Drsgs to abd C&I. Colostomy bag intact c̄ small amount loose brown stool. Pt amb to BR for personal hygiene s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. – [redacted]
	(b)(6)-2

MEDCOM - 20895

STANDARD FORM 509 (REV. 5/1999) BACK

ACLU-RDI 1659 p.57

DOD-034471

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10/11/03 0123	VSS. AO. BS ⊕x4. Colostomy intact and putting out minimal amount of soft formed brown stool. ⊕ pulses to all extremities. PSG intact to Abdomen. Wound is pink s̄ s/s infection. Sutures remain intact to abdominal incision. Voiding light yellow urine, quantity sufficient. (b)(6)-2 [redacted] AN
11 Oct 03- 0700	- Assumed care of pt. A to x3. VSS ø c/o pain or discomfort Lungs clear H2RR Active BS x 4 quads LLQ abd stoma beefy red vascular. Midline abd incision open to air sutures removed this a.m. ø evidence of active bleeding ø s/s of infection Will cont to monitor (b)(6)-2 [redacted] 91WM
	(1710) I concur c̄ above assessment. (b)(6)-2 [redacted] AC
11Oct03	2000: VSS, ø c/o pain @ present, A+O x3, midline abdomen wound open to air, ø drainage noted, will continue to monitor for any drainage, colostomy intact putting out light brown semi solid stool ⊕ BS x 4, tolerates PO, adequate UOP via urinal @ BS, x2 restraints s̄ skin breakdown. Will continue to monitor. (b)(6)-2 [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

MEDCOM - 20896

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	12
12 Oct 0700	Assumed care of pt. A+O x3 VSS Ø c/o pain or discomfort @ this time. Lungs clear ↓ through Active BS x4 quads. Ostomy to LQ of old stoma vascular red. Care given self c̄ assistance. Tolerates PO. Abd incision healing well Ø s/s of infection. Afebrile. Will cont to monitor ——— (b)(6)-2 [redacted] /wmb.
12Oct03	@2030 = VSS, A+O x3, managing pain c̄ percs as ordered, midline abdominal wound open to air & healing, Ø drainage seen, colostomy intact putting out light brown semi-solid stool → pt. does own colostomy care, x2 restraints s̄ skin breakdown Ø other remarkable findings. ——— (b)(6)-2 [redacted]
13Oct03 0916	Received pt resting in bed, VSS, tol PO, A+O x3. Reinforced colostomy care w/ pt. AM care provided. Colostomy to (L) LQ intact + putting out semiformed brown stool. No c/o pain @ this time. BS (+), midline surgical incision OTA w/ well approximated edges. Restraints per EPW protocol, Ø breakdown noted. Ø other remarkable assessments @ this time. Will cont to monitor pt. (b)(6)-2 [redacted]
13Oct03	@ 1930 = VSS, Ø c/o pain, A+O x3, midline abd wound open to air & healing, Ø drainage noted, colostomy intact c̄ brown formed stool being put out, x2 restraints s̄ skin breakdown, Ø other remarkable assessment findings. Continue to monitor. ——— (b)(6)-2 [redacted]

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
14 Oct 03 0700	- Assumed care of pt. cond. stable VSS OK for discharge to epw camp. Remains afebrile abdominal surgical incision sutures removed healing well ∅ s/s of infection. Ostomy to Ⓛ UQ Abdomine vascular beefy red stoma. Self care colostomy change. Lungs CTA. HRRR Tolerate P.O. Ambulates s̄ difficulty (b)(6)-2 [redacted]
14 OCT 03 2148	VSS. AO. ∅ c/o pain @ this time. BS ⊕ x4 and colostomy clean & intact. Abd DSG CDI to lower abdominal site. ⊕ pulses - 2 SCD AB. Up to ambulate x1 for 30 min. s̄ difficult and returned to bed. Resting comfortably in bed. Voiding light amber urine, quantity sufficient. (b)(6)-2 [redacted]
15 oct 03 0700	- Assumed care of pt. cond stable Lungs clear HRRR Active BS tolerating PO well Ambulates s̄ difficulty. Ostomy to Ⓛ UQ. stoma vascular beefy red self care given. Surgical incision to abdomen healing ∅ s/s of infection pt. remains afebrile. Will cont to monitor (b)(6)-2 [redacted]
	(1240) I concur c̄ above assessment. (b)(6)-2 [redacted]
	(1440) Pt D/C to EPW camp - ambulatory - escorted by MPs. (b)(6)-2 [redacted]

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

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

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

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

REGISTER NO. | WARD NO.

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

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 03OCT03 | TIME: 1205

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

SEX: M

AGE: 20

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Cefotaxim 3g; Flagyl 500mg; KCl 60meq

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☒ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☒ NO

CHIEF COMPLAINT: Transfer from Iraqi Hos s/p laparotomy

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1206

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

VITAL SIGNS

TIME	1206				
BP	129/67				
PULSE	107				
RESP	20				
TEMP	100.1 (T)				
WT	—				

LAB ORDERS

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

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

[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 - 20899

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S. 20 yo EPW S/P laporotomy tranferred from Iraqi Hosp. Pt sustained GSW to abdomen + had surgery yesterday @ Iraqi hosp. ∅ C/O pain.

O. Pt arrived via F/A, AD, ∅ resp distress, A+Ox3

4 EENT - NG tube to gravity c̄ bag 150cc out green stuff.
Chest - Rhonchi in all lobes heard.
Heart - RRR ∅ murmurs
Abd - TTP in all quads, Presents c̄ 2 wound drains ~30cc out, NGT to gravity ~150cc out, colostomy ~∅ output, Foley c̄ 1000cc out.
Ext - WNL cap refill <2secs

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
(b)(6)-2
[redacted] ICTAN

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

DIAGNOSIS

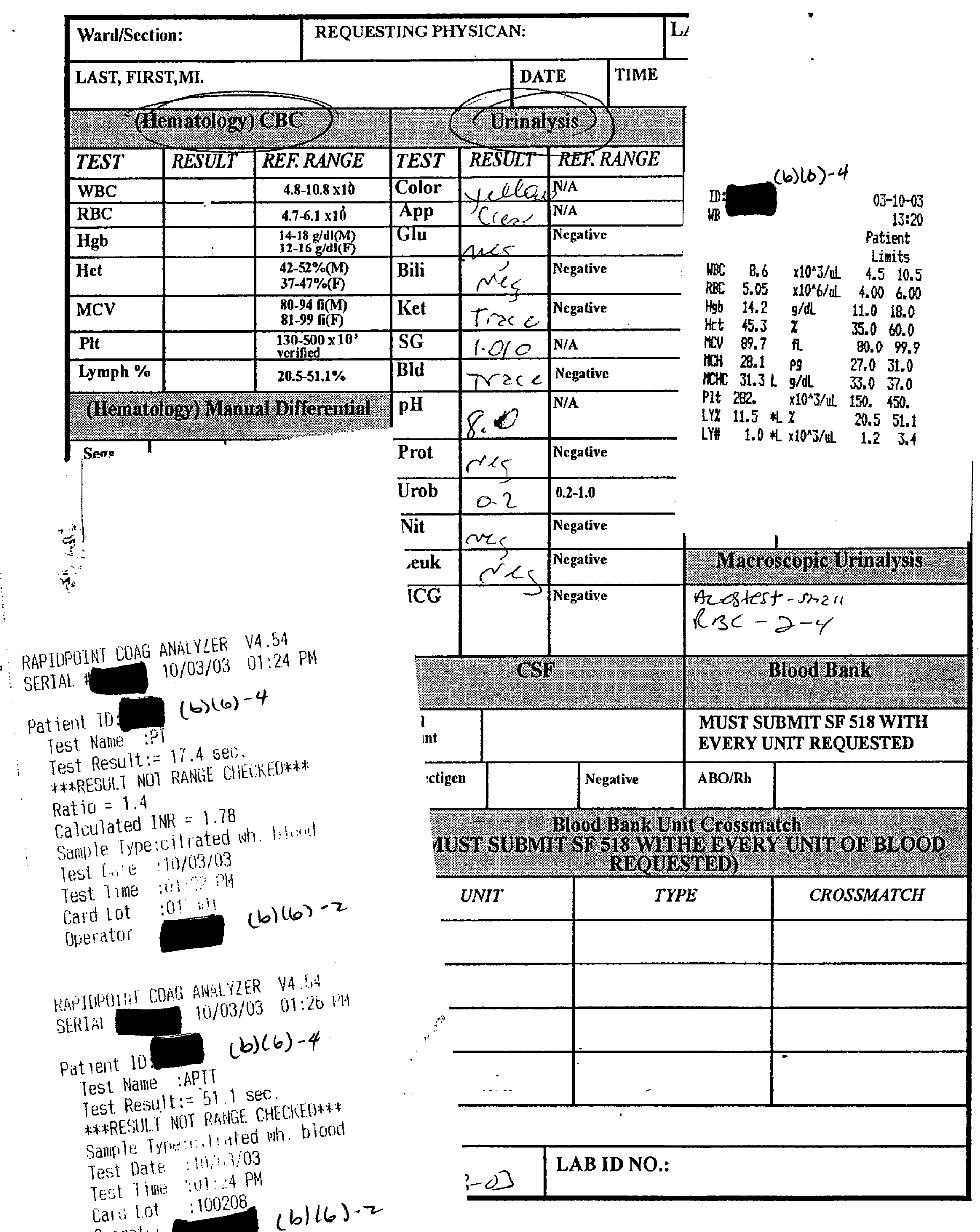
CODES

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

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)
''SAPA V1.00

MEDCOM - 20900



Ward/Section:	REQUESTING PHYSICAN:	L
LAST, FIRST,MI.	DATE	TIME

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
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 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	Trace	Negative
SG	1.010	N/A
Bld	Trace	Negative
pH	8.0	N/A
Prot	neg	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

ID: (b)(6)-4
WB
03-10-03
13:20

			Patient Limits	
WBC	8.6	x10^3/uL	4.5	10.5
RBC	5.05	x10^6/uL	4.00	6.00
Hgb	14.2	g/dL	11.0	18.0
Hct	45.3	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	282.	x10^3/uL	150.	450.
LY%	11.5 *L	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

Macroscopic Urinalysis

Acetest - small
RBC - 2-4

CSF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

...ctigen | | Negative | ABO/Rh |

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

UNIT	TYPE	CROSSMATCH

...-03 | LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL # [redacted] 10/03/03 01:24 PM

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.4
Calculated INR = 1.78
Sample Type:citrated wh. blood
Test Date :10/03/03
Test Time :01:?? PM
Card Lot :01[illegible]
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/03/03 01:26 PM

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 51.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/03/03
Test Time :01:?4 PM
Card Lot :100208
Operator [redacted] (b)(6)-2

Ward/Section: Emt	REQUESTING PHYSICAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. (b)(6)-4	DATE 03Oct03 / TIME 1206	SSN/PEEUDO SSN: (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

```
======= PICCOLO =======
10/03/03            01:52 PM
REFERENCE RANGE:        MALE
PATIENT #: (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2  3142AA4
OPER #            DR #: 000
SERIAL #:
....(b)(6)-4..................
ALB    3.1*   3.3-5.5    G/DL
ALP    63     26-84      U/L
ALT    ♦♦♦    10-47      U/L
AMY    21     14-97      U/L
AST    74*    11-38      U/L
TBIL   1.1    0.2-1.6    MG/DL
BUN    ♦♦♦    7-22       MG/DL
CA++   8.9    8.0-10.3   MG/DL
CHOL   88*    100-200    MG/DL
CRE    1.0    0.6-1.2    MG/DL
GLU    97     73-118     MG/DL
TP     6.2*   6.4-8.1    G/DL

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

BUN – 11

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		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^{+}	136	128-145 mmol/l
K^{+}	3.3	3.3-4.7 mmol/l
CL^{-}	105	98-108 mmol/l
tCO2	26	18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 10-03-03	LAB ID NO.:

MEDCOM - 20902

Ward/Section: ICW1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 30 OCT	TIME 2130	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(b)(6)-4

ID: [redacted] 03-10-03
WB 22:39

			Patient Limits	
WBC	7.4	x10^3/uL	4.5	10.5
RBC	4.83	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	43.8	%	35.0	60.0
MCV	90.6	fL	80.0	99.9
MCH	27.9	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	170. *	x10^3/uL	150.	450.
LY%	11.4 *L	%	20.5	51.1
LY#	0.8 *L	x10^3/uL	1.2	3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 30Oct03	LAB ID NO.:

MEDCOM - 20903

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

LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		

```
======= PICCOLO =======
10/03/03          11:04 PM
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: (b)(6)-2 3154AA7
OPER #: [redacted] (b)(6)   DR #: 000
SERIAL #: [redacted] (b)(6)-4
.................................
ALB    3.1*   3.3-5.5    G/DL
ALP    61     26-84      U/L
ALT    29     10-47      U/L
AMY    27     14-97      U/L
AST    60*    11-38      U/L
TBIL   1.1    0.2-1.6    MG/DL
GGT    9      5-65       U/L
TP     6.3*   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 =======
03/10/03             22:36
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted] (b)(6)-4
.................................
GLU    119*   73-118     MG/DL
BUN    8      7-22       MG/DL
CRE    0.8    0.6-1.2    MG/DL
CK     1616*  39-380     U/L
NA+    ***    128-145    MMOL/L
K+     3.9    3.3-4.7    MMOL/L
CL-    99     98-108     MMOL/L
tCO2   23     18-33      MMOL/L

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

Na 136

tC | 18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 3Oct03	LAB ID NO.:

MEDCOM - 20904

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4		13 October ______ HOURS	
		may be transferred to family if	[redacted]
		colostomy care arranged	
		wound dressing change C 2x2 gauze	(b)(6)-2
		1-2x daily	1720
NURSING UNIT: KW#1 / ROOM NO.: 2 / BED NO.: D2		13 Oct 03 1930 [redacted] (b)(6)-2	/30 [redacted] (b)(6)-2

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-2		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 20905

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		4 Oct 1400 ___ HOURS	
Noted (b)(6)-2	1	DC abd drain	
	2	DC fol	
	3	DC NG	
	4	NPO	
		(b)(6)-2 (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.: 1KW/24° V.S. 0400			
PATIENT IDENTIFICATION		DATE OF ORDER: 5 Oct 03 / TIME OF ORDER: 0840 HOURS	
(b)(6)-4 Noted 5 Oct 03 0840 (b)(6)-2	1	Clear liquid diet (b)(6)-2	(b)(6)-2
		V.O. Dr (b)(6)-2 / 2LT	
		(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER: 06OCT03 / TIME OF ORDER: 1200 HOURS	
		DC IVFs	
		Adv diet to reg.	
		V.O. Dr. [redacted]	(b)(6)-2
			(b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.: 2W/0130 7OCT03 (b)(6)-2			
PATIENT IDENTIFICATION		DATE OF ORDER: 7 Oct 1100 / TIME OF ORDER: ___ HOURS	
	1	DC MS	
	2	Percocet 1-2 po q4 prn	
	3	DC IV	
(b)(6)-2 Noted 07OCT03 (b)(6)-2	4	US q shift	
		(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.: 2W/0145 8OCT03 1150		(b)(6)-2	

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

MEDCOM - 20906

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

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

DATE OF ORDER: 30 Oct | TIME OF ORDER: 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

Admit EPW ward
Cond fair
diet 003 drain BID
ambulate qd
VS - q4h
Dx - penetr abd trauma

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

IV D5 1/2 NS 1000 cc with 20 meq KCl at 125 cc/h
NG to gravity drain
Foley
red rubber abd drain - gravity drain (L) LQ wound c gauze qd

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

MS 2-4 mg IV q2h prn pain
CBC lytes am 4 Oct
Heparin SQ 5000 U q12h

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 30 Oct | TIME OF ORDER: 2100 HOURS

CBC lytes LFTs now
cancel 0400 lab

(b)(6)-2

noted (b)(6)-4

NURSING UNIT: ICW 1 | ROOM NO. 24PV 40ct 0320 | BED NO. 0220

(b)(6)-2

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

MEDCOM - 20907

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15
10/3	(b)(6)-2	Act: OOB chair BID. Ambulate ād	06 18 / 18 06													
10/3	(b)(6)-2	VS q 4°	06 18 / 18 06					D/C 07OCT03								
10/3	(b)(6)-2	NG to gravity drain	06 18 / 18 06			D/Ced 4 Oct 03										
10/3	(b)(6)-2	Foley	06 18 / 18 06			D/Ced 4 Oct 03										
10/3	(b)(6)-2	Red Rubber abd drain - gravity	06 18 / 18 06			D/Ced 04 OCT 03										
10/3	(b)(6)-2	Change (L) LQ wound c̄ gauze ād	10													
04 OCT 03	(b)(6)-2	NPO	06 / 18				D/C 5Oct03									
Sat	(b)(6)-2	Clear liquid diet	06 18 / 18 06					D/C 06OCT03								
06 OCT 03	(b)(6)-2	Adv. diet to reg.	06 / 18													
07 OCT 03	(b)(6)-2	VS q shift	06 / 18													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating abd trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 20908

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo Oct Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/3 (b)(6)-2	[redacted]	Admit EPW Ward	10/3			
10/3 (b)(6)-2	[redacted]	Condition, fair	10/3			
10/3 (b)(6)-2	[redacted]	CBC lytes am 4 Oct	10/4	0400	cancelled	
10/3 (b)(6)-2	[redacted]	CBC, lytes, LFTs	10/3	2130	2130	[redacted] (b)(6)-2
04 OCT03	(b)(6)-2 [redacted]	D/C abd drains	04 OCT03	—	1415	[redacted] (b)(6)-2
04	(b)(6)-2 [redacted]	D/C foley	04	—	1415	[redacted] (b)(6)-2
04	(b)(6)-2 [redacted]	D/C NGT	04	—	1415	[redacted] (b)(6)-2
13	(b)(6)-2 [redacted]	May be transferred to facility if	13			
	(b)(6)-2	colostomy care arranged, wound				
		dressing change (2x2) gauze				
		1-2x daily.				

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

MEDCOM - 20909

ACLU-RDI 1659 p.71

DOD-034485

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 3	4	5	6	07	08	9	10	11	12	13	14	15
10/3		IV - D5½NS 1000cc	D/C 18				D/C 06OCT03									
(b)(6)-2		c̄ 20meq KCl @125cc	18 06													
10/3		Heparin SQ 5000u	08													
(b)(6)-2		q̄ 12°	20													
		(b)(6)-2														
07 OCT03		D/C MS	D/T	07OCT 1145												
07		D/C IV	D/T	07OCT 1145												
		(b)(6)-2														

(b)(6)-2

PRN Medication

ORDER DATE	CLERK/ NURSE	MEDICATION					
10/3 d/c 10/6	(b)(6)-2	MS - 2-4mg IV q̄ 2 hr prn pain	Date	6OCT	6OCT	7OCT	D/C 07OCT03
			Time	2345	2345	1115	
			Dose	4mg	4mg	4mg	
	(b)(6)-2		Init				
07 OCT03		Percocet i-ii po q4° prn	D/T	07OCT 1730	7OCT 2250	08OCT 1750	8OCT03 2155; 9Oct 1116; 9OCT 1930; 10OCT 1010; 10OCT 1924; 11OCT 0030; 11OCT03 2115; 12OCT03 2100
			D/T	13OCT 1030	13OCT03 2200		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: Penetrating abd trauma

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 20910

A | Country Code.)

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

(b)(6)-4

3. REGISTER NUMBER 9 10 11 12 13 14 15

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

4. PAY GRADE 16 17

5. SEX 18 M

6. DATE OF BIRTH (YYYYMMDD) 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION 27 28 29 — 2 0 Y

8. RACE 30

9. ETHNIC BACKGROUND 31

RELIGION

10. LENGTH OF SERVICE 32 33 34

ETS

11. FMP 35 36

12. SOCIAL SECURITY NUMBER 37 38 39 40 41 42 43 44 45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS 46

HOUR OF ADMISSION

BRANCH / CORPS (b)(6)-4

14. FLYING STATUS 47 48 49

15. BENEFICIARY CATEGORY 50 51 52

16. ZIP CODE OF RESIDENCE 53 54 55 56 57 58 59 60 61

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

18. MOS 64 65 66 67 68 69 70

19. TRAUMA 71

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION 73 74 — -

22. MTF TRANSFERRED TO 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYYYMMDD) 81 82 83 84 85 86 87 88 — 2 0 0 3 1 0 1 5

24. CLINIC SVC - ADMITTING 89 90 91 92

25. MTF TRANSFERRED FROM 93 94 95 96 97 98

26. DATE THIS ADMISSION (YYYYMMDD) 99 100 101 102 103 104 105 106 — 2 0 0 3 1 0 0 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only) 107 108

28. MTF OF INITIAL ADMISSION 109 110 111 112 113 114

29. DATE INITIAL ADMISSION (YYYYMMDD) 115 116 117 118 119 120 121 122

FOR LOCAL USE

Dx: 86330 86344 V443 E9912

Pr 4652 8741 8801

Inj Trauma 450

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

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

MEDCOM - 20911

3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission 20Y	8. Race X	9. Ethnicity 9	Religion ISLAMIC
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4
Organization (Active Duty Only)	13. Marital Status Z	Hour of Admission 12:06	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee
		Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-15
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-03
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-03

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

1st admis

Admission Diagnosis Narrative: GSW ABDOMEN

Procedure Narrative(s):

Cause of Injury Narrative: INJURED BY US SOLDIERS WHILE ATTEMPTING MURDER

Admitting Officer (Signature, as required) (b)(6)-2 (b)(6)-2	Signature of A... (b)(6)-2

'omated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 20912

Automated Facsimile

IN...TIENT TREATMENT RECORD C...ER SHEET

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

(b)(6)-4

1. Register Nbr	2. Name (b)(6)-4				3. Grade	Admission Remarks
4. Sex M	5. Age 22Y	6. Race Z	7. Religion UNKNOWN	8. LnthOfSvc	9. ETS	10. PrevAdm NO
11. FMP 20	12. SSN	13. Organization (b)(6)-4				14. Ward ICW1
15. FlyStatus N/A	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case DIS
21. Source of Admission Direct from ER			22. Hour Of Adm: 14:33	23. Clinic Service AEA - ORTHOPEDICS		
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-10-10		
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-04	AdmittingOfficer: (b)(6)-2	
29. ReportingMTF - Iraq (b)(2)-2				30. Date Init Adm 2003-10-04	32. Units Blood Components	

31. Selected Administrative Data

Marital Status: Z   DoB:

In/Out Patient: Inpatient   MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW LEFT SHOULDER

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature ... Officer (b)(6)-2 ... of PAD or Medical Records Officer (b)(6)-2 (b)(6)-2

(b)(6)-2

MEDCOM - 20913

Automated Facsimile - DA FORM 3647, May 79

ACLU-RDI 1659 p.75

DOD-034489

(b)(6)-4
(b)(7)(c)-5 ; (b)(6)-5

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

[X] Offense against Coalition Forces [check one] If "Other" then describe:

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [X] Assault/Attack on Coalition Forces: SHOOTING AT U.S. FORCES
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

Apprehending Unit: (b)(2)-2 | Location Grid:

Date of Incident (D/M/Y): 4/10/03 to / / | Time of Incident: 1300 hrs to hrs | Date of Report: (D/M/Y) / / | Time of Report: hrs

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

(b)(6)-4
(b)(6)-4
(b)(7)(c)-5
(b)(6)-5

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

[ ] Vehicle Information | Vehicle Number ____ of ____ Vehicle(s) | Owner:

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

Contraband/Weapons in Vehicle:

[ ] Property/Contraband [ ] Weapon | Photo Taken of Suspect with Weapon/Contraband. Yes/ No

Type:	Model	Color/Caliber
Serial No / Quantity	Make	Receipt Provided to Owner Yes/ No
Other Details	Where Found	Owner

Email, Phone, or Contact Info:

Name of Assisting Interpreter:

Detaining Soldier's Name (Print): CONTACT UNIT BTL CDR — Last, First MI

Signature:

Email:

Unit Phone: Date: / /

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

Signature:

Email: Date: / /

Unit Phone:

(b)(6)-1
(b)(7)(c)-1

MEDCOM - 20914

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22 y/o ♂ sustained GSW to (L) shoulder. Iraqi detainee.

(-) PMH

(-) NKDA

(-) allergies

Last P.O. 0600

PHYSICAL EXAMINATION

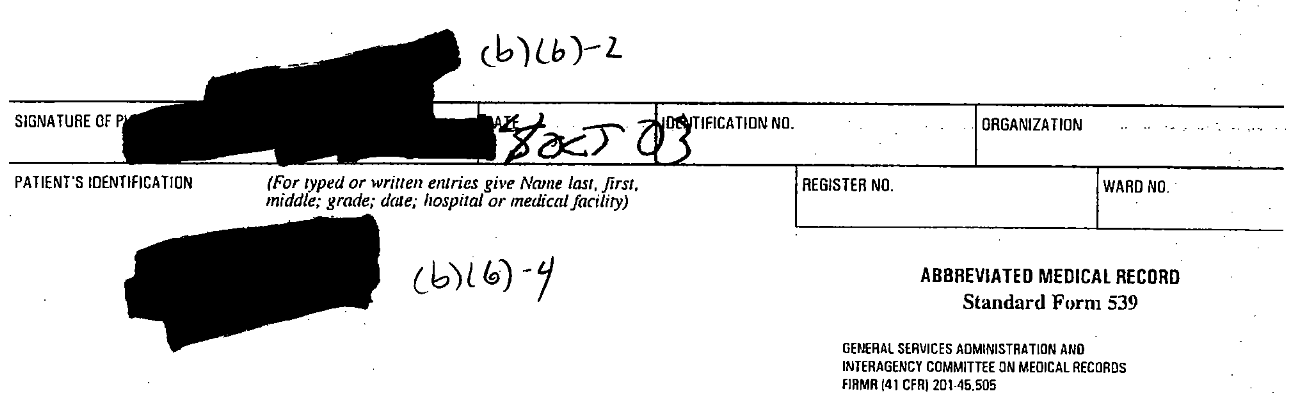
Through & through soft tissue wound posterior (L) shoulder entering posteriorly, then exited laterally as posteriorly. Neurovascular intact.

Wound: [illegible]
[illegible]
[illegible]
[illegible] [illegible]

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

(1) GSW (L) shoulder

(P) I+D in OR.



(b)(6)-2

SIGNATURE OF P[redacted]	DATE 8 OCT 03	IDENTIFICATION NO.	ORGANIZATION

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

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4/27/03 1939	Ortho Op Note
	Pre Op Dx - GSW (L) shoulder
	Post Op Dx - Same
	Procedure - I+D (L) shoulder
	Surgeon - [redacted] (b)(6)-2
	EBL - min
	Bwss - 1000 LR
	Findings - Through and through wound through deltoid muscle. No bony involvement. Minimal necrotic muscle, Irrigated 3 liters through and through, then posterior wound closed over penrose, Deltoid defect closed with 0-vicryl but otherwise skin wound left open
	PWW - W Ancef Repeat I+D 48 hours
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2
	CDR m

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 OCT 03	Pre Op Dx: GSW (L) shoulder
1640	Post Op Dx - Same
	Procedure: I&D, DPC (L) shoulder
	Surgeon: [redacted] (b)(6)-2
	EBL: MIN
	FLUIDS: 300 cc
	Findings: Mod. [illegible] clean. Closed in [illegible]
	Plan: Discharge to GPW camp in 2 days
	[redacted] (b)(6)-2

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

MEDCOM - 20917

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03	(S) Pt. was seen raising a handgun from behind other Iraqis who were throwing rocks at coalition forces. When he stepped out from behind & raised pistol, he was ~~shoot~~ shot by US soldier in (R) ant. shoulder.
	(O) wound cleaned & dressed c̄ gauze bandage. VS taken at the scene were stable, not recorded by 91W. (R) hand FAROM & fingers N/V/I
	– transported to [redacted] for x-rays & further eval. (b)(2)-2
	* x-rays show sig schrapnel to (R) shoulder c̄ poss. intracapsular involvement
	(A/P) (1) GSW (R) shoulder
	– transfer of care to orthopedic surg @ [redacted] (b)(2)-2 for surgical debridement of wound.
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2
	CPT [redacted] PROFIS Physician
	(b)(2)-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

[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 - 20918

AUTHORIZED FOR LOCAL REPRODUCTION

5

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/Oct/03 2120	Received pt. from ICW#3. AO. Speaking small english & Arabic. Pt. shivering and provided blanket. ⊕ pulse to LUE and CR ≤2 sec. Warm to touch. BS ⊕ x4, LSCLAB. S.S. 2 IV's in LUE and LR @ 125 cc/hrs. PERRLA. Started on IV AB and placed NPO ō MN for surgery on 5 OCT 03. (b)(6)-2 [redacted]
5 Oct 03 0500	VSS Alert + Oriented OOB ambulated to BR with steady gait. Tolerated Reg diet for Breakfast IV saline lock Ⓡ FA and SL present to Ⓡ hand. Both saline lock patent and intact. Ⓛ Shoulder drsg reinfx to posterior area, noted serosanguinous drainage to drsg. Lungs clear. BS ⊕ x4 abd soft non distended. Peripheral pulses palpable. Will continue plan of care. (b)(6)-2 [redacted] 2nd
5 OCT. 03 1930	Pt A+Ox3, VSS, LS. CTA Ⓑ, ⊕BSx4, tol PO well, SL to Ⓡ Hand + Ⓡ FA, intact s̄ s/sx of infx or infiltration, dsg to Ⓛ shoulder CDI, ø noted drainage, denies pain @ this time, able to move fingers, radial pulses equal Ⓑ, ambulates s̄ difficulties,

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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont.	voiding well, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] (b)(6)-2
ø6OCTø3	(164ø) Assumed care of pt @ ø6øø p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol. Drsg to Ⓛ shoulder CDI. Pt remains NPO for surgery today. Pt OOB this am to BR for personal hygiene. Amb well. Voiding s̄ difficulty. IVF infusing @ TKO into IV in Ⓡ forearm s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
	(18øø). Pt not on surgery schedule. Given reg diet. (b)(6)-2 [redacted]
6 OCT. ø3	Pt awake, A+Ox3, VSS, LS CTA Ⓑ, ⊕ BSx4, OOB to BR, pain controlled c̄ percs, dsg Ⓛ shoulder CDI, IV HL Ⓡ FA intact, flushes well, ø s/sx of infex or infiltration, voiding well, ø skin breakdown or poor circulation on pts of restraint. (b)(6)-2 [redacted]
	(b)(6)-2 [redacted]
ø7OCTø3	(163ø) Assumed care of pt @ ø6øø p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb in hallway well. SS in Ⓡ forearm d/cd - catheters intact. 2øg IV started in Ⓛ forearm flushes well s̄ s/sx infiltration. Drsg to Ⓛ shoulder Δd - wet → dry to exit wound. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. (b)(6)-2 [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
9Oct03	0001 = IVF's initiated P/T NPO p MN. [redacted]
9Oct03	VSS. Alert & oriented. OOB → BR for
0900	AM care. Pt NPO & O/C for OR this AM.
	(L) FA IV patent & intact. OOB → BR
(b)(6)-2	[redacted] at gd [illegible]. (L) Shoulder drsg dry & intact.
	Peripheral pulses +2. Voiding without difficulty
	quantity sufficient. Awaiting pickup from
	OR. Will continue care as ordered [redacted] (b)(6)-2
9Oct03	VSS Received from PACU Alert & Oriented
1730	(L) Shoulder drsg dry & intact. (L) FA IV patent
	& intact infusing LRO 150cc/hr. Voiding clear
	yellow urine. Regular diet given for dinner
	Tolerating well. Will report to next
	shift of pt's condition [redacted] (b)(6)-2
9 OCT 03	VSS. AO - ⊕ pulse, warm to touch @ LUE. DSG CDI
2013	c̄ mild c/o pain and provided 2 percocet. Voiding QS
	light yellow urine [redacted] (b)(6)-2
10OCT03	(1050) Assumed care of pt c̄ [illegible] p̄ report from night
	shift. Pt alert, speaking Arabic. VSS. Pain controlled
	c̄ Tylenol. Drsg to (L) shoulder Δd this am, sutures
	CDI. SL in (L) forearm flushes well s̄ s/sx infection/
	infiltration. Tol. reg diet well. Voiding s̄ difficulty.
	Pt OOB to BR this am for personal hygiene. Amb
	well. 2 point restraints in place s̄ s/sx complications.
	Will continue to monitor. Awaiting D/C to EPW camp.
	(b)(6)-2 [redacted]
	(1620) Pt d/c to camp - amb - escorted by MPs [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

(b)(6)-2

MEDCOM - 20921

ACLU-RDI 1659 p.83

DOD-034497

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 OCT. 03 1945	Pt A+O x3, VSS, OOB to ambulate, dsg to (R) shoulder CDI, pain controlled c̄ percs, HL IV (L) FA intact ~~infusing~~ (b)(6)-2 ∅ s/sx of infex or infiltration, abd soft flat nontender, voiding s̄ diff, 2 pt restraint in place c̄ ∅ s/sx of poor circulation or skin breakdown, LS CTA(B), ⊕BSx4. (b)(6)-2 [redacted] (b)(6)-2
08OCT03	(1640) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol. Dsg to (L) shoulder Δd wet→dry. Pt OOB to BR for personal hygiene this am. Amb well. Tol reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
8Oct03	1845: VSS, ∅ c/o pain @ present time, A+O, speaks Arabic to communicate, dsg to (L) shoulder CDI, OOB & ambulates s̄ difficulty, x2 restraints when in bed ⊖ skin breakdown noted, IV HL 18G to (L) FA flushed + patent, continuing IV Ancef. Continue to monitor for acute Δ's. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 20922

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Oct 03	Ortho Discharge Note
	22 yo male sustained (L) shoulder through and through GSW on 9 oct 03
	Went to OR 9 oct 03, I+D done.
	DPC done 9 oct 03.
	Plan: Every other day dressing changes
	Sutures out 17 Oct 03
	Keflex 250 mg QID x 10 days #40
	Percocet 1-2 P.O. Q 4-6 hrs prn #20
	(b)(6)-2
	CO2 MC
	(b)(6)-2

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY (b)(2)-2
		RECORDS MAINTAINED AT	

PATIENT'S [redacted] DUTY STATION (b)(6)-4

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL — DATE *(Day, Month, Year)*: 09OCT03 — TIME: 1625

TRANSPORTATION TO FACILITY: MEDEVAC

SEX: M

AGE: 22

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: PT Denies

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS — DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (L) shoulder

CATEGORY OF TREATMENT

☐ EMERGENT ☐ URGENT ☐ NON-URGENT

TIME: 1625

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

VITAL SIGNS

TIME	1625				
BP	128/68				
PULSE	66				
RESP	16				
TEMP	100.9				
WT					

LAB ORDERS

X CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: met 8
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	TIME	PATIENT'S RESPONSE
1731	[illegible] (b)(6)-2	[redacted]		(b)(6)-2
1731	Tetanus (b)(6)-2	[redacted]		(b)(6)-2

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 20924

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: 22 HEIGHT: WEIGHT: 67 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Inguinal hernia repair

4. PROPOSED SURGICAL PROCEDURE:
I&D (L) shoulder GSW

5. ADDITIONAL INFORMATION: Last PO: 0000 Medical Hx: Ø Implants: Ø Medications: Ø
Jewelry removed: (yes)/no Family waiting: yes/(no)
(+) \ watch

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	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	Ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

MEDCOM - 20925

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	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø 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	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø 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. No dentures	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø 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] 1LT/AN (b)(6)-2 4 OCT 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt. s̄ s/s of distress
Drsg - CDI

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 1LT/AN (b)(6)-2	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 1LT/AN (b)(6)-2
DATE: 4 Oct 03 TIME: 1740	DATE: 4 OCT 03 TIME: 1940

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

MEDCOM - 20926

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the pro[...]y is [...]ffice of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING VIA litter BY anesthesia

2. PATIENT IDENTI[...]ORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 9 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1545 (b)(6)-2 NUMBER 1-2 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], 91D (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted], 66E (b)(6)-2	RELIEF CIRCULATOR INT:	Maj [redacted] - EOC

7. POSITION AND POSITIONAL AIDS *(Specify)* Arms @ side

☑ 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)* Beta / Beta [...]
SITE: (L) Shoulder BY WHOM: (L) [redacted] CPT [redacted]
SITE: BY WHOM: (b)(6)-2
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES

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

C = Correct I = Incorrect

10. COUNTS			Initial Other	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☐ Yes	☐ No	C	/	/	SPC [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	C				
Instrument	☐ Yes	☐ No	/		/	/	/
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

9 OCT 03

[redacted] (b)(2)-2

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

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

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

MEDCOM - 20927

13. PROSTHESIS, IMPLANTS	[ ] Y	NO	IF YES NAME: ID NUMB	ACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*
~~ABD PAD~~ 4x4
Tape
4x8 dsg

19. ADDITIONAL INFORMATION
WC I (b)(6)-2
Surgeon: [redacted]
Anesthesia: Maj [redacted] / General
(b)(6)-2

20. OPERATION(S) PERFORMED
I & D (L) shoulder, DPC

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3 (b)(6)-2 (b)(6)-2	1640	

22. REGISTERED NURSE SIGNATURE
[redacted] MAJ AN / [redacted] CPT/AN

REV[redacted] OF DA FORM 5179-1, OCT 87 MEDCOM - 20928 USAPA V1.00

MEDICAL RECORD — INTRAOPERATI[VE DOC]UMENT

For use of this form, see AR 40-407, the propon[ent agen]cy is the office of The Surgeon General.

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

2. PATIENT IDENTIFI[CATION REC]ORD REVIEWED AND PROCEDURE VERIFIED BY 1LT (b)(6)-2

3. DATE 4 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1820 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: S/P GSW (L) shoulder
NKDA, NPO p̄ (b)(6)-2 0600

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	SPC (b)(6)-2 91D (1905)
ASSIGNED CIRCULATOR	1LT (b)(6)-2 66E	RELIEF CIRCULATOR INT.	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. lateral on padded OR table. RUE on padded arm board - axillary roll (R) axilla LUE on padded arm holder Pillow between legs

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (L) shoulder BY WHOM: 1LT (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES

Pillow

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

LEGEND X Ground Pad -- S[...] === Tourniquet N/A [hatched] - prep

INITIAL: PFC 1LT (b)(6)-2

10. COUNTS

	Yes	No	Other**	First Closing Count	Final Closing Count
Sponge	[X]	[ ]	/	C	C
Needle Sharp	[X]	[ ]	/	C	C
Instrument	[ ]	[X]	/	/	/
Other	[ ]	[X]	/	/	/

C = Correct I = Incorrect

SCRUB: PFC (b)(6)-2, SPC (b)(6)-2 CIRCULATOR: 1LT (b)(6)-2

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

(b)(6)-4

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

[X] ESU NO: VL Force 40 Cut: 30 Coag: 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 68245 Exp 2005-02

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

[ ] BIPOLAR NO:

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

MEDCOM - 20929

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
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

	1.	2.	3.
TYPE/SIZE	1. 3/8" Penrose drain	2.	3.
SITE	1. Ⓛ shoulder wound	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix

19. ADDITIONAL INFORMATION (b)(6)-2
SURGEON: Dr. [redacted]
ANESTHESIA: MAJ [redacted]
(b)(6)-2
GETA WC: III
DA5179 Initiated.

20. OPERATION(S) PERFORMED I&D GSW Ⓛ shoulder

21. PATIENT TRANSFERRED TO PACU | TIME SEE DA 7389 | METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] 1LT/AN

ACLU-RDI 1659 p.92

DOD-034506

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	4 OCT 03	5 Oct	06 OCT 03	07 OCT 03	08 OCT 03	9 OCT 03	10 OCT 03	
19 / HOUR	2312	0938	19 / 1608	2008	2008	1846 / 0800	1657	0800

PULSE (O) / TEMP. F (•): 180 / 104°; 170 / 103°; 160 / 102°; 150 / 101°; 140 / 100°; 130 / 99°; 98.6°; 120 / 98°; 110 / 97°; 100 / 96°; 90 / 95°; 80; 70; 60; 50; 40

TEMP. C: 40.6°; 40.0°; 39.4°; 38.9°; 38.3°; 37.8°; 37.2°; 37.0°; 36.7°; 36.1°; 35.6°; 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

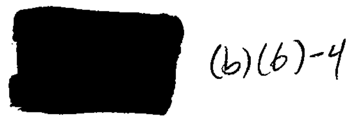
Record special data only when so ordered

BLOOD PRESSURE	128/46		118/64	114/57	160/44	123/50	118/64	127/49	112/47	119/56	109/53	119/56
	60	127/62	61		70		66				30	
	58²		98⁵		98³		98				98.1	
HEIGHT: / WEIGHT →	98% RA	96	98%								97°	
O2				98% (RA)	98%	97% (RA)	96%	98% (RA)	O2 97% RA	95%		99% (RA)
O2 Sat RA									RA			

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

REGISTER NO.

WARD NO.



(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 - 20931

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

LAST, FIRST, MI. (b)(6)-4	DATE 04Oct	TIME 1630	SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

ID: (b)(6)-4 ... 03
WB
17:40

			Patient Limits	
WBC	15.1 H	x10^3/uL	4.5	10.5
RBC	5.55	x10^6/uL	4.00	6.00
Hgb	16.0	g/dL	11.0	18.0
Hct	51.6	%	35.0	60.0
MCV	92.9	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	406.	x10^3/uL	150.	450.
LY%	19.1 *L	%	20.5	51.1
LY#	2.9 *	x10^3/uL	1.2	3.4

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		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 20932

Ward/Section: EMT

REQUESTING PHYSICIAN:

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

LAST, FIRST, MI. (b)(6)-4 | DATE 04Oct | TIME | SSN/PSEUDO SSN: (b)(6)-4

(i-STAT)			(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l
Cl		98-109 mmol/L	ALT		10-47 u/l
pH		7.31-7.45	AMY		14-97 u/l
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl
sO2		95-98%	CHOL		100-200 mg/dl
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl
AnGap		10-20 mmol/L	GLU		73-118 mg/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl
BUN		8-26 mg/dl	(Piccolo) Metlyte 8		
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl
Hct		38-51% PCV	BUN		7-22 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)
TEST	RESULT	REF. RANGE	NA^{+}		128-145 mmol/l
Troponin-I			K^{+}		3.3-4.7 mmol/l
Drug of Abuse			CL^{-}		98-108 mmol/l
			tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE
tCO_2		18-33 mmol/l

```
======= PICCOLO =======
04/10/03              17:40
REFERENCE RANGE:       MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2  3141AA4
OPER #: (b)(6)     DR #: 000
SERIAL #: (b)(6)-4
..........................
GLU    92    73-118   MG/DL
BUN     9    7-22     MG/DL
CRE    1.1   0.6-1.2  MG/DL
CK     900*  39-380     U/L
NA+    130   128-145  MMOL/L
K+     4.1   3.3-4.7  MMOL/L
CL-    101   98-108   MMOL/L
tCO2   20    18-33    MMOL/L

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

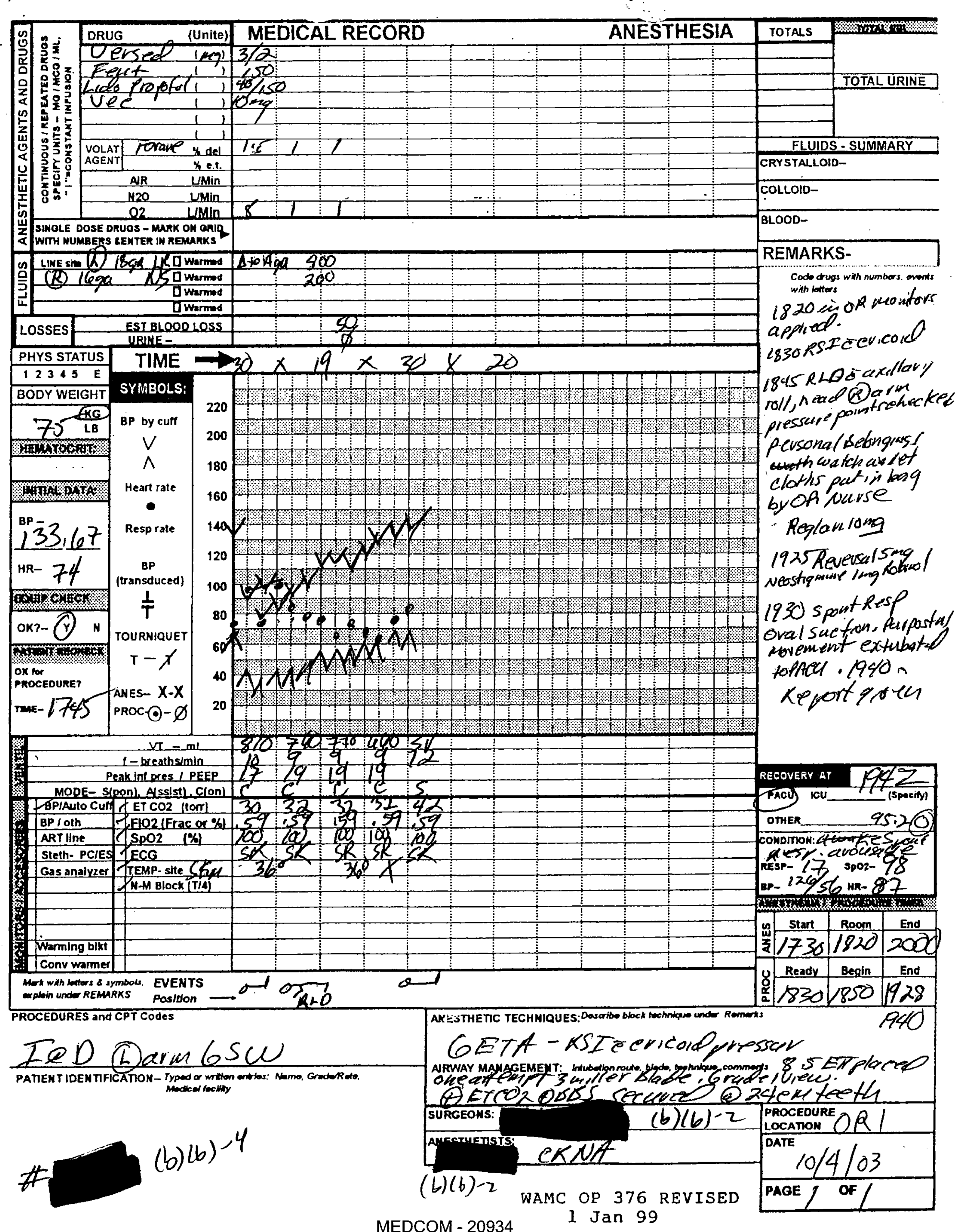
REMARKS:

REPORTED BY: (b)(6)-2 | **DATE:** 10-2-03 | **LAB ID NO.:**

MEDCOM - 20933

ACLU-RDI 1659 p.95

DOD-034509



MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)	
Versed (mg)	3/2
Fent	150
Lido Propofol	40/150
Vec	10mg
VOLAT AGENT Forane % del	1.5
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	8

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

FLUIDS
LINE site (L) 18ga LR ☐ Warmed — 400
(R) 16ga NS ☐ Warmed — 200

LOSSES — EST BLOOD LOSS 50; URINE – 0

PHYS STATUS 1 2 3 4 5 E
BODY WEIGHT 75 KG
HEMATOCRIT:
INITIAL DATA: BP – 133/67; HR – 74
EQUIP CHECK OK? – (Y) N
PATIENT RECHECK OK for PROCEDURE? TIME – 1745

TIME → 30 X 19 X 30 X 20

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

VT – ml	810	740	770	400	SV
f – breaths/min	10	9	9	9	12
Peak inf pres / PEEP	17	19	19	19	
MODE– S(pon), A(ssist), C(on)	C	C	C	C	S
ET CO2 (torr)	30	32	32	32	42
FIO2 (Frac or %)	.59	.59	.59	.59	.59
SpO2 (%)	100	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP- site Skin	36°		36°	X	
N-M Block (T/4)					

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

Mark with letters & symbols, explain under REMARKS — EVENTS; Position → R LD

TOTALS — TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID– COLLOID– BLOOD–

REMARKS- Code drugs with numbers, events with letters

1820 in OR monitors applied. 1830 RSI c cricoid 1845 RLD c axillary roll, head (R) arm pressure points checked personal belongings watch wallet cloths put in bag by OR Nurse

Reglan 10mg

1925 Reversal 5mg Neostigmine 1mg Robinul

1930 spont Resp oral suction, purposeful movement extubated to PACU. 1940 Report given

RECOVERY AT 1942 (PACU) ICU (Specify) OTHER 95.2 (O)
CONDITION: stable spont resp. arousable
RESP- 17 SpO2- 98 BP- 126/56 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1730	1820	2000
	Ready	Begin	End
PROC	1830	1850	1928

1940

PROCEDURES and CPT Codes: I&D (L) arm GSW

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA - RSI c cricoid pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.5 ETT placed one attempt 3 Miller Blade, Grade I View. (+) ETCO2 BBS secured @ 24cm teeth

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

PROCEDURE LOCATION OR 1
DATE 10/4/03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 20934

22 y/o S/P GSW (L) Shldr (?) PMH AX I i D 10/4 GA & Comm. MP II,
NKA Anes 0600, Prev. KPN B1 CTA, Harrgh
II T. NPO p MN VS ?, -64-16 112/47 97% SaO2 RA

MEDICAL RECORD - ANESTHESIA

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

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)						TOTALS
Midazolam (mg)	2.5					2.5
Fentanyl (mcg)	<150>					200
Propofol (mg)	<100>					100
VOLAT AGENT Sevo % del / % e.t.	2.5	3.0	2.5	2.5 X		
AIR L/Min						
N2O L/Min						
O2 L/Min	2	2	2	2	10	

TOTAL EBL: <50
TOTAL URINE: Ø

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

FLUIDS

LINE site 18G (L) AC ☒ Warmed — LR# (900) — 200
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS / URINE -

FLUIDS - SUMMARY
CRYSTALLOID- 300
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
① Pre-op sedation to OR, monitors O2
② SV >8 + <30 BPM To litter + to PACU. Report to nurse. OA removed @ (?) the pt.

PHYS STATUS: 1 ②3 4 5 E
BODY WEIGHT: 75 (KG) LB
HEMATOCRIT: 51 10/4
INITIAL DATA:
BP- 111/58
HR- 72
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE? [redacted] (b)(6)-2
TIME- 1530

TIME ➔ 1545 1600 . 30 . 1700 . 30 . 1800

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	—	500	370	340
f - breaths/min	—	13	10	9
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	—	44	53	54
✓ BP/oth	✓ FIO2 (Frac or %)	0.51	0.51	0.51	0.49
ART line	✓ SpO2 (%)	99	99	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site Available				
	N-M Block (T/4)				
✓ Warming blkt	✓ x 1 Blanket ⟶ ⟶ ⟶				
Conv warmer					

Mark with letters & symbols, explain under REMARKS
EVENTS ① ②
Position: ① Turned 45°

RECOVERY AT 1645
(PACU) ICU ____ (Specify)
OTHER
CONDITION: Stable awake
RESP- 20 SpO2- 98
BP- 143/60 HR- 84

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1545	1650
	Ready	**Begin**	**End**
PROC	1555	1608	1638

PROCEDURES and CPT Codes: I & D & DPL (L) shoulder wound

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] Wd 1 Bed 2C
(b)(6)-4
(b)(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* OA - 10cw

SURGEON: [redacted] (b)(6)-2
A[redacted] CRNA

PROCEDURE LOCATION: 1
DATE: 9 Oct 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 20935 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00
[redacted] (b)(6)-2

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 32 DAYS MOS YRS   Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: ______
SURGICAL SERVICE: ______
NPO SINCE: ______   NPO since 6am

ASA Physical State 1 (2) 3 4 5 E
WT: 75kg KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 2ppd
ETOH: Ø
DRUGS: Ø

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

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

LABORATORY STUDIES:
HB/HCT: 16 / 51.6
U/A: ______
OTHER: ______

130 | 101 | 9 / 92
4.1 | 24 | 1.1

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Inguinal hernia as child
No anesthetic compl.

PHYSICAL EXAMINATION
BP 120/80 HR 66 R 16 T ___
Pain Scale 0-10 ___
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck ______
Oropharynx MP II
Nares ______
CHEST: CTA (B)
CARDIAC: RRR s M/R/G
EXTREMITIES:
IV Access: 19 g
Ulnar Filling: ______
BACK: ______
OTHER: ______

NPO Since ______

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ______ Date: ______ Time: ______ Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ______

[redacted] (b)(6)-4

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

..EDICAL RECORD - DOCTOR'S ORDE...
For use of this form, see MEDCOM Circular 40-5

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
9 Oct 03	1650 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. PRN SaO2 < 95%		
(3)	(Morphine) / Meperidine ~~mg IV now~~ and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
(4)	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x~~		
(5)	Metoclopramide 10 mg IV prn N/V x 1.		
~~6~~	Droperidol ___ mg IV prn N/V x 1.		
~~7~~	Phenergan ___ mg IV prn N/V x 1.		
(8)	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: NS @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] (b)(6)-2 [redacted] (b)(6)-2 CRNA/MAJ		

PATIENT IDENTIFICATION

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

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

Diagnosis: ______

Height: ______ Weight: ______ Diet: ______

Allergies: ______

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE (b)(2)-2 MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4		4 OCT 03 — 1650 HOURS	
	1	ADMIT KW-1	
	2	S/P GSW (L) SHOULDER	
	3	VS ROUTINE	
	4	NPO	
NURSING UNIT / ROOM NO. / BED NO.	5	BED REST	
	6	IV LR @ 125 cc/hr	
PATIENT IDENTIFICATION	7	MSO4 2-8 mg IVP Q 1 HRS HOURS PRN	
	8	TO OR IN AM	
		(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION (b)(6)-4		4 OCT 03 — 1730 HOURS	
	1	TO ICW-1	
	2	S/P GSW (L) SHOULDER	
	3	CONDITION FAIR	
	4	VS ROUTINE	
	5	UP AS WB PER EPW ROUTINE	
NURSING UNIT ICW#1 / ROOM NO. / BED NO.	6	REGULAR DIET	
	7	IV LR @ 125 cc/hr HLOCK	
PATIENT IDENTIFICATION (b)(6)-2		W/W TOLERATE P.O. WATER HOURS	
	8	ANCEF 1 Gm IVP Q 8 HRS	
	9	TYLENOL 650 mg P.O. Q 4 HRS PRN	
	10	PERCOCET 1-2 P.O. Q 4-6 HRS PRN	
	11	MSO4 2-8 mg IVP Q 1-2 HRS PRN	
	12	NPO AFTER MIDNIGHT 5 OCT 03 FOR OR 6 OCT 03	
NURSING UNIT / ROOM NO. / BED NO.			

(b)(6)-2

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

MEDCOM - 20938

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 8Oct03 2000 [redacted] (b)(6)-2		8Oct03 (b)(6)-2 2000 (b)(6)-2 HOURS	
		V.O. Dr. [redacted] / LT [redacted]	
		NPO p MN [redacted]	/AN
		(b)(6)-2	
NURSING UNIT: ICW#1 / ROOM NO.: 2 / BED NO.: C		(b)(6)-2 24° V [redacted] /AN 9Oct03	0100
PATIENT IDENTIFICATION		DATE OF ORDER 10 Oct 03 / TIME OF ORDER 0750 HOURS	
Noted (b)(6)-2 [redacted] 10Oct03 0825	①	Discharge to EPW camp	
	②	Keflex 250 mg Q10 x10 days	
	③	Percocet 1-2 PO Q4-6 hrs prn #20	
	③	Dressing change every other day	
NURSING UNIT / ROOM NO. / BED NO.		(b)(6)-2 [redacted]	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER [redacted] ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 20939

ACLU-RDI 1659 p.101

DOD-034515

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		9 OCT 03 ______ HOURS	
Noted 9 Oct 03 1[illegible]	1	Resume previous orders	
	2	Regular Diet	
	3	IV [illegible] at 150cc/hr. [illegible]	
		[illegible] PO. [illegible]	
NURSING UNIT / ROOM NO. (b)(6)-2 / BED NO.	4	[illegible] NPB q8 hrs x 3 [illegible]	
		[illegible] Keflex 250mg QID PO	

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER	
		(b)(6)-2	
		(b)(6)-2	[illegible]
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, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 20940

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.* 10 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				4	5	6	7	8	9	10						
4		VS: Routine	6	X												
		(b)(6)-2	18													
4		up ad lib per	6	X												
(b)(6)-2		EPW protocol	18													
4		Regular diet	6	X												
		(b)(6)-2	18													
10 Oct 03		DSG change every	10	/	/	/	/	/	/		/		/		/	
(b)(6)-2		other day														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓛ shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 20941 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

Ine 1000 ms Ine 1000

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	(b)(6)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	admit ICW, fair	04 OCT 03	—		[redacted] (b)(6)-2
(b)(6)-2 4	[redacted]	NPO p MN 5 Oct for OR 6 OCT 03	5 OCT	2359	2359	[redacted] (b)(6)-2
(b)(6)-2 8 Oct 03	[redacted]	NPO p MN	9 OCT 03	0001		[redacted] (b)(6)-2
9 Oct	(b)(6)-2 [redacted]	Resume Previous orders	9 Oct	1800	1800	[redacted] (b)(6)-2
10 OCT 03	(b)(6)-2 [redacted]	Discharge to EPW camp				
	(b)(6)-2					

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

USAPA V1.00

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 07 9/8 9 10
4 (b)(b)-2		LR@125cc/hr HL when tol p.o. well	6 18	X — D/C pre-op order
4 (b)(b)-2		Ancef 1 gm IVPB Q8°	6 14 22	X X
9 oct (b)(b)-2		LR @ 150cc/hr Hep lock when taking P.O well	06 18	
9 oct (b)(b)-2		~~Ancef~~ Ancef 1 gm IVPB Q8° x 3 doses then begin	06 14 22	3
9 oct (b)(b)-2		Keflex 250mg QID P.O	06 12 18 24	
10 OCT 03 (b)(b)-2		D/C meds: Keflex 250mg QID Percs 1-2 po q4-6° prn	✓	10 OCT 03 Rx to pharmacy
		PRN meds:		
4 (b)(b)-2		Tylenol 650mg po Q4° PRN	D/T D/I	[illegible entries]
4 (b)(b)-2		Percocet 1-2 po Q4-6° PRN	D/T D/I	[illegible entries]
4 (b)(b)-2		MSO4 2-8mg IVP Q1-2hrs PRN	D/T D/I	

(b)(b)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: GSW (L) shoulder

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

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 20943

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 22 yr

Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 4 Oct 03
Time In: 1949
Allergies: NKDA
Pre-op V/S: 133/67/74
Procedures: 1&D (L) Shoulder GSW

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

OR Intake: Crystalloid 1000 Colloid Ø
OR Output: UOP Ø EBL 50
Meds/Times: 5 mg Versed 100mcg Fent 1940

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SaO2	98	96	98	97	97	98
FiO2						
Methods	RA	RA	RA	RA	RA	RA
RR	27	10	14	16	10	19
T	95.2				96.5	
Time						
Pain (0-10)						
LOS						

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2151	NS LR	900	R fore	IV	100cc

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	Ø	Ø	Ø
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)

(b)(6)-2 [redacted] 91 WM6

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 17

MEDCOM - 20944

Previous edition is obsolete

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	LUE	LRom	+	+	B	W	PK
15'	LUE	LRom	+	+	B	W	PK
30'							
45'							
60'							
90'							
D/C	LUE	LRom					

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 1949	(L) Shoulder	Bulky	Ø
30' 2149	(L) Shoulder	Bulky	Ø
60'			
D/C	(L) Shoulder	Bulky	Ø

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2135	NSR	Ø	Ø

NURSING NOTES

Pt Admitted to PACU @ 1749. S/P I&D (L) Shoulder PARS 8 O_2 97 on RA. Dressing CDI Pt still unconscious, arousable to painful stimuli ——— SPC (b)(6)-2

Pt Transferred to ICW by SPC (b)(6)-2 via Litter report given to LT (b)(6)-2. PARS 10 x 9 ——— SPC (b)(6)-2

Discharge Criteria:

Date: 11 Oct 02 Time: 2135 PARS: 9

BP: 125/58 T: HR: 60 RR: 20 Sa02: 98

Pain Level at D/C (0-10): Ø

Intake: 100cc NS Output: Ø

Additional Data: Ø

Transferred To: ICW

Report Given To: LT (b)(6)-2

Transferred Via: W/C (Litter) Gurney Ambulance

Transferred By: SPC (b)(6)-2

MEDCOM - 20945 V Recovery (b)(6)-2

MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1712	Holen	2mg MSO4	IV			[redacted] (b)(6)-2

NURSING NOTES

Male Iraqi EPW admitted to PACU S/P I+D © shoulder closure 130/98 RA VSS. IV Ⓛ Arm NS@TKO Patient Pt A+O. —— [redacted] SSG/CN (b)(6)-2

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?

Discharge Criteria:
Date: [illegible] 03 Time: 1720 PARS: 10
BP: 143/61 T: HR: 70 RR: 20 Sa02: 98
Pain Level at D/C (0-10):
Intake: Output: Ø
Additional Data: [illegible]
Transferred To: ICW 1
Report Given To: 1LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

ACLU-RDI 1659 p.108

DOD-034522

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: 9Oct03 Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block (Mask)

Time In: 1650

Allergies: NKDA OR Intake: Crystalloid 200cc Colloid

Pre-op V/S: 4/58 72 OR Output: UOP Ø EBL 450cc

Procedures: I+D shoulder dosure Meds/Times:

ASA II
75kg
HCT 51
200mg Fent
2.5 Ver

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1650	1655	1700	1715	1730
SaO2	97	98	98	98	98
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140	^	^	^	^	
					^
120					
100					
80	•				
		•	•	•	
60	V	V		V	•
			V		V
40					
20					
RR	25	14	16	28	15
T	97				
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

V/S: X = A-line BP, ˆ = Cuff BP, • = Pulse

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

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

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

(Continue on reverse)

PREPARED BY [redacted] (b)(6)-2 DEPARTMENT/SERVICE/CLINIC [signature] DATE 09Oct03

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

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

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

(b)(2)-2

Admission and Coding Information

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

Field	Value
1. Reporting MTF	0580 [redacted]
2. MTF Loca.	IZ
3. Register Number	[redacted] (b)(6)-4
Name (Last, First, MI)	[redacted] (b)(6)-4
4. Pay Grade	
5. Sex	M
6. DoB (YYYYMMDD)	[redacted]
7. Age at Admission	22Y
8. Race	Z
9. Ethnicity	Z
Religion	UNKNOWN
10. Length of Service	ETS
11. FMP	20
12. Social Security Number	[redacted] (b)(6)-4
Organization (Active Duty Only)	
13. Marital Status	Z
Hour of Admission	14:33
Branch / Corps:	
14. Flying Status	N/A
15. Beneficiary Category	K78-PRISONER OF WAR/INTERNEES
16. Zip Code of Residence:	
17. Unit Location	IZ
18. MOS	
19. Trauma	DIS
Prev. Admission	NO
20. Source of Admission	Direct from ER
Ward:	ICW1
Name / Relationship of Emergency Addressee	
Address of Emergency Addressee	
Name and Location of Medical Treatment Facility:	0580 [redacted] Iraq; No Install Provided (b)(2)-2
Telephone Number of Emergency Addressee	
21. Type of Disposition	TRF-OTH
22. MTF Transferred To	
23. Date of Disposition (YYYYMMDD)	2003-10-10
24. Clinic Svc - Admitting	AEA - ORTHOPEDICS
25. MTF Transferred From	
26. Date this Admission (YYYYMMDD)	2003-10-04
27. Location of Occurrence	
28. MTF of Initial Admission	
29. Date of Initial Admission	2003-10-04

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW LEFT SHOULDER

880.00
E991.2
83.65

Procedure Narrative(s):

Cause of Injury Narrative:

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

[redacted]e of Admitting Clerk (b)(6)-2

MEDCOM - 20948

Automated Facsimile DA FORM 3025 MAR 2000

9	10	11	12	13	14	15	4. PAY GRADE 16	17	5. SEX 18

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

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

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

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

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

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

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

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

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

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

FOR LOCAL USE

Dx. 88000 E9612   Pr 8604

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

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

Ing Trauma

[redacted] (b)(6)-4

MEDCOM - 20949

Automated Facsimile
(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name (b)(6)-4	3. Grade FGN	Admission Remarks
4. Sex M	5. Age 35Y	6. Race X	7. Religion ISLAMIC
8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 20	12. SSN	13. Organization (b)(6)-4	14. Ward ICW1
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER	18. BranchCorps	19. UIC / ZIP
20. Type Case DIS			
21. Source of Admission Direct from ER	22. Hour Of Adm: 14:33	23. Clinic Service AEA - ORTHOPEDICS	
24. Name/Relation of Emergency Addressee	25. Type Disp HOME	26. Date of Disp 2003-10-10	
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm: 2003-10-04	AdmittingOfficer: (b)(6)-2
29. ReportingMTF 0580 Iraq (b)(2)-2		30. Date Init Adm 2003-10-04	32. Units Blood Components

31. Selected Administrative Data

Marital Status: Z — DoB:

In/Out Patient: Inpatient — MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

I & D R SHOULDER

880.10
E991.2

86.28 (10/4/03)
81.96 (10/4/03)
86.28 (10/8/03)
86.59 (10/8/03)

DX 88010 E9912
PROC 8628 8659.

I IN
0 450

35. Total Days This Facility

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

35. Total Days This Facility

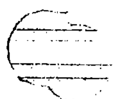
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
		(b)(6)-2			

Signature of Attending Medical Officer (b)(6)-2

...f PAD or Medical Records Officer (b)(6)-2 MAJ (b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 20950



MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

35 Y.O. Iraqi ↑ shot in (R) shoulder with an M-16 today. Admitted for I&D

(-) PMH

(-) ROS

NKDA

(b)(6)-2

(-) Tobacco [redacted] 0900

PHYSICAL EXAMINATION

Heart - WNL

Lungs - Clear

Chest - CTA

Ext 1x1 cm wounds x 2, over (R) anterior shoulder, N/V intact.

X-rays fragments (R) shoulder probably extending into GH joint.

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

(A) GSW - (R) shoulder

(B) I&D (R) shoulder

(b)(6)-2

SIGNATURE [redacted] | DATE 9 Jul 03 | IDENTIFICATION NO. | ORGANIZATION

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

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4OCT03@1930	Pt admitted from EMT GSW (R) shoulder. (L) AC c LR @ 125cc/hr. NPO. Interpreter explained NPO status & OR tonight. (R) shoulder 4x4 dsg applied to entrance wound. no exit wound noted VSS. Plan: monitor until OR. [redacted] (b)(6)-2
4OCT03@1945	Pt released to OR staff. Placed on litter. (b)(6)-2 [redacted]
4OCT03@ 2300	Pt received from PACU, placed in bed, 2pt restraints on s s/sx of skin/circulation compromise. Drowsy, but awakens to verbal stimuli. LS CTA, Sats 97% RA. (L) AC IV intact c LR@125cc/hr. (+) BS, due to void by 0600. Tol sips of po H_2O. (R) shoulder c bulky dsg CDI, sling & swath in place. (+) CMS to RUE. Plan: monitor pain, monitor NV status, IV abx as ordered. (b)(6)-2 [redacted]
5OCT03 0900	VSS alert & Oriented Consume Regular diet for breakfast Tolerated well. (L) AC IV Saline Lock pat[illegible]/intact. (R) Shoulder dsg dry & intact c sling/swath in place. Lungs clear BS (+) x 4 quad. Abd. soft non distended Peripheral [illegible]

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

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

(b)(6)-2 [redacted] 2471

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.

(Continued)

[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)
5 OCT 03	(continue)
0900	pulses palpable. Refused to ambulate @ this time. Will attempt again later. Will continue plan of care (b)(6)-2 [redacted]
5 OCT. 03 2015	Pt resting in bed, A+O X3, VSS, denies pain @ this time, LS CTA (B), ⊕ BSx4, dsg on (R) shoulder CDI, SL (L) AC intact, tolerating PO well, able to [redacted] (b)(6)-2 move fingers (B), radial pulse equal (B), voiding s̄ diff, abd soft flat non tender. ø s/sx of poor circulation or skin breakdown on pts of restraint. (b)(6)-2 [redacted]
6 OCT 03	(1700) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. Drsg to (R) shoulder cdi. staples intact. Penrose drain draining small amount sero.sang drainage. Ace wrap in place around (R) arm to immobilize. Pt OOB to BR this am for personal hygiene. Amb. well. Pt able to move fingers on (R) hand. Cap refill <3secs. SL in (L) forearm flushes well s̄ s/sx infection/infiltration. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx ~~infection~~ [redacted] (b)(6)-2 complications. Will continue to monitor. (b)(6)-2 [redacted]
6 OCT. 03	Pt awake, speaking arabic, VSS, c/o pain + headache, medicated c̄ 2 percs as per orders, dsg (R) shoulder CDI, pt OOB to BR, ambulates s̄ diff., SL (L) FA patent, flushes well, ø s/sx of infex or infiltration, pt able to move fingers

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4Oct03	(S) Shot by US Forces attempting to control a riot of >30,000 Iraqi civilians. Was seen throwing rocks at Iraqis and coalition forces trying to control the mob.
	(O) VS taken at the scene were stable - not recorded by medics (91W) - thru & thru GSW to (L) dorsal shoulder & back with sig (?) deltoid tissue damage
	dressed c̄ gauze bandage
	A/P (1) GSW (L) dorsal shoulder
	- x-rays taken demonstrate ∅ intraarticular trauma and no fx of (L) shoulder
(b)(2)-2	- pt transported to [redacted], and transferred to orthopedic surgeon's care.
	(b)(6)-2 [redacted]
	(b)(6)-2 CPT [redacted] MD
	[redacted] PROFIS surgeon
	(b)(2)-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.)*

[redacted] (b)(6)-4

[redacted] (b)(6)-2

[redacted] (b)(6)-4

[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 - 20954

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
	Ortho Op Note
4 OCT 03	Pre-Op Dx - GSW (R) shoulder with
2145	intra-articular fragment
	Post Op Dx - Same
	Procedure: I+D (R) shoulder with arthrotomy
	Surgeon: [redacted] / [redacted] (b)(6)-2
	EBL - 400 cc (b)(6)-2
	Fluids - 1300 crystalloid.
	Findings - 2 GSWs to (R) shoulder, through deltoid, into gleno-humeral joint. 2 of three fragments removed. Extra-articular fragment not found. Capsular wound extended to improve joint irrigation. No bony involvement of joint surface. Irrigated 6 liters. Closed over penrose drain, after closing capsule extension with #2 ethibond.
	Plan: IV antibiotics, observation, sling and swath. Consider repeat I+D

(b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED [redacted] (b)(6)-2

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
Cont.	cap ref <3 sec, radial pulses equal (B), ø skin breakdown or poor circulation on pts of restraint.
	(b)(6)-2 [redacted] 91W
	(b)(6)-2 [redacted] CRP
Ø7OCTØ3	(1650) Assumed care of pt @ Ø6ØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain Drsg to (R) shoulder Δd this am. Ace wrap in place to immobilize (R) arm. SL in (L) forearm flushes well s̄ s/sx infection/infiltration. Amb well. Tol reg diet. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
7OCT.Ø3 2015	Pt asleep but easily aroused, denies pain, IV SL (L) FA intact, flushes well, ø s/sx of infex or infiltration, dsg on (R) shoulder CDI, sling + swath in place to immobilize arm, voiding well, cont. abx therapy, 2 pt restraint in place, ø s/sx of poor circulation or skin breakdown.
	(b)(6)-2 [redacted] 91W
	(b)(6)-2 [redacted] CRP

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

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 20956

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 Oct 03 0715	Ortho Op Note
	Pre Op Dx - GSW (R) shoulder
	Post Op Dx - Same
	Procedure - I+D (R) shoulder
	EBL - min Surgeon (b)(6)-2
	Findings - Wound clean, down to capsule. No necrotic tissue. Closed in layers over a penrose drain
	(b)(6)-2
	(b)(6)-2
	CB2
Ø8OCTØ3	(1645) Assumed care of pt @ ØØØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt to OR this am for I&D (R) shoulder. Drsg CDI. Ace wrap in place to immobilize (R) arm. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2
8Oct03	1900 = VSS, A+O x3, Ø C/O pain, Dsg to (R) shoulder CDI c̄ Ace wrapped around chest & back intact, IV HL 18G to (L) FA flushed & patent, Continuing IV Antibx around the clock, up ad lib s̄ difficulty, UOP adequate, tolerates PO, x2 restraints when in bed, (-) skin breakdown, will

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

MEDCOM - 20957

ACLU-RDI 1659 p.119

DOD-034533

MEDICAL RECORD	PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
8Oct03@	1900 (continued) ~~Will~~ continue to monitor. (b)(6)-2 [redacted]
9Oct03@ 0800	VSS Alert & Oriented. OOB ambulated to BR. Tolerating Regular diet. (L) FA Saline lock patent & intact. (R) Shoulder Drsg dry & intact. Sling & swath in place to (R) Shoulder. Peripheral pulses +2 (R) hand fingers capillary refill < 3 sec. Lungs clear bilateral. Abd soft non distended BS (+) X4 quad. Will continue care as planned (b)(6)-2 [redacted]
9OCT03 2035	VSS. AO. (+) pulse to RUE & CMS intact. DSG intact to (R) shoulder. Voiding [illegible] urine quantity sufficient. All other systems WNL. Applied warm compress to LUE c tenderness @ infiltration site. (b)(6)-2 [redacted]
10OCT03	(1025) Assumed care of pt @ 0800 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Drsg to (R) shoulder D/C this am by MD. Staples CDI. Ace wrap in place to immobilize (R) arm/shoulder. SL in (L) forearm flushes well s s/sx infiltration/infection. (L) forearm remains swollen/tender @ old IV site. Pt OOB to BR for personal hygiene. Amb well. Tol. reg diet well. Voiding s

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)

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICW#1

PROGRESS NOTES
Medical Record

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

MEDCOM - 20958

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10OCT03 (1025)	(cont) difficulty. 2 point restraints in place s̄ s/sx complications. Awaiting D/C to EPW camp. Will continue to monitor. (b)(6)-2 [redacted]
	(1620) D/C to camp - ambulatory - escorted by MPs. (b)(6)-2 [redacted]

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

MEDCOM - 20959

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
	Ortho Discharge Note
10 Oct 03	
	35 y/o: sustained GSWs to (R) shoulder 4 oct 03. Taken to OR, fragments removed from gleno-humeral joint and I+D done. Capsule closed. Repeat I+D 8 oct 03. Wound clean, closed over a drain. Drain removed 10 oct 03. Discharge today.
	PLAN: Dressing change every other day. Staples out 7 days. Keflex 250 mg Q 6 x 10 days. #46. Percocet 1-2 PO Q 4-6 hrs prn #20 Sling and swath x 3 weeks.
	(b)(6)-2 [redacted]
	[redacted] (b)(6)-2
	COL MC

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 20960

NSN 7540-01-075-3786

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

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION [redacted] (b)(6)-4

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 4 Oct 03 | TIME 1458

TRANSPORTATION TO FACILITY

SEX M

AGE 35

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 pt denies

ALLERGIES pt Denies

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

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

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

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

INITIALS

VITAL SIGNS					
TIME	1444				
BP	123/72	121/69			
PULSE	91				
RESP	16				
TEMP	98.1				
WT	75				

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 | ACUTE ABDOMEN | SINUS | ANKLE R/L | C-SPINE | LS SPINE | HEAD CT | X (R) arm

ORDERS

☒ PULSE OX 100%

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	CO	TIME	PATIENT'S RESPONSE
1458 (b)(6)-2	(b)(6)-2 [redacted]	[redacted]	[redacted]		(b)(6)-2
1606	[redacted]		(b)(6)-2		(b)(6)-2
(b)(6)-2		(b)(6)-2			

DISPOSITION ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

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

AP Lido ? Scapula view R shoulder

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 - 20961

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC		SUP 02	PH	P02	RESULTS	
	H/H		PC02	SAT	OTHER		
	PLT		U/A DIP			EKG INTERPRETATION	
PT			U/A MICRO				
APTT	BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

See ortho admit note

(b)(6)-2

[redacted] DO (b)(6)-2
MAJ, MC
FP/Spt

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

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 - 20962

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: 35
HEIGHT: 74 cm
WEIGHT: 75 kg

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

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

4. PROPOSED SURGICAL PROCEDURE:
I & D Rt. Shoulder

5. ADDITIONAL INFORMATION: Last PO: 1000 hrs Medical Hx: Ø 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 X Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. o Maintain family interface.
B. AERATION X Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT X Potential impairment of skin integuity due to bovie pad; position; fluid shift	Ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

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

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

MEDCOM - 20963

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ɸ 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. ɸ Check that safety straps are correctly applied. ɸ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ɸ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	ɸ Pt. will be transferred to OR table without difficulty. ɸ Pt. will not experience unnecessary physical discomfort.	ɸ Have sufficient people available for transfer. ɸ Insure proper body alignment. ɸ Allow patient to lie in position of comfort while waiting for surgery. ɸ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ɸ Pt. will be made aware of surroundings prior to anesthesia induction. ɸ Pt. will be transferred safely to OR table. ɸ Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	ɸ Introduce self. Keep pt. informed as to where he/she is and what is happening. ɸ Inform pt. in which direction to move and assist if necessary. ɸ Speak clearly and slowly. ɸ Address pt. from either side. ɸ Validate pt.'s understanding of verbal communications. little or no English 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.

(b)(6)-2 [redacted] CPT/AN 4 Oct 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: intact
Dsg.: C&D
Resp: Spontaneous

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

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

DATE: 4 Oct 03 TIME: [redacted]5

MEDCOM - 20964

13. ~~PRE~~ post OPERTIVE EVALUATION PREPARED BY (Signature and Title)

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

DATE: 4 Oct [redacted] TIME: 2154

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFICATION REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 4 Oct 03 TIME PATIENT ARRIVED IN SUITE 1949

4. PATIENT IN ROOM TIME 1949 (b)(6)-2 [redacted] NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n

SITE: Rt. arm & shoulder BY WHOM [redacted]

SITE: BY WHOM (b)(6)-2

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES

90° 90°

LEGEND X Ground Pad -- Safety Strap === Tourniquet (b)(6)-2

10. COUNTS

C = Correct I = Incorrect Initial C [redacted] / [redacted] (b)(6)-2

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

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

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

EPW

Age 35

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

☒ ESU NO: Force 40 RBB 10239S 50/50

GROUND PAD: BRAND REM Valleylab

LOT NO: 68245

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 20965

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 [X]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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

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

16. LABORATORY SPECIMENS

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

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

	1.	2.	3.
TYPE/SIZE	3/8" Penrose		
SITE	Rt. shoulder		

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
ABD
~~Coverall~~ Tape Ace swathe

19. ADDITIONAL INFORMATION

Surg: [redacted] (b)(6)-2 Anesth: [redacted] (b)(6)-2 CRNA Type: General

20. OPERATION(S) PERFORMED

I&D Rt. Shoulder GSW

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	2256	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN (b)(6)-2

REVERSE OF DA FO[redacted]79-1, OCT 87 USAPA V1.00

MEDCOM - 20966

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: [illegible]

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

3. DATE: 08 OCT 03 — TIME PATIENT ARRIVED IN SUITE: —

4. PATIENT IN ROOM TIME: 0600 NUMBER: 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt placed on padded OR table c̄ Ⓛ arm on armboard

8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify): Beta / Beta
SITE: Ⓡ shoulder BY WHOM: [redacted]
SITE: BY WHOM: (b)(6)-2
COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES

(b)(6)-2 [redacted] (b)(6)-2 [redacted] N/A

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

10. COUNTS

C = Correct I = Incorrect

	Yes	No	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: (b)(6)-2 [redacted]

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

COMMENTS:

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

[redacted] (b)(6)-4

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

☒ ESU NO: R8B 10239 S 30/30
GROUND PAD: BRAND: Valleylab
LOT NO: (2005-01 Exp) 7011

☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 20967

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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2. 3/16" [redacted] (b)(6)-2	3.
SITE	1. (R) shoulder	2. (R) s	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
staples

19. ADDITIONAL INFORMATION
[redacted] (b)(6)-2
[redacted] (b)(6)-2
Pt c̄ blisters (tape) noted preop (R) axillary near nipple.
Dressing D+I
Postop Bone site D+I
Sleepy
[illegible]

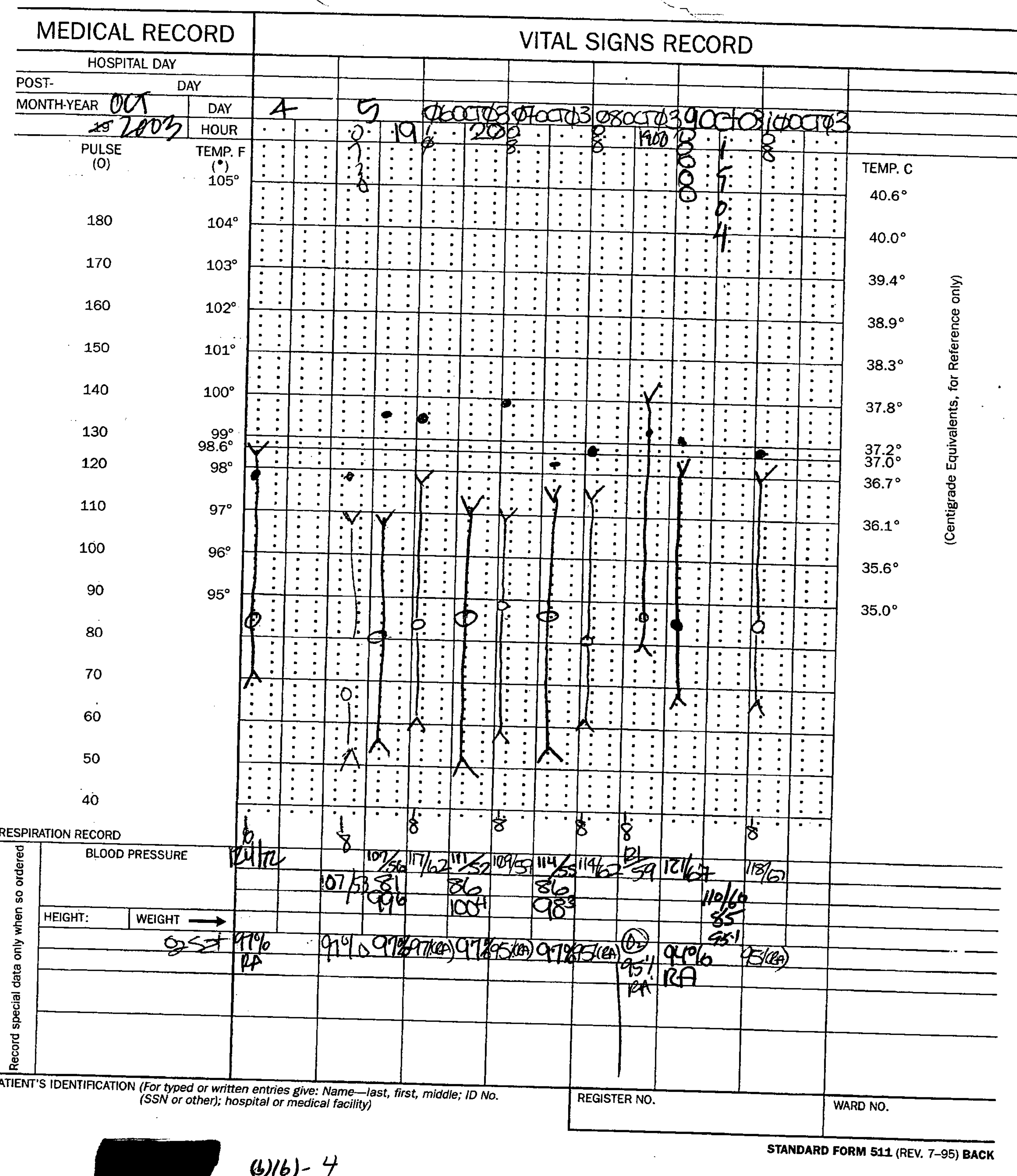
20. OPERATION(S) PERFORMED
I+D (R) shoulder

21. PATIENT TRANSFERRED TO PACU TIME 0645 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT (b)(6)-2

REVERSE OF DA FORM [redacted] OCT 87 USAPA V1.00

MEDCOM - 20968



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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

(b)(6)-4

MEDCOM - 20969

Ward/Section: Emt

REQUESTING PHYSICIAN: (b)(6)-2

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

LAST, FIRST, MI. # (b)(6)-4

DATE: 4 Oct

TIME: 1700

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		

(b)(6)-4

ID:
WB

04-10-03
17:48

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.25	x10^6/uL	4.00	6.00
Hgb	12.8	g/dL	11.0	18.0
Hct	39.6	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	61. L	x10^3/uL	150.	450.
LY%	18.3 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

(Hem...)

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
...et		Negative
		N/A
		Negative
		N/A
		Negative
		0.2-1.0
		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 4 Oct 03

LAB ID NO.:

MEDCOM - 20970

ACLU-RDI 1659 p.132

DOD-034546

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-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
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
A		
A		
A		
A		
A		
T		
B		
C		
C		
C		
C		
T		

```
======= PICCOLO =======
04/10/03            17:47
REFERENCE RANGE:      MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #             DR #: 000
SERIAL #:
.........(b)(6)-4..........
GLU    100   73-118    MG/DL
BUN     13   7-22      MG/DL
CRE    1.0   0.6-1.2   MG/DL
CK     802*  39-380    U/L
NA+    131   128-145   MMOL/L
K+     4.0   3.3-4.7   MMOL/L
CL-    104   98-108    MMOL/L
tCO2    21   18-33     MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
Y		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 4/10/03	LAB ID NO.:

MEDCOM - 20971

(b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICAN	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. # (b)(6)-4 DATE 5070B TIME 0500 SSN/PSEUDO SSN: (b)(6)-4

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
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 x10³ verified
Lymph %		20.5-51.1%

Segs	71	Mono	8
Bands	4	Eos	1
Lymph	14	Baso	
Atyp	2	Imm	

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

Urinalysis

TES	
Colc	
App	
Glu	
Bili	
Ket	
SG	
Bld	
pH	
Pro	
Uro	
Nit	
Leu	
HC	
Cell Count	
Directigen		Negative

(b)(6)-4

ID: WB

05-10-03 05:04

			Patient Limits	
WBC	8.9	x10^3/uL	4.5	10.5
RBC	4.16	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	38.5	%	35.0	60.0
MCV	92.5	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	33.0 L	g/dL	33.0	37.0
Plt	188.	x10^3/uL	150.	450.
LY%	21.2 *	%	20.5	51.1
LY#	1.9 *	x10^3/uL	1.2	3.4

Misc. Serology

TEST	RESULT	REF. RANGE
		Negative
		Negative

Microbiology

ce		
n		
Bld		Negative
ylori		Negative
o sites		
aria		
P		
er		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 20972

Ward/Section: ICW 1 | REQUESTING PHYSICIAN: (b)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. (b)(6)-4 | DATE 6 OCT 03 | TIME 0450 | SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph

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

Urinalysis

(b)(6)-4

ID [redacted] 06-10-03
WB 05:03

			Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	4.37	x10^6/uL	4.00	6.00
Hgb	13.2	g/dL	11.0	18.0
Hct	40.7	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	30.1	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	190.	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	——	x10^3/uL	1.2	3.4

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDICAL RECORD - ANESTHESIA

For u[redacted] is form, see AR 40-66; the proponent agency is th[redacted]

NKVH (b)(6)-2

DRUG (Units)									TOTALS
Propofol (mg)	200								200
Sux (mg)	80								80
Fentanyl (mcg)	<200>			50					250
MSO4 (mg)			6	4	4				14

TOTAL EBL: 250 (b)(6)-2

TOTAL URINE: Ø

VOLAT AGENT Iso % del	1.5	1.5	2.0	2.0	1.5	1.5	1.0	X	
AIR L/Min									
N2O L/Min									
O2 L/Min	10	2	2	2	2	2	2	2	10

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

FLUIDS: LINE site 18G (L) A ☐ Warmed — LR#1, #2

LOSSES: EST BLOOD LOSS 50, 100, 200; URINE - Ø

FLUIDS - SUMMARY
CRYSTALLOID- 1200 mL
COLLOID- Ø
BLOOD- Ø

REMARKS (b)(6)-2
Code drugs with numbers, events with letters PLTs 610[redacted]
1. Pre-op assessment Phenergan 25mg IV
2. OR, monitors, O2, induced, eyelids taped, OG + soft bite block
3. TV > 4ml/kg; RR > 8 + < 30 BPM. Responsive. OP suctioned. Extubated s complications
4. TO PACU Report to nurse

PHYS STATUS: (1) 2 3 4 5 (E)
BODY WEIGHT: 75 (KG)
HEMATOCRIT: 39
INITIAL DATA: BP- 131/80; HR- 84
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK OK for PROCEDURE? [redacted] (b)(6)-2
TIME- 2130

TIME: 1945, 2000, 30, 2100, 30, 2200

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

8.7 / 12.8 / 34.6 (61 [redacted]) [redacted] (b)(6)-2

VENTIL									
VT - ml	720	720	750	750	750	750	560	500	270
f - breaths/min	8	10	10	9	8	8	6	6	10
Peak inf pres / PEEP	—	17	18	18	18	19	16	13	X
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S

MONITORS/ACCESSORIES										
✓ BP/Auto Cuff	ET CO2 (torr)	40	36	34	30	30	31	35	43	60
✓ BP/oth	FIO2 (Frac or %)	0.57	0.57	0.57	0.57	0.58	0.58	0.58	0.54	0.50
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	available		Axial 35.3	35.2	35.3	35.1	35.2	35.1	X
	N-M Block (T/4)	BS	+							
✓ Warming blkt	X1 Wool Blkt									
Conv warmer										

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

RECOVERY AT 2154
(PACU) ICU ___ (Specify)
OTHER T-95.1
CONDITION: Stable, OA
RESP- 20 SpO2- 98%
BP- 170/64 HR- 67
ANESTHESIA / PROCEDURE TIMES T-95.1 Ax

	Start	Room	End
ANES	1930	1945	2205
	Ready	Begin	End
PROC	1955	2022	2135

PROCEDURES and CPT Codes: I+D (R) shoulder

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA RSI c cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 MAC 3 Grade I view 8.0 OETT stylette, 23 cm, Ø teeth + BBS, sust ETCO2, 10mL air cuff

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

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

ANESTHETIST: [redacted] CRNA/ (b)(6)-2

PROCEDURE LOCATION: 2(2)
DATE: 4 Oct 03
PAGE 1 OF 1

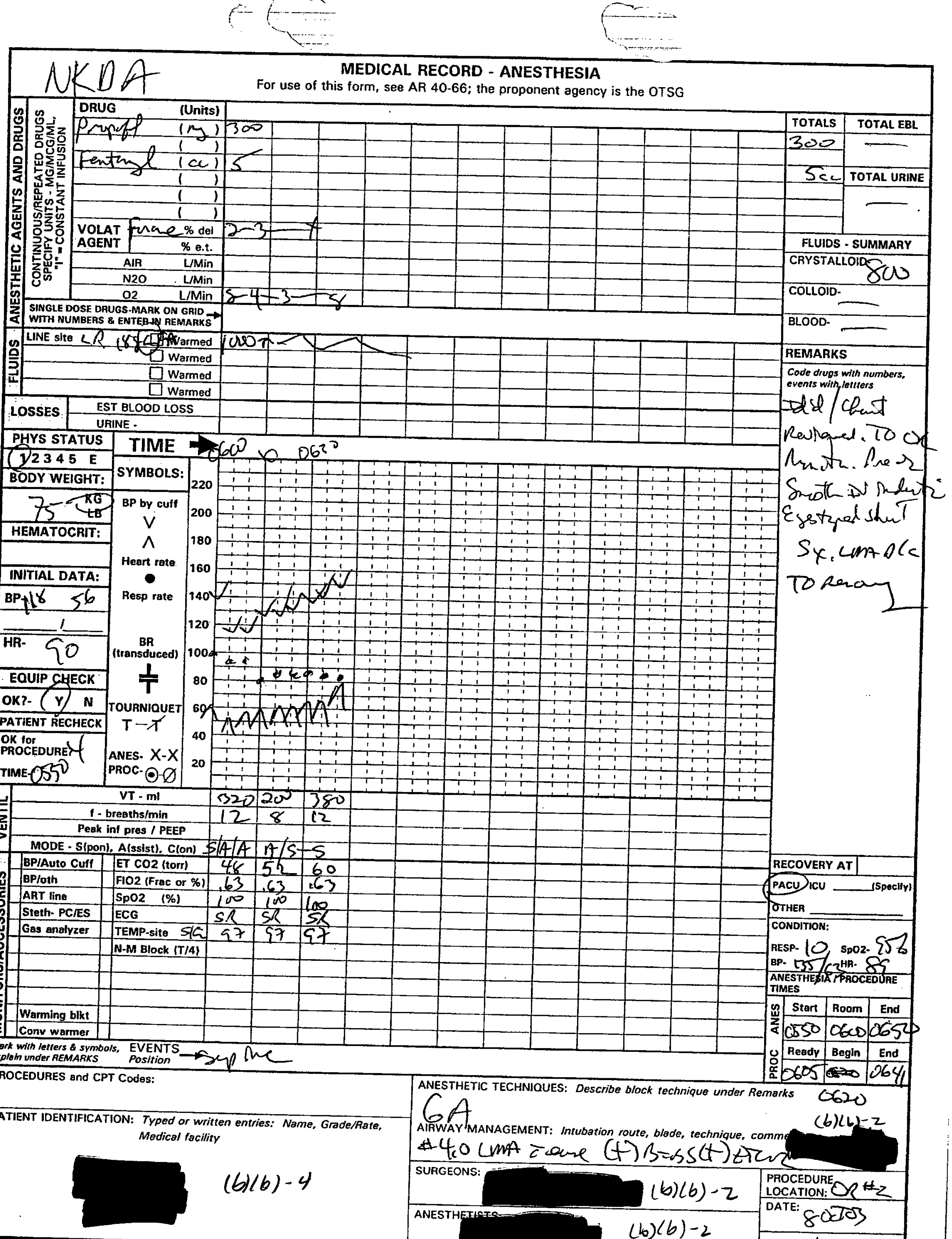
DA FORM 7389, FEB 1998 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

(b)(6)-2

MEDCOM - 20974

ACLU-RDI 1659 p.136

DOD-034550



NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)		TOTALS
Propofol (mg)	300	300
Fentanyl (cc)	5	5cc
VOLAT AGENT Forane % del	2-3	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	8-4-3-8	

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

TOTAL EBL: —

TOTAL URINE: —

FLUIDS — LINE site LR 18g [illegible] Warmed: 1000

Warmed / Warmed / Warmed

LOSSES — EST BLOOD LOSS; URINE -

FLUIDS - SUMMARY
CRYSTALLOID- 800
COLLOID- —
BLOOD- —

REMARKS
Code drugs with numbers, events with letters
Id'd / Chart Reviewed. TO OR Monitors placed Smooth IV Induction Eyes taped shut Sx. LMA d/c TO Recovery

PHYS STATUS: (1) 2 3 4 5 E

TIME: 0600 0620

BODY WEIGHT: 75 KG

HEMATOCRIT:

INITIAL DATA:
BP- 118/56
HR- 90

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE ✓ TIME- 0550

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

VENTIL

VT - ml	320	200	380
f - breaths/min	12	8	12
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	S/A/A	A/S	S

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

ET CO2 (torr)	46	52	60
FIO2 (Frac or %)	.63	.63	.63
SpO2 (%)	100	100	100
ECG	SR	SR	SR
TEMP-site S/G	97	97	97
N-M Block (T/4)			

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

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

CONDITION: RESP- 10 SpO2- 95 BP- 135/[illegible] HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0550	0600	0650

	Ready	Begin	End
PROC	0605	0620	0641

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4.0 LMA [illegible] (+) BBS(+) ETCO2 (b)(6)-2

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

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2

PROCEDURE LOCATION: OR #2

DATE: 8 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 20975 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: I&D (R) shoulder
SURGICAL SERVICE: ortho
NPO SINCE: NPO since 10am

ASA Physical State (1) 2 3 4 5 (E)
WT: 75 KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: Ø

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

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

LABORATORY STUDIES:
HB/HCT: ___ / ___
U/A:
OTHER:
8.7 > 12.8 / 39.6 < 61

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	(N)	Y	denies
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	Ø hepatitis
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	denies
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 127/72 HR 91 R 16 T ___
Pain Scale 0-10 ___
HEENT - Teeth poor dentition
Trachea midline
MP III TMJ/Neck FROM
Oropharnyx
Nares
CHEST: CTA (B)
CARDIAC: RRR S M/R/G
EXTREMITIES:
IV Access: 18G (L) A
Ulnar Filling:
BACK:
OTHER:

NPO Since ___

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

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

The pa[redacted] (b)(6)-2 [redacted]derstand and agrees. Questions answered.
Sig[redacted] CRNA/MAJ Date: 4 OCT 03 Time: 2000 Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

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

SEDATION KEY:

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

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

MEDCOM - 20976

PATIENT RECORD COPY

Previous edition is obsolete

518-124

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4159

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of* ____ *units)*
- [ ] CRYOPRECIPITATE *(Pool of* ____ *units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)*

VOLUME REQUESTED *(If applicable)* 1 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 04Oct03

DATE AND HOUR REQUIRED 1740 04Oct03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)* B

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to ® shoulder

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 04Oct03

TIME VERIFIED 1740

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO / Rh

RECIPIENT: ABO A / Rh POS

TEST INTERPRETATION: ANTIBODY SCREEN | CROSSMATCH

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4Oct03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)* [ ] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

SEX M | WARD EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 20977

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
10-07-03	2200 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. PRN SaO2 < 95%		
(3)	(Morphine) / Meperidine ~~___mg IV now~~ and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
~~4~~	~~Zofran ___mg IV prn N/V q 15 min, may repeat x ___.~~		
(5)	Metoclopramide 10 mg IV prn N/V x 1.		
~~6~~	~~Droperidol ___mg IV prn N/V x 1.~~		
~~7~~	~~Phenergan ___mg IV prn N/V x 1.~~		
(8)	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] (b)(6)-2 [redacted] CRNA/MAJ (b)(6)-2		

PATIENT IDENTIFICATION

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

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

Diagnosis: ______

Height: ______ Weight: ______ Diet: ______

Allergies: (b)(2)-2

Nursing Unit	Room No.	Bed No.	Page No.
PACU, [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 OCT 03 — TIME OF ORDER: 1659 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit KW-1
2. Dx - GSW (R) shoulder
3. Condition stable
4. VS - routine
5. Bed rest
6. NPO
7. IV LR @ 125 cc/hr
8. To OR tomorrow
9. MSO4 2-8 mg IVP Q 1 hr PRN

[redacted] (b)(6)-2

PATIENT IDENTIFICATION — NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 OCT 03 — TIME OF ORDER: 2145 HOURS

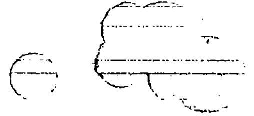
1. To KW-1
2. S/P I&D (R) shoulder
3. Condition stable
4. VS - routine
5. Up ad lib per EPW routine
6. Sling + swath (R) shoulder
7. Regular diet
8. IV - LR @ 150 cc/hr, hep lock when taking P.O. well
9. Tylenol 650 mg P.O. Q 4 hrs PRN
10. Percocet 1-2 P.O. Q 4-6 hrs PRN
11. Ancef 1 gram IVPB Q 8 hrs
12. Ciprofloxacin 400 mg IVPB Q 12 hrs
13. MSO4 2-8 mg IV Q 2 hrs PRN
14. CBC with diff in AM.

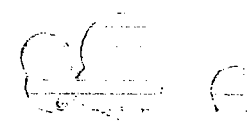
[redacted] (b)(6)-2

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

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

MEDCOM - 20979





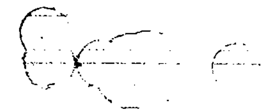
CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4		Ø7OCTØ3 / 16ØØ HOURS	
		NPO p̄ MN for surgery	
		Ø8OCTØ7	
		V.O. Dr. [redacted] (b)(6)-2 [redacted] (b)(6)-2	
		(b)(6)-2	
NURSING UNIT: ICW#1 / ROOM NO.: 2 / BED NO.: E 2[illegible]/0458OCT03 [redacted] (b)(6)-2			
PATIENT IDENTIFICATION		DATE OF ORDER: 08 Oct 03 / TIME OF ORDER: 0715 HOURS	
(b)(6)-4 Noted [redacted] 080720		① Resume previous orders	
		② Regular diet	
		③ IV - LR @ 125cc/hr, HLP	
		LOCK WHEN TAKING PO WELL	
		④ SLING AND SWATH Ⓡ ARM	
NURSING UNIT: 24O [redacted] / ROOM NO.:	BED NO.:			
PATIENT IDENTIFICATION 8 Oct 03 1930 (b)(6)-2		DATE OF ORDER / TIME OF ORDER [redacted] HOURS (b)(6)-2	
		(b)(6)-2 [redacted]	CDL [illegible]
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 20980



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
Noted (b)(6)-2 10/12/03 0820		DATE OF ORDER: 10/12/03 TIME OF ORDER: 0810 HOURS	
(b)(6)-2	1	Discharge to EPW camp	
	2	Keflex 250 mg Q 6 x 10 days #40	
	3	Percocet 1-2 PO Q 4-6 hrs prn #20	
	4	Every other day dressing changes	
NURSING UNIT / ROOM NO. / BED NO.		(b)(6)-2	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
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 - 20981

CLINICAL RECORD | THER[redacted]TIC DOCUMENTATION CARE PLAN (NO[redacted]EDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon Gen[redacted]

Mo. 10 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				4	5	06	07	08	09	10	11					
4	[redacted]	VS routine	6	X												
	(b)(6)-2		18													
4	[redacted]	up ad lib per	6													
(b)(6)-2		EPW routine	18													
4	[redacted]	Sling & swath (R)	6	X												
(b)(6)-2		shoulder	18													
4	[redacted]	Regular diet	6	X												
(b)(6)-2			18													
18Oct03	[redacted]	Every other day drsg	10	/	/	/	/	/	/	[redacted]	/		/		/	
(b)(6)-2		Δs														

(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ItD (R) shoulder

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 1Ø Yr 2003			
Order Date	Clerk Nurse	(b)(6)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	Admit ICW#1, stable	04 OCTØ3	—		[redacted] (b)(6)
(b)(6)-2 4	[redacted]	CBC c diff in Am.	5OCT	Ø430	—	[redacted] (b)(6)-2
(b)(6)-2 Ø8 OCTØ3	[redacted]	NPO p MN for surgery Ø8OCTØ3	Ø8 OCTØ3	ØØØ1	—	[redacted] (b)(6)
(b)(6)-2 Ø8 OCTØ3	[redacted]	Resume previous orders	Ø8	—		[redacted] (b)(6)-
(b)(6)-2 1Ø OCTØ3	[redacted]	Discharge to EPW camp				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
----	----		
----	----		
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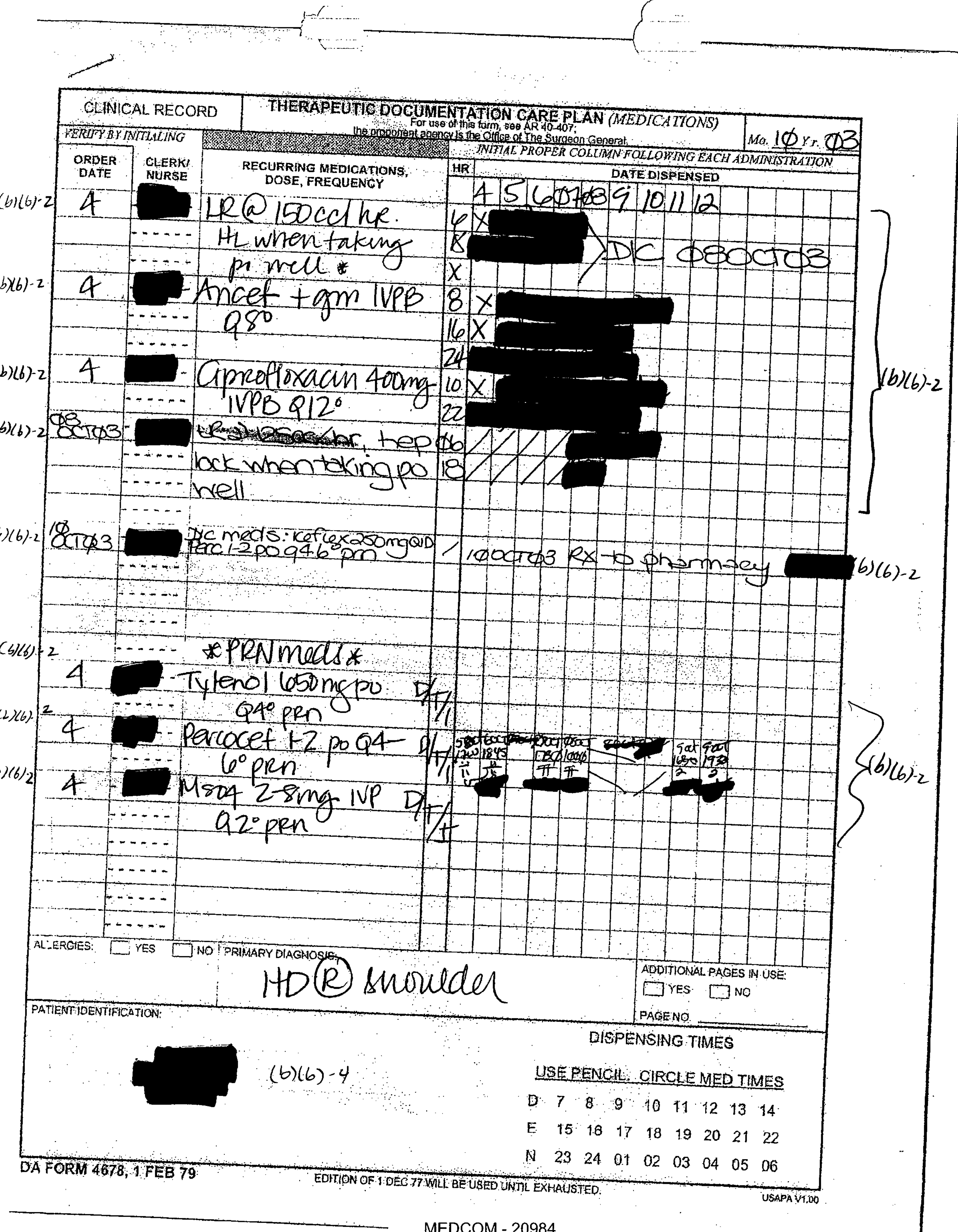
MEDCOM - 20983

USAPA V1.00



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. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 4 5 6 7 8 9 10 11 12
(b)(6)-2 4	[redacted]	LR @ 150cc/hr. HL when taking po well *	6, 8, X	X [redacted] DC 08OCT03
(b)(6)-2 4	[redacted]	Ancef 1 gm IVPB Q8°	8, 16, 24	X [redacted]
(b)(6)-2 4	[redacted]	Ciprofloxacin 400mg IVPB Q12°	10, 22	X [redacted]
(b)(6)-2 08 OCT03	[redacted]	~~LR @ 125cc/hr~~, hep lock when taking po well	06, 18	//// [redacted]
(b)(6)-2 10 OCT03	[redacted]	D/C meds: Keflex 250mg QID Perc 1-2 po q4-6° prn	/	10OCT03 RX to pharmacy [redacted] (b)(6)-2
(b)(6)-2		* PRN meds *		
4	[redacted]	Tylenol 650mg po Q4° prn	D/T/I	
(b)(6)-2 4	[redacted]	Percocet 1-2 po Q4-6° prn	D/T/I	5?, 1200, 1845, 0800?, 1000, 1000?, 1650, 1930 [redacted]
(b)(6)-2 4	[redacted]	MSO4 2-8mg IVP Q2° prn	D/T/I	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: HD (R) shoulder

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 - 20984

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: 4OCT03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 2208

Allergies: NKDA OR Intake: Crystalloid 1200 LR Colloid

Pre-op V/S: 131/80 / 84 OR Output: UOP Ø EBL 400

Procedures: I&D R Shoulder Meds/Times: 150 mcg fent, 200 mg morph

plate 61000 [illegible]

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	2205	2210	2215	2220	2235	2250
SaO2	96	94	98	97	95	
FiO2						
Methods	RA	4	02	RA	RA	
RR	12					
T	95.4		96.4			

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
2208	NS	600	LAC	IV	600

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	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	Ø	Ø	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	8	10

Codes

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

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

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

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

(Continue on reverse)

(b)(6)-2 [signature]

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 Oct 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOW CHART

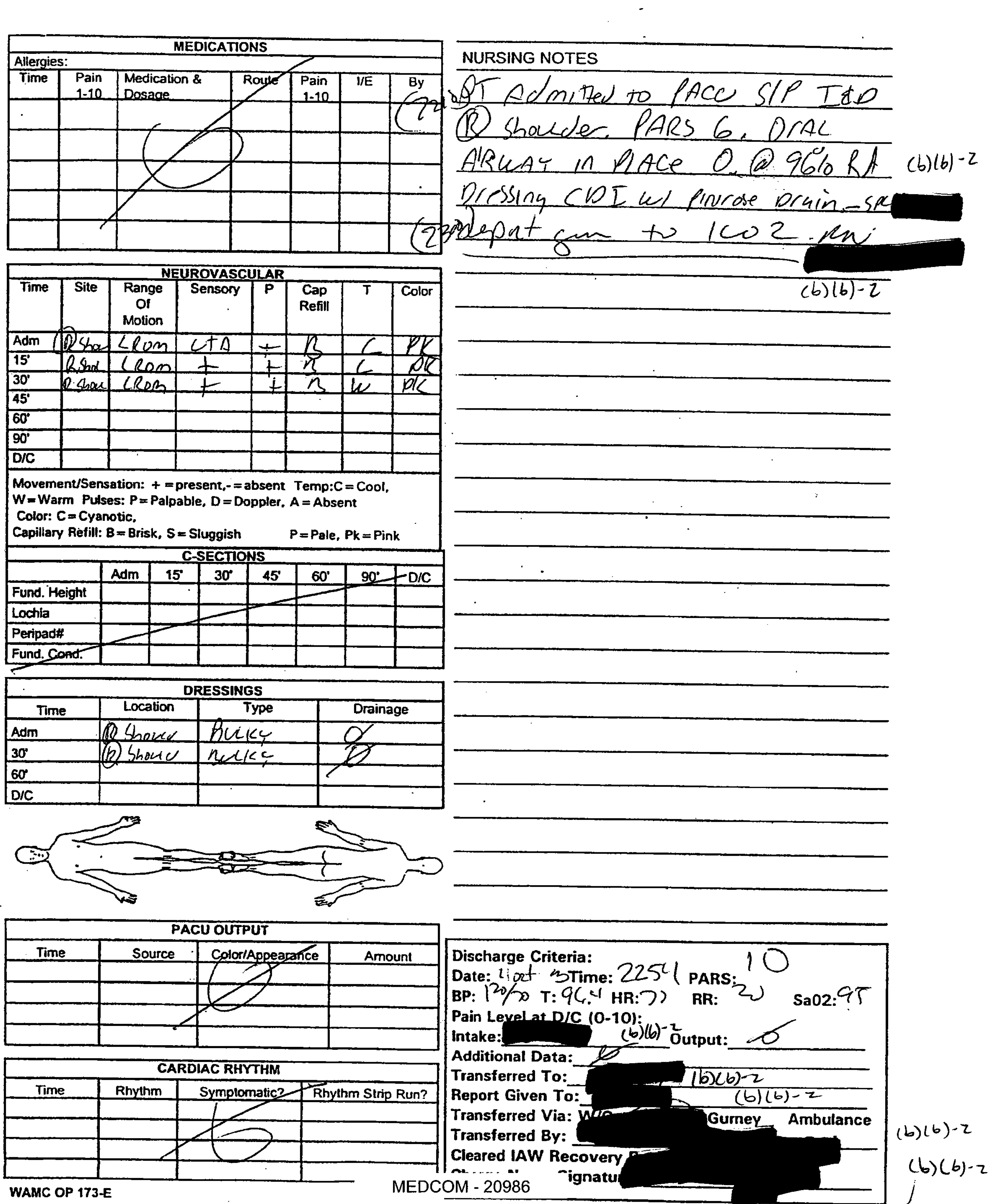
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

MEDCOM - 20985



MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) Sho	LROM	CTA	+	B	C	PK
15'	R Shd	LROM	+	+	B	C	PK
30'	R Shou	LROM	+	+	B	W	PK
45'							
60'							
90'							
D/C							

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Shoulder	Bulky	Ø
30'	(R) Shoulder	Bulky	Ø
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount
		Ø	

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		Ø	

NURSING NOTES

(2238) PT Admitted to PACU S/P I&D (R) shoulder. PARS 6. Oral Airway in place O_2 @ 96% RA (b)(6)-2
Dressing CDI w/ penrose drain. [redacted]
(2255) depart gurney to ICO2 [redacted]
(b)(6)-2

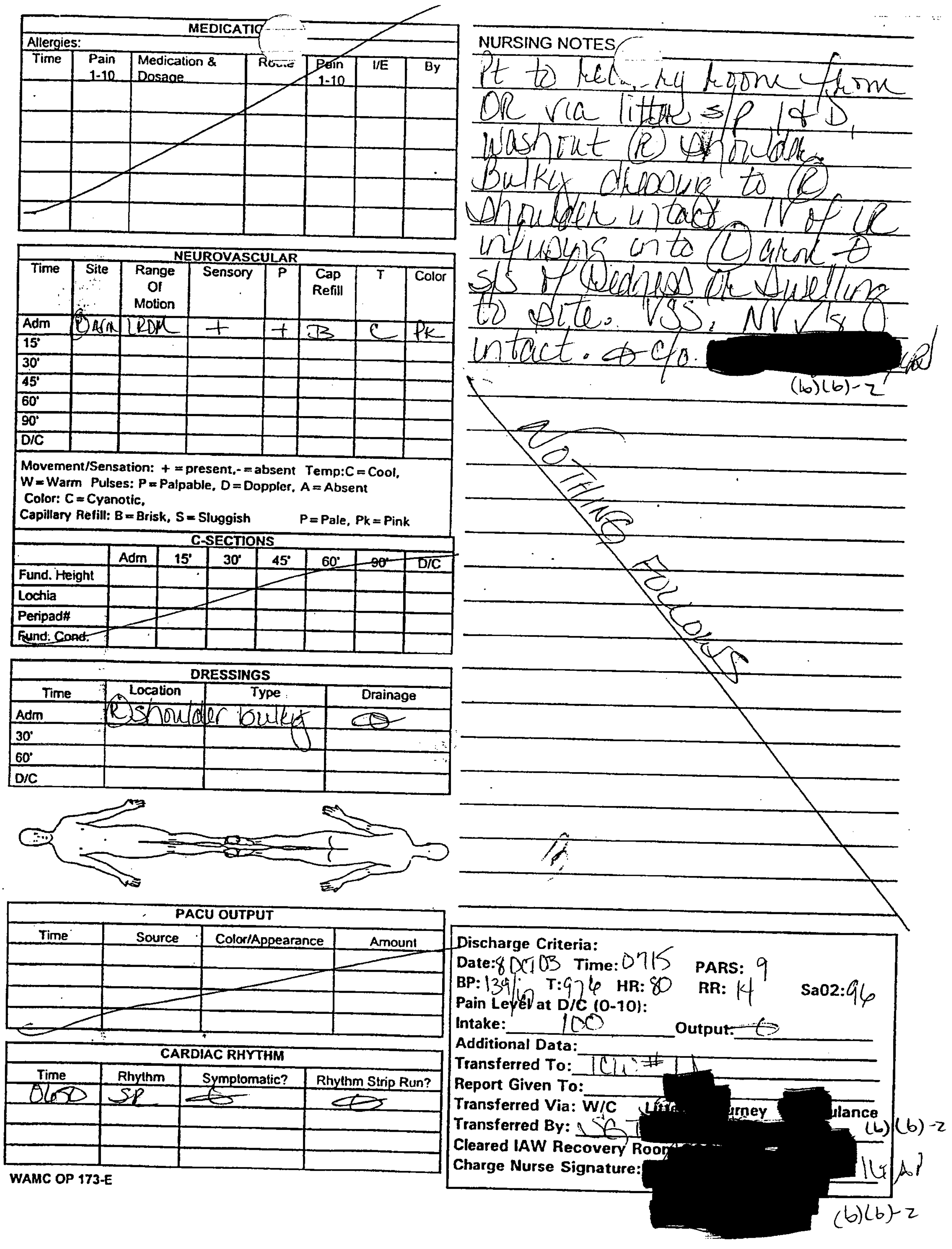
Discharge Criteria:
Date: [illegible] Time: 2254 PARS: 10
BP: 120/70 T: 96.4 HR: 77 RR: 20 Sa02: 95
Pain Level at D/C (0-10):
Intake: [redacted] (b)(6)-2 Output: Ø
Additional Data: Ø
Transferred To: [redacted] (b)(6)-2
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Gurney Ambulance (b)(6)-2
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted] (b)(6)-2

WAMC OP 173-E

MEDCOM - 20986

ACLU-RDI 1659 p.148

DOD-034562



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) arm	FROM	+	+	B	C	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) shoulder	bulky	⊘
30'			
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0650	SR	⊘	⊘

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D, washout (R) shoulder. Bulky dressing to (R) shoulder intact. IV of LR infusing into (L) arm ⊘ s/s of redness or swelling to site. VSS, NV's (R) intact. ⊘ c/o. [redacted]
(b)(6)-2

NOTHING FOLLOWS

Discharge Criteria:
Date: 8 OCT 03 Time: 0715 PARS: 9
BP: 139/70 T: 97.6 HR: 80 RR: 14 Sa02: 96
Pain Level at D/C (0-10):
Intake: 100 Output: ⊘
Additional Data:
Transferred To: ICU #1
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance [redacted]
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] 1LT AN
(b)(6)-2

MEDCOM - 20987

ACLU-RDI 1659 p.149

DOD-034563

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: 08 Oct 03
Time In: 0650
Allergies: NKDA
Pre-op V/S: 120/69 80
Procedures: I&D wash out of (R) shoulder

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL min
Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	650	0655	0700	0715
SaO2	94			
FIO2				
Methods	M	RA	RA	RA
RR	13	13	20	20
T	97.6			

Vital signs graph (240–20): BP approx. 130/55–60, pulse approx. 85–90.

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0650	LR	300	L arm	OR	100

X-rays: — Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, ˇ = Cuff BP, • = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

Time										
Pain (0-10)										
LOS										

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

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 [redacted] 1LT AN

DEPARTMENT/SERVICE/CLINIC: ICU ITT

DATE: 8 Oct 03

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

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

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

DA FORM 4700, MAY 78 — MEDCOM - 20988 -DN) — Previous edition is obsolete — USAPPC V2.00

(b)(6)-4, (b)(6)-5, (b)(7)(c)-5

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

[X] Offense against Coalition Forces [check one] If "Other" then describe:

[ ] Violation of Curfew
[ ] Illegal Possession of Weapon
[X] Assault/Attack on Coalition Forces SHOOTING AT U.S. FORCES
[ ] Theft of Coalition Force Property
[ ] Trespass on Military Installation or Facility
[ ] Photographing/Surveilling Military Installation or Facility
[ ] Obstructing Performance of Military Mission
[ ] Other

Apprehending Unit: (b)(2)-2

Location Grid:

Date of Incident (D/M/Y) 4/10/03 to / /

Time of Incident: 1300 hrs to hrs

Date of Report (D/M/Y) / /

Time of Report: hrs

Detainee #: (b)(7)(C)-5, (b)(6)-5

(b)(7)(c)-5 (b)(6)-5 (b)(6)-4

Last Name: (b)(6)-4

First Name: Given Name:

Hair Color: BLK

Scars/Tattoos/Deformities:

Eye-Color: BRN Weight: lb Height: in

Address:

Place of Birth:

Ethn/Tribe/Sect: Sex: [X] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular

[ ] Passport [ ] Dr. license [ ] Other (specify)

Document #:

Key Connected Person: [ ] Victim [ ] Witness

Last Name:

First Name: Given Name:

Hair Color: Scars/Tattoos/Deformities:

Eye-Color: Weight: lb Height: in

Address:

Place of Birth:

Ethn/Tribe/Sect: Sex: [ ] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular

[ ] Passport [ ] Dr. license [ ] Other (specify)

Document #:

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

[ ] Vehicle Information Vehicle Number ____ of ____ Vehicle(s) Owner:

Make: Color: VIN:

Model: Type: Plate No.: Number of People in Vehicle:

Year: Names of People in Vehicle:

Contraband/Weapons in Vehicle:

[ ] Property/Contraband [ ] Weapon Photo Taken of Suspect with Weapon/Contraband. Yes/ No

Type: Model Color/Caliber:

Serial No: Quantity Make Receipt Provided to Owner Yes/ No

Other Details Where Found Owner

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Contact BTL CPT Last, First MI

Signature: (b)(6)-4

Email:

Unit Phone: Date: / /

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

Signature:

Email:

Unit Phone: Date: / /

MEDCOM - 20989

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? Throwing rocks at coalition forces. Sustained GSW to shoulder - transferred to [redacted] for treatment of wounds. (b)(2)-2

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

(b)(2)-2

Admission Coding Information

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

1. Reporting MTF	2. MTF Location	
0580 - [redacted]	IZ	

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

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	35Y	X	9	ISLAMIC

10. Length of Service		11. FMP	12. Social Security Number
ETS		20	[redacted] (b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	14:33	

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

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

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

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
0580 - 28th CSH - Iraq; No Install Provided	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
HOME		2003-10-10

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-10-04

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-04

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: I & D R SHOULDER

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

Admitting Officer (Signature, as required)	[redacted] of Admitting Clerk
(b)(6)-2 [redacted]	(b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000 MEDCOM - 20991

Automated Facsimile

(b)(6)-4

INPATIENT TREATMENT RECO... COVER SHEET

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

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

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

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	19:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-02

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-04	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] - Iraq (b)(2)-2	2003-10-04	

31. Selected Administrative Data

Marital Status: Z

DoB: [redacted]

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW ABDOMEN

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	30	30

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	30	30

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

Automated F[redacted] DA FORM 3647, May 79

(b)(6)-2

MEDCOM - 20992

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 y/o Iraqi EPW (?) s/p GSW abd x-lap 9/30. At
28N → x-lap 9/22 Adhesions. feeding tube. for [illegible]
pt [illegible] [illegible] [illegible] [illegible]
[illegible] = TUBE, [illegible] [illegible]

PMH ∅ [illegible] [illegible] Abx meds: [illegible] 200 [illegible] 78
[illegible] 80 78

PHYSICAL EXAMINATION

NAD
Heart nl [illegible]
Chest [illegible] B [illegible], [illegible]
Abd: [illegible] [illegible] - [illegible] [illegible]. [illegible] [illegible].
[illegible] PT. [illegible].
[illegible] → [illegible] (R) [illegible] 3 x 5 cm [illegible]
(L) hip 2 x [illegible] [illegible]

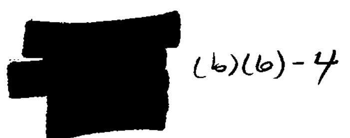
PROGRESS *(Enter date of discharge and final diagnosis)*

A/ GSW Abdomen.

P/ CT Abd IV/PO.
wound care
TF
Nutrition

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	10/9		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
(b)(6)-2		

 (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04OCT03	(b)(2)-2 Department of the Army [redacted] (32)
1400	CH
	NARRATIVE SUMMARY
	DIAGNOSIS: - [illegible], Prolonged ileus, malnutrition
	PROCEDURES: 22Sept03 - Ex Lap/[illegible]/J-tube placement
	HISTORY OF PRESENT ILLNESS: 25 yo IRAQI male who was shot while attacking US Forces in Kirkuk 30AUG03 and was taken to the 250th FST. He received 4 GSW and underwent Exp Lap w/ (R) Hemicolectomy, and ileostomy, mucous fistula, SP tube. He also had a large (R) buttock wound (L) hip soft tissue wound. He was transferred here on 15 Sept03.
	(b)(2)-2
	HOSPITAL COURSE: The patient became intolerant of food shortly after arrival here at [redacted] and developed a SBO from dense adhesions. He underwent exp lap/Adhesiolysis and placement of Feeding Jejunostomy tube (16Fr Malecot) on 22Sept03. He initially did well but became intolerant of TF and po diet ~01OCT03 - and again was made

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted] (b)(6)-4			

DATE	NOTES
	HOSPITAL COURSE (CONTINUED): NPO and TF stopped. An ileus pattern was seen and NGT decompression begun. Pt has had a persistent leukocytosis (23K) but no fever. His working dx is seemingly still his gut but greatly diminished amounts and liquid stool.
	DISPOSITION: Transfer to [redacted] for further evaluation - abdom CT scan.
	RECOMMENDATIONS: CT Abdomen.
	MEDICATIONS: IV fluids.

(b)(6)-2 [redacted]

(b)(6)-2 [redacted] MD
MAJ, MC USA
CHIEF, DOS

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

MEDCOM - 20995

ACLU-RDI 1659 p.157

DOD-034571

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
5OCT.03	Pt admitted to ICW #1 from ER,
0445	BP - 107/63 P-67 T- 96.7 SPO2% - 99%,
	pt lethargic, easily aroused IV central line
	Ⓡ SCl infusing LR @ 75 cc/hr, ∅ s/sx of
	infex or infiltration, colostomy bag intact
	on Ⓡ lower quad, bag empty, J tube
	infusing 30cc/hr of Jevity, NG tube to
	LIS in place draining greenish fluid, dsg
	over abd CDI, ∅ c/o pain @ this time,
	IS @ bedside, decub ulcers on hips Ⓑ cover-
	ed c̄ dsg's CDI, dsg on Ⓛ inner thigh CDI,
	dsg on Ⓡ flank CDI, foley to gravity
	draining c/y urine, pt on 2pt restraint s̄
	s/sx of poor circulation or skin break d-
	own. (b)(6)-2 [redacted] giw
5 OCT 03	- Pt A+O×3. VSS Lungs clear to (b)(6)-[redacted] all fields
0800-	anteriorly and posteriorly. HRRR S1 S2 present. Active
	BS. Ostomy to Ⓡ upper quad brown liquid stool. stoma beefy
	red vascular. Ⓛ side of abdomen stoma open to air moist
	∅ stool noted. NG tube LIS in place draining green bile fluid
	Superpubic cath to gravity draining light yellow urine.
	Jevity @ 30 cc to catheter Ⓛ lower quad abdominal insertion

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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont	Midline surgical incision abdomen healing minimal drainage 4x4 dressing applied. IVF LR @ 75cc/hr to (R) subclavian central line care given 5 Oct 03. GSW x2 (L) flank and (L) posterior thigh healing wet & dry dressings applied. Active BS poor nutrition. Consult to dietary. MSO4 5mg given for pain will cont to monitor ——— (b)(6)-2 [redacted]
5Oct03 @	2100: VSS, ∅c/o pain @ present time, A+O, follows signal commands well, verbalizes needs in arabic, NGT to LIS ~~draining~~ suctioning dark greenish liquid, Q4 flushes to NGT, verified placement → ⊕ placement, marked NGT @ (R) nare entrance, feeding tube intact, insertion site on (L)UQ running Jevity @ 30cc/ via alaris pump. (R)SC CL intact running LR @ 75cc/ s̄ difficulty, site c̄ DSG CDI, ∅ S/S infection/irritation. Colostomy site to (R) quad intact - putting out brown liquid stool - stoma site beefy red & healthy appearance. Stoma to (L) quad beefy red - not putting out anything, ∅ colostomy bag, new DSG placed over site CDI (dry). Midline Abdominal incision has one small section dehisced - packed c̄ wet 2x2 & covered c̄ Dry 4x4. Duoderm applied to wound (ulcer?) to (L) thigh (inner). W→D DSG Δ'd to (R) butt/hip area CDI - open flesh wound - beefy red - ∅ drainage or bleeding assessed. Pt. is NPO, ⊕ BSX4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
continued 5 Oct 03 @ 2100	quads, NGT flushes (irrigates) c̄ difficulty. Pt's gown Δ'd after D&G Δ'S, precautions to prevent decub ulcers/further breakdown, (B) LE'S elevated to keep heels off of pressure, LABS QAM (CBC & chem 8), reinforced IS while awake. POC = Pain Management, Wound Care/Preventive Wound Measures, Palliative Measures, ↑ independence, infection control, IV antibiotics. Will continue to monitor for acute Δ'S throughout shift. ——— (b)(6)-2 [redacted] RN
Addendum:	x2 restraints when in bed, ⊖ skin breakdown, ~~FTG draining~~ SP cath intact (cath care done c̄ alcohol) draining clear yellow urine ——— (b)(6)-2 [redacted] RN
6 Oct 03 1718	Received pt resting in bed, VSS, NPO, a&ox3. Pt NG to L suction putting out green bile, colostomy (R) LQ liquid stool brown, Drg to (R) buttock + (L) thigh/hip Δ'd, serosang drainage. foul odor to butt wound. tube feeds cont after CT procedure @ 30cc/hr to J-tube, SP cath - clr yellow urine, abscess drainage bright yellow drainage

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

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

EPW # [redacted]

(b)(6)-4

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PROGRESS NOTES
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MEDCOM - 20998

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cat	e ne IS, amb to u/c for procedure transfer. (R) SC flushes easily. LR infusing @ 75cc hr. will cat to monitor [redacted] (b)(6)-2
26OCT03@ 2030	Nursing: Assumed care of pt @ 1800. VSS. Alert, speaking arabic. LS CTA, IS encouraged, (+) BS, void per SP catheter clear/yellow urine. (R) subclavian CL c LR @75cc/hr & IV Abx; flushes well, dsg Δ'd per sterile technique. ML abd incision healing well. (R) LQ ostomy c brown liq stool, LUQ ostomy c ∅ output, covered c damp 4x4 & dsg. GT c Jevity @ 30cc/hr, 10cc residual ✓ @ 2000. GT & SP cath insertion sites red c slight purulent drainage noted around cathe. Will notify MD in AM. Site care provided c NS & ½ strength H2O2. Small 1cm x 1.0cm wound @ ML c WTD dsg → small amt of greenish tissue noted. Pigtail insertion site covered & line secured to leg. (L) hip 4.0cm x 2.0cm wound WTD dsg → healthy granulating tissue noted. (R) buttocks wound 10.0cm x 6.0cm WTD dsg → healthy granulated tissue noted. (R) hip small 2.0cm x 2.0cm healing wound OTA. (L) inner thigh dsg c duoderm CDI. NGT to LIS c minimal green liquid output noted, flushed q4° s difficulty. 2pt restraint on s s/sx of skin or circulation compromise. Pt refused to ambulate this P.M. Plan: pain control, enc AMB. Addendum: Pigtail abscess drain to foley bag yellow-green chunky fluid. Will monitor. [redacted]

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(b)(6)-2

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

MEDCOM - 20999

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
7OCT03	shift totals
@0545	outs: urine = 1350cc; NG = 1050cc; abscess = 350cc; stool (ostomy) = 1100 — ins: LR = 1900 cc; NG irrigation = 150cc; Jevity = 450cc
	(b)(6)-2 [redacted]
7Oct03	USS. Alert & oriented. Lungs clear Bilateral.
0800	BS ⊕ abd soft, tender to touch, non distended. Suprapubic cath intact & draining clear yellow urine. NG to LCS draining greenish drainage. Abscess drain thick yellow drainage. Jevity @ 30cc/hr. HOB↑. Ⓡ SC IV intact & patent infusing LR @ 75cc/hr. Will continue plan of care. No clysters or discomfort noted or voiced — [redacted]
	(b)(6)-2
7OCT03	Radiol.
	Ⓛ paracolic catheter drainage measures 350cc c/w likely communication of Ⓛ paracolic gutter/cath with enteric contents. CT w/contrast through catheter planned for 8OCT AM [redacted] MD (b)(6)-2

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

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[redacted] (b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 Oct 03	
1440	Pt OOB Ambulated to hallway to get
	on stretcher, transported to CT SCAN per
(b)(6)-2	Dr [redacted] (b)(6)-2 [redacted] 2LT (b)(6)-2
	Tube feeding D/C as ordered by Dr [redacted]
	(b)(6)-2 [redacted] 2LT AN
7OCT03	- assumed care of pt @ 1800. Sleeping, but awakens
2015	to voice, speaking arabic. LS CTA, enc IS. ⊕BS,
	hypoactive, Ⓡ colostomy c̄ brown-green liquid
	stool. NG to LIS, green liquid output. NG flushed
	q4° as ordered. GT to LLQ clamped, flushes well,
	∅ residual. LLQ pigtail draining abscess c̄
	yellow-green thick fluid noted. SP cath draining
	yellow urine. Tube care provided to all tubes.
	ML incision OTA, healing well; sm 1.0cm x 1.0cm
	wound @ ML c̄ WTD dsg, slight purulent
	drainage noted. Ⓛ UQ stoma covered c̄ dsg, ∅
	output noted. Ⓛ hip & Ⓡ buttocks dsg WTD
	Δ'd, both c̄ healthy granulating tissue.
	Ⓛ inner thigh duoderm CDI. Medicated c̄
	percocets (per GT) & MSO4 IV c̄ good pain relief
	noted. Plan: NPO for sx in AM, tube care,
	I+O's cont, IVFs as ordered, encourage AMB &
	IS. ∅ pt restraint on while in bed s̄ s/sx of
	skin or circulation compromise. Will
	continue to monitor. [redacted] LT
	(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8OCT03	Daily I+O's Totals (7OCT03)
@0600	Ins: Jevity = 210cc Outs: Urine = 1550cc
	IVFs/meds = 2300cc NGT = 1400cc
	Irrigation = 180cc Colostomy = 500cc
	2490cc Abscess = 850cc
	4300cc
	(b)(6)-2 [redacted] (b)(6)-2 [redacted]
8Oct03	VSS. Alert & Oriented. Lungs Clear Bilateral
0800	BS(+) but hypoactive. NG draining greenish drainage. Colostomy stoma pink & moist. Drsg dry & intact to Abscess and GT tube. Abscess draining bile colored drainage. (R) buttock & Ching drsg dry & intact will change later during this shift. GT flushed without difficulty. (R) subclavian CL patent & intact infusing LR @75 cc/hr. HOB ↑ 30°. Will continue care as planned
	(b)(6)-2 [redacted]
8OCT03	assumed care of pt @1800. VSS. C/o generalized
@2145	abdominal pain, MSO4 given c̄ good relief noted. LS CTA, ⊕ BS, Jevity @30cc/hr to PEG. NGT D/C'd, tol small amts of clears. Mid incision (CONT'D)

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT (b)(6)-2

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3OCT03 2145	(cont'd) healing well s̄ exception small 1.0cm x 1.0cm wound c̄ WTD dsg, purulent drge noted. LUQ stoma s̄ output, RLQ stoma c̄ brown-green liquid stool per colostomy. LLQ pigtail drain for abscess c̄ green thick liquid. (totals, see I+O's) SP cath c̄ clear yellow urine draining. Tube care provided to all tubes. (R) SC central line infusing s̄ S/Sx of infection. (L) hip & (R) buttocks dsg Δ'd per MD. (L) inner thigh duoderm CDI. Plan: monitor GI status & toleration of clears, monitor pain control, monitor I+O's. (b)(6)-2 [redacted] CPT
	Addendum: 2pt restraints on s̄ S/Sx of skin/circulation compromise. [redacted] CPT (b)(6)-2
9OCT03 @0500	24° totals I+O's
	Ins: Jevity = 330cc; IV = 2400cc; PO = 440cc; 3170cc. Outs: Urine = 1250; NG = 550 (d/c'd); Colostomy = 550; Pigtail = 200 (Ø dayshift recording)
	(b)(6)-2 [redacted] CPT

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 Oct 03 1500	VSS. A & O able to make needs known. Cardiovascular & Pulmonary system intact. (+) BS. Jevity (b)(6)-2 30cc on pump per gastric tube. Voiding cloudy yellow urine quantity sufficient via foley. Skin warm & dry. Abscess drain to gravity draining brown cloudy drainage. (L) hip & buttock drsg Δ done. (L) hip c̄ small amount purulent drainage. Colostomy (L) c̄ brown liquid (b)(6)-2 stool. (R) stoma pink s̄ output. Drsg Δ'd. (L) inner thigh wound c̄ purulent drainage. Duoderm applied. Pt medicated c̄ MSO4 5mg IVP for c/o pain @ 0830 & 1240. Will continue to monitor. (R) subclavian central line patent LR @ 75cc°. Drsg Δ done.
	(b)(6)-2 [redacted]
9 Oct 03 1507	Pt 2 - 2pt restraint s̄ skin/circulation compromise.
	(b)(6)-2 [redacted]
9 Oct 03 @ 1845	Assumed care @ 1800, VSS, pt A&O speaking arabic, S1S2, LS CTA (B); (+) BSx4, Jevity @ 30cc° on (b)(6)-2 IVAC pump via G-tube; FTG draining QS, dark yellow, cloudy urine; abscess drain to gravity draining dark cloudy fluid; colostomy bag draining brown liquidy stools, pt performs own colostomy care, stoma pink, moist, s̄ s/sx infection; all dsgs Δ, minimal purulent drainage to all; pcecs c̄ MSO4 for pain; CL patent, infusing LR @ 75cc° s̄ s/sx infection/infiltration; cont to monitor

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

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

PROGRESS NOTES
Medical Record

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MEDCOM - 21004

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 OCT 03	Assumed care of Pt at 0600 hrs. Pt Awake
1130	A&O. SP cath draining cyu c̄ sediment. TF
	c̄ Feed @ 30cc hr. CL via subclavian Flushed
	& Patent. (L) hip Drsg Δ. wound appears pink
	on the outer edge of wound. Tissue grey in the
	center. (R) Buttock Drsg Δ'd. Wound begining
	to tunnel superiorly. Pigtail wound drain in abdomen
	Drain minimal amounts of Blood fluid c̄ heavy
	sediment Pt c/o pain. Controlled c̄ percocet
	and MSO4. (b)(6)-2 [redacted] 91WM6
10oct03 @ 2115	Assumed care @ 1800; All VSS, pt A&O, pain controlled c̄ percocet;
	SP tube patent, draining QS, clear, yellow urine, free of sediment;
	G-tube patent, infusing Jevity @ 30 cc/hr; CL patent infusing LR @
	75 cc/hr s̄ s/sx infection/infiltration; dsg to (L) hip Δd, min. drainage noted,
	(R) buttock dsg Δd, ⊖ drainage noted; dsg to (b)(6)-2 [redacted] medial aspect of (L)
	thigh Δd c̄ duoderm, excessive amt of purulent drainage noted, wound
	cleaned & duoderm was (b)(6)-2 [redacted] replaced; dsg to old stoma site Δd, stoma
	wet & pink, ⊖ drainage, ⊖ s/sx infection; colostomy intact, pt performs
	own colostomy care; abscess drain patent, draining thick yellow fluid;
	cont to monitor (b)(6)-2 [redacted]
11 OCT 03	Assumed care @ 0600. LS CTA (B). ⊕ BM x4 quads
	pain controlled c̄ percocet. (b)(6)-2 [redacted] Jevity Feed @ 30 cc/h.
	CL infusing LR @ 75 cc hr. DSG to (L) hip, sacrum, (L)
	thigh CDI. LS CTA (B), $S_1 S_2$ present. ⊕ BS x4 quads
	Colonostomy LLQ. Pain controlled c̄ MSO4. Will
	continue to monitor. (b)(6)-2 [redacted] 91WM6
	(1510) I concur c̄ above assessment. [redacted]

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(b)(6)-2 USAPA V1.00

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DOD-034581

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(2100) 11OCT	Rt alert, VSS, pain controlled c percocet, [redacted] cath intact draining dark yellow urine.
(b)(6)-2	foley draining cyu. CL patent infusing LR @ 75cc/hr. ⊖ redness or edema noted. Ⓡ buttock, Ⓛ thigh drsg D&I (minimal drainage). Jevity infusing @ 30cc/hr. 2pt restraints on ⊖ compromise to skin or circulation. will monitor — [redacted] (b)(6)-2
	colostomy draining unformed. brownish yellow
12OCT 0530	BM. pt performs own colostomy care. [redacted] (b)(6)-2 abscess drain c 200cc all shift, thick yellow citrus smelling drainage. Pt consumes OJ often during the day. G-tube flushed (residual 3cc). Tagamet infusing @ this time. Will monitor — [redacted] (b)(6)-2
12OCT03 0945	Assumed ~~pt~~ care of Pt @ 0600. Pain controlled c percocet & MSO4.
(1920)	Pt awake, VSS, c/o severe pain to abd. (site of abscess drain). 5mg MSO4 given c noted relief. CL patent & infusing LR @ 75cc/hr. ⊖ edema or redness noted. foley draining adeq. cyu. Jevity

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

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PROGRESS NOTES
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\# [redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12OCT @ (1920)	infusing @ 30cc/hr. colostomy intact, stoma pink/moist. Drsg Δ'd. Restraints on ∅ compromise to skin or circulation. Will monitor ——— (b)(6)-2 [redacted] 91WM6.
13OCT03 1510	Pt Awake. Pain controlled c̄ MSO4 e perco-cet. Drsg to (L) hip (R) Buttocks Δ. Pig tail Draining Dark citrus smelling Fluid c̄ sediment. S/P cath Draining Yellow urine c̄ sediment. Jevity Feed @ 30 cc/h. CL Patent. Will continue to monitor ——— (b)(6)-2 [redacted] Spc. 91WM6
13OCT03 @ 2300	assumed care of pt @ 1800. VSS. C/o pain, Percs given c̄ good relief noted. Mid abd [redacted] incision (b)(6)-2 healing well. Colostomy c̄ brown liquid stool. LUQ stoma covered c̄ 4x4 drsg. SP cath draining c/y urine. Pigtail drain c̄ green cloudy output. GT c̄ Jevity @ 30cc/°. Tube care provided. Tol reg diet well. CL flushes well c̄ good blood return noted. ~~Plan~~ (R) buttocks & (L) hip drsg Δd. Plan: pain control, monitor GI status. Hos. [redacted] CRQ (b)(6)-2
14OCT03	Radiology. (L) Abscess/J-tube removed after CT demonstrated no significant (L) paracolic fluid collect as d/w Dr. [redacted] (b)(6)-2 ∅ complic EBL ∅. (b)(6)-2 [redacted] MD

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14OCT 2215	(CONT) – Ⓡ subclavian line drsg CDI, line flushes well, ⊕ blood return on distal port. LR @ 150cc/° continues. Plan: pain control, enc po intake, enc OOB to AMB, IV abx as ordered. 1 pt restraint on s S/Sx of skin/circulation (b)(6)-2 [redacted] CPL
15OCT 0115	Pt c/o pain to groin area. Pt voided through urethra clear yellow urine, approx 200cc. Will monitor. (b)(6)-2 [redacted] CPL
15OCT03 0900	USS Alert & Oriented OOB → Chair for Breakfast, AM & Colostomy care. Tolerated well. Ⓡ subclavian line intact & patent. will Δ drsg later this shift as ordered. Lungs clear BS ⊕ x4 quad. Abd – soft non-distended. Colostomy stoma pink & moist. Peripheral pulses palpable +2. Supra pubic cath draining cloudy yellow urine. Ambulated in hallway with out assist. Will continue care as planned. [redacted] (b)(6)-2 2LT AN
15OCT03 1015	Pt's supra pubic cath clamped. Informed Pt to void in urinal. ~~at~~ Urinal @ BS within reach. (b)(6)-2 [redacted] 2LT AN
15OCT03	Radiology. Ⓛ paracolic drain removal site unremarkable. [redacted] MD (b)(6)-2 [redacted] (b)(2)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 OCT 03	- Assumed care of pt. A+Ox3. VSS. Medicated
0100	prior shift & c/o pain or discomfort @ this
	time. Breakdown stage II (R) buttocks dressing Δ'd wet
	to dry. (L) hip boney stage II' 2x2 minimal drainage
	2x2's applied. Lungs clear HRRR. suprapubic cath to
	(L) LQ of abd. Feeding tube in place 30cc Jevity infusing
	(R) subclavian site patent Ø s/s of infection. On call
	CT this AM Will cont to monitor (b)(6)-2 [redacted]
1000-	pt ambulated to CT ̄s difficulty (L) abscess hip J-tube
	removed. Jevity tube feedings per MD will resume
	tomorrow c/o pain medicated ̄c percocet II tabs
	for relief. Will cont to monitor (b)(6)-2 [redacted]
14OCT03	assumed care of pt @1800. alert, speaking arabic.
@2215	VSS. c/o abd pain, medicated ̄c Percocet ̄c good relief
	noted. LS CTA. ⊕BS x4 quads. LUQ stoma ̄s output,
	covered ̄c Dsg CDI. RLQ stoma ̄c brown liquid stool.
	ML incision OTA, healing well. G-tube clamped (for bowel
	rest). SP cath draining clear-yellow urine. Tube
	care provided, dsgs applied. Smamt of yellow drainage
	noted around GTube. (R) buttocks dsg Δd, (L) hip
	drsg Δd, both ̄c smamt of brown drainage noted. (CONT)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] (b)(6)-2

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(b)(6)-2
15 Oct 03	Pt has voided twice [redacted] via urethra
1700	c̄ suprapubic cath clamped. Upon unclamping
	suprapubic p̄ voids < 30cc of urine noted
	Will inform Dr. [redacted] (b)(6)-2 (b)(6)-2 [redacted] 2017B
15 Oct Ø3	2010 = VSS, A+O x3, Ø c/o pain @ present time, CL to
	Ⓡ SC running LR @ 75 cc/° s̄ difficulty, SP
	cath clamped → residual √'s post-void
	c̄ urinal → monitoring UOP c̄ residual. Feeding
	tube intact & plugged → flushed & patent. DSG'S
	over SP cath site & TF site Δ'd, dehiscence to
	midline abd wound c̄ Ø drainage, covered
	c̄ DSG CDI, DSG's to Ⓡ buttock & Ⓛ hip CDI,
	Δ'ing BID. ⊕ BS x 4 quads, tolerates PO well,
	X2 Restraints s̄ skin breakdown noted. Pt.
	does own colostomy care PRN. Ø other remarkable
	assessment findings. POC: Wound Mgt, Pain
	Management, I&O's. Continue to monitor [redacted] AW
16 OCT 03	Assumed care of Pt. VSS. SP cath plugged. CL (b)(6)-2
1200	Flushed Patent 75cc/h LR. JT Feed Tube plugged. LLQ
	Colostomy CDI Draining Loose brown Stool. $S_1 S_2$
	Present. LS CTA Ⓑ ⊕ BS x 4 quads. Pt Ambulator

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(b)(6)-4

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MEDCOM - 21010

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6)-2
	X1 Today. OOBTC for 1 hour. SP cath [redacted]
	fell out of LRQ. Dr (b)(6)-2 [redacted] replaced and
	sutured in place. Antibiotic continue[redacted] Will cont.
	to monitor. (b)(6)-2 [redacted] [illegible]
16OCT03	Assumed care of pt @1800. VSS. alert speaking
@2030	arabic. LS CTA, ⊕BS x4 quads, RLE colostomy c̄
	brown liquid stool noted. LUQ ostomy c̄ dsg, ∅
	output noted. SP cath draining to foleybag clear
	yellow urine. Midline abd incision healing well.
	Tol reg diet well c̄ good appetite noted. G Tube
	clamped. Ⓡ buttocks wound & Ⓛ hip wound WTD
	dsg Δ'd, both c̄ brownish-serous drainage noted.
	Ⓡ SC central line c̄ dsg CDI, flushes well, ⊕ blood
	return. 2pt restraints on s̄ S/Sx of skin/circulation
	compromise. Pt ↑ AMB c̄ min. assist. Plan: enc
	activity, enc po intake, enc independence c̄ colostomy
	care, cont ABX as ordered, pain control. (b)(6)-2 [redacted]
17OCT03	Pt colostomy leaking under seal around stoma. Old bag
@0115	removed skin cleaned, new bag placed. Pt ↑ to
	BR to wash up. Buttocks dsg Δ'd D/T soiling outer
	layer of dsg c̄ colostomy leak. Will monitor. [redacted]
	(b)(6)-2
17 oct 03	- Assumed care of pt. A+O x3 VSS. ∅ c/o pain or
0200	discomfort @ this time. AM care given. Encouraged
	to ambulate ward. Dressing to Ⓡ buttocks wet + dry CDI. Dsg
	to Ⓛ hip wet + Dry CDI ∅ active bleeding noted. Residual check
	of suprapubic cath and penis cont; clamped @ this time. IVF and
	ABx tx discontinued. Δ'd to PO meds. Will cont to monitor [redacted]

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(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Oct 03 1000 -	Suprapubic catheter clamped for residual check void 250 cc per urethra in to urinal. Foley to gravity unclamped 100 cc residual output - cath left unclamped. Will cont to monitor (b)(6)-2 [redacted]
	(1740) I concur c above assessment (b)(6)-2 [redacted]
17 OCT 03 @1845	per instructions by Dr [redacted] (b)(6)-2, pt's SP cath left to drain to foley bag. Will retry bladder training tomorrow. (b)(6)-2 [redacted]
17 OCT 03 2300	assumed care of pt @1800. VSS, c/o abd pain. percs given c good relief noted. Alert, speaking arabic. LSCTA, ⊕BS x4 quads, tol reg diet well. LUQ stoma s drainage covered c dsg. RLQ colostomy c brown semi-solid stool. G tube clamped. SP cath to foley bag c clear yellow urine. Voiding through urethra at times, approx 100-200 cc ea. void. Tube care provided. Ⓡ buttocks wound & Ⓛ hip wound drsgs Δ'd WTD, both c brown drainage noted on drsgs. Ⓛ inner thigh wound OTA. Pt amb s assistance in hallway. Pt demonstrating good colostomy care. Plan: monitor pain control, monitor GI status, 2pt restraints on s s/sx of skin/circulation compromise. (b)(6)-2 [redacted]

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

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDCOM - 21012

ACLU-RDI 1659 p.174

DOD-034588

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Oct 03	-Assumed care of pt. A+O x3. C/O pain to abdominal area
0700	lungs clear, HRRR. Active BS tolerating PO well Colostomy site
	beefy red vascular. able to do self care without assistance. Inactive
	stoma (L) side ø drainage minimal oozing dressing applied. Dsg to
	(R) buttock wet → dry stage II increased ambulation Q2° position
	changes to promote proper healing. (L) hip stage II healing wet
	to dry dsg intact. Superpubic cath to gravity light yellow
	urine. Also voids per urinal through his urethra. Resume residual
	checks today. strict I+O's will cont to monitor (b)(6)-2 [redacted]
1	(1455) I concur c above assessment (b)(6)-2 [redacted]
18OCT03	assumed care of pt @ 1800. VSS. C/O small amt of abd pain,
@2330	controlled c Percocets. LS CTA, ⊕BS, tol reg diet c good
	appetite, void per SP cath/urethra. Instructed by
	Dr [redacted] to clamp SP cath & monitor voids.
	See I+O's sheet. Minimal residual noted @ this time
	LUQ stoma c drsg & no output; RLQ colostomy c brown semi-
	formed stool. Vaseline gauze drsg to LUQ ostomy. G tube clamped
	WTD drsg to (R) buttocks & (L) hip, green color drainage noted from both
	wounds. (L) inner thigh wound OTA, encrusted over, healing well.
	Tube care provided. Pt ↑ amb s difficulty. Pt demonstrating
	good ostomy care techniques. 2pt restraint on s s/sx skin or
	circulation compromise. Plan: ↑ amb ↑ independence, PO ABX
	as ordered, monitor voids & residuals. (b)(6)-2 [redacted]
19OCT03	Residuals checked through night. (See I+O's). For 3 voids
@0645	each had residual of <50cc after draining for
	30 minutes. Will monitor. [redacted]
	(b)(6)-2

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[redacted] Et / (b)(6)-4 MEDCOM - 21013

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(b)(6)-2
Cont	S/P SP tube in place, colostomy bag intact, pt voiding in urinal c/y urine, dsg on abd CDI, medicated for pain c̄ 2 percs, 2 pt restraint in place s̄ s/sx of complications.
	(b)(6)-2 (b)(6)-2
21 OCT 0700	- Assumed care of pt. A+O x3. VSS c/o pain medicated c̄ relief. Lungs clear. HCRR Active BS feeding tube to (L)UQ abdomin clamped tolerating PO well. Voiding QS clear yellow urine per urethra Residual checks cont'. SP catheter remains clamped (L)Q of abdomin. Colostomy self care (R)UQ. Stoma (L)LQ inactive vaseline gauze CDI Ø s/s of infection remains afebrile. Decub to (R) buttock (L) hip dsg Δ wet→dry CDI Will cont to monitor (b)(6)-2
21 OCT 1400	- Notice pt is having minimal leakage around SP catheter removal site. 4x4 sponge dsg in place. Pt cont to void per urethra s̄ difficulty Ø evidence of bladder distention (b)(6)-2

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 21014

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21OCT.03 1900	Pt A+O x3, VSS, OOB to ambulate, self colostomy care, colostomy bag intact, (R) buttock + (L) hip dsg's Δ'd, (b)(6)-2 [redacted] ~~wounds~~ ulcers healing well, dsg's on abd CDI, J-tube LUQ clamped ø s/sx of infex, pain controlled c̄ percs, LS CTA (B), active BS, 2 point restraint s̄ s/sx of complications. (b)(6)-2 [redacted] 91W
1915	Abd non distended soft [redacted], voiding s̄ diff c/y urine amount sufficient. Tol PO well. (b)(6)-2 [redacted] 91W
	(b)(6)-2 [redacted] CAG
22OCT03	(1210) Assumed care of pt @ 0800 p̄ report from night (b)(6)-2 [redacted] shift. Pt alert, speaking Arabic. VSS. ø Pain controlled c̄ Percs. Pt OOB to BR for personal hygiene and amb in hallway s̄ difficulty. Wet → dry drsgs to (R) buttock and (L) hip Δd. ø S/Sx infection @ wound sites. Drsg to inactive stoma in LUQ Δd. Stoma pink and moist s̄ drainage noted. Colostomy bag intact - pt doing own colostomy care. Gravity tube feeding started @ 40cc/hr into J-tube in LUQ. J-tube flushed s̄ difficulty. ø S/Sx complications from tube feeding. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted] 91W (b)(6)-2

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MEDCOM - 21015

ACLU-RDI 1659 p.177

DOD-034591

MEDICAL RECORD | PROGR[illegible] | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
22 OCT 03 2030	Assumed Pt care @ 1800. Pt A&O LS CTA (B) S, S2 Present, (+) BS x4 quads. Stoma pink wet & s̄ s/sx of infection. Draining Brown loose stool. Tube feeding Jevity @ 40cc/hr. J tube flushed & Patent. Colostomy bag intact. Pt performs own care. Will continue to monitor [redacted] (b)(6)-2
23 OCT 03	(1245) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb well. Colostomy bag Δd this am. Drsg to inactive stoma CDI. Wet→dry drsgs to (R) hip, RUQ, and (R) buttock Δd. ∅ s/sx infection @ wound sites. J-tube flushes s̄ difficulty. Jevity infusing @ 100cc/hr s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
24 OCT 03 0020	Assumed care of pt @ 1800 hrs 23 OCT 03. Pt completed colostomy self care. LS CTA (B), S, S2 present. (+) BS x4 quads. J tube flushed & patent sutured in (L)LQ. (−) s/sx of infection. Running Jevity feed @ 40 cc hr. Drsg Δd to Buttocks, (L) hip & (L)UQ Stoma. Pain controlled

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

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[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME		MIDDLE	NUMBER

DATE	NOTES
24OCT03	percocet Will continue to monitor
cont.	(b)(6)-2 [redacted] Spc 91WM6
24 oct 03	- Assumed care of pt A+O [redacted] VSS Ø c/o pain or
0700	discomfort @ this time. Lungs Clear HRRR Active BS
	Good appetite Jevity to feeding tube (L)UQ @ 40 cc/hr per
	alaris pump. Colostomy to (R)UQ of abdomen self care
	stoma vascular beefy red. Urinating QS ŝ difficulty
	(R) buttock stage II healing pink (L) hip stage II healing wet +
	dry dsg Δ CDI will cont to monitor (b)(6)-2 [redacted]
24OCT03	assumed care of pt @ 1800. VSS. C/o pain to ML ab incision,
@2200	percocets given c̄ good relief noted. ML incision healing well, RLQ colostomy c̄ brown liq stool output; colostomy bag Δ'd d/t leakage, new bag applied c̄ pt assist. LUQ stoma c̄ vaseline gauze, Ø output noted. G tube c̄ Jevity @ 40cc/h, tol well, Ø residual noted. Jevity bottle & IV Δ'd this pm. (R) buttocks & (L) hip drsgs Δ'd, sm amt brown dinage noted. Pt ↑ amb ŝ difficulty. 2pt restraints on ŝ s/sx of skin/circulation breakdown. Plan: enc po intake, enc amb, enc independence. (b)(6)-2 [redacted]
25OCT03	Pt voided x3 c̄ total of 900 cc of clear yellow urine ŝ
@0500	difficulty. Jevity cont @ 40cc/hr. (b)(6)-2 [redacted]
25 OCT 03	- Assumed care of pt A+O x3. VSS Ø c/o pain or discomfort
0700	Lungs CTA HRRR Active BS Colostomy to (R)UQ slight irritation
	to tape site redness. Instructed to leave off 15 mins q change. Self care
	Urinating QS per urinal ambulates ŝ difficulty to bathroom.
	(R) buttocks and left hip wet + dry dsg change CDI stage II healing
	well Ø s/s of infection Will cont to monitor [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRE[SS N]OTES**

DATE	NOTES
25 OCT 03 @ 2300	assumed care of pt @ 1800. VSS, no c/o. alert, speaking Arabic. LS CTA, ⊕ BS tol reg diet & Jevity @ 400cc/hr per G Tube. Ø residuals noted from G tube. RLQ colostomy c̄ light brown liquid stool. LUQ ostomy ø output noted, vaseline gauze dsg intact. Voiding per urinal s̄ difficulty. Pt ↑ amb, doing own colostomy care. Ⓡ buttocks & Ⓛ hip wound healing; greenish drainage noted from Ⓡ buttocks wound. WTD dsgs completed. 2pt restraints on while in bed s/s sx of skin/circ compromise. Plan: cont po Abx, enc po intake, enc AMB, enc independence. Will cont. to monitor. ——— [redacted] (b)(6)-2
26 OCT 03 0700	Assumed care of pt. A&O x3. VSS. Denies pain. Lungs CTA. HRRR Active BS colostomy to Ⓡ LQ self care stoma vascular (b)(6)-2 Ⓛ [redacted] stoma inactive vaseline gauze 4x4 dsg in place. Feeding tube to Ⓛ LQ of abdomen Jevity 40cc/hr Tolerates PO well good appetite. Voiding QS. per urinal ambulates s̄ diff. Will cont to monitor ——— (b)(6)-2 [redacted]
27 OCT 03 1400	VSS. AO. S'd colostomy. Moist & intact. S'd DSG's to Ⓛ hip and Ⓡ buttock. Both wounds diminished in size and pink. Ⓔ s/s infection. Voiding bright yellow urine quantity sufficient. Skin integrity ⊕. Ambulated on ward x1 for 1° and performed colostomy care. [redacted]

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

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 21018

LAST NAME	FIRST NAME	MIDDLE INITIAL	NUMBER

DATE	NOTES
27OCT03 @2140	assumed care of pt @ 1800. VSS. c/o ML abd pain. ML incision healed, RLQ colostomy c̄ brown liquid output, LUQ stoma covered c̄ vaseline gauze, due to be Δd tomorrow. Jevity @ 40cc/° per GT, tol well c̄ ⊖ residual. Ⓡ buttocks dsg; Ⓛ ~~buttock~~ error hip wound healing, dsg Δ'd WTD, some green drainage noted to buttocks. Pt ↑ AMB, tol well. Void per urinal s̄ difficulties. Plan: monitor; enc po intake, monitor dsgs; TF. 2pt restraints on s̄ S/Sx skin/circulation comp. Will monitor. (b)(6)-2
28 OCT 03 0700	Assumed care of pt - sleep yet easily arousable A+O x3. VSS Ø c/o pain or discomfort. Lungs CTA Hd RR Active BS colostomy to Ⓡ UQ self care stoma vascular Good appetite. Ⓡ buttock dsg Δ 4x4 wet to dry Ⓛ hip dsg change stage ## healing Ø s/s of infection remains Afebrile Will cont to monitor (b)(6)-2
29oct03	Assumed care @ 1800; AVVSS, pt A+O, pain controlled c̄ percs; All dsgs Δd ⊖ drainage noted to hip, minimal drainage to buttock; pt performed own colostomy care; Jevity to G-tube @ 40 cc/hr s̄ ~~[redacted]~~ complications; pt OOB to BR; Restraints in place, ⊕ circ. ⊖ skin break ↓ cont to monitor (b)(6)-2
29OCT03 @1600	Assumed care of pt. @ 0600. V.S.S. except BP 95/45. Pt. encouraged to drink water, pt. compliant. G-Tube flushed, Jevity infusing @ 40cc/°. W→D DRSNG to Ⓛ hip + Ⓡ buttocks Δ'd; scant drainage to old DRSNG. Colostomy intact. Pt. ambulates well, steady gait. Pt. medicated ~~to~~ [redacted] with ii percocet for pain x 2. (b)(6)-2 2LT, AN
29OCT03 @1800	All other assessments WNL, pt. in 2 point restraints, Ø signs of skin breakdown. (b)(6)-2 2LT, AN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(b)(6)-2
29 OCT 03	Assumed care of Pt @ 1800. Pt A&O / ∅ Pain
2300	controlled ē percs. Pt completed [redacted] colostomy
	care. Wound to Buttock Δ'd Drsg t[redacted] (b)(6)-2
	Drsg to (L) hip Δ'd. VSS. Will cont to
	monitor ——— (b)(6)-2 [redacted] Spc 91WM6
30 OCT 03 @ 1400	Assumed care of pt. @ 0600, V.S.S. A&O, ∅ C/O of pain at
	this time. W→D DRSNG to (L) hip Δ'd, scant drainage. W→D DRSNG
	to stage II decub to (R) buttock, moderate thick yellow drainage.
	Old stoma site cleaned & new petroleum gauze applied. New colostomy
	bag @ bedside. Pt. will Δ bag when old bag is full. Pt.
	ambulates well s̄ difficulty in hallway. All other assessments
	WNL. Pt. in 2-point restraints, ∅ signs of skin breakdown.
	Will cont. to monitor. ——— (b)(6)-2 [redacted] 2LT, AN
30 OCT 03 @ 1440	Pt. given ii Percocet for C/O pain. Pt. receiving Jevity @
	40cc/° via PEG-tube. ——— (b)(6)-2 [redacted] 2LT, AN
30 OCT 03	Assumed care of Pt @ 1800. A&O. Percocet controls pain.
2200	Drsg to R Buttocks Δ'd. Wound appears Red, granulated
	and Health. Drsg to L hip Δ'd. Wound is smaller than last
	Few days. All but ½ inch area is [redacted] (b)(6)-2 Closed. Pt completed
	colostomy care. Ambulated For 20 min. J Tube Flushed
	& Patent. 40 cc/h Jevity via J Tube. Will cont-

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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MEDCOM - 21020

LAST NAME | FIRST N | T | NUMBER

DATE	NOTES
30 OCT 03 cont	to Monitor. ——— SPC 91WM6 (b)(6)-2
31 Oct 03	Assume care of PT @ 0600. A+O x3, VSS. C/O pain given 2 percocet. Ambulatory. Δed drsg on (R) hip c D.I. and drsg on (R) side buttocks CAI. In 2pt restraint Ø signs of skin irritation. Will cont. to monitor. (b)(6)-2 91WSPC
1 NOV 03 @ 0245	assumed care of pt @ 1800. VSS, no C/O. alert, speaking arabic, LSCTA, ⊕BS, colostomy c chunky brown stool. RUQ stoma c drsg CDI. (R) buttocks & (L) hip drsg Δ'd. GT clamped. Pt states (through interpreter) that MD said to stop TF. Pt refuses to let ~~me~~ staff connect TF. Pt voiding per urinal s difficulty. 2pt restraints in while in bed s S/Sx of skin/circulation compromise. Plan: pain control, monitor drsgs, clarify TF order c MD. (b)(6)-2
1 NOV 03 0200	Assumed care pt. A+O x3. VSS Ø c/o pain or discomfort. Ambulating per ward s difficulty. Lungs clear HEAR Active BS good appetite colostomy. (RUQ) stoma vascular self care. feeding tube to (L) abdominal wall clamped - (R) buttock and (L) hip stage II decub healing well. Ø s/s of infection Will cont to monitor (b)(6)-2 SPC 91WM6.
2 NOV @ 0200	assumed care of pt @ 1800. VSS, no C/O. (L) hip & (R) buttocks drsg Δ'd, healing well. LUQ stoma c vaseline drsg, CDI. RLQ colostomy c brown semi-formed stool, colostomy bag Δ'd. GT clamped. Tol reg diet well. Amb to BR & in hallway s difficulty. 2pt restraints on s skin compromise. Plan: monitor pain, cont. enc independence (b)(6)-2

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

(b)(6)-4 (b)(6)-2

MEDCOM - 21021

NSN 7540-01-075-3786

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

LOG NUMBER | TREATMENT FACILITY (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS (b)(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 4 Oct 03 | TIME 1905

TRANSPORTATION TO FACILITY medevac

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 ∅

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

med Hx ∅
surg Hx ∅

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME 1905

INITIALS (b)(6)-2

VITAL SIGNS

TIME	1905	~~0032~~	2330	0000	0030
BP	111/64	~~95/66~~	107/68	98/60	95/66
PULSE	88	~~80~~	62	78	80
RESP	16	~~19~~	18	18	18
TEMP	98.6		98.4	98.4	98.5
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100%
☐ MONITOR
☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2230	Fentanyl 50 mcg IV				(b)(6)-2
0025	Fentanyl 50 mcg IV				
0200	Fentanyl 50 mcg IV				
0300	Fentanyl 50 mcg IV				

DISPOSITION

☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

(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		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			Na / Cl / Bun / Glu	SUP 02	PH	PO2	RESULTS	
H/H			K / CO3 / Cr	PCO2	SAT	OTHER		
PLT				U/A DIP			EKG INTERPRETATION	
PT				U/A MICRO				
APTT		BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

24 y/o Iraqi ♂ here for eval c̄ LTC [redacted] (b)(6)-2

See H&P

WBC / Hb / Hct / Plt

Procedure: Central line — Sterile procedure. Indication: Abd abscess/peripheral difficulty. Ⓡ subclavian: prepped x3 (povidone iodine/alcohol/iodine). placed c̄ some difficulty. ∇ by chest, Line draws easily/flush is positional. [illegible] T.L.

[redacted] (b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all notes)

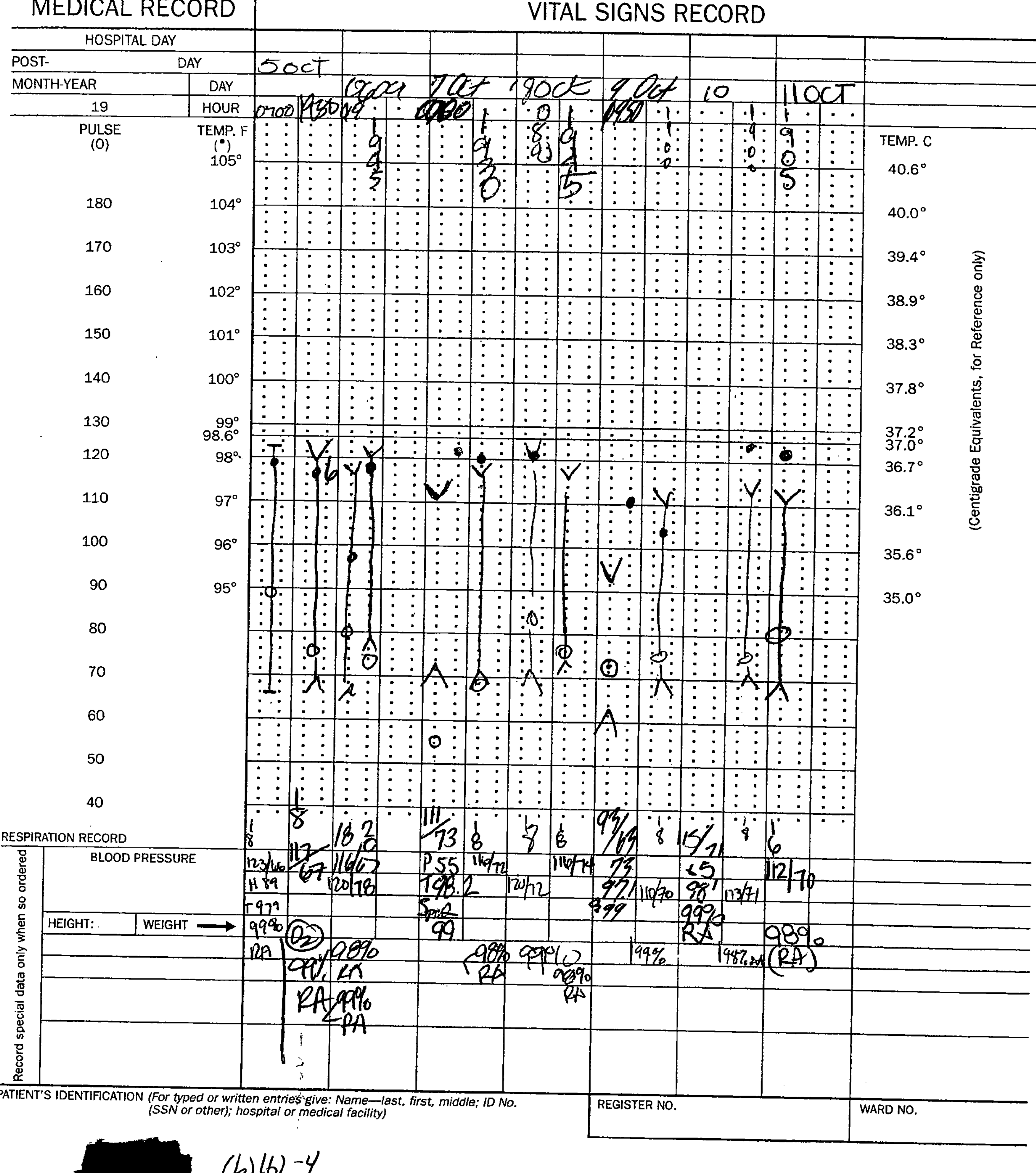
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	0700		Pt ambulated to back to bathe himself, emptied 150cc semi-solid stool from ileostomy. R/U no longer patent, new 20G started to (L) FA. Pt drank 650cc fluid for breakfast - NG canister emptied (full) assessment performed (see DA4700). Will monitor - plan to evac to Baghdad then possibly Ballad for TPN [redacted] SGT/LPN (b)(6)-2
	0900		Pt ambulated outside for a few minutes, upon returning c/o severe pain. MD @ bedside - 4mg MSO4 given IV - Will monitor for relief. [redacted] SGT/LPN (b)(6)-2
	1100		All dressings Δd, pt Δd own ileostomy bag - emptied 50cc liquid stool, VSS - will monitor [redacted] SGT/LPN
	1300		Pt ambulated to get another Xray done - ate (drank) all of lunch. Pt c/o pain - 4mg MSO4 given (b)(6)-2 [redacted] SGT/LPN (b)(6)-2
		1500	Pt resting s̄ c/o pain (b)(6)-2 [redacted] SGT/LPN
		1700	Pt put on E-mycin IV q8° - Δd times for Zantac - First dose hung. Pt s̄ c/o pain or nausea. Will monitor. (b)(6)-2 [redacted] SGT/LPN
		1730	Pt being transferred to Baghdad via litter - NG clamped. (b)(6)-2 [redacted] SGT/LPN
6 OCT			CT Procedure
1400			(L) paracolic abscess drainage catheter placed
OP [illegible] [redacted] (b)(6)-2			w/o complication. 30cc serous, cloudy
			aspirate to Microbiology for culture. EBL Ø Anesthesia:
(b)(6)-2			7cc 1% lidocaine. No complications [redacted] MD (b)(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD



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

REGISTER NO.

WARD NO.

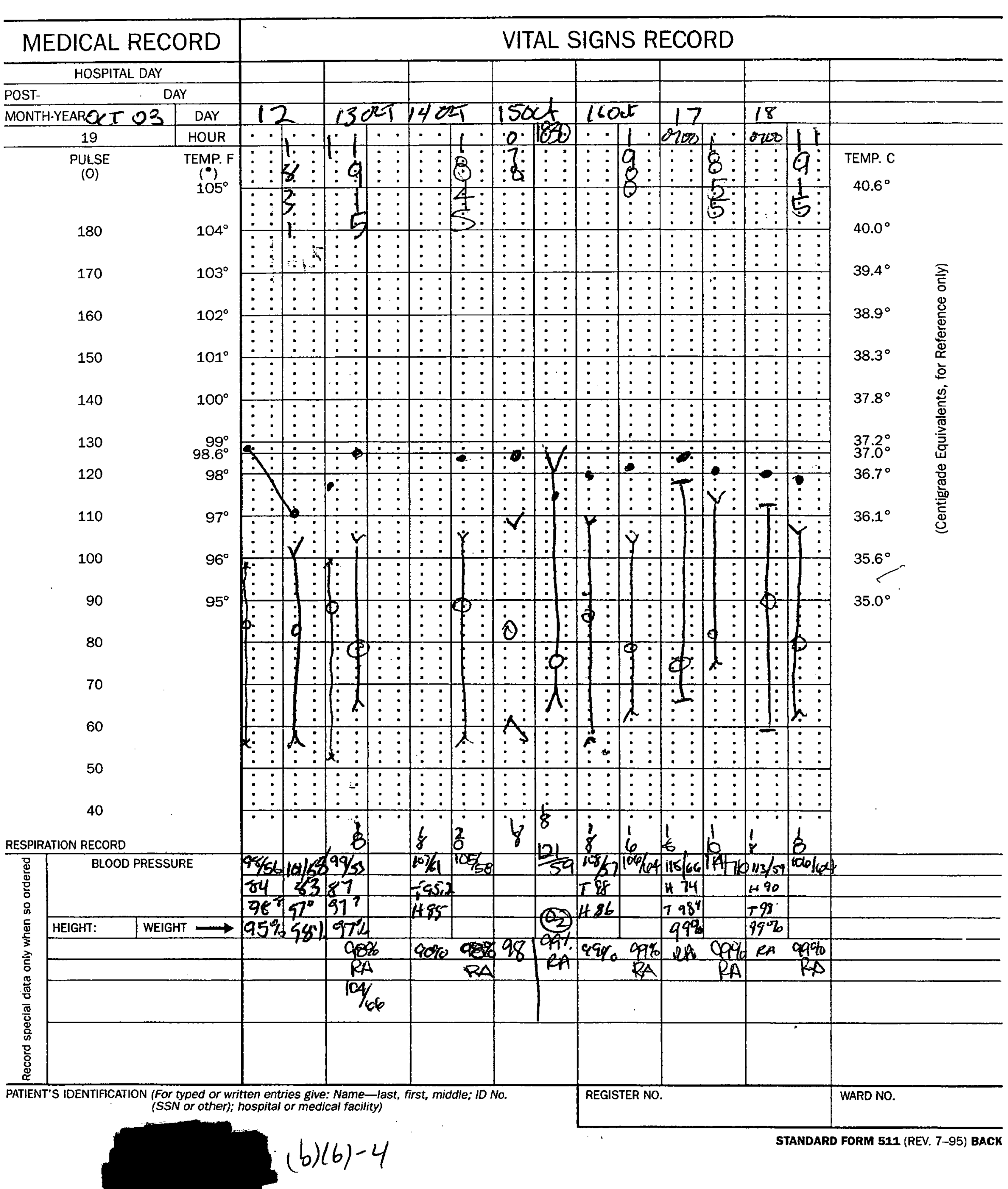
(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 21025



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 03 — DAY: 12, 13 OCT, 14 OCT, 15 Oct, 16 Oct, 17, 18

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° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE: 98/56, 101/68, 99/53, 101/61, 105/58, 121/59, 108/57, 106/64, 115/66, 113/59, 106/64; 104/66

HEIGHT: WEIGHT

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

REGISTER NO.

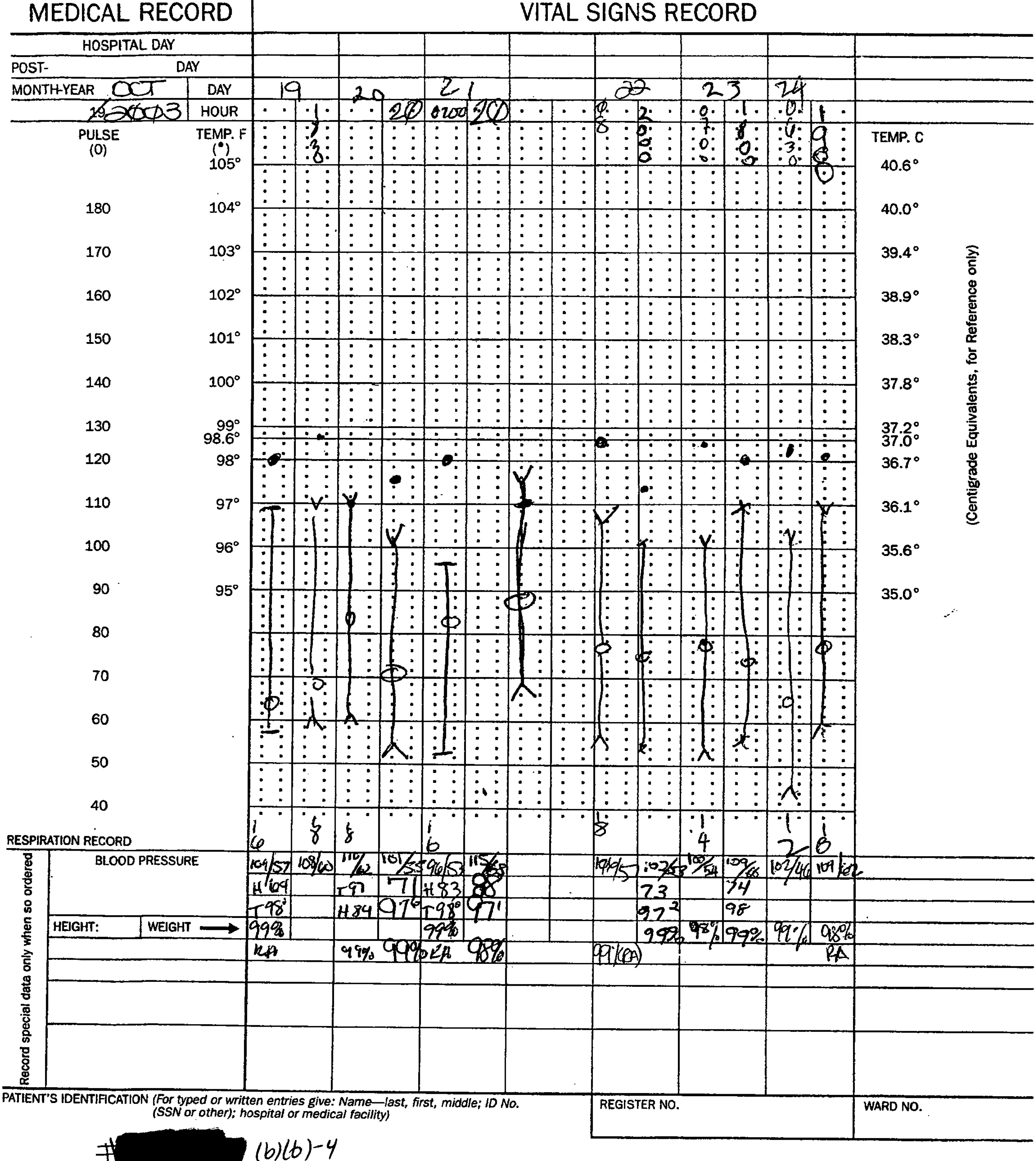
WARD NO.

(b)(6)-4

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

MEDCOM - 21026

MEDICAL RECORD — VITAL SIGNS RECORD



HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 2003 DAY 19 20 21 22 23 24

HOUR

PULSE (O) TEMP. F (•) TEMP. C

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

105° 40.6°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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.

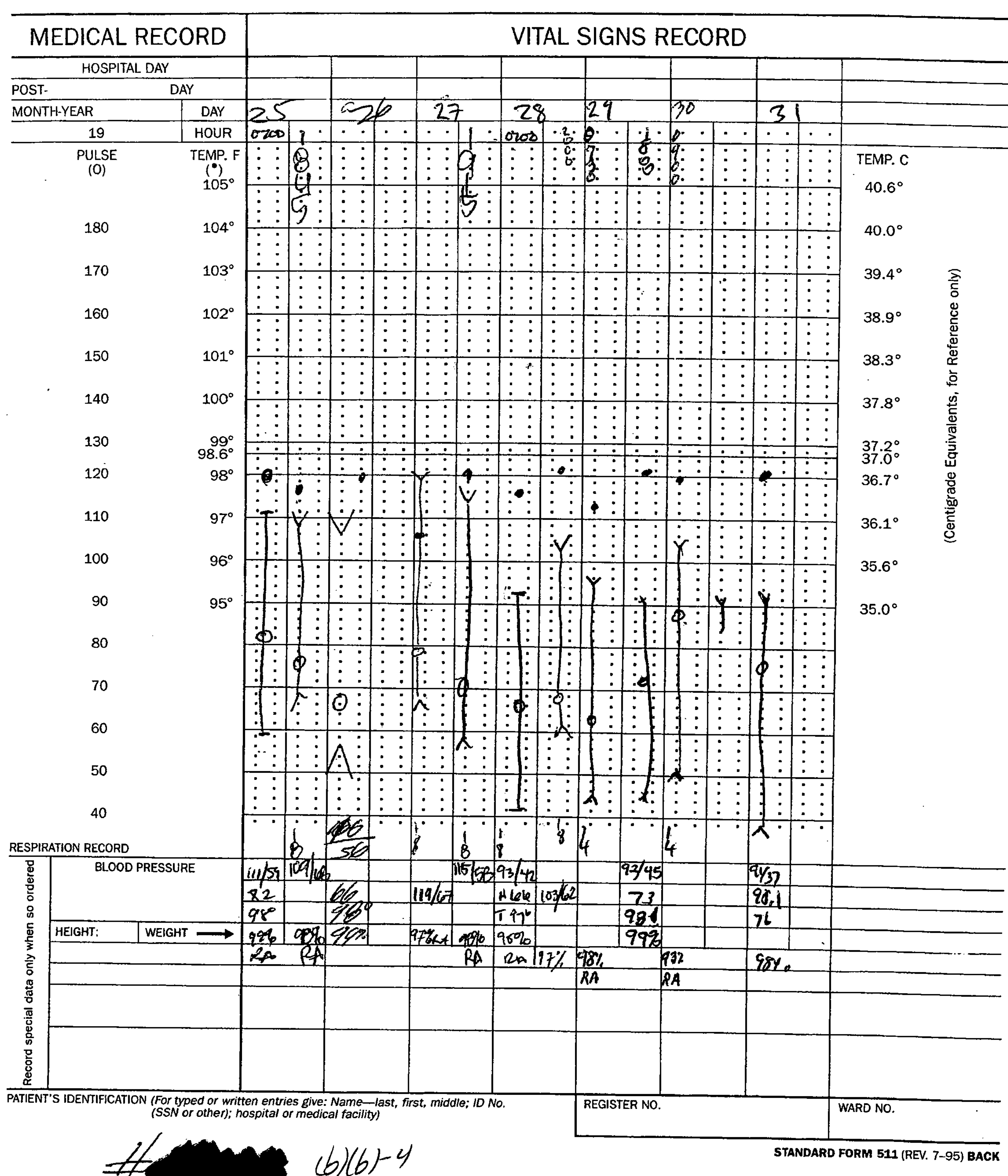
(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 21027



MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY 25 26 27 28 29 30 31
19 HOUR 0700 0700

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

105° | 40.6°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered
BLOOD PRESSURE
HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

MEDCOM - 21028

ACLU-RDI 1659 p.190

DOD-034604

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY			
POST- DAY			
MONTH-YEAR NOV	DAY	1	2
19 2003	HOUR	0915	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD 18

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

O2 SATS 98%

Source RA

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

REGISTER NO.

WARD NO.

(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 - 21029

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 6Oct03

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
				1800		LR@75	12° shift =		900cc
				0600cc 0600		RL c 75			1000 cc
						LR@75			900
									1900
	Jevity TF								
↑1500	30cc/hr								
0600	450cc total								

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
5Oct03 2200	NGT irrigation	30cc	30cc
6Oct03 0200	NGT irrigation	30cc	60cc
6Oct03 0600	NGT irrigation	30cc	90cc
6Oct 1800	NG irrigation		60cc total
	NG irrigation	x3/30cc	90cc
			150cc total

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

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

SDW

[redacted] (b)(6)-4

MEDCOM - 21030

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
6OCT03 0530	FOLEY 500cc	500cc				0545	1200cc	Dark Green Brown liquid	1200cc out
6Oct 1800	Foley	700cc				6OCT03 1800	80	dark green	
7Oct 0500	Foley	1050				7Oct 0500	1000	dark green	1050
		1850							

CHEST						EMESIS Abcess drain			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
						1800	150	bright yellow	150
						7Oct 0500	200	yellow	350

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
6Oct03 0130	green-BROWN	Loose c̄ chunks	600cc	600cc
6Oct 1800	green brown	brown liquid	600cc	600cc
7Oct 0500	brown	liquid	500	1100

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
~~2300~~	~~10cc~~	Residual	
~~0500~~	~~20~~		
0500	10cc	〃	20cc

GRAND TOTAL OUTPUT

06 7Oct 10cc (total) 10cc

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

MEDCOM - 21031

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 7OCT03 - 8OCT03

INTAKE

ORAL Jevity

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	Jevity	30cc/hr	210
	d/c @ 1300		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	75cc/hr	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagamet	100	~~1300~~ 1300	1100
1800	100	Tagament	100	100	1200
2200	100	Tagament	100		1300
0600	100	Tagament	100		1400
LR	18-06	LR	900		2300

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
10	30 H_2O	30	30
14	30 H_2O	30	60
18	30 H_2O	30	90
22	"		
02	"		
06	"		180cc

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

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

[redacted] (b)(6)-4

MEDCOM - 21032

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	900	900			
1700	350	1250			
0500	350	1550			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
1300	900	Green	900
1700	200	Green	1100
0500	300	greenish	1400

~~CHEST~~ Colostomy

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	200	200			
1700	150	350			
0500	150	500			

~~EMESIS~~ Abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
1300	100	bile color	100
1700	400	bile color	500
05	350	green, chunks	850

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 8-9OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1900	water	200	200
1930	broth	120	320
0030	broth	120	440

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	75c/hr	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagamet	100	1300	1100
1800	100	Tagamet	100	1830	1200
2200	100	Cipro	100		1300
24	100	Tagament	100		1400
06	100	Tagament	100		1500
06	75cc/° LR		900		2400

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
10	water	30	30
14	water	30	60
18	water	30	90

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

Jevity

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
↑1900	Jevity @30cc/°	330cc	330cc

GRAND TOTAL INTAKE

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

MEDCOM - 21034

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1700	850	850				1700	450	Greenish	450
0500	400	1250				1900	100	green	550
								d/cd	

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS Colostomy

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1700	~~350~~ green	liquid	350	350
05	"	"	200	550

Pigtail ~~OTHER OUTPUT~~ Abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
05	200	green/yellow	200
dayshift ??			

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 9 OCT 2003

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

Jevity

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
~~0600~~ 1800	Jevity (+) 30cc°	360	360
1800-0600	Jevity 30cc°	360	720

GRAND TOTAL INTAKE

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

MEDCOM - 21036

ACLU-RDI 1659 p.198

DOD-034612

OUTPUT

URINE (Foley)						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
0600-1200	900	900							
1200-1700	200	1100cc							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS (Colostomy)				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT (Abscess Drain)			
TIME	AMOUNT	TYPE	ACCUM TOTAL
0600-1800	125	Cloudy brown drainage	125cc

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

MEDCOM - 21037

ACLU-RDI 1659 p.199

DOD-034613

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 13-OCT03

INTAKE

~~ORAL~~ (G TUBE)

TIME	TYPE	AMOUNT	ACCUM TOTAL
12 OCT @ 0300	GTUBE (residual)		3cc
1300T	18-06 —		2cc
1300T 18-06	Jevity @ 30cc/° —		360cc
	(residual = 5cc @ 2200)		
	residual = 2cc @ 0500		
	7cc total		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
18-06	75cc/°	LR	900	06	900

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
~~2000~~ 1300T	FLUSH GT	20cc	20cc
0500	" "	20cc	40cc

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

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

MEDCOM - 21038

ACLU-RDI 1659 p.200

DOD-034614

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
13 2100	1500	1500							
14 06	900	2400							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS Colostomy

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
30CT 2200	brown liq	———	200	200
01000	"		300	500

~~OTHER OUTPUT~~ pigtail abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
18 0600	75cc	green	75cc

GRAND TOTAL OUTPUT

REMARKS

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
120	LARGE SOUP BOWL 240
SMALL FRUIT CUP 160	LARGE WATER GLASS ... 240
COFFEE MUG 180	PLASTIC OR PAPER JUICE CONTAINER 180

DD FORM 792, JAN 74

MEDCOM - 21039

ACLU-RDI 1659 p.201

DOD-034615

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 14OCT03 15OCT03

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2100	Ensure	200		18-06	75cc/°	LR	900	06	900
1830	H_2O	100	300	2200	100cc	Cipro	100		1000
0100	H_2O	100	400	2400	100	Tagamet	100		1100
				06	100	Tagamet	100		1200

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

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

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

MEDCOM - 21040

ACLU-RDI 1659 p.202

DOD-034616