INPATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
1. REGISTER NUMBER	(b)(6)-4
2. NAME (Last, First, MI)	(b)(6)-4
3. GRADE	TCN
4. SEX	M
5. AGE	
6. RACE	IRAQI
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	NO
11. FMP	99
12. SSN	(b)(6)-4
13. ORGANIZATION	
14. WARD	ICU5
15. FLYING STATUS	
16. RATING/DSG	
17. DEPT./BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	TRANS
22. HOURS OF ADMISSION	1118
23. CLINIC SERVICE	ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	TRANS
26. DATE OF DISPOSITION	2 APR 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	30 MAR 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	86TH COMBAT SUPPORT HOSPITAL, KUWAIT
30. DATE OF INTIAL ADMISSION	
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED	
ADMISSION REMARKS	
ADMITTING OFFICER	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW to chest

E 992.1
875.0

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
				2	2

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: = original signed =

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: (b)(6)-2

DA FORM 3647, MAY 79 — EDITION OF 1 AUG 76 IS OBSOLETE — USAPPC V1.10

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — (b)(3)-1
2. MTF LOCATION: 7 8 (State or Country Code.)

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4

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

4. PAY GRADE: 16 17 — X X

5. SEX: 18 — M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — (lined out)

7. AGE AT ADMISSION: 27 28 29 — 2 7 ~~7~~

8. RACE: 30 — X

9. ETHNIC BACKGROUND: 31 — 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE: 32 33 34 — Z

ETS

11. FMP: 35 36 — 9 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4

ORGANIZATION (Active Duty Only): Kuwaiti ~~IRAQI~~ CIVILIAN

13. MARITAL STATUS: 46 — Z

HOUR OF ADMISSION: 1118

BRANCH / CORPS: Kuwaiti Civ

14. FLYING STATUS: 47 48 49 — (lined out)

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — 0 9 3 3 0 0 0 0 0

17. UNIT LOCATION (State or Country Code): 62 63 — (lined out)

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 — (N)

PREV. ADMISSION: YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — 1

WARD: ICU5

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION: 73 74 — 2 2

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 0 2

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B A A

25. MTF TRANSFERRED FROM: 93 94 95 96 97 98 — (b)(3)-1 —

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 3 3 0

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108 — K u

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

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

GSW to chest

DX: 8751

Note Terrorist incident @ PX. Was turned over to Kuwaiti atnorities.

Trauma Injury 450

CODE: ~~E 992.1, 875.0~~

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 2000

MEDCOM - 3542

USAPA V1.00

.NT TREATMENT RECORD COVEF

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		X				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4	IRAQI CIV	ICU5

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
TRANS	1930	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TRANS	4 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		3 APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1, KUWAIT		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Ⓡ Thigh

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
				1	1

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
	(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/03	Ortho
0700	GSW to (B) LE's and s/p D&I c̄ post-splinting
	~~on~~ of (L) LE as of 4/2/03 sent c̄ appropriate
	initial surgical treatment. Please see
	GS note re: central body trauma.
	PE: Brisk cap refill
	2+ PT pulses
	FHL/EHL intact on (L)
	FHL intact on (R).
	A: (R) Distal thigh GSW c̄ peroneal n. palsy.
	(L) open medial femoral condyle fx (Based on OP report)
	P: Post splint adequate.
	D&I done @ FST
	Admit, abx, Tet
	(b)(6)-2 MD
	(b)(6)-2
4/2/03	Review of radiographs show (L) distal
	femur fracture without intercondylar
	extension.
	(b)(6)-2 MD.
	(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4/2/03	PT Arrives to ICU via stretcher. PT Alert and Calm. PT BP Low 80/20's in ER. PT Received 2L of LR in EMT Area, PT Rate started at 160 cc/hr upon MD orders. PT Blood pressure did come up but continues to go up and down. PT current BP 95/42 (61) PT HR 141. PT moving good air on both sides. PT has 2 PIV; (1) L Hand 2) RT Arm. PT has NG tube to (R) LWS. PT started on simple face mask 2 lts PT was having some problems keeping his O2 sats up. PT O2 sats currently 100% with O2. PT foley Draining light yellow urine c̄ some sediment. PT did Request some of his pain medication. PT currently resting c̄ no problems to report
	(b)(6)-2
03APR03	0700Z Pt. is stable temp 101.9 pt receiving 1 unit O+ blood started at 0630Z. Pt colostomy ⊖ signs of infection lung sounds clear. ⊕ bowel sounds heard. AxO x3. Pt. ready for transfer. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/04	Surgery / Kyn[illegible]
2000	20s Iraqi male seen at (b)(3)-1 for
	GSW x2 to back c low neck, ex lap, diverting colostomy, presacral drain. Pt
	also c apparent bilat GSW legs c flesh
	wound to (R) thigh, open fracture (L) femoral
	condyle. Pt in shock cardiac & hypovolemic
	p 144, BP 85/36 p 2L NS. Abdomen is
	[illegible] c [illegible] colostomy. Plan
	(1) fluid resuscitation
	(2) Film bilat LEs + pelvis
	(3) Ortho consult
	(4) Admit ICU (b)(6)-2
4/3/03	Pt received @ 1915 hrs from Air Evac on litter. Pt
	attached to telemetry - found to be hypoxic. 100% O2
	applied. Sat ↑ to 95%. Pt c/o pain gave 10mg
	MSO4 per MD verbal order. 2 wounds to RLE, 2
	wounds LLE - all wounds irrigated & redressed. - J. [illegible]
4/3/03	2015 Anesthesia note - therapeutic intubation performed.
	8.0 OETT, MAC 4 Blade, DL X1 c Cricoid pressure.
	RSI c 20 mg Etomidate, 100 mg Anectine, 5 mg Versed.
	(+) BBS (+) $ETCO_2$. Tube 22 cm @ teeth + secured c
	silk tape + ETT holder. 10 mg Vecuronium p intubation.
	Vent settings V_T 800 RR 10 FiO_2 30% PEEP 5 cm H_2O
	SIMV. Propofol 50 ug/Kg/min. (b)(6)-2 CPT AN CRNA

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/04	Surgery / Kyr [illegible]
2000	20s Iraqi male near [illegible] (b)(3)-1 [illegible]
	GSW x2 to back c low neck [illegible] in [illegible]
	ex-lap, [illegible] colostomy, presacral drain. Pt
	also c apparent bilat GSW legs c flesh
	wound to (R) thigh, open fracture (L) femoral
	condyle. Pt in [illegible] cardia & hypovolemic
	p 144, BP 85/36 p 2L NS. Abdomen is
	[illegible] c [illegible] colostomy. Plan
	(1) fluid resuscitation
	(2) Film bilat LEs & pelvis
	(3) Ortho consult
	(4) Admit ICU (b)(6)-2
4/3/03	Pt received @ 1915 hrs from Air Evac on litter. Pt
	attached to telemetry - found to be hypoxic. 100% O2
	applied. Sat ↑ to 95%. Pt c/o pain gave 10mg
	MSO4 per MD verbal order. 2 wounds to RLE, 2
	wounds LLE - all wounds irrigated & redressed. - J. Sinclair [illegible]
4/3/03	2015 Anesthesia note - therapeutic intubation performed.
	8.0 OETT, MAC 4 Blade, DL X1 c Cricoid pressure.
	RSI c 20 mg Etomidate, 100 mg Anectine, 5 mg Versed.
	(+) BBS (+) ETCO2. Tube 22 cm @ teeth + secured c
	silk tape + ETT holder. 10 mg Vecuronium p intubation.
	Vent settings Vt 800 RR 10 FiO2 30% PEEP 5cm H2O
	SIMV. Propofol 50 ug/kg/min. (b)(6)-2 CPT AN CRNA

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3Apr03	2020hrs - Pt intubated to maintain airway.
	Bilat breath sounds auscultated. PCXR done.
	ETT 22cm @ teeth. #8.0 ETT used. Mech vent
	settings: FiO2 40%, titrated ↓ 30%, TV 800, PEEP 5, Rate 10
	and SIMV mode. Pt sat 98-100%. Propofol drip
	Started @ 50mcg/kg/min, 75kg. LR infusing
	wide open. Will start MIVF after bolus given.
	Tylenol Elixir given via OGT @ 2040hrs for
	temp of 101.8°F. CBC & Chem 7 send to lab.
	Will continue to monitor closely - telemetry, VS,
	comfort level and wound drainage. (b)(6)-2
4 Apr 03	(b)(6)-2 CPT A
	0645 - pt remains stable condition, VSS,
	ETT still in place, pt SAT 100% c̄
	vent FiO2 30%, TV 800, PEEP 5, Rate 10
	will give report to oncoming staff.
	(b)(6)-2
4APR03 0730	0730 ResP. Note. PT orally Intubated c̄ 8.0mm ETTube
	placed @ 23cm at teeth & secured c̄ Tube holder/bite block
	Ascultated coarse BBS c̄ ↓ In bases. Lavage + SX
	c̄ 14F sterile catheter. yielding small amt of clear
	secretions. VS 125/52, 134 SaO2 95-100% →

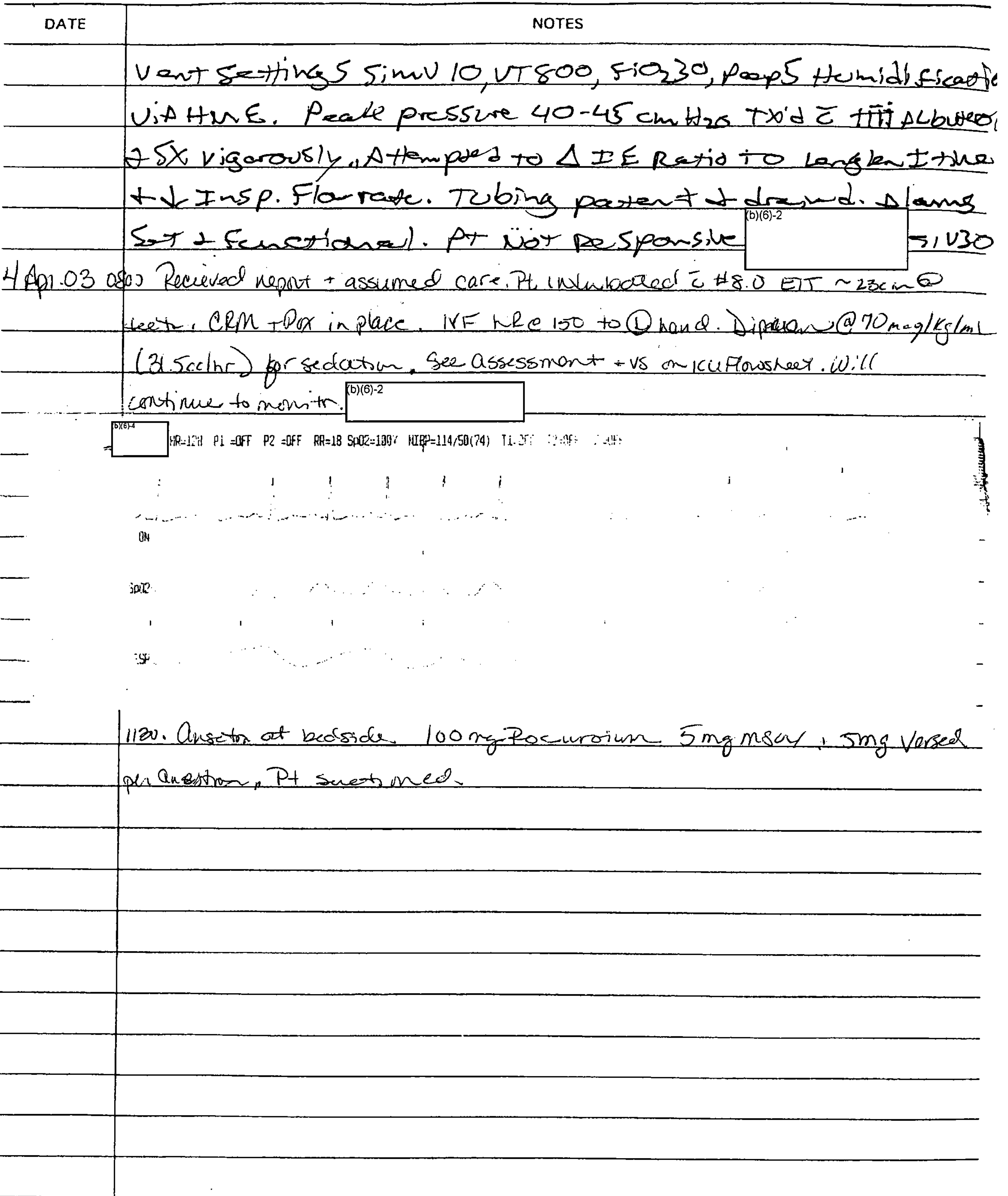
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)



DATE	NOTES
	Vent settings SIMV 10, VT 800, FiO2 30, Peep 5 Humidification
	via HME. Peak pressure 40-45 cm H2O Tx'd c̄ ↑↑↑ Albuterol
	+ SX vigorously. Attempted to Δ I:E Ratio to lengthen I time
	+ ↓ Insp. Flowrate. Tubing patent + drained. Alarms
	set + functional. Pt not responsive (b)(6)-2 5/V30
4 Apr.03 0800	Received report + assumed care. Pt intubated c̄ #8.0 ETT ~23cm @
	teeth. CRM + Pox in place. IVF NS @ 150 to (L) hand. Diprivan @ 70mcg/kg/min
	(31.5cc/hr) for sedation. See assessment + VS on ICU Flowsheet. Will
	continue to monitor. (b)(6)-2
(b)(6)-4	HR=120 P1 =OFF P2 =OFF RR=18 SpO2=100% NIBP=114/50(74)
	ON
	SpO2
	RESP
	1120. Anesthesia at bedside. 100mg Rocuronium 5mg MSO4 + 5mg Versed
	per Anesthesia. Pt suctioned.

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

Kg. 75

PATIENT NAME: EPW (b)(6)-4

DATE: ~~3Apr03~~ 4Apr03

VITAL SIGNS

TIME:	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500
BP ARTERIAL LINE												
BP CUFF	111/50	103/45	115/48	125/52	112/50	114/50	125/64	116/53				
MAP	71	69	78	79	74	74	89	76				
TEMPERATURE				99' Ax			100' Ax					
PULSE	128	129	133	132	131	128	120	135	141			
RESPIRATIONS	20	18	19	19	13	18	18	18	10			
PULSE OXIMETER	100%	99%	100%	99%	98%	100%	100%	100	100			
CVP	/	/	/									
PAIN (0 – 10)	UTA	UTA	UTA	UTA								
MSO4												
					3mg	2mg		5mg				

RESPIRATORY

	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500
OXYGEN (L/%)	~~NRB~~ 30% ~~Vent~~	30% ~~Vent~~	30%	30%	30%	30%	30%	30%				
O2 METHOD	Vent	vent	Vent	vent	vent	vent	vent	ven				
VENT SETTINGS:	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0	↓				
FIO2	30%	30%	30%	30%	30%	30%	30%	↓				
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	↓				
TV	800	800	800	800	800	800	800	↓				
RATE	10	10	10	10	10	10	10	↓				
PEEP	5	5	5	5	5	5	5	↓				
PS												
Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE

	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500
LR	150	150	150	150	150	150	150	150	150			
IVPB-Zosyn			100									
IVPB-Zantac									50			
					50							
Diprivan				31.5	31.5	31.5	31.5	31.5	31.5			
				70 (b)(6)-2								
PO	NPO											
TOTALS												

OUTPUT

	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500
URINE – Foley			200		250		400					
NGT												
Colostomy								100				
STOOL												
TOTALS												

MEDCOM - 3550

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: EPW # (b)(6)-4 DATE: 3 Apr 03

DIAGNOSIS: GSW, colostomy PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	1920	1930	2000	2030	2100	2130	2200	2300	2400	0100	0200	0300
VITAL SIGNS	BP ARTERIAL LINE	/	/	/	/	/	/	/	/	/	/	/	/
	BP CUFF	126/55	105/47	136/60	143/70	133/55	138/66	125/57	121/57	114/55	111/46	105/47	109/49
	MAP	82	68	89	96	86	94	85	79	76	73	71	73
	TEMPERATURE	101.8 A					98.2				99.5	98.7	
	PULSE	156	144	141	140	130	133	128	125	125	128	128	129
	RESPIRATIONS	30	25	26	10	10	10	13	15	18	15	20	19
	PULSE OXIMETER	97%	97%	97%	99%	100%	100%	100%	98%	100%	100%	95%	99%
	CVP	/											
	PAIN (0 – 10)	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA
RESPIRATORY	OXYGEN (L/%)	100%	100%	100%	40%	30%	30%	30%	30%	30%	30%	30%	30%
	O2 METHOD	NRB	NRB	NRB	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent
	VENT SETTINGS:	N/A	N/A	N/A	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0	#8.0
	FIO2				40%	30%	30%	30%	30%	30%	30%	30%	30%
	MODE				SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	TV				800	800	800	800	800	800	800	800	800
	RATE				10	10	10	10	10	10	10	10	10
	PEEP				5	5	5	5	5	5	5	5	5
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar

Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

		1920	1930	2000	2030	2100	2130	2200	2300	2400	0100	0200	0300
INTAKE	LR		1000		1000	1000	1000	150	150	150	150	150	150
	IVPB-Zosyn							100					
	IVPB-Zantac									50			
			NPO										
	PO												
	TOTALS												
OUTPUT	URINE – Foley			750				525					575
	NGT												400
	Colostomy							50					
	STOOL												
	TOTALS												

MEDCOM - 3551

MEDICAL RECORD - ICU FLOW

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: EPW I (b)(6)-4

DATE: 3 Apr 03

	TIME: 2000 INITIAL (b)(6)-2	TIME: 4 Apr 03 0800 INITIAL (b)(6)-2
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	pt sedated on propofol drip pt unresponsive to stimuli; pupils equal + sluggish @ [illegible]	Pt sedated/intubated [illegible] Diprivan 70 mcg/kg/min
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Sinus tach 120-150 Ø ectopy LR @ 150 cc/hr present pulses all extremities +3 edema BLE cap refill < 3 sec	ST 120-140's Ø ectopy PP x 4 generalized edema +3 Cap refill <3sec
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	pt mech ventilated c #8 ET tube 23 @ teeth (b)(6)-2 scattered rales, scattered rhonchi, diminished bases Bilat; vent: SIMV, 10 BPM 500 ml TV, FiO2 30%, 5 PEEP	ETT #8 23 @ teeth. secured Vent: SIMV 30%. 2 10 TV 500 PEEP 5 Sats. 100% Bilat. BS. c rhonchi/rales Suctioned. for mod. secretions
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	L upper quad colostomy pink tissue Ø break down at site OG tube (R) side mouth Faint BS Abdomen slightly firm + tender NPO	NPO OGT to suction c yellow [illegible] secretions hypoactive BS. (L) colostomy - tissue pink small amt drainage. lg midline incision dressing intact.
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley for gravity draining light amber urine c small amount of sediment	Foley to BSD c clear amber urine : QS.
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	MAE, BUE strong BLE weak, Temp cast to LLE	Sedated. Soft cast to (L) leg. drainage marked. ⊕ Pedal pulse
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	multiple wounds bilat lower extremities Bulky dressing applied to midline incision. (R) posterior chest incision	Multi wounds bilat l ext. (L) leg. ace wrap & splint ⊕ pedal pulse ⊕ cap refill. slightly cool. drainage marked. (R) thigh. wound dressed. and drainage Rectal penrose drains.
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	pt sedated c propofol morphine ordered prn	Pt sedated. MSO4 for pain.
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Non-english speaking EPW. Sedated at this time.	Sedated, unable to assess

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: EPW # (b)(6)-4 DATE: 3 Apr 03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	(R) hand #14g	4/2/03 - patent
IV SITE # 2	(L) AC #18g	Started 4/3/03
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	1925 hrs	(b)(6)-2
IV SITE CARE PROVIDED	1925 hrs	
IV TUBING CHANGED	1925 hrs	

COMMENTS: Both sites s̄ erythema

4/4/03 0800

	LOCATION	CONDITION
IV SITE # 1	(R) hand.	patent → LR + Diprivan
IV SITE # 2	(L) AC 18g	patent → SL / IVPB
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

02 April 03

745th Forward S[illegible] Team Intraoperative [illegible]mentation

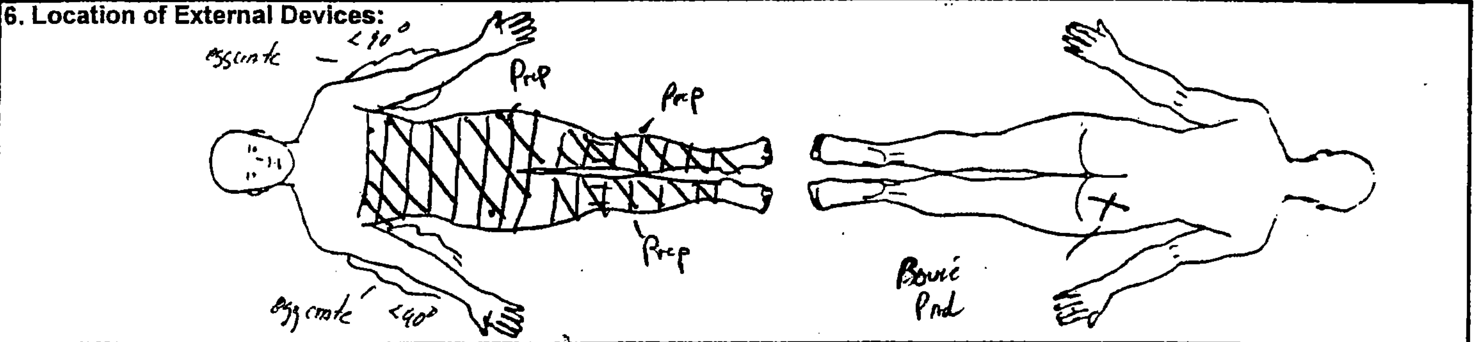
1. Patient Identification:	2. Assigned Scrub:
IRAQI EPW # (b)(6)-4	SSG (b)(6)-2 SSG PFC (circled)
	3. Assigned Circulator: CPT SSG

4. Position and Positional Aids:
Supine (circled) Prone Lateral - Right Side Up Left Side Up
Comments:

5. Skin Preparation:
Hair Removal - Yes (circled) No
Razor (circled) Clip
Comments: No cuts noted

Dura Prep - Abdomen - see prep below
Prep Solution - Betadine Paint
Site: Bilat Lower Extremities - See prep below By CPT (b)(6)-2
Comments: No pooling noted

6. Location of External Devices:



7. Counts: C = Correct I = Incorrect

	First	Final	Other
Sponge	C	C	
Needle/Sharp			
Instrument	Not Done - Emergency Case		

Scrub: SSG (b)(6)-2, SSG (b)(6)-2, PFC (b)(6)-2
Circulator: CPT (b)(6)-2

8. Implants/Drains Yes (circled) No
Penrose x 2 presacral area

9. Electrosurgery Device

	Yes	No
ESU # SN 2021073B	✓	Valleylab
Ground Pad	Brand	Valleylab E7507
	Lot #	62382 2004-07
		Cut 30 Coag 30

10. Medications/Orders

Medications	Dosage	Time	Method	Prepared By	Given By

Wound Irrigation: .9% NaCl

Other Orders:	Time	Carried Out By

11. Additional Information
PT came to OR ē Foley draining Tea colored urine

12. Dressing/Immobilization
Moist Kerlix covered by 4X8's - Abdomen | Kerlix Right Flank w/ Betadine
Betadine Kerlix Right Leg | moist Kerlix Left Leg ABD left Flank

13. Operation Performed
~~Recto Sigmoid~~ Ex Lap
Hartman's Pouch/Colostomy (Sigmoid)
Pre sacral Drain for Rectal Injury
Debridement of left medial thigh wound
I+D Right + left lower extremity wounds.

14. PT Transferred To	Time	Method
(b)(3)-1	1730	~~Litter~~ MEDEVAC

15. Registered Nurse Signature (b)(6)-2

16. Physicians Signature

Dressings cont -
Plaster OCL splint Left leg
(b)(6)-2

MEDCOM - 3554

Operativ _ : S=2 Apr

Pre Op Dx : 1) Acute abdomen 2° GSW to back ×2 over (B) iliac crests
2) Hematochezia on DRE
3) (B) LE GSW

Post Op Dx : 1) Extraperitoneal rectal injury (low)
2) Fracture of (R) medial femoral condyle (No X-Ray) (unstable Knee)

Surgery : 1) Exploratory laparotomy
2) Mobilization of ascending/descending colon c̄ end sigmoidostomy & pre-sacral drain
3) Wash-out of (B) LE GSW's

Surgeons : Primary = MAJ (b)(6)-2 / 1st Assist = LTC (b)(6)-2 / 2nd Assist = LTC (b)(6)-2

Anesthetists : MAJ's (b)(6)-2 / (b)(6)-2 → (b)(6)-2

EBL = 300 cc Crystalloids = 5000 cc crystalloid UOP = 800 cc

Findings = Extraperitoneal & retroperitoneal staining around rectum & extending along (B) lateral gutters of colon. No intraperitoneal injuries noted. (B) ureters identified. No evidence of iliac vessel injury. Due to gross blood on DRE, retro & extraperitoneal staining from GSW's, an end sigmoidostomy was performed. Pre-sacral drain placed as well from below. [On entering pre-sacral space, rectal hole noted on posterior midline above anal canal.] Exploration of GSW's of (B) LE's revealed bone fragments off of (R) medial femoral epicondyle. No instability of joints & vascularly intact.

Drains = Pre-sacral penrose drains ×2

Disposition = Medevac to EPW medical treatment (b)(3)-1 slice

(b)(6)-2 LTC MC

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY Wed

MONTH-YEAR Apl/03 | DAY | HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

HOUR					2300		2015	0230 / 0500	0625	0645	0700	0715	0740	0750
BLOOD PRESSURE	88/54 (59)	95/42 (61)	102/40 (63)	101/41 (62)	105/40 (67)	95/42 (61)	88/42 (59)	93/48	108/56	102/44	99/38	110/61	102/60	114/52
HEIGHT: WEIGHT →									Pulse	136	134	137	136	133
SPO2	89%	97	100%		100%		99%	99	99%		93%	97%	91%	90%
	LA	LA	Simple mask		S M		SM	6L			6L	6L		
RR	39	34	30	29	33	32	32	34	34	44	34	32	40	32
	LR Bolus 1000cc		LR 160		MSO4 4mg given		100.0	101.?	101.9	100.5		100.7	100.6	100.7

- output 0800 700cc

Urine output 800cc over 6 HRS

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

REGISTER NO. (b)(6)-4

WARD NO. ICU 1

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

*U.S.GPO:1998-404-763/40069

OD (b)(6)-4

MEDCOM - 3556

511-119

MEDICAL RECORD

NSN 7540-00-634-4

VITAL SIGNS RECORD

HOSPITAL DAY				
POST- DAY				
MONTH-YEAR / DAY	03APR03			
19 / HOUR	0805	0815	0830	0845

PULSE (O) — TEMP. F (•)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	103/53	118/53	111/54	107/55
Pulse	137	136	137	135
HEIGHT: WEIGHT →				
Resp	32	34	32	32
Temp	101.7		100.2	100.3
SaO2	92%	93%	10%	94%
	6LO2	6LO2	6LO2	6LO2

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.

VITAL SIGNS RECORDS

Medical Record

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

Form 1 — Chemistry I

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M./P.M.
	2120	P.M.

RESULTS	REQUESTED	(X)
120	GLUCOSE	
21	UREA N.	
	CREATININE	
	URIC ACID	
141	SODIUM	
4.0	POTASSIUM	
107	CHLORIDE	
21	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
21	Hct	
7	Hb (est)	
7.344	ph	

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

REMARKS

REQUESTING PHYSICIAN'S SIGNATURE

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

TECH

MD DATE 2 Apr 03

CHEM URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

OD# .

Arterial
ph 7.325
PCO2 38.2
PO2 53
HCO3 20
BEecf -6

Form 2 — Chemistry I

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M./P.M.
3APR03	2115	

RESULTS	REQUESTED	(X)
105	GLUCOSE	
19	UREA N.	
1.5	CREATININE	
	URIC ACID	
137 ↓	SODIUM	
4.5	POTASSIUM	
106	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
26	Hct	
9	Hgb	

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77)
General Services Administration and Interagency Committee on Medical Records, FIRMR (41 CFR) 201-45.505

REMARKS (b)(6)-2

Chem 7

REQUESTING PHYSICIAN'S SIGNATURE

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

TECH

MD DATE 3Apr03 2146

CHEM I URGENCY: ☒ ASAP ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☒ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

(b)(6)-4

EPW ICUS

Form 3 — Hematology

#(b)(6)-4 ICUS

EPW

SPECIMEN/LAB RPT. NO.

HEMATOLOGY URGENCY: ☒ ASAP ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☒ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE X (b)(6)-2

REPORTED BY (b)(6)-2

DATE 03 Apr 03 2250

LAB. ID. NO.

REMARKS CBC

TEST(S)	RESULTS
SPECIMEN TAKEN — DATE	3APR03
TIME	2115
REQUESTED (X)	
RBC COUNT	3.24 x10
HEMOGLOBIN	9.8
HEMATOCRIT	30.3
MCV	93.4
MCH	30.1
MCHC	32.2
WBC COUNT	9.0 x 10³
WBC DIFF AND BLOOD CELL MORPH — IMMATURE (Meta)	1
NEUTRO-BANDS	24
NEUTROSEGS	64
LYMPHS	8
EOSINOPHILS	
BASOPHILS	
MONOCYTES	3
PLATELETS	SL Dec / N
RBC	N/N
SED. RATE	
PLATELET COUNT	152 x 10³
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PT — CONTROL	
PT — PATIENT	
PTT — CONTROL	
PTT — PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	8.5
LE PREP	47% / 0.8x10³

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

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)* 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 3 Apr 03

DATE AND HOUR REQUIRED: 3 Apr 03 0710

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)* Dr. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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 [signature]

DATE VERIFIED: 03 APR 03

TIME VERIFIED: 0745 Z

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

	DONOR	RECIPIENT
ABO	O	
Rh	POS	

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 3 Apr 03

REMARKS:

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND (b)(6)-2

AT *(Hour)* 0745 ON *(Date)* 3 Apr 03

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)* (b)(6)-2 [signature]

2nd VERIFIER *(Signature)* (b)(6)-2 [signature]

PRE-TRANSFUSION

TEMP. 100.6 | PULSE 136 | BP 102/60

DATE OF TRANSFUSION: 03APR03 | TIME STARTED: 0745 Z

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 0845 03APR03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	100.3	135	107/55

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.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 [signature]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX: Male | WARD: ICU I

CD # (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

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) 450 ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 3 Apr 03

DATE AND HOUR REQUIRED: 3 Apr 03 0615

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): Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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: 03 APR 03

TIME VERIFIED: 0615Z

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO: O

Rh: POS

RECIPIENT

ABO

Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 3 Apr 03

REMARKS:

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) (b)(6)-2 (b)(6)-2

AT (Hour) /0615 ON (Date) 3 Apr 03

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

2nd VERIFIER (Signature) (b)(6)-2 [signature] MAJ AN

PRE-TRANSFUSION

TEMP. 101.9 PULSE 122 BP 93/48

DATE OF TRANSFUSION: 03 APR03

TIME STARTED: 0630Z

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 0740Z 03APR03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.6	136	102/60

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.)

- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 [signature]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

OD #(b)(6)-4

SEX: Male

WARD: ICU I

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR		M		ICU5	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 3 APR 03

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

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
	3 Apr 03	

RADIOLOGIC REPORT

ETT tip approx 3 cm from carina - recommend ~1 cm withdrawal → approaching (R) mainstem intubation. There is diffuse ↑ opacification of (L) hemithorax but symmetric lung volumes. ? ↓ aeration of (L) lung

Prominence of pulm. vasc + ↑ heart size likely 2° technique.

Enteric tube tip in region of gastric fundus.

Patchy atelectasis

(b)(6)-2

Rad (b)(3)-1

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

EPW

#(b)(6)-4

Foreign National

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
4/2/03 2045 [illegible]		Admit to Surgery	
		Dx: (B) GSW + 2 back [illegible]	
		[illegible]	
		(B) (R) femoral fracture	
		Condition [illegible]	
NURSING UNIT / ROOM NO. / BED NO.		VS per protocol	
		NKDA	

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
		Bedrest	
		Foley to gravity	
		Povidone [illegible] + 2 [illegible]	
		Wet to Dry dressing [illegible] (R) [illegible]	
		[illegible] wound daily	
NURSING UNIT / ROOM NO. / BED NO.		[illegible]	
		[illegible] back [illegible] gauze daily	

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
		NPO	
		LR @ 160cc/hr	
		MSO4 4mg IV Q1° prn pain	
		Phenergan 12.5mg IV Q4° prn	(b)(6)-2
		Ancef 1g IV Q8°	
NURSING UNIT / ROOM NO. / BED NO.		Gentamicin 300mg IV Qd	
		O2 2L NC	

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
		ABG c H+H, Chem-7 [illegible]	
		Bilat LE x-rays now	
		Pelvic x-ray now	
		(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
4/3/03 0430 2JL		use 2U prbc's now NG to suction (b)(6)-2 (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.				

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		3 Apr 2003	0530 HOURS	
		Clarification (1) transfuse c 2 units O2 blood ✓ (2) Suction to low intermediate ✓ (b)(6)-2 (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.				

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
OD (b)(6)-4				
NURSING UNIT / ROOM NO. / BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

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

1. admit ICU 5
2. D(x) s/p GSW ex lap, colostomy
3. vitals q 1hr
4. NG to LCIS
5. Foley
6. call MD abnormal vitals

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

7. O_2 to keep SO_2 > 94%
8. NPO
9. LR @ 150cc/hr
10. CBC
11. Unasyn III gm IVPB q 6hr
12. NPO
13. Zantac ~~15~~ 50mg IVPB q 8hrs

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

14. Morphine 10mg now then 1-5mg q 1hr
15. Heparin 5000 u BID.

(b)(6)-2

(b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 4/3/03 | TIME OF ORDER 2025 HOURS

1. Vent Settings: V_T 800 F 10 PEEP 5 SIMV, FiO_2 30%
2. Propofol gtt 50ug/kg/min titrate to keep SBP > 100
3. Versed 2mg IV q 1H opposite MSO4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 3564

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		2145	03APR03 HOURS	(b)(6)-2
	1	Albuterol 4 puffs MDI q 4°		
	2	Atrovent 2 puffs q 4°		
		(b)(6)-2		
		(b)(6)-2		(b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		03Apr03	2222 HOURS	(b)(6)-2 3Apr03
		D/C Unasyn		
		Zosyn 3.375gm IVPB		
		q6hrs		
		(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 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

...RAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Apr Yr 2003

Order Date	Clerk Nurse (Verify by Initialing)	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(b)(6)-2	admit ICU 5	3Apr03	20:50	2050	(b)(6)-2
		Dx sp GSW, ex lap, Colostomy	3Apr03	2030	2030	
		Foley	3Apr03	20:50	2050	
		NG to LIS	3Apr03	2030	2030	
		Call MD for abnormal vitals	3Apr03	2030	2030	
		O_2 to keep SO_2 > 94%	3Apr03	2030	2030	
		NPO	3Apr03	2030	2030	
		CBC	3Apr03	2100	2110	
		Vent settings: V_T 800 f 10 PEEP 5 SIMV	3Apr03	2030	2030	
		FiO2 30%				

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 (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Apr Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10
3 April 03	(b)(6)-2	vitals q 1 hr	D	/							
			E	/							
			N	(b)(6)-2							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW, Colostomy

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

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. Apr 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
3Apr03	(b)(6)-2	LR @ 150cc/hr	D	/				
			E	/				
			N	(b)(6)-2				
3Apr03	(b)(6)-2	Unasyn III gm IVPB q 6hrs	06	/		D/C		
			12	/				
			18					
			24					
3Apr03	(b)(6)-2	Zantac 50 mg IVPB q 8hrs	08	/				
			16	/				
			24	(b)(6)-2				
3Apr03	(b)(6)-2	Heparin 5000 U BID	06	/	held			
			18	(b)(6)-2				
3Apr03	(b)(6)-2	Propofol gtt 50ug/kg/min titrate to keep SBP >100	D	/				
			E	/				
			N	(b)(6)-2				
3Apr03	(b)(6)-2	Zosyn 3.375 gm IVPB Q6hrs	06	/				
			12	/				
			18	/				
			24	(b)(6)-2				
3Apr03	(b)(6)-2	Albuterol 4 puffs MDI Q 4hrs	06	/	(b)(6)-2			
			10	/				
			14	/				
			18	/				
			22	(b)(6)-2				
			02					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW s/p exlap, colostomy

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 TIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. ______ Yr. ______

Verify by Initialing

Order Date	Clerk/ Nurse	ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3 Apr 03	(b)(6)-2	Morphine 10 mg now	4/3/03	1945	1945	(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED
	(b)(6)-2	~~Morphine 15 mg q 1hr~~ (b)(6)-2	D/C	(b)(6)-2
	(b)(6)-2	Morphine 1-5 mg	I	
		Q 1hr	E	
	(b)(6)-2	Versed 2 mg IV		
		c̄ OH opposite MSO4		

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 342-027/70450

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo.____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	3	4	5	6	DATE DISPENSED			
				3	4	5	6	7	8	9	10 (b)(6)-2
3 Apr 03	(b)(6)-2	Atrovent 2 puffs	06	/	(b)(6)-2						
	------	Q 4 hrs	10	/							
	------		14	/							
	------		18	/							
	------		22	(b)(6)-2							
	------		02								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Sq exlarg, Colostomy

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

TIL EXHAUSTED.

DA FORM 1 FEB 79 4678

EDITION OF ...

MEDCOM - 3570

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. Apr Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	2	3	4	5
2 Apr	------	Ancef 1g IV Q8°	05	/	(b)(6)-2		
	------		11	/			
	------		19	2100			
2 Apr	------	Gentamycin 300mg IV	06	/	(b)(6)-2		
	------	QD.					

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P GSW x 2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

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.

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 Apr 2046	(b)(6)-2	O2 2LNC			2048	(b)(6)-2
2 Apr 2048		ABG c H+H Chem 7 via ISTAT	2 Apr 20	2058	2059	
2 Apr 2048		Bilat LE XRAY NOW	2 Apr 2048	NOW	DONE	
2 Apr 2046		Pelvic X-RAY NOW	2 Apr 2048	NOW	Done	
2 Apr 2046		Foley to gravity	2 Apr 2048	2080	2080	
3 APR 03		transfuse 2 units O+ blood	03 APR 03	0530		

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
2 April 2046	(b)(6)-2	Phenergan 12.5mg IV Q4HR PRN (b)(6)-2	(b)(6)-2
2 April 2046	(b)(6)-2	MSO4 4mg IV Q1° PRN Pain	0100 4mg, 0230, 0400, 0530, 0700, 0815, 0840, 1040 4mg

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

MEDCOM - 3572

CLINICAL RECORD

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

*Mo.*____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	2	3	4	5
2 April 2005	-----	Diet NPO	05	/	(b)(6)-2		
	(b)(6)-2		09	/			
			13	/			
2 April 2005	-----	VS Q Shift	05	/	(b)(6)-2		
	(b)(6)-2		11	/			
	-----		17	(b)(6)-2			
2 April 2005	-----	Wet to Dry Dressing Δ	09	/	(b)(6)-2		
	(b)(6)-2	Ⓡ		/			
2 April 2005	-----	Δ midline ABD dressing	09	/	/		
	(b)(6)-2	w/ 6/7 back gauze QD		/			
	-----						
2 April 2005	-----	Bed Rest Q shift	05	/	(b)(6)-2		
	(b)(6)-2		12	/			
			18	(b)(6)-2			
	-----						
03 APR 05	(b)(6)-2	Suction to low-int.	04 16	(b)(6)-2			
	-----		16 04	/			

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW x2 Back c̄
Ⓡ femoral fracture

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

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.

-AL RECORD - SUPLEMENTAL MEDICAL DATA

r use of this form, see AR 40-66; the ...ency is the Office of the Surgeon General

OTSG APROVED (Date)

EPORT TITLE

TRAUMA FLOWSHEET

☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

(b)(6)-2 INITIAL ASSESSMENT

ate: (b)(6)-4 2 APR 0? Arrival Time: 1918 Sex: (M) F Age: ______ Wt: ______

Tetanus Status: UTD (Unknown)

llergies: ______

MP: Last Meal:

hief Complaint: GSW to abd, (L) LE injury

Medications:

MH:

reatments PTA:

ITAL SIGNS: BP: 76/24 P: 153 RR: 28 TEMP: SAO2: 91

HEST
RAUMA ☐ YES ☐ NO
AIN ☐ YES ☐ NO
OB ☐ YES ☐ NO
UNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R_____mm L_____mm
GLASCOW SCORE:______

PUPIL SIZES: 2 3 4 5 6 7 8 9

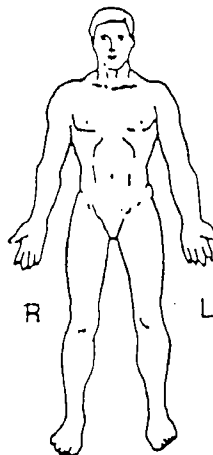
GLASCOW COMA SCALE

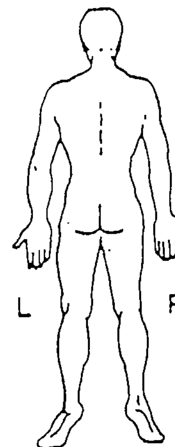
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obedient	6
To Voice	3	Confused	4	Purposeful	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible	2	Flexion	3
		None	1	Extension	2
				None	1

XTREMETIES
] DISTAL PULSES.
] RT X 2 ☐ LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

XCEPTIONS TO BOVE ARAMETERS:

SPLINTS:





A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW (I/Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

REATMENTS:
2: LPM NC MASK ORAL AIRWAY NASAL AIRWAY
TT # MM
IONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
IG TUBE #
OLEY: #
HEST TUBE ☐ R ☐ L
DPL ☐ POS ☐ NEG
CM H20

(Continue on reverse

REPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC (b)(3)-1 | DATE

ATIENT'S IDENTIFICATION (For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility) (b)(6)-4

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

		IV FLUID/BLOOD	AMOUNT INFUSED		OUTPUT
					CHEST TUBE:
					EMESIS:
					NG TUBE:
					URINE:
					EBL:
					OTHER:

TOTAL IN:__________ OUTPUT:______

NURSING NOTES

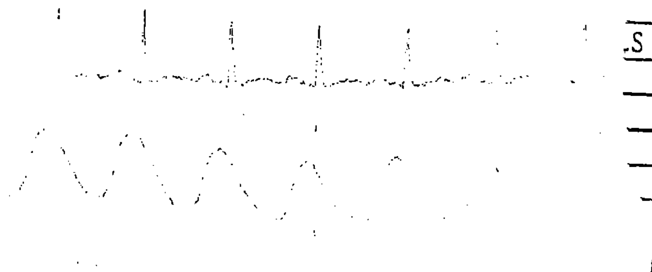
TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT
1930	76/37	144	32		O_2 Sat ↓ 81%. Placed on 10L O_2 via NRB.
1941	92/51				O_2 Sat ↑ to 100%. (b)(6)-2
					400cc UOP from foley. Clear, light
2000	84/23				tea-colored urine (b)(6)-2

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA

OTHER:__________________

XRAYS:

TIME	MED



PROCEDURES/PROGR

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)
(b)(3)-1	K U	EPW

3. REGISTER NUMBER: (b)(6)-4 — OD# (b)(6)-4

4. PAY GRADE: X X
5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19830101
7. AGE AT ADMISSION: 20 Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION: MUSLIM

10. LENGTH OF SERVICE:
ETS:
11. FMP: 20
12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only): IRAQI CIVILIAN
13. MARITAL STATUS:
HOUR OF ADMISSION: 1930
BRANCH / CORPS: IRAQI CIV

14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K91 K78
16. ZIP CODE OF RESIDENCE: 093300000

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1
WARD: ICU5
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 Kuwait
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION: 22 Trans
22. MTF TRANSFERRED TO: (b)(3)-1
23. DATE OF DISPOSITION (YYYYMMDD): 20030404

24. CLINIC SVC - ADMITTING: ABAA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYYYMMDD): 20030403

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

FOR LOCAL USE

GSW (R) thigh

DX: 86355
82131
5180
E9912

Px: 4575
5411
7965
9355

Trauma
I

Injury
450

CODE:

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

...ENT TREATMENT RECORD COVER

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

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

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICU5

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Trans.	1930	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	USS com.	4 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		3 APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
(b)(3)-1 KUWAIT		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

open Tib/fib fx

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
1				1	1

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/03	Ortho
0740	HPI: 25 yo Iraqi ♂ ~~s~~ s/P Ex Fix (L)
	open tibia ~~today~~ & transferred
	to our facility.
	Xray: Mid-diaphyseal tibia fx 2°
	to frag/GSW.
	Also had I&D to ~~soft tissue~~ wound
	(L) distal thigh.
	PMH: Ø PSH: Ø
	All: Ø Meds Ø.
	Isolated injuries as noted.
	PE: Old ~~how~~ Howmedica unilateral
	fixator in place.
	FHL/EHL intact. Brisk cap refill
	2+ pulses.
	A: (L) open tibia fx
	P: Adm't
	Ancef/Gent
	Relook 4-10 days
	(b)(6)-2 (b)(6)-2 MD

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.

OD # (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	NOTES
	Ortho
3/4/03	(L) LE. Ex Fix in place
1830	moving all toes
	Sens. appears intact + CT
	2 sec. cl.
	pulse DP.
	Assisting, transfer to comfort
	(b)(6)-2 [illegible]
3APR03	2000 - Started IVF NS @ 100, 5mg IV MSO4 given for pain, start 1gm Ancef IVPB. 300cc urine voided x1. Pt resting (b)(6)-2 LTRN
3APR03	2000 - Pt resting, HRR, lungs CTA, +BS, Pt tried bedpan but had only flatus. +BS x all quadrants. +circ & pulse checks x all extremities, warm. External fixature to (L) tib/fib open fx. Dressing c marked sero sanguous drainage. (b)(6)-2 LTRN

Med Sheets

		03	04	05
Ancef	04	Given		
~~Gent~~	12	missed		
	20	[illegible]		
Gent	11	Given		

See green/white sheets

DATE	NOTES
3APR03 2200	MSO4 5mg IV given for pain (b)(6)-2 [illegible]
4APR03	@ 0310 - Pt voided 325cc amber urine in urinal. Nothing follows (b)(6)-2 CPT, RN

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3Apr03	1925 - Admission VS: 115/64 HR 100, RR 26, 98% Pox RA. Adult male alert, external fixator to LLE, +Pulses x all extremeties. 2 ID bracelets #J & #0098 g[illegible]
03 APR 03	00 98 M/O 20-30 yo FX
	on Ancef/Gent since 02 APR 03 / X-Fix 02 APR 03.
	PE NC/AT
	n supple
	CTA B/L
	RRR
	ABD soft / non ⊕
	c̄ 2⊕ RADIAL pulse
	2⊕ DP pulse / X-Fix Appears stable / In-place
	A/P - open Tib/Fib Fx s/p X-Fix yesterday
	- continue Antibiotics
	- start IVF
	- NPO [illegible]
	- Analgesics / IV c̄ MSO4
	DR. (b)(6)-2 SAW PT (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.

00 # (b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3apr03 450z	Pt alert, eating MRE - Vitals - Spo^2 - 98%, 87 pulse, 98.3 temp, 120/50 BP, 20rr
3Apr03 0509Z	Pt lungs CTA, Heart RRR, BS present x4. Pt has external fixature on (L) leg c̄ Dsg min amount drainage. Pt s̄ c/o pain @ present time. Will continue to monitor — (b)(6)-2 1LT/AN
	Medication Sheet
	03 | 04 | 05
Ancef 03	(b)(6)-2
11	(b)(6)-2
19	1LT/RN 2000hr
	03 | 04 | 05
Gentamycin	
11	(b)(6)-2
~~3APR03~~	~~Vicodin [illegible]~~ (b)(6)-2
3APR03	Vicodin ii tabs PO given for Pain
4/3/03 1230Z	(L) open TIB FX s/p ex-fix (4/2/03)
	Ancef/GENT D#2
	Bandage c̄ soakage @ mid shaft and @ fx sites
	Relook on 4/6/03 - 4/12/03
	Pain Control
	EVAC Priority (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
2APR03 0905	Pt denies any pain. IV flushed out and 1Gm Rocephin IV given. Moderate drainage from bandage - no additional bleeding. Traction pins intact. (+) pedal pulse. (+) cap refill. Pt refused water and food. — (b)(6)-2 CPT
0926	BP 97/61 PR 65 R 20 SpO2 99
	voided 350cc
1740	pt's dsg CDI. (+) pedal pulse. Pt voided 250cc. Pt denies any pain. Pt tolerating regular diet well. ↑ 1000cc NS — (b)(6)-2
	B6-4
	Pt temp 99.3 BP 137/73 % SpO2: 86 pulse 73
2APR03 2015 Z	25 yo Iraqi EPW # [redacted] admitted to ICW #1 via wheeled litter, to bed c̄ A3. Alert, c/o pain, external fixator in place on (L) LE, dressing soiled c̄ serosanguineous drainage. Cooperative to care, lungs clear, abd soft, nontender BS (+) x 4 quads, IV placed in (L) wrist, S1 + S2 clear, peripheral pulses palpable and correspond c̄ heart sounds. Operative extremity warm, elevated, distal pulses palpable CRT <3 sec. Pt writhing in pain. MSO4 3 mg IV given. Vicodin 2 tabs P.O. given. Pt resting c̄ eyes closed. BP 137/87 HR 92 RR 22 T 99.3. — CPT (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.)*

EPW # (b)(6)-4 (b)(6)-2

(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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 Mar 03 0700	Assume pt care; VSS; temp 99.5; NPO p̄ MN; IV of NS @ 100 in (L) forearm; site s̄ s/s of complications; able to communicate c̄ hand gestures; GSW to L/E extremity c̄ ext fixation; pulse present & capillary refill <3 sec; able to wiggle toes; extremity ↑ on blanket; pain med given @ 0815 by RN; Voided s̄ assist x1; NUI; —— (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.

#5 (b)(6)-4

PROGRESS NOTES
Medical Record

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

...ICAL RECORD - ICU FLOWS...

SECTION I - PATIENT ASSESSMENT DATA

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

DIAGNOSIS: S/P Ext. Fixator to (L) tib/fib open fx

DATE: 3 APR 03 / 4 APR 03

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	1925	2000	2100	0700								
VITAL SIGNS	BP ARTERIAL LINE	—	—	/									
	BP CUFF	115/64	—	/	130/72								
	MAP												
	TEMPERATURE				99.5								
	PULSE	100	70	/	64								
	RESPIRATIONS	26	18	/	16								
	PULSE OXIMETER	98%	—	/	99%								
	CVP												
	PAIN (0 – 10)	yes	yes	sleeping 0									
RESPIRATORY	OXYGEN (L/%)	RA	RA	/	RA								
	O2 METHOD												
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:												
INTAKE													
	PO												
	TOTALS												
OUTPUT	URINE												
	STOOL												
	TOTALS												

...CAL RECORD - ICU FLOWSH...

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	Ⓛ AC	OK
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS: NS @ 100

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

See Progress notes. —— (b)(6)-2 CRW ——

Page 3 of 4

SE

~~ME~~DICAL RECORD - ICU FLOWSH~~EET~~

PATIENT ASSESSMENT DATA - REVIEW

PATIENT NAME:

DATE:

	TIME: INITIALS:	TIME: 1925 INITIALS: (b)(6)-2
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.		WNL
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring		∅ edema to extremities x 4, brisk cap. refill RRR, S1+S2
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach		CTA, Pox 98% RA, ⊖ cough
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions		+BS, +flatus, ∅BM tonight Bedpan/BS commode (NPO p̄ 2400 per order)
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia		Voiding well urinal
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia		NWB to LLE, Ext. fixation to Ⓛ tib/fib fx, dressing intact, ~~[illegible]~~ Serosanguinous drainage noted, marked. Guarded mvt + ↓ strength to LLE. (b)(6)-2
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing		skin dry & intact. Brisk cap. refill, all extremities (b)(6)-2
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity		Pain controlled c̄ MSO4. Pt able to report pain + location. Pt able to sleep
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others		Responds appropriately, Verbalizes to interpreters. Tries to tell staff of his needs. Able to laugh + talk c̄ fellow pt + interpreters.

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY ANES	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2
3. DATE 1 APR 03 TIME PATIENT ARRIVED IN SUITE 1400	4. PATIENT IN (b)(6)-2 TIME 1400 NUMBER 16

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

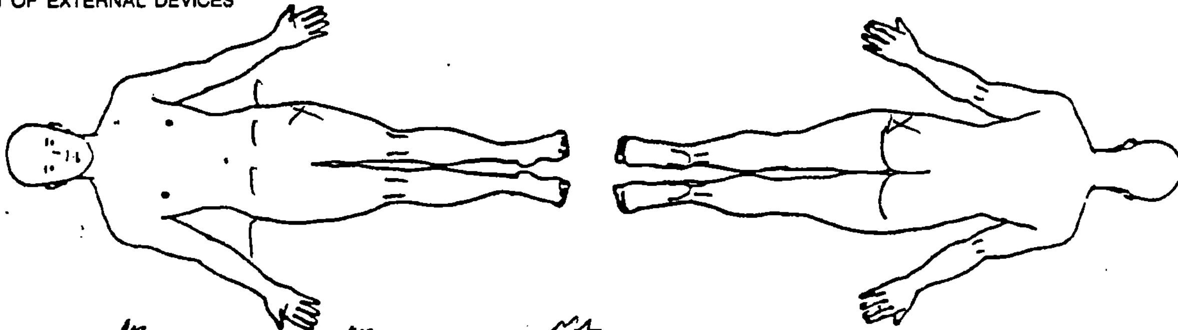
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* BETA/BETA
SITE: (R) LEG BY WHOM: SOTZO
SITE: BY WHOM:
COMMENTS: NO POOLING

9. LOCATION OF EXTERNAL DEVICES



MS MS MS

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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	C	C	(b)(6)-2	(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;)*

EPW # (b)(6)-4
31 MA 1APR03

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

@ 30/30
OR Ø82

☐ ESU NO:
GROUND PAD: BRAND VALLEY LAB
LOT NO: 38592

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 80, WHICH IS OBSOLETE.

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
Methylene Blue 1:20 INNS	100cc	1505	INJ	(b)(6)-2	(b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
Fluffs
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
I & D, EX FIX (L)

21. PATIENT TRANSFERRED TO ICU TIME 1540 METHOD Gurney c O2 / MASK

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ/AN

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 3588

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of

IN OR 1415 | ANES. END 1558 | DATE 1 APR 03

OPERATION PERFORMED: WASHOUT OF GSW LLL

SURGEON(S) (b)(6)-2 | 1423 | SURG START 1438 | DRESSING 1525 | OR NO. (b)(3)-1

PREOPERATIVE

☑ IDENTIFIED ☐ ID BAND ☑ QUESTIONING
☑ CHART REVIEWED ☑ NPO SINCE 30 hrs
☑ PRE-OP MEDICATION:

Drug	Dose	Route	Time
MIDAZOLAM	2	IV	1412

Pre-Anesthetic State: ☐ CALM ☐ APPREHENSIVE ☑ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☑ ANES. MACHINE # 10499 & EQUIP. CHECKED
☑ NON-INV. B/P ☐ PNS
☑ CONT. EKG ☐ V LEAD EKG
☐ ESOPH. STETH. ☐ PRECORD STETH.
☑ PULSE OXIMETER ☑ O2 ANALYZER
☑ END TIDAL CO2 ☐ MASS SPEC.
☑ TEMPERATURE NASOPHARYNX
☐ WARMING BLANKET ☐ FLUID WARMER
☐ AIRWAY HUMIDIFIER
☐ N/G TUBE ☐ O/G TUBE
☑ IV(s) ⓛ AC in place
☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
☐ EYE CARE
☑ PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

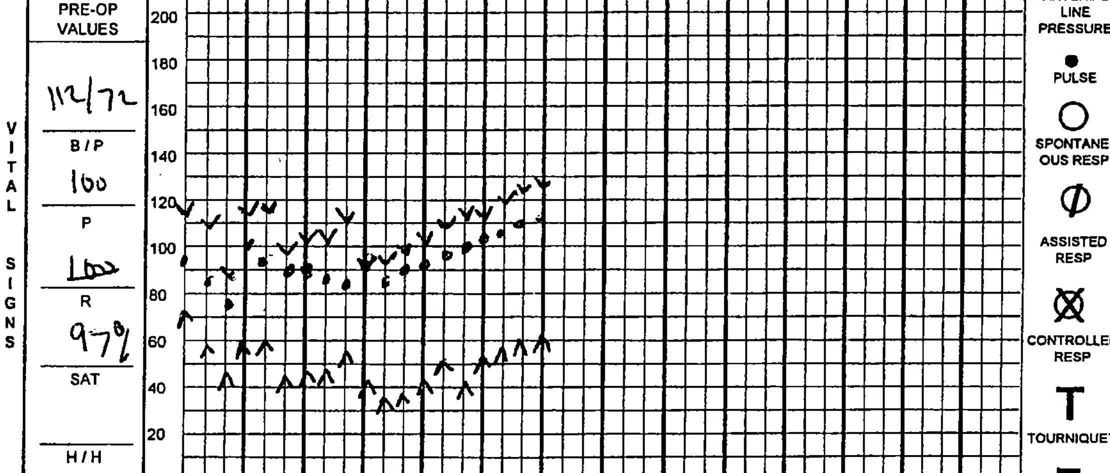
☑ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☑ PREOXYGENATION ☐ INHALATION
☑ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL
☐ cricoid pressure

AIRWAY MANAGEMENT

☑ INTUBATION ☑ ORAL ☐ NASAL
☑ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☑ STYLET USED
☑ ATTEMPTS x 2 ☐ BLADE MAC 2+3
☑ ETT SIZE 7.5 ☐ DOUBLE LUMEN
☑ STRAIGHT ☐ RAE ☐ ANODE
☑ CUFFED 6 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ___ CM H2O
☑ ETT SECURED AT 23 CM
☐ BREATH SOUNDS ⊕ BBS
☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ LMA SIZE
☐ ⊕ ETCO2



	1415	1430	1500	1530			TOTALS
AGENTS							
FENTANYL	100	50		50		50	
KETAMINE	100						
SUCCINYLCHOLINE	100						
MSO4		2	2	2 2	2		
ISOFLURANE	1.0	0.9	0.8	1.1			
AIR		0.8	0.4				
N2O L/min							
O2 L/min	4	0.8	0.6				
FLUIDS							
LR	600	—	900	1000	—	1100	
ANCEF	1 gm						
Urine							
EBL							
MONITORS							
EKG	SR	SR	SR	SR	SR	SR	
% O2 Inspired	100	48	47	58	51	100	
O2 Saturation	100	100	100	100	100	100	
End Tidal CO2	39	38	35	46	55	52	
Temperature	36.6	36.9	36.4	36.1	35.9	36.0	
PNS							

VITAL SIGNS — PRE-OP VALUES: B/P 112/72; P 100; R 100; SAT 97%; H/H

RESP						
Tidal Volume	700	640	640	600	320	360
Resp Rate	10	10	10	10	19	17
Peak Pressure	26	26	26	28	—	—

Symbols for Remarks; Position

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; ∨ ∧ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; • PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION		
1549	Stable		
B/P 129/69	PULSE 91	RESP	02 SAT 100

REMARKS — TEMP 96.3

REPORT TO: PARRS:

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation. ☐ Significant changes from preop plan / evaluation.

chart reviewed, pre-op/anesthesia eval completed, discussed plan thru translator, to OR, safe x-fer to OR table, monitors, pre-ox, smooth rapid sequence induction c̄ cricoid pressure, DLx1, MAC-2, inadequate view, MAC-3, Grade I, 7.5 ETT @ 23 cm, ⊕ ETCO2, ⊕ BBS, spont. vent, [illegible] suction [illegible] extubate [illegible]

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	1200	EBL	30
		Urine	∅
		Gastric	∅
Blood	∅		

(b)(6)-2 (b)(6)-2 PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION (b)(3)-1

TRAUMA #3

(b)(6)-4

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE 33 | (M) F | HEIGHT | WEIGHT 60

PROPOSED OPERATION: WASHOUT GSW ~~[illegible]~~, EX-FIX TIB-FIB

PREOPERATIVE VITAL SIGNS: B/P 112/72 P 100 R 24 97%

PREVIOUS ANESTHESIA / OPERATIONS [X] NEGATIVE

CURRENT MEDICATIONS [X] NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS [ ] NEGATIVE

ALLERGIES [X] NKDA

AIRWAY / TEETH / HEAD & NECK: TMD 4

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY: Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	[X]	Tobacco Use: [X] No [ ] Yes ___ Pack/Day for ___ Years	Chest X-ray / Pulmonary Studies
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	[X]		EKG
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	[X]	Ethanol Use: [ ] No [ ] Yes Frequency ___	LFTs NPO ~~[illegible]~~ 30 hours
NEURO/MUSCULOSKELETAL: Arthritis, DJD, Neuromuscular disease, Syncope, Weakness, Back problems, Headaches, Paralysis, Seizures, CVA/Stroke, Loss of consciousness, Paresthesia, TIAs	[X]		
RENAL/ENDOCRINE: Diabetes, Urinary retention, Renal failure/Dialysis, Urinary tract infection, Thyroid disease, Weight loss/gain	[X]		Urinalysis / Thyroid / FBS
OTHER: (Anemia), Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC / Lytes

PROBLEM LIST / DIAGNOSES

1. Anemia
2. GSW to
3. Tib-Fib Fx (L)

ASA: 1, (2), 3, 4, 5, (E)

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, (General Anes.)
Other: ____________
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ____________ DATE ____________

EVALUATOR(S) SIGNATURE

CRNA ____________ DATE ____________

PHYSICIAN (b)(6)-2 DATE 1 APR 0[illegible]

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ____________

SIGNED: ____________ TIME: ____________

(b)(6)-4

Standard Form 517

CLINICAL RECORD — ANESTHESIA

(b)(6)-2

ANESTHETIC(S) — HOUR

ISOFLURANE
NA PENTO 100
ZEMURON 5mg
ANECTIN 120
FENT 0.1 0.05
CEFAZOLIN
SPO2 98 97 98 97 98 99
OXYGEN 4
CO2 ABSORB. 40 40 38 44 40 40

LEVEL OF ANAL-ANES.

INDUCTION

SATIS. ✓

UNSATIS AND WHY

REMARKS

CODE
- ● PULSE
- ○ RESP.
- V Λ B. P.
- X ANES.
- ◎ OPER.
- T TOURN.

220 200 180 160 140 120 100 80 60 40 20

FLUIDS
- B BLOOD
- N SALINE
- G 5% G/W
- DX EXPAND.

NUMBERS FOR REMARKS ① ② ③

IV FLUIDS — LR 1000

POSITION

AGENTS AND TECHNICS ① smooth IV induct, rapid sequence c cricoid pressure — atraumatic intubation c 8.0 OETT ... BBS ② Suctioned & extubated, ... (b)(6)-2

ENDOTRACHEAL: SIZE 3 BLADE MILLER ORO 80 NASO ______ CUFF T PACK ______

REMARKS: rapid sequence

OPERATION PERFORMED: I+D (L) TIB FIB EXPLOR GSW

TOTAL FLUIDS: LR 1000 LR

NAME(S) OF SURGEON(S)

Signature of Anesthetist.

RECOVERY
- REFLEX IN O.R.
- EMESIS
- ASPIR.
- EXCITEMENT
- HYPOTENSION
- OTHERS

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

(b)(6)-4

REGISTER NO. | WARD NO. | DATE

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

517-112

NSN 7540-01-185-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
AP + lateral of [illegible] & knee				[illegible]	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print) (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)-2

DATE REQUESTED 1 April 03

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

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

RADIOLOGIC REPORT

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

EIW (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW (b)(6)-4

ICU 2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 APR 03 — TIME OF ORDER: 1605 HOURS — LIST TIME ORDER NOTED AND SIGN

1 Admit Patient to ICU
2 Diagnosis: s/p (L) open tib/fib Fracture DST ... ex-fix
3 Condition: Stable/Serious/Critical
4 Allergies: NKDA/
5 Vital signs q hr/q2hr/q6hr/q8hr/q shift
6 ~~Cardiac respiratory monitoring~~ (b)(6)-2
7 Diet: NPO / regular/ soft/ clear liquid — advance as tolerated

8 Activity: AD LIB/ Strict BR/ BR with BSC/ NWB R or L LE
9 HOB up 30 degrees
10 ~~Nursing I/O; CDB/ NG to LIS/ LCS~~ (b)(6)-2
11 ~~Labs: Chem 7/ H/H/ PT/PTT/ CBC q AM/ 4 hrs/ 8 hrs/ BID~~
12 ~~EKG q AM~~

13 ~~PCXRAY q AM/QOD~~ (b)(6)-2
14 IVF NS/ LR/ D5NS/ D51/2NS To run @ 125 cc/hr.
15 Ancef 1 GM IV Q 8 hrs — Heplock when tolerating PO
16 Gentamycin 350 mg IV Q day
17 ~~Cefoxitin 2gm IV q8hrs.~~ (b)(6)-2
18 O2 titrate to keep SPO2 >
19 ~~Versed gtt 1-10mg/hr IV titrate to~~ (b)(6)-2

Lovenox 30 mg SQ q 12 hr.

~~Ramsey Scale of~~ (b)(6)-2
20 ~~Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of~~
21 ~~Vecuronium 1mcg/kg/min~~
22 MSO4 1-6 MG IV q3-4 HR PRN Pain
23 Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24 MOM 30cc PRN Gastric upset

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

LTC MC ... ORTHOPAEDIC SURGERY

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

MEDCOM - 3593

CLINICAL RECORD - DOCTOR'S ORDERS

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

[DOC]TOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD [I]S USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
[I]D # (b)(6)-4 NURSING UNIT / ROOM NO. / BED NO.		TIME OF ORDER 19:25 HOURS Admit ICU 5 Dx open (L) tib/fib Fx s/p Ext. Fixation nursing VS q shift Bed rest c̄ Bedside urinal/commode non-wt bearing	
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER / TIME OF ORDER ____ HOURS Diet NPO p̄ midnight IV D5LR @ 100cc/hr Ancef 1gm IVPB q 8° until 05 APR 03 Gentamycin 400mg IV q 24° until 05 APR 03 MSO4 5mg IV q 3-4° PRN	(b)(6)-2
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER / TIME OF ORDER ____ HOURS Consult orthopedics for eval of tib/fib fx (b)(6)-2 MD (b)(6)-2	(b)(6)-2
PATIENT IDENTIFICATION NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER / TIME OF ORDER ____ HOURS	

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

DA FORM 4256, 1 APR 79

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
OD # (b)(6)-4		DATE OF ORDER: 4/2/03 TIME OF ORDER: 0745 HOURS	
		Admit to minimal care ward	
		Dx: (L) open tibia fx	
		Cond: Stable	
		VS routine	
		Activity: NWB on (L) LE	
NURSING UNIT / ROOM NO. / BED NO.		Nursing: Leave dressing in place. Reinforce as needed	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	
		Diet: Reg	
		IV hep lock	
		Meds: Ancef 1g IVPB Q8° x72°	
		Gentamicin 400mg IV Q24° x72°	
		Vicodin I-II PO Q4-6° prn pain	
NURSING UNIT / ROOM NO. / BED NO.		Evac Priority Litter.	
		(b)(6)-2 MD	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME (b)(6)-2 HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

CLINICAL RECORD

THE...TIC DOCUMENTATION CARE PLA... ...EDICATION)

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

Mo. Apr Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3
1 Apr	(b)(6)-2	Vital signs q hr / q2hr / q6hr / q8hr /	07	(b)(6)-2		
	------	q shift (circled)	19			
	------	Cardiac Respiratory monitoring	07			
	------		19			
1 Apr	(b)(6)-2	Diet: NPO / Regular (circled) / Soft / Clear	07			
	------	Liquid Advance as tolerated	19			
1 Apr	(b)(6)-2	Activity: Ad Lib / Strict BR (circled) / BR with	07			
	------	BSC / NWB (circled) R or L LE (circled)	19			
	------	HOB up 30 Degrees	07			
	------		19			
	------	Nursing I/O, CDB / NG to LIS / LCS	07			
	------		19			
	------	Labs: Chem 7 / H&H / PT/PTT /	04			
	------	CBC q AM / 4 hrs / 8 HRS / BID	08			
	------		12			
	------		16			
	------		20			
	------		24			
	------	EKG q AM / QOD	06			
	------	PCXRAY q AM / QOD	06			
	------	Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07			
	------	q shift	19			
	------	Vascular checks q 1hr / 2 hr / 4 hr /	07			
	------	6 hr / q shift	19			

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P (L) open tibia Fx D&I

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

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

Treatment Facility (b)(3)-1

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

Verify by Initialing		...UTIC DOCUMENTATION CARE PL... (NON-MEDICATION)	Mo Apr Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1Apr	(b)(6)-2	Admit Patient to ICU	1Apr			(b)(6)-2
1Apr		Diagnosis: S/P (L) open tibia Fx D&I	1Apr			
1Apr		Condition: (Stable) / Serious / Critical	1Apr			
1Apr		Allergies: NKDA /	1Apr			

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

MEDCOM - 3597

...APEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 04 Yr 03

Order Date	Clerk Nurse (Verify by Initialing)	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3APR 03	(b)(6)-2	Admit to ICW5				(b)(6)-2
3APR 03		Consult ORthopedics for eval of tib/fib fx	3APR03	now	19:25h	
			3APR03	now	2000h	

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

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.* 04 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 03	04	05
3APR03	(b)(6)-2	Dx: open (L) tib/fib fx, s/p	07	(b)(6)-2		
		Ext. fixation	19			
3APR03	(b)(6)-2	Nursing VS q shift	07			
			19			
3APR03	(b)(6)-2	Bedrest c̄ BS urinal &	07			
		commode, NWB	19			
3APR03	(b)(6)-2	Diet: NPO p̄ midnight	07			
		on 3APR03	19			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p Ext. fixation of (L) tib/fib fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

(MEDICATIONS)

Mo. 04 Yr. 03

Initialing						
Order Date	Clerk/ Nurse	GLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
			TIME/DATE DISPENSED													
03 APR 03	(b)(6)-2	MSO4 5mg IV q 3-4° PRN	03APR 2000 5mg	3APR 2245 5mg	4APR 0055 5mg	4APR 0818 5mg	4APR 1155 5mg									

☆ U.S. G[illegible]RNMENT PRINTING OFFICE: 1993 342-027/70450

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. 04 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 03	04	05												
3APR03	(b)(6)-2	IVF D5LR @ 100cc/hr or	07	(b)(6)-2														
		whatever fluids available	19															
3APR03	(b)(6)-2	Ancef 1gm IVPB q 8° until	04				X	X	/									
		05APR03.	12				X	X	X									
			20				X	X	X									
3APR03	(b)(6)-2	Gentamycin 400 mg IVPB	11				X	X	X									
		q 24° until 05APR03	X	X	X	X	X	X	X									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p Ext. fixation of Ⓛ fib/fib fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)-4

EPW

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, FEB 79 — MEDCOM - 3601 — EDITION OF 1 ...

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 04 Yr. 03

Order Date	Clerk/ Nurse	GLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION					TIME/DATE DISPENSED									
03 APR 03	(b)(6)-2	MSO4 5mg IV q3-4° PRN	03APR 2000h 5mg	3APR 2215 5mg	4APR 0055 5mg	4APR 0815 [illegible]	4APR 1155 5mg										

☆ U.S. G[illegible]ERNMENT PRINTING OFFICE: 1993 342-027/70450

TIME	1700										
GENITOURINARY NCP □7 □ Initiated □ Ongoing □ Closed Priority #____											
Method of Urination: Normal Foley Suprapubic Condom Cath In/Out Cath Ostomy Incontinent	None										
Urine Color: Yellow Amber Hematuria	Ø										
Urine Character: Clear Cloudy Sediment Blood clots	Ø										
Genital Edema: Y/N	N										
Genital Discharge: White Yellow Green Bloody None Menstruating	Ø										
SKIN/WOUNDS NCP □8 □ Initiated □ Ongoing □ Closed Priority #											
Color: Pale Pink Mottled Dusky Cyanotic Jaundiced Flushed	WNL										
Temperature: Hot Warm Cool Clammy Diaphoretic	C										
Specialty bed Egg crate Other	N/A										

Code (Document by Numbers) with Time and Initials

1.	Abrasions	11.	Laceration
2.	Avulsion	12.	Petechiae
3.	Burn	13.	Rash
4.	Cast	14.	Retention Sutures
5.	Contusion	15.	Staples
6.	Decubitus	16.	Sutures
7.	Dressing	17.	Tear
8.	Ecchymosis	18.	Wound
9.	Erythema	19.	Ext Fx
10.	Incision	20.	______

[ ] Clear except as otherwise indicated

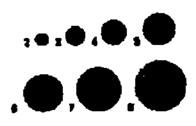
7
19

Wound Location:	L Leg										
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D,C,I	D										
Drain: JP Malencott Other ______											
Drainage: Serous Sanguineous Purulent None Other:______											
Wound Location :											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D,C,I											
Drain: JP Malencott Other ______	NA										
Drainage: Serous Sanguineous Purulent None Other:______											
Wound Location :											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D,C,I											
Drain: JP Malencott Other ______											
Drainage: Serous Sanguineous Purulent None Other:______											
MISCELLANEOUS NCP □9A □9B □9C □ Initiated □ Ongoing □ Closed Priority #____											
Psycho-social: Calm & appropriate Anxious Angry Denial Coping Withdrawn Combative Restless	C										
Hygiene: Bath Oral Perineal Eye Cath Linen changed Shave	None										
Activity: Ambulate BR- bedrest BSC Chair ROM Turned (Left Back Right) HOB Up Repositions Self Dangle	BR										
Call light within reach Side Rails up x ____ Y/N	Restraints										
Patient teaching provided Y/N (See patient teaching flowsheet)	—										
Nurse's Initials	(b)(6)-2										

Physician Dr (b)(6)-2 Allergies NKDA Code Status: Full DNI Chemical DNR

1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
		96.3 (A)								
		88	88							
		126/69	128/81							
OR		20	20							
		97%	98%							
		NA	NA							
OR		SR								
		+3	+3							
		+2	+3							
		5								
		3								
		5?								
		Doesn't speak English								
		3B	3B							
OR		Sedated	D							
OR										
		Patent	Patent							
		20	20							
		RA	RA							
	1200 OR	125	125	125						
				100						
OR										
	1300 / 1300	125 / 1325	125 / 1445	225 / 1670						
				575						
OR	30 OR									
	30 / 30			575 / 605						

Reaction
Brisk
Sluggish
Fixed



Responsiveness
A-Alert
O-Oriented
D-Disoriented
L-Lethargic
P-To pain only
PR-Paralyzed
S-Sedated
U-Unresponsive
SL-Sleeping

Mode
V-Vent
TC-Trach collar
NC-Nasal Cannula
SM-Simple mask
VM-Venti mask
NRB-Non-rebreather mask
FT-Face tent

Ectopy
P-PVC
PA-PAC
M-Multifocal
N-None
F-Frequent >10/min
O-Occasional
R-Rare

Best Eye Opening
4-Spontaneous
3-To speech
2-To pain
1-None

Best Verbal Response
5-Oriented
4-Confused
3-Inappropriate
2-Incomprehensible
1-None, ETT, Trach

Best Motor Response
6-Obeys commands
5-Localized to pain
4-Withdrawl to pain
3-Flexion to pain
2-Extension to pain
1-None

Circulation
1+Faint
2+Weak
3+Normal
4+Bounding
A-Absent
D-Doppler

Cardiac Rhythm
SR-Sinus Rhythm
SA-Sinus Arrhythmia
SB-Sinus Bradycardia
ST- Sinus Tachycardia
SVT-Supra Ventricular Tachycardia
VT-Ventricular Tachycardia
VF-Ventricular Fibrillation
AF-Atrial Fibrillation
AFL-Atrial Flutter
1HB-First Degree Heart Block
2HB-Second Degree Heart Block Type I
2HB2-Second Degree Heart Block Type II
3HB-Third Degree Heart Block
JUN-Junctional
BI-Bigemeny
TRI-Trigemeny

Admission Wt	Ventilator Day
Today's Wt	Central Line Day Site:
Yesterday's Wt	Arterial Line Day Site:
Difference +/-	PIV Day Site:
Total Input	PIV Day Site:
Total Output	Foley Day
Difference +/-	

MEDCOM - 3604

Date 1 Apr 03 ICU Day 1 [illegible]gnosis/Surgery ~~DOS~~ S/P L Open [illegible] Post Operative Day DOS

TIME	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
VITAL SIGNS													
Temperature													
Heart Rate													
NBP													
NMAP													
ABP													
~~AMAP~~ Resp													
SpO2													
ICP/CPP													
CVP													
PAS/PAD													
PAWP													
PVR													
CO/CI													
SVR													
Cardiac Rhythm/ Ectopy													
Circulation RUE LUE													
Circulation RLE LLE													
CNS Responsiveness													
CNS Best eye opening													
CNS Best verbal response													
CNS Best motor response													
CNS Pupil Size & Reaction R/L													
PAIN ASSESSMENT													
Pain/discomfort scale: Denies 0 (no pain) – 10 (worst pain gets)													
Location:													
Quality: Sharp Dull Pressure Radiating to ______ Other													
Intervention: Medication Hotpack Coldpack Reposition Other													
Pain Reassessment: Denies 0 (no pain) – 10 (worst pain gets)													
RESPIRATORY													
Mode													
Rate													
Tidal Volume													
FiO2													
Pressure Support/ PEEP													
INTAKE													
LR													
IV Meds													
TOTAL INTAKE													
OUTPUT													
Urine													
Stool													
EBL													
TOTAL OUTPUT													
COMMENTS Nurse's Initials													

MEDICAL RECORD-SUPPLEMENTAL MEDICAL RECORD
For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE	OTSG APPROVED DATE
CRITICAL CARE FLOWSHEET	

TIME	NURSING PROGRESS NOTES
1822	Pt arrived in ICU2 from OR via litter @ 1550. See PostOp sheet for post op VS x1 hr. Pt tried to void in urinal but was unable to go. Pt denies any pain per interpreter. Pt currently laying in bed c̄ HOB 30°, hands in restraints, pt resting. Will continue to monitor. (b)(6)-2 CPT (b)(6)-2

(b)(6)-2 CPT/AN	DEPARTMENT/SERVICE/CLINIC ICU	DATE 1 Apr 03

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

Trauma (b)(6)-4

☐ HISTORY/ PHYSICAL ☐ FLOWSHEET
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES Supplement to SF 510
☐ TREATMENT

TIME	1700											
NEUROLOGICAL NCP 1 Initiated Ongoing Closed Priority #												
PUPIL SIZE/REACTION: R/L Brisk Sluggish Fixed	3B / 3B											
RESPONSIVENESS: Alert Oriented X1 X2 X3 Disoriented Lethargic Sedated Sleeping Arousable Pain only Paralyzed Unresponsive	Waking up from Anesthesia											
BEST EYE OPENING: Spontaneously Or to: Speech Pain None	S											
BEST VERBAL RESPONSE: Oriented Confused Inappropriate words Incomplete sounds None Intubated Trach	Doesn't speak English											
BEST MOTOR RESPONSE: Obeys commands Moves all extremities Localizes pain Withdraws from pain Flexes to pain Extends to pain None	M											
MOTOR FUNCTION: Strong Weak Purposeful Spontaneous None — UE R/L												
MOTOR FUNCTION — LE R/L												
SENSATION: Intact Tingling Numbness Absent — UE R/L												
SENSATION — LE R/L												
MEMORY: Long +/- Short +/-												
NEURO BLOCKADE: Y/N Train of 4 __of 4 mAMP	N/A											
VENTRICULOSTOMY: Monitor Open to drain Clamped												
Vent/drainage level: ___cm above: FOM-Foramen of Monro Other												
Zeroed ICP monitoring system at: FOM-Foramen of Monro Other												
CSF drainage: Serous Sanguineous Clear Purulent												

CARDIOVASCULAR NCP 2A 2B 2C Initiated Ongoing Closed Priority #												
RHYTHM: SR SA SB ST SVT VT VF JUNCT AFIB PAC AFL 1HB 2HB 2HB2 3HB PVC	SR											
HEART SOUNDS: S1 S2 S3 S4 Distant Murmur Rub	$S_1 S_2$											
PACER: Transvenous Tv, Transcutaneous Tc, Permanent (Implant) — Method	N/A											
Mode												
Rate												
Output/ Sensitivity												
EDEMA: +1 Trace, +2 Minimal, +3 Moderate Pitting, +4 Severe Pitting; General, None — RUE/LUE	N / N											
RLE/LLE	N / +1											
Facial	N											
SCDs/TEDs On/Off	None											
JVD (+) (-) @ 30 degrees	(-)											
Homan's Sign (+) (-)	(-)											
CAP REFILL B< 3SEC S>3SEC — RUE/LUE	B / B											
RLE/LLE	B / B											
PULSES: Absent Doppler, 1+ Faint 2+ Weak 3+ Normal, 4+ Bounding Regular, Irregular — Rad R/L	3+ / 3+											
PT R/L	3+ / 3+											
DP R/L	3+ / 3+											

INVASIVE LINES NCP 3 Initiated Ongoing Closed Priority #

Appearance	Line Type	Site	Date Started	Size												
Dry Intact Drainage Edema Erythema Dsg Δ Infiltrated Flushed	PIV	(L) [illegible]	1 Apr	18g	Patent											
Zeroed at Phlebostatic axis: Y/N					N/A											
Swan ________ cm @ hub																

(b)(6)-4

Trauma (b)(6)-4

Post Procedure/Post Operative Anesthesia Notes

Received from: OR **By:** MAJ (b)(6)-2 **Time in:** 1550 **ASA:** 2E Anemic
Procedure: Washout GSW (L) Tib/Fib **Complications:** Ø
Physician: Dr. (b)(6)-2 **Anesthesia Provider:** Dr. (b)(6)-2
Medical/Birth History
Anesthetic Agents Used: General
Narcotics Reversed NA/Yes/(No) Time____ **Muscle Relaxant Reversed** NA/ Yes/(No) Time____ **Epidural catheter** Yes/(No)
Medications given via epidural catheter: N/A
Pre Proc/Op Vital Signs: P 100 R__ B/P 112/72 T__ **Pre Proc/Op Medications**
97% SaO2

Post Procedure/Operative Intake and Output, Miscellaneous Information

Intake	Amount	Output	Amount	Airway Support	Invasive lines	Site	Fluid	Rate
Crystalloids	1200	EBL	30	PATENT X ORAL ___ ETT ___	Cordis/Swan	N/A		
Colloids		Urine	Ø	NT ___ TRACH ___	Arterial line			
PRBC		NG/Emesis		Oxygen Delivery:	PIV	L A/C	LR	
Hespan				NC SM VM NRB TM VENT	PIV			
				O2% (lpm or FiO2)				
Total IN	1200	**Total Out**	30					
Net Fluid	+/-							

Medications given during procedure/operation:
10mg Morphine 1gm Ancef
150 Fentanyl

Medications Given During Recovery Period:

Time	Medication	Effect	Initials
	None given		

Frequent Vital Signs and Post Procedure/Operative Documentation

Time	BP	P	R	SpO2	O2	T	Act	Resp	Cir	Loc	Skin	PAR	Pain (0-10)	Dermatome Level	Pulse L Ped	Pulse R Ped	Comments	Initials
1550	129/69	89	20	100%	RA	96.3 (A)	0	1	2	1	2	6	Sleeping	N/A	3+	2+	Pt doesn't	(b)(6)-2
1555	131/71	92	20	100%	RA										3+	2+	speak English	
1600	126/69	88	20	97%	RA										3+	2+		
1615	129/67	79	20	98%	RA										3+	3+		
1630	136/71	80	20	100%	RA										3+	3+		
1645	123/74	75	20	100%	RA										3+	3+		
1700	128/51	88	20	98%	RA		2	2	2	2	2	8?			3+	3+		

PAR Activity 2-moves 4 extremities, 1-moves 2 extremities, 0-moves 0 extremities
Resp 2-cough & deep breathe, 1-dypnea, airway, 0-apnea
Cir 2-20%+/- preop BP, 1-20-50%+/- preop BP, 0-50% +/- preop BP
LOC 2-Fully awake, 1-Verbally aroused, 0-No response
Skin 2-pink, 1-pale, dusky, 0-cyanotic

...ICAL RECORD - SUPLEMENTAL MEDICAL DATA

...r use of this form, see AR 40-66; the ... gency is the Office of the Surgeon General

OTSG APROVED (Date) 2APR03

...EPORT TITLE

TRAUMA FLOWSHEET

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☒ MINIMAL

...ate: 02APR03 Arrival Time: 1918zulu Sex: (M) F Age: 25 Wt: 140 lbs

...llergies: NKA Tetanus Status: UTD Unknown

...MP: Last Meal:

...hief Complaint: (L) leg injury (Post Op)

...MH: Medications:

...reatments PTA:

...ITAL SIGNS: BP: 126/67 P: 95 RR: 18 TEMP: SAO2: 99%

...HEST
...RAUMA ☐ YES ☒ NO
...AIN ☒ YES ☐ NO
...OB ☐ YES ☐ NO
...UNG SOUNDS
R L
☒ ☒ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☒ WARM
☒ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☒ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☒ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R____mm L____mm
GLASCOW SCORE:______

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obedient	6
To Voice	3	Confused	4	Purposeful	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible	2	Flexion	3
		None	1	Extension	2
				None	1

...XTREMETIES
☒ DISTAL PULSES,
☐ RT X 2 ☐ LT X 2
☐ MOVES EXTREMETIES X 4
☒ NO EDEMA
☐ NO DEFORMITIES

...XCEPTIONS TO ...BOVE ...ARAMETERS:

SPLINTS:

...REATMENTS:
...2: LPM NC MASK ORAL AIRWAY
...TT # MM NASAL AIRWAY
...IONITOR ☐ Y ☒ N EKG ☐ Y ☒ N
...IG TUBE #——
...OLEY: #——
...HEST TUBE ☐ R ☐ L
DPL ☐ POS ☐ NEG
CM H20

R L L R

FRONT BACK

A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW (Size)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

(Continue on revers...)

...REPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC (b)(3)-1 | DATE 2APR03

...ATIENT'S IDENTIFICATION (For typed or written ...ntries give: Name - last; first; middle; grade; date; ...ospital or medical facility)

(b)(6)-4

OD #(b)(6)-4

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

...A FORM 4700, MAY 78

MEDCOM - 3609

#(b)(6)-4

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
ADULT TRAUMA FLOW SHEET

OTSG APPROVED *(Date)*

PREHOSPITAL INFORMATION

TRANSPORT TIME IN: ________

☐ Scene ☐ Police
☐ Auto ☐ Ambulatory
☐ Ambulance ☒ MEDVAC Unit: ________
☐ CCATT: Report From: ________
☐ Ref Hospital ________
☐ Ref Physician ________

MECAHNISM OF INJURY

☐ MVA: ☐ Driver or ☐ Passenger ☐ Front ☐ Back ☐ Seat Belt on
☐ MCA: ☐ Driver or ☐ Passenger ☐ Helmet worn ☐ Protective Clothing Worn
☐ Speed: ________ mph
☐ BCA: ☐ Front ☐ Back ☐ Helmet worn
☐ Pedestrian vs. Auto Speed: ________ mph
☐ Fall ______ ft ☐ Assault
☒ GSW ☐ Stab ☐ Frag wound ☐ Crush ☐ Burn
☐ Aircraft: Type ________
☐ Other ________

PREHOSPITAL TREATMENT

PROCEDURES PRIOR TO ARRIVAL

☐ Oral Airway ☐ Nasal Airway
☐ ET Tube # ________ ☐ NT Tube # ________
☐ Crico # ________
☐ O2 @ ______ L/min via ________
☐ Breath Sounds: LT: ________ RT: ________
☒ IV # ______ (Peripheral) Subclavian Femoral Intraossesous: Site (L) (R) AC
☐ Fluids: ☒ IV 1 2 3 4 5 ☐ Blood 1 2 3 4 5
☐ CPR: Time started ________ Stopped ________
☐ PASG Legs Abd
☐ Urinary Cath : Size ________ ☐ NG Tube ☐ OG Tube
☐ Chest Tube: ☐ RT ☐ LT ☐ Both
☐ Medication ________
☐ C-Collar ☐ Spine Immobilization Device Time On: ________
☐ Splints: ______ Type: ________
☐ Other: ________
☐ Tourniquet: Time On ______ Location: ________

AMPLE HISTORY

Allergies: NKDA	Last Meal:
	Last Tetanus:
Medications: None.	Events: See Note in Rear
Past Illnesses: Unremarkable per Translator	
	Pregnant: ☐ Yes ☐ No LMP:

PREPARED BY *(Signature & Title)* (b)(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(3)-1

DATE 1 Apr 03

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

EPW # (b)(6)-4

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

DA FORM 4700, MAY 78
MECU OP 36, 1 AUG 98
MRRC apprvl, 9 Jul 98

MEDCOM - 3610

USAPPC V2.00

DD FORM 1 FEB 63 602

REPLACES DD FORM 602, 1 OCT 51 PREVIOUS EDITIONS ARE OBSOLETE
REMPLACE DD FORM 602, 1 er OCTOBRE 1951 LES ÉDITIONS PRÉCÉDENTS SONT CADUQUES

OD #- (b)(6)-4

(b)(6)-4

☆U.S.GPO. 1992-318-678

PATIENT EVACUATION TAG — FICHE D'ÉVACUATION DE PATIENT
(Tie this tag to patient — Attacher cette fiche au patient)

FROM (*Medical treatment facility*)
ORIGINE (*Installation de traitement médical*)
(b)(3)-1

NAME (*Last first-middle initial*)
NOM (*Nom de famille-premier prénom—initiale deuxième prénom*)
(b)(6)-4

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL (*Service or employer and nationality*) CATÉGORIE DE PERSONNEL (*Service ou employeur et nationalité*)

DIAGNOSIS
DIAGNOSTIC

CLASS—CLASSE		DISEASE MALADIE	BATTLE CASUALTY BLESSÉ AU COMBAT	INJURY BLESSURE
1A	2A			
1B	2B			
1C		CABIN OR COMPARTMENT NO. NO. CABINE OU COMPARTIMENT		BUNK NUMBER NUMÉRO COUCHETTE
3	4			

VSI
TRÈS GRAV. MAL.
☐ Yes Oui ☐ No Non

BAGGAGE TAG NUMBER(S)
NUMÉROS ÉTIQUETTES BAGAGES (EPW #3) OD (b)(6)-4

DESTINATION DESTINATION	SHIP/AC (*Number/type*) NAVIRE/AVION (*Matricule/type*)

TREATMENT RECOMMENDED EN ROUTE (*If no treatment is required a notation to this effect is made*)
TRAITEMENT RECOMMANDÉ EN ROUTE (*Indiquer si aucun traitement n'est nécessaire*)

SIGNATURE OF MEDICAL OFFICER SIGNATURE DU MÉDECIN	DATE DATE

REGULAR DIET RÉGIME NORMAL	SPECIAL DIET (*Describe*) RÉGIME SPÉCIAL (*Description*)

SHIP'S RECORD OFFICE TAB — FICHE POUR ARCHIVES TRANSPORTS

FROM (*Medical treatment facility*)
ORIGINE (*Installation de traitement médical*)

NAME (*Last first-middle initial*)
NOM (*Nom de famille-premier prénom—initiale deuxième prénom*)

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT DATE DÉPART
DESTINATION DESTINATION	ARRIVAL DATE DATE ARRIVÉE

EMBARKATION TAB — FICHE D'EMBARQUEMENT

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF — 1 2 3 4 5 6 (b)(3)-1
2. LOCATION (State or Country Code.) — 7 8: K U

3. REGISTER NUMBER — 9 10 11 12 13 14 15 (b)(6)-4

NAME (Last, First, Middle Initial): EPW ~~OD#~~ (b)(6)-4

4. PAY GRADE — 16 17: X X
5. SEX — 18: m

6. DATE OF BIRTH (YYYYMMDD) — 19–26: 19780101
7. AGE AT ADMISSION — 27 28 29: 25
8. RACE — 30: X
9. ETHNIC BACKGROUND — 31: 9
RELIGION: MUSLIM

10. LENGTH OF SERVICE — 32 33 34: —
ETS
11. FMP — 35 36: ~~9 9~~ 20
12. SOCIAL SECURITY NUMBER — 37–45: (b)(6)-4

ORGANIZATION (Active Duty Only): IRAQI CIVILIAN
13. MARITAL STATUS — 46: Z
HOUR OF ADMISSION: 1930
BRANCH / CORPS

14. FLYING STATUS — 47 48 49: —
15. BENEFICIARY CATEGORY — 50 51 52: ~~K97~~ K78
16. ZIP CODE OF RESIDENCE — 53–61: 093300000

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION — 72: 1
WARD: ICU5
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 Kuwait
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION — 73 74: 22
22. MTF TRANSFERRED TO — 75 76 77 78 79 80: (b)(6)-4
23. DATE OF DISPOSITION (YYYYMMDD) — 81–88: 20030404

24. CLINIC SVC - ADMITTING — 89 90 91 92: AEAA
25. MTF TRANSFERRED FROM — 93 94 95 96 97 98
26. DATE THIS ADMISSION (YYYYMMDD) — 99–106: 20030403

27. LOCATION OF OCCURRENCE (Battle Casualty Only) — 107 108: K u
28. MTF OF INITIAL ADMISSION — 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (YYYYMMDD) — 115–122

FOR LOCAL USE

Open tib/Fib FX

DX: 82332
E9912

Px: 7817
7966

Trauma
Injury
450

CODE:

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

MEDCOM - 3612

IN. ATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
1. REGISTER NUMBER	(b)(6)-4
2. NAME (Last, First, MI)	# (b)(6)-4
3. GRADE	EPW
4. SEX	M
5. AGE	
6. RACE	X
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	
11. FMP	99
12. SSN	(b)(6)-4
13. ORGANIZATION	Iraqi Civ
14. WARD	ICU5
15. FLYING STATUS	
16. RATING/DSG	
17. DEPT./BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	Trans
22. HOURS OF ADMISSION	1930
23. CLINIC SERVICE	AEMA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Tran (b)(3)-1
26. DATE OF DISPOSITION	4 Apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	3 Apr 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1 KUWAIT
30. DATE OF INTIAL ADMISSION	
32. UNITS OF WHOLE BLOOD, COMPONENT TRANSFUSED	

ADMISSION REMARKS

ADMITTING OFFICER

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

~~R Chest wound~~

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
//original Signed//	

DATE	NOTES
2223	5mg Versed IV push. BP-103/53 P-101 R-31. T. On Vent-AC mode. Push Per CPT (b)(6)-2 AN. (b)(6)-2 9/WMb5RT
03 April 03 2230	blisters R LE unknown etiology. No clear burn today. · base injected c̄ lidocaine · fluid aspirated - tissue obtained - will send for analysis. (b)(6)-2 [illegible]
2300 03APR03	P-95 BP 103/51 (68) T 98.7° R-24 PO 100% Pt continues on vent AC 10 TV 650 FiO2 40% Peep 5 over breathing c̄ R-20-30; sat 100% b/lat breath sounds L>R Chest tube to suction 20cm Drsg change & [illegible] to (R) LL sent to (b)(3)-1 per DR (b)(6)-2 Drsg change to (L) ankle - 1 inch laceration irrigated c̄ 50% NS & 50% hydrogen peroxide. Pt has 18g (R) wrist put in on 3APR03 @ 2000hrs infusing Propofol @ 72.5mcg/kg/min, Pt has second IV in (L) FA 18g put in 3APR03 @ 1950hrs infusing LR @ 150cc/hr. Pt has Foley drng cloudy amber blood tinged urine. Pt has small incision around umbilicus c̄ sutures site closed Ø s/s of infection. BSAX4 hypoactive. Pt started on antibiotics @ 2100hrs. Will continue to monitor & assess. (b)(6)-2
4APR03 0740	PT orally Intubated c̄ ET tube placed 23 cm at lip + secured c̄ tube holder/Bi Ascultated BBS VS 124/55 78 100% SaO2 + FiO2 to 30% SX using inline cath yielding sm amt bloody secretions. Vent settings SIMV 10, VT 750, FiO2 peep 6 PIP 24 IE 1:2 c̄ HME. Tubing patent + drained & alarms set + functioning.

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03 April 03 1930	Pt arrived via litter. VS upon arrival HR 148 BP 171/91 Temp 101.9° axillary R - 60. Pt had chest tube with seal in pleuravac broken & leaking. Placed pt chest tube to heimlich valve. Now pleuravac hooked up to patient to gravity. Pt has burns to right elbow, (R) chest wall below chest tube insertion site. Pt has external fixator to (R) femur & blisters to Right ankle. Placed drsg to (R) foot blisters. Pt given 1L bolus of LR. Unasyn started 3gm IV & pt given Morphine 2mg initially & 3mg for total of 5mg Morphine until 2020hrs. Pt Prepared for intubation by Col (b)(6)-2 Pt intubated @ 2010 hrs. Et tube #8.0cm 23 cm @ teeth secured c̄ tube taner. Vent settings AC R10 FiO2 40% TV 65 Peep 5 sats 100% initially. Pt given 5mg Versed IV, 10mg Etomidate IV, 100mg Sucs IV for intubation. CS
03APR03 2025	Pt hypertensive 240/160 manual BP HR 100 notified MDs. Pt given 10mg Vec IV x1 per COL (b)(6)-2 BP @ 2039 163/96 HR 138. (b)(6)-2
03APR03 2050	Pt hypertensive c 192/100 HR 126 pt given 10cc of propofol IV push x1
2054	P-134 BP 144/68 2058 P125 BP 111/56 2108 P125 BP 171/98
2140	P 117 BP 135/69 2200 P-101 BP 92/54 (b)(6)-2
2108 03APR03	Late entry pt given 100mcg Fentanyl IV push x1 for pain. (b)(6)-2
2155	Pt given 2mg Morphine IV for pain (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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: EPW (b)(6)-4 DATE: 3APR03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION		LOCATION	CONDITION
IV SITE # 1	LFA 18g	CDI WNL	IV SITE # 1		
IV SITE # 2	RW 18g	CDI WNL	IV SITE # 2		
IV SITE # 3			IV SITE # 3		

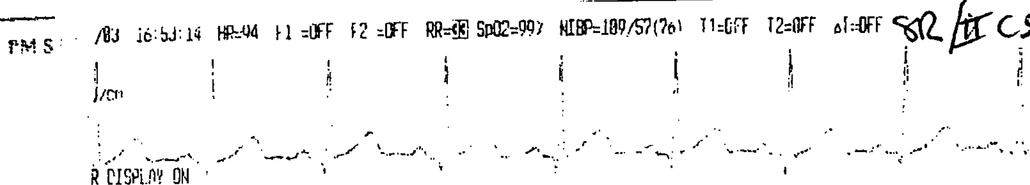
	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED	2000, 2400	CS	IV PATENCY CHECKED		
IV SITE CARE PROVIDED	2000, 2400	CS	IV SITE CARE PROVIDED		
IV TUBING CHANGED			IV TUBING CHANGED		

COMMENTS:

COMMENTS:

AM STRIP

PM S



SR/II CS

SECTION III - SHIFT NOTES

0114/04Apr03 – Heparin 5000u Given SQ to LL of umbilicus. To/5 EVENT on vent (b)(6)-2
0130 Pt reassessed. Respiratory rate continues to increase. Pt medicated ē morphine for pain & versed for ventilator compliance. Propofol gtt increased to 75mcg/kg/min @ 0300hrs. Pt peak pressure increasing & resp rate continues to increase. Propofol gtt increased to 77.5mcg/kg/min @ 0330hrs. ∅ other changes in TX or status @ this time. Will continue to monitor & assess. (b)(6)-2
0400 Pt reassessed. Resp status rate continued in 30's & Peak pressures increasing to 30's. Notified Dr. (b)(6)-2 Pt Placed on SIMV R10 TV 750 40% FIO2 PS rate decreased to 10-20. No other changes in assessment. (b)(6)-2

MEDCOM - 3616

PATIENT NAME:

MEDICAL RECORD - ICU FLOW[illegible]

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

DATE:

	TIME: 2030 INITIALS: CS	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Alert unable to communicate c̄ pt. Translator able to speak c̄ pt. Pupils Perrl	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	ST 130-140's pulses 2+ Ⓛ Bilat Ⓡ 1+ Bilat cap refil < 3sec	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Resp 30-60's Breath sounds Ⓛ > R crackles c̄ Ⓡ base chest tube to gravity Δ'd to suction 20cm Intubated 2010hrs #8, 23cm teeth	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Vent AC R10 TV650 40% PS 5 BSAx4 w/ hypoactive incision to umbilical area suture CDI Ø S/S of infection Ø BM	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley cloudy amber blood tinged q s° 1°	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Pt has external fixator to Ⓛ femur c̄ drsg	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Pt has Lac to Ⓛ ankle, Drsg Δ Chest tube to Ⓡ lateral chest Drsg CDI, Burns to R FA & Chest-lateral, Pt has blisters to Ⓡ ankle - CX sent to (b)(3)-1	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Pt grimaces c̄ mvt chest arm & leg. Medicated c̄ Morphine	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Pt appeared calm before intubation.	

MEDCOM - 3617

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	Ⓡ Hand #18g	patent, WNL
IV SITE # 2	Ⓛ ARM #20g	WNL
IV SITE # 3		

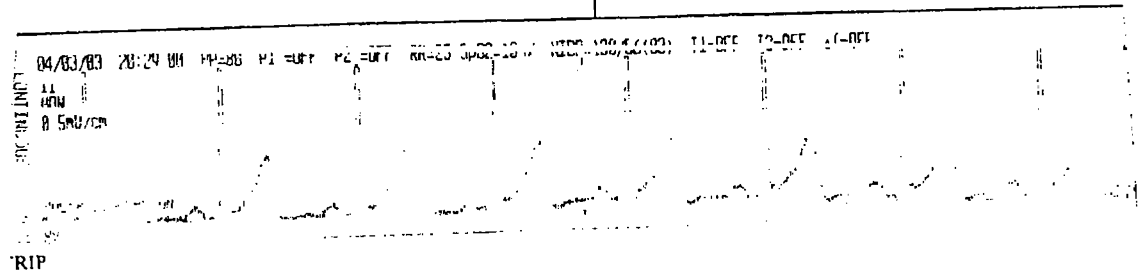
	TIME	INITIALS
IV PATENCY CHECKED	0710	(b)(6)-2
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:



SECTION III - SHIFT NOTES

0700 · RT administered 4 puffs albuterol / atrovent, FiO2 ↓ 30%
0900 - Pt awoke while changing out propofol bottle 40mg IVP given —
pt resting comfortable @ 0920, 2mg MSO4 given IVP @ 0910
LR ↑ to 300/hr for ↓ urine output (dark) pt prepared for Aerovac

MEDCOM - 3618

MEDICAL RECORD - ICU FLO[W SHEET]

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME:

DATE:

	TIME: 0710 INITIALS: (b)(6)-2	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	PERLA Pt sedated, on vent	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	All extremities +2 pulses, cap refill <3sec; edema bilaterally lower extremities	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Diminished breath sounds Ⓡ side #8 ET tube @ 23cm chest tube right side	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	soft, no BM since arrival, +BS q4 quads, pt has sutures (3cm vertical incision, above umbilicus	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter - clear yellow urine	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Ⓛ femur - external fixature c̄ ace wrap	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Blisters to Ⓡ ankle intact, dressing CDI; Ⓡ side of chest and Ⓡ arm - open blisters - dry	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	sleeping/sedated/med for pain	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	sleeping/sedated	

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: EPW # (b)(6)-4 DATE: 3 APR 03

DIAGNOSIS: S/P [illegible] PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	2400	0100	0200	0300	0400	0500	0600					
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	114/62	115/62	118/62	106/56	120/60	114/57	128/53	130/56				
	MAP	88	81	83	76	83	79	82	83				
	TEMPERATURE	98.7	97.2°	97.6		97.7			97.7				
	PULSE	94	92	92	92	91	83	85	80				
	RESPIRATIONS	15	15	17	21	24	10	23	13				
	PULSE OXIMETER	100%	100%	100%	99%	99%	100	100%	100%				
	CVP												
	PAIN (0 – 10)	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	UTA				
RESPIRATORY	OXYGEN (L/%)	.40	.40	40	40	40	.40	.40	.40				
	O2 METHOD	AC	AC	AC	AC	AC	SIMV	SIMV	SIMV				
	VENT SETTINGS:												
	FIO2	40	.40	40	.40	40	.40	.40	.40				
	MODE	AC	AC	AC	AC	AC	SIMV	SIMV	SIMV				
	TV	650	650	650	650	650	750	750	750				
	RATE	10	10	10	10	10	10	10	10				
	PEEP	5	5	5	5	5	5	5	5				
	PS	/											
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE	Propofol	30.5	30.5	30.5	30.5	33.6	33.6	33.6	33.6				
	LR	150	150	150	150	500	150	150	150				
	IVPB 100		100						100				
	PO												
	TOTALS												
OUTPUT	URINE 400		175	75	50	50	50	275	325				
	Chest tube												
	STOOL												
	TOTALS			650	700	750	800	1075	1400				

MEDCOM - 3620

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

DATE: 4Apr03

PATIENT NAME: #(b)(6)-4

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

DIAGNOSIS: MVA

VITAL SIGNS												
TIME:	0710	0800	0900	1055								
BP ARTERIAL LINE	TF ~~125/53~~											
BP CUFF	125/53	120/50	126/52	121/53								
MAP	80	50	80	78								
TEMPERATURE	97.7 Ax		97.4 Ax									
PULSE	81	83	85	77								
RESPIRATIONS	26	25	20	18								
PULSE OXIMETER	100%	99%	99%	100%								
CVP												
PAIN (0 – 10)	sleep	sleeping	sleep	sleep								

RESPIRATORY												
OXYGEN (L/%)												
O2 METHOD												
VENT SETTINGS:	SIMV	SIMV										
FIO2	40%	30%	30%	30%								
MODE	SIMV	SIMV	SIMV	SIMV								
TV	750	750	750	750								
RATE	10	10	10	10								
PEEP	6	6	6	6								
PS	—	—		—								
Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE												
LR		150	150	300								
Proprofol		33.6	30.6	67.2								
IVPB		0	0	0								
PO		~~183.6~~	~~183.6~~									
TOTALS		183.6	183.6	362.2								

OUTPUT												
URINE	—	200	160	160								
Chest tube	—	0										
STOOL												
TOTALS		200	160	160								

MEDCOM - 3621

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY			APR	APR					
MONTH-YEAR / DAY	2 APR	2	2	2					
19 / HOUR	0450 05	0530 06	0630 0700	08 1500					

PULSE (O) / TEMP. F (•) / TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	29	46 40	37	32 34 22	26
BLOOD PRESSURE	131 / 61	132 / 63	137 / 59	143 149 / 66 65 / 100 99	
SPO2					
HEIGHT: / WEIGHT →					
OUTPUT Urine		1400		500	800
Chest tube		110		Ø	20

Record special data only when so ordered

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

(b)(3)-1

(b)(6)-4

OD

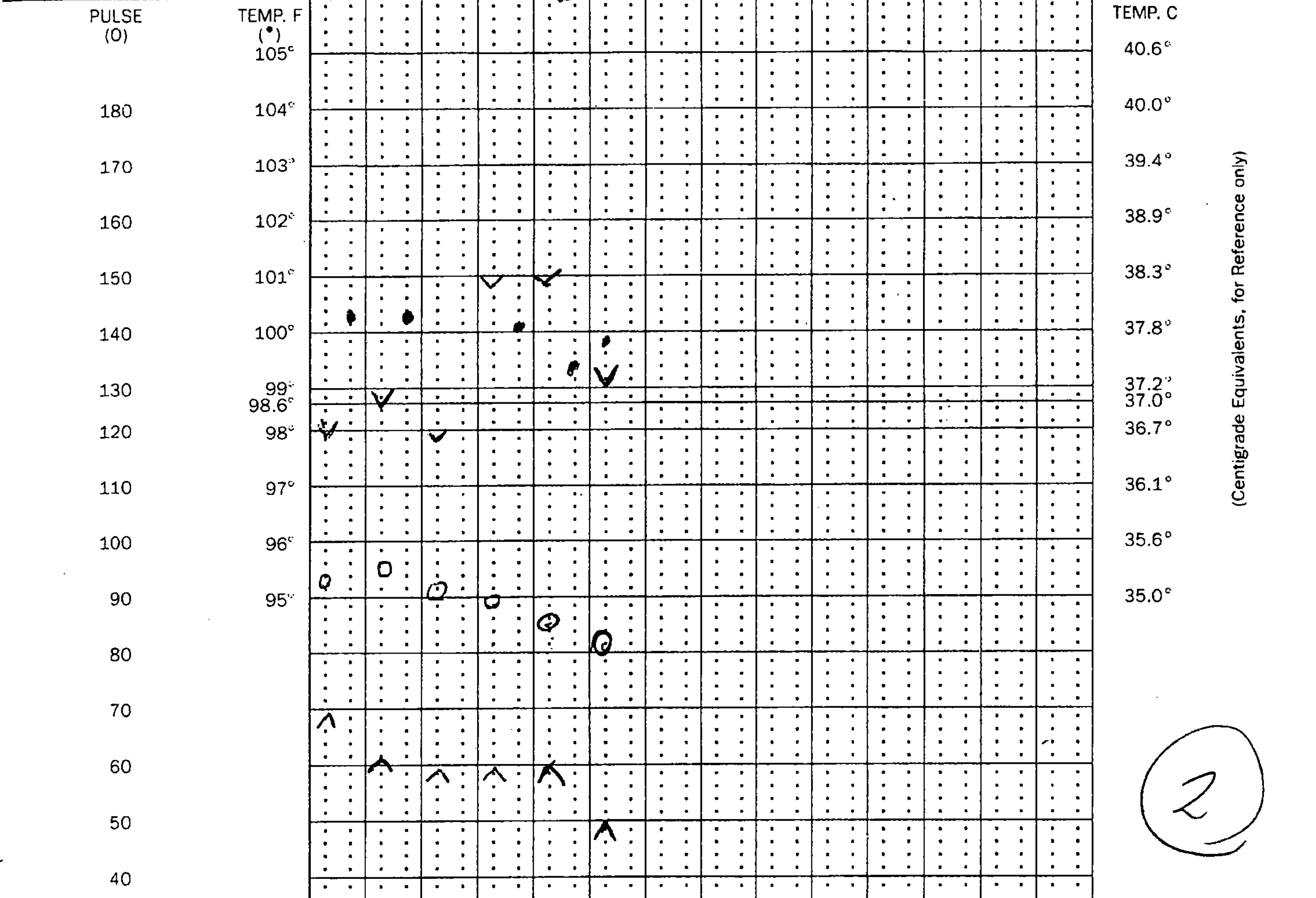
REGISTER NO.

WARD NO.

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

MEDCOM - 3622

MEDICAL RECORD — VITAL SIGNS RECORD



HOSPITAL DAY	Admit					
POST- OP DAY						
MONTH-YEAR / DAY	2 Apr 2003		3 Apr 2003		3APR03	
19 / HOUR	0300	0330	0400	1810	0400	1000
RESPIRATION RECORD	36	34	32	30	26	33
BLOOD PRESSURE PO	97%	93%	96%		96%	97%
Urine	~~850~~ 220 cc	1600	1400cc 0245		900cc 0200	

PULSE (O) / TEMP. F (•) / TEMP. C

(Centigrade Equivalents, for Reference only)

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.

OD # (b)(6)-4

(b)(3)-1

(2)

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

*U.S.GPO:1996-404-763/40069

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

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) ________ ML

REMARKS:

TYPE OF REQUEST (Check ONLY If Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED STAT

DATE AND HOUR REQUIRED STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? N/A

REQUESTING PHYSICIAN (Print) (b)(6)-2 MAJ

DIAGNOSIS OR OPERATIVE PROCEDURE: Blunt Trauma

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 (b)(6)-2

DATE VERIFIED 30 MAR 03

TIME VERIFIED 1850

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	CROSSMATCH	PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD; SIGNATURE OF PERSON PERFORMING TEST
DONOR	RECIPIENT			
ABO	ABO			
Rh	Rh			

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

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. (b)(6)-4

1st VERIFIER (Signature) (b)(6)-2 CPT/AN.

2nd VERIFIER (Signature) (b)(6)-2

PRE-TRANSFUSION TEMP. | PULSE 104 | BP

DATE OF TRANSFUSION 30 MAR 03 | TIME STARTED 1855 Z

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)

~~POW~~ EPW # (b)(6)-4

(b)(3)-1

SEX M | WARD ATLS

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 - 3624

Medical Record Copy

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR		M		ICU5	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)*

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED: 3 APR 03

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

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
	3 Apr 03	

RADIOLOGIC REPORT

ETT tip 6 cm from carina

Lungs symmetrically aerated with bilateral diffuse patchy opacities to include bibasilar consolidations

Prominent pulm. vasc + heart → cannot exclude ~~heart~~ pulmonary venous hypertension or CHF

Ⓡ pleural tube – NO PTX.

Impr: Diffuse patchy Air Space Disease – pulm. edema vs. infectious infiltrates vs. hemorrhage vs atelectasis → correlate clinically

(b)(6)-2

Rad, (b)(3)-1

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

(b)(6)-4 Foreign National

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

LIST TIME ORDER NOTED AND SIGN

DATE OF ORDER 03 [illegible] 03 TIME OF ORDER 1930 HOURS

(1) admit ICW-5
(2) vitals q 1hr
(3) D(x) s/p injury - unknown type → No records available
(4) Morphine 1-5 mg IVPB q 1hr.

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

1st dose 2000 CS

IDENTIFICATION (b)(6)-4 EPW ICW5

ROOM NO. BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(5) NGT to gravity
(6) I+O
(7) Foley
(8) call MD abnormal vital signs
(9) NPO
(10) Zantac 50mg IVPB q 8hrs

IDENTIFICATION (b)(6)-4 EPW ICW5

UNIT ROOM NO. BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(11) IVF= LR @ 150cc/hr.
(12) call MD abnormal vital signs
(13) CBC Done (b)(6)-2
(14) Unasyn III gm IVPB q 6hr (b)(6)-2

1st dose 2000 (b)(6)-2

M

IDENTIFICATION (b)(6)-4 EPW ICW5

NURSING UNIT ROOM NO. BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(15) CXR Done (b)(6)-2
(16) Heparin 5000u BID SQ (b)(6)-2

MD

PATIENT IDENTIFICATION (b)(6)-4 EPW ICW5

NURSING UNIT ROOM NO. (b)(6)-2

[illegible] 3bPR032350

...WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD
[PRO]BLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

LIST TIME ORDER NOTED AND SIGN

DATE OF ORDER 4-3-03 TIME OF ORDER 2025 HOURS
(1) ✓ Versed 2-3mg IV q other hour
alternate c morphine.
(2) ✓ Vecuronium 10mg IV Now & Repeat
PRN for tube & ventilator tolerance
(b)(6)-2 , MD
CPT, MC

(b)(6)-2

[ROOM] NO. BED NO.

DATE OF ORDER 4-3-02 TIME OF ORDER 2050 HOURS
~~START propofol~~
(1) ✓ Propofol infusion @ 50 mcg/kg/min titrate to effect
(2) ~~Vecuronium 2mg/hr~~
so pt is not breathing over vent
and BP remains stable
(SBP 110 - 150 DBP 50-80)
(3) Vent TV 650 R10 Peep 5
AC mode FiO2 40% 1:1/1:2
(b)(6)-2
(b)(6)-2
(b)(6)-2
(b)(6)-

[R]OOM NO. BED NO.

DATE OF ORDER TIME OF ORDER HOURS
(4) ✓ Fentanyl 100 mcg IV x1

03 April 03 . 2221
D/C Unasyn
Zosyn 3.375 gm IVPB
q 6hrs.
(b)(6)-2 MD

[LOCA]TION (b)(6)-4

5

ROOM NO. BED NO.

DATE OF ORDER 03 April 03 TIME OF ORDER 2240 HOURS
(1) albuterol / atrovent MDI
q 4hrs prn
(2) ✓ silvadene cream to
umbilical vendor
BID
(b)(6)-2

[LO]CATION (b)(6)-4
ICU 5

RO[OM] (b)(6)-2

3r ... 2350

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

EPW

ICU5

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 04 April 03 | TIME OF ORDER: 0425 HOURS | LIST TIME ORDER NOTED AND SIGN

1. SIMV, TV = 750, FiO2 = 40%
2. Bolus 500cc LR (b)(6)-2 then 150cc/hr.

(b)(6)-2

(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.

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 APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6
3 APR 03	(b)(6)-2	Vitals q 1°	07		(b)(6)-2		
		See	15				
			23				
3 APR 03		Vent Settings: AC R-10	07		Δ'd 4/4/03 (b)(6)-2		
		V650 FiO2 40% Peep 5	15		(b)(6)-2		
		I:E 1:2	23				
3 APR 03		CT to gravity	07	/	(b)(6)-2 CPT/		
			15	/			
			23		4/3/03		
3 APR 03		CT to suction	07	(b)(6)-2			
			15				
			23				
3 APR 03		I & O's	07				
			15				
			23				
3 APR 03		Foley	07				
			15				
			23				
3 APR 03		Call MD c abnormal VS	07				
			15				
			23				
3 APR 03		NPO	07				
			15				
			23				
4 APR 03		Vent: SIMV TV750 FiO2 40%	07				
		R10 Peep 5 I:E 1:2	15	/			
			24	/			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P injury unknown type — not available.

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

PATIENT IDENTIFICATION:
EPW # (b)(6)-4 ICU 5

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo APR Yr 03	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3APR03	(b)(6)-2	Dcx) s/p injury - unknown type ≈ No records available	3APR03	ASAP	1930	(b)(6)-2
3APR03		) CBC	3APR03	1930	1950	
3APR03		- CXR	3APR03	1930	2030	
4APR		Bolus 500cc LR then ↓ rate to 150cc/hr	4APR03	0425	0430	

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: APR 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
3APR03	(b)(6)-2	Zantac 50mg IVPB	08	/	(b)(6)-2			
		q 8hrs	16	/				
			24		(b)(6)-2			
3APR03		Unasyn III/IV gm IVPB	06					
		q6hrs	12			D/C'd		(b)(6)-2
			18					
			24					
3APR03		LR @ 150cc/hr	07					
			15					
			23					
3APR03		Heparin 5000u SQ	10					
		BID	22					
3APR03		Zosyn 3.375mg IVPB	06					
		q6hrs	12					
			18					
			24					
3APR03		Sulfadiazine cream to	10					
		vesicles BID	22					
3APR03		Propofol infusion @ 50mcg/kg/hr	07					
		titrate to effect so pt	15					
	------	not breathing over vent & BP	23					
	------	remains stable SBP						
	------	110-150 DBP 50-80						

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Injury unknown type - no records

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:
EPW # (b)(6)-4 ICU5

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 TIL EXHAUSTED.

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Mo. April Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3APR03	(b)(6)-2	Fentanyl 100mg IV x 1	3APR03	ASAP	2108	(b)(6)-2
"		Versed 5mg IV x 1 } Per Anes. - intubation	3APR03	ASAP	2010	
"		Etomidate 10mg IV x 1	"	ASAP	2010	
"		Succs 100mg IV x 1 cor (b)(6)-2	"	ASAP	2010	
"		Versed 5mg IV x 1 per Dr. Osterholt	3APR03	ASAP	2223	
"		Propofol 10cc IV push x 1 per	3APR03	ASAP	2050	
		MAJ (b)(6)-2 (Pt agitation)				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED							
3APR03	(b)(6)-2	Morphine 1-5mg IVPB q1°	2000 5mg	2155 2mg	2230	0230	0300	0710 4Apr 3mg	0900 8mg 4Apr	
		(b)(6)-2								
3APR03		Versed 2-3mg q other hr, alternate c morphine	2130 0326	3mg 1150						
		(b)(6)-2								
3APR03		Vecuronium 10mg IV prn for tube & Ventilator tolerance	2010	2100						
		(b)(6)-2								
3APR03		Albuterol/Atrovent MDI q 4hrs PRN	2215	4Apr 0750						
		(b)(6)-2								

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 342-027/70450

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial): OD # (b)(6)-4
2. SSN:
3a. STATUS:
3b. SERVICE: Iraqui
4. PRECEDENCE: U ✓ P R
5. GRADE:
6. AGE:
7. SEX: ✓ Male / Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): AMBULATORY / LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER:
15a. DESTINATION FACILITY:
15b. DESTINATION FACILITY PHONE NUMBER:
16. NUMBER OF ATTENDANTS — 16a. MEDICAL / 16b. NON MED

17. DIAGNOSIS
① Fractured pelvis
② Ⓡ knee & fem c ext fixat

18. ✓ BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		✓	HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.		✓	CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARS/SINUS	j.			SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS
20a. DATE: 2 Apr 2003
20b. TIME: 1000Z
20c. ALLERGIES: NKDA
20d. DIET: REG / 3GM NA / CARDIAC / DIABETIC ____ CALS
RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4
TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ____ OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr
20e. IV/BLOOD
20f. SPECIAL EQUIPMENT: SUCTION / NG TUBE / STRYKER FRAME / INCUBATOR / TRACTION / IV PUMP / TRACH / ✓ MONITOR / ✓ FOLEY / ORTHOPEDIC BRACES / ✓ CHEST TUBE/HEIMLICH / RESTRAINTS / OTHER (Explain in 23)
O2: LITERS: ROUTE:
VENTILATOR SETTINGS
20g. ALTITUDE RESTRICTION:
20h. RECORDS TO ACCOMPANY PATIENT: OUTPATIENT RECORDS / INPATIENT RECORDS / NARRATIVE SUMMARY / X-RAYS / OB RECORDS / DENTAL RECORDS / FINANCIAL / OTHER (Specify)

20i. MEDICATIONS/TREATMENTS
IV Fluid support
Chest tube to underwater seal
O_2 @ FiO_2 of 30% – 50%
maintain O_2 sats

21. PRE-FLIGHT VITALS:
21a. DATE/TIME / 21b. TEMP / 21c. PULSE / 21d. RESP / 21e. BP

22. BRIEF NARRATIVE
Pt wound @ March 30th → had fractured pelvis, Ⓡ femur fracture & Chest tube placed on Ⓡ
Pt has received 2 units PRBCs c H/H 28/9 on 2 April 2003

23. ASSESSMENT/PROGRESS
DATE/TIME — NOTES

(b)(6)-2 ...ms

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN
(b)(6)-2 ...ms LTC

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM ...
Point of Contact (1st Sgt, etc.):
POC phone #:
Unit (here):
DOB:

MEDCOM - 3633

DD FORM 1 FEB 63 602

REPLACES DD FORM 602, 1 OCT 51
PREVIOUS EDITIONS ARE OBSOLETE
REMPLACE DD FORM 602, 1 er OCTOBRE 1951
LES ÉDITIONS PRÉCÉDENTS SONT CADUQUES

☆U.S.GPO: 1992-318-678

PATIENT EVACUATION TAG — FICHE D'ÉVACUATION DE PATIENT

(Tie this tag to patient — Attacher cette fiche au patient)

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
(b)(6)-4

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*

DIAGNOSIS
DIAGNOSTIC (R) femur fx c external fixator
(R) renal laceration
(R) side chest tube ? right humerus fx

CLASS–CLASSE		DISEASE MALADIE	BATTLE CASUALTY BLESSÉ AU COMBAT	INJURY BLESSURE
1A	2A			
1B	2B			
1C		CABIN OR COMPARTMENT NO. NO. CABINE OU COMPARTIMENT		BUNK NUMBER NUMÉRO COUCHETTE
3	4			
VSI TRES GRAV. MAL. ☐ Yes Oui ☐ No Non		BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGE		
DESTINATION DESTINATION		SHIP/AC *(Number/type)* NAVIRE/AVION *(Matricule/type)*		

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*

SIGNATURE OF MEDICAL OFFICER SIGNATURE DU MÉDECIN	DATE DATE

REGULAR DIET RÉGIME NORMAL	SPECIAL DIET *(Describe)* RÉGIME SPÉCIAL *(Description)*

SHIP'S RECORD OFFICE TAB — FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT DATE DÉPART
DESTINATION DESTINATION	ARRIVAL DATE DATE ARRIVÉE

EMBARKATION TAB — FICHE D'EMBARQUEMENT

MEDCOM - 3634

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1-6): (b)(3)-1
2. LOCATION (7-8) (State or Country Code.): K U

3. REGISTER NUMBER (9-15): (b)(6)-4
NAME (Last, First, Middle Initial): EPW (b)(6)-4 (b)(6)-4
OD#

4. PAY GRADE (16-17): X X
5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19-26): —
7. AGE AT ADMISSION (27-29): —
8. RACE (30): X
9. ETHNIC BACKGROUND (31): 9
RELIGION: MUSLIM (b)(3)-1

10. LENGTH OF SERVICE (32-34): —
ETS
11. FMP (35-36): 9 9
12. SOCIAL SECURITY NUMBER (37-45): (b)(6)-4 K

ORGANIZATION (Active Duty Only): IRAQI CIVILIAN
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 1930
BRANCH / CORPS: Iraqi Civ

14. FLYING STATUS (47-49): —
15. BENEFICIARY CATEGORY (50-52): ~~K 9 1~~ K18
16. ZIP CODE OF RESIDENCE (53-61): 0 9 3 3 0 0 0 0 0

17. UNIT LOCATION (State or Country Code) (62-63): —
18. MOS (64-70):
19. TRAUMA (71): INJ
PREV. ADMISSION: YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1
WARD: ICU5
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 Kuwait
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION (73-74): 2 2
22. MTF TRANSFERRED TO (75-80): (b)(3)-1
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81-88): 2 0 0 3 0 4 0 9 OK

24. CLINIC SVC - ADMITTING (89-92): A E A A
25. MTF TRANSFERRED FROM (93-98):
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99-106): 2 0 0 3 0 3 3 1 (corrected from 0 4 0 3)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107-108): K u
28. MTF OF INITIAL ADMISSION (109-114):
29. DATE INITIAL ADM (115-117...):

Adm Change 2003 3 31

FOR LOCAL USE

~~(R) chest wound~~
(1) Fractured pelvis
(2) (R) knee + femur c̄ ext. fixation

DX: 8088
8210D
E9889

Px: 7815
3404

Injury 169

CODE:

ADMITTING OFFICER (Signature, as required)
SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

ME CORD - PATIENT PROBLEM LIST

or u... of this form, see MEDCOM Circular 40-5

SECTION I - ACTIVE PROBLEMS. *Date and initial each problem. Use initials to document outcome "Met" or "Not Met" with date. Outcomes not met require note for post-discharge follow-up in Section II. See Section IV for authentication of initials.*

DATE	INITIALS	PROBLEM (Active)	EXPECTED OUTCOMES/GOALS	MET	NOT MET	DATE ACHIEVED/ REVISED
		Ineffective Airway Clearance R/T	Breath sounds clear; Lungs CTA bila®			
			Minimal secretions; able to maintain own			
			airway without intervention			
3APR03	(b)(6)-2	Impaired gas exchange R/T	Resolution/Improvement of hypoxemia			
			with or w/o O2; ABG w/in range			
		Ineffective Breathing Pattern R/T	ABG w/in range; Adequate performance of			
			IS >=1500 q2 WA; TC&DB self			
		Alt in Hemodynamic Status R/T	Cardiac Rhythm stable;VS & Neuro status			
			stable; UO WNL; No Uncontrolled bleed;			
			H/H acceptable range; strong palp pulses			
3APR03	(b)(6)-2	Pain R/T	Pain decreasing & manageable per pt			
			report; decreasing non-verbal cues of pain;			
			cooperation/participation in activities;			
			increased periods of uninterupted sleep			
		Knowledge Deficit R/T	Verbalizes understanding of diagnosis &			
			medications, treatments, and importance of			
			compliance			
		Alteration in Cerebral Tissue Perfusion R/T	ICP>20mmHg; CPP>70mmHg; No			
			complications from elevated ICP			

(Continue on reverse)

SECTION II - FOLLOW-UP PLANS. *Note follow-up actions for any outcomes not met at time of patient discharge/release. Include any problem or chronic illnesses to be transferred to Master Problem List (DA Form 5571) or Adult Preventive and Chronic Care Flowsheet (DD Form 2766).*

PATIENT IDENTIFICATION

EPW # (b)(6)-4

ICU 5

1. REPORTING MTF — LOCATION (State or Country Code.)

ADMISSION AND CODING INFORMATION

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

1	2	3	4	5	6	7	8
(b)(3)-1						K	U

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4						

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

OD#

4. PAY GRADE

16	17
X	X

5. SEX

18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION: MUSLIM (b)(6)-2

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
(b)(6)-4								

OK

ORGANIZATION (Active Duty Only): IRAQI CIVILIAN

13. MARITAL STATUS

46

HOUR OF ADMISSION: 1930

BRANCH / CORPS: Iraqi Civ

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	6

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

INJ

PREV. ADMISSION: YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
6

WARD: ICU5

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: NOT AVAILABLE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NOT AVAILABLE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 Kuwait

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: NOT AVAILABLE

21. TYPE OF DISPOSITION

73	74
2	2

22. MTF TRANSFERRED TO

75	76	77	78	79	80
(b)(3)-1					

23. DATE OF DISPOSITION (Y Y Y Y M M D D)

81	82	83	84	85	86	87	88
2	0	0	3	0	4	0	4

OK

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	A	A

25. MTF TRANSFERRED FROM

93	94	95	96	97	98
(b)(3)-1					

26. DATE THIS ADMISSION (Y Y Y Y M M D D)

99	100	101	102	103	104	105	106
2	0	0	3	0	3	3	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 (Y Y Y Y M M D D)

115	116	117	118	119	120	121	122

FOR LOCAL USE

~~(R) chest wound~~

Changed

CODE:__________

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

MEDCOM - 3637

.ENT TREATMENT RECORD CO\ ...

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

1. REGISTER NUMBER (b)(6)-4
2. NAME (Last, First, MI) # (b)(6)-4
3. GRADE: OD
ADMISSION REMARKS
4. S... M
6. RACE: IRAQI
7. RELIGION
8. LENGTH OF SVC
9. ETS
10. PREVIOUS ADMISSION: NO
11. FMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION
14. WARD: ICW 3
15. FLYING STATUS
16. RATING/DSG
17. DEPT./BEN
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE: INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: TRANS
22. HOURS OF ADMISSION: 1500
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION: TRANS
26. DATE OF DISPOSITION: 15 APR 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION: 10 APR 03
ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 KUWAIT
30. DATE OF INTIAL ADMISSION
32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (R) FlANK / (R) FOREARM

~~E999~~

~~E991.9 881.00~~

~~879.4~~

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
	5			5	5

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: = Original signed =

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9 APR 03	Tmp oral 101.2 RR 20 SpO2 RA 98% 88 HR 103/58
1700	Pt given ī T3 for pain to (R) hand & fever. (b)(6)-2 LPN, SGT
1730	Keflex 500mg PO (b)(6)-2 LPN, SGT
1842	Tmp oral 99.6° (b)(6)-2 LPN, SGT
1905	650mg Tylenol for fever & pain (b)(6)-2 LPN, SGT
2330Z	Keflex 500mg P.O. given (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

EPW # (b)(6)-4

509-113

NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
14 April 03	pt admitted to ICU #3 @ 12:15. A+Ox3, MAE, VSS BP 148/71 (100), HR-114 sinus tach, O2 sat 100% on RA, temp 38.4°C. BBS CTA, RLL ↓ fine crackles, Good pulses, cap refill < 2 sec. Abd. soft, but tender. (R) flank GSW covered with dressing. Significant amount of pain in this area. (R) UE (forearm) ē penetrating wound. Pending XR. Awaiting OR. Foley to SD ē good amount of urine. IVF infusing via 2 IV's (LUE). Labs (CBC, lytes) within acceptable limits. (b)(6)-2
12:30	Seen by surgery & anesthesia. Abx given. Awaiting
10-800cc	OR. 13:00 (Z) XR done.
15:17	Post-op: HR-85 NSR, BP 127/55, Temp-37.5°C, RR-19 bpm, O2 sat 97% on RA. Resting comfortably
2200 Z	Foley d/c'd. Pt was complaining of pain + discomfort from cath.
25 April 03 05:25 (Z)	Pt resting comfortably, BP-101/43 HR-107 RR-28 O2 sat-99% RA VSS (R) UE immobilized. No neurovascular deficits. (R) flank dressing saturated with serosang. drainage (reinforced.) Pain well controlled. temp 98.3°F. Will cont. with pulmonary toileting.
08:00	101.3°F, HR-115, 98% O2 sat on RA, BP 111/48 RR-20 bpm. Medicated for pain ē good results.
0912 Z 05 Apr 03	NPW C/O ↑ Temp to Translator T-101.6F RN Notified (b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

EPW # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

110
x8
1200

PROGRESS NOTES

DATE	
09:38 (R)	Cooling bath given. Tylenol po given (b)(6)-2
Voided 900a	Void 450ml @ 1100Z RS [illegible]
11:37 (R)	O_2 sat 97%. RR - 24, HR - 106, BP 103/42 temp 102.2°F.
	Remains febrile despite tylenol ; cooling bath.
1800a In +1000a	MD informed. Cont with dbx (b)(6)-2
2200	
c 1800a	
1445Z 5Apr03	assumed care of pt. changed Δ to (R) flank, packed W-D dressing sterile condition. 121/44 P116 POX 92% RA RR, 20 & looking comfortable. (R) arm in splint - good CMS to fingers. Patent PIV to (L) AC. Lungs CTA. Temp 99' axillary. HS normal, BS present all 4 quads; pt. voids on his own clear yellow urine. (b)(6)-2 CPT AN.

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

EDICAL RECORD | PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
APR03 0202	Pt to ICW #1, Alert + cooperative, (R) arm in splint cast CMS intact + RUE. (R) flank area dressing intact, slightly soiled c̄ serosanguineous fluid wound red c̄ granulation tissue, dressing posterior to that CD+I. Lungs clear throughout, S_1 + S_2 clear and crisp, peripheral pulses palpable & correspond c̄ heart sounds. Pulses bounding. Abd soft, nontender BS(+) x4. Restarted IV in (L) forearm. BP 130/80 HR 98 RR 20 T=101.0. Tylenol 650 mg PO given for ↑ temp. Pt denies pain. (b)(6)-2
6 APR03 0435z	Vitals – Temp 99.4, B/P 130/78, Pulse 80, SpO2 98%, Resp 20 (b)(6)-2
6 Apr 03	0440 Zulu pt alert + cooperative. PERRLA, S_1S_2 heart sounds present, and lungs clear bilaterally. +2 peripheral pulses in all 4 extremities. (R) UE in splint cast. Pt has full sensation and cap refill <3 sec in RUE. Pt able to move all fingers in (R) hand. Dressing intact in (R) flank area. Dressing is soiled at this time. Abdomen is soft & non-tender c̄ hypoactive bowel sounds. (L) forearm IV patent c̄ LR running at this time. Pt denies pain but stated he is hungry. (b)(6)-2
6 APR03 0715z	5 mg of morphine for pain. (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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

Doc 's Orders

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/6/03	(1) Admit (R) FA / (R) Fine injury to MCWAT 1
0340	(2) Dx: see (1)
	(3) Condition stable
	(4) Vitals q shift
	(5) Diet: Regular
	(6) Fluids: LR @ 75/°
	(7) X-ray (R) FA (AP/Lat)
	(8) Meds:
	Ancef 1 gm IV Q 8°
	Gent 350mg IV q day (b)(6)-2
4/6/03	(1) MSO4 2-5mg IV Q 3° prn
0725	(2) Tylenol, Motrin, Vicodin, T3
	prn po @ appropriate intervals
	(b)(6)-2
4/9/03	(1) D/C Ancef/Gent
1240Z	p̄ 72°
	(2) Add Keflex 500mg po QID p̄ Ancef/Gent D/C'd
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | [DEP]ART./SERVICE | RECORDS MAIN[TAINED AT]

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

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

REGISTER NO. | WARD NO.

(b)(6)-4 (b)(3)-1

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
Apr 03 1445Z	Pt c/o HA. admin 1 tab Tylenol (500mg) PO per dr (b)(6)-2 order (b)(6)-2 2LT/AN
APR03 1700	RR 20 TMP oral 99.9 HR 71 SPO2 RA 97% BP 108/48. Pt talking c̄ no pain Replaced dressing s̄ reapplying. No complaints (b)(6)-2 LPN, SGT
APR 03 1800	Ancef 1gm IV (b)(6)-2 LPN, SGT
2110	T3 i for pain &fever TMP 99.6 (b)(6)-2 LPN, SGT
APR03 0328	1gm Ancef IV. Pt laying in bed c̄ Ø complaints. LPN, SGT
3.31	Pt tmp 99.3 oral (b)(6)-2 LPN, SGT
April 03 0430Z	VS obtained, RR 24, T 99.8°F, BP 122/60, O_2 sat on RA 98% and P 75. pt denies any pain at this time (b)(6)-2 2LT/AN
4/8/03 0450Z	(R) open ulnar fx / (R) FLANK DEEP SOFT TISSUE WOUND AF/VSS ANCEF/GENT (R) ARM SPLINTED / Dressing c/d/i (R) FLANK: Dressing mild yellow/green/white Ø blood P) O/W Surgery (R) flank - Delayed Primary Closure? EVAC Priority (b)(6)-2
8APR03 - 0540Z	pt. given 2 T3's PO for pain. (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
		0082

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

(b)(6)-4 (b)(3)-1

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
4/6/03 0720	(R) ULNAR FX
	(R) FLANK Deep Soft Tissue Injury
	VS: 99.4 130/78 88 SpO2 98% RA R-18
	(R) FA splinted / Dressing c/D/i
	(R) FLANK good granulation 6X3cm wound
	w→D Δ'D
	P) ① Ancef / Gent
	② EVAC
	③ wound care
	④ Pain Control
	⑤ Regular Diet
	(b)(6)-2
/03 0800z	350mg Gent IV ↑ at this time. Pt resting quietly — 2LT/AN (b)(6)-2
/03 1641	RR 24 HR 85 SPO2 98% RA TMY 101° 134/89 orel no change since last exam
1700	Pt ↑ T3 for fever & pain (b)(6)-2 — LPN, SGT
1900	Pt recieved ancef 1g IV ← (b)(6)-2 SPC (b)(6)-2
2320	Pt slept through night s̄ complaints. Urinated 5x/Afebrile TMP 99.6° LPN SGT
/03 0500	130/80, 90 HR, 20 Resp, 99° Temp (b)(6)-2 2LT AN
/03	0600z Pt receiving 350mg Gent IV at this time — 2LT/AN (b)(6)-2
/03	(R) ULNA FX Ancef/Gent
52	(R) FLANK Deep Soft Tissue Injury
	VSS / AF
	(R) FA splinted – c/D/i (original dressing placed 4/5/03)
	(R) Flank – pseudomonas colonization 6X3cm wound
	entrance/exit w→D Δ'D
	P) ① EVAC Priority ② wound care ③ Discuss Soft Tissue c̄ Surgery

ed on Recycled Paper

(b)(3)-1

'DARD FORM 509 (REV ...) BACK

(b)(6)-2

DATE	NOTES
8 Apr 03 1200 Z	Pt c/o pain. Admin 2 Tylenol #3 tabs (PO) —— (b)(6)-2
1210 Z	Pt's temp 101.8. Admin 800 mg motrin for fever —— (b)(6)-2
1300 Z	Pt temp now 100.4 —— (b)(6)-2
8APR03 1630	RR20 97% O2 RA 70 HR tmp 99.6 118/60: Pt Given Tylenol TWO TAb 500 for Fever
1953	Ancef IV and MSO4 5mg for c/o PN —— SPC (b)(6)-2
9Apr03	@ 0420 Bp 119/60 p84 T-100.7 RR-16 Psa 98
9April03	9mg MSO4 IVP for pain (b)(6)-2 SGT 91W20
9April03	Dressing Δ (b)(6)-2 SGT 91W20
9April03	0800 - Pt c/o Pain Received ii T3 po —— (b)(6)-2
4/9/03 1233z	(R) open ulna fx ANCEF/GENT D 3/3
	(R) Flank Deep Soft Tissue wound
	VS 118/60 84 100.7 16 98% SaO2 (08Apr03) Tmax 101.8
	(R) arm splinted / dressing intact
	(R) Flank (+) serosanguinous drainage ∅ necrosis
	W→D dressing Δ'D
	P) Eval Priority
	D/C Ancef / Gent p 72°
	will start Keflex 500g po QID
	(b)(6)-2
9April03 1303	Pt c/o of Abd pain; Pt states has no Bowel Movement x 6 Days, did rectal exam, exam was neg, Continue to monitor —— (b)(6)-2

PLEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Transfer for
1/10/03	NSG Note: See Med com Form 689-R for transfer (b)(6)-2 MAJ
1020	in note. (b)(6)-2 CNN

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.

OD (b)(6)-4

PROGRESS NOTES
Medical Record

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

EPW # (b)(6)-4

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
14 April 03	pt admitted to ICU #3 @ 12:15. A+Ox3, MAE, VSS, BP 148/71 (100), HR-114 sinus tach, O2 sat 100% on RA, temp 38.4°C. BBS CTA, RLL ↓ [illegible] crackles, Good pulses, cap. refill < 2 sec. Abd. soft, but tender. (R) Flank GSW covered with dressing. Significant amount of pain in this area. (R) UE (forearm) c̄ penetrating wound. Pending XR. Awaiting OR. Foley to SD c̄ good amount of urine. IVF infusing via 2 HL's (LUE). Labs (CBC, lytes) within acceptable limits ——— (b)(6)-2
12:30	seen by surgery & anesthesia. Abx given. Awaiting
IO-800cc	OR. 13:00(Z) XR done.
15:17	Post-op: HR-85 NSR, BP 127/55, Temp-37.5°C, RR-19 bpm, O2 sat 97% on RA. Resting comfortably
2200 Z	Foley D/c'd. Pt was complaining of pain + discomfort from cath.
25 April 03 05:25 (Z)	pt resting comfortably, BP-101/43 HR-107 RR-28 O2 sat-99% RA VSS. (R) UE immobilized. No [illegible] deficits. (R) Flank dressing saturated with serosanguinous drainage (reinforced.) Pain well controlled. temp 98.3°F. Will cont. with pulmonary toileting
08:00	101.3°F, HR-115, 98% O2 sat on RA, BP 111/48 RR-20 bpm. Medicated for pain c̄ good results.
0912Z 05 Apr 03	NPN C/O ↑ Temp to Translator T-101.6F RN Notified (b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

EPW # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY (b)(3)-1
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION — STREET ADDRESS / CITY / STATE / ZIP CODE

ARRIVAL — DATE *(Day, Month, Year)*: 4 Apr 03 — TIME: 1145 — TRANSPORTATION TO FACILITY

SEX: M

AGE

DUTY/LOCAL PHONE: AREA CODE / NUMBER

HOME PHONE: AREA CODE / NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Ø

ALLERGIES: PCN

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 INITITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (R) Flank protrating (R) Arm Injury

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1150
INITIALS: [signature]

VITAL SIGNS

TIME	1150				
BP	105/59				
PULSE	115				
RESP	34				
TEMP	100.4				
~~WT~~ SPO2	98 RA				

LAB ORDERS

✓	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	UA MSCC/CATH		CHEM:	
	BLOOD C&S X				
	Lipase				
	Chem 7				

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
	IV LR			1155	18g (L) Bicep

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: ICW 3

TIME OF RELEASE: 1215

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

(b)(6)-4

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 8-96)
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		SUP O2	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

EPW s/p GSW (R) flank >24° ago - has (B) UE injuries s/p GSW. Arms are bound @ wrist ∴ limit exam.

meds: ∅   All: PCN   Surg Hx: ∅   TOB: ⊕

PE: HEENT: nc/at atrm
Cor: RRR s m/g/r
Pul: CTA/b
Abd: NT/ND s-
B/E: FROM/MAEW ī (B) UE - bound - 6cm x 3cm wound to extens[illegible] surface (R) arm

Abd wound / flank 8cm deep flank extends to deep soft tissue ∅ evidence of musculature

A/P: wounds 24° ago - explore wound debride / possible explor

CONSULT WITH	TIME	ACTION
CBC amylase		
Chem 7		
X-ray (R) arm		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

Penetrating Wounds (R) Flank + Arm

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

AL RECORD - PATIENT ACTI\ , FL SHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

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

Time 1020 To ICW3 From ☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician (b)(3)-1

Procedure/Diagnosis GSW (R) Anesthesia (Specify): Ø

LOC AAOX3 B/P 130/70 P 96 R 20 T 100.6

Dressing/cast (R) arm & (R) flank stain / foul odor Neurovascular checks AAOX3

Intake (IV, po) NA Tubes None

Output (EBL, other) ______ Voided ☒ No ☐ Yes Amount: ______

Medication Keflex [illegible] po QID

Other ______

Report From NO [illegible] Received By (b)(6)-2

VITAL SIGNS

TIME:	1020														
BP ARTERIAL LINE	4/10														
BP CUFF	130/70														
TEMPERATURE	100.6														
PULSE	96														
RESPIRATORY	20														
OXYGEN (L/%)	—														
PULSE OXIMETER	98%														
O_2 METHOD															

Oxygen Method Key: NC = Nasal cannula, MT = Mist tent, NR = Non rebreather, PR = Partial rebreather, FM = Face mask, A = Aerosol, VM = Venturi mask, TC = Trach collar

PAIN

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

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: ______

TODAY'S WEIGHT: ______

WEIGHT CHANGE: ______

*Per hospital policy.

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

PATIENT IDENTIFICATION

OD (b)(6)-4 (b)(3)-1

DIAGNOSIS: ______

DRG: ______ ADMISSION DATE: ______

LOS: ______ EXPECTED RELEASE: ______

CASE MANAGER: ______

PRIMARY CARE MANAGER: ______

ISOLATION REQUIRED (Specify): ______

II - PATIENT ASSESSMENT - REVIEW OF

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

	TIME: 1030 INITIALS: (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ 4/10/03	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ RRR	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ CTA Bilat	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ vds (+)	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ Dsg redone (R) flank c̄ Saline/H_2O_2 - Repacked wet to dry. wound (R) flank c̄ good granulation.	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Grimaced when dsg. changed (R) flank. Foul odor to dsg. yellow/green D/C.	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ Speaks no English. Interpreter present.	☐	☐

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

Column 1	Column 2	Column 3
TIME: ____ INITIALS: (b)(6)-2	TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____
IV patency ✓ q __ hr:	IV patency ✓ q __ hr:	IV patency ✓ q __ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: * IV site dc'd (L) forearm 2° Ø date, dsg dirty, peeling off. Ø S+S infection.	Comments:	Comments:

MEDICAL RECORD — **LRMC INTRA[illegible] 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 BY ANES

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

3. DATE 4APR03 TIME PATIENT ARRIVED IN SUITE 1330

4. PATIENT IN TIME 1330 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: ON BEAN BAG BUMP TO Ⓡ HIP / ROLL ū Ⓡ SHOULDER TO SUPPORT / PILLOW ū Ⓡ LEG

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: NA

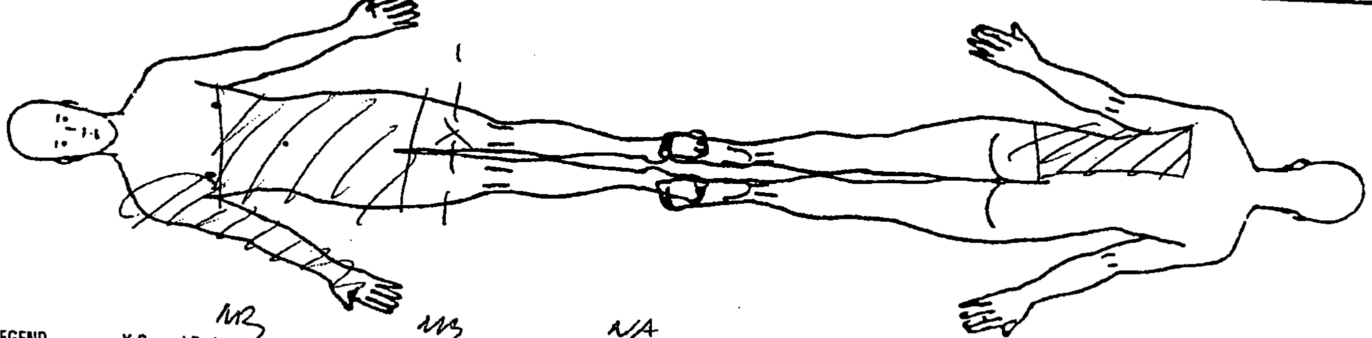
PREP SOLUTION *(Specify)* BETA / BETA

SITE: ABDOMEN/Ⓡ FLANK BY WHOM: BOZZO

SITE: Ⓡ ARM BY WHOM: BOZZO

COMMENTS: NO POOLING

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad MB ·· Safety Strap MB --- Tourniquet N/A

10. COUNTS

C – Correct I – Incorrect

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

SCRUB (b)(6)-2

CIRCULATOR (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 EPW

(b)(6)-4

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

☐ ESU NO: OR Ø 82

GROUND PAD: BRAND VALLEY LOT NO: 38592

☐ ESU NO:

GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87

ES DA FORM 5179-1 (TEST) DEC 83 [illegible] CEL[illegible] 358, 2 Mar 00 USAPA V1.00

PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUMBER: MANUF

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% N

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16Fr Foley		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*
FLANK / 4x8 SILK TAPE
(R) ARM FLUFFS/KERLIX ACEWRAPS

19. ADDITIONAL INFORMATION
The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the NA side.

Verified by: NA Patient/guardian NA Surgeon NA Anesthesia NA Operating Room Nurse

20. OPERATION(S) PERFORMED
WOUND EXPLORATION (R) FLANK
D&I (R) FOREARM

21. PATIENT TRANSFERRED TO ICU 3	TIME	METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ/AN

REVERSE OF DA FORM 5179-1, OCT 87

EUL OP 358, 2 Mar 00
RC apprvl - 3 Feb 00

USAPA V1.00

(THIS FORM IS SUBJECT TO THE PRI... T OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205

ANESTHESIA RECORD

Celotctac 26m in ICU

Page 1 of ...

ANES. START	IN OR	ANES. END	DATE
1230	1320	1508	4 APR 03
TOTS	SURG START	DRESSING	OR NO
1325	1353	1455	

OPERATION PERFORMED: X-lap washout (R) arm I&D

SURGEON(S) (b)(6)-2 / (b)(6)-2

PREOPERATIVE

☒ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 40
☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1320

Pre-Anesthetic State: ☒ CALM ☐ APPREHENSIVE ☐ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

AGENTS

Time: washout 1315 30 45 | 1400 15 30 45 | 1500

Agent							TOTALS
Fentanyl cc	2			1	0.5	0.5	
Sux mg	120						
Propofol	160						
Vec			3	2	2		
Ephedrine	5	5	5				
Robinul/Neostigmine						4/0.6	
N2O L/min Air	1	1	1	1	1	X	
O2 L/min	5	0.8	0.8	0.8	0.8	0.6	

FLUIDS

Fluid			
LR	1000	LR 1500	
NS	500		
Urine	100		240
EBL		150	

MONITORS AND EQUIPMENT

ANES. MACHINE # ___ & EQUIP. CHECKED
NON-INV. B/P ☒ PNS
CONT. EKG ☐ V LEAD EKG
ESOPH. STETH. ☐ PRECORD STETH.
PULSE OXIMETER ☒ O2 ANALYZER
END TIDAL CO2 ☐ MASS SPEC.
TEMPERATURE N.P.
WARMING BLANKET ☐ FLUID WARMER
AIRWAY HUMIDIFIER
N / G TUBE ☐ O /G TUBE
IV(s) 18 G (L) arm
ARTERIAL LINE
CENTRAL LINE
SWAN-GANZ
FOLEY INSERTED ☐ O.R. ☒ FLOOR
EYE CARE ointment
PRESSURE POINTS CHECKED / PADDED Arm on arm board

MONITORS

Monitor						
EKG	ST	ST	ST	SR	ST	SR
% O2 Inspired	.9	.32	.32	.44	.38	.36
O2 Saturation	100	100	100	100	100	100
End Tidal CO2	43	40	37	35	52	53
Temperature N.P.			37.4		37.8	37.7
PNS		4/4	0/4	4/4	4/4	

ANESTHETIC TECHNIQUE

GENERAL ☐ LOCAL / MAC
REGIONAL ☐ NERVE BLOCK

INDUCTION

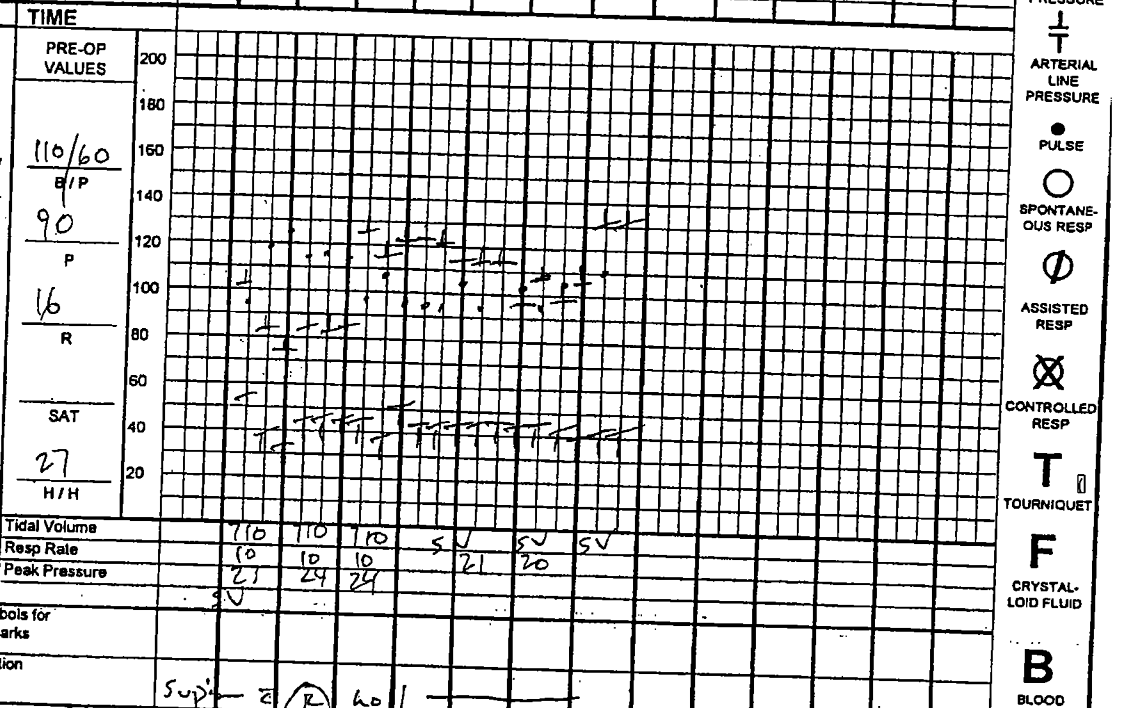
PREOXYGENATION ☐ INHALATION
RAPID SEQUENCE ☐ INTRAMUSCULAR
INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

INTUBATION ☒ ORAL ☐ NASAL
DIRECT VISION ☐ BLIND ☐ AWAKE
FIBER OPTIC ☒ STYLET USED
ATTEMPTS x 1 ☐ BLADE 4 MAC
TT SIZE 8 ☐ DOUBLE LUMEN
STRAIGHT ☐ RAE ☐ ANODE
CUFFED 10 ML AIR INJECTED
UNCUFFED, LEAKS AT ___ CM H2O
TT SECURED AT 23 CM
BREATH SOUNDS
AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
MASK CASE ☐ VIA TRACHEOSTOMY
NASAL CANNULA ☐ SIMPLE O2 MASK
MA SIZE

VITAL SIGNS

PRE-OP VALUES: B/P 110/60; P 90; R 16; SAT; H/H 27



TIME

RESP						
Tidal Volume	710	710	710	SV	SV	SV
Resp Rate	10	10	10			
Peak Pressure	21	24	24	21	20	

SV

Symbols for Remarks

Position: Supine (R) arm boo...

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; V Λ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

IN PACU	CONDITION		
O2	stable		
	PULSE	RESP	O2 SAT
		16	
REMARKS RA			TEMP

REPORT TO: PARRS:

REMARKS: ☒ Patient reevaluated. No change from preop plan / evaluation.
☒ Significant changes from preop plan / evaluation.

BP cuff (R) calf 2° UE injuries and IV
1458 opens eyes SV oropharynx suctioned extubated c (+) pressure

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	2900	EBL	150
...S	1000	Urine	200
...		Gastric	

(b)(6)-2

MAJ / CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION # (b)(6)-4

EUH OP 100, APR 00(Rev) (MRRC APP. : 29 MAR

MEDCOM - 3655

(b)(3)-1 (b)(6)-4

Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

HEIGHT	WEIGHT 70 lb
PREOPERATIVE VITAL SIGNS: B/P	P	R

PROPOSED OPERATION: I/D Rt arm wound / Lt flank wound

CURRENT MEDICATIONS ☑ NONE

PREVIOUS ANESTHESIA / OPERATIONS ☑ NEGATIVE

ALLERGIES ☐ NKDA
PCN

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☑ NEGATIVE

AIRWAY / TEETH / HEAD & NECK: Class I uvula exposed; chin → m 3FB; open 3FB

SYSTEM	WN	COMMENTS
RESPIRATORY: Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☑	Tobacco Use: ☐ No ☑ Yes ___ Pack/Day for ___ Years Last PM Am – 6 [illegible]
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☑	
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☑	Ethanol Use: ☐ No ☐ Yes Frequency ___
NEURO/MUSCULOSKELETAL: Arthritis, Neuromuscular disease, Syncope, Weakness, Back problems, Headaches, Paralysis, Seizures, CVA/Stroke, Loss of consciousness, Paresthesia, TIAs	☑	
RENAL/ENDOCRINE: Diabetes, Urinary retention, Renal failure/Dialysis, Urinary tract infection, Thyroid disease, Weight loss/gain	☑	
OTHER: Anemia, Malignancy, Bleeding tendencies, Sickle cell trait, Hemophilia, Transfusion history		

PERTINENT STUDY RESULTS

Chest X-ray	Pulmonary Studies	
EKG		
LFTs		
Urinalysis	Thyroid	FBS
Hgb / Hct / CBC		Lytes

PROBLEM LIST / DIAGNOSES

ASA: (1) 2 3 4 5 (E)

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered. Patient / legal guardian voices understanding and gives consent for :

Local / MAC, SAB, Epidural, IVR, (General Anes.)

Other: ___

Appropriate alternative as backup.

NPO status explained.

EPW

PATIENT'S SIGNATURE ___ DATE ___

EVALUATOR(S) SIGNATURE

(b)(6)-2

CRNA ___ DATE 4 APR 03

PHYSICIAN ___ DATE ___

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ___

TIME: ___

SIGNED: ___

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Cefotetan 2 Gm in ICU

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
1230	1320	1508	4 APR 03
TOTS	SURG START	DRESSING	OR NO
1325	1353	1455	

OPERATION PERFORMED: X-lap washout (R) arm I&D

SURGEON(S): (b)(6)-2 / (b)(6)-2

PREOPERATIVE

☒ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 4°
☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2 mg	IV	1320

Pre-Anesthetic State:
☒ CALM ☐ AWAKE
☐ APPREHENSIVE ☐ SEDATE
☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

ANES. MACHINE # ____ & EQUIP. CHECKED
NON-INV. B/P ☒ PNS
CONT. EKG ☐ V LEAD EKG
ESOPH. STETH. ☐ PRECORD STETH.
PULSE OXIMETER ☒ O2 ANALYZER
END TIDAL CO2 ☐ MASS SPEC.
TEMPERATURE n.p.
WARMING BLANKET ☐ FLUID WARMER
AIRWAY HUMIDIFIER
N / G TUBE ☐ O / G TUBE
IV(s) 18 G (L) arm
ARTERIAL LINE
CENTRAL LINE
SWAN-GANZ
FOLEY INSERTED ☐ O.R. ☒ FLOOR
EYE CARE ou tape
PRESSURE POINTS CHECKED / PADDED
Arms on arm board

ANESTHETIC TECHNIQUE

GENERAL ☐ LOCAL / MAC
REGIONAL ☐ NERVE BLOCK

INDUCTION

PREOXYGENATION ☐ INHALATION
RAPID SEQUENCE ☐ INTRAMUSCULAR
INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

INTUBATION ☒ ORAL ☐ NASAL
DIRECT VISION ☐ BLIND ☐ AWAKE
FIBER OPTIC ☒ STYLET USED
ATTEMPTS x 1 ☐ BLADE 4 MAC
ETT SIZE 8 ☐ DOUBLE LUMEN
STRAIGHT ☐ RAE ☐ ANODE
CUFFED 10 ML AIR INJECTED
UNCUFFED, LEAKS AT ____ CM H2O
ETT SECURED AT 23 CM
BREATH SOUNDS
AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
MASK CASE ☐ VIA TRACHEOSTOMY
NASAL CANNULA ☐ SIMPLE O2 MASK
LMA SIZE

AGENTS / FLUIDS / MONITORS

Time: washout 1315 30 45 1400 15 30 45 1500 — TOTAL

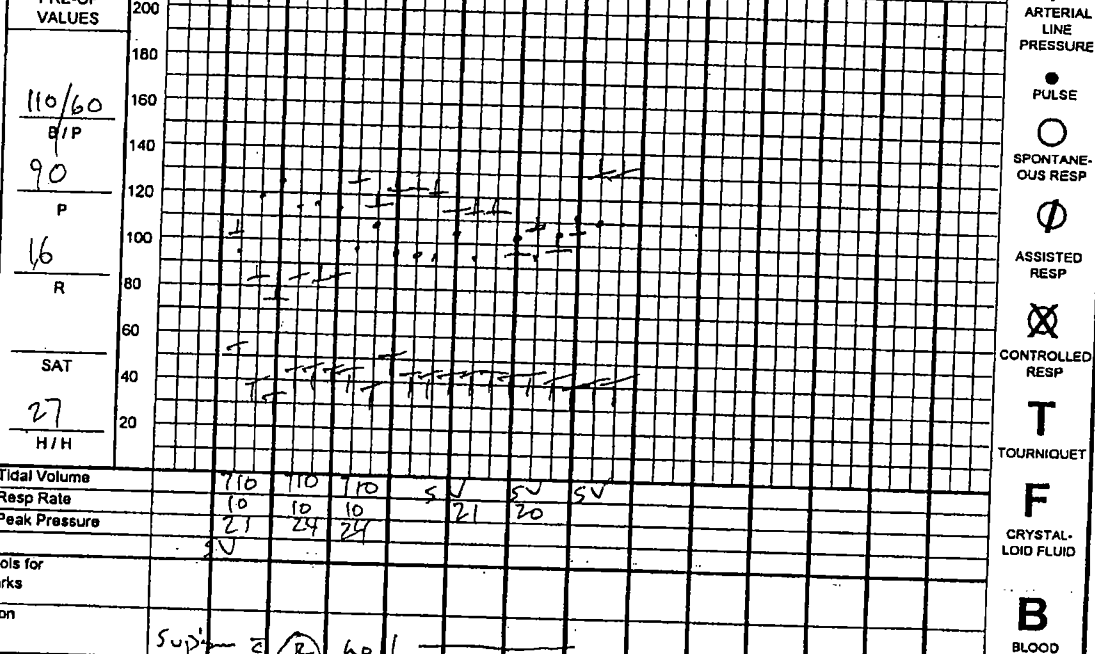
Agents							
Fentanyl cc	2			1	0.5	0.5	
Sux mg	120						
Propofol mg	160						
Vec mg			3	2	2		
Ephedrine	5	5	5				
Robinul / Neostigmine						4/0.6	
N2O L/min Air	1	1	1	1	1		X
O2 L/min	5	0.8	0.8	0.8	0.8	0.6	

Fluids			
LR	1000	LR 1500	
NS	500		
Urine	100		200
EBL	150		

Monitors						
EKG	ST	ST	ST	SR	ST	SR
% O2 Inspired	.9	.32	.32	.44	.38	.36
O2 Saturation	100	100	100	100	100	100
End Tidal CO2	43	40	37	35	52	53
Temperature p.r.n.			37.4		37.8	37.7
PNS		0/4	0/4	1/4	4/4	

VITAL SIGNS

PRE-OP VALUES: B/P 110/60; P 90; R 16; SAT; H/H 27



RESP						
Tidal Volume	710	710	710	SV	SV	SV
Resp Rate	10	10	10	21	20	
Peak Pressure	21	24	24			

Symbols for Remarks

Position: Supine c (R) roll

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; ∨ ∧ B/P CUFF PRESSURE; ⊥ ARTERIAL LINE PRESSURE; • PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

REMARKS: ☒ Patient reevaluated. No change from preop plan / evaluation.
☒ Significant changes from preop plan / evaluation.

BP cuff (R) calf 2° UE injuries and IV

1458 opens eyes SV oropharynx suctioned extubated c (+) pressure

Tourniquet Time:

RECOVERY

IN PACU	CONDITION
O2	stable

PULSE	RESP	O2 SAT
	16	

REMARKS RA — TEMP

REPORT TO: — PARRS:

FLUIDS TOTALS

IN	OUT
Crystalloid 2900	EBL 150
NS 1000	Urine 200
	Gastric

(b)(6)-2

[illegible] CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION
(b)(6)-4

EUH OP 100, APR 00(Rev) (MRRC AP, : 29 MAI MEDCOM - 3657

MEDICAL RECORD SUPPLEMENTAL ME[illegible]
[illegible] AR 40-66; the proponent agency is the Offi[illegible]

REPORT TITLE

POST ANESTHESIA CARE RECORD

OTSG APPROVED (Date)

Time In:
Procedure:
Physician:
Anesthesia Provider:
ASA Grade (I – V):
Pre-Op Vitals: T= P= R= BP= / SaO2=

ANESTHESIA: General Spinal Epidural
Sedation Local Nerve Block:________
Intrathecal w/ narcotic:________ time:______
Other:________

REVERSALS: Narcotic: No / Yes time:______
Muscle Relaxant: No / Yes time:______

Allergies: PCN
Latex allergy: N / Y
Medical/Birth Hx:________
Complications:________
Tourniquet time:

INTAKE: OR / PACU
Crystalloids ____/____
Blood Prod ____/____
Colloids ____/____
Irrigations ____/____
Other ____/____

OUTPUT: OR / PACU
Urine ____/____
EBL ____/____
Drains ____/____
Emesis ____/____
Other ____/____

VITAL SIGNS							POST ANESTHESIA RECOVERY SCORE						PAIN ASSESSMENT					OTHER			
Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	Derm Level	N/V	Nurse action				Init
:17	127/55	37.5	85	19	97%	RA															
35	125/56	37.3	87	17	99%	RA															
45	135/57	37.2	88	19	99%	RA															
00	133/100		85	20	100%	RA															

. SIGNS
blood pressure
ulse
spirations
mperature ax = axillary
= oxygen saturation

Activity (Act)
2 = Moves 4 extremities
1 = Moves 2 extremities
0 = Moves 0 extremities

RESPIRATIONS (Resp)
2 = Cough/deep breath
1 = Dyspnea, airway
0 = Apnea

CIRCULATION (Circ)
2 = 20% +/- PRE-OP BP
1 = 20% - 50% +/-
0 = 50% +/-

LEVEL OF CONSCIOUSNESS (LOC)
2 = Fully awake
1 = Verbally aroused
0 = Unresponsive
No nystagmus w/ ketamine

SKIN
2 = Pink
1 = Pale, dusky
0 = Cyanotic

uction IS = Incentive spirometry C/DB = cough/deep breath HOB = elevate head of bed EE = elevate extremity ICE = cold compress CDI = clean/dry/intact Init = initials
patient teaching – see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow-by Other:
y Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp
leeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:
on Codes: H = head F = face Fd = fundus Tr = throat N = neck Sd = shoulder B = back Ch = chest ABD = abdomen U = umbilicus UE = upper extremity LE = lower
ity Ht = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

PROBLEM/COMPLAINT For analgesic include Quality, Intensity (0-10), and Location	MED DOSE/ROUTE	INIT	REASSESSMENT/RESPONSE For analgesic include Quality, Intensity (0 – 10), and Location	TIME	INIT

RED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

(Continue on reverse)

DATE

T'S IDENTIFICATION (For typed or written entries give: Name — last, ddle; grade; date; hospital or medical facility)

EPW # (b)(6)-4

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

RM 4700, MAY 78

MCEUL OP (Rev), 19 Sep 01
prv 02 Aug 01

MEDCOM - 3658

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

1. Admit Patient to ICU #3
2. Diagnosis: ~~Guarded~~ GSW ... / ARV
3. Condition: ~~Stable~~/Serious/Critical ✓
4. Allergies: ~~NKDA~~ PCN
5. Vital signs q hr/q2hr/q6hr/q8hr/q shift
6. Cardiac respiratory monitoring
7. Diet: NPO / regular/ soft/ clear liquid

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ______ HOURS

8. Activity: AD LIB/ Strict BR/ BR with BSC/ NWB R or L LE
9. HOB up 30 degrees
10. Nursing I/O; CDB/ NG to LIS/ LCS
11. Labs: Chem 7/ H/H/ PT/PTT/ CBC q AM/ 4 hrs/ 8 hrs/ BID
12. EKG q AM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

DATE OF ORDER | TIME OF ORDER ______ HOURS

13. PCXRAY q AM/QOD
14. IVF NS/ LR/ D5NS/ D51/2NS To run @ 150cc/hr. ✓
15. Ancef 1 GM IV Q 8 hrs
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs. ✓
18. O2 titrate to keep SPO2 >
19. Versed gtt 1-10mg/hr IV titrate to

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

Ramsey Scale of

20. Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of
21. Vecuronium 1mcg/kg/min
22. MSO4 1-2 MG IV q 3-5 min prn ~~HR PRN Pain~~ BV ... CPHA
23. Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24. MOM 30cc PRN Gastric upset

NURSING UNIT | ROOM NO. | BED NO.

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

AL RECORD - DOCTOR'S OR

Fo. use o orm, see AR 40-66, the proponent a. is .

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

O.D. # (b)(6)-4

NURSING UNIT: ICW3 | ROOM NO. | BED NO.

DATE OF ORDER: 10 APR 03 | TIME OF ORDER: 1815 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT To ICW-3 (Ortho)
2. Dx: ~~(1) Forearm~~
   1. (R) ulna fx
   2. (R) flank deep soft tissue injury
3. COND: stable
4. VITALS: TID
5. ACTIVITY: As tolerated

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

6. ALLERGY: NKDA
7. NURSING: Dry dressing packing QD
8. DIET: ~~Ar~~ Regular (No pork)
9. MEDS: 1. Keflex 500mg PO QID
   2. Percocet ii tabs PO Q6°
   3. Motrin 800mg TID WF

(b)(6)-2 MD (b)(6)-2 CPT

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Apr 03 | TIME OF ORDER: 1900 HOURS

Valium 5-10mg PO. q 4-6hrs as needed for pain

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

noted (b)(6)-2 10Apr03 1930

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

"USE BALL POINT ... N PAPER REQUIRED"

MEDCOM - 3660

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER ______ HOURS	LIST TI ORDE NOTED SIGN
	25	NS/ LR bolus X liters		
	26	Neuro checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		
	27	Vascular checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		
		(b)(6)-2	(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.				

PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		5APR03	0915 HOURS	
	①	Advance diet to clear liquid no[illegible] (b)(6)-2		
	②	Tylenol 650mg p.o. x T[illegible]		
		(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.				

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 04 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 04	05
04	(b)(6)-2	Vital signs q hr / q 2hr / q6h4 / q8hr /	07	(b)(6)-2	
		q shift Δ to 5Apr03	19		
		Cardiac Respiratory Monitoring	07		
			19		
04	(b)(6)-2	Diet: NPO / Regular / Soft / Clear	07	[illegible]	D/C [illegible] 5 Apr [illegible]
		Liquid	19	X	
		Activity: Ad Lib / Strict BR / BR with	07		
		BSC / NWB R or L LE	19		
04	(b)(6)-2	HOB up 30 Degrees	07	(b)(6)-2	
			19		
		Nursing I/O, CDB / NG to LIS / LCS	07		
			19		
		Labs: Chem 7 / H&H / PT/PTT /	04		
		CBC q AM / 4 hrs / 8 hrs / BID	08		
			12		
			16		
			20		
			24		
		EKG q AM / QOD	06		
		PCXRAY q AM / QOD	06		
		Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07		
		q shift	19		
		Vascular checks nq 1hr / 2 hr / 4 hr /	07		
		6 hr / q shift	19		
05	(b)(6)-2	Advance diet as	07	X	(b)(6)-2
		tolerated	19	X	

ALLEGIES: [X] YES [ ] NO — PCN

PRIMARY DIAGNOSIS: (R) Flank penetrating wound; (L) Forearm injury

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO

PAGE NO:

PATIENT IDENTIFICATION: EPWH (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

Treatment Facility: (b)(3)-1

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

Verify by Initialing		...ERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 04	Yr 03		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
04	(b)(6)-2	Admit Patient to ICU #3	04/04/03	12:15	12:15	[illegible]
04		Diagnosis: GSW to (R) Flank, (R) Forearm injury	↓	↓	↓	↓
04		Condition: (Stable) / Serious / Critical	↓	↓	↓	↓
04		Allergies: ~~NKDA~~ PCN	↓	↓	↓	↓
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo. 04 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		✱ Tylenol 325mg ÏÏ PO NOW	4APR03	2332(z)	2332(z)	(b)(6)-2
05	(b)(6)-2	Tylenol 650mg po x1	5/pm	9:37(z)	9:37	
05		200 mcg Fentanyl	5	14:56	14156	
05		10 mg MSO4 } For dressing change	↓	↓	↓	
05		2 mg Versed } (b)(6)-2	↓	↓	↓	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY (Post-op)	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED			
04	(b)(6)-2	MSO4 1-2mg IV Q 3-5min prn pain	CCOZ 5APR03 2mg IV (b)(6)-2	5Apr 03 2mg IV	5Apr 2mg IV	5Apr 2mg I
			(b)(6)-2			

MEDCOM - 3664

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	6	7	8	9	10
4/6/03	Nurse	~~[illegible] IV Q 3°~~	03	(b)(6)-2				D/C
			11	(b)(6)-2				
			19	(b)(6)-2				
4/6/03	Nurse	~~Gentamycin [illegible] mg IV q day~~	08	(b)(6)-2				D/C
4/6/03	Nurse	MSO4 2-5mg IV Q 3° prn	PRN	0715 (b)(6)-2	2300	2000		
			PRN			0300 (b)(6)-2		
			PRN					
4/6/03	(b)(6)-2	Tylenol #3 1 tab prn		1615 (b)(6)-2	2	0540 2 tab (b)(6)-2		1045
4/6/03		LR @ 75°	04		(b)(6)-2			
			16		2K			
		~~Tylenol #3 i ii PO prn pain~~				0540 2145 (b)(6)-2		
4/9/03	(b)(6)-2	Keflex 500mg PO QID	06	/	/	/		1000 (b)(6)-2
			12	/	/	/		1400
			18	/	/	/	(b)(6)-2	
			24	/	/	/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: DCW3

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

OD (b)(6)-4 (b)(3)-1

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

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. 04 *Yr.* 05

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 04/05
(b)(6)-2	(b)(6)-2	LR e 150cc/hr	07	(b)(6)-2
			19	
(b)(6)-2	(b)(6)-2	Cefoxitin 2 gm IV	04	
		Q 8hrs	12	
			20	

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
(R) Flank penetrating wound
(R) Forearm injury

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

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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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. 4 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12
(b)(6)-2 10April03	(b)(6)-2	Keflex 500mg PO	06	/		
	......	QID	12	/		
	......		18	(b)(6)-2		
	......		24			
~~10April03~~	(b)(6)-2	~~Percocet II tabs PO~~				
	......	~~Q6°~~				
10April03	(b)(6)-2	Motrin 800mg TID	07	/		
	......	c̄ food	13	/		
	......		19	(b)(6)-2		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Ulnar Fx
Flank deep soft tissue Injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

CD # (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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 4 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10Apr03	(b)(6)-2	Percocet ii tabs po	10Apr 1945 (b)(6)-2													
.....	.....	q 6 prn														
10Apr	(b)(6)-2	Valium 5-10mg po														
.....	.....	every 4-6 hrs prn														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

NAME (Last, First, Middle Initial) # (b)(6)-4 (b)(6)-4 | 2. SSN | 3a. STATUS | 3b. SERVICE | 4. PRECEDENCE U P R X | 5. GRADE

AGE 26 | 7. SEX X MALE | FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F)-- AMBUL X LITTER | 11. ACCEPTING MD | 12. CITE/AUTH #

APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS 16a. MED 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #3 | 15B. DESTINATION FACILITY PHONE NUMBER

DIAGNOSIS

(R) flank GSW s/p ex lap
GSW (R) arm s/p I&D

X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		X	Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

PHYSICIANS ORDERS

a. DATE 5 APR 03 | 20b. TIME 0450 | 20c. ALLERGIES NKA

d. DIET X REG | 3GM NA | CARDIAC | DIABETIC CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE | OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr

e. IV / BLOOD

f. SPECIAL EQUIPMENT

SUCTION		TRACTION		FOLEY CATH
NG TUBE		IV PUMP		ORTHO BRACES
STRYKER		TRACH		CHEST/HEIMLICH
INCUBATOR		MONITOR		RESTRAINTS
				OTHER (USE 23)

OXYGEN: PERCENT or LITERS ROUTE:
VENT SETTINGS:

g. ALTITUDE RESTRICTION: Yes / No feet

h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21d. RESP: | 21c. PULSE | 21e. BP

22. BRIEF NARRATIVE

26 y.o. ♂ s/p GSW (R) flank explored, s/p GSW (R) arm c̄ fracture s/p I&D
Stable for transport

i. MEDICATIONS / TREATMENTS

Cefoxitin 2gm IV q8°
Percocet i-ii p.o. q6° PRN pain

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

STAMP AND SIGNATURE OF ATTENDING PHYSICIAN
(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

OD (b)(6)-4 (b)(3)-1

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

3a. STATUS | 3b. SERVICE

4. PRECEDENCE: U | P | R X

5. GRADE

6. AGE: 36

7. SEX: X MALE | FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F)-- AMBUL | X LITTER

11. ACCEPTING MD

12. CITE/AUTH

13. APPT/SURG DATE

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #3

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED | 16b. NON-MED

17. DIAGNOSIS

(R) flank GSW s/p ex lap

GSW (R) arm s/p I&D

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		X	Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 5 APR 03

20b. TIME: 0450

20c. ALLERGIES: NKA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC CALS

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE | OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION	TRACTION	FOLEY CATH	
NG TUBE	IV PUMP	ORTHO BRACES	
STRYKER	TRACH	CHEST/HEIMLICH	
INCUBATOR	MONITOR	RESTRAINTS	
		OTHER (USE 23)	

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
X	INPATIENT RECORDS	X	OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Cefoxitin 1gm IV q8°

Percocet 1-II p.o. q6° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21d. RESP: | 21e. BP

22. BRIEF NARRATIVE

36 y.o. ♂ s/p GSW (R) flank explored, s/p GSW (R) arm c̄ fracture s/p I&D

Stable for transport

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form

MEDCOM - 3670

ADMISSION AND CODING INFORMATION

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

Field	Value
1. REPORTING MTF (1-6)	(b)(3)-1
LOCATION (State or Country Code.) (7-8)	K U
3. REGISTER NUMBER (9-15)	(b)(6)-4
NAME (Last, First, Middle Initial)	EPW (b)(6)-4 ~~OD#~~
4. PAY GRADE (16-17)	X X
5. SEX (18)	M
6. DATE OF BIRTH (YYYYMMDD) (19-26)	1968/01/01
7. AGE AT ADMISSION (27-29)	36Y
8. RACE (30)	Y
9. ETHNIC BACKGROUND (31)	9
RELIGION	MUSLIM
10. LENGTH OF SERVICE (32-34)	—
ETS	
11. FMP (35-36)	~~9 9~~ 20
12. SOCIAL SECURITY NUMBER (37-45)	(b)(6)-4
ORGANIZATION (Active Duty Only)	IRAQI CIVILIAN
13. MARITAL STATUS (46)	Z
HOUR OF ADMISSION	1500
BRANCH / CORPS	
14. FLYING STATUS (47-49)	—
15. BENEFICIARY CATEGORY (50-52)	~~K 9 1~~ K78
16. ZIP CODE OF RESIDENCE (53-61)	0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code) (62-63)	—
18. MOS (64-70)	
19. TRAUMA (71)	
PREV. ADMISSION	YEAR: ; NO: X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	1
WARD	ICU5
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	NOT AVAILABLE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	NOT AVAILABLE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1 Kuwait
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	NOT AVAILABLE
21. TYPE OF DISPOSITION (73-74)	2 2
22. MTF TRANSFERRED TO (75-80)	(b)(3)-1
23. DATE OF DISPOSITION (YYYYMMDD) (81-88)	2 0 0 3 0 4 1 5
24. CLINIC SVC - ADMITTING (89-92)	A B A A
25. MTF TRANSFERRED FROM (93-98)	(b)(3)-1
26. DATE THIS ADMISSION (YYYYMMDD) (99-106)	2 0 0 3 0 4 1 0
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107-108)	K U
28. MTF OF INITIAL ADMISSION (109-114)	
29. DATE INITIAL ADMISSION (YYYYMMDD) (115-122)	

FOR LOCAL USE

GSW (R) Flank (R) Forearm

~~E991.9~~ ~~881.00~~ DX: 8795
~~899.4~~ 81392
E9912
Px. 5411
7962

Trauma 1
~~Injury~~ 450

CODE:__________

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: (b)(6)-4
2. NAME (Last, First, MI): (b)(6)-4
3. GRADE:
4. SEX: M
5. AGE: ~~20~~ 34
6. RACE: IRAQI
7. RELIGION:
8. LENGTH OF SVC:
9. ETS:
10. PREVIOUS ADMISSION:
11. FMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION:
14. WARD: ICW 2
15. FLYING STATUS:
16. RATING/DSG:
17. DEPT./BEN:
18. BRANCH/CORPS:
19. UIC/ZIP:
20. TYPE CASE:

ADMISSION REMARKS

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIR
22. HOURS OF ADMISSION: 2200
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
25. TYPE DISPOSITION: evac
26. DATE OF DISPOSITION: 11 APR 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
27b. TELEPHONE NO.:
28. DATE OF THIS ADMISSION: 4 APR 03

ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
30. DATE OF INTIAL ADMISSION:
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW R thigh Dx: 890.0 Trauma 0 Inj 450

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
7	7				7

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

SI[GNATURE] (b)(6)-2

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

DA FORM 3647, MAY 79 EDITION OF 1 A[...] USAPPC V1.[...]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Shrapnel (R) thigh
GSW

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)*

(b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 539-106

M... ICAL RECORD - SUPLEMENTAL ... AL DATA

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

T-0

REPORT TITLE

TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 26 May Arrival Time: 2130 Sex: (M) F Age: 20+ Wt:

Allergies: NKDA per chart

Tetanus Status: UTD (Unknown)

LMP: Last Meal: unk

Chief Complaint: GSW R thigh

PMH:

Medications:

Treatments PTA:

VITAL SIGNS: BP: 119/72 P: 111 RR: 20 TEMP: SAO2: 96 2 RA

CHEST
TRAUMA ☐ YES ☒ NO
PAIN ☐ YES ☐ NO
SOB ☐ YES ☐ NO
LUNG SOUNDS
R L
☒ ☒ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☒ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☒ DISTENDED
☐ TENDER
BOWEL SOUNDS
☒ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R____mm L____mm
GLASCOW SCORE:____

PUPIL SIZES: 2 3 4 5 6 7 8 9

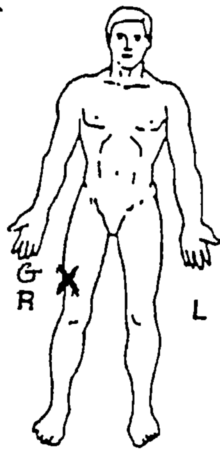
GLASCOW COMA SCALE

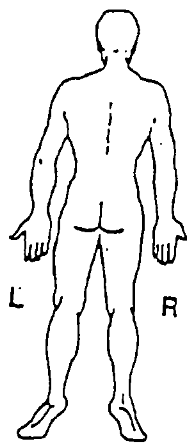
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obedient	6
To Voice	3	Confused	4	Purposeful	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible	2	Flexion	3
		None	1	Extension	2
				None	1

EXTREMETIES
☒ DISTAL PULSES
☒ RT X 2 ☒ LT X 2
☒ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS:

SPLINTS:





A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW- (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

TREATMENTS:
O2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: #
CHEST TUBE ☐ R ☐ L DPL ☐ POS ☐ NEG
CM H20

PREPARED BY (Signature & Title)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC
399th CSH

DATE

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

IV SOLUTIONS/SITES

TIME	SITE/SIZE	IV FLUID/BLOOD	AMOUNT INFUSED		OUTPUT
					CHEST TUBE:
					EMESIS:
					NG TUBE:
					URINE:
					EBL:
					OTHER:

TOTAL IN:__________ OUTPUT:_____

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA
OTHER:______________________
XRAYS: ____

MEDICATIONS

TIME	MED	DOSE	ROUTE	INITIALS

PROCEDURES/PROGRESS NOTES

VS
(b)(6)-2 96 SpO2
111 hr
119/78bp

015

509-113 NSN 7540-00-634-4122

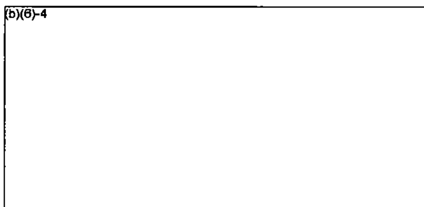
MEDICAL RECORD | PROGRESS NOTES

DATE	
	Ward MO Admit Note
3/24/03	cc: Mild pain (R) thigh/GSW
1500	HPI: 34 yo Iraqi civilian noncombatant going to grocery
GMT	store in taxi w/ family. Driver intoxicated/speeding
	+ sped twd US check point, vehicle fired upon + pt
	sustained GSW (R) distal lat. thigh. Brought via
	helo casevac to surg. Co.; c/o mild pain (R) thigh.
	PMH Ø
	Alls: NKMA
	PE: 98.6 139/67 94 18
	Alert, speaking clearly, WDWN ♂ NAD
	Heent unremark
	Neck: Ø Trauma
	CV: RRR S1S2 no LCA (B)
	Abd benign
	GU nml
	Ext: 1x2 cm superficial penetrating wound (R)
	lat thigh; small amt necrotic tissue (a)
	rim of wound; slight oozing of blood,
	Ø erythema
	Ø exit wound
	DP/PT pulses strong (B)
	Normal sensation + full strength LE's (B)

(Continue on reverse side) over

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

REGISTER NO. | WARD NO.


(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
	(A/P) GSW (R) lat distal thigh, Ø exit wound
	bullet either w/in thigh or did not penetrate
	- Irrigate wound & bandage
	- Ancef x1
	- Pain meds prn
	- Td at next echelon
	- Frequent wound & pulse √'s.
	- Routine Medevac. (b)(6)-2
	, MC
1800.	pt arrived via liter and Security escorts. Pt alert responds to
	Commands upon interpreters. RESP Reg. Lungs CTA Bil. Pt denies CP
	SOB @ this time. Bowel sounds x4 quadrand. nontender upon palpation.
	Pt with superficial lateral gsw to R lateral thigh. D-DSG DONE By MD.
	good pedal pulses Noted Bilateral. Pt C/O PAIN given T3 2 tab PO @ 1840.
1'	will continue to assume care [illegible] ↑ LR 1000 cc @ KVO infusing [illegible]
1900	pt C/O PAIN to (R) lateral thigh. MSO4 mg given IV. will reassess
	in 30 min. VS stable 117/65 P 75 R 16 (b)(6)-2
2020	Pt vital signs taken, A+O x3, wound dressing changed, 4x4 saturated c̄ blood
BP 132/61	Ø pus/purulent discharge, Pedal pulse (B), cap refill intact Pt complained of
T- 99.1°	pain upon changing of dressing. Will continue Pt. care (b)(6)-2
P - 82	
2240	Pt. woke up from sleep drank H_2O P.O. V.S. Stable. Dressing saturated
	c̄ blood. Strong pedal pulse (B). I.V. site intact + patent. ⊕ cap refill (b)(6)-2
0120 -	Pt. woken up for assessment. V.S. stable. Pt in no apparent discomfort. [illegible]
	Pedal pulses strong (B) ⊕ cap-refill. will continue pt. care (b)(6)-2

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 Mar	
0744	pt sleeping awakens easy same [illegible] pain asks for shot
	VSS CV RRR Abd soft
	thigh GSW [illegible] warm [illegible] pulse
	moving [illegible] warm thigh
	A/P GSW thigh
	keep IV OK PO food
	pain meds PRN (b)(6)-2
~~1000~~	~~Pt has folley cath~~
1000	Folley cathere placed - 800cc on placement.
1100	Pt tolerating pain well. VSS, RRR
	GSW (R) lateral thigh (-) signs of infection
	minor oozing of blood. ~~positi~~ (+) minor edema (-) erythema
	applied d/d dressing. (+) Pedal Pulses Bilat. (b)(6)-2
1130	Output from Folley 400cc. Pt sleeping. Changed IV fluid 1000 ml LR KVO. (b)(6)-2
3/25/03 1231	Pt was unable to void this am → Foley placed, total 800 cc out likely 2° to retention 2° to Morphine; Pt will ↓ doses morphine → trial w/ foley out.
1245	DC cathiter. Pt tolerated well 900cc (b)(6)-2
1440	Applied D-Drsg Ø sign of infection. Min oozing of blood. (+) pedal pulses. Pt tolerating pain well. (b)(6)-2

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

RECORDS MAINTAINED AT:

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

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 3678

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25MAR03 1545	Pt tolerating pain well. V/S stable. Pedal P intact bilaterally.
1620	Administered Phenergan 25mg IVP.
1715	~~I/O - 500ml, Out 300ml~~, U/O 300cc
25MAR03	Pt in bed resting comfortably. Ø c/o acute pain or distress. Physical exam
1730	unremarkable. Dressing to (R) leg c̄ slight drainage noted. Ø ~~[illegible]~~ dressing Δ
	required at this time. (R) foot c̄ ⊕ pulses and warm to touch. Will cont
	to monitor (b)(6)-2 [illegible]
25MAR03	
2030	Applied D-Drsng Ø sign of infection. ⊖ oozing of blood. ⊕ Pedal P. Pt
	tolerating pain. (b)(6)-2 LN
2210	DC IV. Pt tolerated pain. LN
2215	U/O 200ml.
0200	(R) leg Dsg changed. Sanguinous Drainage, semi soaked.
26MAR03	
0416	Pt is in good general condition. ~~AVPU(x3)~~ ERROR PT ALERT EQUAL/NORMAL LUNG SOUNDS BILAT
	NORMAL HEART RATE / BOUNDING PULSES ON ALL 4 XTREMITIES. DRESSING TO LAT (R) THIGH
	C/D/I. WILL CONTINUE TO MONITOR PT. HM3 (b)(6)-2
0632	VS - 130/70 PR-68 R-12. URINE OUTPUT 200 CC. PT IN GOOD GENERAL
	CONDITION. WILL CONT TO MONITOR. HM3 (b)(6)-2
	HM3
	NFE [illegible]
	over

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
	HD# 3 GSW Ⓡ thigh
3/26/03	(S/O) Ø complaints Taking PO, ambulating
	VSS AF
	Ⓡ LE: wound: Ø further bleeding, Ø erythema
	strong DP pulse
	FROM LE
	(A/P) GSW Ⓡ Thigh
	stable, Ø complications, awaiting transfer.
	(b)(6)-2
	LCDR Sams, MC
3/26/03 1400	VSS. Pt up and walking, tolerating pain well.
	D. Drsg A. Ø sign of infection, minor oozing of blood.
	Ø erythema, pedal pulses strong, intact. Will continue
	to monitor. (b)(6)-2
3/26/03 1530	Transfer Summary
	Pt HD#3 s/p GSW to Ⓡ thigh, no exit wound,
	Wound irrigated & bandaged only.
	Meds: T#3 or morphine prn pain
	Diet: Regular
	Stable, NVI throughout.
	Transfer today (b)(6)-2
	LT MCHENRY

FPI LEX Printed on Recycled Paper — STANDARD FORM 509 (REV. 5-99) BACK

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	IMP: GSW (R) DISTAL LATERAL THIGH
	• CONSERVATIVE MGMT TO DATE - STABLE
	PLAN: X-RAY (R) FEMUR
	TETANUS BOOSTER
	CONTINUE CURRENT MGMT
	NV ✓
	(b)(6)-2
	MD
26 Mar 03	.5 g Tetanus adm IM per [illegible] @ 2320 - Pt denies
2320	Pain. Dsg D'd (b)(6)-2
	Gave Pt meal - did not eat - withheld Motrin Pt denies
	pain currently (b)(6)-2
27 Mar 03	Pt slept quietly through night - Drsg (R) thigh intact, VS taken
0645	through. (b)(6)-2
27 MAR 03	PN HD3
1015	PT DOING WELL. ∅ c/o PAIN
	AMBULATORY
	VSS / AFEB X RAY (R) THIGH: ∅ FX
	WOUND C/D/I
	NVI
	IMP: HD3 s/p GSW (R) LAT THIGH
	PLAN: CONT CURRENT MGMT
	TO MIN CARE WARD TODAY (b)(6)-2
	MD

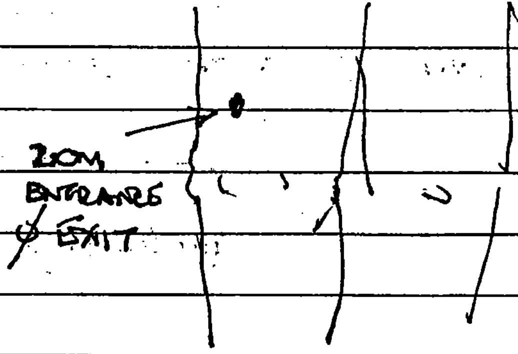
STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 3681

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Mar 03	20+ yo ♂ c wound Ⓡ thigh – ? possible broken nose
2210	unable to communicate to [illegible] [illegible] [illegible] Allergy / Med/
	[illegible] / meds. Dsg applied Ⓡ thigh – drainage on
	dsg noted. Ⓑ nostril packed. Hand restraint applied
	to [illegible] p arrival. (b)(6)-2
26 MAR 03	ADMIT H+P
2240	34 Y.O. IRAQI CIVILIAN NONCOMBATANT PER TRANSFER NOTES
	(NO TRANSLATOR AVAILABLE) SUSTAINED GSW Ⓡ DISTAL LAT
	THIGH 24 MAR 03. WOUND IRRIGATED OUTPT – PT WALKED
	AND NOT [illegible] INPT STAY @ PREVIOUS FACILITY.
	TRANSFERRED IN STABLE CONDITION
	GEN: NAD
	HEENT: NOSTRILS PACKED Ⓑ ? NOSE INJ SUSTAINED
	WHILE IN MOTOR VEHICLE
	C/L: CTA Ⓑ
	ABD: SOFT NT/ND ⊕ BOWEL SOUNDS
	LE: Ⓡ DP/PT PULSES INTACT
	Ⓡ THIGH SWOLLEN BUT SOFT
	WOUND SITE C/D/I – DSG Δ'D
	DIFFICULTY c Ⓡ LOW RANGE
	OTHERWISE NL MOTOR EXAM →



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

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

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
27 MAR	Pt c/o GSW to (R) thigh. (+) ABC's (+) Cap refill ≤ 2 sec ē (+) ROM. PN to (R) leg ē flexing. no other apparent injurys (BP 120/50 pulse 80 RR 16 Temp. 96.5
	By Spc (b)(6)-2
27 MAR 03 1625	See Prior progress note HD #3 SHRAPNEL (R) thigh Q Day Dressing Δ ē Bacitracin Ointment Nasal packing? - Probably not needed
	Cont current care (b)(6)-2
	~~Ancef 1gm IM now~~ (≈1100)
27 MAR 2030	T3 given for severe (R) leg pain — [illegible]
28 MAR 03 0630	pt alert x3 no c/o pain Drsg C/D/I
BP 100/60	Lungs CTA bilat Abd soft non tender no distention
P. 80	VSS no other complaints @ this time (b)(6)-2
R 16	
T 97.1	
28 Mar 03 0822	pt. currently in no pain, has small saturation in dressing, has good ROM, can bend his knee w/some help, has distal pulses +2. Spc (b)(6)-2
1039	asked pt. about nasal packing, he stated he has chronic disease, & wants to leave packing in place. Spc (b)(6)-2

(Continue on reverse side)

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

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

BED 7

PROGRESS NOTES

DATE	
28 Mar 03	1400 - Drsg Δ to (R) thigh, pt ambulate x 1. pt c/o mild discomfort during irrigation/cleaning of GSW site. GSW has white exudate c̄ small amount of necrosis. Will continue to monitor. — Sgt (b)(6)-2
	1700 - C/o pain to GSW site on (R) thigh, pt was given 650mg tylenol + 800mg Motrin. SPC (b)(6)-2
28 Mar 03 0800	HD 4
	(R) thigh shrapnel
	Ambulating neurovascular intact
	∅ evidence of infection (b)(6)-2
	D/C soon
28 MAR 03 2019	BP 118/54 P 58
	Pt has no complaints SPC (b)(6)-2 91W
29 Mar 03 0840	Dressing Change to (R) thigh. PT in mild discomfort PT given 800mg Motrin Sgt (b)(6)-2 91W20
29 mar 03 0905	BP - 118/76 P 80 R 16 Sgt (b)(6)-2 91W20
29 mar 03 1230	PT C/O Burning Pain. Gave PT 650 mg tylenol PO Sgt (b)(6)-2 91W20
29 mar 03 1715	BP - 118/58 P-70 R-16

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24MAR03	(R) thigh shrapnel
2020	wound healing well
	P/C [illegible] (b)(6)-2
25MAR03 2030	Dressing Δ. Wounds look good. pt has Ø complaints.
	SPC (b)(6)-2 91W
27MAR03 2110	VS BP 110/60 P 82 R 18 T
30MAR03 1800	Δ dressing to (R) thigh s̄ s/s of infx. (b)(6)-2 91WM6
	BP 108/68 P 80 Temp 97.7 R: 16 — SPC (b)(6)-2 91W
30Mar03 1830	Tylenol 975 mg po for c/o pain @ thigh [illegible]
28MAR03 2015	VS BP 120/80 HR 73 R 12 T 97.3 Dressing Δ given
	975 for pain @ site. SPC (b)(6)-2 91W
31MAR03 0830	FP PN GSW R thigh: wound s̄ s/sx infection
	NVI distally; PRN Pain control.
	Encourage Ambulation (b)(6)-2, MD
	(b)(3)-1
31Mar03 0758	BP 110/46 P-76 - R-14 (b)(6)-2 SGT 91W
31Mar03 2115	BP 114/62 P 68 R 16 T 98.3 Dressing Δ done
	minimal pus drainage noted (b)(6)-2, SGT 91W

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

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

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

REGISTER NO.	WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1APR03	FP PN / VSS AF
0800	R Thigh: minimal serosanguinous D/C.
	Imp. GSW R Thigh - Doing well.
	Plan: Local wound care; prn pain control /
	(b)(6)-2
	CPT [illegible]

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

511-118 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	24Mar03	26Mar03
POST- DAY		
MONTH-YEAR / DAY	1800 2030 2039 2020 ... 1115 1500	
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 1240

BLOOD PRESSURE: 139/87, 117/65, 132/64, 122/78, 128/77, 120/73, 134/68, 116/65, 120/66, 129/82, 125/70, 130/70, 130/70, 124/72, 117/68

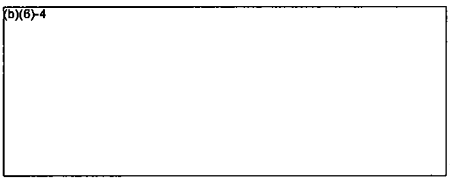
I/O 10/300

Record special data only when so ordered

HEIGHT: WEIGHT →

T3 2tabs @1840
MSO4 4mg IV 1900
Phenergan

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.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	26 Mar 01	27 Mar 01					
POST- DAY	2200	0645					
MONTH-YEAR / DAY							
19 / HOUR							

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	96/62 (b)(6)-2	/
HEIGHT: / WEIGHT →		

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

(b)(6)-4

REGISTER NO.

WARD NO.

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

*U.S.GPO:1996-404-763/40069

NSN 7540-0

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
3/24/03 1450 GMT			Admit EPW to Evac Ward		
			Dx: GSW (R) distal Lat thigh		
			Condition: stable Triage Delayed		
			Allg: NKMA		
			VS ~~q4°~~ q2° x2; if stable then q4°		
			Dorsalis Pedis Pulse check q2°		
			Activity: Bed Rest		
			Diet: Regular		
			IV: KVO first liter then Hep lock		
			Meds: Tylenol #3, 1-2 tabs q4° prn pain		
			check wound q8° for evidence of infection		
MAR 24 1829			~~PT RECEIVED 2 TABS~~ MED	(b)(6)-2	
				LCDR R. Sams, MC	
MAR 03 1829			Pt received 1 T3 for pain		
			[illegible] u/nc 3/24/03.		
3/24/03 1542 GMT			Morphine 4 mg IV push now		
			Morphine 2-4 mg IV q2° prn for pain		
			Phenergan 25 mg IVP q6° prn nausea		
			Thanks! (b)(6)-2	(b)(6)-2	
				LCDR R. Sams, MC	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, ... medical facility)

(b)(6)-4

REGISTER NO. | WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)

3-25-03
1903 Zulu ① D/C IV
② D/C IV Meds
③ Tylenol #3 2 tabs po q 4-6° prn pain
Morphine 2-4 mg IM q 4° prn severe pain
KW

(b)(6)-2

CAPT, MC, USN

3/26/03 ① Transfer per PMR
1530 ② See transfer summary

(b)(6)-2
MD
MC USNR

(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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 26 MAR 03 | TIME OF ORDER 2230 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICU 2
2. DX: GSW (R) THIGH
3. COND: STABLE
4. VS PER SHIFT - INCLUDE DISTAL PULSE ✓
5. ACT: AD LIB - ENCOURAGE AMBULATION ̄c CRUTCHES OR ASSISTANCE

DATE OF ORDER | TIME OF ORDER HOURS

6. ALL NKDA (PER TRANSFER NOTE)
7. DIET: REGULAR
8. MOTRIN, 800 mg PO TID WM
9. VICODIN, 1-2 TAB PO Q6 HR PRN BREAKTHROUGH PAIN
10. DRESSING CHANGE DAILY - ALERT MD IF SIGNS INFECTION

(b)(6)-2

DATE OF ORDER | TIME OF ORDER HOURS

11. TETANUS 0.5 mg IM X 1

(b)(6)-2

~~27 MAR 03 / 1620~~
27 MAR 03 / 1620
1. Admit to MCW
2. GSW (R) thigh
3. Condition Stable
4. Vitals ~~q day~~ BID

DATE OF ORDER | TIME OF ORDER HOURS

5. Diet Regular
6. Motrin / Tylenol PRN
7. Narcotics prn breakthrough pain

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

DA FORM 4256 1 APR 79

MEDCOM - 3691

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. 3 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3/26	27	28
26 Mar 03	(b)(6)-2	Reg Diet				
26 Mar 03	(b)(6)-2	NPO p MN				
26 Mar 03		VS q shift c Distal Pulse check				
26 Mar 03	(b)(6)-2	Encourage ambulate c assistance				
26 Mar 03	(b)(6)-2	Drsg A'd qd				
26 Mar 03	(b)(6)-2	Reg Diet	07	/	/ (b)(6)-2	
			11	/		
			17	/		
26 Mar 03	(b)(6)-2	NPO p MN	24	(b)(6)-2		
26 Mar 03	(b)(6)-2	VS q shift c Distal Pulse check	06	/	(b)(6)-2	
			14	/		
			22	(b)(6)-2		
26 Mar 03	(b)(6)-2	Encourage Ambulate c assistance	06	/	/	
			14	/		
			22	/		
26 Mar 03		Drsg A'd qd		(b)(6)-2		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (R) Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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. 3 *Yr.* 01

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				26
	(b)(6)-2	Motrin 800g tid 2 weeks	06	/
			14	/
			22	/

ALLERGIES: YES NO

PRIMARY DIAGNOSIS: GSW Ⓡ Thigh

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 1 FEB 79 4678 EDITION OF · MEDCOM - 3693 HAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. 3 Yr. 01

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26 mar 03	(b)(6)-2	Tetanus 0.5 IM x1	26 mar 03	2300	2300	(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
26 mar 03 / 28 mar 03	(b)(6)-2	Vicodin 1-2 Tab po q6h PRN	

*U.S. GPO: 1996-454-110/95216

MEDCOM - 3694

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF — MTF LOCATION (State or Country Code)

(b)(3)-1

3. REGISTER NUMBER: (b)(6)-4

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

4. PAY GRADE: —

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D): 1983 0 1 0 1

7. AGE AT ADMISSION: 2 0 4 — 34/ 25

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION:

10. LENGTH OF SERVICE: —

ETS:

11. FMP: 20

12. SOCIAL SECURITY NUMBER: (b)(6)-4 7

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 2200

BRANCH / CORPS:

14. FLYING STATUS: —

15. BENEFICIARY CATEGORY: K78

16. ZIP CODE OF RESIDENCE: 093300000

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA: 9 INJ

PREV. ADMISSION — YEAR — NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 Direct

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

21. TYPE OF DISPOSITION: 05

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 2003 04 11

24. CLINIC SVC - ADMITTING: ABAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 2003 0404 (corrected 0324)

27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

Dx: ~~Shrapnel Flesh Wound~~ GSW (R) thigh

Dx: 8900
E9912
Proc: 8827

Trauma 19 / 0 Inj 450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 (b)(6)-2 MAJ, MC

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

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

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

Field	Entry
1. REGISTER NUMBER	(b)(6)-4 20
2. NAME (Last, First, MI)	EPW (b)(6)-4 (b)(6)-4
3. GRADE	
4. SEX	M
5. AGE	46
6. RACE	IRAQI
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	
11. FMP	99
12. SSN	(b)(6)-4
13. ORGANIZATION	
14. WARD	ICW2
15. FLYING STATUS	
16. RATING/DSG	
17. DEPT./BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	DIR
22. HOURS OF ADMISSION	2200
23. CLINIC SERVICE	ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Evac
26. DATE OF DISPOSITION	5 APR 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	24 MAR 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1 IRAQ
30. DATE OF INTIAL ADMISSION	
31. SELECTED ADMINISTRATIVE DATA	
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED	
ADMISSION REMARKS	
ADMITTING OFFICER	

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

R upper Back & Flank GSW

E991.2 876

Debridement wound 86.28

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
12	12				12

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 (b)(6)-2 MBS, MC

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

DA FORM 3647, MAY 79 EDITION OF 1 AU[illegible] USAPPC V1.10

MEDCOM - 3696

MEDICAL RECORD | PROGRESS NOTES

DATE (b)(3)-1

BP: 118/69
P: 100
R: 18
T:
O2 SAT: 96%
ALLERGIES: NKDA
PMH: ∅
PSH: ∅

46 yo AM
GSW x 2
1) (L) upper back ? entrance/exit
2) (R) buttock ? entrance/exit
? stool in wound on (L) buttock
No other injuries noted

PE) WN/WD AM NAD
Alert, conversant c̄ interpreter
NC/AT PERRL o/p cl
Neck supple, FROM, nontender
Chest - CTA =BS
CV - RRR
Abd - soft, min tender, BS ⊕
Pelvis - stable
Rectal - large defect in post wall of rectum
(R) 6-7 cm. Gross blood in stool. Fx coccyx.
Ext - AT, FROM
Neuro - nonfocal

A/P) GSW (L) upper back c̄ chest ok.
GSW to buttock c̄ rectal injury.
IVF. Triple abx. To OR for I&D, wound exploration,
procto. Ex lap c̄ diverting colostomy.

(Continue on reverse side)

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

NAME:
SSN: OD # (b)(6)-4
UNIT: (b)(3)-1

REGISTER NO. (b)(6)-2
WARD NO. (b)(3)-1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE

24 MAR 03

OPERATIVE NOTE

DIAGNOSIS: GSW to back
GSW to buttock / rectum

PROCEDURE: 1) I&D GSW sites
2) Procto
3) Expl lap
4) Diverting sigmoid colectomy
5) Distal stump washout

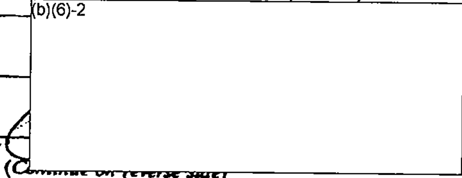
SURGEON: Peoples / Craig

FINDINGS: (L) upper back GSW. No entrance into chest. (R) buttock GSW c (L) side prob exit c stool in wound. Also bone fragments in wound. At expl lap contusion / hematoma in mesorectum. No intraperitoneal soilage.

FLUIDS: EBL: 100 cc

End sigmoid colostomy.
Distal sigmoid (Hartmann's) tacked to peritoneum @ colostomy site.

No comps.
To SICU stable, extubated.



(b)(6)-2

MD

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

OD (b)(6)-4

(b)(3)-1

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

25 MAR 03

POD # (b)(6)-4 s/p diverting colostomy / distal rectal w/o / presacral drainage for GSW to rectum.

Comfortable AVSS

Abd soft, NT/ND, BS +/-

Incis c/d/i

Ostomy pink

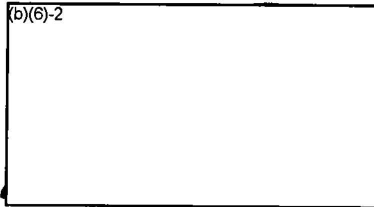
(B) buttock wounds putting out small amt stool.

A/P) D/C NGT → clrs this pm

Dressings A/d

Cont Cefotetan

Ambulate



MD

EPW # (b)(6)-4

24 MAR 03

Surgery

POD # (b)(6)-4

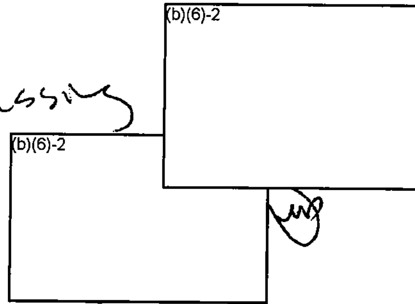
s/p I+D, expl lap, diverting colostomy
for rectal inj assoc GSW.
VSS this AM.
Comfortable
Abd soft Chest CTA
Dressings intact

A/P) stable postop
MSO4 2 Q2H
Cont abx
Δ (L) buttock dressing

144 | 111 | 29 / 231
4.4 | . |

39
13

CXR ⊖ PTX from
(L) post chest wound.



Name:
SSN:
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE: 24 MAR 03
TIME: 0330

Additional Orders/Charting:

24 MAR 03 0945
1) MSO4 2mg Q2H
2) Δ Ⓡ buttock dressing
(b)(6)-2

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** S/P ex lap / colostomy / I&D
3. Condition: VSI SI Stable
4. **Allergies:** NKDA
5. **VS:** Q5min x 3; Q15 min x 3, then Q1 hr; Q2 hrs; Q4 hrs;
Notify MD for SBP: > 180 or < 90; DBP: > 100 < 50;
HR: > 120, < 60; RR: > 20, < 10; Temp: > 102
6. **IVF: IVF:** LR @ 75 cc/hr; NS @ ____ cc/hr;
Albumin @ ____ cc/hr; Hespan @ ____ cc/hr
7. Monitor: Cardiac; Pulse Ox; Neuro Q ____ m/hr; A-line;
8. I&O: Q1 hr; Q ____ hrs
9. Drains: NG to Low/Cont suction; Foley to gravity
10. CT #1: 20 cm H2O suction, H2O seal; Heimlich
11. CT #2: 20 cm H2O suction, H2O seal; Heimlich
12. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ____ hrs; PRN
Hct now & Q ____ hrs; Chem now & Q ____ hrs; UA
13. **BLOOD:** T&S ____ units; T&C ____ units;
Transfuse: ____ units PRBC or Whole Blood for Hct < ____ %
14. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB; ____
Keep Stats > 92%, > 95%, ____
15. **VENT:** SIMV; TV: ____; RR: ____; Fio2: ____%; PEEP
ABG Q ____ hrs;
16. X-Ray: CXR in AM.
17. **MEDS:**
Morphine 2, 4, or 6 mg IVP Q 30 min/hr prn Pain
Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
Zofran 2-4 mg IVP Q 6 hrs prn Nausea
Zantac 50 mg IVPB Q 8 hrs
Drip: Dopamine: (400mg/250cc) 2–10 mcg/kg/min
Drip: Epi: (8mg/250cc) 0.01-0.1 mcg/kg/min
Drip: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg
Drip: Ativan 0.05-0.1 mg/kg IV over 2-5 min; (2-4mg IV)
Drip: Norepi/Levophed: (8mg/250) 0.01-0.2 mcg/kg/min
Cefotetan 2 gms IVPB Q12H.

18. **BURNS:** IVF: 4cc/% BSA burn/kg = total 24 hr fluids;
Give ½ over 1st 8 hrs from Time of Burn
19. **Head Injury:** Neuro checks (GCS) Q ____ min/hrs;
C-Spine: Clear/NOT Clear; Keep Head in midline position;
Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-50 min
Notify MD for Mental Status changes
20. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;

MD (b)(6)-4

(b)(3)-1 Post-OP Orders, By (b)(6)-2 as of 29 Nov 2001
(b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0800 28 Mar 03	emptied foley output was 1100 mL (b)(6)-2 SGT/91W
28 MAR 03 0820	Keep Midline wound uncovered
	MMVR @1000 D/C IV
	MMVR @1000 D/C Foley
	Keflex 500g PO Q6°
	Regular Diet (b)(6)-2
28 Mar 03 1000	Took out foley output was 50 mL, also had to replace colostomy bag feces was weeping into wounds. Irrigated the wounds changed dressing and informed patient to make staff aware if colostomy bag falls off. (b)(6)-2 SGT/91W
28 Mar 03 1130	gave patient keflex 500mg PO (b)(6)-2 SGT/91W
28 MAR 03 1610	P-91 SaO_2 - 97%
	R-16 B/P - 127/60
	T-101.2° Acetaminophen 325mg po tabs ii taken (b)(6)-2
1847	T - 99.9 (o)
28 Mar 03 2200	Pt given 500 mg Keflex PO. Lungs CTA x 4 lobes. Colostomy intact LUQ s̄ stool @ this time. Hypoactive BS x 4 quads. Tolerating PO's well. (b)(6)-2 SSG/LPN
2350	Pt had 500cc of urin output c̄ some difficulty SPC (b)(6)-2
29 Mar 03 0600	BP - 130/68 RR - 16 Sats - 98% via RA
	P - 90 Temp - 98

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 MAR 03	Surgery
	POD # (b)(6)-4
	S/p GSW to rectum
	Comfortable
	T 99 95 132/72 Sat 97%
	Abd soft, NT/ND, BS ⊕
	Ostomy pink, edematous
	Dressings intact.
	A/P) Stable
	Ambulate
	Clear liquids
	Δ dressings (B) buttocks
	Cont abx (b)(6)-2
	MD
26 Mar 03	Changed dressing on (2) buttocks, wound was
1733	clean + looked to be healing well. SPC (b)(6)-2
26 Mar 03 2134	I agree with above assessment, tolerating PO water + crackers, having a small
	amount of gas passage in colostomy (b)(6)-2 1LT/AN
27 Mar 03 1350	Pt admitted to new location. Pt sleeping stable condition (b)(6)-2
28 Mar 03 0012	No changes from previous exam except output (stool) in colostomy (b)(6)-2 1LT/AN
28 Mar 03 0050	VSS, colostomy bag changed 25 mg Benadryl given for sleep (b)(6)-2 1LT/AN

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.

OP/EPW # (b)(6)-4

(b)(3)-1

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

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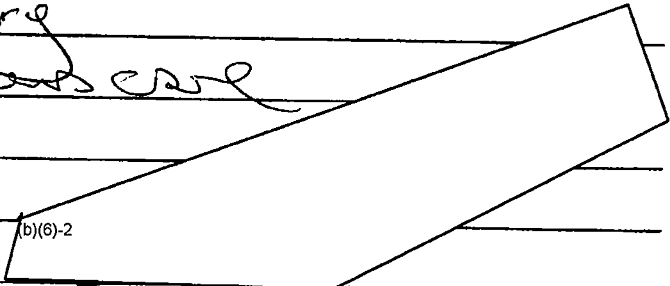
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Mar 03 1150	Requests antiacid tab. Given one Pk
29Mar03 1330	POD# (b)(6)-4 S/P GSW to Back AND GSW buttock [illegible] Rectum S/P X-LAP c Diverting sigmoid Colostomy
	C/O foul odor and (L) buttock pain
	AF/VSS
	Midline incision healing well
	Colostomy red/beefy - good output
	(L) buttock wound c purulent
	↳ Bandage and wound soaked c fecal material
	? Fistula
	(R) smaller buttock wound c fecal drainage
	A/ ? Fistulous tracts (B)
	P/ Confer c Surgery
	Continue wound care



(b)(6)-2

29 Mar 03	Pt. Assessment completed. Pt. colostomy emptied and dressings [illegible] see physician note above. No s/s of infection noted at this time. chucks replaced + patient cleaned. All assessments WNLs ~~[illegible]~~ Error other

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.

OD (b)(6)-4 (b)(3)-1

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)*
Continued –	than ones mentioned above. No s/s of infection and no c/o pain
	(b)(6)-2 2LT AN

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50818

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Mar 03 0400	Pt given 500mg Keflex PO. Dssg's Δ'd to (L) buttocks draining liquid feces. Dssg Δ'd to (R) buttocks. BP - 130/90, Pulse - 80, Resp 20, Temp - (b)(6)-2 SSG/LPN
29 Mar 03 1030	Pt assessment completed. Pt colostomy (L) abdomen w/ stool present. Bowel sounds are Hypoactive x4. Pt complains
1140	Pt Colostomy emptied. (b)(6)-2 2LT AN
1945	No Δ's from previous exam, drsg Δ to (L) buttock, stool in dressing. 50mg Benadryl given for c/o not sleeping VS 130/72, P 90, SpO2 100, T 98.2 (b)(6)-2 1LT/AN
30 Mar 03 1100	POD # (b)(6)-4 S/P GSW to Back ; GSW (B) buttocks and Rectum S/P X-LAP c diverting sigmoid colectomy Ø complaints Ø Temp recorded today otherwise good vitals Colostomy looks good c good output (B) buttock wounds draining pus / fecal matter P) NPO Surgery today (b)(6)-2
30 Mar 03	Pt. assessment completed. Pt is NPO awaiting surgery. Dressing Δ'ed dressing was saturated fecal contents. Wounds on (L)+(R) Butt were (Cont →)

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

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

REGISTER NO. | WARD NO.

EPW # (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)*
(Continued)	cleaned and irrigated with NS. Colostomy was emptied, cleaned
	and reapplied. All other assessments WNL's. No c/o pain
	at this time. (b)(6)-2 2LT AN
30 Mar 03	B/P 120/64 P: 95 SAT 96% Temp: 100.4
1236	
31 Mar 03 0930	IV infiltrated, DC'd.
31 MAR03 0950	18g IV done in (L) [illegible] Forearm c 1L NS (b)(6)-2
31MAR03 1002	4mg MSO4 IV push (b)(6)-2
31 Mar 03	Drsg Δ done by Surgery service to (L) hip (b)(6)-2 (b)(6)-2 CPT
1015	
3/31/03	POD# (b)(6)-4 S/P GSW to Back & GSW
1102	to buttocks and Rectum S/P Ex LAP c
	Diverting sigmoid colectomy
	VS Temp ?
	Buttock wound c gas burning pain
	NPO
	FURTHER Surgical Debridement
	Midline incision Looks good
	Remove staple suture
	(b)(6)-2
	ERROR
31 March 03 1630	Pt c/o Pain tx c 2.5mg MSO4 (b)(6)-2 2LT AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Brief Op Note
30Mar03	Dx: Infected buttock wound
17[30]	Proc: I&D (R) buttock
	Procto c̄ wound Hartmann pouch
	Surg: (b)(6)-2
	An: (b)(6)-2
	Findings: Gangrene necrotic subcutaneous fat c̄ cavity diving down into gluteus. Widely debrided + drained c̄ penrose.
	(b)(6)-2
	~~B/P 118/60~~
2130	B/P 118/60 P86 R10 SAO2 96 T 99.3 Pt states some PN and vertigo. Pt dressing and collostomy are good SPC (b)(6)-2
2220	Pt given 2mg MSO4 IV and gentamyoson SPC (b)(6)-2
	Pt also given Phenagran 12.5mg IV SPC (b)(6)-2
2250	Pt given Gentamycsin 240mg IV SPC (b)(6)-2
2400	Gave Pt 3.0g Unison IV. Pt c/o PN, Pt was given Vicodin. SPC (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)*

OD (b)(6)-4 (b)(3)-1

REGISTER NO.	WARD NO.

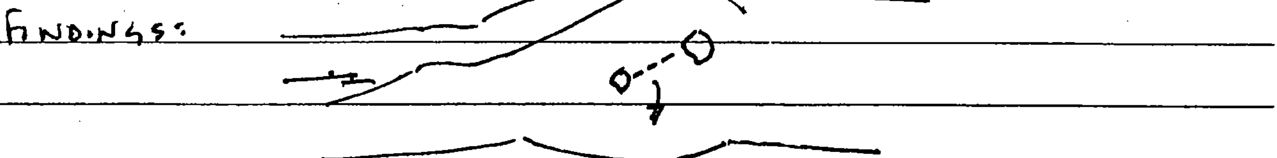
PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 MAR 03	OP NOTE
1715	PRE OP DX = GSW (L) BUTTOCK / ABDOMEN
	↳ S/P EX LAP / DIVERSION 3/24/03
	↳ S/P (L) BUTTOCK WASHOUT / DEBRIDEMENT 3/30/03
	FECAL DRAINAGE VIA BUTTOCK WOUND R/O ABSCESS / FISTULA
	POSTOP DX: SAA
	ADD DISTAL RECTUM TRAUMA - PENETRATION OF GSW
	PROCEDURE: DEBRIDEMENT OF (L) BUTTOCK WOUND / IRRIGATION
	RE - EX-LAP
	OSTOMY TAKEDOWN FOR DISTAL WASHOUT
	REPLACEMENT OF ~~[illegible]~~ OSTOMY
	SURGEONS: (b)(6)-2 MD ASSIST: (b)(6)-2 MD
	IVF:
	EBL: 150 cc
	ANESTH: (b)(6)-2 (b)(6)-2, MD)
	COMPS: NONE
	FINDINGS:



STOOL / DRAINAGE FROM BUTTOCK WOUNDS - WOUNDS JOINED FOR EXPLORATION →

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.

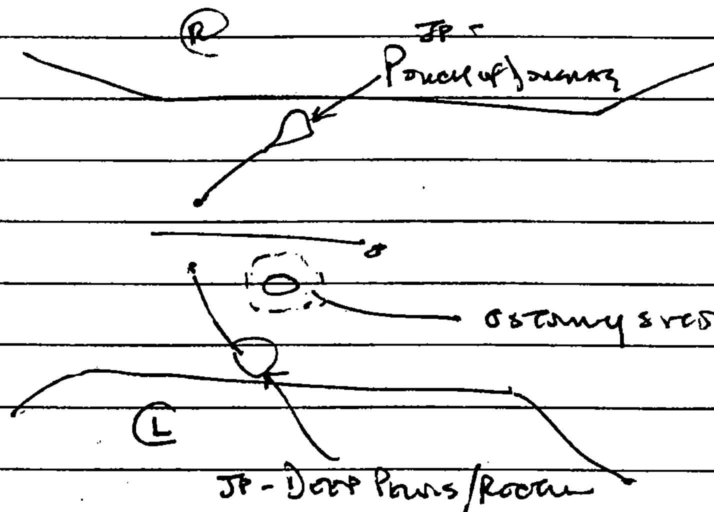
♂ / EPW (b)(6)-4

(b)(3)-1

PROGRESS NOTES
Medical Record

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

DATE	NOTES
	GSW PATH TRACKED TO PELVIS.
	EX LAP FOR PELVIC EXPLORATION. RETROPERITONEAL MOBILIZATION
	OF DISTAL RECTUM. GSW INJURY TO RECTUM 4cm FROM
	ANAL VERGE c̄ OPEN DRAINAGE OF SUCCUS FROM APERTURE.
	COPIOUS IRRIGATION OF PELVIS
	OSTOMY TAKEDOWN FOR DISTAL WASHOUT c̄ IRRIGATION
	UNTIL CLEAN OUTPUT FROM RECTUM. REPEAT COPIOUS IRRIGATION
	OF PELVIS.
	JP PLACED IN DEEP PELVIS ADJACENT TO LOWER RECTUM
	JP PLACED IN POUCH OF DOUGLAS



DATE	NOTES
	OSTOMY REPLACED AND WOUND FASCIA CLOSED - SKIN OPEN.
	Pt TOL PROCEDURE WELL. EXTUBATED c̄ DIFFICULTY
	TO RR IN STABLE CONDITION
	(b)(6)-2
	(b)(6)-2 MD

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Mar 03 1830	Patient arrived to RR in stable condition. Confused, non-communicative. Several attempts made @ pain control. Δ order for meds by Dr. (b)(6)-2 IV flowing @ 140cc/hr ō Δ redness/swelling. Bandages CDI to abdomen. JP #1 & #2 present ē serosanguinous fluid, Bowel Sound hypo. (b)(6)-2
1845	Sats >95% on Room Air (b)(6)-2
2200	Pt alert c/o severe abdominal pain, S/P wound debridement of GSW to abdomen. BS hypoactive x4, lungs CTA Ⓑ Dressing to abdomen C, D, I. VSS, PAO2 95% on RA. Given 10 mg MSO4, which put the patient into a deep sleep for 2 hours. Pt voiding via Foley 730 cc/hr, dark yellow urine. Pn control is the main issue with this pt. will continue to monitor (b)(6)-2 91C3H
0100	Pt again c/o pain to abdomen. Δ'd pain control meds to 100 mg Demerol. Pt saturating 95% on RA. (b)(6)-2 91C3H
0300	Pt c/o pain. Given 70 mg of Demerol + 12.5 phenergan. Checked JP drains, One had come open. Closed + reapplied suction. Pt c/o dizziness, stating "I feel as if to die". Checked V.S., stable ē slight tachycardia (rate 123). See flow sheet. UOP 730 cc/hr via foley. Dark yellow, s̄ sediment. (b)(6)-2 SSG, 91C3H

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

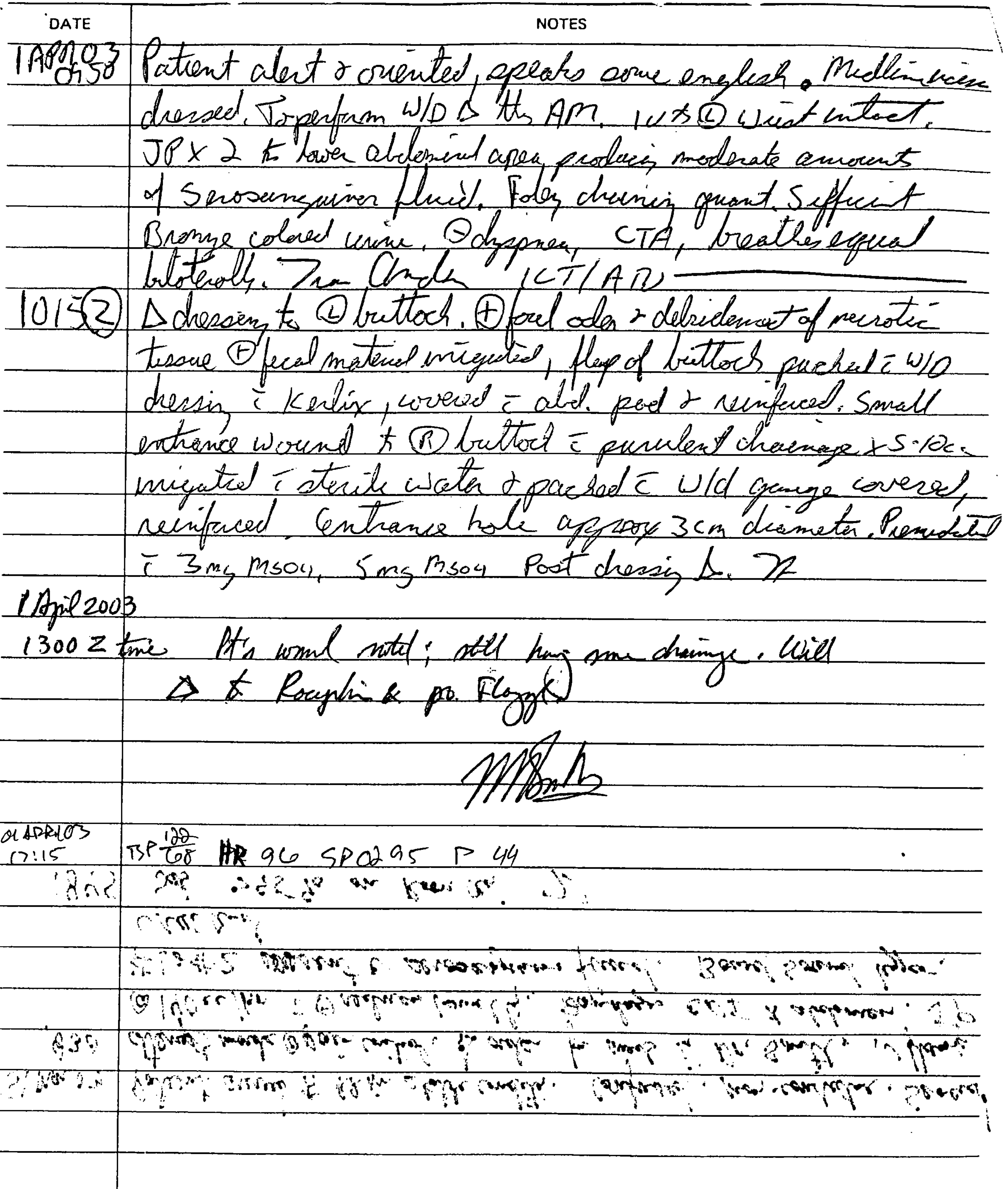
DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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.

OD (b)(6)-4 (b)(3)-1

PROGRESS NOTES
Medical Record

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



DATE	NOTES
1APR03 0150	Patient alert & oriented, speaks some english. Midline incision dressed. To perform W/D Δ this AM. IV x ⓛ wrist intact. JP x 2 to lower abdominal area producing moderate amounts of serosanguinous fluid. Foley draining quant. sufficient bronze colored urine. ⊖ dyspnea, CTA, breathes equal bilaterally. [illegible] ICT/AR
1015 ②	Δ dressing to ⓛ buttock. ⊕ foul odor & debridement of necrotic tissue ⊕ fecal material irrigated, flap of buttock packed c̄ W/D dressing c̄ Kerlix, covered c̄ abd. pad & reinforced. Small entrance wound to Ⓡ buttock c̄ purulent drainage x 5-10cc irrigated c̄ sterile water & packed c̄ W/d gauze covered, reinforced. Entrance hole approx 3cm diameter. Premedicated c̄ 3mg MSO4, 5mg MSO4 post dressing Δ. [illegible]
1 April 2003 1300 Z time	Pt's wound noted; still has some drainage. Will Δ to Rocephin & po. Flagyl.
	[signature]
01APR03 2 17:15	BP 120/68 HR 96 SPO2 95 P 44
[illegible]	[illegible]
	[illegible]
	[illegible]
	[illegible]
930	[illegible]
[illegible]	[illegible]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1APR03	Pt Alert + Oriented x3, NAD. Dressing to Abdomen is
1839Z	CDI. Dressings to (B) Buttocks. (R) buttock has a 4x4
	gauze covering wound, which is CDI. (L) Buttock has
	a dressing which covers entire buttock, exterior of
	dressing is clean, dry, and intact, however, the
	interior gauze appears saturated by serous
	fluid. pt has no complaints at this time.
	(b)(6)-2 91C3H
1 Apr 03	Pt [illegible] from [illegible] 1 — Pt [illegible] — [illegible] 450
1944	cc [illegible] urine from Fog — LR @ 140ah — (R) [illegible]
	JP #2 (R) [illegible] — [illegible] O/C — [illegible], Lo [illegible] Dg — c/d/i
	(L) buttock Drg — intact, [illegible] — [illegible] (L) [illegible]
	[illegible] x 4 [illegible]. + lung sound (R) lower [illegible]. (b)(6)-2
2216	Δ'd outer Drg (L) buttock — (saturated) — (b)(6)-2
4/2 20	— 1,000cc LR (b)(6)-2
4/02/03 0215	↑ 50cc LR (b)(6)-2
0100 4/2	Fog output since 1944 = 500 cc O/C [illegible] urine
	JP #1 — 25cc s/s d/c JP #2 10cc s/s d/c (b)(6)-2
	ABD drg intact — [illegible] = [illegible] d/c — [illegible] pink
	(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.)* (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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02APR03	S/P ex-Lap c diversion (24MAR03)
	D+I (L) buttock (30MAR)
	Dressing Δ today (Gen. Surgery) (b)(6)-2
	Rocephin / Flagyl
4-2 1000	pt A/O, follows simple commands, R-ON RA, lungs CTA, CV-B/P stable, pulses +/+, GI ML INC well to ory, green serous drg soiled dressing changed, (L) ABd colostomy min serous drg, JP x2 to bulb sx min drg. GU - foley to gravity = urine amber output min, LR 140 CC/HR, skin warm dry, dressing changed BL buttocks wet to dry [illegible]. pt denies pain, NPO ice to mouth (b)(6)-2
2APR03	Assessment completed - Pt speaks - understands some English
1720	(+) BS (B) Upper Quads - Mod brown liquid stool w colostomy - stoma pink WNL, IV site (R) Fa patent, foley patent - c/y/a, (L) Rhonchi (L) LLobe - + cough sound (R) LLobe - Requested pt to cough - coughed up clear sputum, Abd dsg, (L) (R) buttock Drg c/d/intact (+) JP x4 ext. (L) JP 2 mod ss d/c. Pt denies pain (b)(6)-2
1940	100 mg Demerol for pain IV (b)(6)-2
0055 4/3	10 mg Demerol + 12.5 mg Phenergan IV (b)(6)-2
4/3 0100	Foley output 400cc, DK Amber urine. JP #1 15cc ss d/c. JP #2 10cc ss d/c. Mod brown liquid stool w colostomy -
4-3-02	0800- Δ'ed (L) buttock dressing w/o D c DR (b)(6)-2 still foul smelling c mod stool serous leakage, Δ'ed (R) buttocks GSW w/o D packing Δ'ed ML Abd INC drsg, drsg serous c Green spots DR (b)(6)-2 said [illegible] colonization Δ'ed colostomy, stoma pink c min stool. JP x2 c min drg, pt Alert responds speaks little English. Pt needed c 5mg of MSO4, 3 2mg of [illegible] for DR (b)(6)-2 (b)(6)-2

AUTHORIZED FOR LOCAL REPROD

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 Apr 03 2000	Assessment completed — ↓ LS (B) lower base, Pt resting - easily aroused. Hyperactive BS x upper quad. Med abd Drsg c/d/i, return from colostomy ... - MW brown liquid stool in bag - JP 1+2 c MW ss d/c - Foley drained - 1500cc DK amber urine (B) buttock Drsg c/d/i. —— (b)(6)-2
3 Apr 03 2155	Gave pt 1 Maalox ... for Heartburn —— (b)(6)-2
3 Apr 03 2155	12.5 g phenergan + 10 mg Decadron for pain + nausea —— (b)(6)-2
0500 4/4	Foley out put 450, JP 1 10cc JP2 60 cc ... ss d/c - Colostomy 450cc liquid brown stool. Pt c/o ... tired —— (b)(6)-2
4 Apr 03 1600	Assessment completed, ... - (R) FA, Foley patent 500cc amber urine in bag. Lungs CTA ... (B) - Med abd drsg c/d/i - stoma pink. Colostomy c MW liquid brown stool. (L) (B) ... abd same - ... for lower BS - (b)(6)-2
	Pt requesting med to sleep - 10 mg Ambien - po (b)(6)-2
4/5/03 0020	Ambien ... by ... per ... (b)(6)-2
0114	Emptied 350cc liquid brown stool ... drsg - med abd (L) upper back + (B) buttock —— (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.

OD (b)(6)-4 (b)(3)-1

PROGRESS NOTES
Medical Record

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

DATE	NOTES
05APR03 0430	VS T 99.1 Ax BP 140/78 R18 P97; DSG (L) Back CDI; DSG
	(L) Buttock Appears in need of changing. Colostomy looks good
	Ø sign infection (2) JP's empty. SPC (b)(6)-2 91W
0700	Pt being Evac'd. Did not receive 0700 meds. SPC (b)(6)-2 91W

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDICAL RECORD | **INTRAOPER[illegible] [illegible]CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: field litter BY: (b)(3)-1

2. PATIENT IDENT[illegible] (b)(6)-2 VERIFIED BY / [illegible] AND PROCEDURE: cpt/[illegible]

3. DATE: 24 MAR 03 TIME PATIENT ARRIVED IN SUITE: 0115

4. PATIENT IN ROOM TIME: 0115 NUMBER: 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt sleepy upon arrival

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Debridement of posterior wounds then supine for exploratory laparotomy

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Dr. (b)(6)-2

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Back BY WHOM: Cpt (b)(6)-2
SITE: Abd BY WHOM: Cpt (b)(6)-2
COMMENTS: Rectum

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS (C = Correct I = Incorrect)

10. COUNTS		Initial/Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2 SSG	(b)(6)-2 Cpt
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
Other	☒ Yes ☐ No	C	C	C		

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

OD (b)(6)-4

(b)(3)-1

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

☐ ESU NO: F1048
GROUND PAD: BRAND Valley Lab
LOT NO: 36098

☐ 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.

13. PROSTHESIS, IMPLANTS ☐ Y. IO IF YES NAME: ID NU F JFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NSS

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. Penrose 7/8	2.	3.
SITE	1. (L) buttock	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

4x8
Colostomy bag
Fluffs
Silk tape

19. ADDITIONAL INFORMATION

DR. (b)(6)-2

DR. (b)(6)-2

Anes - (b)(6)-2 CRNA - Gen

20. OPERATION(S) PERFORMED

Exploratory Laparotomy, Colostomy I&D of wounds

21. PATIENT TRANSFERRED TO ICU TIME 0315 METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

OD (b)(6)-4 (b)(3)-1

MEDCOM - 3718

MEDICAL RECORD

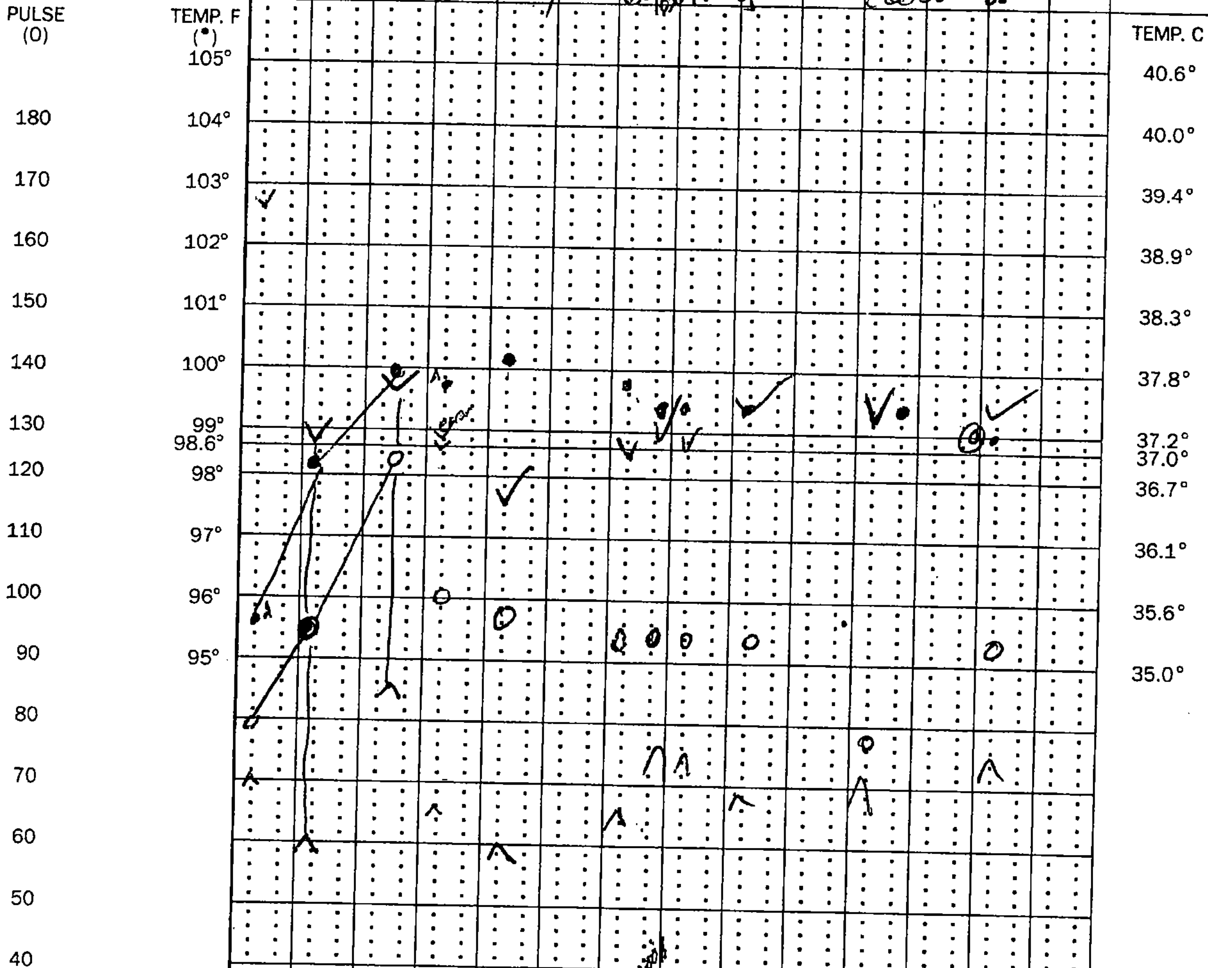
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 31MAR03 1APR03 1APR 2APR 03APR 04APR 05APR

19 HOUR 1930 2200 0600 1000 1944



RESPIRATION RECORD 18 22 16 16 16 16 16 16 R

BLOOD PRESSURE 166/71 122/60 138/86 126/66 117/97 128/96

SpO2 95% 95% 100% 93%

HEIGHT: WEIGHT

Urine 90cc 700 350 950 600 450

JP1 35 75 15 25 10

JP2 25 75 5 10 60

Colost 450

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 - 3719

EPW # (b)(6)-4

Vital Signs

Time	BP	HR	SpO2	RR	Pain
0900	115/73	86	100	13	resting
1000	113/68	96	100	13	resting ~~dressing Δ'd on~~
1100	119/79	94	100	14	resting
1200					
1300					
1400					
1500					
1600					
1700					
1800					
1900					
2000					
2100					
2200					
2300					
2400					

Medications

Due:
- 1200 Zantac 50 mg IVPB Q8h / 2mg MSO4
- 1300
- 1400 2mg MSO4
- 1500
- 1600 2mg MSO4
- 1700
- 1800 2mg MSO4 / Cefotetan [illegible]g Q12°
- 1900
- ~~[illegible]~~: 2000 Zantac 50 mg IVPB Q8h / 2mg MSO4
- 2100
- 2200 2mg MSO4
- 2300
- 2400 2mg MSO4

I & O

Time	IN	OUT
0900	80 cc LR	100/100
1000	80 cc LR	100/200
1100	80 cc LR	100/300
1200		
1300		
1400		
1500		
1600		
1700		
1800		
1900		
2000		
2100		
2200		
2300		
2400		

Notes

1000 Dressing Δ'd on (L) posterior c̄ Kerlex & 3" tape, Dressing on Abdomen CDI.

OD (b)(6)-4 (b)(3)-1

EPW # (b)(6)-4

LR @ 75 cc/hr

I+O

0400 100
0500 200 / 300
0600 250 / 550
0700 100 / 650
0800
0900
1000
1100
1200
1300

LABS

DRAW H+H in AM
Na 144 K 4.4 Cl 111 Bun 29
Glu 231 Hct 39 Hgb 13

X-RAY

CXR in AM

MEDS

MORPHINE 4mg IVP Q30min prn pain
Zofran 2-4mg IVP Q 6h prn nausea

Zantac 50mg IVPB Q8h
0400 ✓
1200
2000

Cefotetan ii g IVPB Q12H.
0600 ✓
1800

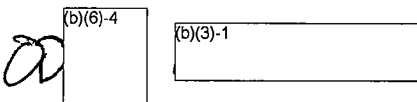
Gentamycin 240mg IVQD
☐ 2300 30 MAR
☐ 2300 31 MAR
☐ 2300 01 APR

Pain Management

0845 4 mg MSO4
0955 4 mg MSO4
1200
1400

Unasyn 3 Gm IV Q6°

31MAR	☐ 0000	☐ 0600	☐ 1200	☐ 1800
01 APR	☐ 0000	☐ 0600	☐ 1200	☐ 1800
02 APR	☐ 0000	☐ 0600	☐ 1200	☐ 1800



MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)					
Fentanyl (cc)	32	5			
Ketamine (mg)	50				
Sux (mg)	100				
Vec (mg)	5	5	5		
Mag (g)					
Morphine/Hydromorph (mg)				10	3/.4
VOLAT AGENT Forane % del	1.5	1	1	1	1
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	3	3	3	3	3 3 3 3

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

FLUIDS: LINE site 18G Ⓡ ☑ Warmed 1000 — 600; ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE – 600

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT KG LB

HEMATOCRIT

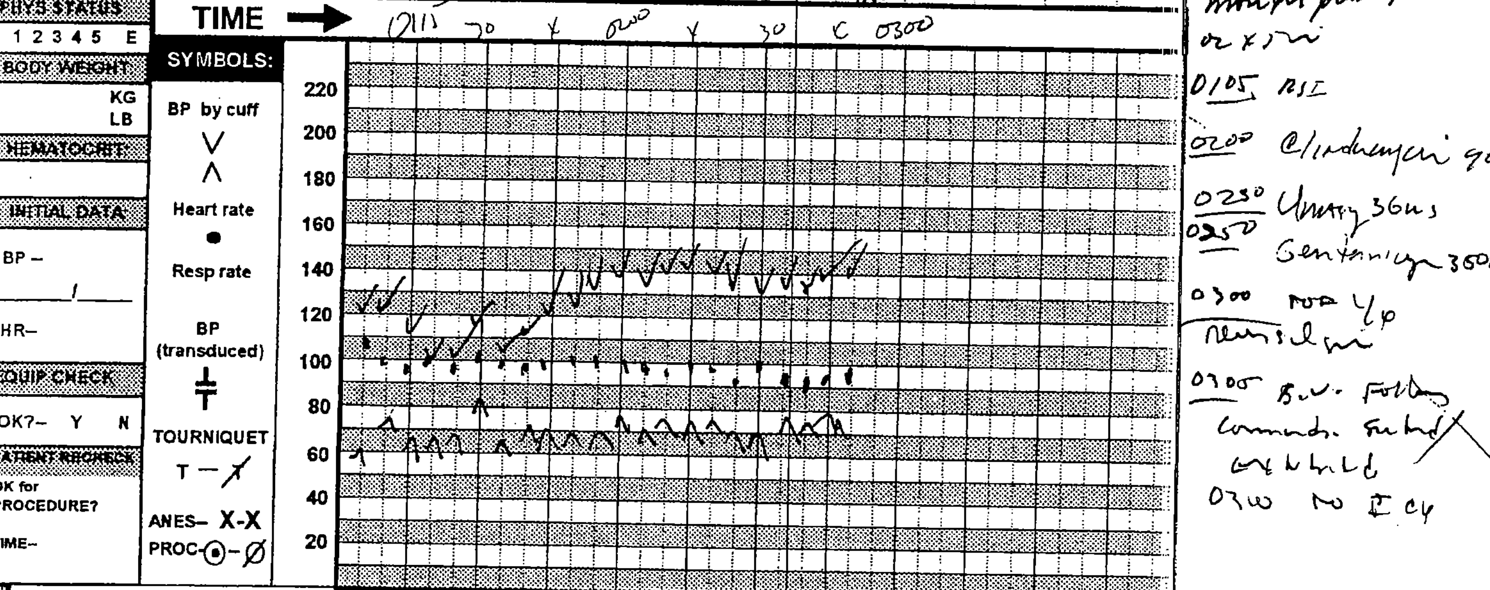
INITIAL DATA: BP – ___/___ HR–

EQUIP CHECK OK?– Y N

PATIENT RECHECK OK for PROCEDURE? TIME–

TIME → 0115 30 X 0200 X 30 C 0300

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



VENT: VT – ml; f – breaths/min; Peak inf pres / PEEP

MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S
ET CO2 (torr)		31	40	30	30	30	29	26	
FIO2 (Frac or %)	>40	.40	.41	.39	.39	.33	.33	.33	
SpO2 (%)	100	100	100	100	100	100	100	100	
ECG	SR	SR	SR	SR	SR	SR	SR	SR	
TEMP- site									
N-M Block (T/4)					4/4		4/4		

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 → (supine)

TOTALS: TOTAL EBL 50 ml; TOTAL URINE 600 ml

FLUIDS – SUMMARY: CRYSTALLOID– 1600 ml; COLLOID–; BLOOD–

REMARKS– Code drugs with numbers, events with letters

0100 in room monitors placed O2 x 3 min
0105 RSI
0200 Clindamycin 900
0230 Unasyn 3Gm
0250 Gentamicin 350mg
0300 to PACU 40 [illegible]
0300 B.V. Following commands, extubated [illegible]
0310 [illegible]

RECOVERY AT: PACU ICU ______ (Specify) OTHER ______

CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0100	0100	0310
	Ready	Begin	End
PROC	0110	0115	0300

PROCEDURES and CPT Codes: Ex Laparotomy, Colostomy R+A GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — Miller RSI 8.0 ETT w/cricoid pressure, BBS Ⓔ ETCO2 x4, ETT @ 22 cm lips

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility — OP/EPW (b)(6)-4 (b)(3)-1

SURGEONS: (b)(6)-2 (b)(6)-2

ANESTHETIST: (b)(6)-2 CRNA

(b)(6)-2

PROCEDURE LOCATION

DATE 24 Mar 03

PAGE 1 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 3722

☆ U.S. GPO: 1999 – 528-336/10085

(THIS FORM IS SUBJECT TO THE PRIVACY A[...] 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[...]

ANESTHESIA RECORD

Page 1 of

ANES.	IN OR	ANES. END	DATE
1612	1623		3/30/2003
TOTS	SURG START	DRESSING	OR NO
1638	1644	1720 / 1735	

OPERATION PERFORMED: WASHOUT TO DISTAL STUMP

SURGEON(S) (b)(6)-2

PREOPERATIVE

☒ IDENTIFIED ☒ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE 3/29
☒ PRE-OP MEDICATION: ✓

Drug	Dose	Route	Time
Versed	2mg	IV	1620

Pre-Anesthetic State:
☒ CALM ☒ AWAKE
☐ APPREHENSIVE ☐ SEDATE
☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☐ ANES. MACHINE # & EQUIP. CHECKED
☒ NON-INV. B/P ☐ PNS
☒ CONT. EKG ☐ V LEAD EKG
☐ ESOPH. STETH. ☐ PRECORD STETH.
☒ PULSE OXIMETER ☒ O2 ANALYZER
☒ END TIDAL CO2 ☐ MASS SPEC.
☐ TEMPERATURE
☐ WARMING BLANKET ☐ FLUID WARMER
☐ AIRWAY HUMIDIFIER
☐ N/G TUBE ☐ O/G TUBE
☒ IV(s) Ⓡ hand
☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
☐ EYE CARE
☐ PRESSURE POINTS CHECKED / PADDED
☒ Conversion

ANESTHETIC TECHNIQUE

☒ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☒ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☒ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

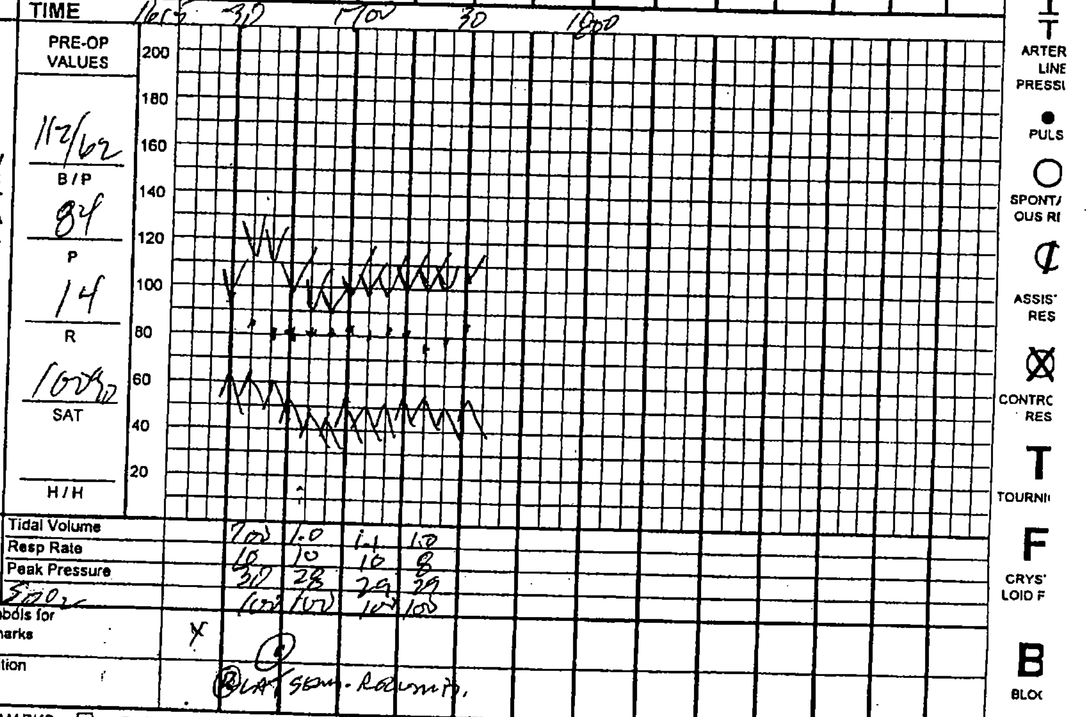
☒ INTUBATION ☒ ORAL ☐ NASAL
☐ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☒ STYLET USED
☒ ATTEMPTS x 1 ☒ BLADE 3.0 MAC
☒ ETT SIZE 7.5 ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☒ CUFFED 1 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ___ CM H2O
☒ ETT SECURED AT 21 CM
☒ BREATH SOUNDS = bilat
☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ LMA SIZE

AGENTS / FLUIDS / MONITORS

	1615	30	1700	30	1800
Versed	2				
Propofol	150		50		
Sux	100				
Nimbex		5			
ISO		1.5	1.2	.8	
N2O L/min					
O2 L/min / AIR	4	2/2	1/2	4/2	
LR	500		500		
Urine					
EBL					
EKG	SR	SR	SR	SR	SR
% O2 Inspired	.47	.53	.53	.43	.53
O2 Saturation	100	100	100	100	100
End Tidal CO2	30	28	27	28	40
Temperature	—	—	—	—	—
PNS	—	—	—	—	—

TIME 1615 30 1700 30 1800

PRE-OP VALUES: B/P 112/62; P 84; R 14; SAT 100% RA; H/H



RESP				
Tidal Volume	700	1.0	1.1	1.0
Resp Rate	10	10	10	8
Peak Pressure	30	28	29	29
300	100	100	100	100

Symbols for Remarks: X ①

Position: Ⓡ LAT / Semi-Recumbent

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation. ☐ Significant changes from preop plan / evaluation.

Symbols: X ANESTH[...]; ⊙ OPERA[...]; V ^ B/P CU[...] PRESS[...]; ARTER[...] LINE PRESS[...]; ● PULS[...]; ○ SPONT[...] OUS R[...]; ⊄ ASSIS[...] RES; ⊠ CONTR[...] RES; T TOURN[...]; F CRYS[...] LOID F[...]; B BLO[...]

TOTA[...]

RECOVERY

TIME IN PACU	CONDITION		
1740	STABLE		
B/P	PULSE	RESP	O2 SAT
120/75	81		98
REMARKS			TEMP 98.3 ax

REPORT TO: PARRS:

FLUIDS TOTALS

IN		OUT	
Crystalloid	700 LR	EBL	100
		Urine	—
Blood	—	Gastric	

Tourniquet Time:

(b)(6)-2

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION: # (b)(6)-4

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 29 MAR

MEDCOM - 3723

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F (M circled)	HEIGHT	WEIGHT

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

missing tooth,

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD Dyspnea, Pneumonia, Productive Cough Recent cold, SOB, Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF Exercise Tolerance, Hypertension, MI Murmur, MVP, Pacemaker Rheumatic fever	☐		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis Hiatal Hernia, Jaundice, N&V Reflux/Heartburn, Ulcers	☐	Ethanol Use: ☐ No ☐ Yes Frequency ____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke DJD, Headaches, Loss of consciousness Neuromuscular disease, Paralysis, Paresthesia Syncope, Seizures, TIAs Weakness	☐		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease Urinary retention, Urinary tract infection, Weight loss/gain	☐		Urinalysis Thyroid FBS
OTHER Anemia, Bleeding tendancies, Hemophilia Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC Lytes

PROBLEM LIST / DIAGNOSES

ASA 1 2 3 4 5 E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: ____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE DATE

EVALUATOR(S) SIGNATURE

CRNA ____ DATE ____

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE:

SIGNED: TIME:

OD (b)(6)-4

(b)(3)-1

MEDCOM - 3724

(THIS FORM IS SUBJECT TO THE PRIVACY AC[T OF 1]974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[...]

ANESTHESIA RECORD

Page 1 of 1

ANES. START: 15[...] | IN OR: 1525 | ANES. END | DATE: 31 MAR 03
TOTS: 1530 | SURG START: 1542 | DRESSING: 1712 | OR NO

OPERATION PERFORMED: I&D Buttocks, Ex lap

SURGEON(S) (b)(6)-2

PREOPERATIVE

☑ IDENTIFIED ☑ ID BAND ☐ QUESTIONING
☐ CHART REVIEWED ☐ NPO SINCE
☐ PRE-OP MEDICATION:

Drug / Dose / Route / Time: midaz 2mg IV 1520

Pre-Anesthetic State: ☑ CALM ☐ APPREHENSIVE ☑ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☑ ANES. MACHINE # ___ & EQUIP. CHECKED
☑ NON-INV. B/P ☐ PNS
☑ CONT. EKG ☐ V LEAD EKG
☐ ESOPH. STETH. ☐ PRECORD STETH.
☑ PULSE OXIMETER ☑ O2 ANALYZER
☐ END TIDAL CO2 ☐ MASS SPEC.
☐ TEMPERATURE
☐ WARMING BLANKET ☐ FLUID WARMER
☐ AIRWAY HUMIDIFIER
☐ N/G TUBE ☐ O/G TUBE
☑ IV(s) PIV (R) arm
☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
☑ EYE CARE taped
☐ PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

☑ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☑ PREOXYGENATION ☐ INHALATION
☑ RAPID SEQUENCE ☐ INTRAMUSCULAR
☑ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

☑ INTUBATION ☐ ORAL ☐ NASAL
☑ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☑ STYLET USED
☑ ATTEMPTS x 1 ☑ BLADE Mil 2
☑ ETT SIZE 7.0 ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☑ CUFFED 6 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ___ CM H2O
☑ ETT SECURED AT 20 CM
☑ BREATH SOUNDS Bilat
☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ LMA SIZE

AGENTS / GASES

Time	1530	X	1600	X	30	X	1700	X	30	X	1800
Propofol	200										
Sux	100										
Fentanyl	150	50									
Vec		4	2								
Neostigmine							5				
Robinul							1	4			
MSO4											
150		1.5	2.0	2.0	2.0	.5	.4	X			
Air (N2O L/min)		1	1	1	1	1	X				
O2 L/min	8	1	1	1	1	1	6				

FLUIDS: Urine / EBL

MONITORS

EKG	ST	SR	SR	SR	SR	SR	SR	SR	SR
% O2 Inspired	1.0	.55	.54	.54	.58	.58	.56	1	
O2 Saturation	100	100	100	100	100	100	100	100	
End Tidal CO2		36	38	38	34	34	34	38	
Temperature									
PNS		0/4		4/4	0/4	0/4		4/4 sustained	

VITAL SIGNS

TIME: 1530 X 1600 X 30 X 1700 X 30 X 1800

PRE-OP VALUES: B/P, P, R, SAT, H/H (graph scale 20–200)

RESP

Tidal Volume	SV	670	670	660	630	700	SV	SV	
Resp Rate	14	10	10	10	10	10	12	16	
Peak Pressure		28	29	30	31	31			

Symbols for Remarks

Position: supine

Symbols: X ANESTH; ⊙ OPERAT; V Λ B/P CUFF PRESS; ARTERIAL LINE PRESS; ● PULSE; ○ SPONTANEOUS RESP; ¢ ASSIST RESP; CONTROL RESP; T TOURNIQUET; F CRYSTALLOID F; B BLOOD

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation. ☐ Significant changes from preop plan / evaluation.

1720 - out OR to ICU stable

Tourniquet Time:

RECOVERY

TIME IN PACU: 1720 | CONDITION: Stable

B/P | PULSE 80 | RESP 14 | O2 SAT 97

REMARKS | TEMP

REPORT TO: | PARRS:

FLUIDS TOTALS

IN		OUT	
Crystalloid	2000	EBL	100
		Urine	100
Blood	0	Gastric	

PHYSICIAN / CRNA: (b)(6)-2 (b)(6)-2 MD

PATIENT'S IDENTIFICATION: EPW (b)(6)-4 OD (b)(6)-4 (b)(3)-1

OD (b)(6)-4 (b)(3)-1

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
	POST ANESTHESIA CARE UNIT ORDERS		
1	OXYGEN: 2 litres via Mask /Prongs to maintain O2 Sats greater than 94%;	(b)(6)-2	(b)(6)-2
	Wean to room air.	1749	1749
2	IVF: LR @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-5 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
5	~~ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1~~		
6	~~DROPERIDOL: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1~~		
7	~~REGLAN: Give 10 mg IV PRN nausea X 1~~		
8	Release from "PACU" when Aldrete score is 9 or greater		
9	Call Anesthesia for any questions or concerns		
	SIGNED (b)(6)-2		

PATIENT IDENTIFICATION

Pt # (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.

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

30 Mar 03
1730

To ICU
S/P I+D buttock wound
Condition stable
VS per routine
NKDA
Activity ad lib
If pt does not void,

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ____ HOURS

may place foley.
Regular diet
LR @ 100cc/hr
MSO4 4mg IV Q1° prn pain
Phenergan 12.5mg IV Q4° prn nausea
Unasyn 3.0g IV Q6°
Gentamicin 240mg IV Qday
Tylenol 650mg PO Q4° prn T>100.5
or 2 L NC

Noted (b)(6)-2

(b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

[illegible] 2200

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)-2

3/31/03 1105
1. NPO NOW
2. ON CALL TO OR today

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2030 31 March 03

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER

OD (b)(6)-4

(b)(3)-1

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 31Mar03 | TIME OF ORDER: 1730 HOURS | LIST TIME ORDER NOTED AND SIGN

To ICU
S/P Debridement on table washout, presacral drains
Condition stable
VS per routine
NKDA
Bedrest

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

Foley
Stoma care
JP x 2
Wet to Dry to midline
NPO
LR @ 140cc/hr
MS 4mg IV Q1° prn pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

Phenergan 12.5mg IV Q4° prn nausea
Unasyn 3.0g IV Q6°
Gentamycin 250mg IV Qd
O2 2L NC
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

Demerol 100mg IV x1 (b)(6)-2
VO. Dr (b)(6)-2 / LT (b)(6)-2
(b)(6)-2

31 March 2003 (b)(6)-2 1900
↑ morphine sulfate 2 – 30mg IV q 2 (b)(6)-2
or Demerol 100mg IV q 1h prn

NURSING UNIT | ROOM NO. | BED NO.

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE (b)(6)-2

31 Mar 03 2200 Charted

DA FORM 1 APR 79 4256

MEDCOM - 3728

12
28

CLINICAL RECORD - DOCTOR'S ORDERS

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

ALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD
), WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

LIST TIME ORDER NOTED AND SIGN

DATE OF ORDER: 1 April 2003
TIME OF ORDER: 1300Z HOURS

① Δ antibiotics to Rocephin [illegible] IV qd &
Flagyl 500mg po BID
[illegible] LTC

Noted (b)(6)-2 (b)(6)-2 1500 (b)(6)-2

TIFICATION
(b)(6)-4

UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ________ HOURS

4/3/02 Reg diet (b)(6)-2

(b)(6)-2

IDENTIFICATION
PW # (b)(6)-4

0520

04 APR 03 0455
① Zantac 150mg po bid (b)(6)-2
② Dressing Δ per Gen. Surgery

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4/5/03
TIME OF ORDER ________ HOURS

Ativan - 1g po [illegible]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ________ HOURS

PATIENT IDENTIFICATION (b)(6)-4
OD (b)(3)-1

NURSING UNIT | ROOM NO. | BED NO.

REPLACE[illegible]TION OF 1 JUL 77, WHICH MAY BE USED.

non Meds

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. 03 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6
31 Mar	(b)(6)-2	VS per routine 2 04/16	07 19	(b)(6)-2						
		2 16/04	19 07							
31 Mar		Bedrest 2 04/16	07 19							
		2 16/04	19 07							
31 Mar		Foley 2 04/16	07 19							
		2 16/04	19 07							
31 Mar		stoma care 2 04/16	07 19							
		2 16/04	19 07							
31 Mar		JP x 2 2 04/16	07 19							
		2 16/04	19 07							
31 Mar		Wet to dry to midline 2 04/16	07 19							
		2 16/04	19 07							
		2								
31 Mar		diet ADA (b)(6)-2 4/3/03 2 04/16	07 19							
	------	2 16/04	19 07							

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P Debridement Washout

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

PATIENT IDENTIFICATION:
ID/EPW# (b)(6)-4
(b)(3)-1

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.

non Meds

MEDCOM - 3730

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. 03 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31 Mar	(b)(6)-2	Condition stable	done		1845	(b)(6)-2
31 Mar		Admit to ICU	done		1845	

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

*U.S. GPO: 1996-454-110/95216

Recurrent Medications and Treatments		3/24/03 date	25	26	27
Zantac 50mg IV q8°	07	0	(b)(6)-2		
	14	(b)(6)-2			
	22				
Cefotan II 2gm IVPB q12°	02			[illegible] (b)(6)-2 (b)(6)-2	
	14	(b)(6)-2			
W/D dressing TID	07	per Doc	(b)(6)-2		
two sites	14	1809 (b)(6)-2			
	22				

Vital signs		3/24	25	26	27
O_2 sats @ 1110 94% RA (Q4°)	4			99.2 130/73 P84	
	8		100.4 87% P102 130/80	124/70 97% 85 99.1	
	12	97.0 140/80 100 22	99.8 P 94 132/72 Sa 95		
	16	144/80 97% 102 98°	96.8 125/74 100.6 97		
	20	T. 100.2 BP 130/60 93% P 107 R 20		P 82 127 T 97.9 73	
	24 (136/76)	93% RA 101 98.8		118/73 89 98.8 20	

PRN Medications and Treatments		3/24	25	26	27
Morphine 4mg q 30min prn pain	d/t	24 March 03	24 March 03	24 March 03	
	amt/int	1400 (b)(6)-2	1820 (b)(6)-2	4, 2030 4mg (b)(6)-2	
	d/t				
	amt/int				
	d/t				
	amt/int				
	d/t				
	amt/int				
	d/t				
	amt/int				
	d/t				
	amt/int				

Name: OD (b)(6)-4

Dx: GSW back & buttock

SSN: (b)(3)-1

All:

Unit: EPW

Blood type:

diet NPO

(b)(6)-4 on pt Hold Log

In/Out

25 March
0649 650cc
1412 700cc

26 March
0504 800cc

IVF	Time	amount	Total	[illegible]	[illegible]
OR/PACU		2800	~~1000~~ 2000		
LR@75cc/hr 1000' TG1100					

Hourly Input and Output		IV		(b)(6)-2	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100			300	900
	1200				
	1300				
	1400				450
	1500				
	1600				
8 hour totals					
	1700	200cc			
	1800				
	1900				
	2000				
	2100				
	2200				
	2300				
	0000				
8 hour totals					
24 hour totals					

OR/PACU (margin note at 1100)

26 Mar
600cc (margin note at 1700)

Total input:
Total output:
Balance:

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 03 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				31 1 2 3 4 5
31 Mar	(b)(6)-2	LR @ 140 cc/hr	07 19	(b)(6)-2
			19 07	(b)(6)-2
		NS 4n		
31 Mar		O2 2L NC	07 19	(b)(6)-2
			19 07	(b)(6)-2 (b)(6)-2
31 Mar		Unasyn 3gm IV Q6°	06 12 18 24	(b)(6)-2 D/C'd
31 Mar		Clindamycin 250mg IV Qd	10	D/C'd
3/1 Apr		Rocephin 1Gm IV qday	07 10	(b)(6)-2 (b)(6)-2
3 Apr		Flagyl 500mg PO BID	09 16	(b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2
4 Apr		Zantac 150mg PO BID	07 16	(b)(6)-2 (b)(6)-2 (b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Pressure area S/P Debridement/Washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:
OD/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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 03 Yr. 03

Order Date	Clerk/Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31 Mar	(b)(6)-2	Demerol 100mg IV x 1	done	1830	1830	(b)(6)-2
1 Apr		Ativan 1 po X 1 [illegible]	now	now	0028	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
31 Mar	(b)(6)-2	MS 4mg IV Q1° PRN Pain	31 Mar @ 1910 (b)(6)-2
31 Mar	(b)(6)-2	Phenergan 12.5 mg IV Q4° prn nausea	1 APR [illegible] (b)(6)-2; 1 APR 1830 12.5 mg (b)(6)-2; [illegible] (b)(6)-2; 4/3 215; 4/4
31 Mar	(b)(6)-2	↑MS 2-30mg IV q2h prn or Demerol 100mg IV q1h prn	31 Mar 10mg 1815 (b)(6)-2; 31 Mar 5mg 1915 (b)(6)-2; 31 Mar [illegible]; 31 Mar [illegible] 10mg (b)(6)-2; 31 Mar 2300 10mg; 01 APR 0105 10mg; 1 APR 0445 6mG (b)(6)-2; [illegible] (b)(6)-2; 4-3 385 (b)(6)-2
			31 Mar 1830 100mg (b)(6)-2; 31 [illegible]; 01 APR 0800 70mg; 01 APR 1830 50mg (b)(6)-2; 4/2 [illegible]; 4/3 [illegible] (b)(6)-2; 4/3 215
3/31	(b)(6)-2	~~Demerol [illegible] (b)(6)-2 [illegible]~~	

*U.S. GPO: 1996-454-110/95216

MEDCOM - 3735

Initial Assessment

Date ____________ Time ____________

(b)(3)-1

ICU____
OR____

NEUROLOGICAL ASSESSMENT

Pupil sizes: 2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level on Consciousness
✓ Awake ✓ Alert __ Drowsy
__ Restlessness __ Lethargic
__ Unconscious

Orientation: ?
__ Time __ Place __ Person

Eyes Open:
✓ Spontaneous
__ To Speech
__ To Pain
__ No Response

Best Verbal:
✓ Oriented & Converses
__ Disoriented & Converses
__ Inappropriate Words
__ Incomprehensible Sound
__ No Response

Best Motor:
✓ Obeys Commands
✓ Localizes Pain
__ Extension
__ No Response

Motor Ability & Strength:

	✓ Strong	Weak	Absent
RA			
LA			
RL			
LL			

PSYCHOLOGICAL
__ Calm __ Combative
__ Cooperative __ Anxious

INTEGUMENTARY
Color: ✓ Normal __ Pale __ Flushed __ Cyanotic __ Jaundiced
Skin: ✓ Warm __ Dry __ Diaphoretic __ Cool __ Clammy
(b)(6)-2

RESPIRATORY
✓ Unlabored __ Labored

Breath Sounds:
✓ Clear Bilaterally
__ Absent R L
__ Rales R L
__ Wheezes R L

ABDOMINAL
✓ Soft ✓ Tender
__ Rigid __ Non-Tender
__ Distended __ Rebound

Bowel Sounds:
✓ Active __ Hypoactive
__ Hyperactive __ Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial		
Femoral		
Pedal		
Edema		

0-Absent + 2-Normal
- 1-Weak + 3-Bounding

Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
2145		100	18	118/64	EPW ♂ to ATLS c̄
2200		110	18	131/58	x4 wounds to back/buttocks
2215		104	17	126/62	bleeding controlled. Pt
					Awake/responsive - non-
					English speaking. Lungs
					CTA Ⓑ, Sats 96% RA.
					(b)(6)-2 ~~Abd~~ Abd tender. foley
					in place 1900cc clear
					yellow urine @ arrival.
24MAR 0310					Pt to ICU s/p ex lap c̄ colostomy (end sigmoid)
					NG tube present. 5L O_2 via facemask 100% SpO_2 Foley to
0317		121	23	165/83	gravity drainage c̄ clear amber urine. Kerlix
0325		98	15	145/71	dsg to Ⓡ buttock dry+intact. Kerlix dsg to
0330		97	15	149/76	Ⓛ buttock c̄ penrose drain dry+intact at this
0345		95	15	150/75	time. Will continue to monitor. Midline abd.
0400		88	12	132/72	dsg dry+intact c̄ ostomy present. IV NaCl
0415		86	12	125/70	0.9% infusing to Ⓛ AC via 18 ga needle -
					(b)(6)-2 55cc/hr

Allergies

Time	IV	MEDICATIONS (dose/route site)
2200	5cc	5mg Morphine
2205	.5cc	Tetanus
2300	100cc	1gm Ancef
0400	100cc	Zantac 50mg IVPB
0600	100cc	Cefotetan 1 g IVPB

24MAR03

Ø Allergies
Ø PMH/PSH
OD# (b)(6)-4
EPW # (b)(6)-4
46 y/o ♂

(b)(3)-1

(b)(6)-4

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric
	0400	↑ [illegible]	100	N/A.	Ø
	Total:				

Pertinent Lab Values
24MAR 0045
Na 144
K 4.4
Cl 111
Bun 29
Glu 231
Hct 35 Hgb 13

ATLS WORKUP SHEET

DA FORM 4700 274th FST OP 1

MEDCOM - 3736

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NO. (b)(6)-4
2 NAME (b)(6)-4
(b)(6)-4
3 GRADE: CIV
4 SEX: F
5 AGE:
6 RACE:
7 RELIGION: MUSLIM
8 LENGTH OF SVC: —
9 ETS: —
10 PREVIOUS ADMISSION: —
11 EMP: 99
12 SSN: (b)(6)-4
13 ORGANIZATION: —
14 WARD: PEDS
15 FLYING STATUS: —
16 RATING/OSG: —
17 DEPT/BEN: —
18 BRANCH/CORPS: —
19 UIC/ZIP:
20 TYPE CASE: INJ
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIR
22 HOUR OF ADMISSION: 1200
23 CLINIC SERVICE: AAAA
24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: (b)(6)-4
25 TYPE DISPOSITION: DOW
26 DATE OF DISPOSITION: 27may03
27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): NA
27b TELEPHONE NO:
28 DATE OF THIS ADMISSION: 27may03
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1, IRAQ
30 DATE OF INITIAL ADMISSION:
31 SELECTED ADMINISTRATIVE DATA
32 UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

ADMISSION REMARKS

ADMITTING OFFICER: MAJ (b)(6)-2

33 CAUSE OF INJURY

☐ Check if Continued on Reverse

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Open head Injury - 873.8
Severe Neurologic damage 781.99

Trauma	Inj
9	999

80065
E9919

35 Total Days This Facility

☐ Check if Continued on Reverse

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

36 Total Days All Facilities

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

SIGNATURE OF A (b)(6)-2 (b)(6)-2

HOSPITAL REPORT OF DEATH

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

NAME AND LOCATION OF HOSPITAL: (b)(3)-1

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

~~EPW~~ (b)(6)-4 COD # (b)(6)-4

(b)(6)-4

Patient's name (Last, first, middle initial), Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 1350 27 mar 03

3. MEDICAL EXAMINER/CORONER'S CASE: ☐ YES ☐ NO

4. RELIGION: UNK

5. CHAPLAIN NOTIFIED: ☒ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH: mother & Father ~~is~~ are patients at this Facility.

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Open head Injury	16 hours
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) Open head injury (exposed brain parenchyma)	16 hours
	(2) Severe neurologic damage	16 hours
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 29 mar 03

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)-2 MAJ, MC

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

DA FORM 3894, 1 OCT 72 — REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

*U.S. GPO: 1993-342-027/80481

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

Field	Entry
NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	Unknown Identified AS EPW # (b)(6)-4
GRADE Grade	CIV
BRANCH OF SERVICE Arme	IRAQ
SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale	(b)(6)-4
ORGANIZATION Organisation	IRAQ Civilian (b)(6)-4
NATION *(e.g., United States)* Pays	IRAQ
DATE OF BIRTH Date de naissance	Unknown
SEX Sexe	☐ MALE Masculin ☒ FEMALE Féminin

RACE Race		MARITAL STATUS État Civil		RELIGION Culte	
CAUCASOID Caucasique		X SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)* UNK
NEGROID Négroide		MARRIED Marié		CATHOLIC Catholique	
X OTHER (Specify) Autre *(Spécifier)*	IRAQ	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

Field	Entry
NAME OF NEXT OF KIN Nom du plus proche parent	~~Unknown~~ (b)(6)-4
RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit	Father
STREET ADDRESS Domicilié à (Rue)	
CITY OR TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)	

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	Open head Injury	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Open head injury (exposed brain parenchyma)	16 hours
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	Severe neurologic damage	16 hours
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	
NATURAL Mort naturelle	
ACCIDENT Mort accidentelle	X
SUICIDE Suicide	
HOMICIDE Homicide	

AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie

NAME OF ~~PATHOLOGIST~~ Physician Nom du pathologiste: (b)(6)-2 MAJ, MC

SIGNATURE: (b)(6)-2

DATE Date: 29 MAR 03

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures: Blast injury causing penetration of skull and exposure of brain.

AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☒ NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année): 1355 (local) 27 MAR 2003

PLACE OF DEATH Lieu de décès:

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci dessus.

Field	Entry
NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médicin sanitaire	(b)(6)-2
TITLE OR DEGREE Titre ou diplôme	MD
GRADE Grade	MAJ / O-4
INSTALLATION OR ADDRESS Installation ou adresse	(b)(3)-1 Iraq
DATE Date	29 MAR 03
SIGNATURE	(b)(6)-2

[1]State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.
[2]State conditions contributing to the death, but not related to the disease or condition causing death.
[1]Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
[2]Préciser la condition qui a contribué à la mort, mais ... aucun rapport avec la maladie ou à la condition qui a pro... la mort.

(b)(6)-4

Died here 27th March.

Father + mother also treated here, now in Nas. Gen. hospital. Three other child died on site.

The Guardian
The Observer

b-6-3

Correspondent

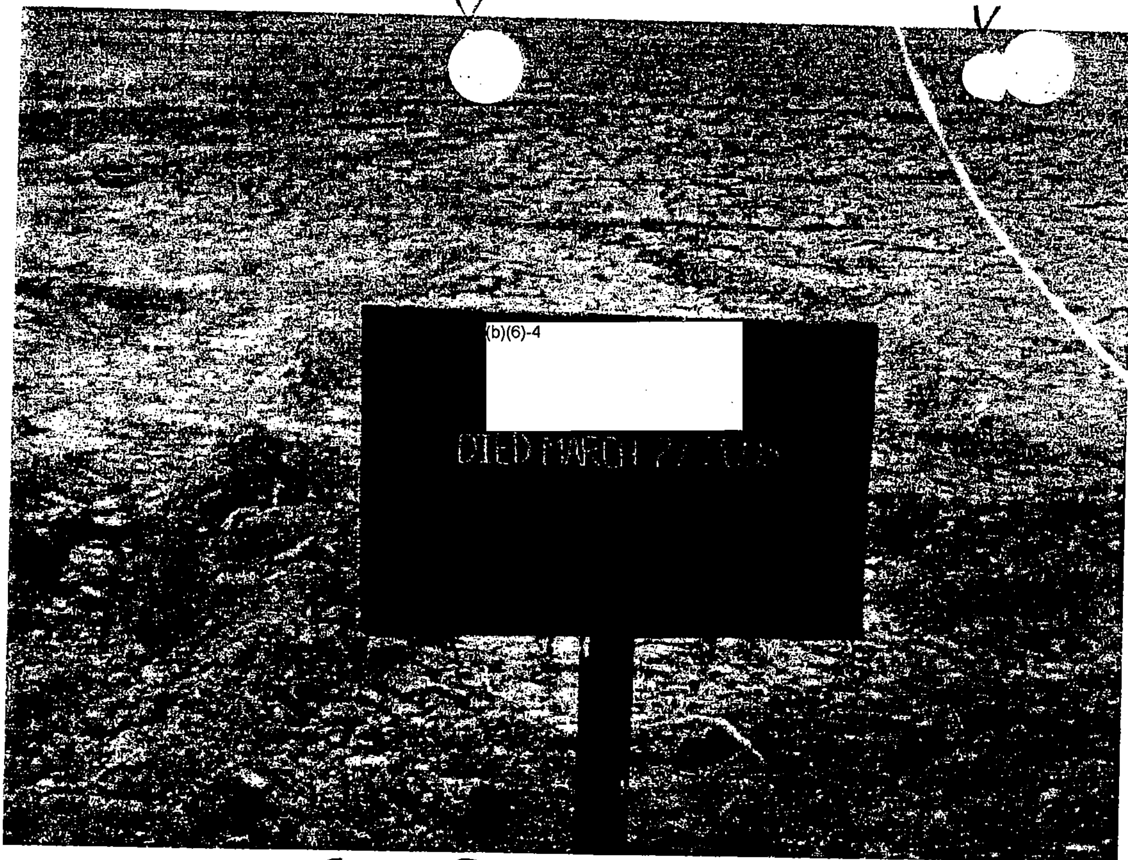
+ Steve Connors (photo).

119 Farringdon Road,
London EC1R 3ER,
Telephone: (+44)20727 (b)(6)-4
ed.vulliamy@guardian.co.uk

(REMOVE, RE... ...SE AND RE-INSERT CARBONS BEFORE COMP... NG THIS SIDE)

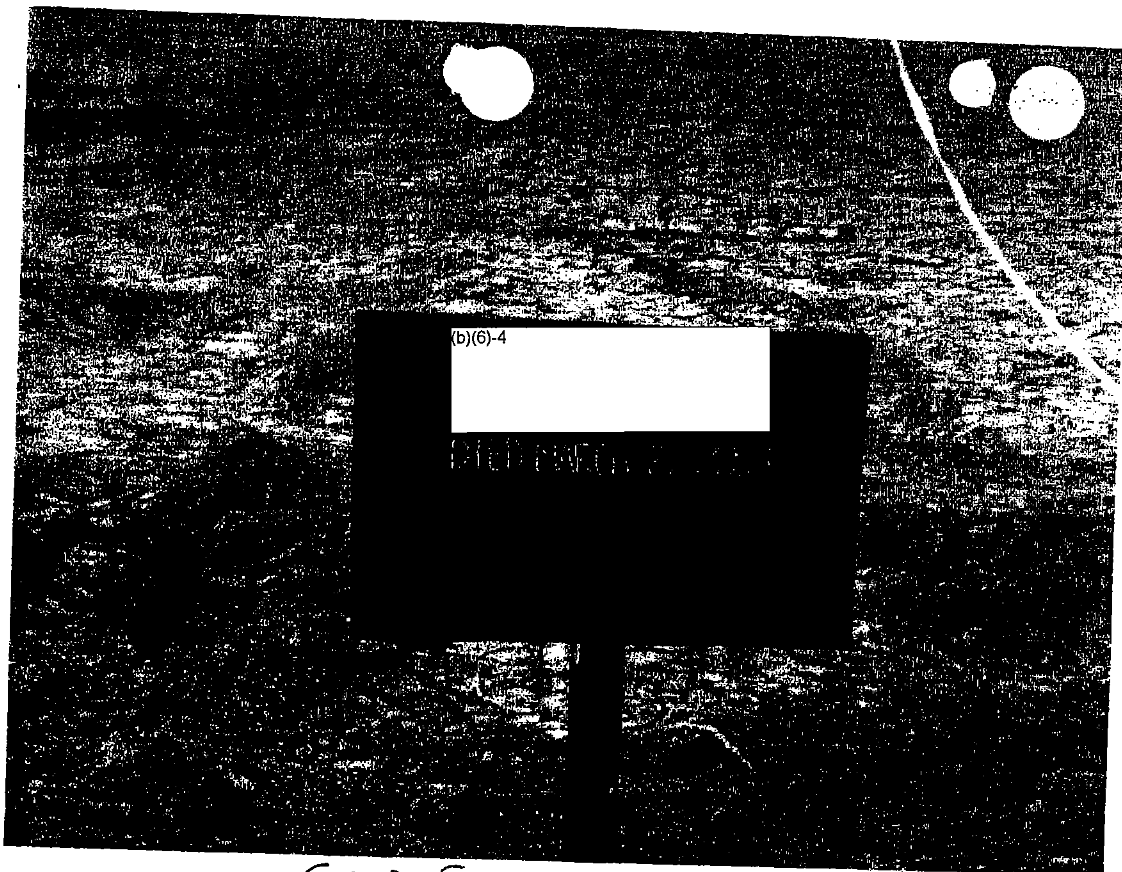
DISPOSITION OF REMAINS				
NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE		OTHER
INSTALLATION OR ADDRESS	DATE	SIGNATURE		
NAME OF CEMETERY OR CREMATORY GRID, Semos (b)(6)-4	LOCATION OF CEMETERY OR CREMATORY			
TYPE OF DISPOSITION ☐ BURIAL ☐ CREMATION ☐ REMOVAL *(Specify)*		DATE OF DISPOSITION		

REGISTRATION OF VITAL STATISTICS			
REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS		
SIGNATURE OF AUTHORIZED INDIVIDUAL			



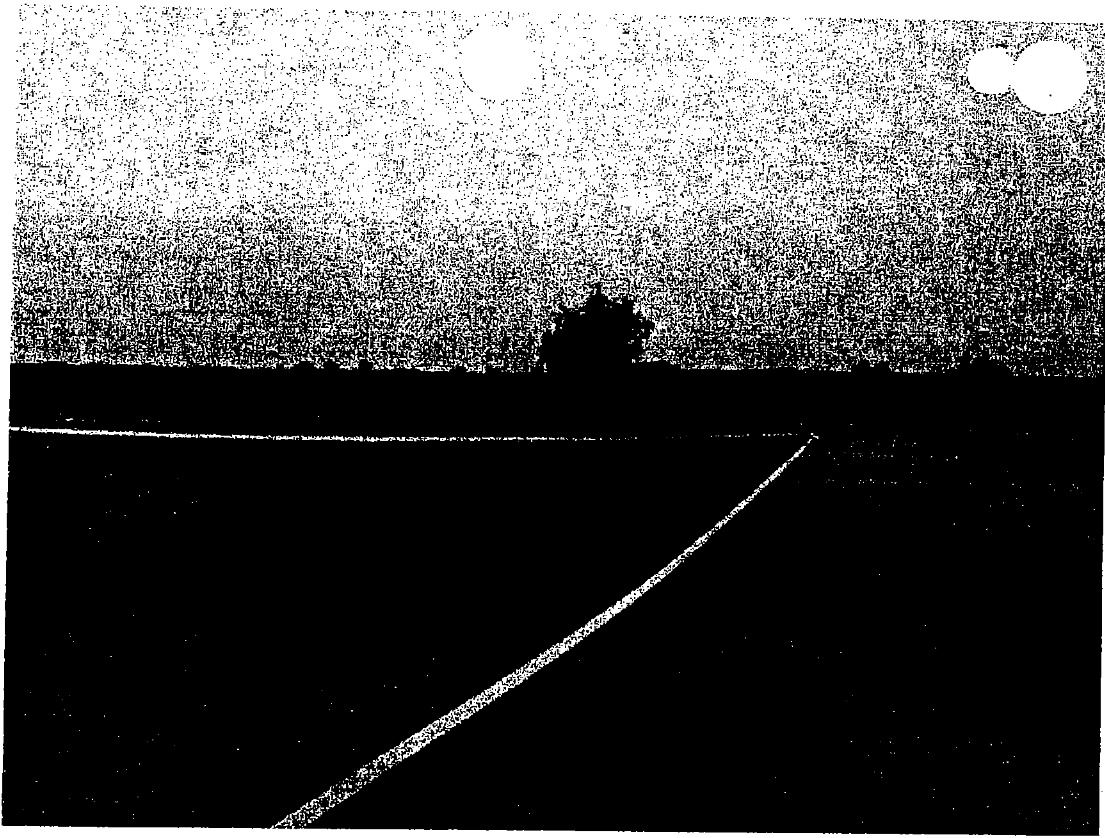
GRID Series

(b)(6)-4



GRID Series

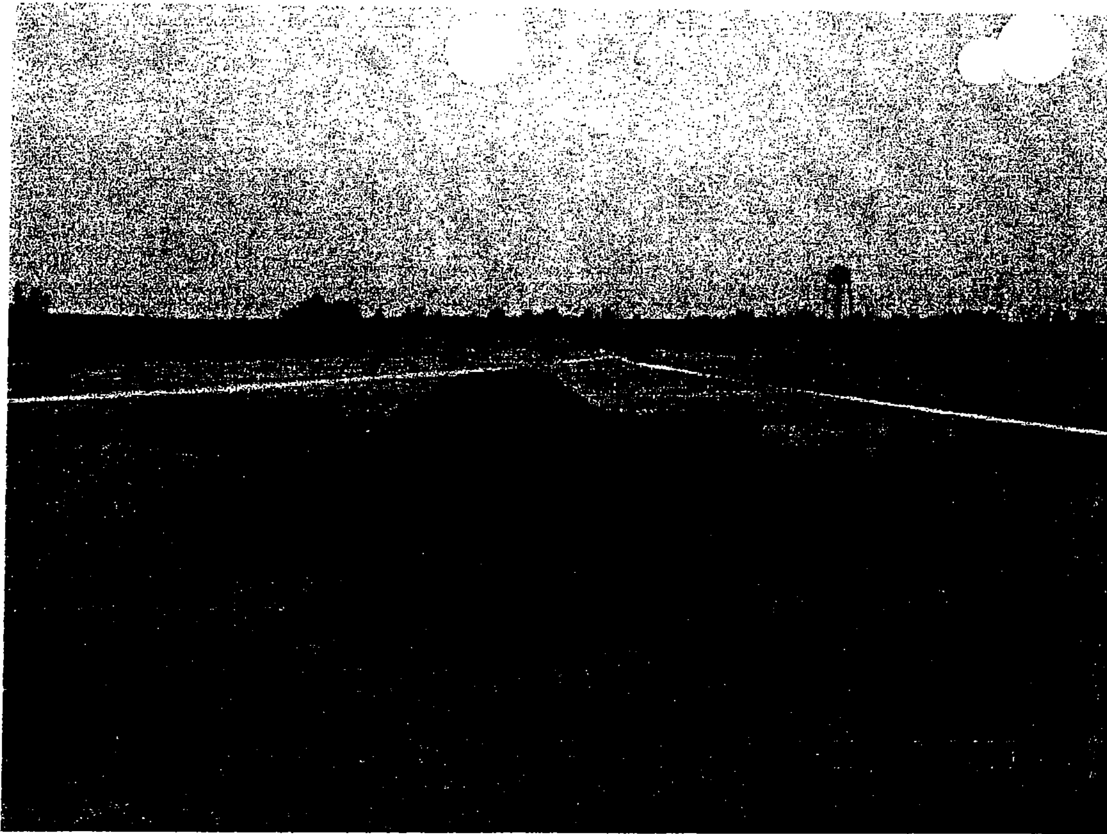
(b)(6)-4



(b)(6)-4

(b)(6)-4

EO# (b)(6)-4



(b)(6)-4

(father)

(b)(6)-4

(mother)

father

(b)(6)-4

mother

(b)(6)-4

For use of this form, see A... proponent agency is the Office of the Surgeon General

MEDICAL RECORD - SUPLEMENTAL ...L DATA

T-c

REPORT TITLE

TRAUMA FLOWSHEET
INITIAL ASSESSMENT

OTSG APROVED (Date)

☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 27 mar 03 Arrival Time: ______ Sex: M (F) Age: ______ Wt: 20 kilos

Allergies: ______

Tetanus Status: UTD Unknown

LMP: Last Meal:

Chief Complaint: OPEN HEAD INJURY

PMH:

Medications: MSO4 TIL MORE FOR PAIN

Treatments PTA:

VITAL SIGNS: BP: P: RR: TEMP: SAO_2:

CHEST
TRAUMA ☒ YES ☐ NO
PAIN ☐ YES ☒ NO
SOB ☒ YES ☐ NO
LUNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☒ NO R 2 mm L 2 mm
GLASCOW SCORE: ______

PUPIL SIZES: 2 (3) 4 5 6 7 8 9

GLASCOW COMA SCALE

1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

Pinpoint

EXTREMETIES
☐ DISTAL PULSES
☐ RT X 2 ☐ LT X 2
☐ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES

Deceased
B55 (local)

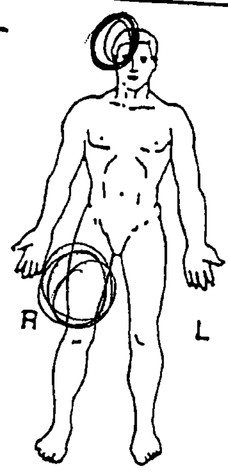
(b)(6)-2

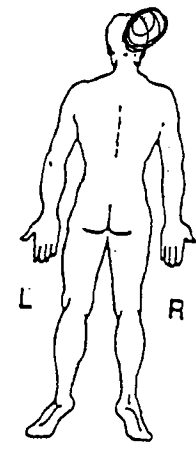
EXCEPTIONS TO ABOVE PARAMETERS:

MAJ, MC

SPLINTS:

TREATMENTS:
O2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: #
CHEST TUBE ☐ R ☐ L DPL ☐ POS ☐ NEG
CM H20





A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW- (#Sites)
L = Laceration
FW = Puncture Wound
S = Stab Wound
O = Other

BRAIN MATTER

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(3)-1

DATE 27 March 03

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

(b)(6)-4

OD
EPW (b)(6)-4
IRAQ CIV

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

..00, MAY 78

MEDCOM - 3748

IV SOLUTIONS/SITES

TIME	SITE/SIZE	IV FLUID/BLOOD	AMOUNT INFUSED	OUTPUT
				CHEST TUBE:
				EMESIS:
				NG TUBE:
				URINE:
				EBL:
				OTHER:

TOTAL IN:__________ OUTPUT:______

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT
1300		84	38		pupils pinpointed, non reactive
1315		120	40		Pupils Pinpointed NR-L – No reaction to Pain ful stimuly
1330		132	28		Pupils Pinpointed NR-L – NR To Painful Stimuli
1345		120	22		Pupils Pinpointed NR-L – NR To painful stimuli
1346		0	0		3 agonal Respirations Noted, ↑ 5 min No resp Noted

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA

OTHER:____________________

XRAYS:

MEDICATIONS

TIME	MED	DOSE	ROUTE	INITIALS

PROCEDURES/PROGRESS NOTES

Pt is a 4 yo female c̄ open head injury. Exam c̄ pinpoint pupils, not responsive to pain. ∅ posturing HR 140 RR 30. Continue as per prior plan c̄ pain management. (b)(6)-2 MD 5011.

12:50 ⊕ BS BILATERAL, ST - 140'S, ⊕ BS PINPOINT PUPILS, NOT AROUSABLE, DO NOT RESPOND TO PAIN STIMULI, CONTINUE TO MONITOR ———— [illegible]

~~1300~~

1350 · Ch (b)(6)-2 notified + Last rites given by chaplain (b)(6)-2

MEDICAL RECORD - SUPLEMENTAL ... AL DATA

For use of this form, see A... The proponent agency is the Office of the Surgeon General

REPORT TITLE

TRAUMA FLOWSHEET — OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 22 Mar 03 Arrival Time: ______ Sex: M (F) Age: ______ Wt: 20 kilos

Allergies: ______ Tetanus Status: UTD Unknown

LMP: ______ Last Meal: ______

Chief Complaint: Open Head Injury

PMH: ______

Treatments PTA: ______ Medications: MSO4 Titrate For Pain

VITAL SIGNS: BP: P: RR: TEMP: SAO2:

CHEST
TRAUMA ☐ YES ☑ NO
PAIN ☐ YES ☑ NO
SOB ☐ YES ☑ NO
LUNG SOUNDS
R L
☑ ☑ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☑ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☒ NO R 2 mm L 2 mm
GLASCOW SCORE: 5

PUPIL SIZES: (2) 3 4 5 6 7 8 9

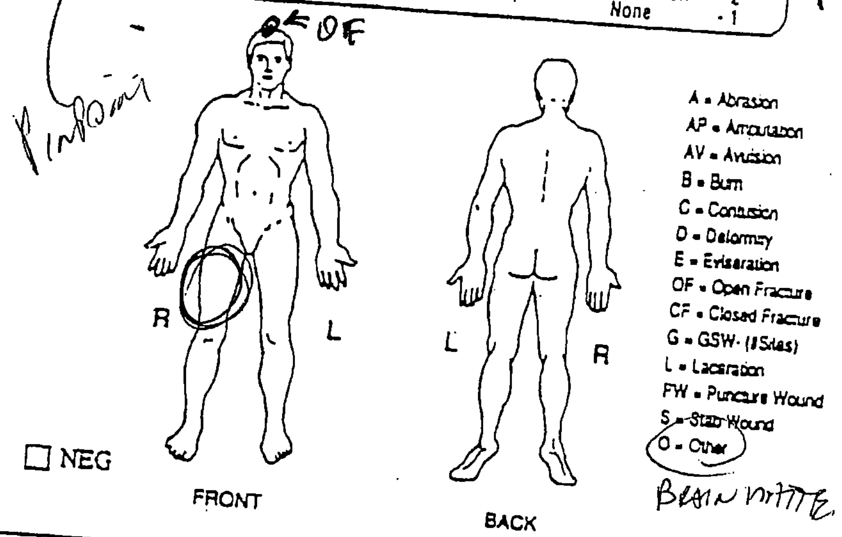
GLASCOW COMA SCALE
1. EYE OPENING: Spontaneous - 4; To Voice - 3; To Pain - 2; None - 1
2. VERBAL RESPONSE: Oriented - 5; Confused - 4; Inappropriate - 3; Incomprehensible - 2; None - 1
3. MOTOR RESPONSE: Obedient - 6; Purposeful - 5; Withdrawal - 4; Flexion - 3; Extension - 2; None - 1

Pinpoint

EXTREMETIES
☑ DISTAL PULSES
☐ RT X 2 ☑ LT X 2
☐ MOVES EXTREMETIES X 4
☐ NO EDEMA
☐ NO DEFORMITIES
EXCEPTIONS TO ABOVE PARAMETERS: Flexion

TREATMENTS: (b)(6)-2 — Expectant
O2: LPM NC
ETT # MM
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: #
CHEST TUBE ☐ R ☐ L

SPLINTS:
ORAL AIRWAY
NASAL AIRWAY
DPL ☐ POS ☐ NEG
CM H20



(Continue on reverse)

PREPARED BY (b)(6)-2 MAJ, MC

DEPARTMENT/SERVICE/CLINIC (b)(3)-1 — DATE

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

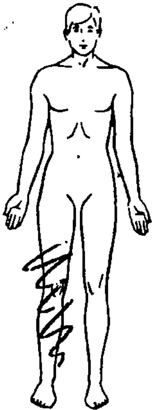
OD EPW (b)(6)-4

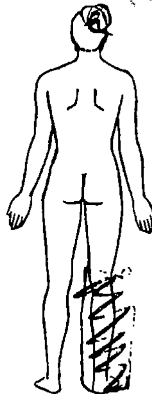
IRAQ CIV

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

OG. MAY 78

MEDCOM - 3750



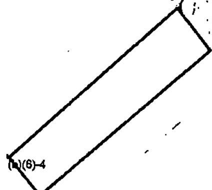


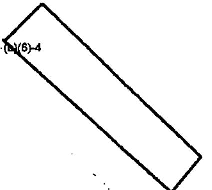
	1851	1920		
	/		/	/
Pulse	68	156		
Resp.	16	20		

(iv) Lactec Rngrs [time] ______ (im) ______ [time] ______

0 † 0

II II





[time] 1740 3/26/03

H 037118 -2-3

unknown age ♀ c̄

wound (R) parietal area / occipital

area c̄ open skull

brain matter, (R) LE injury

fixed to rt gaze 4mm - ↓ React

moving rt side, groans - not

following command in ?

purposeful movement ?

- IV access - injury ?

Rocephin 1gm

METTAG © 1983 JOURNAL OF CIVIL DEFENSE
P.O. BOX 910, STARKE, FLORIDA 32091, U.S.A.
1-800-425-5397
All Rights Reserved

1gm Rocephin IM thigh (1935)

0 †

II

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–7): (b)(6)-4

UNIT LOCATION (State or Country Code) (8): IZ

3. REGISTER NUMBER (9–15): (b)(6)-4

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

4. PAY GRADE (16, 17): — CIV

5. SEX (18): F

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 9 0 1 0 0 1

7. AGE AT ADMISSION (27–29): 0 4 Y

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION:

10. LENGTH OF SERVICE (32–34): —

ETS:

11. FMP (35, 36): 2 0

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only): - Iraq Civilian

13. MARITAL STATUS (46): S

HOUR OF ADMISSION: 1200

BRANCH / CORPS:

14. FLYING STATUS (47–49): —

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

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 0 0 0 0 0

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

18. MOS (64–70): —

19. TRAUMA (71): 9 inj

PREV. ADMISSION: YEAR ☐ NO

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

WARD: MORGUE

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: (b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 IRAQ

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73, 74): ~~41~~ ~~DOW~~ 30

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 200 3 0 3 2 7 1250

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

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 200 3 0 3 2 7

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

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

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

Dx: 8738 Open head Injury

78199 (c exposed brain parenchyma)

Trauma 9 Inj 999

Dx 80065

E 9919

Inj's 443 trauma 1

ADMITTING (b)(6)-2 (b)(6)-2 MAJ, MC

SIGNATURE (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 3752

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4	2. NAME (Last, First, MI) EPW# (b)(6)-4	3. GRADE
(b)(6)-4 Iraqi	7. RELIGION / 8. LENGTH OF SVC / 9. ETS	10. PREVIOUS ADMISSION: No
99 (b)(6)-4	13. ORGANIZATION	14. WARD: ICW2
RATING DSG / DEPT BEN	18. BRANCH/CORPS / 19. UIC/ZIP	20. TYPE CASE: INJ
ADMISSION AUTHORITY FOR ADMISSION: Direct	22. HOURS OF ADMISSION: 2300	23. CLINIC SERVICE: ABAA
NAME RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: Evac	26. DATE OF DISPOSITION: 4 Apr 03
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 27 Mar 03
(b)(3)-1		30. DATE OF INITIAL ADMISSION

ADMINISTRATIVE DATA

OPERATIONS AND SPECIAL PROCEDURES

open head wound 873

35. Total Days This Facility

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

36. Total Days All Facilities

a. SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD
LTC, MC
GENERAL SURGEON
MEDICAL OFFICER (b)(6)-2

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 75 IS OBSOLETE

MEDCOM - 3753

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

2. NAME (Last, First, MI): EPW # (b)(6)-4

3. GRADE

ADMISSION DATA

(b)(6)-4 RACE: Iraqi

7. RELIGION

8. LENGTH OF SVC

9. ETS

10. PREVIOUS ADMISSION: No

13. ORGANIZATION

14. WARD

SSN (b)(6)-4

99

RATING DSG

17. DEPT GEN

18. BRANCH/CORPS

19. UIC/ZIP

20. TYPE CASE: INJ

AUTHORITY FOR ADMISSION: Direct

22. HOURS OF ADMISSION: 2300

23. CLINIC SERVICE: ABAA

EMERGENCY ADDRESSEE

25. TYPE DISPOSITION: Evac

26. DATE OF DISPOSITION: 4 Apr 03

EMERGENCY ADDRESSEE (Include ZIP Code)

27b. TELEPHONE NO.

28. DATE OF THIS ADMISSION: 27 Mar 03

TREATMENT FACILITY (b)(3)-1

30. DATE OF INITIAL ADMISSION

OPERATIONS AND SPECIAL PROCEDURES

open head wound 873.8

Trauma 9 Inj 999

35. Total Days This Facility

OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
8	8			8

36. Total Days All Facilities

OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD
LTC, MC
GENERAL SURGEON

MEDICAL OFFICER (b)(6)-2

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 75 IS OBSOLETE

MEDCOM - 3754

JTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 mar 03	lac to (R) eyebrow Dsd dressing. swelling and
	bruising under and over eye. Abrasion ~~lac~~ to (R) flank, small red
	Ring 1/2 cm - Ø c/o N/V. (b)(6)-2 91WM620
	Tetanus Tox 0.5cc IM
	(b)(6)-2
28 MAR 03	28 MAR 03 / 0750
1600	HR: 90BPM R: T: 98.8 BP: 100/61
	Dressing Δ'ed to (R) eyebrow and (R) flank. 0.5cc Tetanus
	given (R) buttock IM. Ø c/o pain. (b)(6)-2 91WM62
28 MAR 03	Motrin 400 mg PO q 6° prn HA/pain
	(b)(6)-2
1940	400 mg Motrin given for headache. (b)(6)-2 91WM6
29 MAR 03	
0615	T: 97.9 oral 81/43 P87
0730	Pt rested throughout night. No complaints of pain after
	Tylenol given. Dressing changed over the eye to make
	smaller and more comfortable. Only complaint is new
	drsg "oily". Gave report on pt. (b)(6)-2 [illegible]
0820	received report. will continue to monitor. (b)(6)-2 91WM620
	1340 BP 98/49 P: 85 T: 98.7 Ø c/o pain (b)(6)-2

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

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

REGISTER NO.	WARD NO.

EPN (b)(6)-4
Civilian female.

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)*
29MAR03	(1900) - pt. ate dinner and snacks throughout day.
	(b)(6)-2 91WM6
30MAR03	0633 pt rested throughout night, is resting now, no
	signs of pain or distress. (b)(6)-2 91WM6
0730.	report received. pt. eating rice and fruit. ø c/o pain.
0940	- c/o pain under Ⓡ eye. 400mg motrin given. dressing
	Δ^ed to eye and back. (1600) ø c/o pain. eating
	dinner (1750) R: 24 T: 98.4 P: 73 SPO2 98.
pt	pulled scab under Ⓡ eye. ø c/o pain at this
	time.
31MAR03	T: 97.9 Oral R: 20 SPO2: 98 P: 74 pt rested throughout
	night w/ no c/o pain. interacted with other females
	and children in room.
31Mar03	Pt. said she had slight pain
	Gave 400mg of Motrin (oral suspension)
	(b)(6)-2 91WM6
~~31Mar03~~	~~[illegible]~~
	~~Pt. displays distress when [illegible]~~ (b)(6)-2
	~~medical equipment~~ (b)(6)-2 91WM6
31.MAR03 2000	No sign of Distress. Chatting and playing with her sister
	SPC (b)(6)-2 91WM6
0745	Pt. eating veggies & Rice, chicken & tomoato (0830)
01APR03	small amount of pain above Ⓡ eye. 400mg motrin given
	PO. will continue to monitor (1230) bandage Δ on
	Ⓡ eye. ø c/o pain at this time.
1Apr03	T 99.5 BP 115/57 P 91 No c/o pain (b)(6)-2
	No c/o temperature (b)(6)-2
02APR03	(0600) pt. awake, ø c/o pain eating. 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 3756

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
03 APR03	(0350) pt rested well through night. Removed drsg from
	over the eye. No signs of infection. ∅ C/o pain through
	shift. (b)(6)-2 ELWMC
03 Apr. 03	Pt assessment c̄ no change. Laceration to OD healing well
0650Z	open to air ∅ signs of infection or irritation (b)(6)-2
	noted. Plan for D/C home today (b)(6)-2
4 APR03 0250Z	slept throughout night, ∅ c/o Pain - laceration to above the eye noted s̄ (b)(6)-2 MAJ
	drainage or infection (b)(6)-2 1LWMSH

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.

4

OD (b)(6)-4

PROGRESS NOTES
Medical Record

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

T-01

CAL RECORD - SUPLEMENTAL M...IC. ...IA

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

REPORT TITLE: TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 27 mar Arrival Time: 1300 Sex: M F Age: 30 yr Wt:

Allergies: NKDA

Tetanus Status: UTD Unknown

LMP: Last Meal:

Chief Complaint: lacs / abrasions

PMH:

Medications:

Treatments PTA:

VITAL SIGNS: BP: P: RR: TEMP: SAO₂:

CHEST
TRAUMA ☑ YES ☑ NO
PAIN ☑ YES ☐ NO
SOB ☐ YES ☑ NO
LUNG SOUNDS
R L
☑ ☑ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☑ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☑ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☑ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☑ YES ☐ NO R____mm L____mm
GLASCOW SCORE: 15

PUPIL SIZES: 2 3 4 5 6 7 8 9

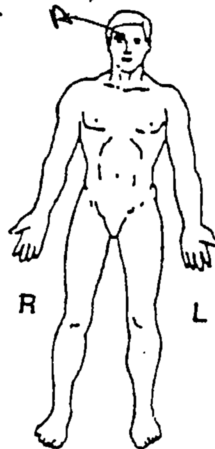
GLASCOW COMA SCALE

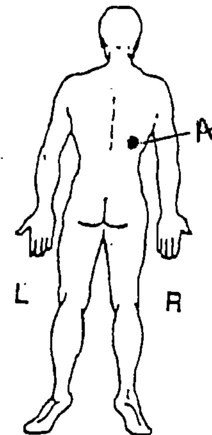
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

EXTREMETIES
☑ DISTAL PULSES
☑ RT X 2 ☑ LT X 2
☑ MOVES EXTREMETIES X 4
☑ NO EDEMA
☑ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS:

SPLINTS:





A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW- (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

TREATMENTS:
O2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: #
CHEST TUBE ☐ R ☐ L
DPL ☐ POS ☐ NEG
CM H20

PREPARED BY (b)(6)-2 MD (b)(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(3)-1

DATE

(Continue on reverse)

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

EPW (b)(6)-4
civilian

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — (b)(6)-4
2. MTF LOCATION (State or Country Code.): 7 8

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4

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

4. PAY GRADE: 16 17
5. SEX: 18

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

10. LENGTH OF SERVICE: 32 33 34
ETS
11. FMP: 35 36 — 9 9
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS: 46
HOUR OF ADMISSION: 2300
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 — INJ
PREV. ADMISSION: YEAR — NO [X]

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — D
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — EVAC
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 0 4

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B A A
25. MTF TRANSFERRED FROM: 93 94 95 96 97 98
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 3 2 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108
28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

open head wound

ADMI (b)(6)-2, MD (as required) (b)(6)-2
LTC, MC
GENERAL SURGEON

(b)(6)-2

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

MEDCOM - 3759

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP
123	124	125	126	127
1	3	4	N	

33. RESIDUAL DISABILITY		
128	129	130

34. DO NOT USE - DATA FILLER #1								
131	132	133	134	135	136	137	138	139

35. CAUSE OF INJURY		
140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
143	144	145	146	147	148	149	150
		8	7	3			

37. SECOND DIAGNOSIS							
151	152	153	154	155	156	157	158

38. THIRD DIAGNOSIS							
159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS							
167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS							
175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS							
183	184	185	186	187	188	189	190

SEVENTH DIAGNOSIS							
.91	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS							
199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*							
207	208	209	210	211	212	213	214

45. SECOND PROCEDURE							
215	216	217	218	219	220	221	222

46. THIRD PROCEDURE							
223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE							
231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE							
239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE							
247	248	249	250	251	252	253	254

SEVENTH PROCEDURE							
	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE							
263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES	
271	272
ϕ	[illegible]

53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES	
273	274
0	0

54. PRIMARY PROVIDER SPECIALTY CODE		
275	276	277

55. BLOOD USAGE Y / N
278

ADMISSION AND CODING INFORMATION

For use of this form, see ...

1. REPORTING MTF (1 2 3 4 5 6): (b)(6)-4

2. MTF LOCATION (7 8) (State or Country Code.): I Z

3. REGISTER NUMBER (9 10 11 12 13 14 15): (b)(6)-4

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

4. PAY GRADE (16 17): — F

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 9 Ø Ø 1 Ø 1

7. AGE AT ADMISSION (27 28 29): 1 3 4

8. RACE (30): X Iraqi

9. ETHNIC BACKGROUND (31): 9

RELIGION

10. LENGTH OF SERVICE (32 33 34): —

ETS

11. FMP (35 36): 2 Ø

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46): S

HOUR OF ADMISSION: 2300

BRANCH / CORPS

14. FLYING STATUS (47 48 49): —

15. BENEFICIARY CATEGORY (50 51 52): K 7 8

16. ZIP CODE OF RESIDENCE (53–61): Ø 9 3 3 Ø Ø Ø Ø Ø

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

18. MOS (64–70): —

19. TRAUMA (71): 9 INJ

PREV. ADMISSION: YEAR ☐ NO ☒

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND (b)(3)-1

21. TYPE OF DISPOSITION (73 74): 22

22. MTF TRANSFERRED TO (75–80): (b)(3)-1

23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 2 Ø Ø 3 Ø 4 Ø 4

24. CLINIC SVC - ADMITTING (89 90 91 92): A B A A

25. MTF TRANSFERRED FROM (93–98):

26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 2 Ø Ø 3 Ø 3 2 7

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

28. MTF OF INITIAL ADMISSION (109–114):

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122):

FOR LOCAL USE

open head wound Dx: ~~8738~~ Trauma 9 Inj 989

Dx 8730
E9289

ADM (b)(6)-2 MD (if required) (b)(6)-2

LTC, MC
GENERAL SURGEON

(b)(6)-2

DA FORM 2985, MAR 2000 MEDCOM - 3761 USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
(b)(6)-4	
2. NAME (b)(6)-4 , MI)	EPW
3. GRADE	
AGE	99
RACE	Iraqi
7. RELIGION	
LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	No
13. ORGANIZATION	
14. WARD	ICW3
(b)(6)-4	
RATING PSG	
BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	INJ
ADMISSION AUTHORITY FOR ADMISSION	
22. HOURS OF ADMISSION	2000
23. CLINIC SERVICE	ABAA
EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Evac
26. DATE OF DISPOSITION	2Apr03
EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO	
28. DATE OF THIS ADMISSION	29Mar03
MEDICAL TREATMENT FACILITY	(b)(3)-1 , IRAQ
30. DATE OF INITIAL ADMISSION	

OPERATIONS AND SPECIAL PROCEDURES

L TIB/FX /Cast Post 823.
Schrapnel Injury E991 L 93.53
Back 876.0

35. Total Days This Facility

a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
4	4			4

36. Total Days All Facilites

a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

ATTENDING MEDICAL OFFICER: (b)(6)-2 MD
LTC, MC
GENERAL SURGEON

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: (b)(6)-2

DA FORM 3647, MAY 79 (b)(6)-2 mh (b)(6)-2 EDITION OF 1 A...

MEDCOM - 3762

INPATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
Number	(b)(6)-4
2. NAME (MI)	EPW (b)(6)-4
3. GRADE	
Race	Iraqi
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	No
13. ORGANIZATION	
14. WARD	ICW3
	99 (b)(6)-4
BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	INJ
EEN	
ADMISSION AUTHORITY FOR ADMISSION	
22. HOURS OF ADMISSION	2000
23. CLINIC SERVICE	ABAA
EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Evac
26. DATE OF DISPOSITION	2 Apr 03
EMERGENCY ADDRESSEE (Include ZIP Code)	
27b TELEPHONE NO	
28. DATE OF THIS ADMISSION	29 Mar 03
30 DATE OF INITIAL ADMISSION	
Facility	(b)(3)-1 / IRAQ

OPERATIONS AND SPECIAL PROCEDURES

L TIB/FX /Cast Post 823.

Schrapnel Injury E991 L 93.53

Back 876.0

35 Total Days This Facility

a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS
4	4			4

36 Total Days All Facilites

a.	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS

(b)(6)-2 MD
LTC, [illegible]
GENERAL SURGEON

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

DA FORM 3647, MAY 79 (b)(6)-2 EDITION (b)(6)-2

558-104 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY
RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW
CITY | STATE | ZIP CODE

ARRIVAL
DATE (Day, Month, Year): 3 Apr 03 | TIME: 0820
TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE	
AREA CODE	NUMBER

AGE

HOME PHONE	
AREA CODE	NUMBER

MILITARY STATUS ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO
IS THIS AN INJURY?		
INJURY/SAFETY FORMS		

WHEN (Date)
WHERE
HOW

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

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

CHIEF COMPLAINT: Shrapnel wounds to back

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 0825
INITIALS

VITAL SIGNS

TIME	0826				
BP	115/73				
PULSE	100				
RESP	24				
TEMP	98.7				
~~WT~~ SpO_2	100%				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0825	IV LR		(b)(6)-2	0825	18g @ AC
	Foley		(b)(6)-2	0835	

DISPOSITION
☐ HOME ☐ FULL DUTY
MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY
☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS
RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE
☐ IMPROVED ☒ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE: ICU 3
TIME OF RELEASE: 0850

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 II (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)

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						
	H/H		SUP O2	PH	PO2	RESULTS	
	PLT		PCO2	SAT	OTHER		
PT			U/A DIP			EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	U/A MICRO			

PROVIDER HISTORY/PHYSICAL

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[signature]
JEFFREY HERMANN MD
MAJ, USA, MC
DEPT OF OB/GYN

DIAGNOSIS
Schrapnel injury to the back

CODES

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

EPW # 44

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)

CLINICAL RECORD	THE... ...UTIC DOCUMENTATION CARE PLAN (N...-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. April Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				03	04												
03	(b)(6)-2	IVF NS / (LR) / D5NS D5 1/2NS To run	07	[illegible]	X	} D/C 03 April 03 (b)(6)-2											
		@ 125 cc/hr	19	X	X												
		Ancef 1 GM IV q 8 HRs															
		Gentamycin IV Q															
		Cefoxitin 2 gm IV q 8hrs															
		02 titrate to keep SPO2 >	07														
			19														
		Versed gtt 1-10mg/hr titrate to Ramsey	07														
		scale of	19														
		Fentanyl gtt start at 50mcg/hr titrate for	07														
		adequate pain control MAX Dose of	19														
		Vecuronium 1mcg/kg/min	07														
			19														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Scharapnel injury to the back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

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

Treatment Facility: (b)(3)-1

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	Mo April Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
03	(b)(6)-2	Ancef 1 gm IV x 1 now	03	9:30	9:30	(b)(6)-2
03		Td 0.5 mg IM x 1 now	03	10:10	10:11	
03		tetanus Immunoglobulin 250 units	03	10:00	10:11	
	-----	IM x 1 now				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
03	(b)(6)-2	Morphine Sulfate 2-4 mg IV q 1 hr PRN pain	
-----	-----	Phenergan 12.5-25mg IV q 4-6 hrs prn N/V	
-----	-----	MOM 30cc PRN Gastric Upset	
-----	-----	NS / LR bolus X ____ liters	
03	(b)(6)-2	Motrin 800 mg 1 po q8° prn pain	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

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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. April Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 03	04
03 April		VS Q 8 hrs	07	(b)(6)-2	
			19		
03		Diet: Regular when XR's cleared	07	(b)(6)-2	
			19		
03		Strict BR c̄ restrains	07	(b)(6)-2	
			19		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Schrapnel injury to the back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPN # (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.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)	Mo April	Yr 03		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
03	(b)(6)-2	Admit to ICU #3	03	09:00	09:00	(b)(6)-2
03		Dgn: Shrapnel injury to the back.	03			
03		Condition: Stable	03			
03		Allergies: NKDA				

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

★ U.S. GPO:1997-418-290/55267

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03 1148 APR03

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (b)(6)-4 (b)(6)-4
2. SSN trauma # (b)(6)-4
3a. STATUS Iraqi EPW
3b. SERVICE
4. PRECEDENCE U P R — X (R)
5. GRADE
6. AGE 32
7. SEX [X] Male [ ] Female
8. WEIGHT
9. BLOOD TYPE
10. CLASSIFICATION (1A-5F) [X] AMBULATORY [ ] LITTER
11. ACCEPTING PHYSICIAN
12. CITE/AUTHORITY NO. 2001769
13. APPT/SURG DATE
14a. ORIGINATING FACILITY (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER FCC #3
15a. DESTINATION FACILITY (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER
16. NUMBER OF ATTENDANTS
16a. MEDICAL Ø
16b. NON MED Security (b)(6)-2

17. DIAGNOSIS

1) Schrapnel penetrating trauma to the back

18. [X] BATTLE CASUALTY [ ] DISEASE [ ] NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.		X	AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.		X	CARRIER(?)	j.		X	SELF-CARE	o.		X	OTHER

20. PHYSICIANS ORDERS

20a. DATE 3APR03
20b. TIME 1010
20c. ALLERGIES NKA
20d. DIET [X] REG [ ] SODIUM NA [ ] CARDIAC [ ] DIABETIC ____ CALS
RENAL ____ Gm prot ____ Gm Na ____ Mleq K ____ mg PO4
TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ____ [ ] OTHER (Specify) ____
TPN: Change to D10 at ____ cc/hr for max of ____ days
TUBE FEEDING ____ at ____ strength at ____ cc/hr
20e. IV/BLOOD
20f. SPECIAL EQUIPMENT

[ ]	SUCTION	[ ]	TRACTION	[ ]	ORTHOPEDIC BRACES
[ ]	NG TUBE	[ ]	IV PUMP	[ ]	CHEST TUBE/HEIMLICH
[ ]	STRYKER FRAME	[ ]	TRACH	[ ]	RESTRAINTS
[ ]	INCUBATOR	[ ]	MONITOR	[ ]	OTHER (Explain in 23)
		[X]	FOLEY		

O2: LITERS: ROUTE:
[ ] VENTILATOR SETTINGS
20g. ALTITUDE RESTRICTION:
20h. RECORDS TO ACCOMPANY PATIENT

[ ]	OUTPATIENT RECORDS	[ ]	X-RAYS	[ ]	FINANCIAL
[X]	INPATIENT RECORDS	[ ]	OB RECORDS	[ ]	OTHER (Specify)
[ ]	NARRATIVE SUMMARY	[ ]	DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS

MSO4 2-4mg Q2° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE	21d. RESP	21e. BP

22. BRIEF NARRATIVE

32 y/o ♂ Iraqi EPW sustained a schrapnel injury on 02 April 03 to the back in a fight with helicopters. Arrived H-D stable.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

24. (b)(6)-2 PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)
1 2 3 4 5 6: (b)(6)-4	7 8: I Z

3. REGISTER NUMBER (9–15): (b)(6)-4

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

4. PAY GRADE (16 17): —

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 7 1 0 1 0 1

7. AGE AT ADMISSION (27–29): 3 2 Y

8. RACE (30): X Iraqi

9. ETHNIC BACKGROUND (31): 9

RELIGION

10. LENGTH OF SERVICE (32 33 34): —

ETS

11. FMP (35 36): 2 0 EPW

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 2000

BRANCH / CORPS

14. FLYING STATUS (47 48 49): —

15. BENEFICIARY CATEGORY (50 51 52): K 78 K 98

16. ZIP CODE OF RESIDENCE (53–61): Ø 9 3 3 Ø Ø Ø Ø Ø

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

18. MOS (64–70): —

19. TRAUMA (71): 9 inj

PREV. ADMISSION — YEAR — NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 IRAQ

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

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

22. MTF TRANSFERRED TO (75–80): (b)(3)-1

23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 2 Ø Ø 3 Ø 4 Ø 2

CLINIC SVC - ADMITTING (89–92): 1 B A A

25. MTF TRANSFERRED FROM (93–98)

26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 2 Ø Ø 3 Ø 3 2 7

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

28. MTF OF INITIAL ADMISSION (109–114)

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122)

FOR LOCAL USE

Dx: 82380 L TIB FX / Cast Post

8760

Pr: 9353

Trauma 9 Ø

Inj 459

ADMITTING OFFICER: (b)(6)-2 MD
LTC, MC
GENERAL SURGEON

(b)(6)-2

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(b)(6)-2

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ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(6)-4
2. LOCATION (State or Country Code.)
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): EPW (b)(6)-4
4. PAY GRADE
5. SEX
6. DATE OF BIRTH (Y Y Y Y M M D D)
7. AGE AT ADMISSION
8. RACE: Iraqi
9. ETHNIC BACKGROUND
RELIGION
10. LENGTH OF SERVICE
ETS
11. FMP: 99
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS
HOUR OF ADMISSION: 2000
BRANCH / CORPS
14. FLYING STATUS
15. BENEFICIARY CATEGORY
16. ZIP CODE OF RESIDENCE
17. UNIT LOCATION (State or Country Code)
18. MOS
19. TRAUMA
PREV. ADMISSION YEAR / NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: D
WARD: ICW3
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: EVAC
22. MTF TRANSFERRED TO
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030402
24. CLINIC SVC - ADMITTING: ABAA
25. MTF TRANSFERRED FROM
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030327
27. LOCATION OF OCCURRENCE (Battle Casualty Only)
28. MTF OF INITIAL ADMISSION
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)

FOR LOCAL USE

L TIB FX / Cast Post

ADMITTING OF(b)(6)-2 MD
LTC, MC
GENERAL SURGEON

(b)(6)-2

DA FORM 2985, MAR 2000 (b)(6)-2 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

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