[IN]PATIENT TREATMENT RECORD COV[ER SHEET]

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

Field	Entry
1. REGISTER NUMBER	(b)(6)-2
2.	(b)(6)-2
3. GRADE	
4. SEX	M
5. AGE	
6. RACE	Iraqi
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	
11. FMP	99
12. SSN	(b)(6)-2
13. ORGANIZATION	
14. WARD	ICU 1
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	2100
23. CLINIC SERVICE	HBAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Trans
26. DATE OF DISPOSITION	30 apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	10 apr 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
30. DATE OF INITIAL 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 L Thigh, L Back

DX: 8761
8901
86804
82032
56400
E9659

PX: 5411
8622
7965

Trauma 1

Surgery 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
					21

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 (b)(6)-2

SIGNATURE (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4043

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	9 Apr 03 SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
#1 BP 102/80	S - EPW PT #B 4th presents c̄ 2 small caliber entry
#2 BP 15:53 96/64	wounds. 1 upper, outer Ⓛ hip. 1 lumbar
T: 96.4	spine Ⓛ side. 36 y/o ♂ in NAD, Lungs - CTA, Abd Soft, NT
P 84	O - 1 small, circular entry wound upper, outer Ⓛ
R 17	hip. Spontaneous blood oozing c̄ manipulation, not
#3 B/P 103/50	bright red. NVI distal
92/70 1640	1 small, circular entry wound, near midline Ⓛ
98/76 1650	side lumbar spine, dark oozing/draining blood
	upon dressing manipulation
Came in field	XRays of hip show no metallic FB noted AP/lat
c̄ 500ml NS	XRay Abd show (AP) show metallic FB lumbar level
orders:	lateral unable to decerne level), DRE - Ø Frank blood
- 1L NS drip	A - Multiple GSW
1600 - 1L NS Bolus	P - 1) Consult surgery
Per Surgeon	2) will have exploratory lap to r/o internal bleed
1700	3) Post op protocols (b)(6)-2
	(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

MEDCOM - 4044

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Apr 03	EPW c̄ GSW (L) low back and (L) lat thigh (entry) Fragments in pelvis area on AP (let mobilizable) pelvis. Projectile also seen (L) of spine c/o low back, thigh pain originally then developed worsening abd pain. Pressures had been 120's systolic on arrival then down to 70's - 80's c̄ ↑ confusion. Responded to ↑ IVF.
	HEENT - NP/OP clear PERRLA
	[illegible] (R) ear.
	neck NT/nl ROM
	Chest CTA (B) S1S2 [illegible] AT [illegible]
	Abd - S/obese/tender low abd / + BS
	Bil fem PT/DP pulses palp Rectal nl tone (-) blood
	(L) back c̄ GSW c̄ mild bleeding
	[illegible] midline NT
	(B) LE c̄ intact sensation 5/5 EHL/DF/PF
KUB 25 stone	(L) lat thigh c̄ [illegible] + GSW laterally [illegible] act bleeding
	Imp - hemodynamic lability + potential for intraabdominal injury
	Plan - Will explore in OR
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) **BACK**

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

MEDCOM - 4045

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 April 03	EPW #3/C was brought in from OR to ICU
19:02	at 1902 vitals are B/P 123/59
NKDA	P. 83
WT 100 Kg	R 23
	SPO2 97
	T 98
1902	IV Fluids LR in (L) AC x 2 Liters PT disoriented, lethargic, UA output 1050ml
	IV Fluids SC (R) AC x 1 Liter. O2 6% via Concentrator, (b)(6)-2 Sgt 91WM6/LPN
1910	Given Demerol 25mg IVP/MAJ (b)(6)-2 (b)(6)-2 Sgt 91WM6/LPN
1920	BP 102/52 HR 83 R 22 Temp 98°F SPO2 (b)(6)-2 Sgt 91WM6/LPN
1935	BP 96/57 HR 82 R 22 Temp 98 SPO2 100% 6% O2 via Concentrator (b)(6)-2 Sgt 91WM6
1950	BP 102/52 HR 83 R 22 T SPO2 100% [illegible] 91W20 2005 BP 123/59 HR 83 T 98°F SPO2 88% [illegible]
9 April 03	To RR → hold — (b)(3)-1
	s/p ex lap wound debridement
	Stable VS q2' I's/O's foley to gravity
	NPO
	IVF LR @ 125cc/hr
	MSO4 - 1-2 mg MSO4 IV q 1°
	Call for HR >110 BP <90 sys, UOP <30cc/hr
	(b)(6)-2 (b)(3)-1

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

MEDCOM - 4046

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Apr 2003	Op note
	Preop – GSW back / L thigh possible intraabdominal injury
	Postop – GSW back / L thigh & intraabdominal injury
	Surgeon – (b)(6)-2 Procedure – ex lap
	Asst – (b)(6)-2 debridement of
	Anest – General back + (L) thigh wounds.
	Indications – hemodynamic lability, worsening abdominal exam
	Findings (L) retroperitoneal hematoma, soft, nonexpanding w/ SB/colon, & intraabdominal (peritoneal) injury
	EBL – min
	Compl – Ø
	Details – Under Gen anesthesia, prepped + draped sterilely. Opened abd through midline incision. Exploration c findings as above. Irrigated + closed midline fascia c #1 looped PDS. Wound divided c staples + packed.
	– explored (L) lat thigh wound minimal debridement required as min. nonviable tissue identified packed
	– back wound similarly explored + pack minimal debridement required.
	Disp – recover + Tx. Would still want to procto and consider IVP though urine is clear

(b)(6)-2

STANDARD

MEDCOM - 4047

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Apr03	
2055	Given MSO 2mg IVP / [redacted] (b)(6)-2 56T 91W20
2055	BP 96/61 HR 92 R 29 Temp 96°F SPO2 95% (b)(6)-2 56T 91W20
2100	Urine 200cc Empty [redacted] 56T 91W20
2110	Given MSO 3mg IVP / DC IV Ⓡ arm (b)(6)-2 56T 91W20
2205Z	B/P: 110/76 T: 96 R: 20 SpO2: 99 P: 87. Pt on O2 15Lpm
	pt resting quietly. (b)(6)-2 - 91W20/56T
2342	Morphine Sulphate 2mg IV slow push for pain, - LTC (b)(6)-2 RN
0055:	Vitals - P: 78 T: 98 R: 22 BP: 118/68 SpO2: 99% (b)(6)-2
0148	Patient awakens periodically, but then readily returns to sleep.
	Abd dressing - dry & intact. Oxygen Concentrator c̄ humidifier continues
	at 4lpm, SpO2 = 99%. - LTC (b)(6)-2
02:36	B/P 116/72, pulse 84 reg, SpO2 97 (4lpm O2), resp 16.
	- LTC (b)(6)-2 RN
0324Z	Pt. IV clogged. New tubing & stopcock added.
	IV flowed as normal. 650 mL clean yellow
	urine drained from foley. - SPC (b)(6)-2 91W10
10 Apr 2003	Surgery
	Doing well ō c/o. Pain controlled
	VSS overnight UOP good
	Abd - st no approximately tender ABD dressing intact
	Back/thigh wounds stable - ⒷLE Ⓟ DP/PT pulses good
	A/P ① still needs proto p̄ fx movement
	② Wound changes today or tomorrow (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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

MEDCOM - 4048

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 APR 03			T-99.4 BP 118/71 P-82 R-18 SaO_2 96% on R/A.
0800			Pt admitted to ICU #3 from EMT s/p ex lap, +
			GSW (L) thigh + (L) back. Pt drowsy but wakes
			easily + follows commands. Dressings to ABD and
			(L) thigh clean, dry + intact. Dressing to back
			intact c small amt serosanguinous drainage.
			Pt in no distress and moves all extremities. (b)(6)-2 [illegible]
F/C →		600cc	
1460			Foley 1200 cc ACU. SPC (b)(6)-2 91WM6

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 4049

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Gen Surg Admit:
10APR03	~35 y/o Iraqi ♀ S/P GSW to (L) back & (L) thigh
	underwent Ex lap @ FST → non-expanding retroperitoneal
	hematoma & debridement of (L) thigh wound
	on 9 APR. Transferred from (b)(3)-1 for
	further post-op care. H/D stable. Foley clear /
	intact. Requiring O2 for 84% sats.
	PE: HR 101 BP 117/64 RR 32
	A&O GCS 15, nonfocal
	HEENT - wnl
	Lungs - CTA (B)
	CV - tachy, reg rhythm
	Abdom - soft, dressing intact, appropriate TTP
	(L) flank dressing intact
	GU - Testes ↓↓ ∅ mass
	Rectal - defer to procto
	Ext - Pulses 2+/=, (L) lat thigh wound dressing
	clean
	A/P S/P GSW to back / (L) thigh S/P Ex lap c̄ debridement
	- (L) thigh Film
	- Plan proctoscopy
	- Admit to ward MD

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

(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(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)

MEDCOM - 4050

509-114

DATE	NOTES
4/10/03	Ortho
1930	S/P GSW (L) prox thigh
	intact to LT? [illegible] motor 2+ DP
	Xray - subtroch femur fx
	Skin traction
	Evac
	(b)(6)-2 MAJ MC
13APR03	Brief op note:
	Preop Dx: (L) subtroch femur Fx S/P GSW
	Postop Dx: same
	Procedure: I & D, washout
	Surgeon: (b)(6)-2
	Anesthesia: MAC
	EBL: min
	Fluids: 200
	Findings: ∅ pus, good granulation
	Drains: ∅ complications: ∅
	Disposition: To ICW / stable
	(b)(6)-2 MD
	MAJ, MC

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4051

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Apr	Pt VSS c/o minimal pain pt scheduled for proctology exam
1900	Dx: Ex-lap and (L) femur accident traction to (L) leg c
	2 bags of NS for weight. Will cont to monitor (b)(6)-2
-	0330 VSS O_2 sat 96% on 10L FM. (L) LE remains
	in Traction. Abd drsg D+I. (b)(6)-2
4/11/00	118/60, 94%, 93 HR, RR 22, T 99.9
	give PO ... (b)(6)-2
11 Apr 03	Airway ... IV infiltrated (L) arm - d/c'd - several
1700	attempts to start IV - request ... pt. - Pt c/o
	... no flatus passed ... Abd drsg c/d/i - (L) thigh (lateral)
	intact - ... to (L). ... DP x 4 ...
	4 mg MSO4 IVP @ 1630 for pain (b)(6)-2
2100 -	Pt c/o ... flatus
	Pt attempting to pull out foley - attempted to ... pt
	pt calmed down (b)(6)-2
4/12 0200	... 2000cc c/g/u off foley - ... 1000cc ... (b)(6)-2
0300	total output 2400cc Intake - IV - 1500cc (b)(6)-2
0400	4 mg ... BP 119/61 P 97 R 20 T 99.6 ... 10L
	(b)(6)-2
0345	Adm 4 mg MSO4 IVP for pain (b)(6)-2
0405	PT resting in bed no c/o pain. lung sound clear b/lat
	Drsg on leg CDI. Reinforced drsg on upper thigh. (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

(b)(6)-4

(b)(3)-1

(b)(6)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 4052

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 APR	0450 changed ABD DSG - wet/dry - pt C/O pain 2mg MSO4 given.
	Pt repositioned in bed (b)(6)-2 9/WMG
	0845 Pt ate few crackers and 3-4 spoonfuls of lentil stew.
	∅ C/O N/V. Output of 950cc dark yellow clear
	urine. Pt c/o pain 2 mg MSO4 given 1230 Pt c/o pain
	in leg gave 2mg MSO4 given 1400 Pt ate only few
	bites of diner. No c/o N/V. c/o pain in abdomen.
	750cc dark yellow urine out.
12 Apr. 19??	Report received, initial assessment complete [illegible]
	[illegible] SOB drsg to Abd and (L) femur [illegible] NPO for
	possible procedure tomorrow. VSS (L) extremity cooler than (R) will
	continue to monitor. I.V. L/R 125cc/h c antibiotic therapy
	(b)(6)-2 [illegible]
	2230 - 1500cc CLEAR URINE OUTPUT FROM FOLEY [illegible] (b)(6)-2 9/[illegible]
13 APR	0645 PT back from OR via litter. S/P I+D of (L) Leg.
	P: 96 BP 126/73 R 100 T. 99.2 (b)(6)-2 [illegible]
	0830 Pt C/O pain in leg. 2mg MSO4 given. (b)(6)-2 9/[illegible]
	1230 Pt had temp 100.5. Gave 650 Tylenol (b)(6)-2 9/[illegible]
	1300 ∆ ABD DSG. Wound clean no s/s of injection + Pt had
	c/o pain. 2mg MSO4 given. (b)(6)-2 (b)(6)-2
	1330 Pt didn't eat but a few bites of dinner. No C/o pain.
13 APR 0? 1700	Assessment complete [illegible] (L) [illegible] - Dsg (L) leg - [illegible]
	(L) thigh Dsg intact. [illegible] [illegible] (b)(6)-2
1800 -	[illegible] MSO4 for pain [illegible] pt (b)(6)-2
2025 -	IV out - [illegible] (b)(6)-2
0300 1400 -	Pt [illegible] need to [illegible] - [illegible] foley - [illegible] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4053

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/14/03 0300	PT c/o ↑ pain Adm [illegible] (b)(4) — IV out —
14APR03	c/o [illegible] Ø N/V tol. regular diet
	⊕ BS abd NT/ND [illegible]
	unable to obtain peripheral IV access → PO abx
	(b)(6)-2 MAJ, MC)
14APR03	(1145) PT unable to void. Placed foley. 650cc Clear amber urine. PT c/o pain Vicodin given. (b)(6)-2 [illegible]
14 Apr	Pt. has foley replaced initial assessment complete adequate output No c/os of pain or SOB. Will continue to monitor Vicodin for pain prn (b)(6)-2 [illegible]
15APR03	Pt resting in bed c/o pain in leg. Breathsounds clr bilaterally. Abdominal sounds active x 4 quad. Pedal pulses equal. Pt able to move toes & feel/sensation. 0500 A DPEG on abdomen. PT tolerated well. Encouraged pt to drink H2O (b)(6)-2
Local time	(1619) Pt to be transfered 45D dark urine w/ blood noted in urine (b)(6)-2 [illegible]
15APR03	1655 RECEIVED PT FROM ICU 2, PT STABLE ON ARRIVAL VSS, Ⓛ LEG ō TRACTION, Ⓛ LEG DRESSING ō SMALL AMOUNT OF SERO SANGUINOUS DNG NOTED, NV STATUS INTACT FOLEY ō SMALL AMOUNT OF AMBER URINE — (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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 (b)(3)-1 (b)(3)-1

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
15APR03	[2010] Pt on BR c HOB @ 30°. A+O x3. PERRLA. USS. HR RRR. Breathe sounds clear Bi-lat. Hyperactive Bowel Sounds x4. Pt (R) leg in external traction. Pulses +3 bounding Bilat on lower extremities. Pt able to move feet/toes bilat. Dressing to Midline C/D/I. Dressing to [illegible] small amount of serosanguinous fluid noted. Foley to gravity draining amber fluid. Pt c/o Flatulence in abdomen. Maalox given @ 1900. Pt ↓ c/o pain @ this time. Will cont to Monitor. (b)(6)-2 SGT LPN. [2310] Pt given i Vicodin for Pain. [illegible] [0350] Pt given ii Vicodin for pain [0410] Pt given 50mg Benadryl for insomnia (b)(6)-2
16Apr03	0730 - Assumed care. Pt resting in bed c HOB ↑30°. A+Ox3. PERRL. HR 90's +S1S2. Lungs. Clear bilat ↓ bases. Shallow breaths.. M membranes pink + moist. Sats 98% RA. (+)BS x4. Foley to BSD c amber urine. Midline abd. dressing C/D/I. Skin traction to (R) leg. (+)PPx4 able to move ext x3. able to move toes (R) foot. Edema to (R) foot. Pt refused breakfast. interpreter @ bedside. Pt frustrated + expressed desire to go home if no further surgery planned. Will discuss with surgeons & will continue to monitor. Pain [illegible] this time (b)(6)-2 [illegible]
	(1000) Medicated for pain per orders. Dressing Δ wet today. (-)S/S of infection (+)granulation Staples to middle of incision site. Will continue to monitor. (b)(6)-2 [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

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

OD# (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)

MEDCOM - 4055

DATE	NOTES
16 Apr 03	(1646) Pt C/o of pain. Given medication per orders. Pt repositioned. Pt expressed relief. Will continue to monitor (b)(6)-2
	(1700) VSS. Pt resting in bed. Ate approx 25% of dinner. Encourage ↑ of PO. Will cont. to monitor (b)(6)-2
16 Apr 03	[2030] Assumed care of pt. Pt currently resting ō HOB ↑ 30° A+Ox3 Lung sound CTA bilat ō diminished bases. HR RRR PERRL. Cap refill < 2 sec. Sats @ 96% on RA VSS. ⊕ BS x4 Abd soft round non-distended ō mid line incision Δ c/d/i ⊕ PP x4. ROM x3. LLE in traction. Pt able to move foot. 18g IV started in Ⓡ forearm hep loc. 2mg MSO4 given @ [2000] for pain. Pt consulted ō interpreter over future status. Verbalizes understanding of ↑. Will continue to monitor.
	[2200] Pt given 30mg of Restoril for sleep aide. [2245] Pt given ii vicodin P.O. for pain (b)(6)2 [0200] Pt given 2mg MSO4 IVP for pain. Taken off traction for 20 min. (b)(6)-2
	[0400] Pt given 2mg MSO4 for pain. [0500] Pt given Vicodin ii PO for pain [illegible]
17 APR 03.	(0800) assumed care. Pt resting in bed HOB ↑ 30° traction in place ⊕ [illegible] ⊕ good cap refill < 2 sec. Able to move toes. [illegible] Ⓡ forearm [illegible]. Lungs CTA bilat ō ↓ bases. Sats 94% RA. Abd. round, soft ō midline [illegible] C/D/I. Pt. refused breakfast but requested [illegible]. Will cont. to monitor (b)(6)-2
	(1100) Pt medicated for dressing [illegible] ō vicodin + MSO4 [illegible] well. Pt resting VSS. (1030) Pt washed self [illegible] @ bedside [illegible] care plan. Pt verbalized understanding (b)(6)-2

(b)(6)-2

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MEDCOM - 4056

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Apr 03	[2030] Assumed care of pt. Resting HOB ↑30°. A&Ox3. Lung sounds CTA Bilat c̄ diminished bases. HR RRR S1 S2 Cap refill <3 sec. PERRL. Sats @ 94% on RA. (+) BSx4 hypoactive Abd soft non-distended c̄ mid-line incision c̄ s̄ c/d/i. (+) PPx4 ROMx3. LLE in traction pt able to move foot. Pt had Ø c/o pain or discomfort @ this time. PIV to (R) forearm hep lock. Will cont. to monitor. (b)(6)-2 LPN SGT.
	Pt void clear yellow urine via foley to gravity.
	[2200] Pt given Restoril for sleep aid. [2300] Pt give vicodin PO x̄ for pain [illegible] [0545] Pt had uneventful night. VSS Did not eat or have BM. 815cc U/O dark amber color. Pt taken off traction @ 0315 for remainder of night (b)(6)-2
18 APR 03	0800 PT SLEEPING INTERMITTENTLY, REQUESTING TEA TO DRINK WHEN OFFERED FLUIDS, CONTINUES TO HAVE LOW PO INTAKE, A&O, C/O PAIN IN (L) LEL RELIEVED BY APPLYING TRACTION DISTAL PULSES +2 IN (L) LE, MIDLINE ABDOMINAL INCISION TO BE Δ THIS AM, CLEAN DRY AND INTACT (b)(6)-2 CMA

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

(b)(6)-4 (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)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18Apr03	Pt seems to be A & O; VSS; afebrile; dressing to abd area C&I; ace wrap to LLE intact c good cap refill; c/o pain to IV site; Δ IV site to (R) AC; given neostrip & vicodin for c/o pain; enema administered by RA; had 1 med BM; foley care given; Ø s/s of irritation to area; NVI; cap refill < 3 sec; DO ADL s assist; HOB ↑; dressing (L) hip area intact; stable, continue monitor (b)(6)-2 9/10WMb
19 APR03	(0800) assumed care. Pt awake. C/o pain- given MSO4 2mg. VSS. Pt refused breakfast lungs CTA. ⊕P.P x4. Midline abd. dressing Δ'd. Pt med. c Tylenol III for dressing Δ. Pt tol well. Will continue to monitor (b)(6)-2 (1330) Pt awake. c/o pain given MSO4 per orders. Pt asking when he'll leave. Informed that evac pending. Encourage ↑PO. Pt ate 2 small pears + 2 cups of H2O. Will cont. to monitor (b)(6)-2 (1630) Pt eating dinner. approx 50%. ↑PO intake noted. UOP less dark. 950cc UOP. Pt c/o of leg pain. Given Tylenol III per orders. Pt talking c other pt's (b)(6)-2
19Apr03 1900	Assume pt care; pt Alert; IV in (L) AC intact s s/s of complications; dressing to abd C&I; dressing to (L) hip C&I; Ace wrap to LLE intact c traction; pulse (+) c cap refill < 3 sec; pt able to wiggle toes; NVI; slight edema to LLE; foley to gravity draining quantity sufficient; HOB ↑; tolerating po well, stable; continue monitor. (b)(6)-2 9/20WMb
b/p 122/70 P- 91 R-18 T: 98.7 O_2 Sat -93%	

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4058

DATE	NOTES
20 APR 03	0930 ASSUMED CARE OF PATIENT AT 0700 PT RESTING ō
	HOB @ 30°, c/o PAIN IN (L) LE RELIEVED ō REPOSITIONING
	~~DUE~~ ^ME^ TO, PATIENT ō POOR PO INTAKE, DUE TO EVAC.
	TODAY PER ONTHO, PATIENT IS ANXIOUS TO DEPART (b)(6)-2
	(1000) Dressings D'd. Pt tol well. Repositioned ō assistance. Medicated for pain. (b)(6)-2
	(1400) Pt c/o of pain/discomfort to groin area. Foley D/C'd. Pt cleaned. (b)(6)-2
	(1445) Pt C/o of pain to leg. Medicated per orders. ⊕ PPx4. Will cont to monitor (b)(6)-2
	(1800) Pt attempting to void. unable to @ this time. Encouraged ↑ PO
	intake. Pt C/o of pressure in and area. Dulcolax supp given. Will
	continue to monitor. (b)(6)-2 [illegible]
20 Apr	
1945	received report, assumed care pt lying in bed, VSS, pt c/o abd pain, pt
	attempted to pass stool, unable to at this time, pain meds given as ordered
	pt currently resting in bed, will continue to monitor. (b)(6)-2
2045	pt tried to move stool, pt was unsuccessful, enema was given, pt able to pass
	stool after enema, stool was formed, pt no longer has urge to have a movement
	will continue to monitor (b)(6)-2 (b)(6)-2 [illegible]
0015	pt was awake throughout night, had diff passing stool enema was given as stated
	before, he had 2 BM during the night, VSS, pt did void at separate occasion,
	has no c/o pain, currently resting at bed side will continue to monitor (b)(6)-2
21 APR 03	0700. Assumed care. Pt sleeping. VSS. Pt c/o of leg pain. Medicated per orders.
	⊕ PPx4. Requested traction. AM care complete. ⊕ void 250 amber urine.
	Pt awaiting evac. Will continue to monitor (b)(6)-2
	(1130) Wound care completed. Pt tol well. Pt request bedpan. ⊕ BM small + liquid.
	⊕ void. 450cc amber urine. Encourage pt to ↑ PO intake. Pt resting. Will cont to
	monitor (b)(6)-2 (1300) Void 400 cc amber urine. Request bedpan. ØBM ⊕ gas. Drinking H2O
	(1600). Void, 700cc light amber urine. Pt resting. Still awaiting evac (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21Apr03	Pt voids 600cc of yellow urine. —SPC (b)(6)-2 91WM6
2000	VS—BP 109/57 HR84 RR16 temp 98.2 SaO2 94% on RA
2120	Pt med with 30 mg Restoril for sleep —— SPC (b)(6)-2 91WM6
2130	Pt voids 400 cc of dark yellow urine——SPC (b)(6)-2 91WM6
2200	Pt given 100 mg Colace ———SPC (b)(6)-2 91WM6. Lovenox given @2200 —SPC 91WM6
22Apr03 0230	Pt voided 400 cc of urine. —— SPC (b)(6)-2 91WM6
0430	Pt currently in bed. LLE slightly swollen. traction in place. Pt c/o pain when
	traction applied. pt can wiggle toes. pulse ox 95% on RA cap refill <3sec in LLE.
	⊕ pulses present in all extremities. Pt given 100 mg of Demerol IM @0100
	per doctors order for pain. IV site at this time. will continue to monitor —SPC (b)(6)-2 91WM6
0545	Pt currently in bed with traction off. Attempted to explain the need for traction
	as long as possible. Pt verbalized understanding. Completed self AM Care —SPC (b)(6)-2 91WM6
0645	Pt performed am care this am. Pt refused breakfast at this time. c/o
	stomach pain at this time. no further changes noted —SPC (b)(6)-2 91WM6
0930	Pt is in bed with c/o pain c̄ traction applied. Pt has VS
BP 118/68	in normal range. Pt has complaints of flatulence & was
P 89	given Maalox, & T3 for pain. Pt voided with 700ml of urine
R 16 / SpO2 91	Pt given Colace for bowel movement. Pt ate 2 pieces of his meal
Temp 97.9	of chicken. Pain med seems to be effective & pt is calm. SPC (b)(6)-2
22 Apr	Pt is A&O x3, c̄ no apparent signs of distress. Pt has been
1428	eating & drinking water all day. Pt is hydrated @ this time.

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4060

DATE	NOTES
	at beginning of shift urine was dark amberish color, & now it is clear/slight yellowish tint. Pt has had flatulence & has voided 1500ml of urine today. Pt has had dressing change to abdomen, & (L) side of (L) hip. Pt has been sitting up & moving/turning in bed. Pt given T3 after dressing change & pt is relaxing. Pt is still waiting to take a stool. (b)(6)-2
22 Apr 03	
1930	Received report from Day Shift assumed pt care, VS: 96% SPO2 18R 84P 115/64 BP T 98.2 will continue to monitor (b)(6)-2
1945	pt resting in bed, no c/o pain at this time, (L) leg in line with traction (+) pulses x4, hob @ 30° as ordered will continue to monitor pt (b)(6)-2
2200	meds given as ordered, colace 100mg and Lovenox 30mg (b)(6)-2
2210	pt c/o pain and restlessness, meds given as ordered #T3 (b)(6)-2 for pain and 1 Restoril for restlessness, will continue to monitor pt (b)(6)-2
23 Apr 03 0200	Pt c/o pain given 2 T3 tabs. left leg traction applied at this time. pt uses bar above bed to move freely around bed w/o complaint. Pt has no other complaints at this time — SPC (b)(6)-2, 91WM6
0500	emptied 600 cc of dark yellow urine. pt requested traction to be off for a while. explained that it had to be put back on soon. Pt understood. No further complaints at this time. — SPC (b)(6)-2 91WM6
0530	Pt c/o abdominal pain. Combine dsg pad to wound wet. changed with a new combine dsg. pt satisfied. Self AM care done. — SPC (b)(6)-2 91WM6
0610	Pt currently in bed with traction applied to left leg. No further complaints or changes at this time — SPC (b)(6)-2 91WM6
0800	BP 118/62 / HR 66 / Resp 16 / SpO2 91% on RA / Temp 96.9°F. Initial assessment performed. S1 S2 audible. Pulses x 4 ext (+)3. Lungs CTA (B). Sating 91% on RA. BS active. Taking

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STANDARD FORM 509 (REV. 5/99) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23APR03 0800 cont.	Colace BID po. Dsg Δ to abd wound Δ'd. Small amt green drainage from bottom abd wound. Wet to dry dsg performed. Trapeze hanging above bed. Pt able to Δ position prn. (L) leg traction on as tolerated by pt. Tol reg diet well c̄ no c/o N/V. —— (b)(6)-2 LTan
0840	2 tylenol #3 given po for pain. Dsg to (L) thigh packed & Δ'd wet to dry. Upon removal of old dsg. gauze c̄ green & red drainage noted, ∅ oozing. —— (b)(6)-2 LTan
1615	2 tylenol #3 given for pain. 400cc amber urine emptied -kd
1930	pt c/o stomach pain / requests dose of Colace at this time. pt given 100 mg of colace at this time. —— SPC (b)(6)-2 91W
2015	pt voided 700 dark yellow urine via urinal —— SPC (b)(6)-2 91WM6
	VS → BP 110/63 HR 81 RR 12 temp 97.5 SaO2 97% on RA
~~2115~~	
T2115	Pt given 1 restoril tab for sleep and 2 T3 tabs for pain —— SPC (b)(6)-2 91WM6
2230	Pt awake at this time. Using trapeze bar to readjust self in bed. Left leg traction applied at this time with no further pt complaints noted. will continue to monitor —— SPC (b)(6)-2 91WM6
0130	pt c/o pain to (L) leg, meds given as ordered, ii T3 given for pain, pt awake and lying in bed, no further c/o pain, will continue to monitor pt —— (b)(6)-2 91

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4062

DATE	NOTES
24Apr03 0030	0310 - Pt c/o of pain in (R) leg. Discussed with ER physician and gave pt 50mg Demerol IV, using Z-Track method as ordered. If pain remains will repeat in an hour. ——— (b)(6)-2
0615	pt slept throughout night mostly, he was medicated 3x pain, pt had no further c/o pain. pt currently laying in bed with traction applied. will continue to monitor pt ——— (b)(6)-2
0830	BP 117/62 / HR 83 / Resp 18 / SpO2 92% on RA / Temp 98.7°F. Initial assessment performed. S_1, S_2 audible. +3 pulses x 4 ext. Lungs CTA (B). Sats >91% on RA. BS active x 4 quads. (+) flatus. Pt has sensation to (L) leg. Traction on as tolerated by pt. Pt able to move (L) toes. Dsg to midline abd Δ c wet to dry. Small amt of pus on old dsg upon removal. Dsg to (L) thigh repacked c wet to dry dsg. Small dsg to back removed. Site cleaned c hydrogen peroxide, packed c iodoform & covered c sterile gauze. Wound to back has red edges, oozing small amt. of pus & warm to touch c foul odor. Pt has been on Levaquin 500mg po qd since 16APR03 & remains afebrile. Tolerating reg. diet well. Able to make slight mvmt Δ's c trapeze assistance which hangs above pt's bed. No c/o pain currently. ——— (b)(6)-2
1845	650cc u/o emptied. Fleets enema given @ 1100 c results. Pt continues to have lg amt of flatus. Fluid intake encouraged. Denies need for pain meds ——— (b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Apr 03	
1930	received report from day shift assumed pt care, VS BP 117/67 P 84 R 18
	SaO2 90% T 99.1, abd dsg c/d/i, (L) leg in traction, pt has no c/o pain
	at this time, will continue to monitor (b)(6)-2 ——— (b)(6)-2
2130	pt c/o pain & restlessness, meds given as ordered, T3 # for pain, [illegible]
	for restlessness, pt has no further c/o pain or restlessness at this time
	will continue to monitor (b)(6)-2 ——— (b)(6)-2
2200	colace 100 mg and lovenox 30 mg given as ordered ——— (b)(6)-2
25 Apr 03 0000	pt c/o pain, pt given Demerol 50 mg IV as 1x order, pt has no further c/o pain
	will contin to monitor (b)(6)-2 ——— (b)(6)-2
0110	emptied 600 cc of dark yellow urine from pt urinal ——— SPC (b)(6)-2 91WM6
0230	reapplied traction to left leg at this time ——— SPC (b)(6)-2 91WM6
0300	pt c/o pain, given 2 T3 tabs at this time ——— SPC (b)(6)-2 91WM6

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

MTF (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)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25APR03 0700	assumed care of pt, pt is resting comfortably in bed, VSS, Ø signs of distress, Ø c/o pain, pt had >90% of breakfast, will continue to monitor pt (b)(6)-2
0915	pt c/o pain to (L) leg, medicated c̄ 2 tabs Tylenol c̄ codeine as ordered, will continue to assess pt's pain level. (b)(6)-2
1200	(L) pt's [illegible] dressing wet to dry as ordered, Ø smell, Ø necrotic tissue noted, will continue to monitor site (b)(6)-2
1330	Dsg to (L) thigh Δ'd wet today. Old dsg had blood & small amt green drainage on it. Back dsg Δ'd c̄ iodoform. Back wound has reddened edges & pus from site. Pt currently has traction on (L) leg, +3 pulses to (L) foot. Pt moving self in bed well c̄ assistance from overhead trapeze. Denies need for pain meds currently. (b)(6)-2
1500	600cc amber UO (b)(6)-2
1830	2 tylenol #3 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 (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4065

DATE	NOTES
25 Apr	
1945	recieved report from night shift, assumed pt care, VS BP 115/62 P 72
	R 18 SAO2% 90 T 98.8°. pt (L) leg in traction, pt has c/o c/o pain
	at this time, will continue to monitor (b)(6)-2 ———— (b)(6)-2 91C
2200	meds given as ordered, 100 mg of colace, 30 mg of [illegible] — (b)(6)-2
2230	pt c/o pains + [illegible], meds given as ordered, T3 [illegible] for pain
	and [illegible] for [illegible], will continue to monitor (b)(6)-2
0400	Pt c/o pain. 2 tabs T3 given @ this time ——— SN (b)(6)-2 91 [illegible]
0600	emptied 100cc of dark yellow urine from pt urinal — SN (b)(6)-2 91 [illegible]
[illegible] 0800	BP 122/40 / HR 72 / Resp 18 / SpO2 92% on RA / 96.6°F.
	Pt VSS. Given 2 tylenol #3 for pain. Am care
	Conducted. Pt did not want to eat breakfast. Initial
	assessment performed. S_1, S_2 audible. +2 pulses x 4
	ext. Lungs CTA (B). BS active x 4 quads. Dsgs to
	ABD, (L) thigh & back changed. All wound sites have
	green drainage. wet to dry dsgs performed on all 3
	wounds. Traction on (L) leg as tolerated by pt. Pt
	moving himself in bed c̄ assistance of overhead
	trapeze. Sensation to (L) foot (+). ——— (b)(6)-2 [illegible]

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4066

ACLU-RDI 1244 p.24

DOD 010545

MEDICAL RECORD	VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR / 19	DAY / HOUR	10 Apr 1800		11 Apr 0300		11 Apr 0800	1700	2100	12 Apr 0300	1200	1800	13 Apr 0300	2400	14 Apr 0400	2200

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
		40.0°
180	104°	39.4°
170	103°	38.9°
160	102°	38.3°
150	101°	37.8°
140	100°	37.2°
130	99° / 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: 20 22 22 20 22 20

BLOOD PRESSURE: 120/67 118/[illegible] 124/67 111/70 114/68

Spo2 RA: 98% 96% 93% 93% 92 91 91% 90% RA; NC NC; 4L 4L; 94 95; 04 l z Mask; O2 [illegible] 94%

HEIGHT: WEIGHT →

Intake: 925 1500

Output / Foley: 900

12 AM
Intake - IV - 1500
Foley - 2400

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

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

(b)(6)-4

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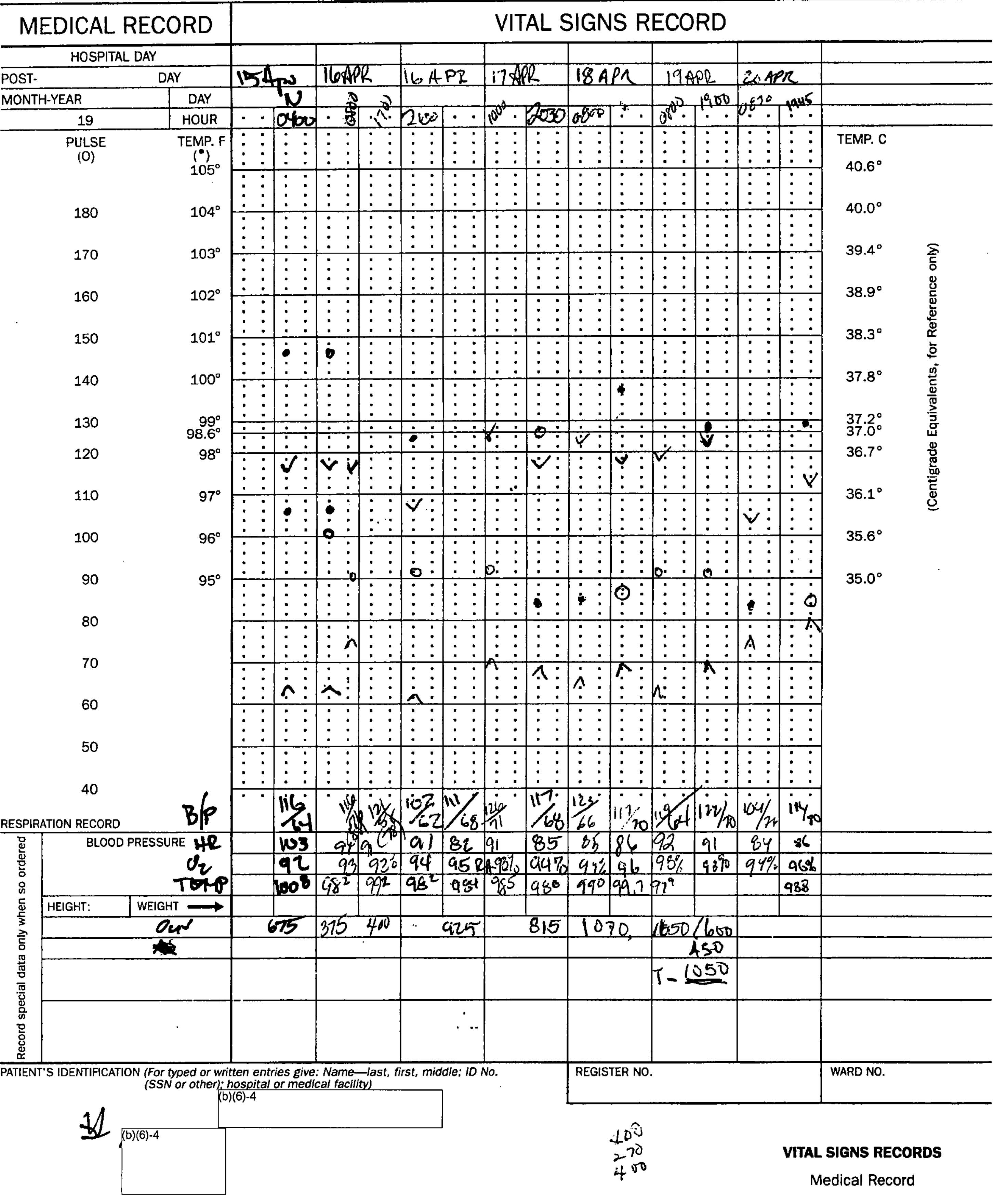
(b)(3)-1

OD # (b)(6)-4

MEDCOM - 4067

511-119

NSN 7540-00-634-4124



MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY	15 Apr	16 APR	16 APR	17 APR	18 APR	19 APR	20 APR	
MONTH-YEAR / DAY	N							
19 / HOUR	0400	0800 / 1700	2100	1000 / 2030	0800	0800 / 1900	0830 / 1945	

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														
B/P	116/64	119/78	121/70	107/62	111/68	126/71	117/68	123/66	117/70	119/64	122/70	104/74	114/70
BLOOD PRESSURE HR	103	94	9[illegible]	91	82	91	85	85	86	92	91	84	86
O2	92	93	92%	94	95 RA	98%	94%	97%	96	98%	98%	94%	96%
TEMP	100.8	98.2	99.2	98.2	98.4	98.5	98.0	99.0	99.1	97.9			98.8
HEIGHT: WEIGHT													
Out	675	375	400		925		815	1070		1650 / 1600			
[illegible]										450			
										T - 1050			

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)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

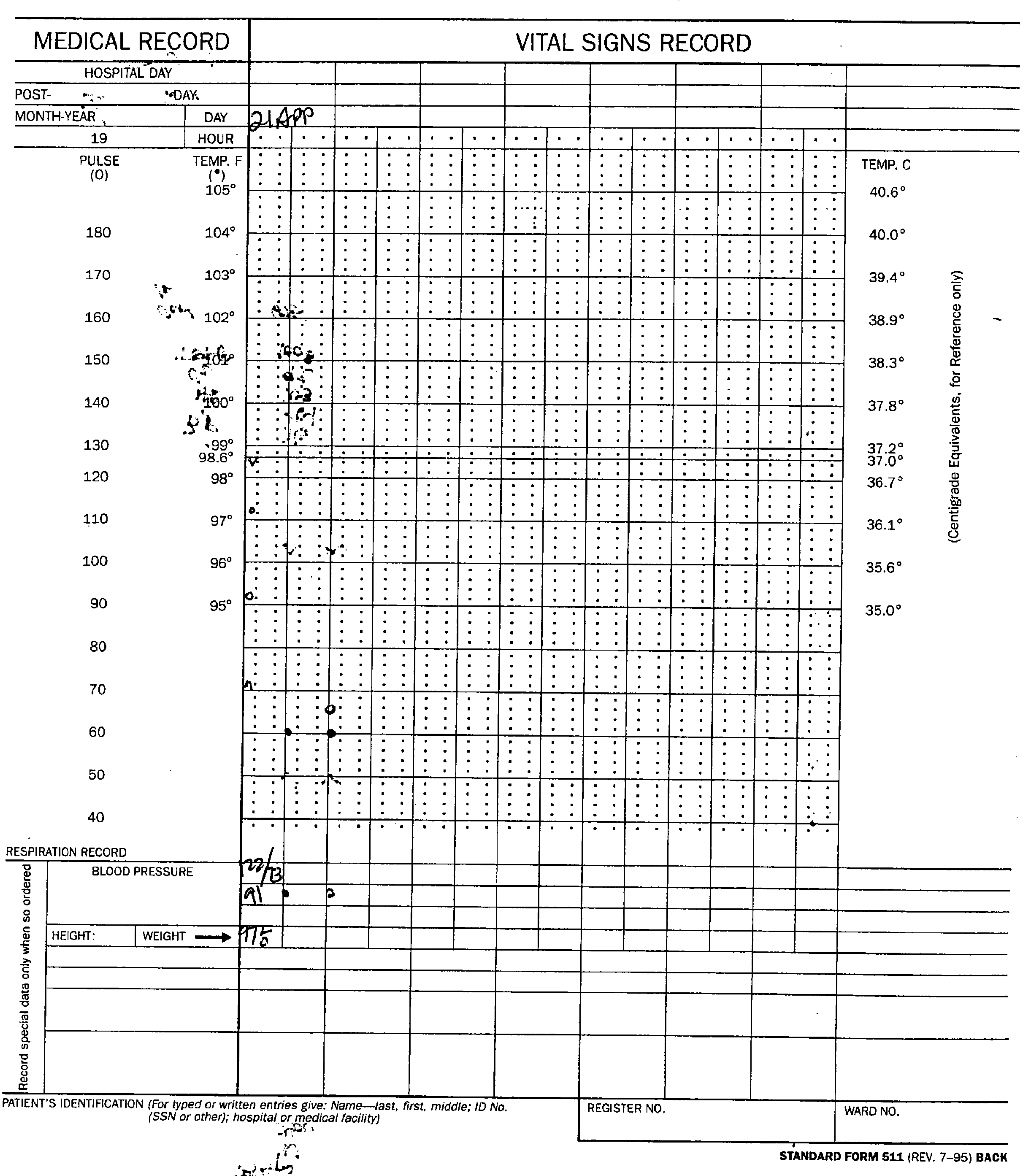
400
270
400

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4068



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR / DAY	21 APR
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: [illegible] / 91

HEIGHT: | WEIGHT → 975

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

REGISTER NO. | WARD NO.

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

MEDCOM - 4069

(THIS FORM IS SUBJECT TO THE PRIVA[CY ACT OF 19]74 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[0]

ANESTHESIA RECORD

Page __ of __

ANES START	IN OR	ANES. END	DATE
0910	0915	0940	13APR03
TOTS	SURG START	DRESSING	OR NO
0926	0928	0941	

OPERATION PERFORMED: I&D (L) elbow power PP

SURGEON(S): Harris

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [x] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

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

ANESTHETIC TECHNIQUE

- [ ] GENERAL [x] LOCAL / MAC (circled)
- [ ] 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 ___ [ ] BLADE
- [ ] ETT SIZE ___ [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [ ] CUFFED ___ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [ ] ETT SECURED AT ___ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE

TIME: 0915 | 30 | X | 10 | X | 30 | X | 11 | X | 30 | X | 12 | X | 30 | TOTAL

AGENTS		
Valium	5	
Robinul	.3	
Ketamine	80	20
Propofol	80	20
N2O L/min		
O2 L/min	3	

FLUIDS		
LR	Cont	
Urine		
EBL		

MONITORS		
EKG	SR	SR
% O2 Inspired	1.0	1.0
O2 Saturation	93	97
End Tidal CO2	—	—
Temperature	—	
PNS	—	

VITAL SIGNS — PRE-OP VALUES: B/P 108/64; P 95; R 12; SAT 95; H/H —

RESP		
Tidal Volume	SV	SV
Resp Rate	14	12
Peak Pressure	—	—

Symbols for Remarks: X ⊙

Position: supine

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

SYMBOLS: X ANESTH; ⊙ OPERAT; V Λ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; • PULSE; C SPONTANEOUS RESP; ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID F; B BLOOD

RECOVERY

TIME IN PACU	CONDITION
0945	Stable

B/P	PULSE	RESP	O2 SAT
124/78	103	16	96-98

REMARKS

TEMP —

REPORT TO: PARRS:

IN	FLUIDS TOTALS	OUT	
Crystalloid LR 200		EBL min	
		Urine —	
Blood		Gastric —	

Tourniquet Time:

MAJ. (b)(6)-2 CRNA, USAR, ANC

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

OD # (b)(6)-4

(b)(6)-4

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE 40s | (M) F | HEIGHT ~5'7" | WEIGHT 230 lb

PREOPERATIVE VITAL SIGNS: B/P P R

PROPOSED OPERATION I&D (L) Above Femur FX

PREVIOUS ANESTHESIA / OPERATIONS [X] NEGATIVE

CURRENT MEDICATIONS [X] NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS [X] NEGATIVE

ALLERGIES [X] NKDA

AIRWAY / TEETH / HEAD & NECK
MPI Opens wide Teeth intact

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: [X] No [ ] Yes Frequency ___	LFTs
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 tendencies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC; Lytes

PROBLEM LIST / DIAGNOSES
Immobility, decreased 2° femur FX
Skin integrity. Alt. of
infection, [illegible]

ASA 1 (2) 3 4 5 E

PREOPERATIVE MEDICATIONS ORDERED
Ancef 1gm IV 8°

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: ________

MEDCOM - 4071

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		(b)(6)-2 0920
1	OXYGEN: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 12.5 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		
	(b)(6)-2		
	COW, ANC		

PATIENT IDENTIFICATION (b)(6)-4

OD # (b)(6)-4

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

Diagnosis: S/P (L) [illegible]

Height: 5'7" Weight: 202# Diet:

Allergies: NKDA

Nursing Unit	Room No.	Bed No.	Page No.
ICW [illegible] 2			

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

MEDCOM - 4072

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

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

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10 Apr 03 — TIME OF ORDER 0654 HOURS — LIST TIME ORDER NOTED AND SIGN

1 Admit Patient to ICU 3
2 Diagnosis: s/p GSW to the (L) thigh, (L) back; s/p ex lap
3 Condition: Stable/Serious/Critical
4 Allergies: NKDA
5 Vital signs q hr/2hr/q6hr/q8hr/q shift x 4 hrs, then q4
6 Cardiac respiratory monitoring
7 Diet: NPO / regular/ soft/ clear liquid → advance to regular diet 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
11 Labs: Chem 7/ H/H/ PT/PTT/
CBC q AM/ 4 hrs/ 8 hrs/ BID
12 ~~EKG q AM~~ Foley to gravity

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

13 PCXRAY q AM/QOD — replace IV if possible
14 IVF NS/ LR/ D5NS/ D51/2NS To run @ 125 cc/hr → [illegible] to ...
15 Ancef 1 GM IV Q 8 hrs — unless [illegible] ... reg diet
16 Gentamycin IV Q
17 Cefoxitin 2gm IV q8hrs. — Cef as replacement [illegible]
18 O2 titrate to keep SPO2 > 93%
19 Versed gtt 1-10mg/hr IV titrate to

PATIENT IDENTIFICATION
(b)(6)-4
(b)(3)-1
OD # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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 lmcg/kg/min
22 MSO4 2-6 MG IV q 1 HR PRN Pain
23 Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24 MOM 30cc PRN Gastric upset

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

MEDCOM - 4073

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 (Cont) | TIME OF ORDER ______ HOURS | LIST TIME ORDER NOTED AND 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
✓ (28) Percocet i-ii PO q4-6° prn pain
✓ (29) Motrin 800mg i PO q8° prn pain
(30) Dressing Δ to Abd, back, + (L) thigh BID (wet-dry on abd only). Just Δ'd in EMT.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

✓ (31) Toradol 30 mg IV x i now

(b)(6)-2
MAJ, USA, MC
DEPT OF OB/GYN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4
(b)(3)-1
OD # (b)(6)-4

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 4074

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 10 APR 03 — TIME OF ORDER: 1425 HOURS

1. Admit ICW - Dr. (b)(6)-2 / Gen Surg
2. s/p ex lap / debridement
3. Stable
4. VS per routine
5. NPO
6. LR @ 125 cc/hr
7. Foley → gravity
8. 1 single film in EMD
9. PKDA
10. Bedrest c̄ HOB 30°
11. O2 per NC - titrate to keep sat ≥ 95%
12. MSO4 1-2 mg IV q 1-3° prn pain
13. Ancef 1 gm IVPB q 8°
14. Notify MD for T > 101.5, P > 120 < 60, SBP > 180 < 110, UOP < 350 cc/shift

(b)(6)-2 MD

MAJ, MC

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4/10/03 — TIME OF ORDER: 1930 HOURS

traction leg c̄ 2x3l bags

(b)(6)-2

1. Regular Diet
2. NPO p̄ hs
3. Wet/Dry dressing NaCl q d

12 MAR 03 / 0450

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2; (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

DA FORM 4256, 1 APR 79

MEDCOM - 4075

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		13 APR03 — 0640Z HOURS	
	1	Resume previous orders	
	2	S/P IED	
	3	Reg Diet	
		(b)(6)-2 MD MAJ, MC	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		13 APR03 — 1230 HOURS	
		Tylenol 650 po q 4° prn (b)(6)-2	Noted (b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		14 APR03 — 0445 Z HOURS	
	1	Heparin 5000 u SQ bid (b)(6)-2 MD	
		14 APR03/0950 (b)(6)-2	
		Dulcolax supp i pr qd prn constipation (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION (b)(6)-4		14 APR03 — 1000 HOURS	
DD # (b)(6)-4	1	Levaquin 500 i po qd	
(b)(3)-1	2	D/C Ancef (b)(6)-2	
	3	D/C IV access	
	4	Vicodin i-ii po q6° prn pain	
NURSING UNIT / ROOM NO. / BED NO.			

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

☆U.S.G ... 710

MEDCOM - 4076

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 15 Apr 03 — TIME OF ORDER: 1625 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICU 1-T ✓
2. Dx: (L) femur fx / ex lap ✓
3. Condition: Stable ✓
4. Activity: Bedrest c HOB @ 30° ✓
5. Diet: Regular ✓
6. Allergies: NKDA ✓
7. Vitals: Q shift c pulse ox / neurovasc VS ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ↓ ↓ TIME OF ORDER ↓ HOURS

8. Meds: Vicodin i-ii PO Q4-6° PRN pain ✓
   Levaquin 500mg PO QD ✓
   Dulcolax supp i PR QD PRN constipation ✓
   Heparin 5000u SQ Q12° ✓
   Tylenol 650mg PO Q6° PRN ✓
   MSO4 2mg IV Q2° PRN ✓
9. IV: ∅

(b)(6)-2 15 Apr 03 165? ...

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ↓ ↓ TIME OF ORDER ↓ HOURS

10. Nursing: wet → dry abd dressing Δ QD ✓
    foley to gravity ✓

(b)(6)-2

(b)(6)-2
MAJ, MC
Internal Medicine

PATIENT IDENTIFICATION

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

(b)(3)-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 16 Apr 03 — TIME OF ORDER: 0855. HOURS

1. Traction to LLE as tolerated

Noted (b)(6)-2 16 Apr 03 ...

(b)(6)-2

(b)(6)-2
MAJ, MC
Internal Medicine

REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

DA FORM 4256 1 APR 79

MEDCOM - 4077

CLINIC... ...RD - DOCTOR... ORDERS

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

THE DOCTOR SHALL REC... ...ATE, TIME AND SIGN EACH SET OF ORD... ...F PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE ... ...M NUMBER IN COLUMN INDICATED BY ... ...BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# (b)(6)-4	16Apr03 2100 HOURS Restoril 30mg QHS PRN for sleep. V.O. Dr. (b)(6)-2 CPT (b)(6)-2 (b)(6)-2	(b)(6)-2
NURSING UNIT: ICU#1 ROOM NO.: T BED NO.: 3		
# (b)(6)-4	18 Apr 03 1830 HOURS 1) Colace 100mg PO BID 2) Fleets enema x 1 tonight (b)(6)-2 MAS, ...	(b)(6)-2 18Apr03 1835
NURSING UNIT: ICU#1-T ROOM NO.: BED NO.: 3		
# (b)(6)-4	19APR03 0840 HOURS 1) Tylenol c Codeine (T3) 1-2 Q4-6° PRN pain. V/O Dr Mays / ...Galloway ... 2) 30mg Lovenox SQ BID. V/O Dr (b)(6)-2 / (b)(6)-2 ...	Noted 19APR03 0845 (b)(6)-2
NURSING UNIT: ICU#1-T ROOM NO.: BED NO.: 3		
(b)(6)-4 OD # (b)(6)-4 (b)(3)-1	20APR03 1800 HOURS 1) Dulcolax supp 1 PR 2) Fleets enema x1 tonight if no results VO. Dr (b)(6)-2 18.. (b)(6)-2	
NURSING UNIT: ICU#1 ROOM NO.: T BED NO.: 3		

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

MEDCOM - 4078

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		22 Apr 03 — 0100 HOURS	
		Demerol 50-100mg IM x1 for severe pain.	
		V.O. Dr. (b)(6)-2 / CPT (b)(6)-2	
		noted (b)(6)-2 CPT, AN	
NURSING UNIT: ICU-1T — ROOM NO.: — BED NO.: 3		4/22/03 @ 0103 hrs	
PATIENT IDENTIFICATION		24 Apr 03 — 0300 HOURS	
		Demerol 50-100mg IM x1 for severe pain.	
		V.O. Dr. (b)(6)-2 / CPT (b)(6)-2	
NURSING UNIT — ROOM NO. — BED NO.		noted (b)(6)-2 CPT AN	
		4/24/03 @ 0305 hrs	
PATIENT IDENTIFICATION		23 APR 03 — 0030 HOURS	
	(1)	Demerol 50mg IM x1 for break through pain	
		V.O. Dr (b)(6)-2 (b)(6)-2 CPT/AN	
NURSING UNIT — ROOM NO. — BED NO.		Noted (b)(6)-2 CPT/AN	
		4/25/03 @ 0038 hrs	
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.

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

MEDCOM - 4079

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	DATE COMPLETED 10	11	12
10Apr03	(b)(6)-2	Vital signs q hr / (q 2hr) q6h4 / q8hr /	07	(b)(6)-2		
		q shift then Q4°	19			
10Apr03		Cardiac Respiratory Monitoring	07			
			19			
10Apr03		Diet: NPO / Regular / Soft / (Clear	07			
		Liquid) advance to Regular as TOL.	19			
10Apr03		Activity: Ad Lib / (Strict BR) BR with	07			
		BSC / NWB R or L LE / adv. ad lib	19			
10Apr03		HOB up 30 Degrees	07			
			19			
10Apr03		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			
10Apr03		O2 titrate SpO2 >93%	16	(b)(6)-2		
	......		20			
	......		24			
	......	EKG q AM / QOD	06			
	......	PCXRAY q AM / QOD	06			
10Apr	(b)(6)-2	Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07	(b)(6)-2		
	......	q shift	19			
	......	Vascular checks nq 1hr / 2 hr / 4 hr /	07			
	......	6 hr / q shift	19			
10Apr03	(b)(6)-2	Foley to Gravity	07/19	(b)(6)-2		
	......		19/07			
	......					

ALLERGIES: [ ] YES [X] NO
NKDA

PRIMARY DIAGNOSIS: s/p GSW (L) thigh, (L) Back; s/p Exploratory Laparotomy.

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

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

ICU #3

Treatment Facility: (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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
			Z	10
10Apr03	(b)(6)-2	Dressings Δ to Abd, Back	04	SL
		and (L) thigh BID ~	12	
		(wet → dry on Abd only!)	/	
			/	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P GSW: (L) thigh, (L) Back; S/P Exploratory Lap.

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

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

ICU #3

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.

MEDCOM - 4081

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				10 11 12 13 14 15 16 17 18 19 20 21 22
10APR	(b)(6)-2	VS per Routine	D	/ (b)(6)-2
~~10APR~~		c̄ pulse ox / neurovasc ✓	N	(b)(6)-2
10APR		NPO	D	/ (b)(6)-2 DC'd 12 APR
			N	(b)(6)-2
10APR		Foley to Gravity	D	/ (b)(6)-2 DC'd 13 APR
			N	(b)(6)-2
10APR		BR c̄ HOB 30°	D	/ (b)(6)-2
			N	(b)(6)-2
10APR		Notify MD for T>101.5	D	/ (b)(6)-2
		P >120 <60 SBP>180	N	(b)(6)-2
		<110 UOP <250/shift		
10APR		Traction to	D	/ (b)(6)-2 D/C'd 4/12
		(L) Leg c̄ 2 x 3l	N	(b)(6)-2
		saline bags		
12APR		Reg Diet	D	/ / (b)(6)-2
			N	/ / (b)(6)-2
12APR		Wet/Dry DSG Δ (ABD) QD	D	/ / (b)(6)-2 (b)(6)-2
15 APR		FOLEY TO GRAVITY	D	/ / / / / (b)(6)-2 D/C
			N	/ / / / / (b)(6)-2
16APR		Traction to (L) LE as	07	/ / / / / / (b)(6)-2
		tolerated	19	/ / / / / / (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

GSW (L) back / Thigh Femur Fx
s/p exp lap c̄ descending [illegible]

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

DD# (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

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

MEDCOM - 4082

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo ___ Yr ___			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 APR	(b)(6)-2	Ⓛ thigh film in EMT	10 APR	DONE		
15 APR	(b)(6)-2	TRANSFER TO ICU 1-T	15 APR	DONE		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
4/14	(b)(6)-2	Vicodin I-II po prn pain	1750 (b)(6)-2; 22a; 0300 (b)(6)-2; 0900 (b)(6)-2; DC

USAPA V1.00

MEDCOM - 4083

ACLU-RDI 1244 p.41

DOD 010562

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. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	22	23	24	25	26	27	28	29	30
10 Apr 03	(b)(6)-2	VS Q S c̄ Pulse Ox and	07	(b)(6)-2								
		neuro vascular ✓	19									
10 Apr 03		Bedrest c̄ HOB 30°	07									
			19									
10 Apr 03		Notify MD for T > 101.5;	07									
		P > 120, < 60; SBP > 180,	19									
		< 110; UOP < 250cc/shift										
12 Apr 03		Regular Diet	07									
			19									
12 Apr 03		Wet to Dry Dsg Δ (abd) QD	10									
16 Apr 03		Traction to LLE as	07									
		tolerated	19									

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) femur fx. GSW (L) back / thigh

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

(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. 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
10Apr03	(b)(6)-2	IVF: LR @125ml/°	07/19	(b)(6)-2	
	-----		19/07		
	-----		/		
10Apr03	(b)(6)-2	Ancef 1gm IV Q8°	07	/	
	-----		15	(b)(6)-2	
	-----		23		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P GSW (L) thigh, (L) Back
S/P Exploratory Lap

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

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

ICU #3

DISPENSING TIMES
USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 4085

ACLU-RDI 1244 p.43

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
10Apr03	(b)(6)-2	Toradol 30mg IV X i pain	10Apr03	ASAP	0830	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
10Apr03	(b)(6)-2	MSO4 2-6mg IV q 1hr prn pain	
10Apr03	(b)(6)-2	Phenergan 12.5-25mg IV q 4-6 hrs PRN N/V	
10Apr03	(b)(6)-2	MOM 30cc PRN Gastric Upset	
10Apr03	(b)(6)-2	Percocet i-ii PO Q4-6° prn Pain	
10Apr03	(b)(6)-2	Motrin 800mg i po q 8° prn pain	

MEDCOM - 4086

ACLU-RDI 1244 p.44

DOD 010565

CLINICAL RECORD

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

Mo.____ Yr.____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12	13	14	15	16	17	18	19	20	21	22	23
10 APR	(b)(6)-2	IVF LR @ 125cc/hr	D	(b)(6)-2				D/Ced 4/14									
			N	(b)(6)-2													
10 APR		O_2 per FM titrate	D	(b)(6)-2													
		to keep Sats ≥ 85%	N	(b)(6)-2				D/C 4/16									
10 APR		Ancef 1gm IVPB	06	(b)(6)-2				D/Cd 14 APR									
		q8°	12	(b)(6)-2													
			20	(b)(6)-2													
14 APR		Heparin 5000 u SQ BID	07					(b)(6)-2				RETIMED					
			19					(b)(6)-2					(b)(6)-2				
14 APR		Levaquin 500 po Qd	07				(b)(6)-2				RETIMED			(b)(6)-2			
15 APR		HEPARIN 5000 u SQ BID	10						(b)(6)-2								
			22					(b)(6)-2				D/C 4/20/03					
15 APR		LEVAQUIN 500 PO QD	10						(b)(6)-2								
18 APR		COLACE 100mg PO BID	06									(b)(6)-2			chg		
			18								(b)(6)-2				(b)(6)-2		
19 APR		Lovenox 30mg SQ BID	10									(b)(6)-2					
~~18 Apr~~		~~Colace 100mg BID~~	22									(b)(6)-2					
18 Apr		Colace 100mg BID	10											(b)(6)-2			
			22														

Recopied 4/22/03 @ 0010hrs (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4

OD (b)(6)-4

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4087

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**
18	(b)(6)-2	FLEETS ENEMA x Ī TONIGHT	18	2100	2100	(b)(6)-2
20		Fleets Enema x Ī tonight if NO results.	20APR	2030	2030	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
10 APR	(b)(6)-2	MSO4 1-2 mg IV q 1-2° PRN pain	2mg 4/10; 4mg 4/10 2000; 4/10 IV; 4/10; 4/10 0500; 4/11 0610; 07; 08; 1200 2mg 11APR; 1300 2mg; 1610 4; 0345; 0455; 2mg 12APR; (b)(6)-2
	(b)(6)-2	MSO4 1-2 mg IV q 1-2° PRN pain	2mg 12APR 0900; 2mg 12APR 1230; 2mg 12APR 1425; 2mg 1730; 2mg 1930; 2mg 2310; 2mg 0114; 2mg 0214; 2mg 13APR 0830; 2mg 13APR 1300; 2mg 13APR 1545; 4/13 1635; 4/13 2200; 4/14 0330; (b)(6)-2
		MSO4 1-2mg IV q 1-2° PRN Pain	2mg 0530 14APR; 2mg 0715 14APR; 2mg 0900 14APR; 2mg 1400; 2mg 0700 16APR; 0100 2mg; 17 APR 1200 2mg; 17 APR 1900 2mg; 4/18 2mg 0230; 18 Apr 1200 2mg; 18 Apr 2345 2mg; 19 Apr 0815 2mg; 19 APR 1330 2mg; (b)(6)-2
14APR	(b)(6)-2	Dulcolax Sup Ī PR q OD constipation	14APR 1035; 20 APR 1830; (b)(6)-2
14 APR	(b)(6)-2	Vicodin Ī-ĪĪ PO q 4° PRN pain	15Apr Ī 2310; 16APR 1600; 16APR ĪĪ 1600; 16Apr ĪĪ 1530; 16APR ĪĪ 1200; 17Apr ĪĪ 0500; 17Apr ĪĪ 1115; 17Apr ĪĪ 1600; 17Apr ĪĪ 2200; 4/18 ĪĪ 0330; 18APR ĪĪ 0430; 18APR Ī 0735; (b)(6)-2
15APR	(b)(6)-2	Tylenol 650mg PO Q6° PRN	
16 Apr		Restoril 30mg Q hs prn for Sleep	30mg 16Apr 2130; 17Apr Ī 2130; 18Apr Ī 2115; 20Apr 0215; 21Apr 2115; (b)(6)-2
		Tylenol c codeine Ī-ĪĪ Q4-6hr PRN	19 Apr 03 0840; 19 Apr 03 1630; 19 Apr 2215 ĪĪ; 20 Apr 0215 ĪĪ; 20 APR 1045 Ī; 20APR 2145; 20 Apr 1945 ĪĪ; 21 Apr 03 0230; 21Apr 0745 ĪĪ; 21APR 1715 ĪĪ

MEDCOM - 4088

ACLU-RDI 1244 p.46

DOD 010567

CLINICAL RECORD | APEUTIC DOCUMENTATION ... PL... EDICATIONS)
For use of this form, see AR 40-40, the proponent agency is the Office of The Surgeon General.

Mo. Apr Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	22	23	24	25	26	27	28	29	30					
15 Apr 03	(b)(6)-2	Levaquin 500mg PO QD	10	(b)(6)-2													
18 Apr 03		Colace 100mg PO BID	10														
			22														
19 Apr 03		Lovenox 30mg SQ BID	10														
	-----		22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) femur fx, GSW (L) back/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4089

CLINICAL RECORD | APEUTIC DOCUMENTATION ... E PL... EDICATIONS)
For use of this form, see AR 40-40, the proponent agency is the Office of The Surgeon General.

Mo. Apr Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
			/	22	23	24	25	26	27	28	29	30						
15 Apr 03	(b)(6)-2	Levaquin 500mg PO QD	10	(b)(6)-2														
18 Apr 03		Colace 100mg PO BID	10															
			22															
19 Apr 03		Lovenox 30mg SQ BID	10															
			22															

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) femur fx, GSW (L) back/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

(b)(6)-4

(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 - 4090 XHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Apr	Yr. 03		
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
22 Apr 03	(b)(6)-2	Demerol 50mg - 100mg IM x 1	22Apr03	0100	100mg given 0105	(b)(6)-2
		Demerol 50mg - 100mg IM x 1	24Apr03	0300	50mg given 0310	
24 Apr	(b)(6)-2	Demerol 50 mg IM x 1	24Apr	0030	0030	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Apr 03	(b)(6)-2	MS04 1-2mg IV Q1-2°														
		PRN for pain														
14 Apr 03		Dulcolax Suppository	2? Apr 0?15 [illegible]													
		i PR PRN QD for constipation	(b)(6)-2													
15 Apr 03		Tylenol 650mg PO Q6 PRN														
16 Apr 03		Restoril 15-30mg QHS	23 Apr 2210 30mg	24 Apr 2115 30mg	24 Apr 2135 30mg	25 [illegible]										
		PRN for Sleep	(b)(6)-2													
16 Apr 03		Tylenol c Codeine I-II	22 Apr 0010 II tab	22 Apr 0800	22 Apr 1420	22 Apr 2145 II tab	23 Apr 0200 2 tab	23 Apr 0535 2 tab	23 Apr 1615	23 Apr 2115 2 tab	23 Apr 0130 2 tab	24 Apr 2135	25 Apr 0300 2 tab	25 Apr 0915 2 tab	25 Apr 1530	25 Apr 2230
		tabs PO Q4-6° PRN				(b)(6)-2										
2? Apr		Tylenol c Codeine I-II	2? Apr 0400 2 tab	2? Apr 0800 2 tab												
		tabs PO Q4-6° PRN	(b)(6)-2	(b)(6)-2												

U.S. [GOVER]NMENT PRINTING OFFICE: 1993 342-027/70450

MEDCOM - 4091

Surgeon (b)(6)-2 / (b)(6)-2

(b)(6)-4

RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

REPORT TITLE

ANESTHETIC RECORD

Preanesthesia Assessment, Time / Date

Drug Sensitivity: NKDA

Premed: Drug/Dose/Time / Effect:

Wt. 110 Kg.

Chart Reviewed / Pt ID'd / Plan Reviewed / Pt. Exam

Pre-induction Vital Signs, BP / P / RR / O2 SAT:

Procedure: EX LAP, (L) hip/Deep Wound EXPLORATION

24 HR. TIME: 1530 1600 1630 1700 1800 TOTAL

Agent	Unit	Values
Oxygen	L/MIN	3, 5, 5, 5, 5, 5, 5
N_2O/Air/He	L/MIN	
Sevoflurane/desflurane/forane	%	2.0, 2.5, 2.5, 0.5, 1.0, .75, 0
Midazolam	mg	
Sufentanil/Alfentanil/Fentanyl	ugm	250
Pentothal/Propofol (KETAMINE)	mg	100
Succinylcholine	mg	120
Vecuronium/Rocuronium/Mivacurium	mg	6, 2, 2, 2 (10)
Ancef 1 gm IVPB		
Labetalol		450
Neosynephrine		200

IV/Blood: 18g, Hand/Arm: R L — 1000, 1300, 1600, 2100

T.O.F.: 4/4 ...

IJ/EJ/SC: R L

1 MONITORS: ECG, ETCO2, Precord., N. Stim., Esoph., Pulse Ox Loc: (L), BP Auto Loc: (R) DE, Temp Loc.

2 INDUCTION: IV, MASK, IM, Other, Pre O2, Cric. Pres.

3 AIRWAY: Oral, Nasal

4 INTUBATION: Oral, Nasal, Trach., Awake, Fiberoptic, Easy, Difficult. Tube Size: 8.0 mm. Depth 23 cm Cuff 10 cc. CO2, Stylet, BS R L

5 MAINTENANCE: Semi Clos., TIVA, Semi Open, IM, Regional, MAC, Insufflation

6 MISCELLANEOUS: BI Warmer, Humidif., OG Tube, Blanket, NG Tube, Eye Oint./Taped, Egg Crate Mat., Fx Table, Arms:Padded/Armboard

Procedure location

Machine/Circuit Check

Temp: 38 36 34 32 30 28 26 24 22 20 C° — 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 20 15 10 5

Temp noted: 35.0, 37.5

SYMBOLS: (1)(2)(3) ... (5)(6)

TV/Pres							
ECG	SR	SR	SR	SR	SR	SR	SR
FiO_2	1.0	1.0	1.0	.45	.50	.50	.50
SaO_2/SvO_2	95	100	100	98	99	99	99
$ETCO_2$	0	35	35	35	35	35	32
PAP							
Blood Loss							
Urine							
Tourniquet							

Total EBL: 1000

Total Urine: 450

Fluids Summary: 2100

Crystalloid

Colloid

Blood

SYMBOLS: Supine, Prone, Lithotomy, Sitting, Jackknife, (R)(L) Lat Decubitus. BP Cuff V ^, Intra-art, Mean, Pulse, Temp. Start Anesthesia X, Intubation T, Start Op ⊙, Extubation E, End Anesth. ⊗, RESPIR Spon O, Asst, Cont

Remarks:

Phys. Status: 1 2 3 4 5 6 (E)

(1) (E) EPW S/P GSW (L) TO OR. BRIEF HIP thru interpreter & Airway exam

(2) Place monitors/PreO2

(3) RSI c CCP GII view

(4) OGT ⇒ decompress

(5) Suction & extubate c defensive airway reflexes intact

(6) To ICU/Recovery c Nasal A/W (L) Naris. Report given VSS.

REVERSAL: 1840 Time

Naloxone ___ ugm

Edrophonium/Neostigmine 5 mg

Atropine/Glycopyrrolate 0.8 mg

N. Stim. Response ___ % TOF

Sust. TET.

PACU/CCU/ICU Time In: Guarded, Satisfactory, Unresp., Awake, ETT, NC/AFM/T.Piece, Ventilator, @ ___ L/m O_2

Mode: TV: R: FiO_2: Peep: (b)(6)-4

BP: P: R: % SAT: 98%

Anes Start 1725

In Room 1721

Out Room 1852

Anes End 1902

TOTS 1735

Surg Start 1755

Surg End 1841

PREPARED BY (b)(6)-2 (Title) CPT, CRNA STAFF

DEPARTMENT (b)(6)-2 CLINIC

DATE 9 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 C (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MED FC OP 562 (Rev)1 MAR 2002

MEDCOM - 4092

MEDICAL RECORD - SUPLEMENTAL MEDICAL DATA

r use of this form, see AR 40-66; nt agency is the Office of the Surgeon G

EPORT TITLE: TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 10APR03 Arrival Time: 1400 Sex: (M) F Age: ______ Wt: ______

Allergies: ______ Tetanus Status: UTD (Unknown)

LMP: Last Meal:

Chief Complaint:

PMH: Medications:

Treatments PTA:

VITAL SIGNS: BP: 112/64 P: 101 RR: 32 TEMP: SAO2: 94

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

GSW

GSW

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 (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

EXCEPTIONS TO ABOVE PARAMETERS:

SPLINTS:

TREATMENTS:
O2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐Y ☐N EKG ☐Y ☐N
NG TUBE #
FOLEY: # DPL ☐ POS ☐ NEG
CHEST TUBE ☐R ☐L CM H20

(Continue on reverse)

PREPARED BY (Signature & Title)

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)

(b)(6)-4

6D (b)(6)-4

(b)(3)-1

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

DA FORM 4700, MAY 78

MEDCOM - 4093

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 # (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
GSW back/(L) thigh. + intraabd. injury (L) subtroch femur fx
S/P ex lap

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

VSI
TRÈS 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)*

Levaquin 500 PO QD
Lovenox 80mg SQ BID ~~or~~ Heparin 5000u.
Traction to LLE
Foley
Reg Diet

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 - 4094

1. NAME (Last, First, Middle Initial) (b)(6)-4	# (b)(6)-4	3a. STATUS EPW	3b. SER	4. PRECEDENCE U P R X	5. GRADE
6. AGE	7. SEX X MALE / FEMALE	8. WEIGHT 100Kg	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)-- AMBUL / LITTER	11. ACCEPTING MD	12. CITE/AUTH # 2001968

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS 16a. MED (b)(6)-2 / 16b. NON-MED (b)(6)-2
	14b. ORIGINATING FACILITY PHONE NUMBER 558-4987	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS
S/P GSW to (L) thigh, (L) back s/p EX lap
c retroperitoneal hematoma

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 10 April 03 | 20b. TIME 0710 (Z) | 20c. ALLERGIES NKDA

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 → Heplock

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:
✓	INPATIENT RECORDS	OB	
	NARRATIVE SUMMARY	DENTAL	
	FINANCIAL		

20i. MEDICATIONS / TREATMENTS
Ancef 1 gm IV q8°
Percocet 1-11 PO q4-6 PRN pain
Motrin 800mg 1 PO q8° PRN pain

19. CLINICAL ISSUES (Please indicate Yes or No on all 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.		↓	Ambulatory
d.		↓	Respiratory	l.		↓	Ambulatory Aid
e.		↓	Ears/Sinus	m.		✓	Self-meds
f.		↓	Motion Sick	n.	X		Adequate Supply of Meds
g.		↓	Vision Impaired	o.			Other:
h.		✓	Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE (b)(6)-2 (b)(6)-2 MD
MAJ, USA, MC
DEPT OF OB/GYN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES

OD # (b)(6)-4
(b)(6)-4

MEDCOM - 4095

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. ...F LOCATION (State or Country Code.): 7 8 — IG

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

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

4. PAY GRADE: 16 17

5. SEX: 18 — M

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26 — 1 9 7 1 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 3 2 4

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 — ~~9 9~~ 20

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: 2100

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

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

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

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

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 — INJ

PREV. ADMISSION: YEAR — NO [X]

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

WARD: ICU I

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 86TH CSH LSA ADDER, IRAQ

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — D/C: Trans

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

23. DATE OF DISPOSITION (YYYYMMDD): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 2 6

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 (YYYYMMDD): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 4 ~~0 5~~ 10

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

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

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

FOR LOCAL USE

GSW L Thigh, L Back
~~890.0~~ ~~876.0~~

DX: 8761
8901
86804
82032
56400
E9659
Px: 5411
8622

Trauma
1
Injury
450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 M.D.

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

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

MEDCOM - 4096

Baghdad

INPATIENT TREATMENT RECORD CO[illegible] . 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
ADMISSION REMARKS
4. SEX
5. AGE
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 3
15. FLYING STATUS
16. RATING/DSG
17. DEPT./BEN K78
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE Inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct
22. HOURS OF ADMISSION 1600
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION Trans
26. DATE OF DISPOSITION 20 May 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 3 May 03
ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1
30. DATE OF INITIAL ADMISSION
32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

BKA

897

CODE:

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
17	17				17

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
X (b)(6)-2

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

DA FORM 3647, MAY 79 (b)(6)-2 EDITION OF 1 AU[illegible] USAPPC V[illegible]

MEDCOM - 4622

ACLU-RDI 1244 p.55

BAghDad

INPATIENT TREATMENT RECORD CO 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
ADMISSION REMARKS
4. SEX
5. AGE
6. RACE Iraqi
7.
10. PREVIOUS ADMISSION
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
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct
22. HOURS OF ADMISSION 1600
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION Trans
26. DATE OF DISPOSITION 20 May 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 3 May 03
ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
86th Combat Support Hospital, LSA Adder, Iraq
30. DATE OF INITIAL ADMISSION
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

BKA

~~897~~

V49.75
80392
20690

CODE:________

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
17	17				17

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
X

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AU

(b)(6)-2

USAPPC V1.10

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(b)(3)-1
	Admit [redacted] CSH
03 May 2003	
1503	Iraqi national male s/p wounding
	with Ⓡ BKA and Ⓛ distal leg
	ex-fix in place. Also has
	bilateral posterior GSW
	PE: GCS - 15
	Chest clear
	CorRRR
	Abd soft
	trauma isolated to lower
	extremities
	partial thickness skin loss
	Ⓡ buttocks
	s/p Ⓡ BKA - healing soft tissue
	injury Ⓡ posterior thigh
	s/p Ⓛ distal leg ex-fix -
	soft tissue injury Ⓛ
	posterior thigh.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

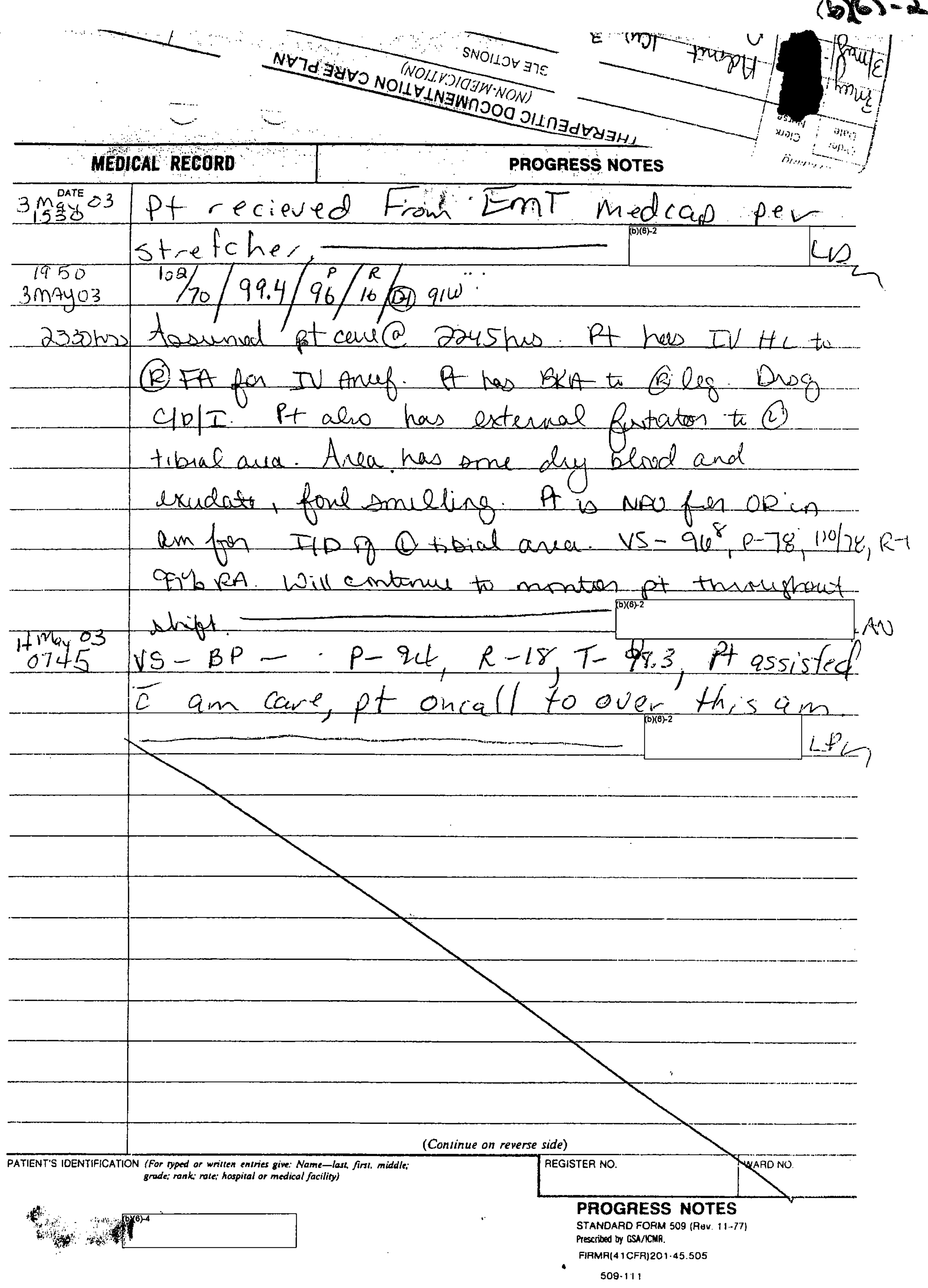
[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

MEDCOM - 4624

(b)(6)-2



THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
3 May 03 1530	Pt recieved From EMT medcap per stretcher. (b)(6)-2 LPN
1950 3MAY03	102/70 / 99.4 / P 96 / R 16 / (D) 91W
2330hrs	Assumed pt care @ 2245hrs. Pt has IV HL to (R) FA for IV Anef. Pt has BKA to (R) leg. Drsg C/D/I. Pt also has external fixator to (L) tibial area. Area has some dry blood and exudate, foul smelling. Pt is NPO for OR in am for I&D of (L) tibial area. VS - 96.8, P-78, 110/78, R-1 97% RA. Will continue to monitor pt throughout shift. (b)(6)-2 AN
4 May 03 0745	VS - BP — P-94, R-18, T-98.3, Pt assisted c̄ am care, pt oncall to OR this am. (b)(6)-2 LPN

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 4625

ACLU-RDI 1244 p.58

NOTES

DATE

01 May 2003

0500 Imp: s/p (R) BKA
s/p (L) distal leg ex-fix
s/p bilateral posterior thigh
soft tissue injury

PLAN: operative debridement

(b)(6)-2

OP Note

4 May 03 I+D multiple wounds + revision Ex fix (L) tibia
findings foul smelly fluid + dessicated necrotic tissue in (L) tibia wound, fibrinous exudate + distal thigh wounds and R tibia stump
Surg (b)(6)-2 Anesth [illegible]
Complic Ø condition good
[illegible] - Ø (b)(6)-2

4 MAY 03 1738 PACU Note: Pt groggy, arousable to voice, VSS, see flowsheet, S/p I+D / revision of (L) LE external fixator + (R) BKA + (B) thigh dressings. All dressings C/D/I, unable to assess distal neuro-vascular to (L) foot, except circulation which is < 3 secs. (B) UE distal neuro-vascular is (+) CSM. LR infusing via (L) FA. Ø s/sx of infection / infiltration. HL to (R) FA flushes easily. A'd LR to HL in (L) FA. VSS. Pt awakens to voice. Will continue to monitor (b)(6)-2, 91C3H

1800 BS ↓ x4, (B) lung sounds CTA, VS continue to be stable, Ø changes

PROGRESS NOTES

DATE	
4 MAY 03	
1800	noted to any dressing, pt still groggy, responds to Verbal stimuli, continues to drift in + out of consiousness. (R) eye (OD) PERRL, Not centered, sclera red, + slight exopthalmus noted. (L) eye (OS), PERRL, sclera red, c̄ some filmy growth over interior aspect of iris, also slight exopthalmus noted, nares patent, oral mucosa dry + foul odor, but otherwise indicative of good circulation. S1+S2 noted, RRR via telemetry, ↓BS x4, bladder (-) distended. Will continue to monitor preparing for transport. (b)(6)-2, 91C3H
1830	Distal Neuro-Vascular to (L) foot - (+) CSM. (b)(6)-2, 91C3H
1945	pt VS: BP 123/90, SpO2 96, P 111 Temp 98.6 R. 16. pt alert but drowsy, grogy, Bandages look good, no oozing. pt has IV in (R) & (L) forearms.
4MAY03 2305	Pt resting comfortably Heplock on R & L forearms, Bandages
BP	look good will continue to monitor (b)(6)-2 91W
T 100.2	Pt received Ancef through IV @ 2400 - (b)(6)-2 91W
R 20	Pt received 2 Tylenol 3's at 0400 for complaints
P 129	of being hot will continue to monitor - (b)(6)-2 - 91W
SpO2 97% RA	
5 may 03 1015	Pt A&O x3, pleasant demeanor c̄ no english spoken language barrier, Lungs CTA, (+) hypoactive bowel sound, (+) pedal pulses on LLE, very faint, (R) BKA able to lift. Pt c/o of pain, but did not want any pain medication will continue to monitor, VS - 110/60, 101, 20, 98.6. (b)(6)-2

☆U.S. GPO: 1995-397-405

ORDERS
agency is OTSG
PROBLEM ORIENTED MEDICAL RECORD

ACLU-RDI 1244 p.60

DOD 011106

MEDICAL RECORD	PROGRESS NOTES
DATE 9 May 03 1345	pt c/o of pain, pt given 2 T-3 pe Dr's order, will continue to monitor for changes (b)(6)-2 (P)
05 May 2003	
1422	low grade temperature 100.2 dressing dry to O.R 06 May for wound irrigation (b)(6)-2
1640 06 May	VS: BP 117/90. P. 103. SpO2 97, R. 20. Temp. 98.6. pt. up, ate some dinner. doing well overall, Dressings good. IV Sites Ⓡ & Ⓛ forearms intact, no infiltration. (b)(6)-2 91W/k
1800	pt's IVs infiltrated, DC and started new IV in Ⓛ hand (b)(6)-2 96 10
2230	pt recieved ancef at 2230 instead of 1600. (b)(6)-2 96
2330	Assumed pt care @ 2245 hrs. Pt has HL to Ⓛ wrist area. Pt c/o pain to bilat. LE, 5mg administered. Pt has external fixator to Ⓛ leg. Ace wrap C/D/I. RLE, BKA, drsg to stump C/D/I. Pt NPO @

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

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

519-301

*U.S. GPO: 1992

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FPI LEX Printed on Recycled Paper

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
6 May 03 1300	Pt recieved from OR c̄ ∅ problems pt A&O x3, VS: 110/70, 78, 20, 97.8, Sat 100% on RA, denies pain @ this time (b)(6)-2 LPL
6 May 03 1300	(+) pedal pulses in LLE, able to wiggle toes on command, responds to tactile stimuli, Drsg dry + intact (b)(6)-2
6 MAY 03	Pt c/o pain or swelling of arm because of IV, Doctor notified
BP 134/82	Temp's pretty high - gave 1 tablet of tylenol 3 @ 2020 (b)(6)-2
T 100.2 R 20 7 May 03	On assessment pt is A&Ox3, lungs CTA, +BSx4 quads
P 116	Drsgs to LE CDI, ≤3sec cap refill in LLE digits
SPO2 96% RA	External fixator in place to LLE. Pt is asleep, VS 120/78, 90, 98%, 20, 98.0°. (b)(6)-2
07 May 2003 1324	Surgery has pain at fracture site Temp 100.2 to O.R 08 May 2003 wound irrigation (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

PROGRESS NOTES

DATE	
	midnight for OR in am. VSS - 98⁶ - 110/70, 18, 99% RA,
	P-68. Will continue to monitor pt throughout
	shift. (b)(6)-2
0430	Pt slept well w/ not complaints. Pt NPO for OR
	this am. (b)(6)-2 LT, AN
6 May 03 0725	Pt A+O x3, Lungs CTA, ⊕ hypo active bowel
	sounds, ⊕ pedal pulse in Ⓛ lower extremity,
	denies pain @ this time, V/S 110/60, 98, 20,
	97.6, Sat 100% on RA, will continue to
	monitor for changes, Pt am care complete
	On call to OR. (b)(6)-2
06 May 2003	OP note
0952	
	open wound on Ⓛ tibia fx
	not amenable to gastroc flap,
	would require free flap
	will consider Ⓛ BKA
	wound no evidence infection
	(b)(6)-2
1015.	ARRIVED TO ICU3 FOR POST I+D LLE, DRESSING CHANGES
	BILATERAL LOWER EXTREMITIES. AROUSABLE, PERLA, PULSES (2 UPPER
	EXTREMITIES, UNABLE TO ASSESS LOWER DUE TO Ⓡ BKA, Ⓛ CAST/DRESSING
	B/P - 132/86, P. 101, RR. 18, SATS 98% RA, LUNGS CTA
	LBS Ⓛ EA 18G RUNNING LR KVO, WILL CONTINUE TO MONITOR

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

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

DATE	NOTES
	8 May 03
	OP Note I+D Left Tibia
	Surgeon [illegible]
	Anesth ketamine TT Ø
	complic
	condition

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)

FORM CLINIC

509-114

MEDCOM - 4631

ACLU-RDI 1244 p.64

DOD 011110

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES PACU
8 May 03	
	1200 - Admit to ICW 3 from OR for post Anesthesia care - procedure: (L) Tib I&D with Foreign... Absent movement - upper extremities. No Discharge from wound site.
1:30	Stable VSS - see record sheet, Lungs CTA, LBS, good pulses x 3 (R) BKA, good capillary refill x 3, arousable, brought at the bedside, had 16M of Ativan during surgery. Waiting for transfer

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)

MEDCOM - 4632

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	8 May 03
	Xray (L) Tib Fib :
	# 390
	ICW3 Requested by (b)(6)-2
	1030
	(Pt Oncall to OR need results stat)
	Results: NSIC in external fixative position
	and alignment of communuted fxs
	of tib/fib c/t 5May03 (b)(6)-2
09 May 2003	
2119	to O.R 10 May for wound examination
	under anesthesia

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

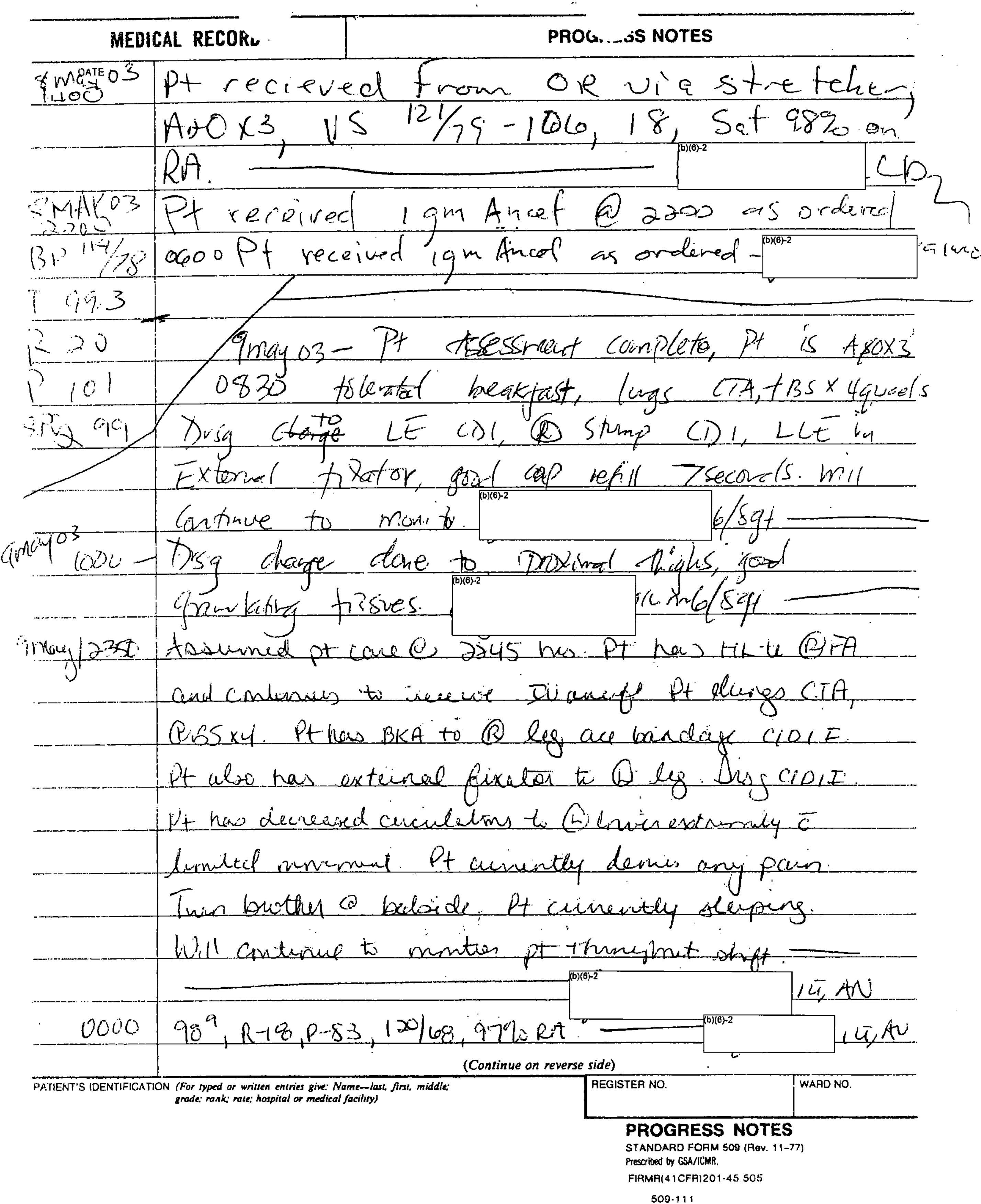
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(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)

MEDCOM - 4633



MEDICAL RECORD — PROGRESS NOTES

DATE	
8 May 03 1100	Pt recieved from OR via stretcher, A&O x3, VS 121/79 - 106, 18, Sat 98% on RA. (b)(6)-2 CD
8 MAY 03 2200	Pt received 1gm Ancef @ 2200 as ordered
BP 114/78	0600 Pt received 1gm Ancef as ordered - (b)(6)-2
T 99.3	
R 20	9 May 03 - Pt assessment complete, Pt is A&Ox3
P 101	0830 tolerated breakfast, lungs CTA, +BS x 4quads
SPO2 99	Drsg change to LE CDI, (R) stump CDI, LLE in
	External fixator, good cap refill 7seconds. Will
	Continue to monitor. (b)(6)-2 6/SGT
9 May 03 1000	Drsg change done to proximal thighs, good
	granulating tissues. (b)(6)-2 6/SGT
9 May / 2350	Assumed pt care @ 2345 hrs. Pt has HL to (R) FA
	and continues to receive IV ancef. Pt lungs CTA,
	(+)BS x4. Pt has BKA to (R) leg ace bandage C/D/I.
	Pt also has external fixator to (L) leg. Drsg C/D/I.
	Pt has decreased circulation to (L) lower extremity c̄
	limited movement. Pt currently denies any pain.
	Twin brother @ bedside. Pt currently sleeping.
	Will continue to monitor pt throughout shift.
	(b)(6)-2 1LT, AN
0000	98.9, R-18, P-83, 120/68, 97% RA (b)(6)-2 1LT, AN

(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

PROGRESS NOTES

DATE	
10 May 03 @ 0800	110/68, HR100, RR18, T98.9°, Pox 98% RA. Resting well. Family @ BS.
	Pt is NPO p 0900 for OR in evening p COL Warren returns from
	MEDCAP today. (b)(6)-2
10 May 03 1618	VS - BP 110/82, P98, R16, T98.5 oral, SpO2 100%
	SPC (b)(6)-2 91W10
10 May	1630. Pt resting. [illegible] to stump & [illegible] to (L) LE [illegible]
	Ex Fix. [illegible] D/I. IV LR STARTED @ 125 cc/hr.
	Pt REMAINS NPO & IS AWARE OF PENDING
	SURGERY THIS EVENING. BROTHER @ BS. (b)(6)-2
10 May ≈2130	TO OR (b)(6)-2
11 May 0030 VS-	P-83-R-18, 99% RA, 124/82, 95.5. Assumed pt
	care from ICU report from SPC Scott. Pt (R) leg
	BKA c ace bandage C/D/I. Pt has external
	fixation (L) lower ext. under ace bandage C/D/I. Pt has
	+ perfusion to toes, ~~color~~ + cap refill. Pt verbalizes
	minimal pain @ this time. Pt has LR to (L)
	FA @ 125cc/hr. Will continue to monitor pt
	throughout shift. (b)(6)-2
11 May 03 1615	Assumed care of Pt @ 1500, NAD noted
	Pt A+Ox3; C/O wanting dsg Δ. Δ'd Dsg
	to Buttocks using Sterile procedures. BP
	106/70 T99.4 P ~~86~~ 100 R18 Pt c 98% O2 Sats
	on R/A; Pt c HL to (L) FA S/S
	of infx. Will continue to monitor
	(b)(6)-2 91W10

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

(b)(6)-4

MEDCOM - 4635

ACLU-RDI 1244 p.68

DOD 011114

20 mg ... 1 Kefzim 600K ...

DATE	NOTES
10 May 2330	Pt admitted to RR @ 2330 - T 95.6, 98% on RA; 128/80; P85. LRCTL. Pt drowsy - responds to voice. External fixator in place to L LE. Dressings clean & dry to R BKA site. Will monitor (b)(6)-2
2345	VS: 119/79; P78; R12; O2 sat 98% on RA; 96.5 (b)(6)-2
2400	VS: 127/80; P77; R14; O2 sat 99% on RA; T 98.3
0015	VS: 129/84; P81 R12 O2 sat 99% on RA T 97
~~0030 - VS~~	
10 May 2003 2341	On note. wound examined under anesthesia debrided. skin edges being brought together gradually (b)(6)-2
11 May 2003 0959	Comfortable ate well today pt aware of our exceptional efforts to save leg. (b)(6)-2

FPI LEX Printed on Recycled Paper — STANDARD FORM 509 (REV 5-99) BAC

MEDCOM - 4636

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Dx	- (R) BKA, (L) Ext fixator to tib-fib fx
	- Upper thigh wound (L)
	- sacral decubitus
Tx	Pt went to OR 19 May 03 for drsg Δ under
	anesthesia. No ~~order~~ further orders. Expect pin care (b)(6)-2
	Sacral decubitus drsg Δ qd
Diet	Reg
VS	Routine
Meds	Cipro 500mg po (b)(6)-2
	Colace 100mg po
PRN	Tylenol #3 1 po q 4HRS
	Ambien 10mg po. qhs
	Tylenol 650mg po q 4° T≥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)

(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)

MEDCOM - 4637

STANDARD FORM 509

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 8 Aug 03

DIAGNOSIS: (L) Fib [illegible]

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

TIME:	1200	1215	1230	1300	1330						
VITAL SIGNS											
BP ARTERIAL LINE	~~[illegible]~~										
BP CUFF	135/81	122/84	139/84								
MAP			106								
TEMPERATURE	97.	96.3	97.7								
PULSE	88	92	97								
RESPIRATIONS	16	18	18								
PULSE OXIMETER	100	100	100								
CVP											
PAIN (0 - 10)											
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

INTAKE											
PO											
TOTALS											
OUTPUT											
URINE											
STOOL											
TOTALS											

MEDCOM - 4638

ACLU-RDI 1244 p.71

DOD 011117

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

549-107

SPECIMEN TAKEN	
DATE	
TIME A.M. P.M.	
REQUESTED (X)	RESULTS
RBC COUNT	3.50
HEMOGLOBIN	10.0
HEMATOCRIT	30.4
MCV	86.9
MCH	28.6
MCHC	32.9
WBC COUNT	6.7
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED RATE	
PLATELET COUNT	
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
P.T. CONTROL	
P.T. PATIENT	
CONTROL	
PATIENT	
% ACTIVITY	
RATIO	
SICKING TEST	
~~PRE~~ Pre Alb	21.3
LFT	1.9

REMARKS: CBC

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 REPORTED BY [signature] TECH (b)(6)-2 MD DATE 5/8/03 LAB. ID. NO.

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

OR/ICU2

(b)(6)-4

HEMATOLOGY
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☒ STAT
PATIENT STATUS: ☐ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)
SPECIMEN/LAB RPT. NO.
...'S MED. RECORD

(b)(6)-4

SPECIMEN/LAB. RPT. NO.

CHEM I

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2 | REPORTED BY (b)(6)-2 | MD TECH | DATE 1737 08MAY03 | LAB. ID. NO.

REMARKS: Chem 12

546-107

TEST(S)	
SPECIMEN TAKEN DATE	8 May 03
TIME A.M. P.M.	1700 / 1630
REQUESTED (X)	RESULTS
GLUCOSE	174 ↑
UREA N.	9 ↓
CREATININE	
URIC ACID	
SODIUM	
POTASSIUM	
CHLORIDE	
CO_2	
PHOSPHATE	
CALCIUM	6
TOTAL PROTEIN	4.7 ↓
ALBUMIN	1.5 ↓
GLOBULIN	
ALKALINE PHOSPHATASE	127 ↑
ACID PHOSPHATASE	
SGOT	
LDH	
CPK	
BILIRUBIN (TOTAL)	0.4
BILIRUBIN (DIRECT)	
CHOLESTEROL	144
TRIGLYCERIDES	
AMYLASE	12 ↓
LIPASE	
PROFILE (Specify)	
ALT	14
AST	20

CHEMISTRY I
STANDARD FORM 546 (Rev. 6-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 4639

ACLU-RDI 1244 p.72

DOD 011118

drug material ... H&P 8 MAY 03

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M F	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

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 tendencies, 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 (b)(6)-2 *MAJ CRNA* DATE *10 MAY 03*

PHYSICIAN DATE

POST ANESTHESIA VISITS

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

DATE:

SIGNED: TIME:

MEDCOM - 4640

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
2116	2140	2344	10 MAY 03
TOTS	**SURG START**	**DRESSING**	**OR NO**
2145	2155	2330	2 L

OPERATION PERFORMED: Drsg Δ; I+D LLE

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State:
- [ ] AWAKE
- [x] CALM
- [ ] SEDATE
- [ ] APPREHENSIVE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 6 & EQUIP. CHECKED
- [x] NON-INV B/P
- [ ] PNS
- [x] CONT. EKG
- [ ] V LEAD EKG
- [ ] ESOPH. STETH.
- [ ] PRECORD STETH.
- [x] PULSE OXIMETER
- [x] O2 ANALYZER
- [ ] END TIDAL CO2
- [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N/G TUBE
- [ ] O/G TUBE
- [x] IV(s) 20; LFA
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [x] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [ ] GENERAL
- [x] 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 ___ [ ] BLADE
- [ ] ETT SIZE ___ [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [ ] CUFFED ___ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [ ] ETT SECURED AT ___ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS

Agent									TOTAL
Versed mg	.5								2.5 mg
MSO4 mg	10	5	5						20 mg
Propofol mg	50	30 30	30/30/50						300 mg
Ketamine mg						10			100 mg

N2O L/min: AIR
O2 L/min

FLUIDS

LR — 500 — 600

Urine

EBL — 100

MONITORS

EKG	SR	SR	SR	SR	SR	SR	SR	SR
% O2 Inspired	RA	RA	RA	RA	RA	RA	RA	RA
O2 Saturation	97	96	96	98	100	98	100	100
End Tidal CO2								
Temperature								
PNS								

VITAL SIGNS

TIME: 2130, 2200, 30, 2300, 30, 0000, 30

PRE-OP VALUES: B/P 101/57; P 88; R 10; SAT 98; H/H

RESP								
Tidal Volume								
Resp Rate	16	10	14	18	20	20	12	12
Peak Pressure								
Symbols for Remarks	SV	SV	SV	SV	SV	SV	SV	SV

Position: 0→

SYMBOLS: X ANESTH; ⊙ OPERAT; ∨ ∧ B/P CUFF PRESS; ⊥ T ARTER LINE PRESS; ● PULSE; ○ SPONTANEOUS R; ⊄ ASSIS RES; ⊗ CONTRO RES; T TOURN; F CRYSTALLOID; E BLO

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation.
[ ] Significant changes from préop plan / evaluation.

Tourniquet Time:

RECOVERY

TIME IN PACU	CONDITION
2340	STABLE

B/P	PULSE	RESP	O2 SAT
129/89	85	16	100

REMARKS

TEMP

REPORT TO: PARRS:

IN	FLUIDS TOTALS	OUT
Crystalloid: 600		EBL: 100
		Urine:
		Gastric: /
Blood: /		

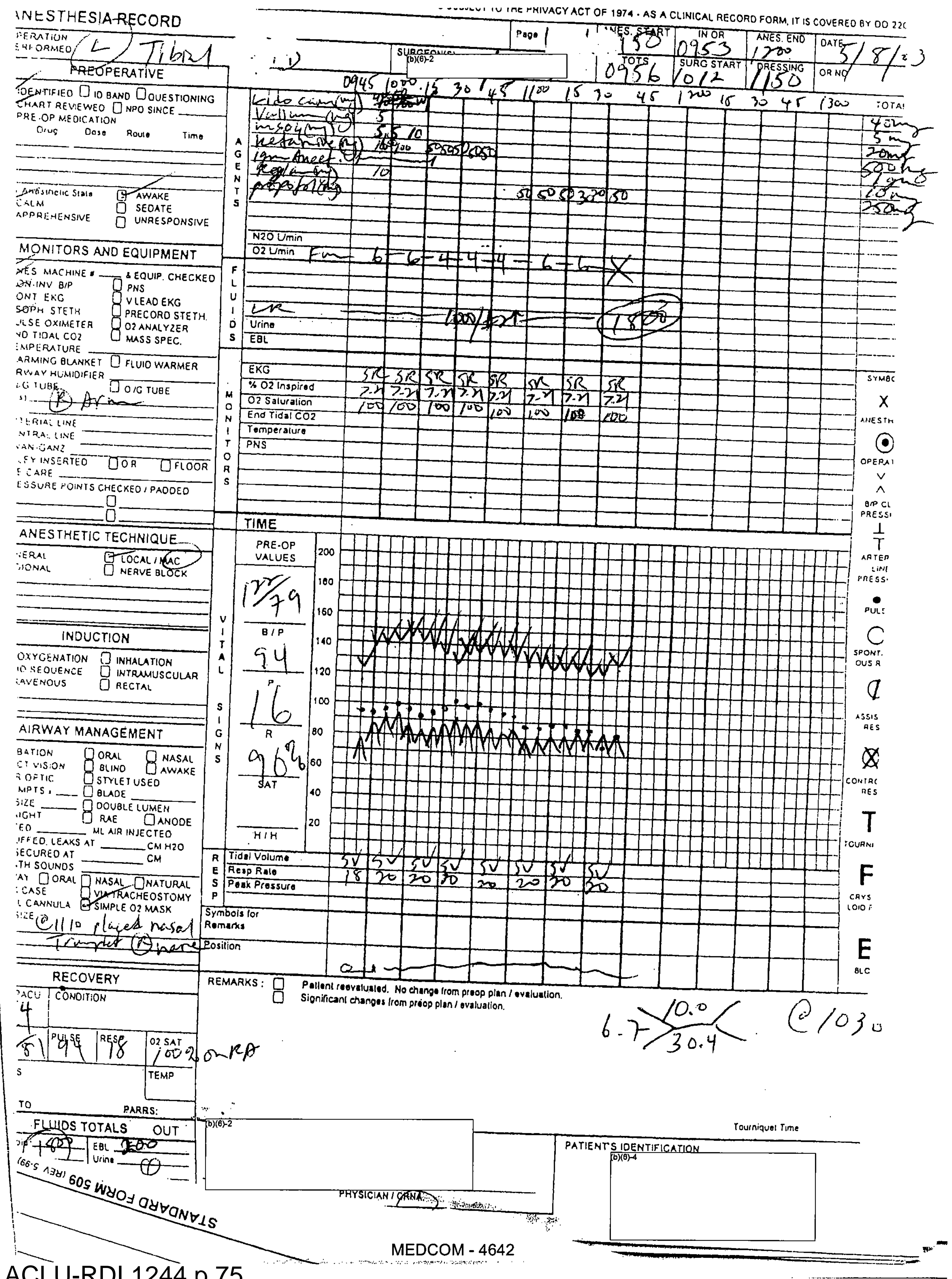
(b)(6)-2 (b)(6)-2 MAJ/CRNA

MAJ CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDCOM - 4641



ANESTHESIA RECORD

SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[illegible]

OPERATION PERFORMED: (L) Tibia

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

Page 1 of 1

ANES. START: 0950 | IN OR: 0953 | ANES. END: 1200 | DATE: 5/8/03
TOTS: 0956 | SURG START: 1012 | DRESSING: 1150 | OR NO

PREOPERATIVE

IDENTIFIED ☐ ID BAND ☐ QUESTIONING
CHART REVIEWED ☐ NPO SINCE
PRE-OP MEDICATION
Drug Dose Route Time

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
NG TUBE ☐ O/G TUBE
IV: (R) Arm
ARTERIAL LINE
CENTRAL LINE
SWAN-GANZ
FOLEY INSERTED ☐ OR ☐ FLOOR
EYE CARE
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
FIBEROPTIC ☐ STYLET USED
ATTEMPTS ☐ BLADE
SIZE ☐ DOUBLE LUMEN
RIGHT ☐ RAE ☐ ANODE
TAPED — ML AIR INJECTED
CUFFED, LEAKS AT — CM H2O
SECURED AT — CM
BREATH SOUNDS
AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
FACE CASE ☐ VIA TRACHEOSTOMY
NASAL CANNULA ☑ SIMPLE O2 MASK
SIZE: @1110 placed nasal Trumpet (R) nare

AGENTS (times: 0945, 1000, 15, 30, 45, 1100, 15, 30, 45, 1200, 15, 30, 45, 1300)

Agent	Entries	TOTAL
Lidocaine (mg)	40/[illegible]	40mg
Valium (mg)	5	5mg
MSO4 (mg)	5, 5, 10	20mg
Ketamine (mg)	100, 100, 50, 50, 50, 50, 50	500mg
1gm Ancef	1	1gm
Reglan (mg)	10	10mg
propofol (mg)	50, 50, 50, 30, 20, 50	250mg

N2O L/min
O2 L/min: Fm 6 - 6 - 4 - 4 - 4 - 6 - 6 X

FLUIDS: LR 1000/[illegible] (1800)
Urine
EBL

MONITORS

EKG	SR	SR	SR	SR	SR	SR	SR	SR
% O2 Inspired	7-21	7-21	7-21	7-21	7-21	7-21	7-21	7-21
O2 Saturation	100	100	100	100	100	100	100	100
End Tidal CO2								
Temperature								
PNS								

TIME

VITAL SIGNS — PRE-OP VALUES: B/P 127/79; P 94; R 16; SAT 96%; H/H

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

RESP

Tidal Volume	SV	SV	SV	SV	SV	SV	SV	SV
Resp Rate	18	20	20	20	20	20	20	20
Peak Pressure								

Symbols for Remarks
Position

SYMBOLS: X ANESTH; ⊙ OPERATION; ∨ ∧ B/P CUFF PRESSURE; ⊥ ⊤ ARTERIAL LINE PRESSURE; • PULSE; ○ SPONT. RESP.; Ⓐ ASSIST. RESP.; Ⓒ CONTROLLED RESP.; T TOURNIQUET; F CRYSTALLOID F.; E BLOOD

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

6.7 > 10.0 / 30.4 < @1030

RECOVERY

PACU 4 | CONDITION
BP 81 | PULSE 94 | RESP 18 | O2 SAT 100% on RA
TEMP
TO — PARRS:

FLUIDS TOTALS: IN: 1800 | OUT: EBL 200, Urine ∅

(b)(6)-2

PHYSICIAN / CRNA

Tourniquet Time

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

STANDARD FORM 509 (REV 5-99)

MEDCOM - 4642

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR
FIRMR(41CFR)201-45 505
509-111

*U.S. GPO: 1992-316-809/60175

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

Xray LFt Tib/Fib

(b)(6)-4

AGE | SEX | SSN *(Sponsor)* | WARD/CLINIC | REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

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

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

tib/Fib Fx, External Fixiator

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
5 May 03		

RADIOLOGIC REPORT

Comm Fx tib/fib c̄ EF readjusted
superior-most component now
traverses intact bone of tibial
metadiaphysis

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

MEDCOM - 4643

ACLU-RDI 1244 p.76

...plained. ... as backup.

PATIENT'S SIGNATURE

EVALUATOR(S) SIGNATURE

DATE

SIGNED:

For use of this ...

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only ... list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which ... 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: _____ litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 100 cc/hr, ~~bolus _____ cc x 1~~		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 15 mg		
4	DEMEROL: 25-50 mg IV q 5-10 minutes PRN pain. MAX dose of 100 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 _____ or greater		
9	Call Anesthesia for any questions or concerns		
10.	Versed 2mg IV for agitation prn. Max dose 4mg.		
	SIGNED (b)(6)-2 MAJ/CRNA		

PATIENT IDENTIFICATION

(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 - 4644

ACLU-RDI 1244 p.77

DOD 011123

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:______litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 100 cc/hr, ~~bolus ______ cc~~ X 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 20 mg		
4	DEMEROL: 50 mg IV q 5-10 minutes PRN pain. MAX dose of 100 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 ______ or greater		
9	Call Anesthesia for any questions or concerns		
	Versed 2mg IV prn agitation q 30 min		
	(b)(6)-2		
	SIGNE[redacted] MAJ/CRNA		

PATIENT IDENTIFICATION

(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 9_ MEDCOM - 4645

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: 2-10 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 100 cc/hr, bolus ____ cc x 1		
3	MORPHINE: 2-5 mg IV q 5-10 minutes PRN pain. MAX dose of 30 mg		
4	DEMEROL: 12.5 mg IV q 5-10 minutes PRN pain. MAX dose of 75 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 8 or greater		
9	Call Anesthesia for any questions or concerns		
	SIGNED (b)(6)-2 CRNA		

PATIENT IDENTIFICATION

(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) ...

MEDCOM - 4646

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 ... at the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written ... 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: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: ______ @ 75 cc/hr, bolus —— cc x 1		
3	MORPHINE: 2 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 ______ or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 25 mg IV PRN N/V may repeat once		
	SIGNED (b)(6)-2 MTJ Cram		

PATIENT IDENTIFICATION

(b)(6)-4

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

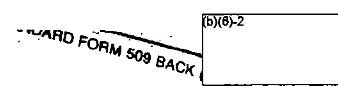
Diagnosis: ______

Height: ______ Weight: ______ Diet: ______

Allergies: ______

Nursing Unit	Room No.	Bed No.	Page No.

MEDCOM FORM 688-R (TEST) (MCHO) M. MEDCOM - 4647 RE OBSOLETE



STANDARD FORM 509 BACK (Rev. 11-77)

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

BED #4

NURSING UNIT | ROOM NO. | BED NO.

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

03 May 2003
1500 ① Admit ICW #?
① Dx: Ⓛ tibia fx
s/p Ⓡ BKA
bilateral posterior
thigh wounds
① VS - Q shift
① NPO
① X-ray Ⓛ tibia/fibula
① Cefazolin 1 gm IV q 8h
① Morphine sulfate 2 to 5 mg IV q 1h prn pain
① Bed rest
① to O.R 03 May 2003 - I&D Ⓛ tibia fx

04 May 03
1 Admit ICW / VS Routine ...
2 Reg diet, supplement calories please
3 X Ray Ⓛ tibia/fibula
4 Ancef 1gm IV q 8hrs
5 Gentamycin 70mg IV one dose ...
6 Morphine sulfate 2-5 mg IV q hr prn
7 Tylenol #3 i-ii po q 3h prn
8 Bedrest
9 IV LR KVO or hep lock

(b)(6)-2

05 May 2003
1421 ① NPO p midnight
① to O.R 06 May 2003
wound I&D

X 06 May 0030 ...

(b)(6)-4

(b)(6)-2

(b)(6)-2

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

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

MEDCOM - 4648

THE DOCTOR SHALL RECORD DATE AND 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

ICW-3

NURSING UNIT | ROOM NO | BED NO.

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

00 May 2003
0953 Post Op Orders
① VS - Q shift
② ... as tolerated
③ Regular diet
④ IVF - LR - 150cc/hr
⑤ Δ IV to hep lock AM

PATIENT IDENTIFICATION

Noted
06 May 03
1510
(b)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

07 May 2003
⑥ Cefazolin 1 gm IV q 8h
⑦ Gentamicin 250mg IV q24h x 3 days, then D/C
⑧ Morphine sulfate ... mg IV q 4h prn pain
⑨ Tylenol #3 ... po q 4h prn pain

NURSING UNIT | ROOM NO | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

07 May 2003
to O.R. 08 May wound irrigation
NPO after midnight

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

07 May 2003
X-ray ⓛ tibia / fibula

(b)(6)-2

- 24hr chart check done / 8 May 03 / 0450 hrs

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4649

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

08 May 2003 Post Op Orders
1212 ✓ ① VS - Q shift
✓ ② Regular diet
✓ ③ Up as tolerated
✓ ④ IVF - LR - 125cc [illegible]
✓ ⑤ Δ IV to heparin lock when tolerating liquids
✓ ⑥ Cefazolin 1 gm IV q8h
✓ ⑦ Morphine sulfate [illegible] IV q 4h prn pain
✓ ⑧ Tylenol #3 1 po q4h prn pain
⑪ ~~[illegible]~~ [illegible] this afternoon
✓ ⑫ change proximal thigh dressings Q day and prn

(b)(6)-2

(b)(6)-2 [illegible] 08/05/03 1600

NURSING UNIT | ROOM NO. | BED NO.

09 May 2003
2117 ① To OR 10 May 2003
② Clear liquids
③ NPO p 0900 AM 10 May 2003
④ Ambien 10mg po hs prn sleep

(b)(6)-2

(b)(6)-4

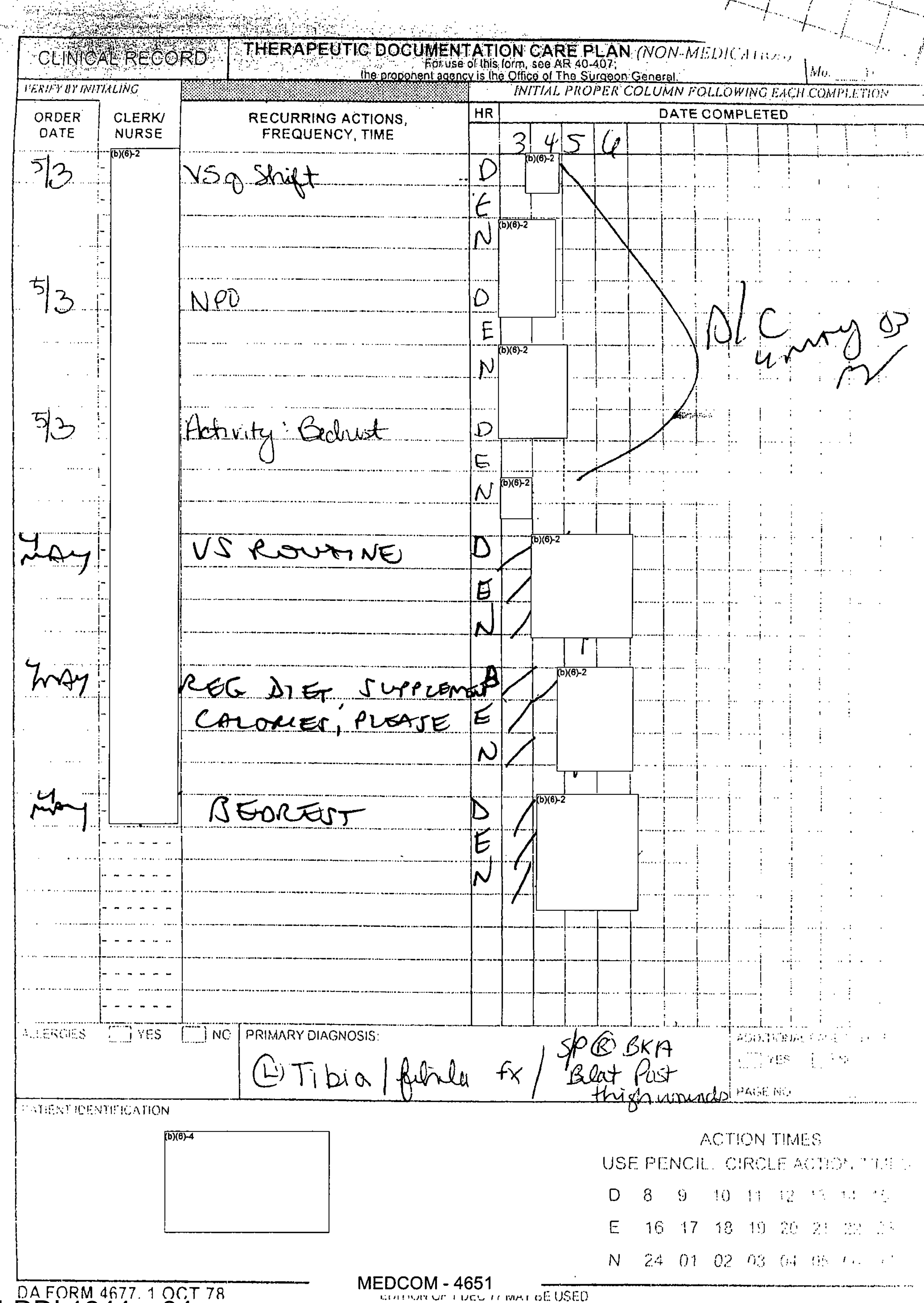
(b)(6)-2

Done 10 May 03 0700h (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 - 4650



CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATIONS)

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	3	4	5	6
5/3	(b)(6)-2	VS q Shift	D		(b)(6)-2		
			E				
			N	(b)(6)-2			
5/3		NPO	D				
			E				
			N	(b)(6)-2			
5/3		Activity: Bedrest	D				
			E				
			N	(b)(6)-2			
4 May		VS ROUTINE	D	/	(b)(6)-2		
			E	/			
			N	/			
4 May		REG DIET, SUPPLEMENT CALORIES, PLEASE	D	/	/	(b)(6)-2	
			E	/			
			N	/			
4 May		BEDREST	D	/	(b)(6)-2		
			E	/			
			N	/			

D/C 4 May 03

ALLERGIES [ ] YES [ ] NO

PRIMARY DIAGNOSIS: (L) Tibia/fibula fx / S/P (R) BKA Blat Post thigh wounds

PATIENT IDENTIFICATION

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — MEDCOM - 4651 — EDITION OF 1 DEC 77 MAY BE USED

ACLU-RDI 1244 p.84

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PL[...] ([M]EDICATION)

For use of this form, see AR 4[...]; the proponent agency is the Office of The Su[...] General.

Mo. [May 03]

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8
6 May 03	(b)(6)-2	VS - Q shift	07 15	(b)(6)-2		
			15 23			
			23 07			
6 May 03		Up as tolerated	07 15			
			15 22			
			23 07			
6 May 03		Regular Diet	07 15			
			15 23			
			23 07			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

MEDCOM - 4652

ACLU-RDI 1244 p.85

DOD 011131

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. 05 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11
8 May 03	(b)(6)-2	VS – Q shift	07 19 19 07	(b)(6)-2			
8 May 03		Regular diet	07 19 19 07	(b)(6)-2			
8 May 03		Up as tolerated	07 15 15 23 23 07	(b)(6)-2			
8 May 03		Change proximal thigh dressing proximal thigh ↓ dressing Q day and prn	10		(b)(6)-2		
9 May		Clear Liquids	B L D				(b)(6)-2

ALLERGIES: YES NO — unknown

PRIMARY DIAGNOSIS: (R) BKA, (L) tib-fib fx c̄ ext. fixator

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

MEDCOM - 4653

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

Mo 05 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8 May		Chem 12 this Afternoon	8 May 03	1730	1730	(b)(6)-2
9 May		OR 10 May 2003	10 May			
9 May	(b)(6)-2	NPO p 0900 Am 10 May 2003	10 May			

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

USAFA V1 00

MEDCOM - 4654

ACLU-RDI 1244 p.87

DOD 011133

CLINICAL RECORD - THERAPEUTIC DOCUMENTATION

For use of this form, see ... the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6
5/3	(b)(6)-2	Cefazolin 1 gm IV q 8h	10				
			18	(b)(6)-2	D/C 4 MAY 03		
			02				
4 MAY		ANCEF 1 gm IV q 8hr	08		(b)(6)-2		
			16				
			24				
4 MAY		IV LR - KVO or HEPLOCK (HEPLOCKED 4 MAY)	D		(b)(6)-2		
			E				
			N				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓛ Tibial fx, S/P Ⓡ BKA, Bilat Post. thigh wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

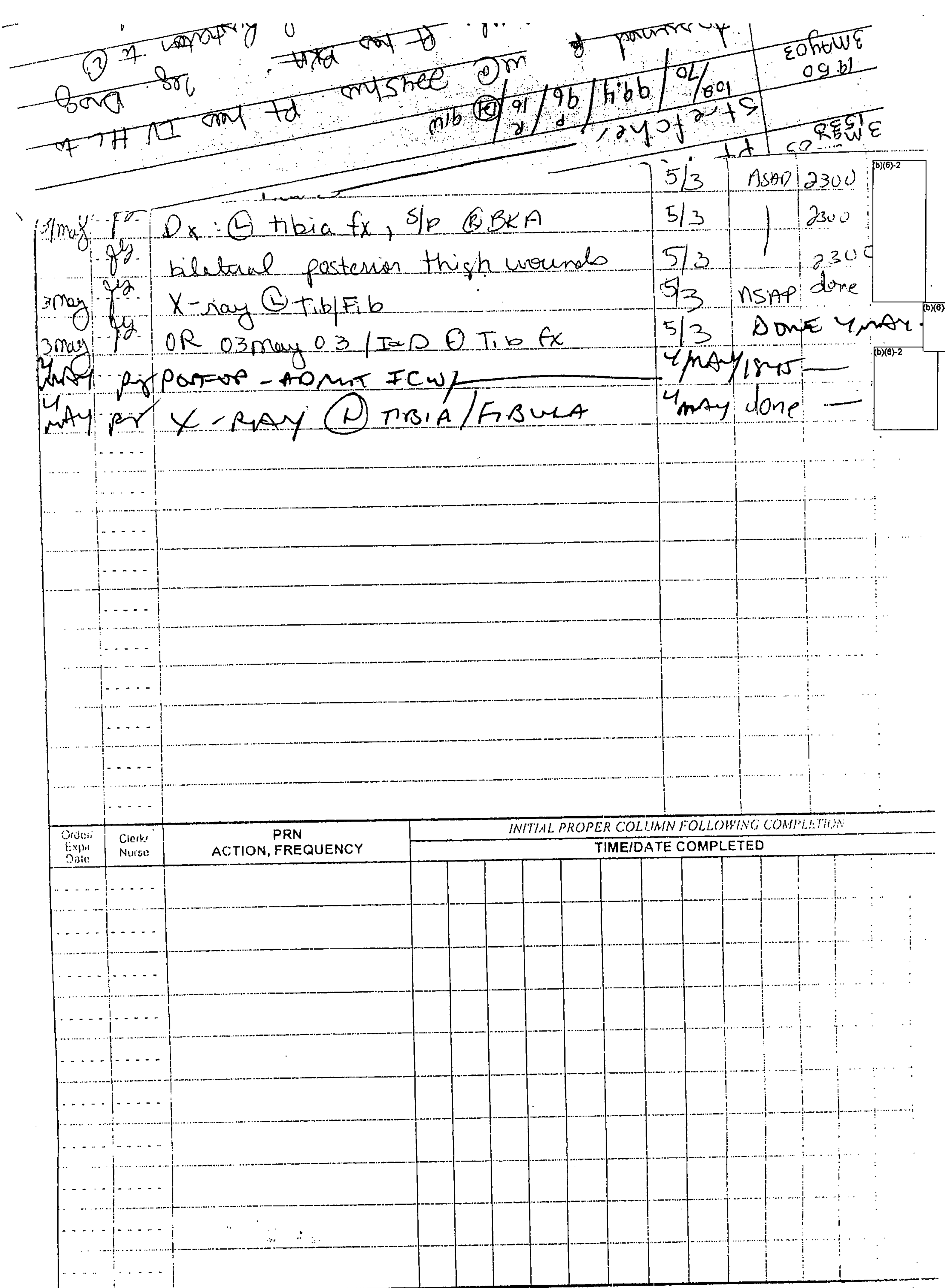
EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4655

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. MAY Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4 MAY	(b)(6)-2	GENTAMYCIN 70 mg IV ONE DOSE ONLY	4 MAY			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED			
5/3	(b)(6)-2	Morphine 1 to 5 mg IV q 1hr prn pain	4 MAY 2210 5mg IV	D/C 4 MAY 03		
4 MAY 03		MORPHINE SULFATE 2-5 mg IV q HR PAIN	D T AMT 1 MG			
4 MAY		TYLENOL #3 i-ii PO q 3 hr PRN	5 MAY 0730 PC	5 MAY 1345 PC	5 MAY	6 MAY 1255 PC

MEDCOM - 4656



Date	Initials	Order	Date	Priority	Time
			5/3	ASAP	2300
3 May	[illegible]	Dx: (L) tibia fx, S/P (R) BKA	5/3	|	2300
	[illegible]	bilateral posterior thigh wounds	5/3		2300
3 May	[illegible]	X-ray (L) Tib/Fib	5/3	ASAP	done
3 May	[illegible]	OR 03 May 03 / I&D (L) Tib fx	5/3	DONE 4 MAY	
4 May	[illegible]	POST-OP - ADMIT ICW	4 MAY	1845	
4 MAY	[illegible]	X-RAY (L) TIBIA/FIBULA	4 MAY	done	

(b)(6)-2

(b)(6)-2

(b)(6)-2

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

MEDCOM - 4657

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. MAY Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8
6 May 03	(b)(6)-2	IVF - LR 150 cc/hr	07 19	(b)(6)-2		
		Δ IV to hep lock	19 07			
		Am (7 May 03)				
6 May 03		Cefazolin 1 gm IV	08	(b)(6)-2		
		q 8 h	16			
			24			
6 May 03		Gentamicin 250 mg	16	(b)(6)-2		
		IV @ 24 h				
		x 3 days then				
		DC				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

MEDCOM - 4658

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

Mo. MAY 03

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11
8 May 03	(b)(6)-2	IVF - LR 125cc/hour	07 15	(b)(6)-2			
		Δ IV to heparin lock	15 23	(b)(6)-2			
		p̄ tolerating liquids	23 07				
8 May		Cefazolin 1 gm	06	(b)(6)-2			
		IV 8h	14				
			22				
9 May	(b)(6)-2	Colace 100mg PO BID	10				
			22				
10 May		LR @ 125 cc/hr	D			(b)(6)-2	
			E				
			N				

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: (R) BKA, (L) ext. fixator to tib-fib fx

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4659

Verify by Initialing

THF EUTIC DOCUMENTATION CARE P

(MEDICATIONS)

Mo. [illegible]

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			
8 May	(b)(6)-2	Morphine Sulfate ii to V mg IV q i prn Pain	8 May 2115 [illegible]	9 May 1700 [illegible] 70	11 May 1250 5 mg [illegible]	11 May 1250 2 mg [illegible]
8 May	(b)(6)-2	Tylenol #3 i po q 4h prn pain	8 May 2000 [illegible]	9 May 1715 [illegible] 70	10 May 1310 [illegible]	[illegible]
9 May		Ambien 10mg PO HS PRN sleep	11 May 0030 [illegible]			
9 May		Dolculax 10-20mg PO HS PRN constipation	10 May 1030 10mg [illegible]			

(b)(6)-4

MEDCOM - 4660

ACLU-RDI 1244 p.93

DOD 011139

7-05

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER (9–15): (b)(6)-4

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

7. AGE AT ADMISSION (27 28 29)

8. RACE (30): X — Iraqi

9. ETHNIC BACKGROUND (31): 9

RELIGION

10. LENGTH OF SERVICE (32 33 34): —

ETS

11. FMP (35 36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46): 2

HOUR OF ADMISSION: 1600

BRANCH / CORPS: ABAA

14. FLYING STATUS (47 48 49): —

15. BENEFICIARY CATEGORY (50 51 52): K91 (ok, 77 crossed out)

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): INJ

PREV. ADMISSION — YEAR — NO

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

WARD: ICW3

NAME: (b)(3)-1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73 74): 26 — TRANS

22. MTF TRANSFERRED TO (75–80): (b)(3)-1

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 2ø03ø52ø

24. CLINIC SVC - ADMITTING (87 88 89 90): A B A A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 2ø03ø5ø3

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

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116)

FOR LOCAL USE

BKA

DX: 8971
7070
8249
8901
E9889

Px: 8622
7966
7847

Trauma 9 — Inj 999

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

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4661

7-055

ADMISSION AND CODING INFORMATION

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

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

(b)(3)-1

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

NAME (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 [handwritten]

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: 1600

BRANCH / CORPS: ABAA

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: IN

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72: Direct

WARD: ICW3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NA (b)(3)-1

21. TYPE OF DISPOSITION 73 74: TRANS

22. MTF TRANSFERRED TO 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y M M D D) 81 82 83 84 85 86: 0 3 0 5 2 0

24. CLINIC SVC - ADMITTING 87 88 89 90: A B A A

25. MTF TRANSFERRED FROM 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D) 97 98 99 100 101 102: 0 3 0 5 0 3

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

28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D) 111 112 113 114 115 116

FOR LOCAL USE

BKA

(b)(6)-2

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

(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4662

FREQ. VITAL SIGNS

TIME	0800	1200		2400	0100	0800									
BP	104/80	108/60		124/70		120/70									
HR	88	96		86		86									
RR	17	14		18		18									
TEMP	99.6	~~97~~ 100.3		99.9	99.4	98.7									
SAO2				97		98									
				NA		NA									

N[illegible]

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PB																			200							

MEDCOM - 4573

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
E																										
UOP		250																								
																				525		275				
BM																										

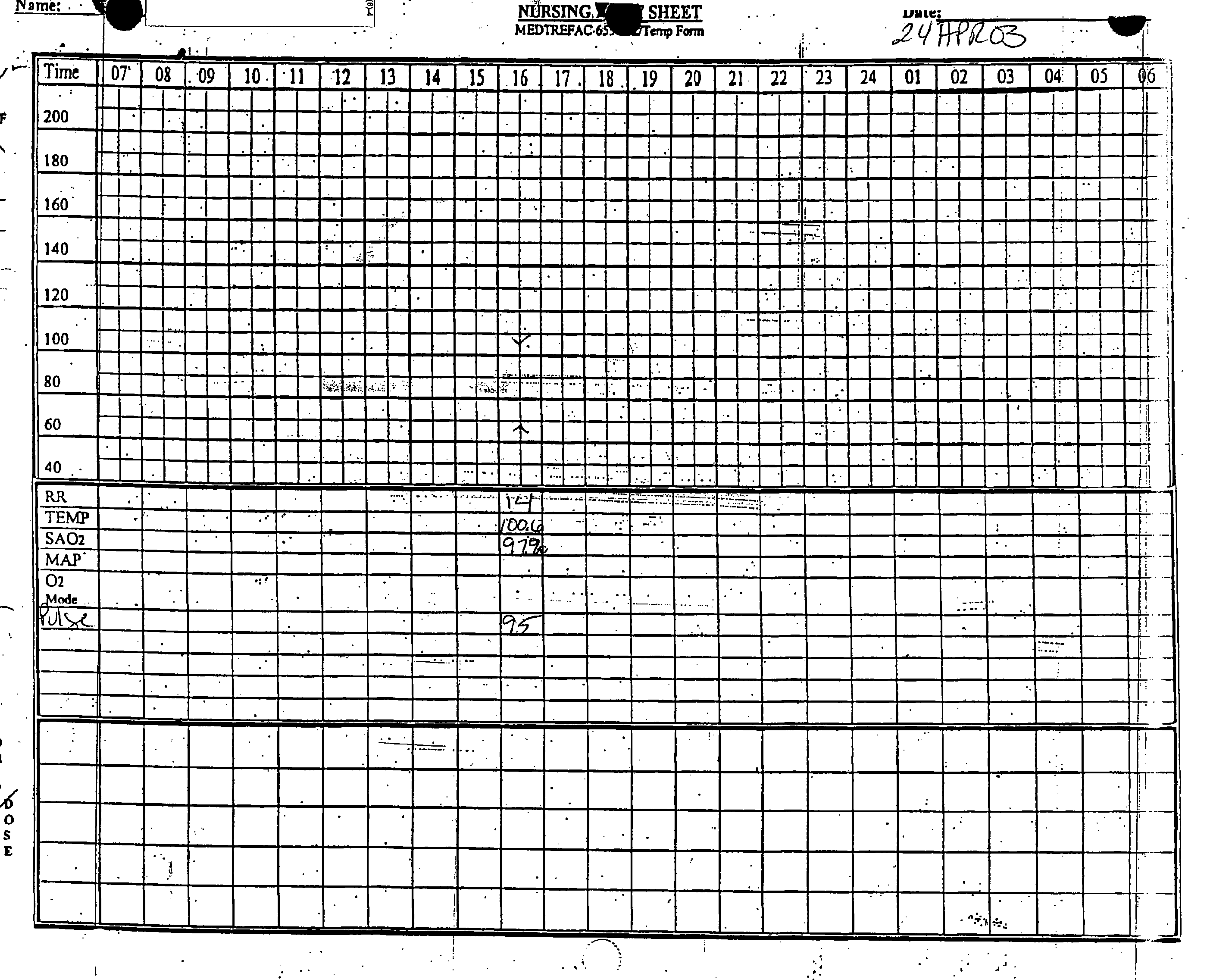
PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 24APR03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100										V														
80																								
60										^														
40																								
RR										14														
TEMP										100.6														
SAO2										97%														
MAP																								
O2 Mode																								
Pulse										95														

DRIP / DOSE

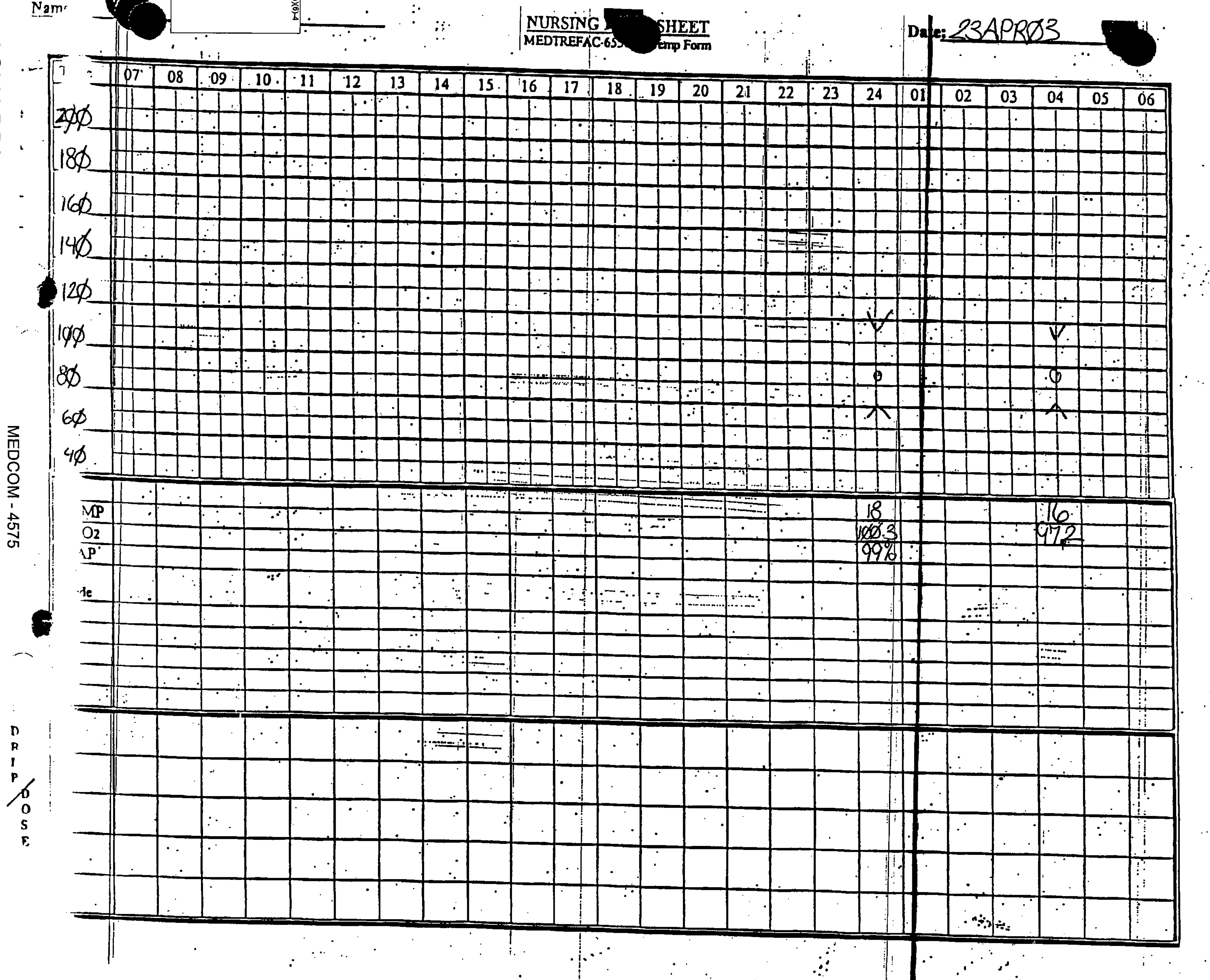
MEDCOM - 4574

ACLU-RDI 1244 p.97

Name (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted] Temp Form

Date: 23APRØ3

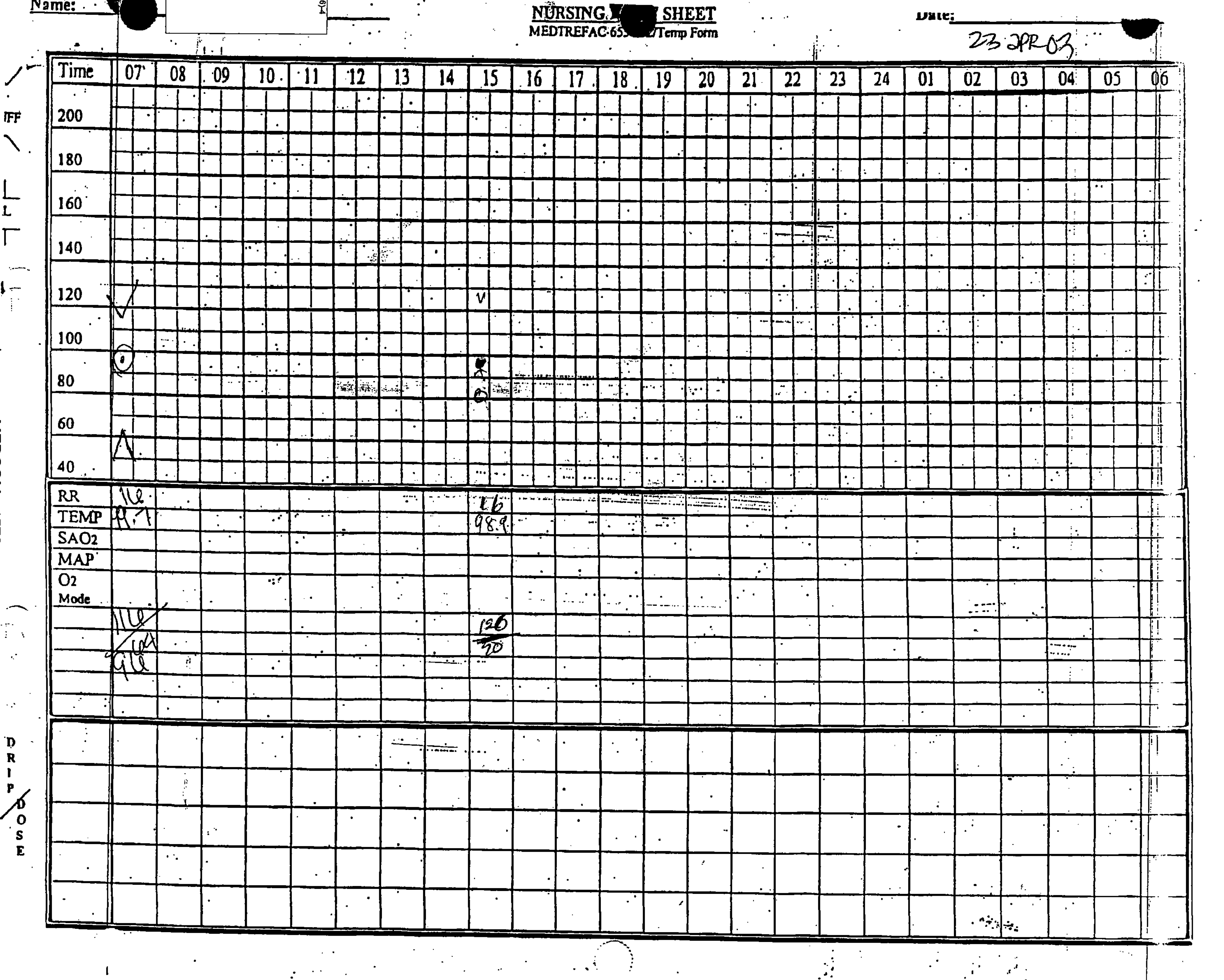


MEDCOM - 4575

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC 65[redacted]/Temp Form

Date: 23 APR 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	16								16															
TEMP	97.7								98.9															
SAO2																								
MAP																								
O2 Mode																								
	116/96								126/70															

DRIP / DOSE

MEDCOM - 4576

ACLU-RDI 1244 p.99

FREQ. VITAL SIGNS

TIME		1500													
BP		126/70													
HR		80													
RR		16													
TEMP		98.9													
SAO2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY				550																						
HOP										450		300														
BM																										

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 4577

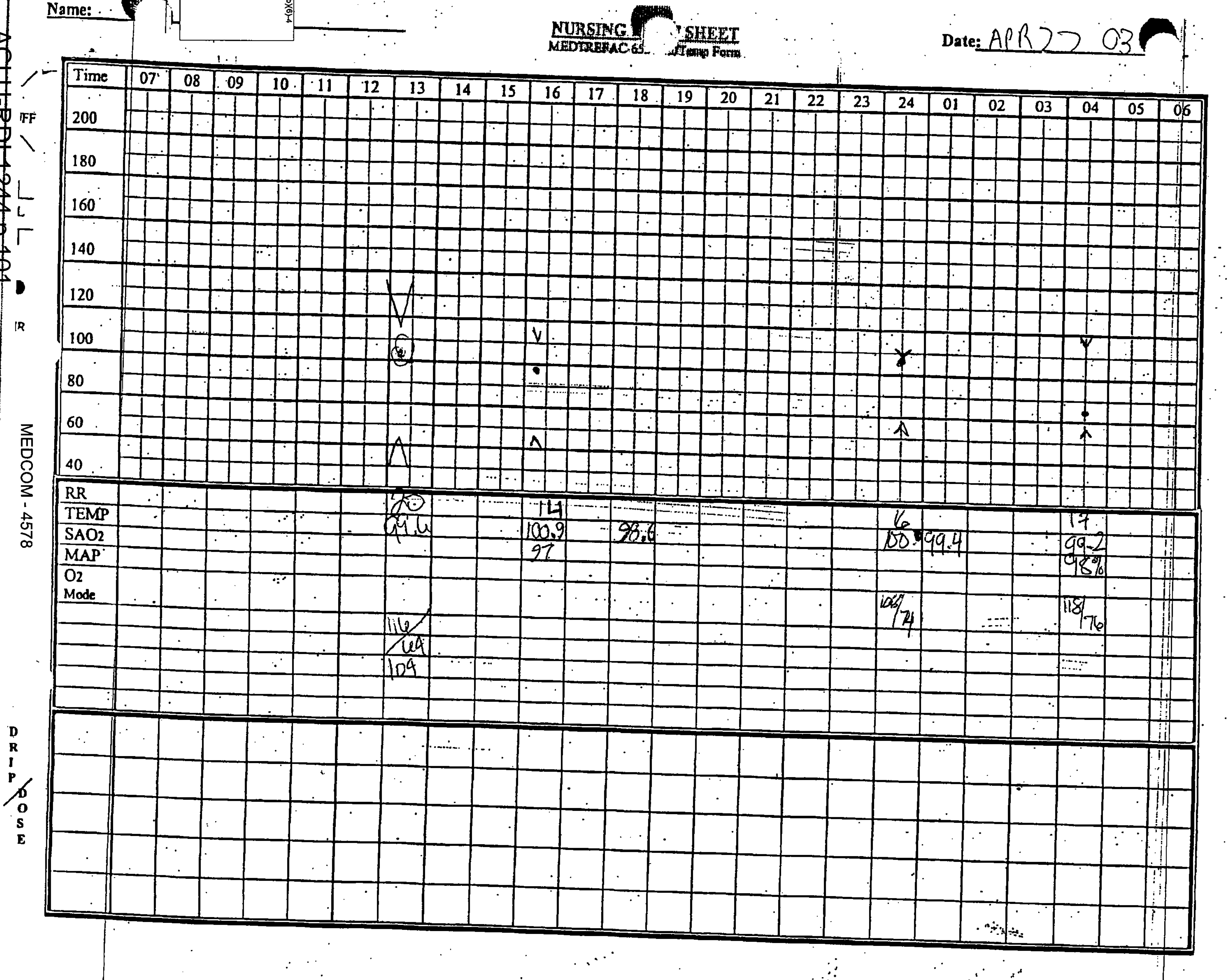
ACLU-RDI 1244 p.100

DOD 011056

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC 65[illegible]/Temp Form

Date: APR 22 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR							[illegible]			14								16				17		
TEMP							97.6			100.9		98.6						100	99.4			99.2		
SAO2										97												98%		
MAP																								
O2 Mode																								
							116/64											104/74				118/76		
							104																	

DRIP / DOSE

MEDCOM - 4578

ACLU-RDI 1244 p.101

DOD 011057

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY							300																			
UOP														500												
																							650			
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT__________ PREVIOUS WEIGHT__________

PRESENT 24 HOUR INPUT__________ PRESENT 24 HOUR OUTPUT__________ PRESENT WEIGHT__________

MEDCOM - 4579

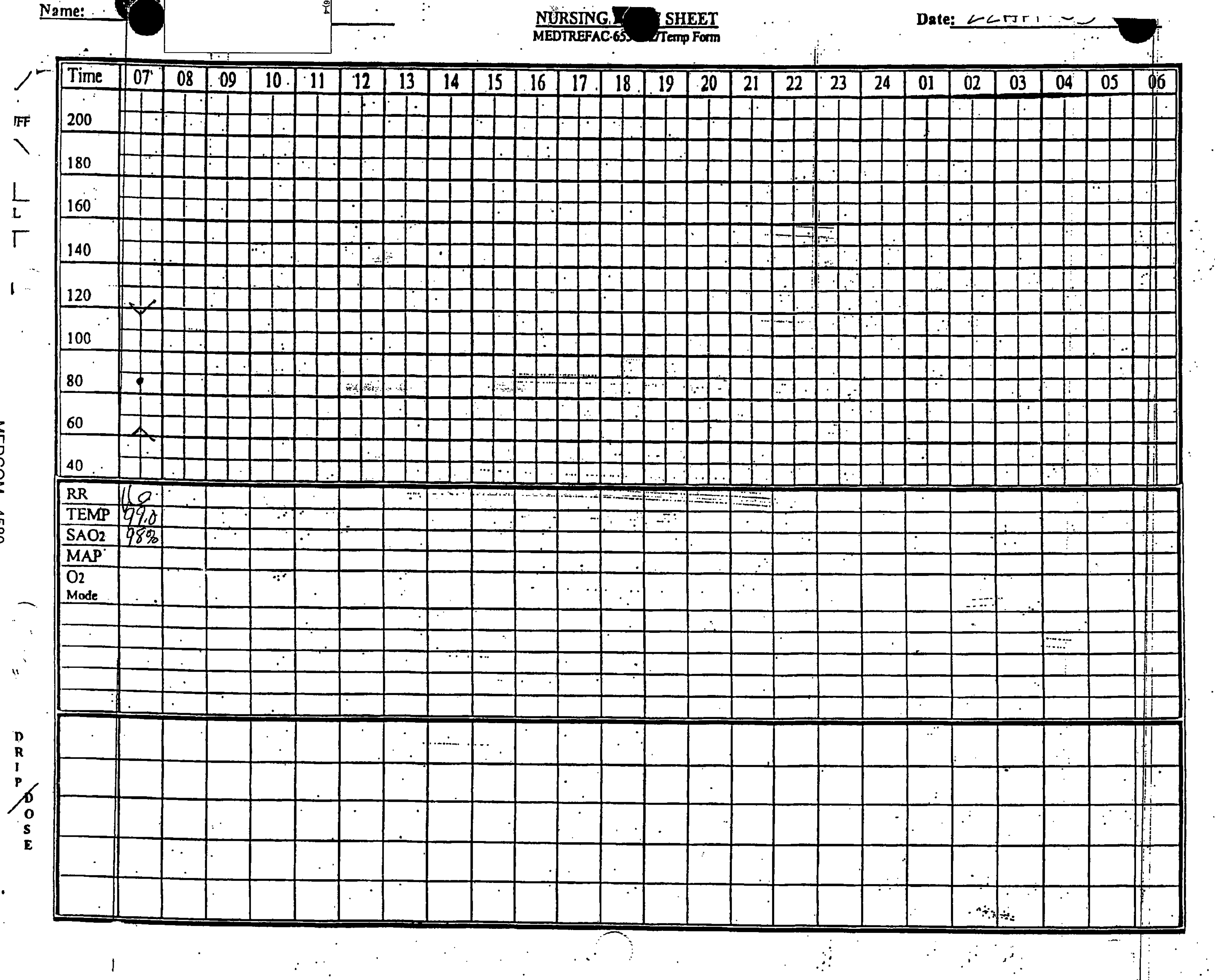
ACLU-RDI 1244 p.102

DOD 011058

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: [illegible]



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	16																							
TEMP	99.0																							
SAO2	98%																							
MAP																								
O2 Mode																								

DRIP/DOSE

MEDCOM - 4580

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:________________________

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP				375																						
BM																										

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 [illegible]UR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 4581

ACLU-RDI 1244 p.104

DOD 011060

~~[illegible]~~
~~[illegible]~~
@ PRE

118/60

101.2
96 %
101 HR
18 RESP

(b)(6)-4

2nd unit

PRBC
22APR03

0010	0015	0020	0035	0050	0105
122/68	120/66	122/64	122/66	118/68	118/62
18	16	16	16	14	16
100.9	100.6	100.8	100.7	100.7	100.7
107-HR	100	101	100	101	~~[illegible]~~97
97	96	97	96	96	97

0205 - Finished
118/64 16
100.2 96
98%

MEDCOM - 4582

~~ACLU-RDI 1244 p.105~~

FREQ. VITAL SIGNS

TIME	2145	2150	2155	2200	2205	2210	2215	2220	2225	2230	2235	2240	2245	2250	2255
BP	126/60	140/70	120/60	120/68	124/78	120/70	120/60	118/70	122/60	122/70	122/70	124/70	124/76	126/70	120/78
HR	104	102	104	103	102	101	101	104	104	101	102	101	103	101	106
RR	18	16	20	18	18	18	18	18	20	18	18	20	16	16	18
TEMP	101.3	100.8	101.2	101	100.6	100.6	101	100.7	100.7	100.7	100.4	100.6	100.5	100.1	100.9
SAO2	97%	97%	96%	97%	96%	96%	95%	95%	95%	96%	97%	96%	96%	98%	98%

Notes:

INPUT/OUTPUT

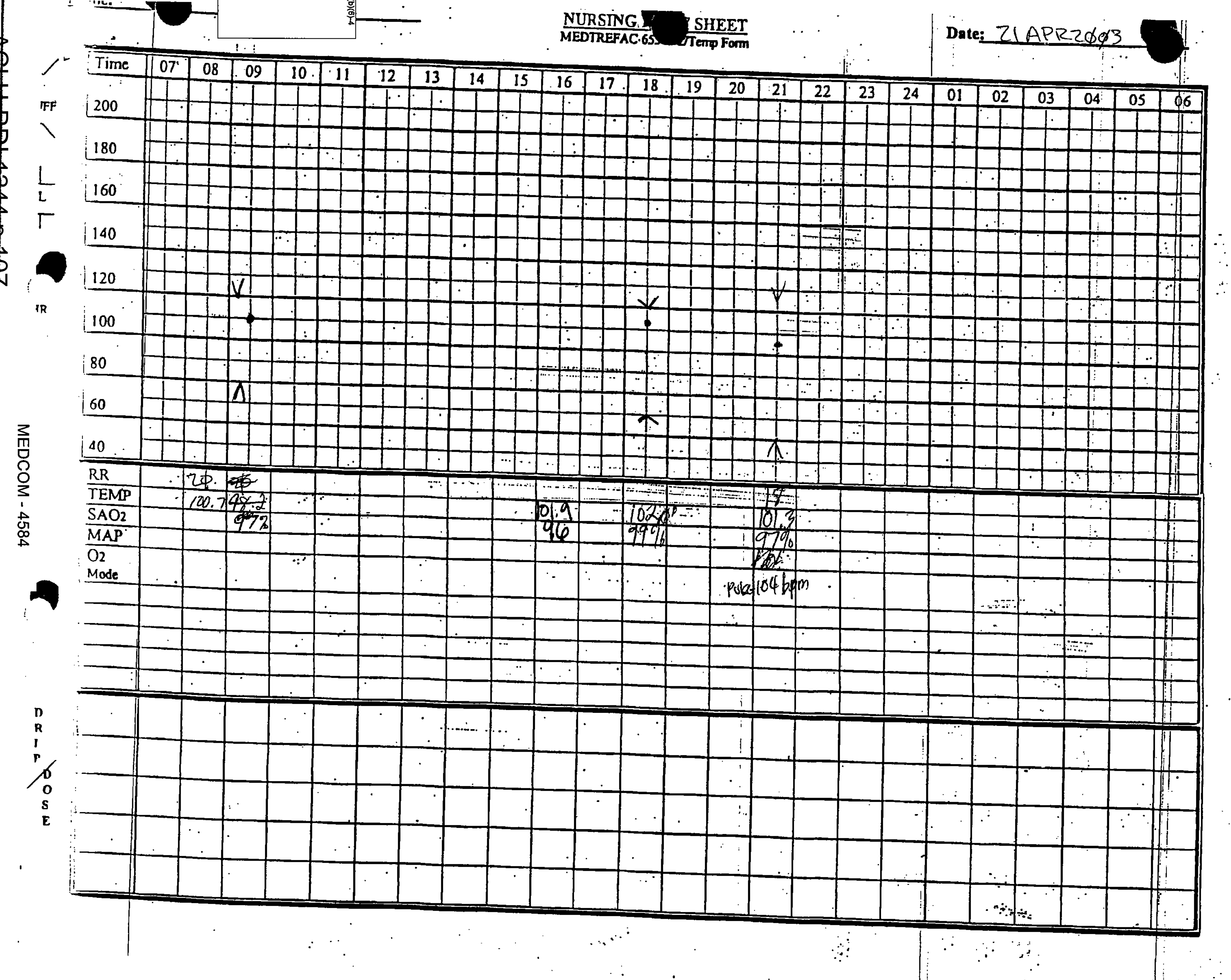
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT.
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TO
FOLEY																										
UOP					700									500		650			400				550			
BM																										

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 4583



(b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 21 APR 2003

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		20	~~20~~												19									
TEMP		100.7	98.2							101.9		102.0			101.3									
SAO2			97%							96		99%			97%									
MAP															[illegible]									
O2 Mode															Pulse 104 bpm									

IFF / L L IR

D R I P / D O S E

MEDCOM - 4584

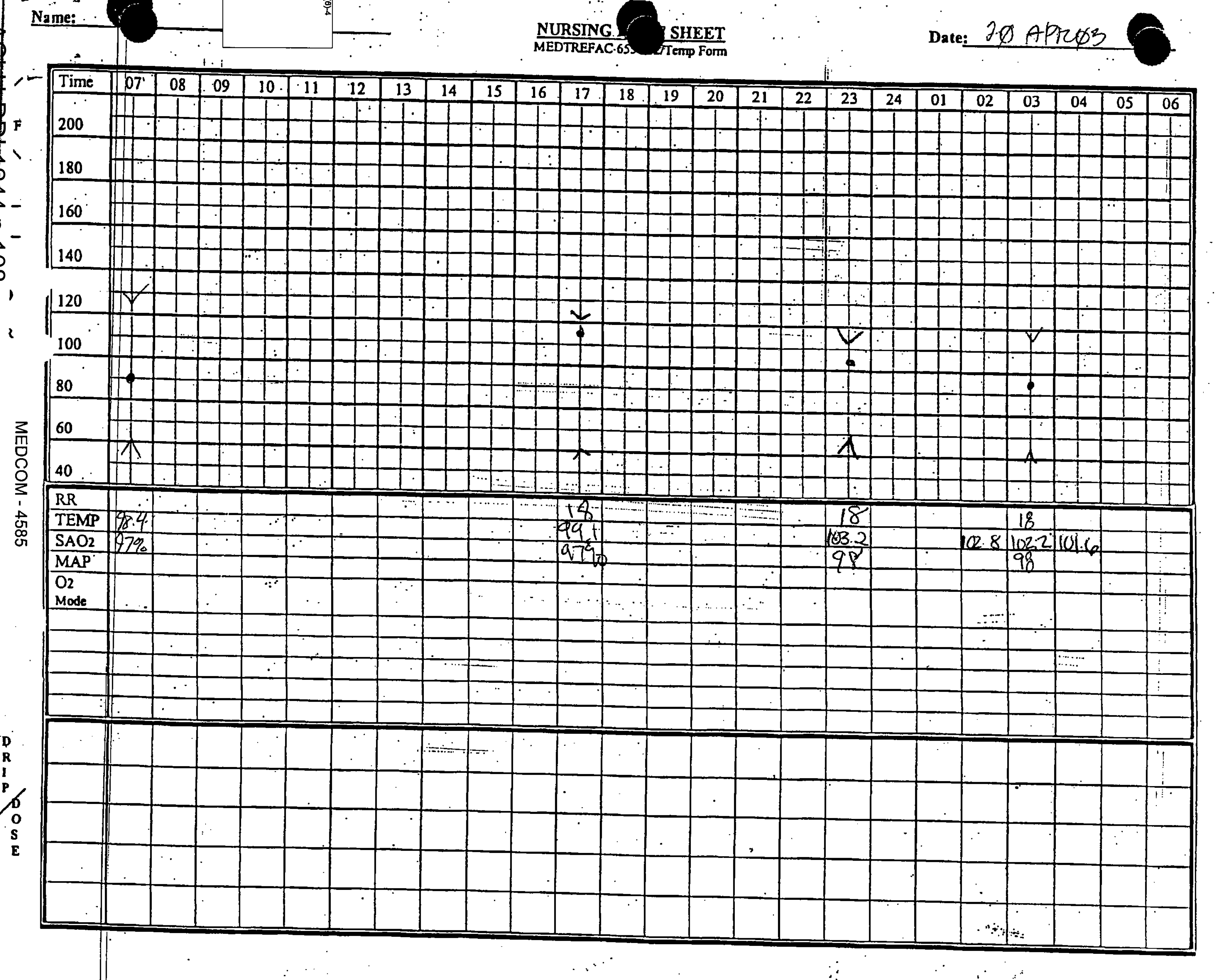
ACLU-RDI 1244 p.107

DOD 011063

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC-65[illegible]/Temp Form

Date: 20 APR 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR											18						18				18			
TEMP	98.4										99.1						103.2			102.8	102.2	101.6		
SAO2	97%										97%						98				98			
MAP																								
O2 Mode																								

DRIP / DOSE

MEDCOM - 4585

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:____

INPUT/OUTPUT

IN.	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO										780																
IVPB														1000 cc												

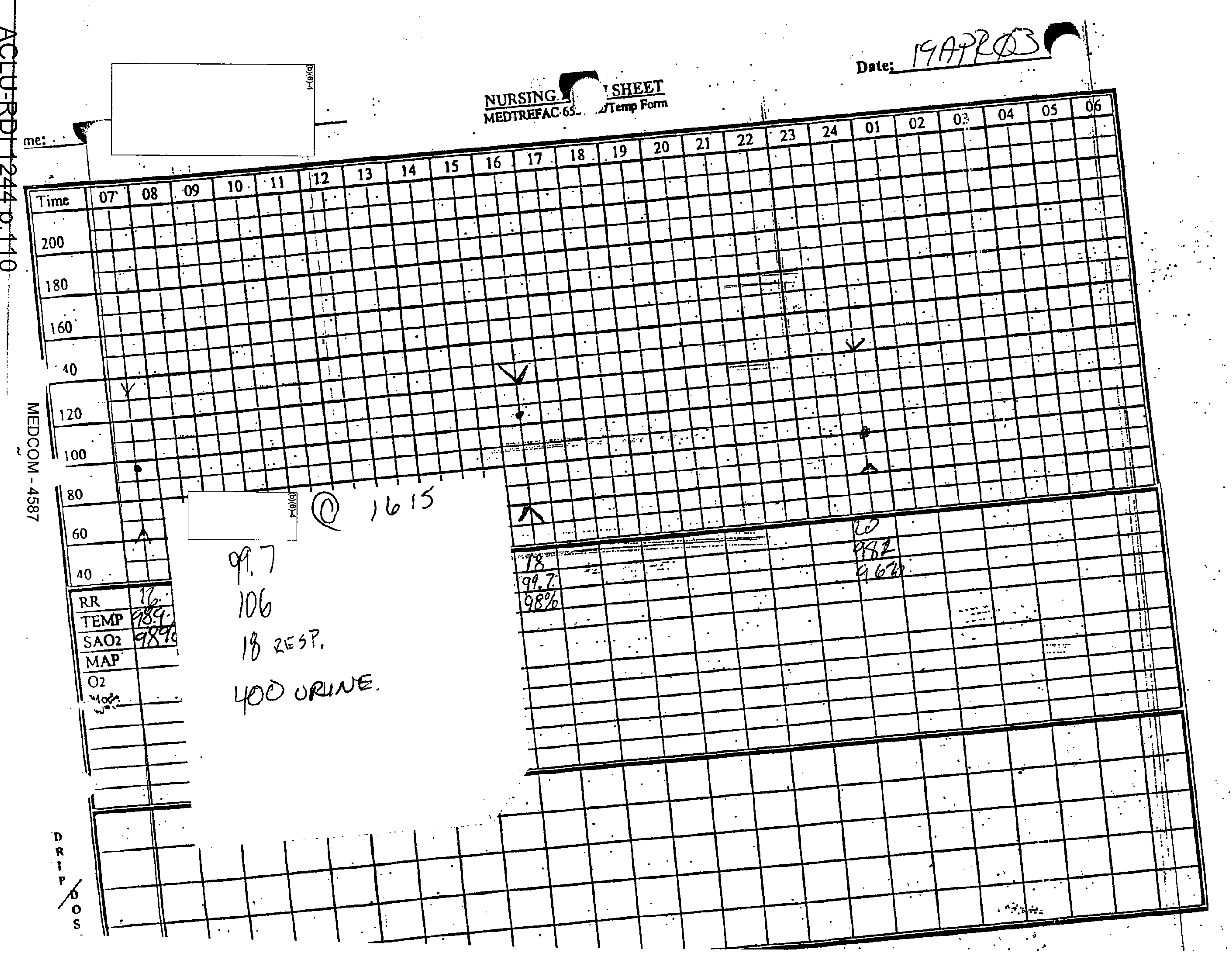
OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP															900				700			525				
																	420									
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT__________ PREVIOUS WEIGHT__________

PRESENT 24 HOUR INPUT__________ PRESENT 24 HOUR OUTPUT__________ PRESENT WEIGHT__________

ACLU-RDI 1244 p.109

DOD 011065



me:

(b)(6)-4

NURSING ... SHEET
MEDTREFAC 65... /Temp Form

Date: 19APRØ3

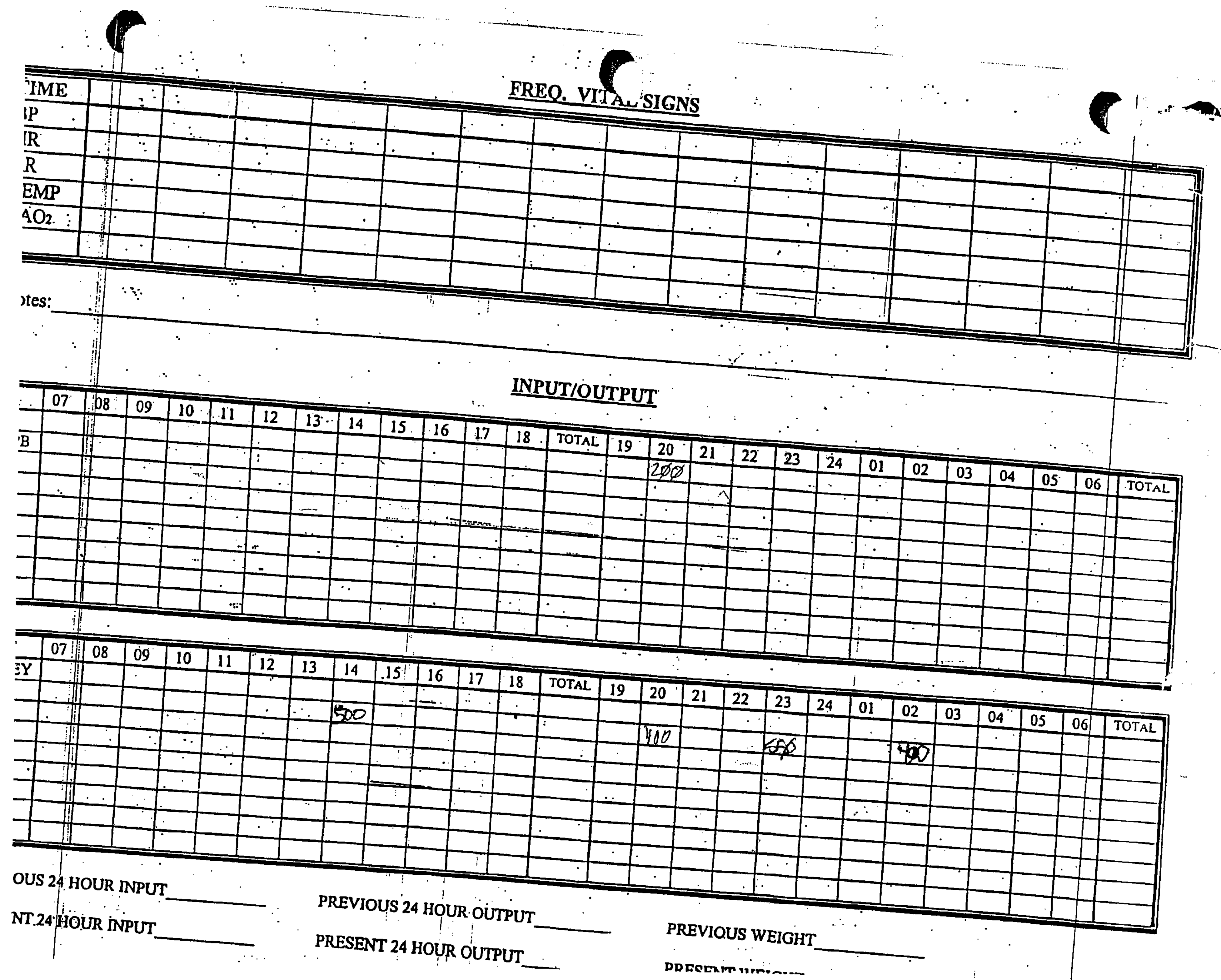
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	16										18								20					
TEMP	98.4										99.7								98.2					
SAO2	98%										98%								96%					
MAP																								
O2																								

(b)(6)-4

@ 1615
99.7
106
18 RESP.
400 URINE.

DRIP / DOS

MEDCOM - 4587



FREQ. VITAL SIGNS

IME															
P															
IR															
R															
EMP															
AO2															

otes:

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
B																										
															200											

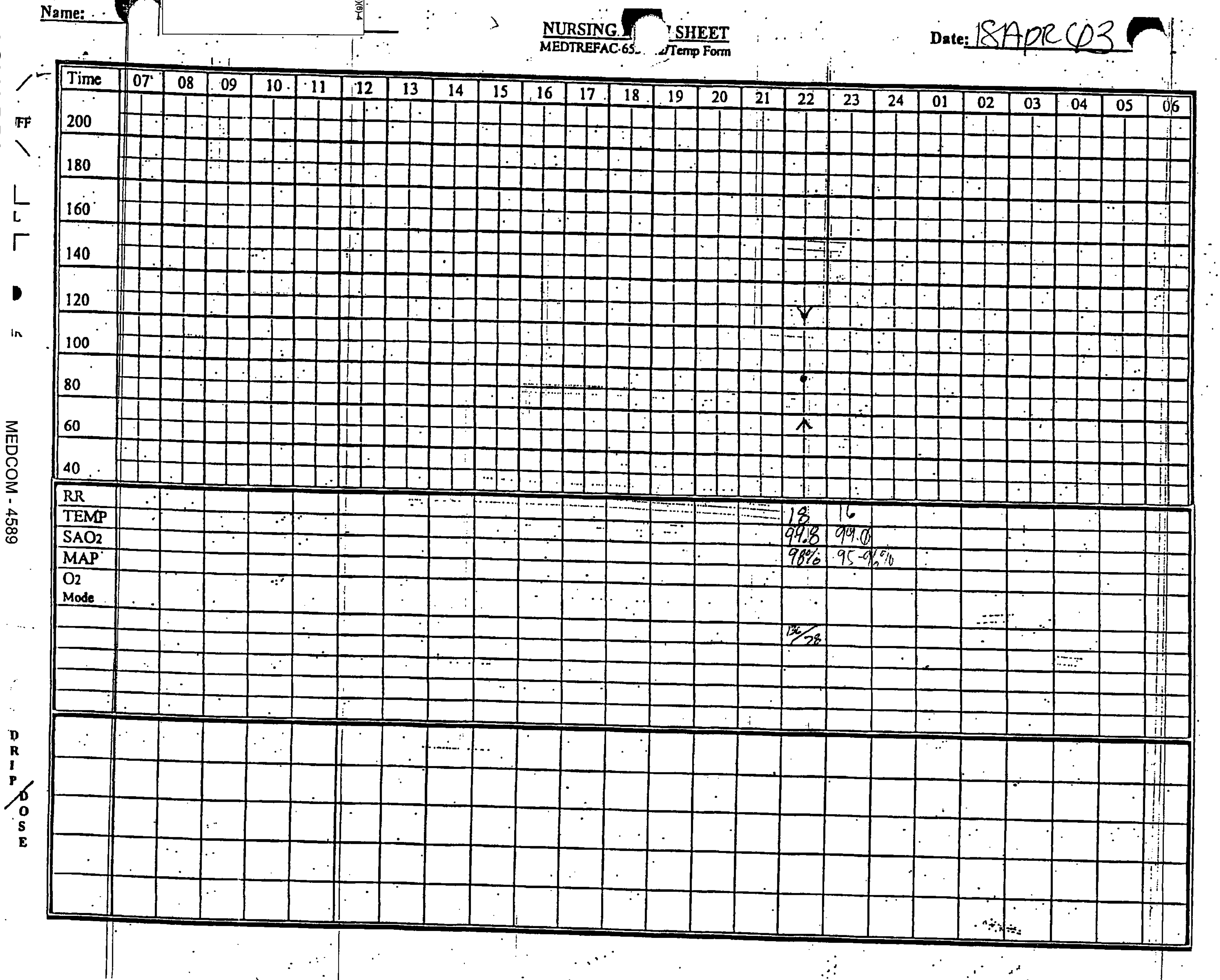
	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
EY																										
								500																		
															400			550			400					

OUS 24 HOUR INPUT ______ PREVIOUS 24 HOUR OUTPUT ______ PREVIOUS WEIGHT ______

NT.24 HOUR INPUT ______ PRESENT 24 HOUR OUTPUT ______ PRESENT WEIGHT ______

ACLU-RDI 1244 p.111

DOD 011067


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

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 18APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR																18	16							
TEMP																99.8	99.0							
SAO2																98%	95-96%							
MAP																								
O2 Mode																								
																136/78								

DRIP / DOSE

MEDCOM - 4589

ACLU-RDI 1244 p.112

DOD 011068

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																216										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP																500	125							600	286	
BM																										

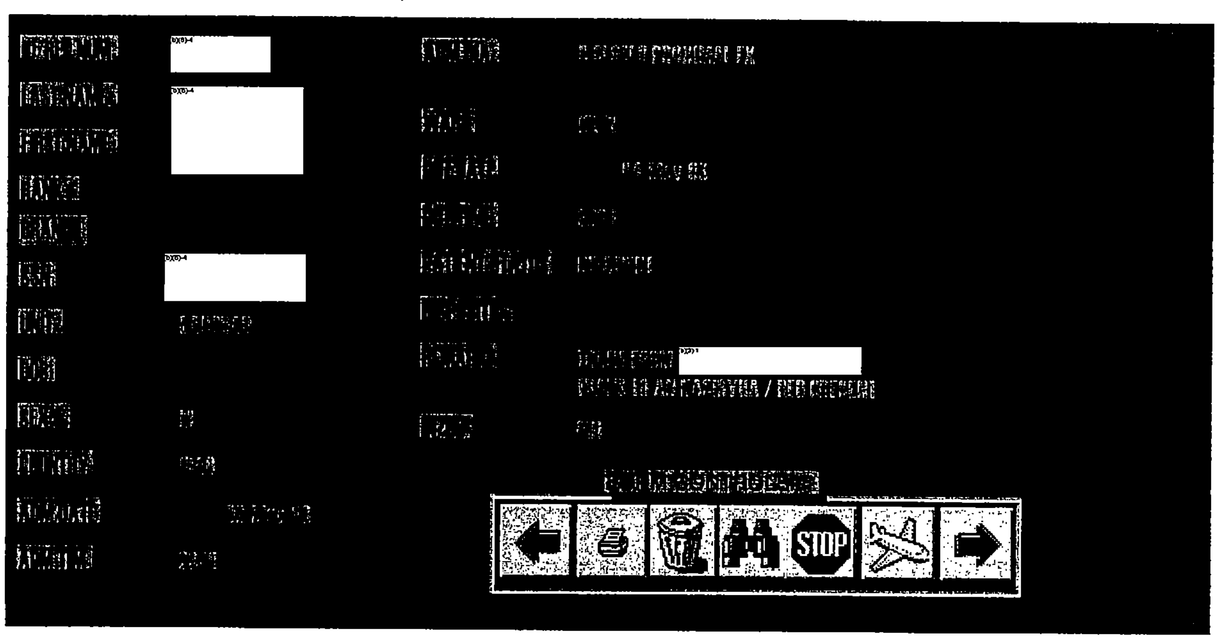
PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 4590

ACLU-RDI 1244 p.113

DOD 011069



MEDCOM - 4591

2240

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

ANTIBIOTIC: ANCEF
TIME GIVEN: Ø930
OTHER:

OPERATION PERFORMED: (L) ANTEGRADE FEMORAL IMNAIL ROD FEMUR

AGENTS AND TECHNICS OF ANESTHESIA: GEN

Spinal Level: N/A

EKG to monitor on

Rhythm: SR

BP art

BP cuff

Pulse = .

% Sat:

HOUR(S) 15 30 45 15 30 45 15 30 45

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

RESP. RATE

NUMBERS FOR REMARKS (1)

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK		100		1455
NC	2	100	1505	1525
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	4100			
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: 350 cc

WARD PRE-OP BP 125/64 mmHg HR 75

TUBES: ☐ N/G ☑ FOLEY

IV IN RUE/LUE 50/700 cc OF LR/LR AT cc/hr AOW

IV IN OF AT cc/hr TOW

ART. LINE IN N/A

T-TUBES, HEMOVAC IN N/A

ADMISSION

FROM MOR/SPEC. STUDY

DATE 4/20/93 HRS 1445

DRESSINGS: LOCATIONS LLE

STATUS: CD:I

DISCHARGE

TO WARD

DATE HRS

STATUS: ØΔ

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☑ NO | ☐ YES ☑ NO

AIRWAY / BREATH SOUNDS

☑ CLEAR (B) ☐ PLAST AIRWAY

☐ OBSTRUCTS EASILY

STATUS: ØΔ

URINARY OUTPUT

	MOR	PACU			DRAINAGE
TIME	1010				
cc	550	260			
TOTAL					
SP. GR					
S/A					

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) ~~AOW from MOR accompanied by~~

RMH: EXTERNAL FIXTURE

Neuro: A&OX3 OBEYS COMMANDS

Pain (Yes)/No Action: MFDS WILL CONT. TO MONITOR

CV: S1 S2 RRR IV: PATIENT

Other: BED RAILS ↑ X2 WARM BLANKET APPLIED

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☑ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	10

RECOVERY:
☐ COMPLICATED
☑ UNEVENTFUL

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

SIGNATURE OF RECEIVING AND RELEASING OFFICERS (b)(3)-1

~~ACLU-RDI 1244 p.115~~

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45		15	30	45		15	30	45		15	30	45

Spinal Level:

EKG Rhythm

BP art

BP cuff

Pulse = .

% Sat:

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

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	(b)(6)-2 SE
1505	MORPHINE SULFATE	3mg	IV	

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(1) Pt received from OR, VS being taken, Pt stable at this time. (2) Pt met all D/C PACU criteria

TOW Note: Neuro: A/OX3

Pain: Yes/No Action:

Pulmonary: Clear RA

CV: NSR

EKG Rhythm: [illegible]

IV: RFA 18 LFA 20

Skin/Wound: LLE C/D/I

Drainage Yes/No Color:

Edema Yes/No

GI: Clear

GU: Foley Yes/No

Color of urine: Yellow

Due to void:

Instructions/Interventions in PACU: [illegible] for pain meds

Report called to: [illegible] By: (b)(6)-2

TOWed to: 4 Fourth [illegible] By:

MEDCOM - 4593

(b)(3)-1

CASUALT[redacted] IVING

LINICAL RECORD

ABBREVIATED MEDICAL R[redacted]RD
(Sign all notes)

: 18APR03 Time: 1630 arrived on board USNS Comfort

TRIAGE CATEGORY (Circle one)
(Immediate) — circled
Delayed
Minimal
Expectant

sported by: (Circle one) (Helo) — circled, Boat, Pier, Other ______

(Circle one) (LITTER) — circled, AMBULATORY

: 22 HEIGHT (ft' in"): ______ Weight (lbs): ______

TORY: Pt. was travelling at 70 mph on Motorcycle and had an accident Fell down.

ERGIES: NKDA
RRENT MEDS: None
ST ILLNESSES: None
ST MEAL: (Date) Today (Time) Morning
nts Preceding Injury: Motorcycle accident.

AL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	CAP REFILL (pres/abs)
MISSION	1649	99.9	101	112/79	18	15	SpO2=96%
CHARGE	1940	99.5	90	140/79	18		

pils: (=) — circled OR ≠ (Circle one)

L (reactive) — circled / sluggish / fixed (Circle one)
R (reactive) — circled / sluggish / fixed (Circle one)

URIES

Airway Obstruction ☐ Yes ☐ No
Breath Sounds (+ ↓ -)
Hemorrhage
Laceration
Puncture
Wound
Trauma, Amputation
Concussion
(Fracture) — circled
Dislocation
Burn

BURN
1° ___ %
2° ___ %
3° ___ %

(Body diagram annotation: fracture)

LAB
(Hb/Hct) — circled
(Lytes/BUN/Glue) — circled
ABG
(UA) — circled
T&C ______ units
Blood Cultures

XRAY
C-spine
CXR
Abdominal
IVP
(Extremity) — circled
(L) Femur including Knee + Hip

Glasgow Coma Score (GCS)

A. Eye Opening — Points
- Spontaneous (4) — circled
- To voice 3
- To pain 4
- None 1

4 (Total "A")

B. Verbal Responses
- Oriented (5) — circled
- Confused 4
- Inappropriate words 3
- Incomprehensible words 2
- None 1

5 Total "B"

C. Motor Responses
- Obeys command (6) — circled
- Localize pain 5
- Withdraw (pain) 4
- Flexion (pain) 3
- Extension (pain) 2
- None 1

6 Total "C"

AGNOSIS: (L) Femur fracture.

IV Site Δ Removed IV from (L) Hand Restart (L) anticubital. (b)(6)-2 RN

Dressing Δ at site of X-Fix. Dressings removed had min drainage c̄ yellowish color (b)(6)-2 RN

Level of Consciousness (LOC) (Circle one)
(A - Alert) — circled
V - Responds to Vocal Stimuli
P - Responds to Painful Stimuli
U - Unresponsiveness

Continue on reverse side

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.

MEDCOM - 4594

ABBREVIATED MEDICAL REC
STANDARD FORM 539
Prescribed by GSA/ICMR

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
(L) femur rodding	22	70	180cm	(1) 2 3 4 5 E	Ø

Chemistries	Hematology	Coags	Urinalysis / HCG	
✓	H / H - ✓	PT - ✓	✓	NPO –
	Platelets -	INR -		Teeth –
	WBCs -	PTT -		Airway – MP I / II / III / IV
				FROM, ___ FB O, ___ FB HM

Respiratory	CV	CNS / Skeletal	Other
Cough: Ø	HTN: Ø	Seizure: Ø	Hepatic: Ø
Sputum:	CAD:	CVA:	Renal:
Asthma:	MI:	LOC:	GI:
COPD:	CHF:	Neuro:	Endo:
Recent URI:	VHD:	Muscle:	Heme:
TB:	Arrythmias:	Skeletal:	
Lung Exam:	Exercise Tolerance: good	Misc	EtOH: Ø
CXR:	Cardiac Exam:		Tobacco:
	ECG:		

Previous Anesthetics: Chest tube + excision of slug from back 1997; Ex Fix (L) femur 2d ago

Family Hx: Ø

Current Medications: Abx; Pain meds; SQ heparin

Premedication: Midazolam 2mg; Fentanyl 100mcg; Ancef 1gm

Preoperative Diagnoses: S/P MVA w/ fx (L) femur

Vitals	Pre-op	DOS
BP: 125/64		
HR: 75		
Resp: 20		
Temp: /		
FHR:		

Evaluator Signature | Date

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☑ (Patient) / parent / guardian understands and accepts risks
- ☑ NPO after MN liq., ___ clears, ___ solids

Plan: GA/ETT

Staff MD / CRNA signature (b)(6)-2 MD (b)(6)-2 CCPR | Date & Time 4/20/03

Patient identification
(b)(6)-2

Post-operative note

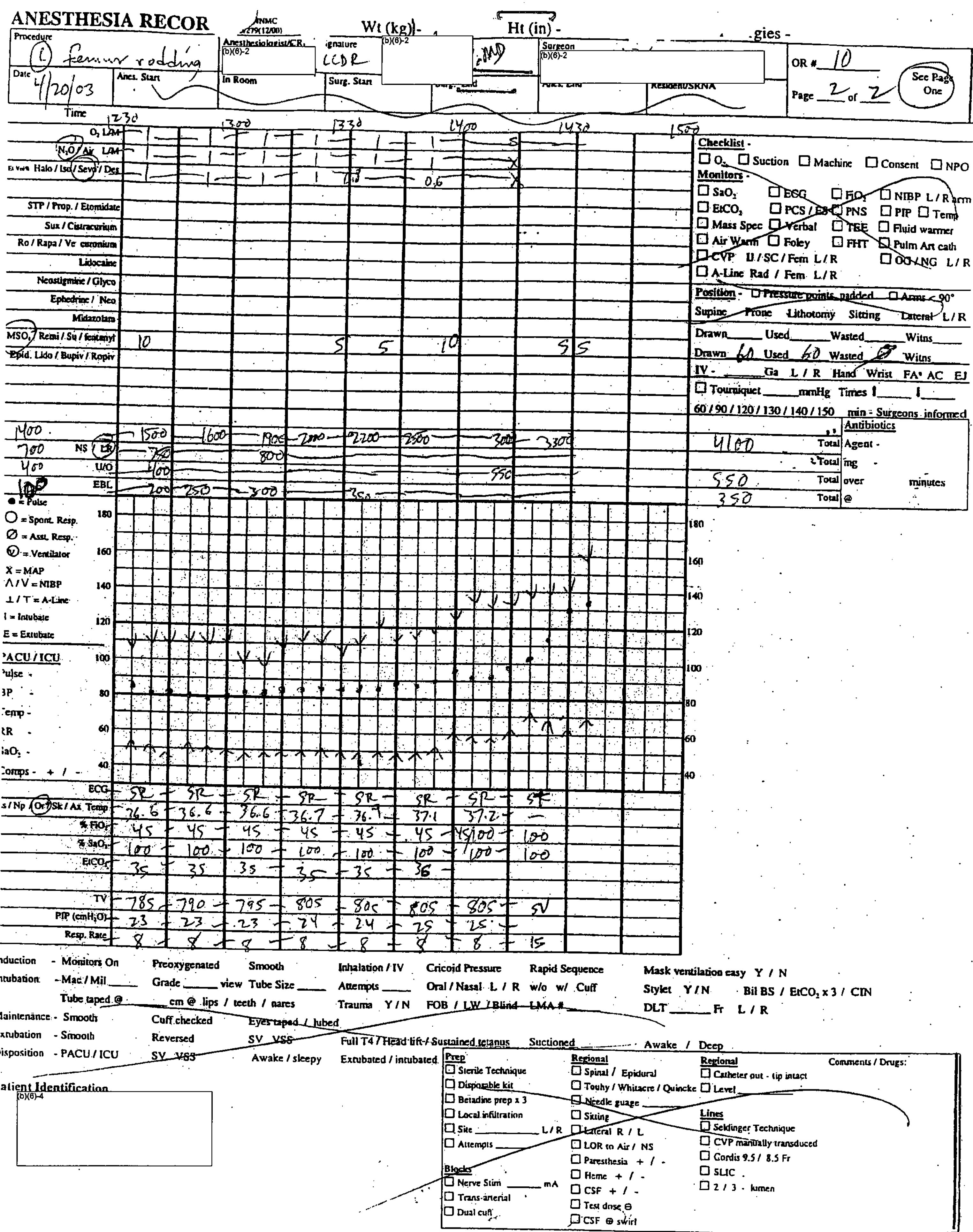
☐ No apparent anesthetic complications

Signature | Date

MEDCOM - 4595

ACLU-RDI 1244 p.118

DOD 011074



ANESTHESIA RECORD

NMC 279 (12/00)

Wt (kg) - Ht (in) - Allergies -

Procedure	Anesthesiologist/CRNA	Signature	Surgeon	OR #
(1) femur rodding	(b)(6)-2	LCDR (b)(6)-2 MD	(b)(6)-2	10

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
4/20/03							2 of 2

See Page One

Time	1230	1300	1330	1400	1430	1500
O_2 L/M	1	1	1	1	S	
N_2O / Air L/M	1	1	1	1	X	
Halo / Iso / Sevo / Des	1	1	0.8	0.6	X	
STP / Prop. / Etomidate						
Sux / Cisatracurium						
Ro / Rapa / Vecuronium						
Lidocaine						
Neostigmine / Glyco						
Ephedrine / Neo						
Midazolam						
MSO4 / Remi / Su / fentanyl	10	5	5	10	5 5	
Epid. Lido / Bupiv / Ropiv						

Checklist - ☐ O_2 ☐ Suction ☐ Machine ☐ Consent ☐ NPO

Monitors - ☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L / R arm ☐ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☐ Pressure points padded ☐ Arms < 90° Supine Prone Lithotomy Sitting Lateral L / R

Drawn ___ Used ___ Wasted ___ Witns ___

Drawn 60 Used 60 Wasted Ø Witns ___

IV - ___ Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet ___ mmHg Times ___ ___

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

										Total
1400		1500	1600	1900	2000	2200	2500	3000	3300	4100
700	NS / LR	700		800						
400	U/O	400						550		550
100	EBL	200	250	300	350					350

Antibiotics Agent - mg - over minutes @

● = Pulse, ○ = Spont. Resp., Ø = Asst. Resp., ⓥ = Ventilator, X = MAP, Λ / V = NIBP, ⊥ / T = A-Line, I = Intubate, E = Extubate

PACU / ICU: Pulse - BP - Temp - RR - SaO_2 - Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	ST
Es / Np / Or / Sk / Ax Temp	36.6	36.6	36.6	36.7	36.9	37.1	37.2	—
% FiO_2	45	45	45	45	45	45	45/100	100
% SaO_2	100	100	100	100	100	100	100	100
$EtCO_2$	35	35	35	35	35	36		
TV	785	790	795	805	805	805	805	SV
PIP (cmH_2O)	23	23	23	24	24	25	25	
Resp. Rate	8	8	8	8	8	8	8	15

Induction - Monitors On, Preoxygenated, Smooth, Inhalation / IV, Cricoid Pressure, Rapid Sequence, Mask ventilation easy Y / N

Intubation - Mac / Mil ___ Grade ___ view, Tube Size ___, Attempts ___, Oral / Nasal L / R, w/o w/ Cuff, Stylet Y / N, Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ ___ cm @ lips / teeth / nares, Trauma Y / N, FOB / LW / Blind, LMA # ___, DLT ___ Fr L / R

Maintenance - Smooth, Cuff checked, Eyes taped / lubed

Extubation - Smooth, Reversed, SV VSS, Full T4 / Head lift / Sustained tetanus, Suctioned ___, Awake / Deep

Disposition - PACU / ICU, SV VSS, Awake / sleepy, Extubated / intubated

Patient Identification

(b)(6)-4

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ___ L / R ☐ Attempts ___

Blocks: ☐ Nerve Stim ___ mA ☐ Trans-arterial ☐ Dual cuff

Regional: ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage ___ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊕ swirl

Regional: ☐ Catheter out - tip intact ☐ Level ___

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

MEDCOM - 4596

ANESTHESIA RECOR[D] NMC 2279(12/00) 22 Wt (kg) - 170 Ht (in) - 180 cm [Aller]gies - Ø

Procedure	(L) femur rod	(b)(6)-2	[Sig]nature LCDR (b)(6)-2	Surgeon (b)(6)-2	OR # 10
Date 4/2/03	Anes. Start 0940	In Room 0955	Surg. Start 1105	Surg. End 1435	Anes. End 1450	Resident/SRNA	Page 1 of 2 See Page One

Time	1000	1030	1100	1130	1200	1230
O_2 L/M	5 — 1	1	1	1	1	1
(N2O) Air L/M	1	1	1	1	1	1
Halo / (Iso) / Sevo / Des	2 — 1	1	1	1 / .6	.7 / .7	1
STP / (Prop) / Etomidate	200					
Sux / Cisatracurium						
Ro / Rapa / (Vecuronium)	10				10	
Lidocaine						
Neostigmine / Glyco						
Ephedrine / Neo						
Midazolam	2					
MSO4 / Remi / Su / (fentanyl)	100					
Epid. Lido / Bupiv / Ropiv						
MSO4 (mg)			10		4	6
NS			1000 LR		1300	1400
NS / (LR)			500		700	700
U/O						400
EBL			25		75/50	75/75 — 75/100

Checklist - ☑ O_2 ☑ Suction ☑ Machine ☐ Consent ☑ NPO

Monitors - ☑ SaO_2 ☑ ECG ☑ FiO_2 ☑ NIBP L / (R) arm ☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☑ Temp ☑ Mass Spec ☐ Verbal ☐ TEE ☑ Fluid warmer ☑ Air Warm ☑ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L/R ☐ OG / NG L/R ☐ A-Line Rad / Fem L/R

Position - ☑ Pressure points padded ☑ Arms < 90° (Supine) Prone Lithotomy Sitting Lateral L/R

Drawn 5 Used 5 Wasted Ø Witns

Drawn 250 Used 200 Wasted 50 (spilled on fl[oor]) Witns

IV - 18 Ga (L)/(R) Hand Wrist (FA) (AC) EJ

☐ Tourniquet ____ mmHg Times ____ ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics: Agent - Ancef in HA; mg; over minutes; @

● = Pulse; ◯ = Spont. Resp.; Ø = Asst. Resp.; Ⓥ = Ventilator; X = MAP; Λ / V = NIBP; ⊥ / T = A-Line; I = Intubate; E = Extubate

PACU / ICU: Pulse - 119; BP - 142/76; Temp - 98.7; RR - 16; SaO_2 - 100%; Comps - + / -

1134 LCDR McMinds(?) [illegible] 1210 for lunch relief

(L) AC IV
(R) FA IV started p̄ induction

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SA	SR
Es / Np / (Or) / Sk / Ax Temp	—	—	36.1	36.1	36.1	36.2	36.1	36.0	36.3	36.6
% FiO_2	100	50	50	50	50	50	49	49	48	45
% SaO_2	100	100	100	100	100	100	100	100	100	100
$EtCO_2$	40	36	33	35	38	38	37	36	35	35
Resp							Ⓥ	Ⓥ	Ⓥ	
TV	bagged	750	675	675	775	800	782	798	810	785
PIP (cmH_2O)		20	19	20	21	21	22	24	26	22
Resp. Rate		8	8	8	6	7	7	7	9	8

Intubation by Dr. (b)(6)-2

Induction - (Monitors On) (Preoxygenated) (Smooth) Inhalation / (IV) Cricoid Pressure Rapid Sequence Mask ventilation easy (Y) / N

Intubation - (Mac) / Mil 3 Grade 1 view Tube Size 8.0 Attempts 2 (Oral) / Nasal L / R w/o (w/) Cuff Stylet (Y) / N Bil BS / ($EtCO_2$) x 3 / CIN

Tube taped @ 22 cm @ lips / (teeth) / nares Trauma Y / (N) FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - (Smooth) (Cuff checked) (Eyes taped) / lubed

Extubation - (Smooth) Reversed SV (VSS) Full T4 / (Head lift) / Sustained tetanus (Suctioned) (Awake) / Deep

Disposition - (PACU) / ICU SV (VSS) (Awake) / sleepy (Extubated) / intubated

Patient Identification (b)(6)-4

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ____ L/R ☐ Attempts ____

Blocks: ☐ Nerve Stim ____ mA ☐ Trans-arterial ☐ Dual cuff

Regional: ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage ____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊖ swirl

Regional: ☐ Catheter out - tip intact ☐ Level ____

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

MEDCOM - 4597

ACLU-RDI 1244 p.120

DOD 011076

ANESTHESIA RECOR

NMC 279(12/00)

Wt (kg) - ~70 Ht (in) - Allergies - NKDA

Procedure	Anesthesiologist	Surgeon	OR #
I&D LLE	(b)(6)-2 (b)(6)-2 CRNA	(b)(6)-2	8

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
13Apr03	1205	1226	1300	1340	1352	—	1 of 1

See Page One

Time	30		(13)		30		(14)		30		(15)
O_2 L/M	10	.7	.7	.7	.7-6	6					
N_2O / Air L/M		1	1	1	1 ⊗						
Halo / Iso / Sevo / Des		.6	.6	.7	.3 ⊗						
STP / Prop. / Etomidate	130										
Sux / Cistracurium	100										
Ro / Rapa / Vecuronium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
MSO4 / Midazolam				22222							
MSO_4 / Remi / Su / fentanyl	250										
Epid. Lido / Bupiv / Ropiv											
NS / LR		300				400					
U/O	∅										
EBL											

Checklist - ☐ O_2 ☐ Suction ☐ Machine ☐ Consent ☐ NPO

Monitors - ☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L (R arm) ☐ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L/R ☐ OG / NG L/R ☐ A-Line Rad / Fem L/R

Position - ☐ Pressure points padded ☐ Arms < 90° (Supine) Prone Lithotomy Sitting Lateral L / R

Drawn 10 Used 10 Wasted ∅ Witns [signature]

Drawn 250 Used 250 Wasted ∅ Witns [signature]

IV - ____ Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times ↑ ____ ↓ ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Total

460cc Total

Total

<50cc Total

Antibiotics - Agent - ∅ mg - over minutes @

● = Pulse
○ = Spont. Resp.
∅ = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 94
BP - 124/71
Temp - 98.4
RR - 14
SaO_2 - 99%
Comps - + / -

ECG	SR	SR	SR	SR	SR
Es / Np / Or / Bk / Ax Temp	36.8	36.8	36.7	36.8	
% FiO_2	1.0 .45	.45	.46	.50	1.0
% SaO_2	100	100	100	100	100
$EtCO_2$	40	36	34	46	46
TV		912	925		
PIP (cmH_2O)	⊗	20	22	○ ○	○
Resp. Rate		9	9	16	14

Induction - Monitors On. Preoxygenated Smooth Inhalation / (IV) Cricoid Pressure Rapid Sequence Mask ventilation easy (Y) N

Intubation - Mac / (Mil) 2 Grade 1 view Tube Size 8.0 Attempts 1 (Oral) / Nasal L / R w/o / (w/ Cuff) Stylet (Y) / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ 23 cm @ (lips) / teeth / nares Trauma Y (N) FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV (VSS) Full T4 / Head lift / Sustained tetanus (Suctioned) (Awake) / Deep

Disposition (PACU) / ICU SV (VSS) (Awake) / sleepy (Extubated) / intubated

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ____ L / R ☐ Attempts ____

Blocks: ☐ Nerve Stim ____ mA ☐ Trans-arterial ☐ Dual cuff

Regional: ☐ Spinal / Epidural ☐ Tuohy / Whitacre / Quincke ☐ Needle guage ____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊕ swirl

Regional: ☐ Catheter out - tip intact ☐ Level ____

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

MEDCOM - 4598

ACLU-RDI 1244 p.121

DOD 011077

NNMC 6320/279 (Dec-00)

Pre / Post-anesthetic Summ.

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I&D LLE	22	70		1 (2) 3 4 5 E	unk

Chemistries

Hematology
H/H - 8.6/25.5
Platelets - 520
WBCs - 13.5
4/22

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – p MN
Teeth – intact
Airway – MP (I) / II / III / IV
FROM, ✓ FB O, 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam:
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam:
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
EtOH:
Tobacco:

Previous Anesthetics: Prev GA Ø prob

Family Hx:

Current Medications: Timentin, Lovenox, FeSO4, Colace, Folate, MVI

Premedication:

Preoperative Diagnoses
Prev Motorcycle Accident

Vitals	Pre-op	DOS
BP:	118/64	
HR:	86	
Resp:		
Temp:		
FHR:		

Evaluator Signature Date

Day of Surgery
☐ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
☐ NPO after _______ liq., _______ clears, _______ solids
Plan:

Staff MD / CRNA signature (b)(6)-2 LCDR NC USN LCDR CRNA (b)(6)-2
Date & Time 23APR03

Patient identification
(b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

MEDCOM - 4599

22K/0
7049

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

ANTIBIOTIC: N/A
TIME GIVEN:
OTHER:

OPERATION PERFORMED: I & D (L) LE

AGENTS AND TECHNICS OF ANESTHESIA: GA — 10mg MSO4

OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10		Adm	1355
T-BAR				
VENTILAT.				

FLUID THERAPY				
TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	450			
RECOVERY ROOM	100			
TOTAL	550			

HOUR(S) 15 30 45 15 30 45 15 30 45

TEMPS: 98.4 98.9

Spinal Level:

EKG to monitor on ☒ Rhythm SR

BP art / BP cuff / Pulse / % Sat: 98 98 98 91 98 98

RESP. RATE: 16 16 14 14 14 14

NUMBERS FOR REMARKS: (1) (2)

BLOOD LOSS IN OR: 250 cc

WARD PRE-OP BP 181/86 mmHg

TUBES: N/G FOLEY

IV IN (L) wrist c 550 cc OF LR AT KVO cc/hr — 20g — AOW

IV IN (R) wrist c 1000 cc OF LR AT KVO cc/hr — 20g — TOW

ART. LINE IN

T-TUBES, HEMOVAC IN

ADMISSION — FROM MOR/SPEC. STUDY: DATE 4-23-03 HRS 1345

DISCHARGE — TO WARD 4F P: DATE 4-23-03 HRS 1430

DRESSINGS: LOCATIONS Ace wrap (L) Leg

STATUS: CDI — STATUS: CDI

ENDOTRACHEAL TUBE – ORAL OR NASAL: ☐ YES ☒ NO — ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS: ☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY — STATUS: CTA

	MOR	PACU	URINARY OUTPUT		DRAINAGE
TIME	AOW	MA			
CC	N/A				
TOTAL	N/A				
SP. GR					
S/A					

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by Nadol MY
PMH: ASA II
Neuro: Sleepy arousable to verbal Stimuli
Pain Yes/(No) Action: No Action taken
CV: (+) s's' brisk cap refill IV: Patent
Other: Pt AOW via gurney siderails up x2 bed locked in low position (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK: MOVEMENT PRESENT AT N/A HRS; SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	1
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	9

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

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

SIGNATURE OF RECEIVING AND RELEASING OFFICERS: AC (b)(6)-2 — TO (b)(6)-2 — (b)(6)-2

MEDCOM - 4600

NAVMED 6320/16 (BACK)

HOUR(S)	15	30	45		15	30	45		15	30	45		15	30	45

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

Spinal Level:

EKG Rhythm

BP ╪ art

BP ^ cuff

Pulse = .

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1400	Timentin	3.1 gm	IVPB	(b)(6)-2

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) A+OX3. VSS. Denies any pain ⓒ this time. PACU discharge criteria met (b)(6)-2

TOW Note: Neuro: Sleepy easily arousable to verbal stimuli

Pain: Yes/(No) Action: No Action taken

Pulmonary: Lung CTA O2 Sats > 95% on RA

CV: (+) s'c2 brisk caprefill <2sec EKG Rhythm: HR: 80's IV: Patent

Skin/Wound: Warm, Pink, Dry Drainage Yes/(No) Color: ——— Edema Yes/(No) ———

GI: NPO No c/o Nausea/Vomiting at this time

GU: Foley Yes/(No) ——— Color of urine: ——— Due to void: 1745

Instructions/Interventions in PACU: Ring call bell for staff assistance first time OOB, Pain, Nausea/Vomiting

Report called to: COR (b)(6)-2 By: LCDR (b)(6)-2 (b)(6)-2

TOWed to: H Found Port By: MN (b)(6)-2 / HM3 (b)(6)-2

ACLU-RDI 1244 p.124

DOD 011080

RECOPIED 4/27

NAVMED 6550/8 (REV. 4-74) S/N 010[illegible]-216-5581

MEDICAL RECORD

MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS

MONTH April 19 2003 DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	20	21	22	23	24	25	26
4/20	Ancef 1gm IV q8h x48 hs	0200	X	(b)(6)-2		X	X	X	X
		1000	X			X	X	X	X
		1800	(b)(6)-2		X	X	X	X	X
4/20	Lovenox 30mg SQ q12h	0900	X	(b)(6)-2			(b)(6)-2		
		2100	(b)(6)-2						
4/20	FeSO4 325mg po TID	0700	(b)(6)-2						
		1100							
		1700							
4/20	Colace 100mg po BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/20	Folate 1mg po qd	0700	X	(b)(6)-2					
4/20	MVI i po qd	0700	X						
4/22	Timentin 3.1gm IV q8h	0600	X	X	(b)(6)-2				
		1400	X	X					
		2200	X	X					

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	HM3	(b)(6)-2		(b)(6)-2	LCDR
	RN EN			(b)(6)-2	

ADDRESSOGRAPH PLATE

(b)(6)-4

(b)(6)-4

WARD NO.

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4602

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/20	MSO4 2-6mg	DATE	4/20	4/20	4/21	4/21	4/21	4/21	4/21	4/21	~~4/21~~	[illegible]	4/21	4/21	4/21	4/21	4/22	4/22
	IV/SQ/IM	TIME	1715	2100	0030	0230	0500	0700	1100	1300	~~1500~~	[illegible]	1545	1626	2145	2335	0400	0700
	q2h prn	DOSE	5	5	5	5	5	5	6	10	~~6~~	/	10	6	5	5	5	5
		INIT.	(b)(6)-2															
4/20	Tylenol 650mg	DATE	4/20	4/21	4/21	4/22												
	po q4h prn	TIME	0010	1706	0004	1510												
	or pr	DOSE	650	650	650	650												
		INIT.	(b)(6)-2															
4/21	Benadryl 25mg	DATE	4/21	4/24	4/26	4/28	4/29											
	PO QHS	TIME	0230	2030	2345	2300	2140											
	PRN sleep.	DOSE	25	25	25	25	25											
		INIT.	(b)(6)-2															
4/20	MSO4 2-6mg	DATE	4/22	4/22	4/22	4/22	4/22	4/23	4/23	4/23	4/23	4/24	4/24	4/24	4/24	4/24	4/24	4/25
	IV/SQ/IM	TIME	0930	1200	1337	1535	2035	0020	0245	1015	1730	0815	1030	1130	1345	1630	1940	1000
	q2h PRN	DOSE	5	5	5	6mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	6mg	4mg	10mg	6mg
		INIT.	(b)(6)-2															
4/25	MSO4 2-6mg	DATE	4/25	4/26	4/26	4/26	4/26	4/26	4/26	4/26	4/27	4/27	4/28	4/29	4/29	4/29	4/29	4/29
	IV/SQ/IM	TIME	1210	1530	0800	2240	0100	1330	1900	2345	1440	0030	2145	0010	0600	0800	1000	1800
	q2h prn	DOSE	6mg	5mg	5mg	6mg	5mg	5mg	5mg	5	5	5mg	6mg	6mg	6mg	6mg	6mg	6mg
		INIT.	(b)(6)-2															
	Percocet 1-2 tabs	DATE	4/26	4/26	4/26	[illegible]	4/27	4/27	4/27	[illegible]	4/27	4/27	4/28	4/28	/	/	/	/
	PO Q4-6h PRN	TIME	1100	1620	2100	/	0108	0800	1200	1545	2000	2330	1250	2150	/	/	/	/
	PAIN	DOSE	2	ii	2	/	2	2	2	2	2	2	2	ii	/	/	/	/
		INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 4603

NAVMED 6550/8 (REV. 4-74) S/N 0103-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH ____ 19 ____ DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/30	5/1	2	3	4	5	6
4/20	Lovenox 30mg SQ q12h	0900	(b)(6)-2						
		2100							
4/20	FeSO4 325mg po TID	0700							
		1100							
		1700							
4/20	Colace 100mg po BID	0900							
		2100							
4/20	Folate 1mg po qd	0700							
4/20	MVI i po qd	0700							
4/29	FORTAZ i gm IVPB Q8° x 35 days	0600							
		1400							
		2200							
4/27	Cipro 500mg PO BID	0900							
		2100							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	...ERS/NC	(b)(6)-2		(b)(6)-2	

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4604

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/25	MSO4 2-6mg	DATE	4/30	4/30	5/1	5/1	5/1	5/1	5/2	5/2								
	IV/SQ/IM	TIME	1905	2330	0200	0430	6mg	5mg	5mg	5mg								
	q2h prn	DOSE	5mg	6mg	6mg	6mg	1010	1945	0330	0630								
		INIT.	(b)(6)-2															
4/20	Tylenol 650mg	DATE	~~5/1~~															
	po q4h prn	TIME	~~0200~~															
	or pr	DOSE	~~1~~															
		INIT.																
4/20	Benadryl 25mg	DATE	5/1															
	po QHS	TIME	0200															
	prn sleep	DOSE	1 tab															
		INIT.	(b)(6)-2															
	Percocet 1-2 tabs	DATE	4/30	4/30	5/1	5/1	5/1	5/2	5/2									
	po Q4°-6° prn	TIME	[illegible]	1945	0110	1200	1730	0145	1420									
	pain	DOSE	ii	ii	ii	2	2	2	2									
		INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 4605

NKDA

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		Regular	4/18		Pulse	Q4		Speech impediment
√	Up in chair	4/24		Tub					Resp		√	Language barrier
√	Ambulate	4/24		Needs assistance		Snacks			B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
				Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O	Q8		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/18		Admit		4/20		D5 1/2 100/hr	
		DR McGlaughlin				HL when tol po	
		Post OP					
4/28		reinforce drsg prn		4/28		consult Dr Peterson	
						of ID for abx	
4/20		OOB → chair + NWB				coverage given recent	
		on L LLE c̄ PT				cx results.	
		for crutch training					
		to begin 4/24					
4/23		W-D packing Ⓛ lat thigh					
		c̄ 1% acetic acid BID					
4/20		TED hose to RLE					
4/28		DR (b)(6)-2 Patient					

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS	AGE	HEIGHT	WEIGHT
Ⓛ femur Fx c̄ External Fixation	PATIENT CLASSIFICATION: Stable		

OP/SPECIAL PROCEDURES		DATE ON	DATE OFF
S/P IM nail Lt femur			
4/23 Ⓛ lat thigh ex fix [illegible]	SI		
FINDINGS:	VSI		
	RELIGIOUS RITES		

MEDCOM - 4606

ALLERGIES: NKDA

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
		PICZ2APR.					
4/18	4/20	Ancef 1gm IVPB Q8H x48h	02 1000 1800	4/18	Trauma panel	CASREC	
4/18	4/20	Lovenox 30mg SQ Q12Hrs	0921	4/18	Blood cx x2	CASREC	
4/19	4/20	FeSO4 ī mg po T.I.D.	07 11 17	4/18	CXR portable	ACP	
4/19	4/20	Folic Acid ī mg po qd	07		CASREC done		
4/19	4/20	MVI ī tab po qd	07	4/18	Ⓛ femur ī hip/knee done		
	4/20	Colace 100mg po BID	09/21	4/19	CBC 4/20	✓	
4/22		Timentin 3.1 gm IV q8h	06 14 22	~~[illegible]~~	~~[illegible]~~		
4/27		Cipro 500 mg po BID	0900, 2100	4/21	Bld cx x2 NOW	(b)(6)-2	
4/29		Ceftaz ī gm IVPB q8 hrs			Urine cx NOW		
		x 35 days			CBC NOW		
				4/21	T&C ī 2 units PRBC		
				4/21	CBC in AM 4/22	(b)(6)-2	
				4/27	CBC in AM 4/28		
				4/30	CBC, ESR, SMA-7 in AM	5/1	☒
4/18		MOM 30cc PO x1 NOW ✓					
4/26		PERCOCET 1-2 TABS PO Q4-6° PRN					
4/20		Tylenol 650 mg po/pr q4 hr po prn					
4/20		MSO4 2-6 mg IV/SQ/IM q2h prn					
4/18		~~MOM 30cc PO PRN constipation~~					
4/18		~~Ambien 5-10mg PO QHS PRN sleep~~					
4/18		~~Tylenol 325mg TT PO Q4 PRN mild pain~~					
4/18		~~Tylenol #3 ī TT PO Q4HR PRN pain~~					
4/18		~~MSO4 2-5mg IVP PRN severe pain~~					

ADDRESSOGRAPH

(b)(6)-4

MEDCOM - 4607

Recopied 4/27

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH ______ 19 ____ — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	27	28	29	30	5/1	5/2	5/3
4/20	LOVENOX 30 mg SQ q 12h	0900	(b)(6)-2						
		2100							
4/20	FESO4 325 mg po TID	0700							
		1100							
		1700							
4/20	COLACE 100 mg po BID	0900							
		2100							
4/20	FOLATE 1 mg po qd	0700							
4/20	MVI i po qd	0700							
4/22	TIMENTIN 3.1gm IV q8h	0600							
~~4/27~~		1400							—
		2200							
4/27	Cipro 500 mg po BID	0900							
		2100							
4/29	Ceftaz i gm IVPB q 8 hrs	0600							
	x 35 days	1400							
		2200							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	HN	(b)(6)-2	ENSIGN	(b)(6)-2	

SEE OTHER MAR

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4608

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN					
4/24	Percocet 1-2 tabs q4 prn po	DATE	4/29	4/29	4/29	4/30	4/30
		TIME	2100	1030	2100	0125	0500
		DOSE	2T	1T	2	2	2
		INIT.	(b)(6)-2				
4/25	MSO4 2-6mg IV/SQ/IM Q2° prn	DATE	4/29	4/30	4/30	4/30	
		TIME	2100	0025	0220	0820	
		DOSE	6mg	3mg	6mg	6mg	
		INIT.	(b)(6)-2				
	SEE OTHER MAR	DATE					
		TIME					
		DOSE					
		INIT.					
		DATE					
		TIME					
		DOSE					
		INIT.					
		DATE					
		TIME					
		DOSE					
		INIT.					
		DATE					
		TIME					
		DOSE					
		INIT.					
		DATE					
		TIME					
		DOSE					
		INIT.					

MEDCOM - 4609

NAVMED 6550/8 (REV. 4-74) S/N 010. r-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS			MONTH April 19 03						DATES GIVEN
ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	18	19	20	21	22	23	24
4/18	Ancef 1gm IVPB Q8H	0200	X	(b)(6)-2					
		1000	X						
		1800	X						
4/18	Lovenox 30mg SQ Q12	0900	X						
		2100	X						
4/19	FeSO4 i ms po T.I.D.	0700	X						
		1100							
		1700							
4/19	Folic Acid i ms po qd	0700	X						
4/19	MVI i tab po qd	0700	X						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2				(b)(6)-2	

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4610

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
MOM 30cc PO X1 Now	4/18						

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN		
4/18	MSO4 2-5mg	DATE	4/18	4/19	4/19
	IVP PRN	TIME	2149	1448	2245
	Severe pain	DOSE	5mg	5	4
		INIT.	(b)(6)-2		
4/18	Tylenol #3	DATE	4/19	4/19	
	i-ii PO Q4-6	TIME	0400	1847	
	PRN Pain	DOSE	ii	ii	
		INIT.	(b)(6)-2		
4/18	Tylenol 325mg	DATE	4/18		
	i-ii PO Q4°	TIME	2128		
	PRN mild	DOSE	ii		
	pain	INIT.	(b)(6)-2		
4/18	Ambien 5-10mg	DATE			
	PO QHS PRN	TIME			
	sleep	DOSE			
		INIT.			
4/18	MOM 30cc	DATE			
	PO PRN constipation	TIME			
		DOSE			
		INIT.			
		DATE			
		TIME			
		DOSE			
		INIT.			
		DATE			
		TIME			
		DOSE			
		INIT.			

COUNT SHEET

ITEMS		QUANTITY	ADDED
SUTURE NEEDLES		12	BTL (4)
KNIFE BLADES		4	
SCRATCH PAD		1	
HYPODERMICS			
CAUTERY TIPS		1	
RAYTEX		10	
LAP TAPES		5's	(10)
COTTONOIDS	1/4 x 1/4		
	½ x ½		
	½ x 1		
	½ x 3		
	1/8 x 1/8		
	1 x 1		
	3/4 x 3/4		
	1 x 3		
	1/4 x 6		
	½ x 6		
	3/4 x 6		
	1 x 6		
	2 x 6		
	3 x 6		
EANUT/KITNERS			
ULL DOGS			
REELS			
EMOCLIPS BOATS			
UBBER SHODS			
RAINS			
OODLES			
MBILICAL TAPES			
UBBER BANDS			
AFETY PINS			
ECK SPONGES			
NN. FISIL TONSIL			
OTTON BALLS			
SCELLANEOUS			

Screws 8mm Trocar

(b)(6)-2

B10

clave 8

km 10

case

DDRESSOGRAPH

(b)(6)-4

INITIALS	OR NURSE SIGNATURE

MEDCOM - 4612

(b)(3)-1

ORATORY 1-71-0 18 Apr 2003@1840 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

eport requested by: System Generated

(b)(6)-4 (b)(6)-4 M/<1d 2395 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 18 Apr 2003@1739 Acc#: 030418 CO 694

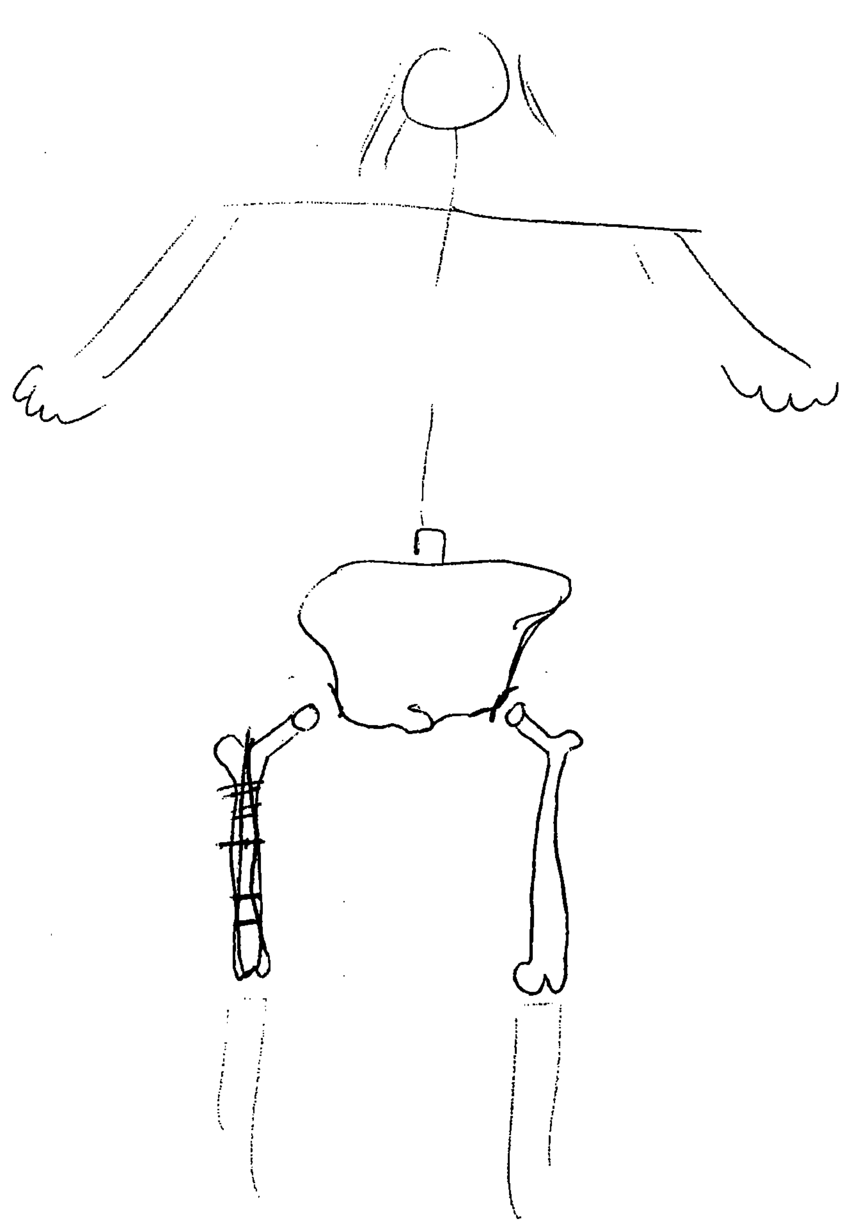
Specimen: BLOOD (PLASMA) Pri: STAT Ord#: 030418-00526

Res Lab: LAB Req Loc: CAS

Test name	Result	Units	Normal range
APTT	19.1 L	Seconds	23.8 - 35.5

*** End of Report ***

HJ



MEDCOM - 4613

2. √

LABORATORY 1-71-0   18 Apr 2003@1840   Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

Report requested by: System Generated

(b)(6)-4   (b)(6)-4   M/<1d 2395   ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2   Col: 18 Apr 2003@1739   Acc#: 030418 CO 694

Specimen: BLOOD (PLASMA)   Pri: STAT   Ord#: 030418-00525

Res Lab: LAB   Req Loc: CAS

Test name	Result	Units	Normal range
PT	10.8 L	Seconds	11.6 - 14.4
INR	0.7		

Interpretation(s):

The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

*** End of Report ***

HJ

2 √

LABORATORY 1-71-0 18 Apr 2003@1830 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

Report requested by: System Generated

(b)(6)-4 (b)(6)-4 M/<1d 2395 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 18 Apr 2003@1739 Acc#: 030418 HM 1255

Specimen: BLOOD (BLOOD) Pri: STAT Ord#: 030418-00523

Res Lab: LAB Req Loc: CAS

Test name	Result	Units	Normal range
WBC	8.6	K/UL	4.8 - 10.8
RBC	4.3 L	1X10 6/UL	4.7 - 6.1
HGB	9.2 L	g/dL	14.0 - 18.0
HCT	29.2 L	%	42 - 52
MCV	67.4 L	fL	80 - 94
MCH	21.3 L	pg	27 - 32
MCHC	31.6	g/dL	31 - 37
RDW	18.8 H	%	12 - 14
PLT CNT	379.0	1x10 3/UL	150 - 450
MPV	6.7 L	FL	7.4 - 10.4
NEUT/100 WBC	71.6	%	
NEUT%	6.2	1x10 3/UL	
LYMPHS/100 WBC	20.0	%	
LY#	1.7	1x10 3/UL	
MONO/100 WBC	8.4	%	
MONO%	0.7	1X10 3/UL	

*** End of Report ***

HJ

2 √

LABORATORY 1-71-0 18 Apr 2003@1851 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

Report requested by: System Generated

(b)(6)-4 (b)(6)-4 M/<1d 2395 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 18 Apr 2003@1739 Acc#: 030418 CH 1608

Specimen: BLOOD (SERUM) Pri: STAT Ord#: 030418-00524

Res Lab: LAB Req Loc: CAS

Test name	Result	Units	Normal range
NA+	133 L	mmol/L	137 - 145
K	4.4	mmol/L	3.6 - 5.0
CL-	96 L	mmol/L	97 - 107
BUN	9	mg/dL	9 - 21
GLUCOSE	97	mg/dL	76 - 110
CREAT	0.7 L	mg/dL	0.8 - 1.5
PHOSPHORUS	3.6	mg/dL	2.5 - 4.5
URIC ACID	2.4 L	mg/dL	3.3 - 8.4
ALBUMIN	3.5	g/dL	3.5 - 5.0
AST	81 H	U/L	15 - 46
ALT	52	U/L	11 - 66
ALK PHOS	118	U/L	70 - 250
TBILI	0.6 L	mg/dL	1.0 - 10.5
GGT	58	U/L	8 - 78

*** End of Report ***

HJ

2 √

LABORATORY 1-71-0 18 Apr 2003@1904 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

Priority Result Notification

Report requested by: System Generated

(b)(6)-4

(b)(6)-4 M/<1d 2395 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 18 Apr 2003@1739 Acc#: 030418 CH 1608

Specimen: BLOOD (SERUM) Pri: STAT Ord#: 030418-00524

Res Lab: LAB Req Loc: CAS

Test name	Result	Units	Normal range
CO2	29	mmol/L	22 - 31
CA	8.6 L	mg/dL	8.8 - 10.4
PROTEIN TOTAL	7.4	g/dL	6.3 - 8.3
LDH	973 H	U/L	313 - 618
CK	330 H	U/L	0 - 203
MG	2.3 H	mg/dL	1.7 - 2.2

Interpretation(s):

*** End of Report ***

HJ

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 21 Apr 03 - 22 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/4d Reg #: 2395
Ph: Military Unit: UNKNOWN

22 Apr 03 @ 0506 (Coll) BLOOD

Test	Result	Flag	Reference	Units
WBC	13.5	H	(4.8-10.8)	K/UL
RBC	3.5	L	(4.7-6.1)	1X10 6/UL
HGB	8.6	L	(14.0-18.0)	g/dL
HCT	25.5	L	(42-52)	%
MCV	73.2	L	(80-94)	fL
MCH	24.6	L	(27-32)	pg
MCHC	33.6		(31-37)	g/dL
RDW	21.6	H	(12-14)	%
PLT CNT	520.0	H	(150-450)	1x10 3/UL
MPV	6.1	L	(7.4-10.4)	FL
NEUT/100 WBC	73.1			%
NEUT%	9.9			1x10 3/UL
LYMPHS/100 WBC	19.4			%
LY#	2.6			1x10 3/UL
MONO/100 WBC	7.5			%
MONO%	1.0			1X10 3/UL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

(b)(3)-1

Peri-operative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient #

Diagnosis: (L) Femur Fx — Planned Procedure: IM Nailing (L) Femur Fx

Date: 4/20/03 — Arrival Time: 0920 — Interviewer: [handwritten initials] (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left — Age: HT: WT:

From: ☐ CASREC ☐ ICU ☒ Ward ____ ☐ OTHER:

Transport Via: ☐ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☐ Chart ☐ Armband ☐ Other

Blood Ordered: ☒ N/A ☐ Yes ☐ Consent ☐ T/C #Units ____ ☐ T/H #Units ____ — Comments:

Surgical/Anesthesia Consent Verified: ☐ Procedure ☐ Consent complete, dated, signed ☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc): ☐ None ☐ Yes — Test/Results:

Drug/Latex Allergies: ☒ NKDA — Allergy/Reaction:

Present On Admission: ☐ N/A ☐ Oxygen ☐ IV Site: #1 ____ #2 ____ ☐ Foley ☐ Endotracheal Tube ☐ Arterial Line Site: ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note #

Past Medical History: ☒ None known ☐ Smoker ppd/yr ☐ ETOH ☐ HTN ☐ GERD ☐ Other:

Past Surgical History: ☐ None known ☐ Yes Guns — List:

Cultural Needs Addressed:

(b)(6)-2

DATE 04/20/03 TIME 02:49:41AM

CYCLE SETTINGS — PREVAC

CYCLE TEST	
EXPOSURE TEMP	135 DEG C.
EXPOSURE TIME	00:04
DRY TIME	00:00
LOAD CONTENTS (b)(6)-2	

wrenches

Pre-Op Pain: ☐ No ☐ Yes Level ____ (0-10) — Action Taken: — Location/type:

In Chart: H&P ☒ Yes ☐ No — EKG ☐ Yes ☐ No — CXR ☐ Yes ☐ No — Other:

Skin Condition: ☐ Intact ☐ Other: Ex Fix (L) thigh

Limitations: ☒ N/A ☒ Language ☐ Mobility ☐ Other:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological respo[nse]

Mental/Emotional Status: ☒ Alert/Oriented ☐ Disoriented ☐ Anxious ☐ Appropriate for age ☐ Other ☒ Calm ☐ Sedated ☐ Unresponsive

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☒ Remain with patient during induction

Pre-o[p]: ☒ N/A ☒ Phy ☒ Pers ☒ Env ☐ Post

CONDITIONING		YES
EXPOSURE	00:04	YES
TEMP MIN 135	MAX 137	DEG C.
CYCLE COMPLETE		YES
CYCLE TIME		00:11

CYCLE HAD NO CAUT./WARN.

VERIFIED BY (b)(6)-2

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outc[ome]

Operative Position: ☒ Supine ☐ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☐ Lateral L / R

Positional Aids: ☐ Arms <90 — Armboard: ☐ L ☐ R — Tucked: ☐ L ☐ R — ☐ Airplane ☒ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: — ☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape — ☐ Bean B[ag] ☐ Gel do[nut] ☐ Pillows ☐ Wilson

QUALITY ASSURANCE

ESU # 10 — Pad Site: R posterior thigh — Pad Lot # 66918 — Site Clear at end of case? ☐ No ☒ Yes — If No, see RN note # ____ — Bipolar: ____ Max Cut ____ Coag ____

DVT Prevention: SCD used ☒ No ☐ Yes — Pressure: ____ ☐ Left ☐ Right — Teds: ☐ No ☐ Yes — **Bair Hugger used:** ☐ No ☒ Yes — Other warming techniques:

Tourniquet: ☐ Arm ☐ Leg ☐ Left ☐ Right ☐ webril applied — # ____ — Appli[ed] — Total

BIOLOGICAL,
CHEMICAL,
VACUUM CHECK
MAINTENANCE
APPROVED BY

(b)(6)-4

Comments:

CYCLE NO.	000108
DAILY CYCLES	01
STERILIZER NO.	00
LOAD CONTROL NO.	0420001

clave 9

Rm 10 case 1

Potential For Infecti– Outcome: Appropriate Actions Taken to Pr[...]nt Infection ☐ Yes ☐ No

Wound Classification: ☐ I ☑ II ☐ III ☐ IV

Shave Prep: ☑ Shave ☐ Clipper
Area: L thigh
By: (b)(6)-2

Skin Prep: ☑ Betadine Scrub ☐ Hibiclens ☐ Duraprep ☐ Other:

Solutions/Medications: ☑ Normal saline ☐ Sterile water ☐ Local ☐ Antibiotics ☐ Other:

Drains/Packing: ☐ None
☑ Foley FR: 16
☐ JP #1 Fr ___ Location: ______ #2 Fr ___ Location: ______
☐ Hemovac: Size ____ Location ______
☐ Chest tube: Location ______
Size ______ H2O Pressure: ______
☐ Packing: type/location: ______
☐ See RN Note # ____ for comments

Dressing: Location:
☑ ABD ☐ Ace ☐ Bias ☐ Band-Aid(s) ☐ Cast
☐ Cervical Collar ☐ Coban ☐ Drip Pad ☐ Fluffs ☐ Kerlix
☐ Kling ☐ Immobilizer ☑ Plains ☑ Sling ☐ Splint
☑ Steri-strips ☑ Tape ☑ Webril ☑ Xeroform ☐ Other:
☐ Benzoin ☐ Mastisol ☐ Bacitracin

Miscellaneous

Counts: (initials)
Scrub: RN: (b)(6)-2

Correct?
Sharps ☑ Yes ☐ No ☐ N/A
Sponges ☑ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A

☐ See RN note # ____ for additional comments

Xray: ☐ None ☐ Portable ☑ C-Arm ☐ Other:

Skin Integrity: ☑ Clear & Intact (other than incision)
Comments:
☐ See RN note # ____ for additional comments.

Implants:
Item / Lot # / Exp Date: See Op Report

☐ See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
☐ None Comments:
☐ See RN note # ____ for additional comments

Transport From OR:
☐ gurney w/ siderails up
☐ Litter w/ safety strap in place
☑ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To: ☑ PACU ☐ ICU ☐ Medivac ☐ Ward ____ ☐ Other

Report by: ☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: IM Nailing (L) Femur

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2
Primary OR RN Signature

Date: 4/20/03

Relief OR RN Signature

Date/Time

USN SHIP COMFORT 1-AH20 28 Apr 2003@0807 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 27 Apr 03 - 28 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/10d Reg #: 2395

Ph: Military Unit: UNKNOWN

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28 Apr 03 @ 0454 (Coll) BLOOD

Test	Result	Flag	Range	Units
WBC	6.5		(4.8-10.8)	K/UL
RBC	3.4	L	(4.7-6.1)	1X10 6/UL
HGB	8.3	L	(14.0-18.0)	g/dL
HCT	25.7	L	(42-52)	%
MCV	75.6	L	(80-94)	fL
MCH	24.3	L	(27-32)	pg
MCHC.	32.1		(31-37)	g/dL
RDW	22.6	H	(12-14)	%
PLT CNT	974.0	H	(150-450)	1x10 3/UL

Result Comment: NOTIFIED CDR (b)(6)-2 @ 0600. SJC.

Test	Result	Flag	Range	Units
MPV	5.6	L	(7.4-10.4)	FL
NEUT/100 WBC.	51.9			%
NEUT%	3.4			1x10 3/UL
LYMPHS/100 WBC	38.0			%
LY#	2.5			1x10 3/UL
MONO/100 WBC.	10.1			%
MONO%	0.7			1X10 3/UL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER (b)(6)-4	(b)(6)-4	3. GRADE	ADMISSION REMARKS
4.	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP	12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD ICW2
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN 1678	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct	22. HOURS OF ADMISSION 1101	23. CLINIC SERVICE AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION 4 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 2 MAY 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

Right Lower Ext (?) ~~821.20~~

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				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

SIGNA (b)(6)-2 SIGN (b)(6)-2 S OFFICER

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

MEDCOM - 4504

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER (b)(6)-4		3. GRADE	ADMISSION REMARKS
4. SEX / 5. AGE / 6. RACE IRAQI		10. PREVIOUS ADMISSION	
11. FMP / 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	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct	22. HOURS OF ADMISSION 1701	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 4 MAY 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 2 MAY 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY 86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ		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

Right Lower Ext Fx(s) ~~821.20~~

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				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

SIGNAT (b)(6)-2 | SIGNA (b)(6)-2 OFFICER

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

MEDCOM - 4505

~~ACLU~~-RDI 1244 p.146

DOD 010984

MEDICAL RECORD | **PROGRESS NOTES**

DATE

18 April 03
16:40

22 y/o Iraqi male, 4-5 days s/p motorcycle accident, says he was driving at 120 Km/hour, wrecked, no other vehicle. Denies L.O.C., had no helmet. Had surgery on his left femur. No bowel movement since then, is eating, little pain.

PMH - Gun shot wound to back + (R) axilla, 1997. Had 15 days of paralysis, no residual.

NKDA
No Meds
ROS - negative

PE. - ENT - No injuries, PERRL, Neck not tender
Chest - clear, not tender - Healed wound (R) axilla, scapula.
Heart - (no) (m) | clear.
Abd - benign
Rectal - normal prostate
Pelvis - stable.
Ext - Neuro/vascular intact. Ext fix (L) femur. Multiple superficial abrasions flanks + thighs.
Neuro - alert.

(Cont)

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

(b)(6)-4

(b)(6)-4

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

MEDCOM - 4506

ACLU-RDI 1244 p.147

PROGRESS NOTES

DATE	
	A: Femur fracture (L)
	P: admit to ortho
	CXR, Femur Xrays, antibiotics.
	CAPT (b)(6)-2
	(b)(6)-2
4/18/03	Ortho Unsrv:
	22 y/o Iraqi ♂ s/p motorcycle MVA / helmet, other vehicle. Sustained (L) closed fem fx, & ... ex fix on date of injury ~5 d ago. Medevaced to USNS Comfort for definitive care.
	PMHx: GSW post upper T-spine 5 yr ago 2w of paraplegia p inj; no permanent sequelae
	PSHx
	Meds
	All:
	PE: pain ... lat (L) femur.
	NVI; good DP & PT pulses
	... (R) antero lat pelvic brim
	FL: (L) femur
	A/P (1) cleared by Gen Surg (2) ortho, neuro/... (3) OR 4/20/03 ... (4) DVT prophylaxis Lovenox (5) NPO ... 4/19 for OR 4/20 (b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20182

STANDARD

MEDCOM - 4507

ACLU-RDI 1244 p.148

DOD 010986

MEDICAL RECORD	PROGRESS NOTES

DATE	
April 19 '03 10:25hrs	APRIL 18 - Hb 9.1 Hct 28.2. Start FeSO4 T tid MULTIVIT T QD folic acid 1mg T QD. 131 | 98 | 10 / 4.5 | 26 | 0.7 > 78. [illegible] (b)(6)-2 (A.POTTS).
19APR03 1520	Medical Nutrition Tx: O: Per RN - ate lunch. Dx: (L) femur fx c̄ external fixation. Wt. ≈ 60kg. Labs 18APR03 Hgb/Hct 9.1↓/28.2↓. Diet Rx: Regular A/P: Kcal needs = 30-35 kcal/kg/day = 1800-2100 kcal/day Protein needs: 1.5g/kg/day = 90g/day. Hgb/Hct↓ - will monitor c̄ FeSO4, MVI, Folic acid tx. PO intake fair - recommend continue encourage PO intake c̄ Regular diet + snacks/ENSURE TID. RD to f/u c̄ 2-3 days. (b)(6)-2 MPH, RD (b)(6)-2 MPH, RD LT, MSC, USNR (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)

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 4508

PROGRESS NOTES

DATE	
4/20/03	ortho f/p ✓
	S/P ⓟ fem in ril
	Pain well controlled
	drg c̄ staining
	NVID ugs. ⓟTA ⓟEHL ⓟ pronos
	A/P ① ✓ AM Labs.
	② wound care
	③ PT for NWB LLE crutch ambul to begin AM 4/21.
	④ DVT prophylaxis
	⑤ 48° post Abx.
	(b)(6)-2 ... MD.
4/21/03	ORTHO POD#1 S/P ⓟ fem [illegible]
	Tm 102.8 increased p.p.; now 100.7 VSS
	dressing c̄ minimal staining
	NVID
	Labs s/p, NT
	21 Apr Labs 9.1 X 7.3 / 22.5 / 455; 131 | 96 | 11 / 4.1 | 30 | .9 > 108 B C×ⓟ U C×ⓟ
	preop 20 Apr 8.4 X 8.3 / 24.8 / 377
	A/P Clinically no fever source; prob post atelectasis
	2° Gen Anesth
	① ⊕ Xfuse for Hct/22 initiated by WMO
	② Follow ⓒ ③ OOB + incentive spirometry
	④ wound care by MD.
	(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/21/03	Hb 7.1 / 22.2
0905 hrs	
	Transfuse 2 units packed cells
	(b)(6)-2
	[illegible]
23Apr 03	P.T. Note
	Pnt seen this AM. for crutch Trng. Required min Ⓐ x 1
	supine ↔ sit and mod. Ⓐ x 1 sit ↔ stand, upon standing
	c̄ crutches Pt c/o feeling dizzy and pain in LLE.
	Will cont crutch Trng in the A.M. — (b)(6)-2 [illegible] P.T. Tech
26APR03	[illegible] POD#2 S/P [illegible] Ⓛ [illegible]
	[illegible] x 48° (b)(6)-2
	[illegible]
	[illegible]
	[illegible] wounds [illegible] by [illegible] c̄ 1% acetic acid soln
	A/P ① daily wound care
	② PT [illegible]
	③ [illegible] (b)(6)-2
	(b)(3)-1 PT TECHNICIAN USN HM (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)

(b)(6)-4

REGISTER NO.	WARD NO.

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

MEDCOM - 4510

PROGRESS NOTES

DATE	
26APR03	P.T. NOTE
	Pnt transfered from supine to EOB c̄ min assist x1, EOB to stand c̄ mod assist x1. Ambulated 8 feet c̄ crutches and CGA x2. Transfered back to bed c̄ mod assist x1. Pnt put forth a good effort but not yet safe c̄ crutches. Cont P.T. QD. — (b)(6)-2 (b)(6)-2 HM USN PT TECHNICIAN SSN: (b)(6)-2
27APR03	P.T. NOTE
	Pnt transfered from supine to EOB to stand c̄ min assist x1. Ambulated approx 100 feet c̄ crutches and SBA x1. Transfered back to EOB c̄ min assist x1. Put forth a good effort and tolerated session well. Pnt ind c̄ crutches and able to ambulate c̄ staff. Pnt discharged from P.T. — (b)(6)-2 HM2 (b)(6)-2
Apr 27 '03	Internal Med
	Consulted re: culture of thigh wound done 4/23 has grown Pseudomonas + Acinetobacter, both [illegible] + both sens ticarcillin, cipro, as well as imipenem. Pt was started to Acineto ward on 4/22 due to blue-stained wound dressing suspicious for P. fluorescens. Blood cx of 4/21 are ⊖. Afeb (< 100 since 4/24 1200). Wounds reported to look good (Pin cx fix sites), but direct path to bone. Rec Add cipro, tx 6 wk total (d/c Timen on dc)

WBC
4 9.5
22 13.5
23 13.5
24 13.5

Timentin #5

(b)

★ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4511

ACLU-RDI 1244 p.152

DOD 010990

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/22/03	Ortho POD#2 ..
	Tm 102 still ; 99+ now
	tol po's.
	PE NAD
	wounds - Surgical incision from 4/20 - clean + dry
	- wound from ex fix (proximal ex fix site +
	distal ex fix site → Blue staining
	IMP Empirical Tx for Pseudomonas Fluorescens
	p̄ D/W I.M. MD.
	Plan (1) Begin IV Timentin
	(2) Xfer to isolation ward.
	(3) ↑ Labs
	(4) DVT prophylaxis
	(b)(6)-2
22APR03	Medical Nutrition Tx F/U:
1905	O: Accepted apple + 1 can ENSURE from RD. Diet Rx: Regular
	Labs 22APR03: Hgb/Hct 8.6↓/25.5↓ MCV/MCH 73↓/24↓
	A/P: PO intake fair - recommend continue to encourage
	PO intake. Hgb/Hct ↓ MCV/MCH ↓.
	Recommend offer MVI + $FeSO_4$ c̄ fruit juice to
	↑ absorption. RD to f/u c̄ 2-3 days.
	(b)(6)-2 MPH, RD

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

(b)(6)-2 MPH, RD
LT, MSC, USNR (b)(6)-2

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 4512

PROGRESS NOTES

DATE	
4/24/03	ORTHO
	Narrative Summary.
	22 y/o Iraqi ♂ s/p Motorcycle MVA
	in Iraq on about 4/13/03. Pt had closed
	left femur fx, and had ex fix placed
	across fx on same date. Pt remained
	in Iraq, c̄ ? drg, Δ's at pin sites for 5
	days. Brought to (b)(3)-1 and
	had films done showing proximal diaphyseal
	oblique fx. Examination of pin sites showed
	long proximal pin incision communicated
	with fracture site, and therefore closed
	fracture was converted to open fracture by ex
	fix. On 4/20 pt underwent antegrade IM nail,
	I+D, and removal of ex fix; proximal nail interlocks
	were placed thru ex fix site incision, c̄ fascia
	closed over interlock screw heads, as there was
	no other option. On POD #2 (4/22) the ex fix
	site wounds, which had been closed over drain,
	were noted to be draining serpurulent drainage and
	blue staining, c/w Pseudomonas Fluorescens, was
	noted on dressing. Pt began turned on IV
	Tx/Meds, c̄ subsequent ↓ Temps, ↓ drainage. Pt
	was then taken to OR on 4/23 for opening of ex fix
	wounds, I+D, packing c̄ acetic acid solution
	for a planned period of 5d, then followed by

(b)(6)-4

STANDARD FORM 509 BACK (Rev. 11-77)

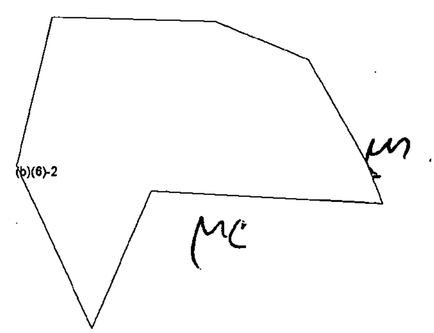
MEDCOM - 4513

(over)

ACLU-RDI 1244 p.154

DOD 010992

wet → dry dsg Δ's until wounds granulate closed.
Now getting Percocet, MVI, Folate, Fe sulfate,
Colace, and IV Timentin (to continue for 10-14d).
Pt needs these meds, and bid dsg Δ's.
P.O. meds Rx'd + dispensed. Pt is to remain
~~NWB~~ NWB LLE, until fx healed. Check fx at
2 mos p̄ injury prior to beginning WBAT. Can ambulate
on crutches, NWB LLE until fx healed.



MEDCOM - 4514

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
25APR03	P.T. NOTE
	Pt transferred from supine to SOB, SOB to stand c̄ mod assist x1. Attempted crutch training but pt c/o dizziness. Transferred back to supine c̄ mod assist x1. c/o pain (sharp) LLE post session. Cont P.T. AD.
	(b)(6)-2
	(b)(6)-2
25APR03	Medical Nutrition Tx F/U:
1510	O: Per RN - ate 75% Breakfast + Lunch. Eating apple.
	Labs 24APR03: Hgb/Hct 8.1↓/24.1↓ MCV/MCH 73.7↓/24.7↓
	A/P: PO intake fair-good - recommend continue to encourage PO intake. Hgb/Hct/MCV/MCH ↓ - recommend offer $FeSO_4$ + MVI c̄ fruit juice to ↑ absorption.
	RD to f/u q̄ 2-3 days. (b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (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 (41 CFR) 201-45.505
509-111

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/29/03	Inf Dis (b)(6)-2
0940	22 y/o S/P MVA (L) femur fx - fix (b)(6)-2
	had infected pins from field hospital c̄
	communication to the comminuted fx.
	Pt underwent femoral nail 4/20/03. 3 d post-op
	had blue wounds - subsequently ⊕ for Pseudomonas (b)(6)-2
	Since then pt doing ok. Pt last febrile (b)(6)-2
	24 Apr 03. c/o occ chills "big" pain (L) thigh + above knee
	PMHx Meds All: NKDA
	GSW '97 Ancef 4/18-22
	MVA '03 c̄ fem fx. Timentin 4/22 →
	Cipro 4/27 →
O:	WD♂ NAD
	HEENT: Ø thrush
	Heart: RRR c̄ (M)
	Lungs: CTAB
	Abd: ⊕ NABS
	Ext: (L) thigh wounds x 2 · serosang d/c.
	Ø odor Ø erythema, good granulation
	4/28: WBC 8.3, Hgb 6.5, Hct 25.7, Plt 974 4/24: WBC 8.1, Hgb 13.3, Hct 24.1, Plt 810 [16, 93, 0.8]
	Cx: Blood 4/18 - NG 4/21 Urine, blood - NG

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
	4/23 wound: Acinetobacter Amik, Unasyn, Sulfa, cipro, Imp, CTZ, Timent.
	Pseudo aeruginosa - Amik, CTZ, Cip, Gent, Imp Timent (S)
	CXR 4/18 (L) effusion vs Atelect.
	femur - fx
	Imp: 22 y/o s/p MVA. Now c femoral rod in place. Had open fx c pseudomonas + acinetobacter causing osteo.
	Rec: 5 more weeks of cipro + 2nd agent. Since Timentin is working would favor keeping it, however needs to be given q 4-6 hr + has high fluid burden. Both isolates (S) to ceftaz - it is tid drug, would Δ to CTZ + cipro + give 5 more weeks (35 d) more. Consider picc for IV Atbx.
	(b)(6)-2 (b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
29APR03	Pnt asked to be seen by P.T. this AM. Pnt f/u performed 10 reps of (L) ankle pumps and heel slides exercises c assistance. Pnt tolerated session well and ind c crutches. Will cont P.T. as per doctor's orders.
	(b)(6)-2 (b)(6)-2 HM - USN PT TECHNICIAN (b)(6)-2 (b)(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

DATE

4/28/03 ortho POD#8 s/p I&D R fem. Cipro 500 po bid
POD#6 I&D Tobramycin 3.1g IV q8

Tolerates po's ..

ambulates c crutches

Duoderm or minimal rad vash - healing well

PE AVSS (x 4d+ now)

wound (L) thigh granulating c minimal fibrinous debris at base of wound.

A/P ① Lovenox SQ continue

② Will have ID enter note Re: Appropriate Abx coverage per Dr Headrick

③ Xfer care to Dr Headrick @ MN tonight.

(b)(6)-2 m.

28APR03 Medical Nutrition Tx: F/U:

1635 S: Per translator - 4/27 - Ate 3 meals + 1 apple + 1 orange. 4/28 - Ate Breakfast + lunch + 1 apple.

O: Diet Rx: Regular. Labs 4/28: Hgb/Hct 8.3↓/25.7↓ MCV/MCH 75.6↓/24.3↓. Meds: $FeSO_4$

A/P: PO intake good. Recommend offer $FeSO_4$ c fruit juice to ↑ absorption. RD to f/u q 3-5 days.

(b)(6)-2 MPH, RD

(b)(6)-2 (b)(6)-4 MPH, RD

LT, MSC, USNR (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)*

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/29/03	ORTHO s/p IM Nail R femur 9d ago,
	6d s/p I&D.
	Sleeping.
	Afebrile
	L femur - small amt. drainage from proximal
	incision
	able to DF ankle
	P: drsg D. done.
	ID c/s appreciated. - CTZ, Cipro 5 more wk
	(b)(6)-2
4/30/03	ORTHO R fem nail 10 d ago (b)(6)-2 7d s/p I&D.
	Comf.
	Afebrile
	P: Cont. present care. (b)(6)-2
4/30/03	ID
1015	Afebrile OOB walking on crutches
	Imp overall doing well pmi osteo c contiguity
ceftaz d8	to fx femur s/p MVA day 8/42
cipro d8	Rec: continue cipro/ceftaz until June 3rd
	will sign off - pls call c questions
	(b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES
DATE	
5/1/03 0945	I-P Afebrile VSS 7.8 > 9.5 / 22.3 < 226 ESR 72
	Doing well 140 / 5.1 | 101 / 33 < 18 / 70 / 0.8
	Exam unchanged
	Imp: Femoral osteo d# 9/42 cip/CTZ
	Rec: continue meds
	repeat CBC 7 days [(b)(6)-2]
	[(b)(6)-2] LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE [(b)(6)-2]
1MAY03 1820	Medical Nutrition Tx F/U:
	S: Per translator - ate 3 meals 4/30 + 5/1.
	O: Diet Rx: Regular. Labs 1MAY03: Hgb/Hct 9.5↓/29.3↓
	A/P: Hgb/Hct ↓, but improved since 25APR03.
	PO intake good. Recommend continue to encourage PO intake.
	RD to f/u ō 3-5 days. [(b)(6)-2] [(b)(6)-2] MPH, RD MPH, RD
	LT, MSC, USNR [(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)

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PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3May02 0250	Nsg Note: PT admitted from EMT @ approx 2315 ambulate c crutches accompanied by staff. PT A&O: Afebrile, HL to (L) FA patent. IV Abx given. C/o pain to (L) hip percocet 2 tabs given. Drsg to (L) hip & reinforced cont. Incision approx 4cm noted above drsg (L) hip c sutures. Wound edges well approximated. Ø drainage or odor noted. Will continue to monitor. (b)(6)-2
Addendum	NO. EXT Fixator or injury noted to (R) foot.
3May03 1330	Client s c/o pain. Client Lungs CTA, ... Client c drsg change to (L) thigh. Provided W-D drsg on 2 location on outside of thigh. Wound bed pink c scant amt of greenish exudate noted, c small odor. Client D/C'ed IV when disconnecting IV piggyback from SL. (b)(6)-2 (b)(6)-2 CPT, AN
3 May 03 @1715	NSG Note - Medicated c 2 percocet by CPT (b)(6)-2 for c/o pain p ambulating outside to Bathroom — SSG (b)(6)-2 91WM6
3 May 03 @1900	NSG Note - PRN Effective. Pt Sleeping — SSG (b)(6)-2 WM6
4May03 0900	Client D/C to LN hospital through red cresecent. Client received W-D drsg to ... (L) hip. Client s c/o pain. Client discharged c SL in (L) FA to receive IV fortaz i gm Q8hr. (b)(6)-2 CPT, AN

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4521
509-114

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2135 18APR03			Assumed pt @ 2200. Pt transported from CASREC. Pt VSS, A&Ox3 ∅ English speaking. Pt PERRLA, lungs CTA (B), Abd soft NT, ND ∅ c/o N/V. Tolerating PO ∅ difficulty. Pt (L) thigh FX c̄ external fixater in place. Pin care completed, guaze changed around pins. Pt neuro ✓ circ ✓ WNL (+) pulses (+) capillary refill <3 secs. Color pink. Pt given tylenol for pain and MSO4. Will continue to monitor.
			(b)(6)-2 RN/NC
19APR03			ASSUMED PT CARE @ 2300. PT LYING ON BACK SLEEPING. HAS EXT FIX ON (L) LE, ∅ DRAINAGE, CAP REFILL < 3 SECS, (+) SENSATION, (+) PULSE, NO SWELLING, PT AOX3. ∅ C/O PAIN @ THIS TIME, VS STABLE, CLEAR LUNG SOUNDS. WILL CONTINUE TO MONITOR (b)(6)-2
19Apr03 @ 0235			Concur c̄ note as written (b)(6)-2
19Apr03			Assumed ~~by~~ pt care @ 1500. Pt ∅ complaints. A&Ox3 c̄ little English speaking knowledge. Pt Perrla, lungs CTA (B). Abd soft NT, ND (+) BS x4 quads. Pt urinating ∅ difficulty. Tolerating PO ∅ problems. Pt (L) leg c̄ external fixater in place. Pin care completed. Neuro/circ ✓ WNL. capillary refil <3secs. Pt able to move leg ∅ problem.

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(b)(6)-4

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4522

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont			will continue to monitor.
			(b)(6)-2 EMS/NC
19APR03	0000		Assumed pt. care. pt. sleeping. very cooperative c care. HR S1S2 present. All pulses strong & equal. Bowel sounds hyperactive. ABD. soft. Ø T&D noted. Pt. A&Ox3. Pt. Has ext. Fix. to (LLE) Looks good pt. has Ø c/o pain. Neuro checks are very good. Motor skills are good. Lungs are clear bilat. V/S stable. Pt. in good (b)(6)-2 cheer. Will continue to monitor pt. (b)(6)-2
20APR03	0300		concur c above note S. Carmack LPN NC
21APR03			Assumed pt care @ 2300. Pt Ø complaints A&Ox3 c English speaking ability. Pt VSS, lungs CTA (B), abd soft NT, ND Ø complaints N/V. Tolerating regular diet Ø difficulty. Pt (L) leg c dressing drainage noted - good/moderate amount serosanguinous drainage to dressing. Pt neuro/circ WNL to (L) leg. all pulses (+) cap refil <3 sec. Pt medicated for pain will continue to monitor
			(b)(6)-2
21APR03	1135		Pt temp @ 101.9. Gave 2 tylenol. IS. (b)(6)-2
		1800	PT TEMP @ 102°F. LARGE AMOUNT OF DRAINAGE ON DRESSING ON LOWER BACK. PT COMPLAINING PAIN ON (L) LE.

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NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22	1000		Alert & oriented X3 - Lungs clear BL, ⊖ Resp distress - Cardiovascularly intact. ⊕ BS x 4 quads, Tolerating reg diet. Voiding quantities sufficient. Frequent complaints of pain. Medicated as ordered - Continues and cooperative c̄ Tx regimen [redacted]
4/22	1220		Transfer to 4 [illegible] at this time [redacted]
23Apr03		1630	Accepted pt. on ward. Given 5 mg MSO4 for pain. Ace to Ⓛ leg clean, dry & intact [redacted]
22APR03		1620	ASSUMED PT CARE. PT HAS Ⓛ FEMUR FX c̄ ACE WRAP TO Ⓛ THIGH. PT HAS A FEVER OF 100.9. WILL CONTINUE TO MONITOR.
22APR		1800	Rec + concur w/ above. Encouraged to use ICS q 1°. Temp ↓ 99.6 c̄ cough & deep breathing. - Will continue to monitor. [redacted] LCDR NC
		2200	Temp ↓ 98.6 (po). Medicated for c/o pain - no apparent distress noted. [illegible]
23 APR 03	0140		Assumed pt care @ 2300. Vital signs WNL, pt resting comfortably. Ⓛ femoral dsg CDI, dsg on Ⓡ hip CDI. Slight temperature of 100.0°F, pt encouraged to use IS. c/o pain & medicated w/ 5mg MSO4. Will continue to monitor. [redacted]
23apr	0800		NPO maintained for I+D of Ⓛ LE wounds. PT instructed. Verbalized understanding. Speaks and understands some English. IV of D5 1/2 NS infusing at 75cc/hr. Initial assessment noted and concur. [redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
CONT			WILL CONTINUE MONITOR THROUGOUT THE SHIFT. (b)(6)-2 -HN
04/21/03		1600	Pt. resting most of shift. pt. had eye pain to (L EYE). Was medicated [illegible]. Nurse AWARE. Pt. had high temp of 102.0 pt. was medicated. Recheck TEMP 101.5. Nurse notified. Pt. voiding without difficulty. Will continue to monitor Pt. closely. (b)(6)-2
0041 22APR03			Assumed pt care @ 2300. Pt ∅ complaints resting comfortably. Pt VSS stable c̄ elevated temperature noted and MDs aware. Pt PERRLA, lungs CTAB, abd soft NT, ND ⊕ BS x4 quad. ⊕ pulses x4 extremities capillary refil <3 sec. Pt L femur wrapped c̄ guaze/silk tape. c̄ drainage serosanguinous marked on dressing. Will continue to monitor. ~~Ex~~ Left Extremity warm to touch, NEURO/CIRC ✓ WNL ∅ deficits. Pt to receive second unit PRBCS this shift will administer and monitor for side effects closely. (b)(6)-2 ENS/NC

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(b)(6)-4

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4525

~~ACLU-RDI 1244 p.166~~

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24APR03	0830		Assumed care of pt. Pt AAO×3. BS ⊕ 4 quads. S1 & S2 ̄c RRR, PPP. VSS, & Lungs CTAB. Pt ate 80% breakfast. Resting @ this time. Will continue to monitor. (b)(6)-2 RN
24APR03		1620	Assumed pt care. VSS, minimal c/o pain. Temp slightly ↑, given pain meds. pt has ace wrap to Ⓛ thigh ̄c edema below the knee. Will continue to monitor. (b)(6)-2
24APR03		1755	Concur ̄c above assessment (b)(6)-2
25APR03	0230		ASSUMED PT CARE @ 2350. TEMP SLIGHTLY ↑, med given, I.S. ENCOURAGED ̄c RN NOTIFIED. BS ⊕ 4 QUADS. Ⓛ THIGH ̄c ACE WRAP ̄c EDEMA. PT. ASLEEP @ THIS TIME. WILL CONTINUE TO MONITOR. HN (b)(6)-2
			PT. IV Ⓡ HAND ̄s S/SX I/I. WILL CONTINUE TO MONITOR HN (b)(6)-2
25APR	0610		Initial assessment noted and concur (b)(6)-2
25APR03	0755		ASSUME CARE OF PT @ THIS TIME. PT COMPLAINS OF PAIN. PT GIVEN 5mg of MSO4. PT EATING BREAKFAST. APPEARS TO BE DOING WELL. DRESSING ON Ⓛ LE APPEARS CLEAN DRY and intact. will continue to monitor pt. (b)(6)-2
25APR03		1630	ASSUMED PT CARE PT IS SITTING UP IN WHEEL CHAIR. PT HAS ACE WRAP BANDAGE TO Ⓛ THIGH WITH 2 J.P. DRAINS DRAINING WELL. PT HAS COMPLAINTS OF MILD PAIN, VSS, AND WILL CONTINUE TO MONITOR. (b)(6)-2

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CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23Apr03 HLN ~~073~~	0737		Assumed care of pt A & OX3 RRR Cl & Bl lung sounds, ⊖ TTP to abdominal area ⊖ distention ⊕ bowel sounds to all 4 quads ⊕ neurochecks ⊕ cap refill. Pt has dressings to Ⓡ & Ⓛ hips (small) large dressings to Ⓛ leg femoral area, dry and intact. IV site in Ⓛ anacub, good. (b)(6)-2 HN
1019			Pt Departed for O/R (b)(6)-2 HN
1417			Pt returned from O/R (b)(6)-2 HN
23APR03		1745	ASSUMED PT CARE. PT HAS Ⓛ FEMUR FX IN ACE WRAP. PT HAS Ø COMPLAINTS OF PAIN. VSS WILL CONTINUE TO MONITOR. (b)(6)-2 (b)(6)-2
24APR03	~~0000~~		assumed PT care. PT c̄ dressing to Ⓛ thigh c̄ moderate amount of serosanguinous drainage noted. Small dressing to Ⓡ hip CDI. Neurochecks within normal limits. Will continue to monitor. (b)(6)-2 HN
24APR03	0600		Initial assessment noted and review. Resting quietly postop (b)(6)-2 am.

Continue on reverse side

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

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

MEDCOM - 4527

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25APR03		1630	ASSUMED PT CARE. PT IS AWAKE & ALERT LYING IN BED. PT HAS ACE WRAP BANDAGE TO (L) THIGH. NUERO CHECKS WNL PT HAS Ø COMPLAINTS OF PAIN & VSS. WILL CONTINUE TO MONITOR PT. — (b)(6)-2
25APR	0130		DRESSING ON (L) THIGH C/D/I; AREA COVERED ē ABD & TAPE. (+) CMS TO AFFECTED EXTREMITY. NO NEEDS @ THIS TIME — (b)(6)-2
26APR03	0745		ASSUME CARE OF PT @ THIS TIME. PT COMPLAINS OF PAIN IN (L)LE ALONG WOUND. PT DRESSING TO INJURY are clean dry and intact. PT DOES NOT WISH TO GET UP @ THIS TIME FOR AM CARE WISHES TO SLEEP INSTEAD. WILL continue to monitor PT. will wake for AM CARE. IN 2 hrs. — (b)(6)-2
26APR03		1747	ASSUMED PT CARE @ 1530 PT A&O X 3. (L) LE DRESSING C/D/I (+) NUERO (+) CIRC CHECKS PT RESTING NOT C/O PAIN @ THIS TIME — (b)(6)-2
26Apr03		2350	Assumed Pt Care @ this time pt Aox3 Pts Ace wrap to LLE CDI Nuero VS WNL Caprefill +3 No C/os @ this time Will Continue to Monitor @ this time — (b)(6)-2

Continue on reverse side

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

REGISTER NO.

WARD NO.

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/27/03	0038		CONCUR c̄ ABOVE ASSESSMENT ——— (b)(6)-2
~~4/27/03~~	~~0803~~		~~Assumed care of pt at 0700. Pt resting comfortably. No c/o ~~PAIN~~ RPS. WNL pt has dressing from Mid thigh to foot c̄ splint on the foot. No apparent drainage. heploc to (R) forearm.~~ ——— (b)(6)-2
4/27/03	0803		Assumed care of pt @ 0700 pt resting comfortably c̄ eyes closed. Pt c/o pn to (L) thigh. Dressing on (L) thigh c̄ no apparent drainage, stitches to outer hip and duoderm to (L) hip joint. Pt VS WNL. Pt requests to take a shower and put on pants and shirt ——— (b)(6)-2 HN
4/27/03	1030		Agree c̄ above assessment. Pt. ambulate c̄ crutches + up to shower. Will cont to monitor ——— (b)(6)-2
27APR03		1530	Assumed pt care. VSS, pt has drsg to (L) thigh/knee CDI. pt c/o minimal pain. drsg. W-D c̄ gauze, Kerlix's ace wrap. Will cont. to monitor ——— (b)(6)-2
27APR03		1850	pt asked for crutches, went to RR & walked around ward x3. Pt had ∅ c/o pain – (b)(6)-2

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NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4529

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28APR03		1900	Assumed Pt care VSS Pt w/ complaints of pain. Pt A&O x3 will continue to monitor Pt Resp & Pain — (b)(6)-2
29APR03	0910		Pt lying in bed @ this time. (R) leg dsg Δ by wound team this AM. Dsg 4x4 gauze/tape to left lateral thigh and knee. Dsg C/D/I. No drainage. N/V WNL. Pt c/o pain in (R) leg. 5mg MSO4 IVP given (b)(6)-2
29APR03		1300	ASSUMED CARE @ 0700. VSS. ⊕ HR, RR, BS. Ø c/o of PAIN. WILL CONTINUE TO MONITOR. — (b)(6)-2
29Apr03		2205	Assumed care of Pt @ 1900. VSS, medicated for pain. Pt ambulated at side of bed. Will continue to monitor — (b)(6)-2
30APR		1000	ASSUMED CARE @ 0700. VSS. PT AMBULATING WELL c̄ CRUTCHES. NEURO CHECKS WNL. (L) LEG HAS GAUZE + TAPE. DSG Δ'd BY WOUND CARE TEAM. WILL CONTINUE TO MONITOR. — (b)(6)-2
30Apr03		2032	Assumed care of Pt @ 1900, VSS, Neurochecks WNL, Pt medicated for pain. Dressing Δ'd by wound care team. Will continue to monitor — (b)(6)-2
1MAY03			[illegible] LLE [illegible] DSG C/D/I c/o mild pain to LLE neuro v WNL v/s WNL mild edema to LLE Ø S/S infection cap refill < 2sec L-CTA ABD - NT/ND HORRG — (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

(b)(6)-4

MEDCOM - 4530

CLINICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28Apr03	0400		Assumed pt CARE 2300. VS WNL. Neuro checks WNL. (L) hip stitched. (L) + (R) side c̄ patch. (L) leg Swollen able to move. ace wrap lLE reinforced top of wrap c̄ drsg pt partial wound exposed. pt resting at this time. will continue to monitor — (b)(6)-2 HM/USN
28Apr	0730		Above noted and concur ~ (b)(6)-2 [illegible]
~~28APR03~~	~~0815~~		~~Pt sitting on side of bed. No c/o pain. Pt has arch braces in mouth. Pt tolerating soft diet. Dsg to (L) cheek Δ'd by MO. Small rectangular area to (L) cheek approx quarter size. Area irrigated and dsg Δ'd W/D Dsg c̄ 1% acetic acid. Area pink c̄ small amount of sangious drainage. Will cont to monitor —~~ (b)(6)-2 LTJG, MC (Error wrong pt.)
28APR03	0830		Pt ~~has~~ lying in bed @ this time. No c/o pain. (L) leg wrapped with kerlex and ace bandage. N/V checks WNL. Pt ambulating NWB c̄ crutches. — (b)(6)-2 LTJG MC

Continue on reverse side

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.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5/1/03	1300		Concur c̄ HM3 Disalvo's assessment, AM care done. Ambulating well on crutches. Dsgs to Ⓛ upper thigh D'd. Dsg #1 on top of thigh approx 2in. in length + 1/2 in deep. Packed c̄ sterile gauze. Draining moderate amt of sanguinous fluid. Dsg #2 (near knee) approx 1in in length. Packed c̄ sterile gauze. Pt. doing well. Minimal c/o pain. Will cont to monitor. (b)(6)-2
1 May 03		2020	Assumed care of Pt @ 1900, VSS, A+O x3, medicated for pain. Pt is ambulating well w/ crutches. Will continue to monitor. (b)(6)-2
2 MAY 03	0100		Patient with dressing BLE, CDI, changed. See ENS Snider's note for details on dressings. will monitor. Pt to leave in am. Supplies at bedside, meds at nurses station. (b)(6)-2 ENS, NC
2 May 03	1050		Assummed care of pt. @ 0700. Pt. showered + awaiting discharge. Dsg's D'd. Dsg. #1 c̄ less drainage today than 1MAY03. Pt. sleeping @ this time. Will cont. to monitor (b)(6)-2

Continue on reverse side

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.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 May 03	1650Z/1950L		(b)(3)-1 . Pt. enplaned via litter s̄ incident. Pt. ⊕ CSM to bilat. L.E's., moves L.E's on own. Skin warm, brown, dry. ⊕ pedal pulses, strong, regular. Pt. resting comfortably on litter. No complaints at this time. ø English speaking. — TSGT (b)(6)-2 USAFR
			Note: unable to visualize dressings to L.E's. — (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4533

ACLU-RDI 1244 p.174

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

(L) Femur Fx, Closed

SURGEON (b)(6)-2 Dr. | FIRST ASSISTANT Dr (b)(6)-2 | SECOND ASSISTANT

ANESTHETIST LCDR (b)(6)-2 | ANESTHETIC Gen ETT (b)(6)-2 | TIME BEGAN: 0955 | TIME ENDED: 1443

CIRCULATING NURSE LT (b)(6)-2 / (b)(6)-2 | SCRUB NURSE HM3 [redacted] | TIME OPERATION BEGAN 1105 | TIME OPERATION COMPLETED 1425

OPERATIVE DIAGNOSIS

(L) Femur fx, open -> proximal external fixator pin incision communicated with fracture.

DRAINS (Kind and number)

1/2 Penrose to each of II pin site incisions/ext. | SPONGE COUNT (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

(L) ANTEGRADE FEMORAL IM NAIL

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.) SEE BELOW

DATE OF OPERATION 20 April 03

VOP: 550
EBL: 350
IV FLUIDS: 3600

(1) Cannulated Femoral Nail
12 mm x 380 mm
MCN: 4525012
Exp: 03/2012
(2) 4.9 mm x 38 (459.38)
(3) 4.9 x 58 (459.58)
(4) 4.9 x 48 (459.48)
(5) 4.9 x 64 (459.64)

Surg [illegible]
Asst [illegible]
post supine on the table
Anesth Genl
incision over posterolat (L) buttock.
II stab portals for distal interlocks
prox interlocks placed thru prior pin site incision lat fem.
close 0-vicryl, 2-vicryl, 3-vicryl skin
drain 1/2 of penrose to each of II pin site prior wounds.
Specimen Ø Stable transfer to PACU.

SIGNATURE OF SURGEON (b)(6)-2

DATE 4/20/03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-2 (b)(6)-4

REGISTER/I.D. NO. | WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-103

MEDCOM - 4534

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDICAL RECORD

PREOPERATIVE DIAGNOSIS

No infx of (L) thigh wounds from ex fix

SURGEON: DR (b)(6)-2

FIRST ASSISTANT: N/A

ANESTHETIST: LCDR

ANESTHETIC: GENERAL VIA ETT

N/A

TIME BEGAN: 1225

CIRCULATING NURSE: LT (b)(6)-2

SCRUB NURSE: HM3 (b)(6)-2

HM3 (b)(6)-2

TIME ENDED: 1300

TIME OPERATION COMPLETED: 1342

OPERATIVE DIAGNOSIS

Same as above..

DRAINS (Kind and number)

NONE

SPONGE COUNT: ... + SHARPS

2 count [illegible]

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

(1) AEROBIC C+S
(2) ANAEROBIC C+S
> (L) PROXIMAL THIGH WOUND

OPERATION PERFORMED

I+D LLE WOUNDS

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (list no.): NONE

DATE OF OPERATION: 23 APR03

UOP: NM
EBL: MIN
IV FLUIDS: ~~1400~~ 450 CRY

Surg (b)(6)-2

Asst Ø

incision open of prior (L) lat thigh ~~[illegible]~~ five wounds from ex fix sites; prior surgical incision clean and not opened.

anesth GEN/ET

Closure # 0-prolene retention sutures.

dressing: plain sterile gauze c̄ 1% Acetic acid

drains Ø cultures ×2 from prox pin site (1 aerobic 1 anaerobic)

Counts correct.

Stable to pacu

Tourniquet not used

SIGNATURE OF SURGEON (b)(6)-2

DATE: 4/23/02

PATIENT'S IDENTIFICATION (b)(6)-2

(b)(6)-4

MEDCOM - 4535

~~ACLU-RDI 1244~~ p.176

DOD 011014

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY				
POST- DAY				
MONTH-YEAR / DAY	2May03	3May03	4May03	
19 / HOUR	2320	06	1600	

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)

	2320 (2May03)	1600 (3May03)
RESPIRATION RECORD	18	
BLOOD PRESSURE	115/57	114/64
	85	85
	98.5	98.2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4536

ACLU-RDI 1244 p.177

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) ______

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

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

DIAGNOSIS OR OPERATIVE PROCEDURE: (L) Femur Fx

DATE REQUESTED: 4/21/03

DATE AND HOUR REQUIRED: ASAP

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.

SIG (b)(6)-2

VOLUME REQUESTED (If applicable): 1 Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

REMARKS: H/H Adm 7/22.4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED: 21 APR 03

TIME VERIFIED: 1020 Hrs

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. 4

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: neg

CROSSMATCH: comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

(b)(6)-2 ...RMING TEST (b)(6)-2

DATE 21 APR 03

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONE...

REMARKS: EXP. 03MAY03

DONOR — ABO: O Rh: POS

RECIPIENT — ABO: O Rh: POS

SECTION III – RECORD OF TRANSFUSION

INSPECT (b)(6)-2

AT (Hour) 2120 ON (Date) 4-21-03

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

PRE-TRANSFUSION TEMP. 101.3 PULSE 104 BP 126/60

DATE OF TRANSFUSION: 4/21/03

TIME STARTED: 2145

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 21APR03 2255

REACTION (b)(6)-2

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 100.9

PULSE: 106

BLOOD PRESSURE: 120/78

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)

(b)(6)-2

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

(b)(6)-4

SEX: M

WARD: 4WD

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 - 4537

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)*

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

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

DIAGNOSIS OR OPERATIVE PROCEDURE: (L) femur fx

DATE REQUESTED: 4/21/03

DATE AND HOUR REQUIRED: ASAP (b)(6)-2

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.

(b)(6)-2

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS: H/H 7/22.4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

DATE VERIFIED: 21 APR 03

TIME VERIFIED: 1020

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COM...

REMARKS: EXP. 03 MAY 03

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2 (b)(6)-2

DATE 21 APR 03

	DONOR	RECIPIENT
ABO	O	O
Rh	POS	POS

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2

PRE-TRANSFUSION DATA

AT *(Hour)* 2345 ON *(Date)* 4-21-03

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 ENS/NC

(b)(6)-2 ENS, NC

TEMP. 100.9 | PULSE 107 | BP 122/108

DATE OF TRANSFUSION: 22APR03

TIME STARTED: 0010

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE (COMPLETED) INTERRUPTED: 22APR03 0205

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE: 100.2 | PULSE: 96 | BLOOD PRESSURE: 118/64

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)*

(b)(6)-2 ENS/NC

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

(b)(6)-4

SEX: M

WARD: 4 FWD

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 - 4538

Medical Record Copy

ACLU-RDI 1244 p.179

DOD 011017

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
18 Apr /03 1700			1) Admit to Orthopedics, Dr [redacted]	B6-2	(b)(6)-2
			2) Condition Stable		
			3) Dx - (L) femur fracture with external fixation.		
			4) NKDA		
			5) Diet - Regular		
			6) I+O Q 8H		
			7) Lab - a) male trauma panel (done in CASREC)		(b)(6)-2
			b) Blood cultures (done in CASREC)		
			8) Radiology - CXR - Portable AP; (L) femur c hip + knee } done in CASREC		
			9) Meds - Ancef 1gm IVPB Q 6H		(b)(6)-2
			10) IV - LR @ 75 cc/hour.		
			11) Pain meds		
			a) Morphine 2-5mg IV push PRN severe pain		(b)(6)-2
			b) Tylenol #3, 1 or ii PO Q 4H PRN pain		
			c) Tylenol 325mg, ii PO Q 4H PRN mild pain		(b)(6)-2
			12) Other meds		
			a) Ambien 5mg PO QHS PRN sleep		(b)(6)-2
			b) Milk of Magnesia 30cc PO when arrive on Ward, then Qday PRN constipation		(b)(6)-2 (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)

18 April 03 1715, Lovenox 30mg SQ q12

(b)(6)-4

REGISTER NO. CAPT (b)(6)-2 [redacted] MD B6-2 (b)(6)-2 — continuation

DOCTOR'S ORDERS (b)(6)-2

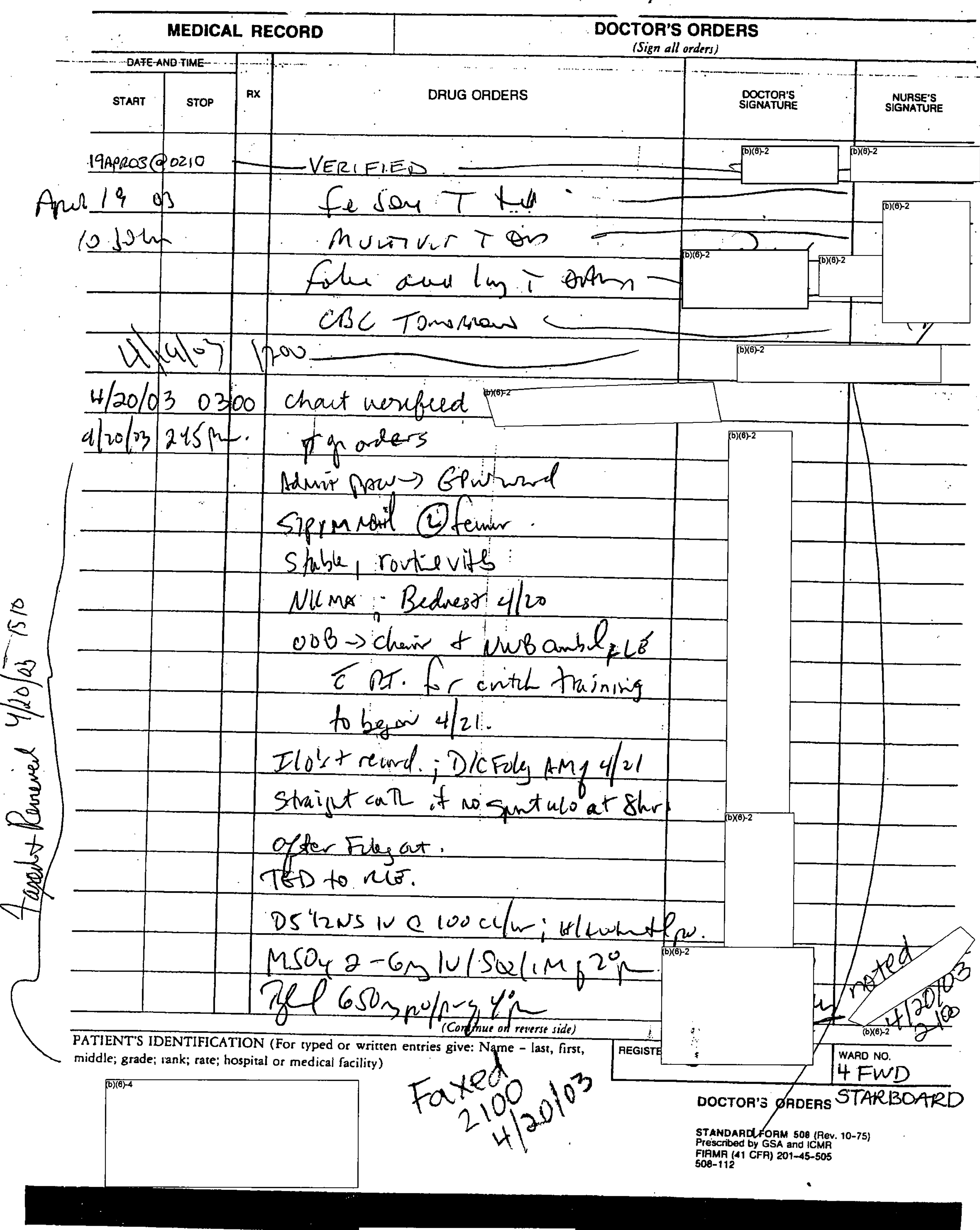
STANDARD FORM 508 (R...)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

18APR 03 NGCCI ENS (b)(6)-2

MEDCOM - 4539

ACLU-RDI 1244 p.180

DOD 011018



MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
19APR03 @ 0210			VERIFIED	(b)(6)-2	(b)(6)-2
April 19 03			Fe SO4 T tid		(b)(6)-2
10 30hr			Multivit T qd	(b)(6)-2	(b)(6)-2
			Colace and lag T qd		
			CBC Tomorrow		
4/19/03	1700			(b)(6)-2	
4/20/03	0300		chart verified	(b)(6)-2	
4/20/03	245pm		ϕ pr orders	(b)(6)-2	
			Admit from → GPW ward		
			S/P IM nail Ⓛ femur		
			Stable, routine VITS		
			NKMA ; Bedrest 4/20		
			OOB → chair + NWB ambul LE		
			c̄ PT. for crutch training		
			to begin 4/21.		
			I/O's + record. ; D/C Foley AM of 4/21		
			Straight cath if no spont void at 8hr	(b)(6)-2	
			after Foley out.		
			TED to RLE.		
			D5 ½NS IV @ 100 cc/hr ; HL when tol po.		
			MSO4 2-6mg IV/SQ/IM q2° prn	(b)(6)-2	
			Tylenol 650mg po/pr q4° prn		(b)(6)-2

Faxed + Renewed 4/20/03 1510

(Continue on reverse side)

noted 4/20/03 2100

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

(b)(6)-4

REGISTE[R NO.]

WARD NO. 4 FWD STARBOARD

Faxed 2100 4/20/03

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4540

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

NSN 7540-00-634-4121

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/20/03 1450			**ANESTHESIA PACU ORDERS**		(b)(6)-2
		1.	Admit to PACU.		
		2.	Allergies: Ø		
		3.	Vital signs per PACU protocol.		
		4.	O2: X FM @ ~~10~~ 5 LPM, ____ % Blowby, ___ NP @ ____ LPM.		
		5.	IVF: LR at 100 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES (NO)		
		7.	Pain medication:		
			~~Ketorolac ____ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~		
			MSO4 2-5 mg IV q 5 min prn; max dose 30 mg		
			~~Fentanyl ____ mcg IV q ____ min prn; max dose ____ mcg~~		
			~~Percocet ____ tab(s) p.o. with sip of water~~		
			Other: ____		
		8.	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			~~Metoclopramide ____ mg IV x1 (0.15 mg/kg; max 10 mg)~~		
			~~Droperidol ____ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other ____		
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (pager ~~1506~~ 178) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)		

(OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name ... grade; rank; rate; hospital or ...)

(b)(6)-4

(b)(6)-2

REGISTER NO. (b)(6)-2

WARD NO.

1455 4/20/03

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4541

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		

Signature ______ Beeper

(b)(6)-2

(b)(6)-2

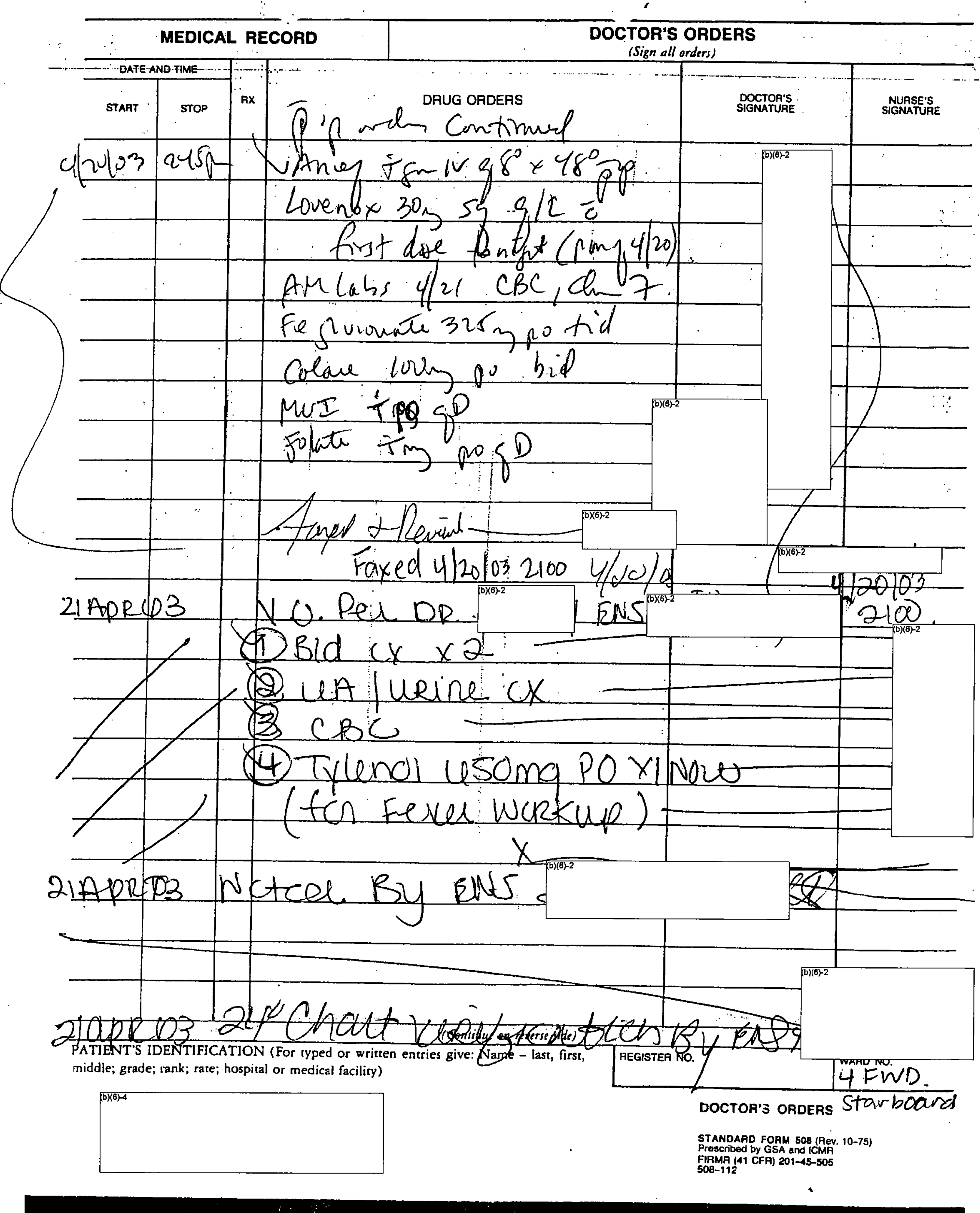
(b)(6)-2

4/20/03

MEDCOM - 4542

STANDARD FORM 508 (Rev. 3-94) BACI

ACLU-RDI 1244 p.183



MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			P'op orders continued		
4/20/03	2245p		Ancef 1gm IV q8° x 48° pp	(b)(6)-2	
			Lovenox 30mg SQ q12 c̄		
			first dose tonight (ring 4/20)		
			AM Labs 4/21 CBC, Chem 7		
			Fe gluconate 325mg po tid		
			Colace 100mg po bid		
			MVI i po qD	(b)(6)-2	
			Folate 1mg po qD		
			Noted & Reviewed (b)(6)-2		
			Faxed 4/20/03 2100 4/20/03	(b)(6)-2	4/20/03 2100
21APR03			V.O. Per DR. (b)(6)-2 / ENS (b)(6)-2		(b)(6)-2
			① Bld cx x2		
			② UA / Urine cx		
			③ CBC		
			④ Tylenol 650mg PO x1 Now		
			(for fever workup)		
21APR03			Noted By ENS (b)(6)-2		
				(b)(6)-2	
21APR03			24° Chart Verification By ENS		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO. 4 FWD. Starboard

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4543

MEDICAL RECORD | **DOCTOR'S ORDERS**
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
April 21 03 0900hr			Type + X match 2 units packed cells + transfuse when ready (APOTT)	(b)(6)-2	
			CBC April 22 '03.		
4/21/03					
22Apr03			24° Chart verification by ENS		
4/22/03	0930		Timentin 3.1gm IV q8°	(b)(6)-2	
			Xfer to isolation (contact iso) ward for EPWs		
			D/C Amy		
				(b)(6)-2	22 Apr 03 1325
4/22/03			NPO p MN (b)(6)-2		
			D5 1/2 NS @ 75cc/hr		
			V/O Dr. (b)(6)-2		
4/23/03	0400		24° chart verification (b)(6)-2		
4/24/03	0330		24° chart verification - no further orders noted (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)

4 Forward port

(b)(6)-4

REGISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4544

508-111

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders) | NSN 7540-00-634-4121

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
23Apr03 1330			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.		
		2.	Allergies: NKDA	(b)(6)-2	
		3.	Vital signs per PACU protocol.		
		4.	O2: ___FM @ 10LPM, ___% Blowby, ✓ NP @ 2-4 LPM.		
		5.	IVF: LR at KVO cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: (YES) NO		
		7.	Pain medication:		(b)(6)-2
			Ketorolac ___mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO4 1-2 mg IV q 2-4 min prn; max dose 20 mg		
			Fentanyl ___mcg IV q ___ min prn; max dose ___mcg		
			Percocet ___ tab(s) p.o. with sip of water		
			Other: ___	(b)(6)-4	
		8.	Antiemetics:		
			Ondansetron ___ mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ___mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other ___	(b)(6)-2	
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (~~pager 1506~~) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)		

(OVER)

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

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

Noted 4/23/03 @ 1355

WARD NO.

DOCTOR'S ORDERS
Medical Record
STANDARD FORM 508

MEDCOM - 4545

~~ACLU-RDI 1244 p.186~~

DOD 011024

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME		RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP				
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		(b)(6)-2
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO	(b)(6)-2	
			(b)(6)-2 (b)(6)-2 LCDR NC USN		
			Signature (b)(6)-2 Beeper		
			Noted (b)(6)-2 LCDR/NC		

STANDARD FORM 508 (Rev. 3-94) BACK

MEDCOM - 4546

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4 24 03 1005am		1.	Turn, Cough & deep breath Q2h Turn towards unaffected side	(b)(6)-2	ENAC
			~~V.O. CDR~~		
4/24/01			VO CDR (b)(6)-2 / (b)(6)-2		
			continue Lovenox FeSO4, colace, Folate, MVT	(b)(6)-2	CDR 1100 4-24-03
4/28/03			24hr chart verification	(b)(6)-2	@ 0032
4/26/03 0235			chart verified		mharper
4-26-03 1055		1.	Percocet 1-2 q 4-6hr prn pain	(b)(6)-2 / (b)(6)-2	1000 4-26-03
4/27/03 0037			chart verified	(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)

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111

☆U.S. GPO: 1988—201-760/80076

MEDCOM - 4547

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/23/03		✓	P op orders		(b)(6)-2
			Adm ward / ortho / McGuyre		
			S/P (L) lat thigh ex fix site		
			wounds.		
			Stable		
			routine VS		
			NKDA		
			OOB to w/c today		
			PT - crutch ambulation training		
			NWB LLE on 4/24.		
			I/O's + record.		
			reinforce dsgs prn.		
			Begin W→D packing of (L) lat		
			thigh wounds c 1%		
			→ acetic acid solution		
			on 4/24, bid		
			Reg diet + snacks + ensure tid		
			Lovenox 30 mg SQ q12°		
			TED to RLE		
			Timentin 3.1 gm IV q 8° given @ 1400		
			MSO4 2-6 mg IV/SQ q 2° prn	(b)(6)-2	
			Tylenol 650 mg po/pr q 4° prn		

(Continue on reverse side)

Noted / WOR/RC

Initial entry

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

(b)(6)-4

(b)(6)-2

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-76)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1989—201-760/80078

1100

4 FWD PORT

MEDCOM - 4548

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

(1) admit to ICW-2
(2) s/p R LE Ex Fix
now c pseudomonas
and acinetobacter 33
(3) vitals q 4 hrs
(4) Regular diet
(5) Notify [illegible]

Not
5/3/0

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER [illegible] HOURS

(b)(6)-2

(6) PT consult
(7) Fortaz 1 gm IV
q 8 hrs
(8) ciprofloxacin 500mg PO BID
(9) Regular diet

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

(10) ~~Pt~~ Percocet 1-2 tabs
po q 4-6 hrs prn
(11) BID dressing Δ
(12) Naprosyn 500mg PO BID
(13) Red crescent
~~HO~~

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

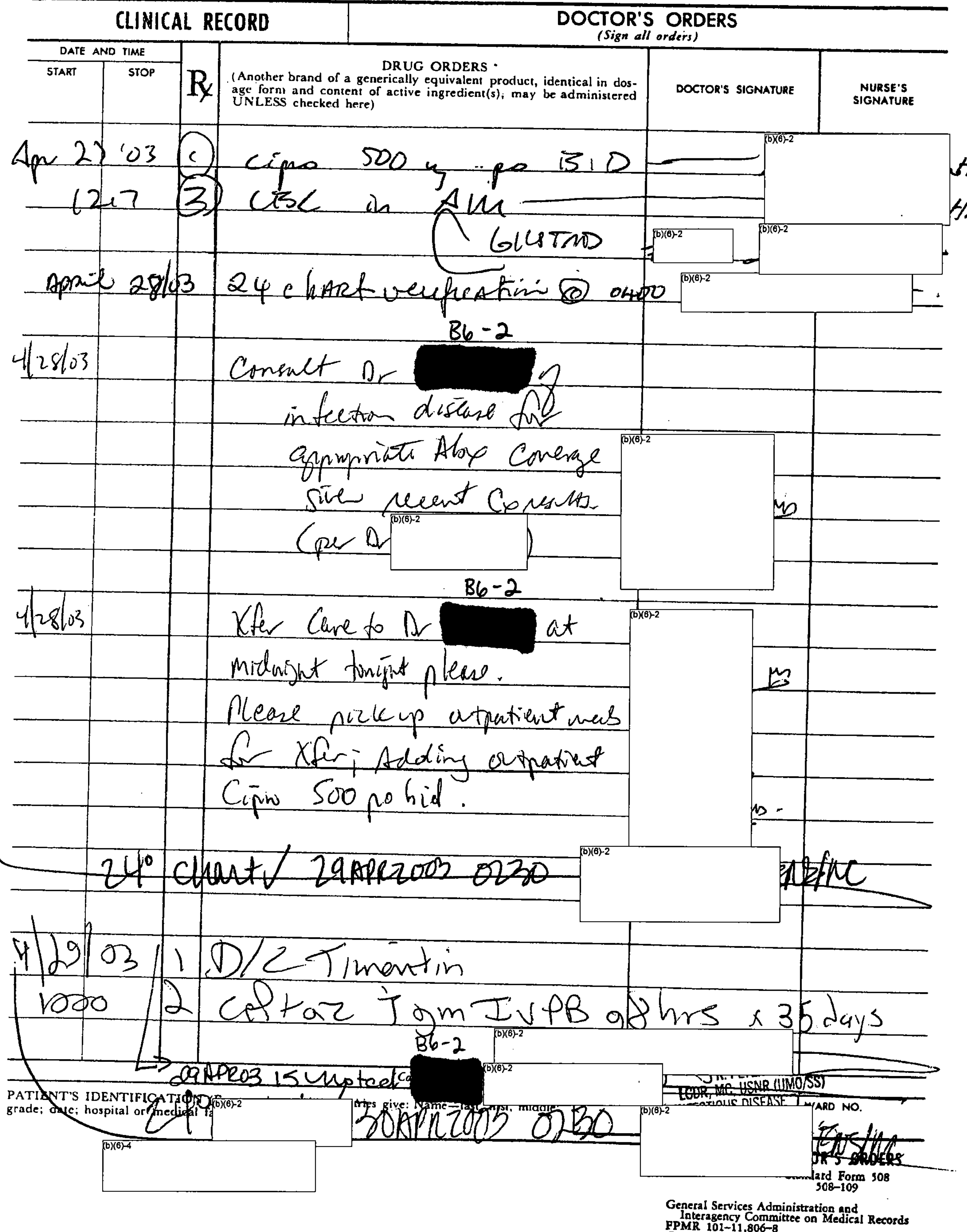
DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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

MEDCOM - 4549

~~ACLU-RDI 1244 p.190~~

DOD 011028



Standard Form 508

CLINICAL RECORD — **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
Apr 27 '03 1217		(c)	Cipro 500 mg po BID	(b)(6)-2	
		(3)	CBC in AM		
			[illegible]	(b)(6)-2	(b)(6)-2
April 28/03			24 chart verification @ 0400	(b)(6)-2	
			B6-2		
4/28/03			Consult Dr [redacted] of infectious disease for appropriate Abx coverage given recent Cx results. (per Dr (b)(6)-2)	(b)(6)-2	
			B6-2		
4/28/03			Xfer care to Dr [redacted] at midnight tonight please. Please pick up outpatient meds for Xfer; Adding outpatient Cipro 500 po bid.	(b)(6)-2	
			24° chart ✓ 29APR2003 0230	(b)(6)-2	
4/29/03 1000		1	D/C Timentin		
		2	Ceftaz 1gm IVPB q8hrs x 35 days	(b)(6)-2	
			B6-2		
			29APR03 15 noted [redacted] (b)(6)-2	LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE	
			24° chart ✓ 30APR2003 0230 (b)(6)-2	(b)(6)-2	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-2 (b)(6)-4 — WARD NO.

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

Standard Form 508

CLINICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	℞	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/30/03		①	CBC } in A.M.	(b)(6)-2	
			ESR		
			SMA-7		
			2140	(b)(6)-2	
			noted 4/30	(b)(6)-2	
24° chart ✓ 01May2003 0200				(b)(6)-2	ENS/RC
24° chart ✓ 02May2003 0100				(b)(6)-2	ENS/RC Ø new orders

(Continue on reverse side)

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.

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

MEDCOM - 4551

CLINICAL RECORD

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4
2 May 03	(b)(6)-2	Fortaz 1 gm IVPB Q 8 hrs	24	(b)(6)-2	
			08		
			16		
			18		
2 May		Cipro 500 mg PO BID	08	(b)(6)-2	
			20		
2 May		Naprosyn 500 mg	06		
			20		
2 May		Diet: Reg	7		
			12		
			17		
2 May		Vitals Q 8°	7		
		Notify MD T>101	15	✓	
		P>110, R>24 BP>101-4	23	(b)(6)-2	
2 May		BID Drsg A	10		
			20		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (R) LE EXT FIX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION: (b)(6)-4

ICW 2

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4552

ACLU-RDI 1244 p.193

DOD 011031

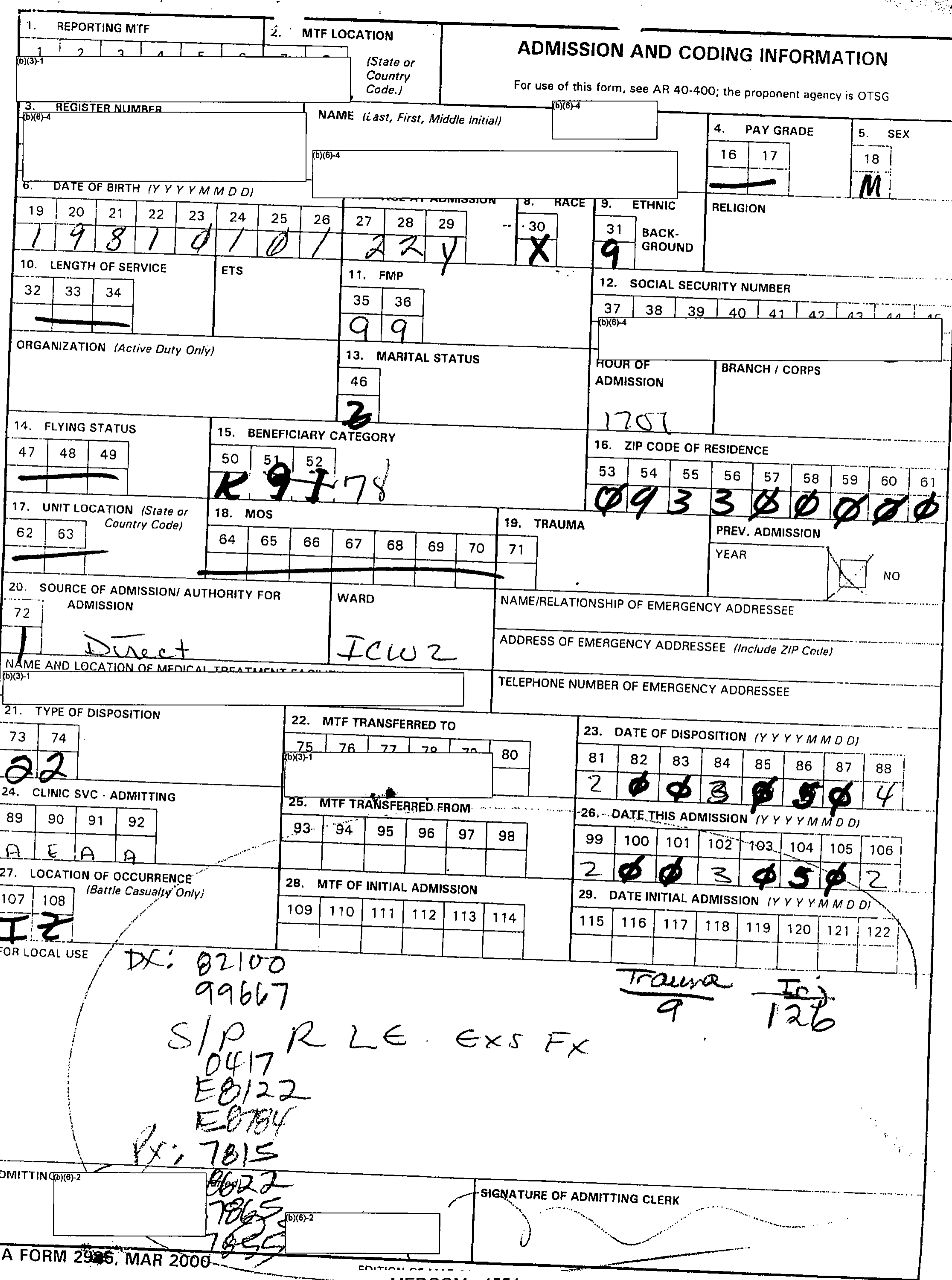
Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Yr.
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 May	(b)(6)-2	Admit ortho 5CW #2	2 May 03	done		(b)(6)-2
		SP (R) LE Ex Fix Now in pseudomonas				
		and				
2 May		Red Crescent				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED		
2 May	(b)(6)-2	Percocet 1-2 tabs	3 May 0100	3 May 1715	3 May 2355
		PO Q4°-6° PRN	2 tabs [redacted]	ii MWB	ii OB
			(b)(6)		

MEDCOM - 4553

USAPA V1.00

ACLU-RDI 1244 p.194



ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code.)
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE: —
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 1 9 8 1 0 1 0 1
7. AGE AT ADMISSION: 2 2 Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION
10. LENGTH OF SERVICE: —
ETS
11. FMP: 9 9
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 1707
BRANCH / CORPS
14. FLYING STATUS: —
15. BENEFICIARY CATEGORY: K 9 I 78
16. ZIP CODE OF RESIDENCE: 0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code): —
18. MOS: —
19. TRAUMA
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)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION: 22
22. MTF TRANSFERRED TO: (b)(3)-1
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 2 0 0 3 0 5 0 4
24. CLINIC SVC - ADMITTING: A E A A
25. MTF TRANSFERRED FROM
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 2 0 0 3 0 5 0 2
27. LOCATION OF OCCURRENCE (Battle Casualty Only): I Z
28. MTF OF INITIAL ADMISSION
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)

FOR LOCAL USE
DX: 82100
99667
S/P R LE Exs Fx
0417
E8122
E8784
Px: 7815
8622
7865
7855

Trauma 9 Inj 126

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

DA FORM 2985, MAR 2000 EDITION OF MAR 9...
MEDCOM - 4554
USAPA V1.00

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)* — (b)(6)-4 (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

AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 — 9 9

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

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 1751

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

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

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

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION — YEAR — NO [X]

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

WARD: ICW 2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL ... (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — ~~TRANS~~ Home

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	5	6	4

24. CLINIC SVC - ADMITTING

89	90	91	92
A	E	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	5	0	2

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

S/P R LE EXS FX

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

DA FORM ... MAR 2000 — EDITION OF MAR 89 IS OBSOLETE

MEDCOM - 4555

USAPA V1.00

~~ACLU-RDI 1244 p.196~~

DOD 011034

MEDICAL TREATMENT FACILITY
USNS COMFORT (T-AH 20)
LIFT OF OPPORTUNITY

NAME (LAST, FIRST, MIDDLE) (b)(6)-4					SOCIAL SECURITY NUMBER
RANK/RATE	OFFICERS ONLY DESIG NOBC	ENLISTED NEC	BIRTH DATE		SEX
BRANCH OF SERVICE	NAMED AND ADDRESS OF PARENT MILITARY COMMAND				SHIP HOMEPORT
UIC	BLOOD TYPE	RELIGIOUS PREFERENCE	MARITAL STATUS	IS SPOUSE ACTIVE DUTY	NUMBER OF DEPENDENTS
NAME OF NEXT OF KIN (NOK)					RELATIONSHIP OF NOK
ADDRESS OF NOK					PHONE NUMBER OF NOK

PRINTED NAME OF PATIENT RECEIVING FLIGHT TRAINING

SIGNATURE OF PATIENT

PRINTED NAME OF MEDHOLD COORDINATOR

(b)(6)-2

(b)(6)-2

LD COORDINATOR

PRINTED NAME OF ATTENDING PHYSICIAN

ING PHYSICIAN

MEDCOM - 4556

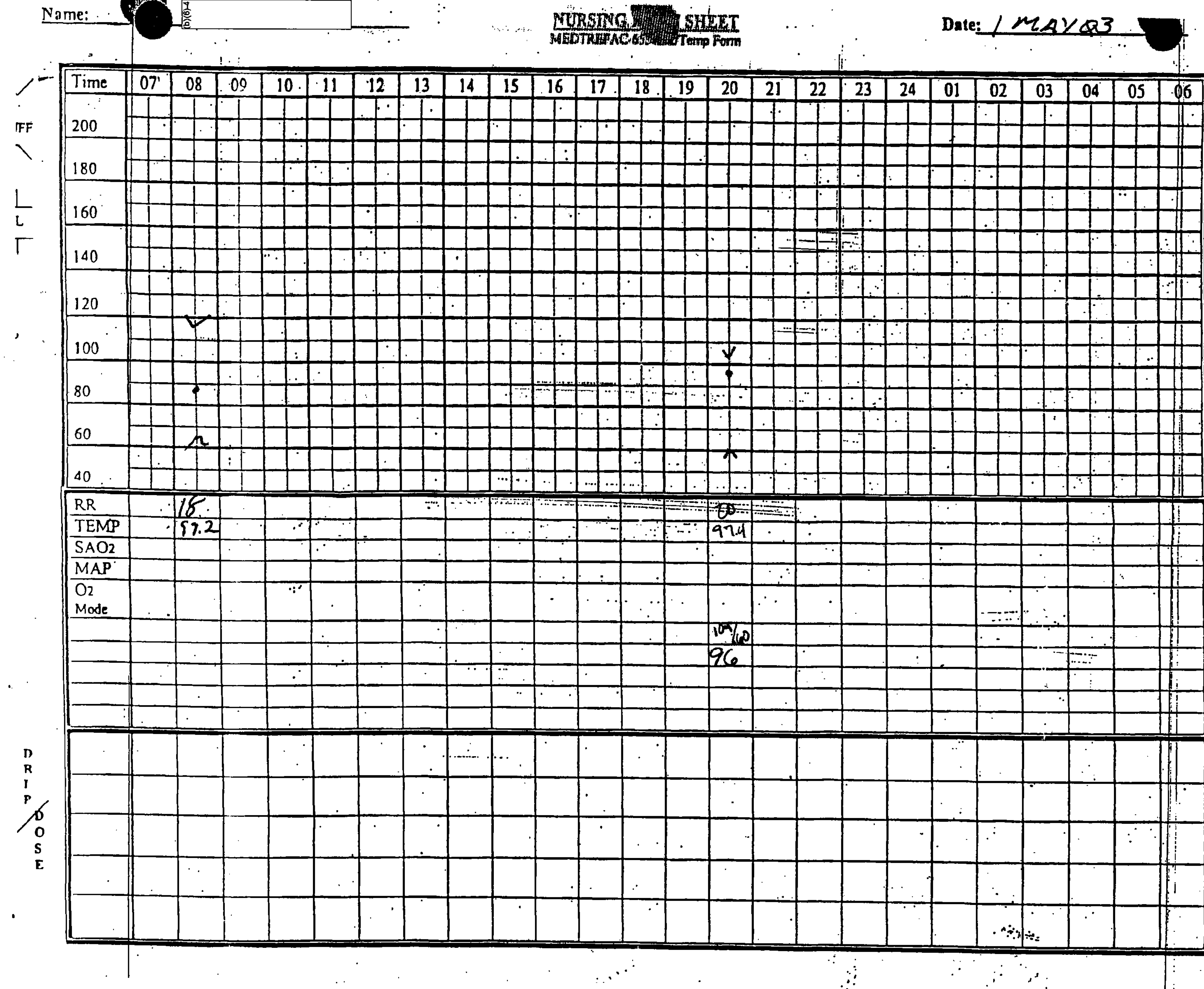
ACLU-RDI 1244 p.197

DOD 011035

Name: (b)(6)-4

NURSING SHEET
MEDTREFAC/65 Temp Form

Date: 1 MAY 03



MEDCOM - 4557

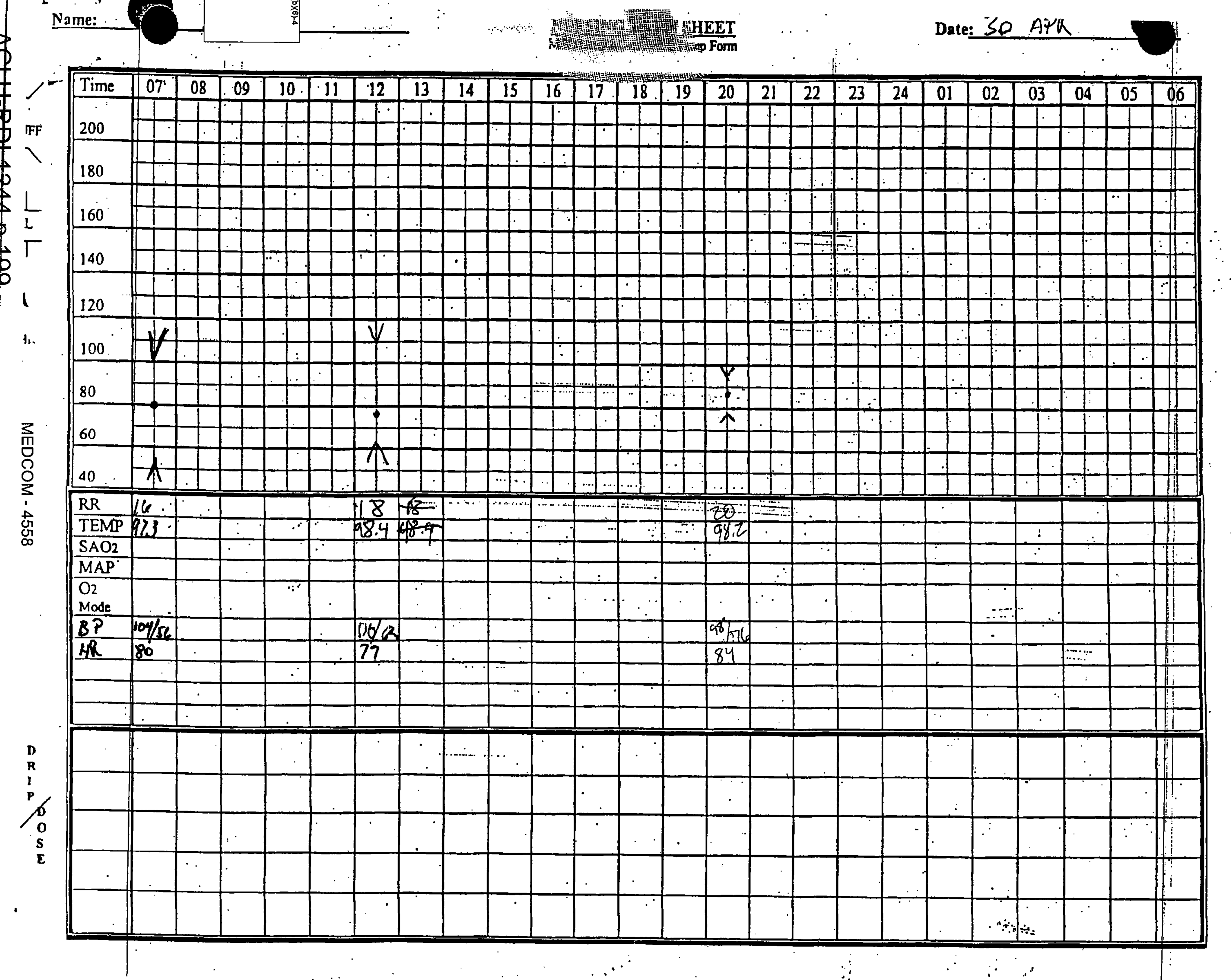
ACLU-RDI 1244 p.198

DOD 011036

Name: (b)(6)-4

SHEET
…p Form

Date: 30 APR



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	16					18	~~18~~							20										
TEMP	97.3					98.4	~~98.9~~							98.2										
SAO2																								
MAP																								
O2 Mode																								
BP	104/56					116/62								98/56										
HR	80					77								84										

DRIP/DOSE

MEDCOM - 4558

ACLU-RDI 1244 p.199

DOD 011037

FREQ. V[illegible]

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

›tes:______________________________

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP																										
													500													
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT__________

PRESENT 24 HOUR INPUT__________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT__________

ACLU-RDI 1244 p.200

DOD 011038

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

Date of Admission: 4/18/2003
Date of Transfer:
Age: Gender: M

History:
22 y/o Iraqi male s/p motorcycle MVA approx 5 days prior to admission; had ex fix placed to L femur fx same day. Mild road rash.

Hospital Course:
begin crutch training, NWB LLE on 4/21

Diagnoses:
R closed proximal diaphyseal femur fracture which was converted to open by proximal ex fix pins which communicated with
fracture site., ,

4/27 - Cultures have grown out a few colonies only of both pseudomonas and Acinetobacter; sensitive to Ticarcillin (Timentin) according to USNS Comfort Lab. Continue IV Abx on Comfort + until clinically [illegible] infx [illegible] return to Iraq. (b)(6)-2

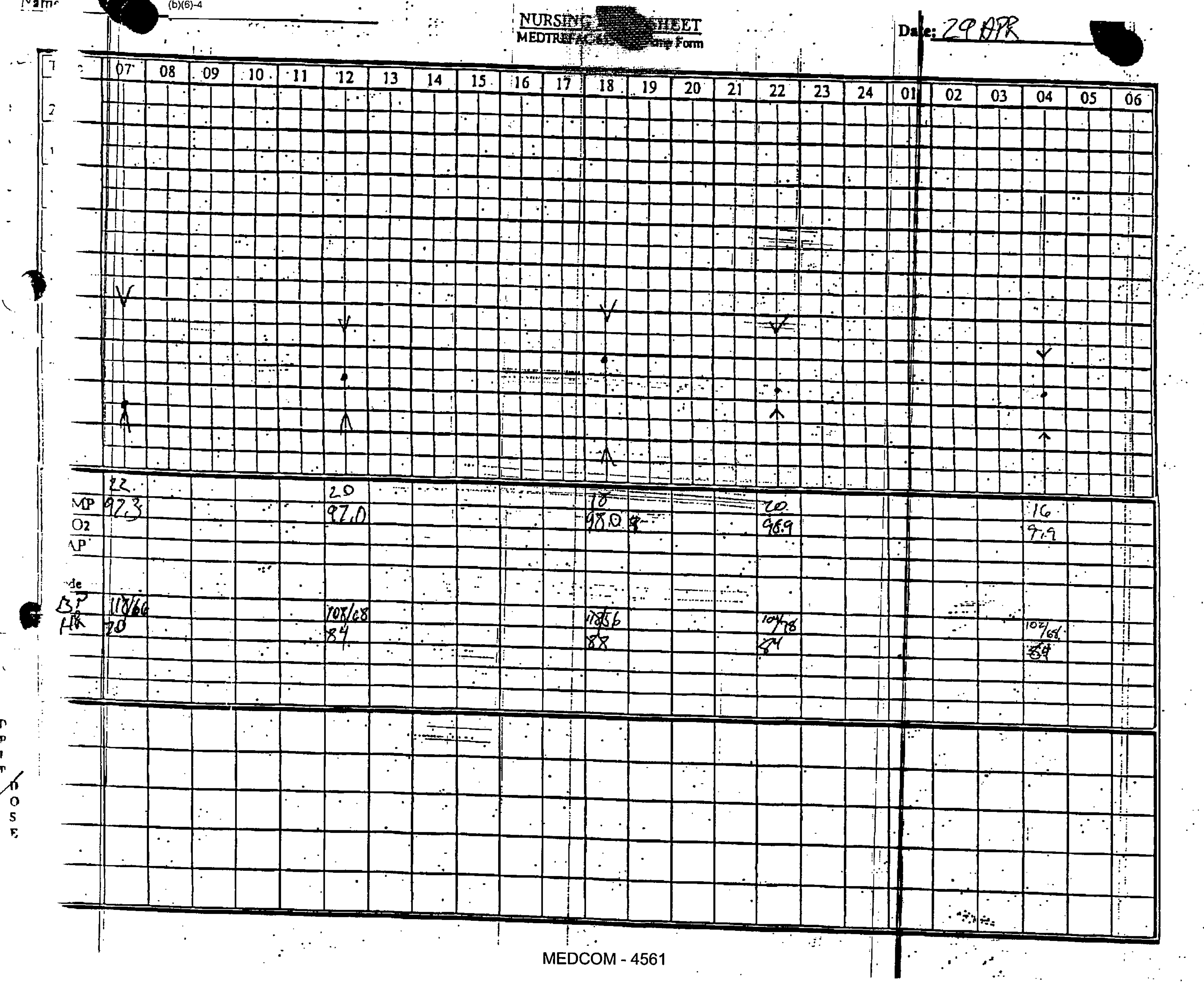
Surgeries/Treatment:
ex fix in field on date of injury; 4/20 removal of ex fix and anterograde IM femoral nail; I&D of ex fix wounds on 4/23 and packed with acetic acid packing., ,

Recommendations:
IM nail done; to begin crutch training NWB LLE on 4/21; needs packing changed with acetic acid through 4/28, then change to wet to dry packing for ex fix wounds only.

Special Needs:
requires packing change qd and wound checks qd; will need staples removed.

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of Orthopedics 4/24/2003



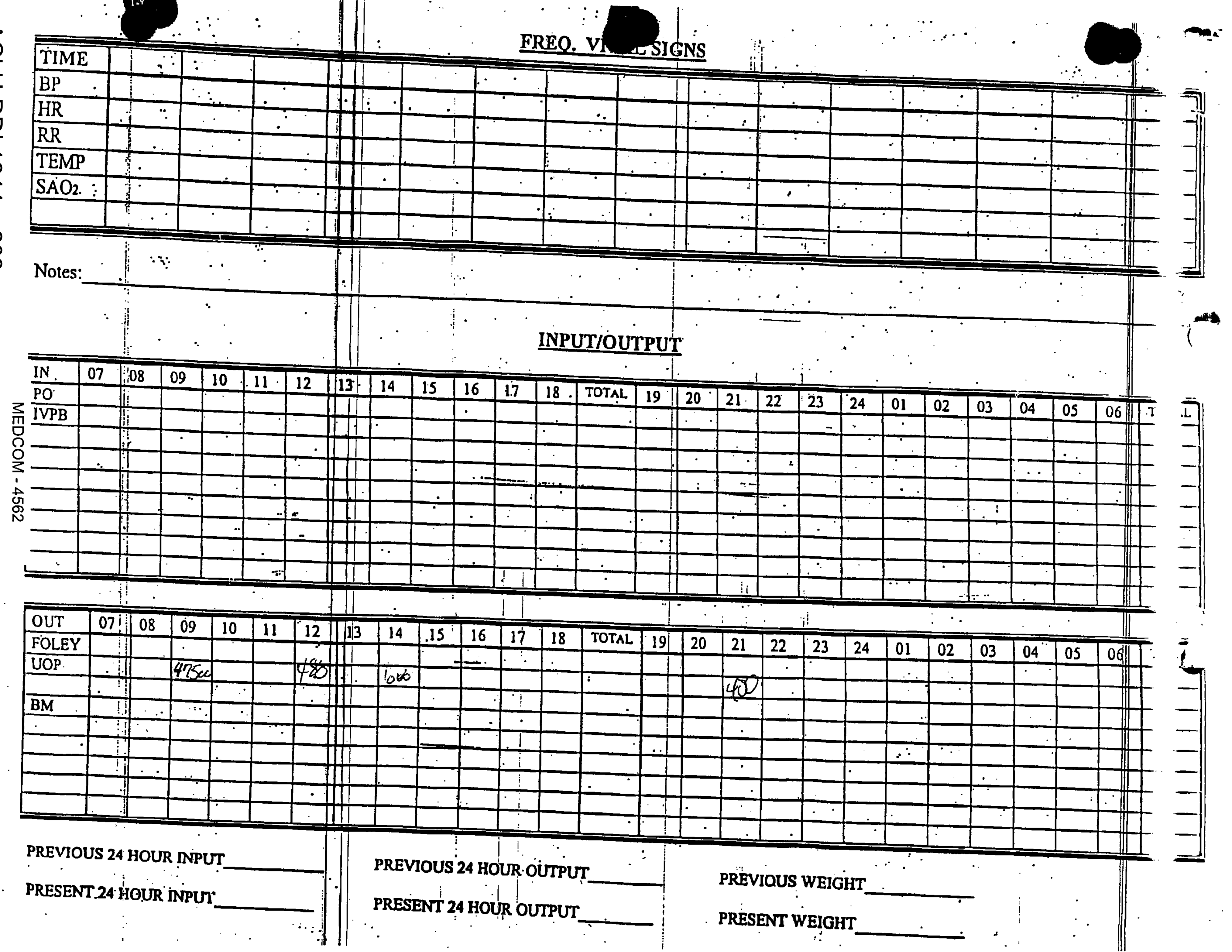
Name (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC [redacted] Form

Date: 29 APR

Time	07	12	18	22	04
[illegible]	22	20	18	20	16
TMP	97.3	97.0	98.0	98.9	97.9
O2					
AP					
BP	118/66	108/68	108/56	104/78	104/68
HR	70	84	88	84	84

MEDCOM - 4561



FREQ. VI[redacted] SIGNS

TIME														
BP														
HR														
RR														
TEMP														
SAO_2														

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY																									
UOP			475cc			480		600																	
																450									
BM																									

PREVIOUS 24 HOUR INPUT________

PRESENT 24 HOUR INPUT________

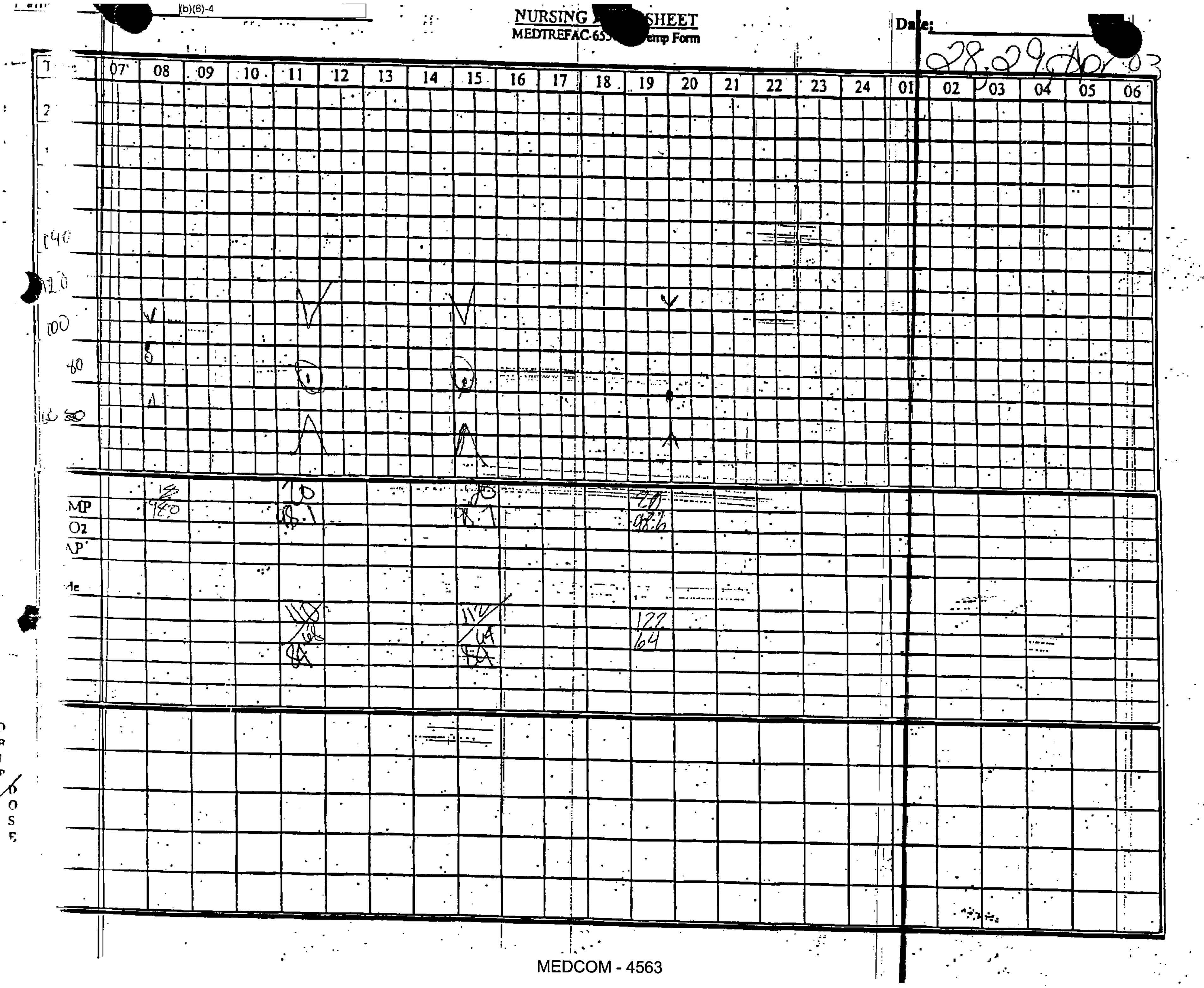
PREVIOUS 24 HOUR OUTPUT________

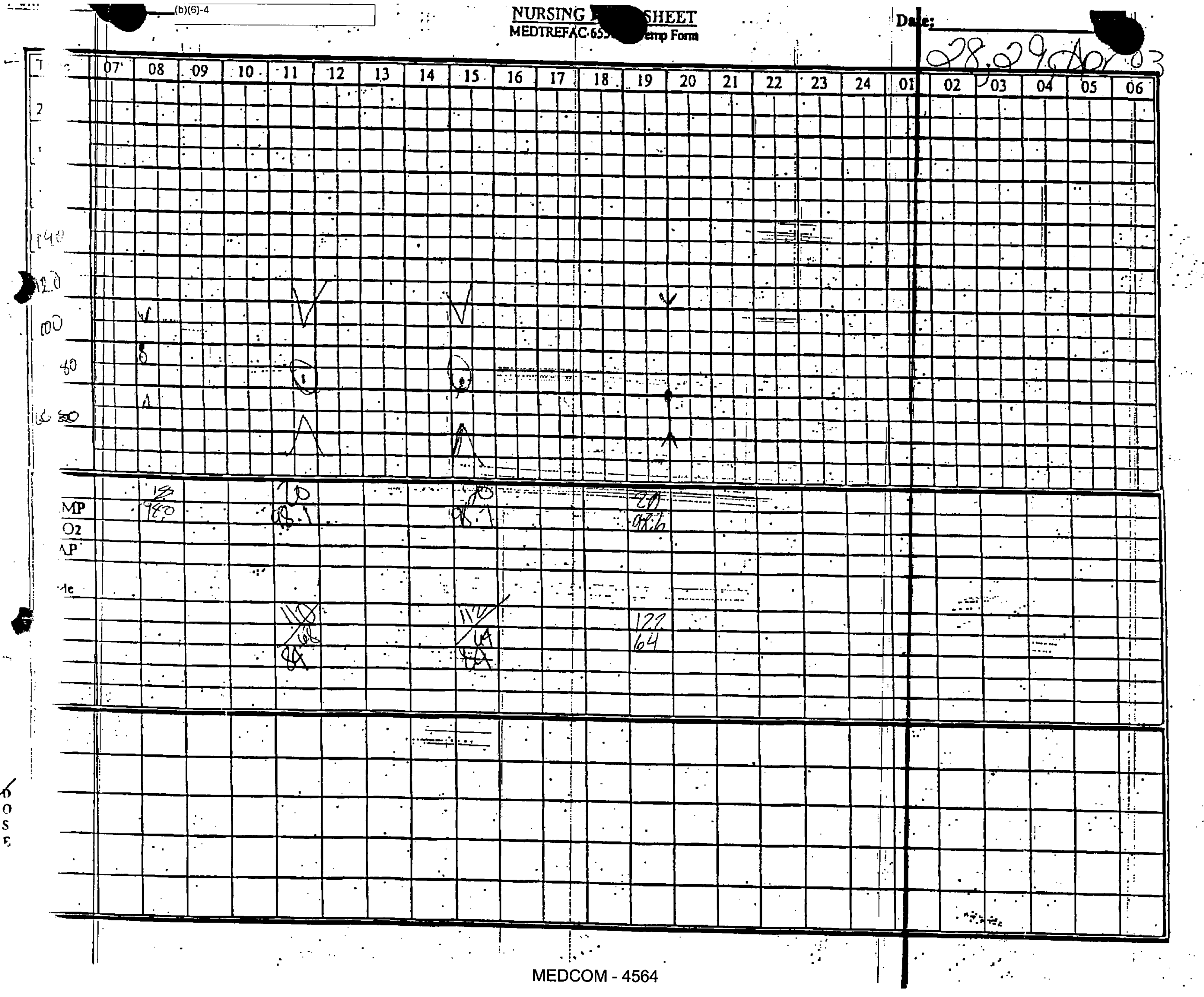
PRESENT 24 HOUR OUTPUT________

PREVIOUS WEIGHT________

PRESENT WEIGHT________

MEDCOM - 4562


(b)(6)-4
NURSING SHEET
MEDTREFAC 653 Temp Form
Date: 28,29 Apr 03
07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06
MP
O2
DRIP / DOSE
MEDCOM - 4563



(b)(6)-4
NURSING SHEET
MEDTREFAC 65 Temp Form
Date:
07
08
09
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14
15
16
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21
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23
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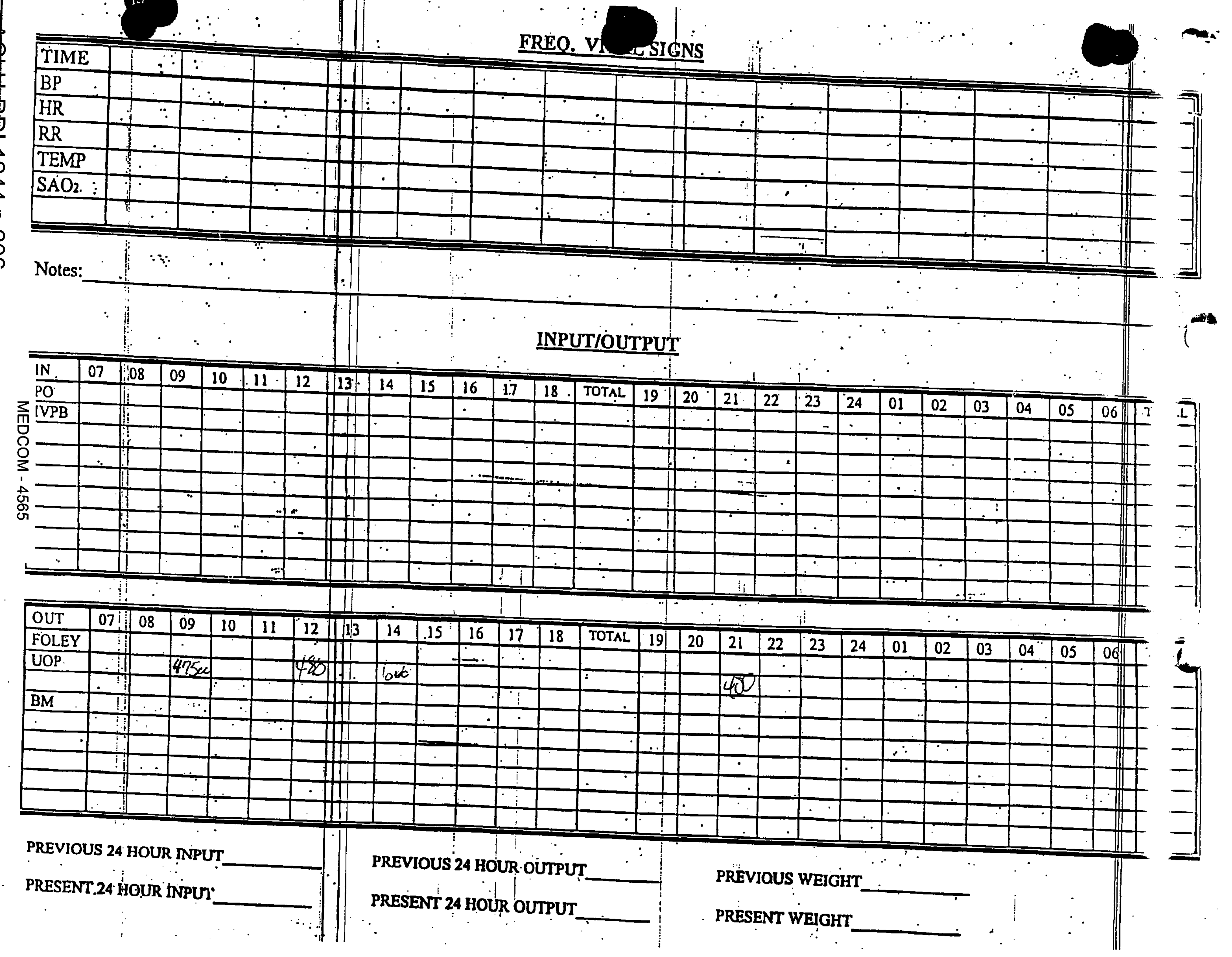
01
02
03
04
05
06
MP
O2
AP
MEDCOM - 4564



FREQ. V[redacted]SIGNS

TIME														
BP														
HR														
RR														
TEMP														
SAO_2														

Notes: ______________________________

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
PO																										
IVPB																										

MEDCOM - 4565

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY																									
UOP			475cc			480		600								450									
BM																									

PREVIOUS 24 HOUR INPUT__________
PRESENT 24 HOUR INPUT__________

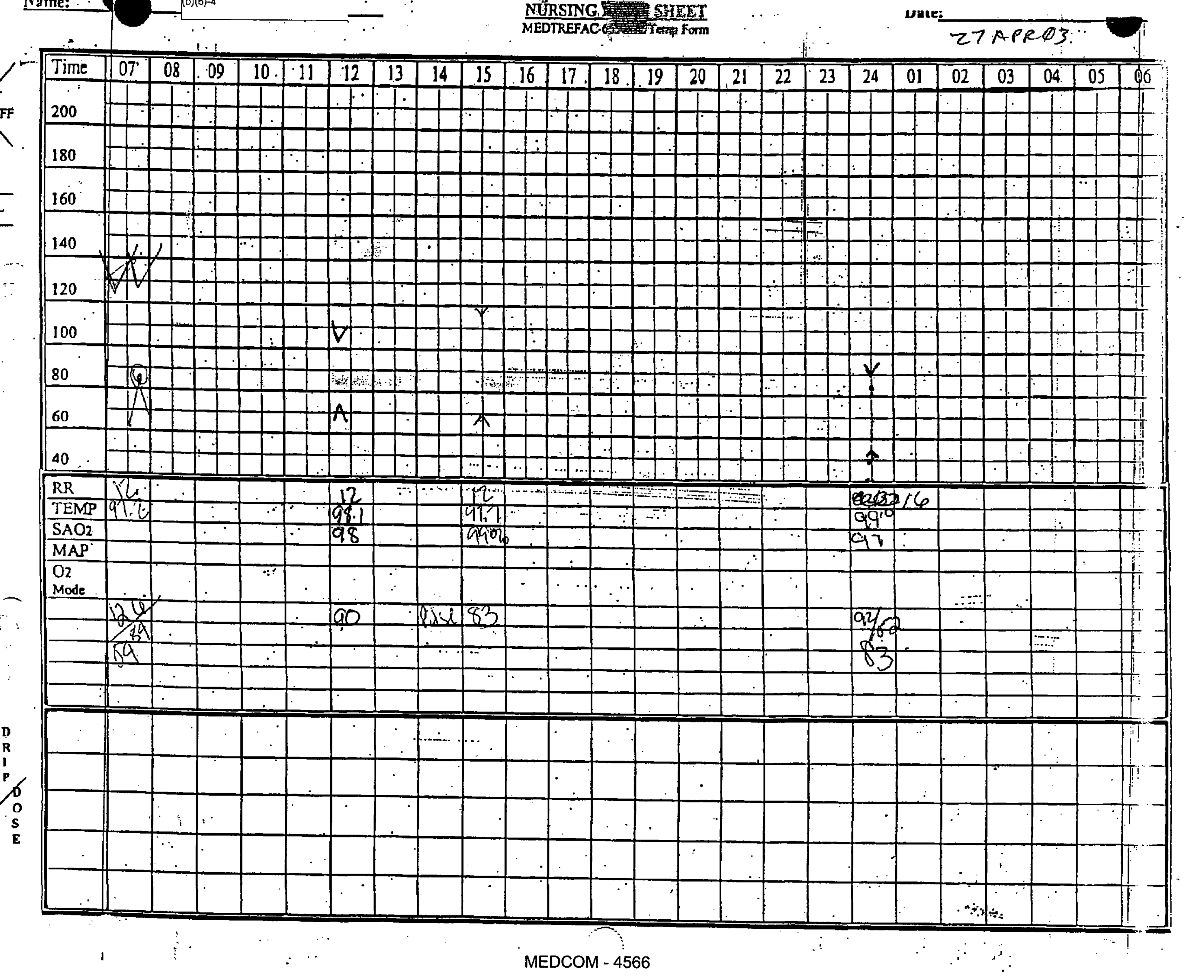
PREVIOUS 24 HOUR OUTPUT__________
PRESENT 24 HOUR OUTPUT__________

PREVIOUS WEIGHT__________
PRESENT WEIGHT__________

Name: (b)(6)-4

NURSING SHEET
MEDTREFAC Temp Form

Date: 27 APR 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	16					12			12									16						
TEMP	97.6					98.1			97.7									99.0						
SAO2						98			99%									97						
MAP																								
O2 Mode																								
	126/84					90		[illegible]	83									92/62						
	59																	83						

DRIP / DOSE

MEDCOM - 4566

FREQ. VITAL SIGNS

IM															
P															
R															
R															
EM															
AO															

otes

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PB																										

MEDCOM - 4567

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
OLE																										
OP						400	500																			
M																1200									518	

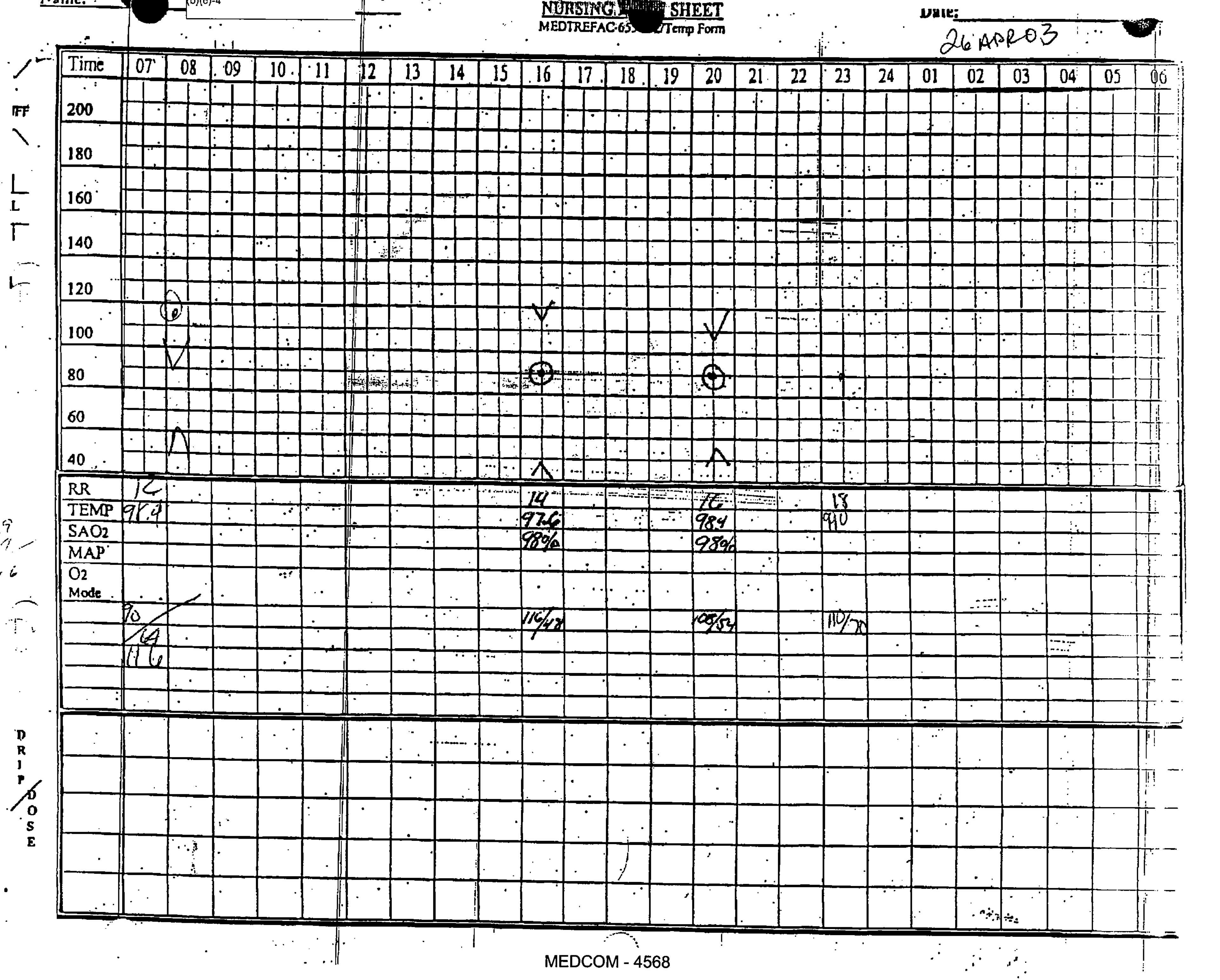
PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 26 APR 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	12									14				16			18							
TEMP	97.4									97.6				98.4			99.0							
SAO2										98%				98%										
MAP																								
O2 Mode																								
	90/64/116									116/48				108/54			110/70							

DRIP/DOSE

MEDCOM - 4568

ACLU-RDI 1244 p.209

DOD 011047

FREQ. V... SIGNS

II															
RP															
HR															
R															
E															
A															

No

INPUT/OUTPUT

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
								540														475			

US 24 HOUR INPUT______ PREVIOUS 24 HOUR OUTPUT______ PREVIOUS WEIGHT______

T.24 JR INPUT______ PRESENT 24 HOUR OUTPUT______ PRESENT WEIGHT______

MEDCOM - 4569

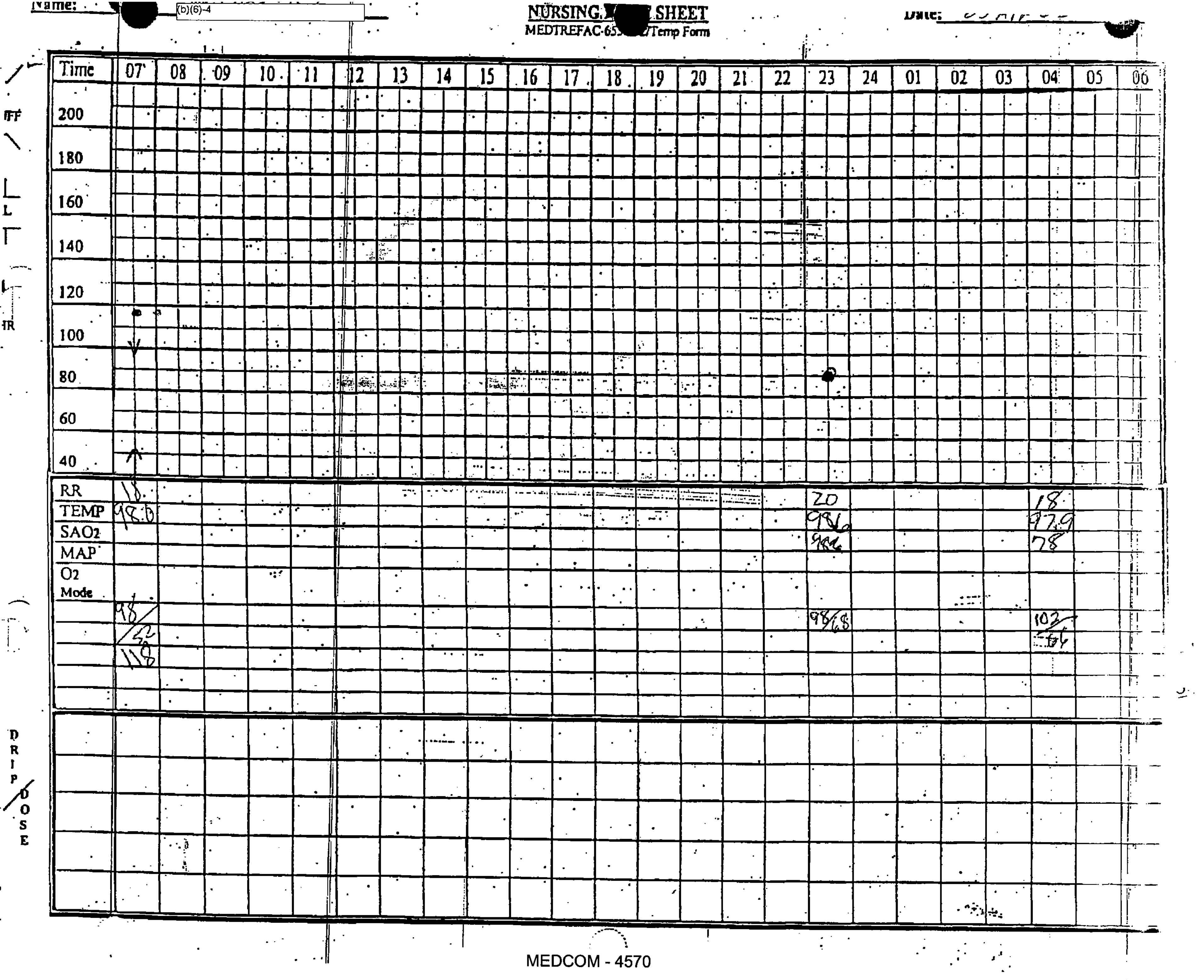
ACLU-RDI 1244 p.210

DOD 011048

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: [illegible]



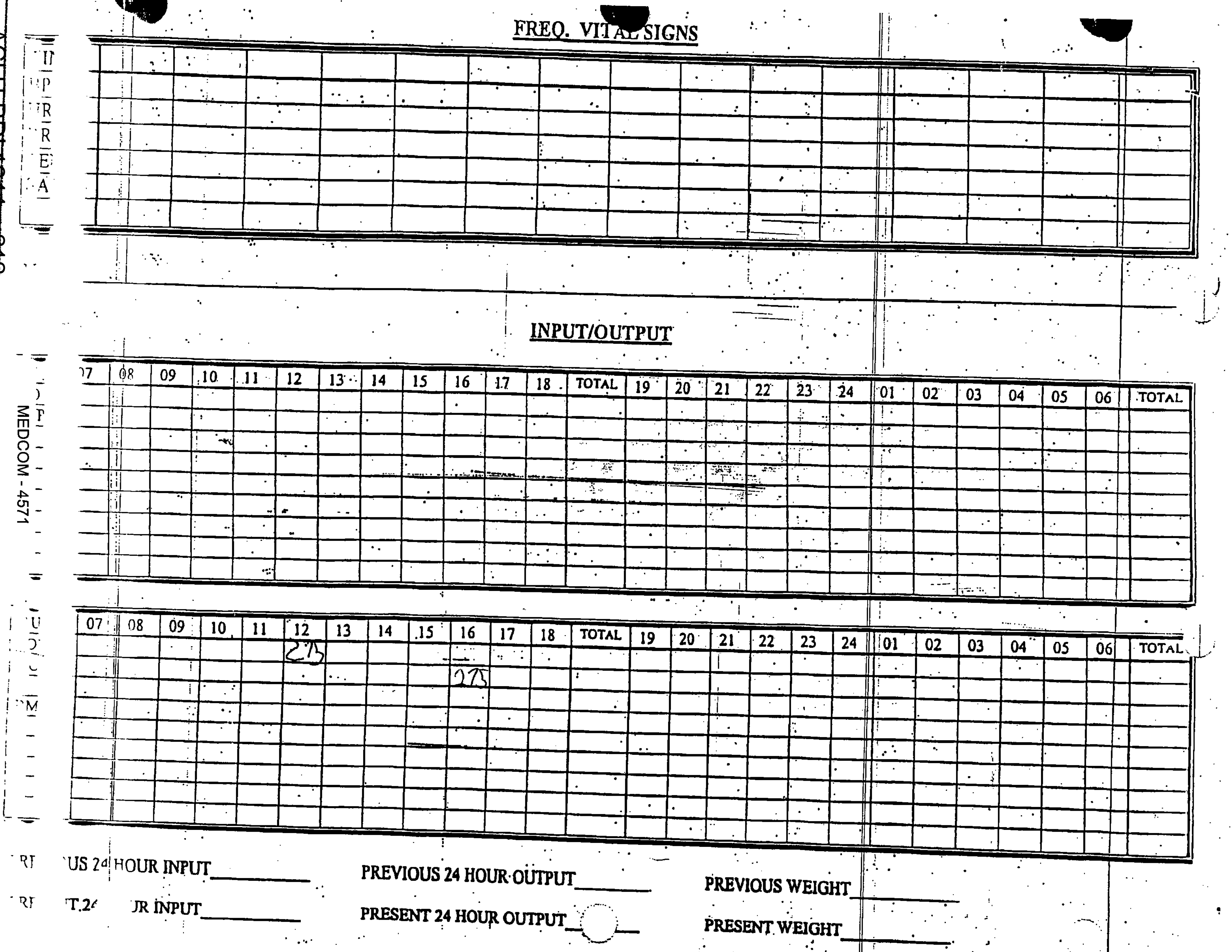
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	18																20					18		
TEMP	98.0																98.6					97.9		
SAO2																	98%					78		
MAP																								
O2 Mode																								
	98/52 118																98/68					102/64		

DRIP / DOSE

MEDCOM - 4570

ACLU-RDI 1244 p.211

DOD 011049



FREQ. VITAL SIGNS

INPUT/OUTPUT

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
					275																				
									275																

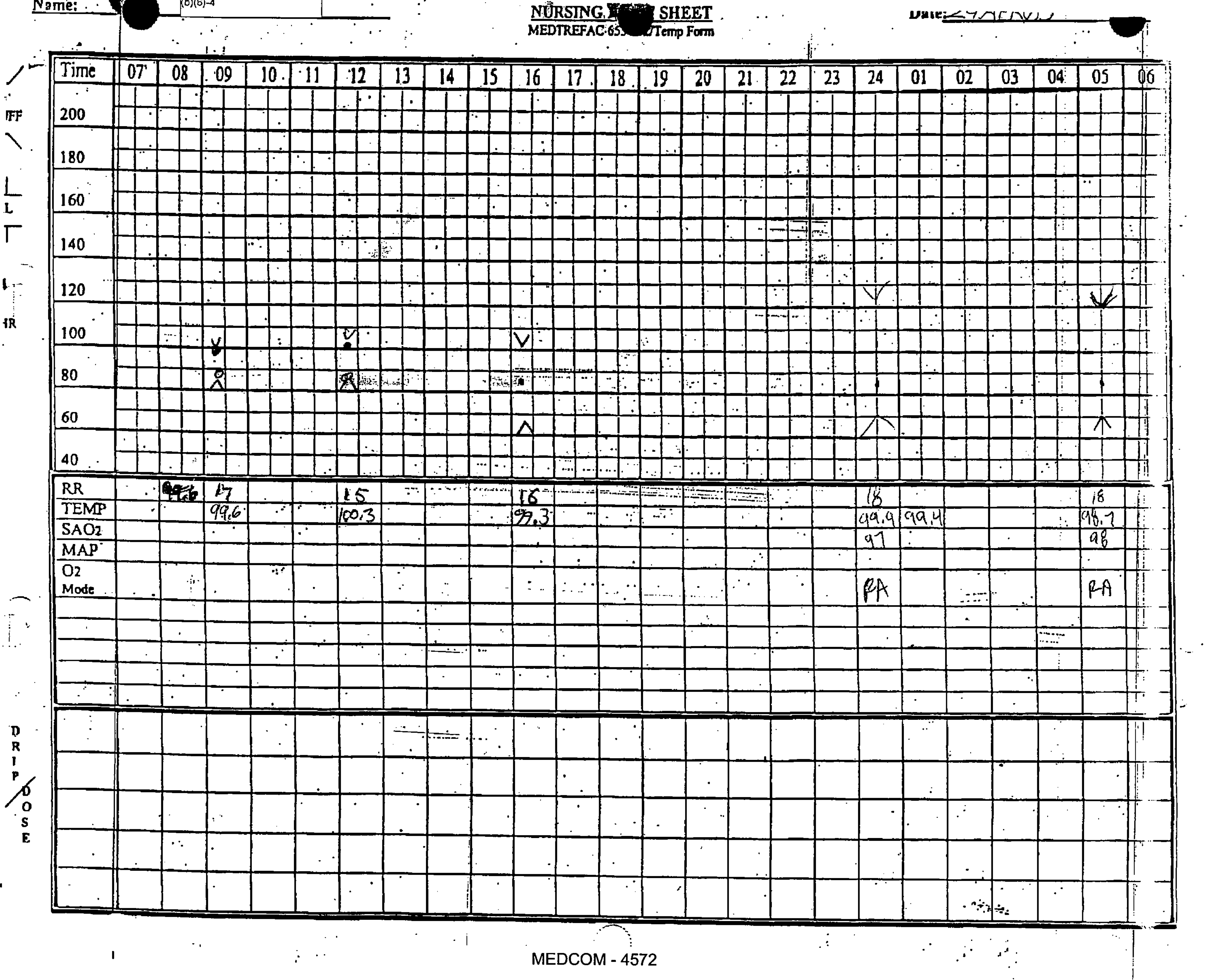
PREVIOUS 24 HOUR INPUT ________ PREVIOUS 24 HOUR OUTPUT ________ PREVIOUS WEIGHT ________

PRESENT 24 HOUR INPUT ________ PRESENT 24 HOUR OUTPUT ________ PRESENT WEIGHT ________

MEDCOM - 4571

ACLU-RDI 1244 p.212

DOD 011050



Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC 65[redacted]/Temp Form

Date: [illegible]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR		[illegible]	17			15				16								18					18	
TEMP			99.6			100.3				99.3								99.9	99.4				98.1	
SAO_2																		97					98	
MAP																								
O2 Mode																		RA					RA	

Chart scale: 200, 180, 160, 140, 120, 100, 80, 60, 40

DRIP/DOSE

MEDCOM - 4572

ACLU-RDI 1244 p.213

DOD 011051

INPATIENT TREATMENT RECORD C[illegible]ER 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
5. AGE
6. RACE
Iraqi
PREVIOUS ADMISSION
ADMISSION REMARKS
11. FMP
12. SSN (b)(6)-4
13. ORGANIZATION
14. WARD ICW3
15. FLYING STATUS
16. RATING/DSG
17. DEPT./BEN K78
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE 1[illegible]
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION
22. HOURS OF ADMISSION 2100
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION Home
26. DATE OF DISPOSITION 03 May 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 02 May 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

Burns R arm, leg & Back
943 / 945 / 942.14

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

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

SIGNA[TURE] (b)(6)-2
SIGNAT[URE] (b)(6)-2

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

MEDCOM - 4494

ACLU-RDI 1244 p.214

DOD 010973

INPATIENT TREATMENT RECORD CO. .. 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
ADMISSION REMARKS
4. SEX 5. AGE 6. RACE Iraqi
PREVIOUS ADMISSION
11. FMP 99
12. SSN (b)(6)-4
13. ORGANIZATION
14. WARD 1CW3
15. FLYING STATUS
16. RATING/DSG
17. DEPT./BEN
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct
22. HOURS OF ADMISSION 2100
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION Home
26. DATE OF DISPOSITION 03 May 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 02 May 03
ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ
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

Burns R arm, leg & Back

~~943~~ / 945 / 942.14

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
1	1			1	/

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

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

MEDCOM - 4495

ACLU-RDI 1244 p.215

MEDICAL RECORD	PROGRESS NOTES

DATE	
2May03/2355	Assumed pt care @ 2300hrs. VSS. T-96', R-26, P-119, 99% RA. Pt has burn to (R) arm/leg, (R) thigh, and (R) flank area. Silvadene applied to all burnt areas. Pt (R) flank covered c̄ burn pad. Administered 5cc elixir motrin. Pt c̄ father. Diaper x1 changed. Will continue to monitor pt throughout shift. (b)(6)-2, ILT AN
3 May/ 0300	Pt itching, father requested medication. 5cc elixir benadryl administered. (b)(6)-2
3 May 0800	VS - P-100, R-20, T- 98.8, Sat-100% on RA A&O x3, responds to commands in ~~Iraqi~~ Arabic language age appropriate, Lungs CTA, BS (+) x4, (+) pedal pulses, will continue to monitor pt for changes. (b)(6)-2 LPN
3 may 0900	Pt had Ø problems throughout Shift pt's father assisted c̄ Care throughout shift, will continue to monitor for changes. (b)(6)-2
3 may 1100	pt given discharge instructions waiting for transport to Red Crescent. (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)

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

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

509-111

MEDCOM - 4496

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/2/07 — TIME OF ORDER: 2200 HOURS — LIST TIME ORDER NOTED AND SIGN

admit to ICW 3

ortho service DR. (b)(6)-2

Condition Good

DX Burn ® arm Leg

Regular Diet

Routine VS

Parent here will do self care

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER ______ HOURS

Diuiny

~~Motrin 100mg/5cc~~

Motrin 100mg/5cc 6cc Q8° PRN

Silvadene, Bacitracin

Benadryl elixer 12.5mg/5cc

5cc q6h PRN

DC pt to home in AM

Noted 2345hrs 2 May 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 0947 — TIME OF ORDER: 03May03 HOURS

1. D/c Home.
2. ~~SHS~~
2. No meds
3. please give supplies dressings + silvadene

(b)(6)-2

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

MEDCOM - 4497

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5
2 May 0	(b)(6)-2	Regular Diet	07	/	(b)(6)-2		
			12	/			
			17	/			
2 May 0	(b)(6)-2	VS q Shift	D	/	(b)(6)-2		
			E	/			
			N	(b)(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn Ⓡ arm/leg, back

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

MEDCOM - 4498

ACLU-RDI 1244 p.218

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	Mo 5 Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/2	(b)(6)-2	Admit ICW 3	5/2	ASAP	2300	(b)(6)-2
5/2		Ortho Service Dr Blum	5/2	ASAP	2300	
5/2		Condition Good	5/2	ASAP	2300	
5/2		Dx:- Burn Ⓡ arm, leg	5/2	ASAP	2300	
5/2		Parent here will know self care	5/2	ASAP	2300	

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

USAPA V1

MEDCOM - 4499

THERAPEUTIC DOCUMENTATI... CARE PLAN
(MEDICATIONS)

Mo. ______ Yr. ______

Verify by Initialing

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED	
5/2	(b)(6)-2	Motrin 100mg/5cc - 6cc Q8° PRN	D	May 03	
			T	2355 5cc	
			I	(b)(6)-2	
5/2	(b)(6)-2	Benadryl elixer 12.5mg/5cc q6h PRN	D	3 May 03	3 May 03
			T/I	0300 (b)(6)-2	1630 f.C (b)(6)-2

MEDCOM - 4500

ACLU-RDI 1244 p.220

DOD 010979

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.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

Mo.____ Yr. ____

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5
5/2	(b)(6)-2	Silvidene / Bacitracin qD	(b)(6)-2	/	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn Ⓡ arm/leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

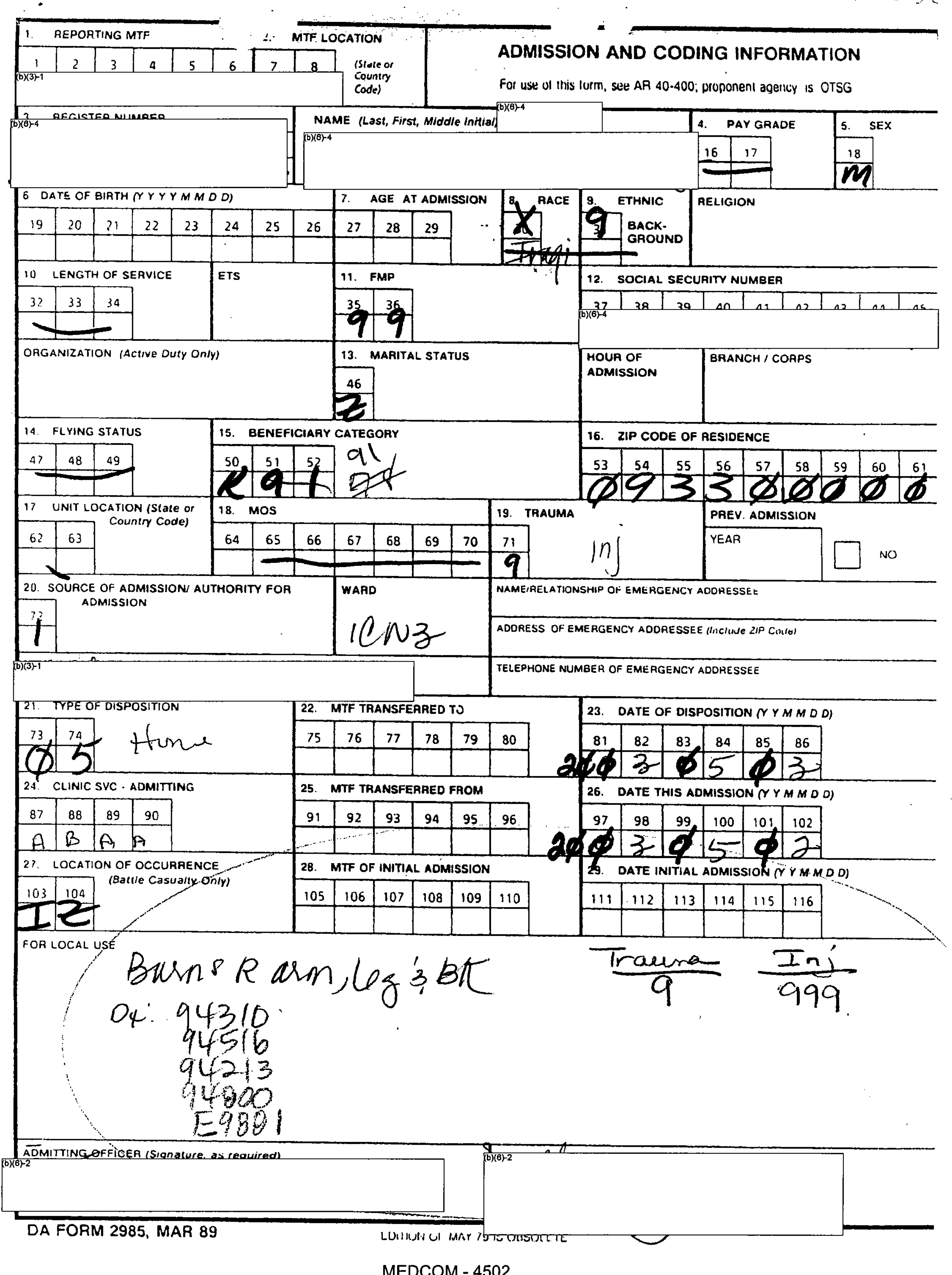
USE PENCIL, CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4501



ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; 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 (b)(6)-4
NAME (Last, First, Middle Initial) (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 20 21 22 23 24 25 26
7. AGE AT ADMISSION 27 28 29
8. RACE X
9. ETHNIC BACKGROUND 9 Iraqi
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 — Z
HOUR OF ADMISSION
BRANCH / CORPS
14. FLYING STATUS 47 48 49
15. BENEFICIARY CATEGORY 50 51 52 — K 9 1 (91)
16. ZIP CODE OF RESIDENCE 53 54 55 56 57 58 59 60 61 — Ø 9 3 3 Ø Ø Ø Ø Ø
17. UNIT LOCATION (State or Country Code) 62 63
18. MOS 64 65 66 67 68 69 70
19. TRAUMA 71 — 9 — Inj
PREV. ADMISSION YEAR — NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 — 1
WARD ICN3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1
21. TYPE OF DISPOSITION 73 74 — Ø 5 Home
22. MTF TRANSFERRED TO 75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y M M D D) 81 82 83 84 85 86 — 2ØØ3 Ø5 Ø3
24. CLINIC SVC - ADMITTING 87 88 89 90 — A B A A
25. MTF TRANSFERRED FROM 91 92 93 94 95 96
26. DATE THIS ADMISSION (Y Y M M D D) 97 98 99 100 101 102 — 2ØØ3 Ø5 Ø2
27. LOCATION OF OCCURRENCE (Battle Casualty Only) 103 104 — I Z
28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110
29. DATE INITIAL ADMISSION (Y Y M M D D) 111 112 113 114 115 116

FOR LOCAL USE
Burns R arm, leg & BK
Dx: 94310
94516
94213
94800
E9881
Trauma / 9 — Inj / 999

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

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4502

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — (b)(3)-1
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) (b)(6)-4 — (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: 2100
BRANCH / CORPS

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — D — OIR
WARD: ICW3
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 — Home
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 5 0 3

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A
25. MTF TRANSFERRED FROM: 91 92 93 94 95 96
26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 5 0 2

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

FOR LOCAL USE
Burns R arm, leg & BK

ADMITTING OFFICER (Signature as required) — (b)(6)-2 — (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY

MEDCOM - 4503

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 (b)(6)-4
3. GRADE	
4. SEX	F
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	ICW 1
15. FLYING STATUS	
16. RATING/DSG	
17. DEPT./BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	Direct
22. HOURS OF ADMISSION	2202
23. CLINIC SERVICE	AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	
26. DATE OF DISPOSITION	03 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	02 MAY 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
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 tibia fx - ~~823.00~~

823.80

29405

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 PHYSICIAN (b)(6)-2

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

MEDCOM - 4486

INPATIENT TREATMENT RECORD CO[illegible] 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 (b)(6)-4
3. GRADE	
4. SEX	F
5. AGE	
6. RACE	IRAQI
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	yes
11. FMP	99
12. SSN	(b)(6)-4
13. ORGANIZATION	
14. WARD	ICW 1
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	Direct
22. HOURS OF ADMISSION	2200
23. CLINIC SERVICE	AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	
26. DATE OF DISPOSITION	03 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	02 MAY 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
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 tibia fx - ~~823.00~~

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 (b)(6)-2

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

MEDCOM - 4487

ACLU-RDI 1244 p.225

DOD 010966

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2may03 Nursing	@2100 - T-97.4 Ax, P 124 RR 24 BP 105/54, admitted from USNS Comfort, alert + appropriate, smiling, interactive c̄ staff + other patients, lungs clear bilaterally, HRR, S1S2, ∅ edema noted, Abd soft, nontender, bowel sounds x 4 quads, MAE x4, cast to RLE - short leg, ⊕ toe movement, cap refill ↓ 2 sec, ∅ IV access - (b)(6)-2 ... , AN
3may03 Nsg.	@0200 - Quiet noc, slept, no Δ from previous assessment - (b)(6)-2 ... , AN
3 may 03 0806	BP NO Baby B/P cuff P-119 O2-99 T-95.3 R 22 SPC (b)(6)-2 ...
3 may03 1045	Pt AA and appropriate. Interacts well c̄ staff and other patients, very friendly. Cast to Ⓡ leg intact. No obvious discomfort, moves toes easily, ambulates c̄ steady gait. Good appetite, diaper changed. - (b)(6)-2 MAT
3 may03 1230	Pt transferred to hosp (civilian) in stable condition - (b)(6)-2 MAT

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
	(b)(3)-1	

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. ICW 1

PROGRESS NOTES
Medical Record

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

MEDCOM - 4488

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		5/2/03	2200 HOURS	
		Admit to [illegible]		
		Dx - (R) [illegible]		
		[illegible]		
		VS PR		
		Reg diet		
NURSING UNIT: 1CW1 / ROOM NO.: / BED NO.: 12		XRay (R) [illegible]		done
		WBAT on (R)	(b)(6)-2	
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER HOURS	
(b)(6)-4		Noted (b)(6)-2 [illegible] 5/3/03 @ 0830		
		24° chart ✓ (b)(6)-2 [illegible] 5/3/03 @ 0830		
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ____ HOURS	
(b)(6)-4				
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER ____ HOURS	
(b)(6)-4				
NURSING UNIT / ROOM NO. / BED NO.				

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

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

MEDCOM - 4489

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. 5 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	2	3	4	5	6	7	8
5/2/03	(b)(6)-2	VS per Routine	(b)(6)-2	/	(b)(6)-2					
			16	/						
			24	(b)(6)-2						
5/2/03	(b)(6)-2	Regular diet	B	/	(b)(6)-2					
			L	/						
			D	/						
5/2/03	(b)(6)-2	WBAT (R) leg	07	/	(b)(6)-2					
			15	/						
			23	(b)(6)-2						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) tibia fx (2/10)

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.

MEDCOM - 4490

ACLU-RDI 1244 p.228

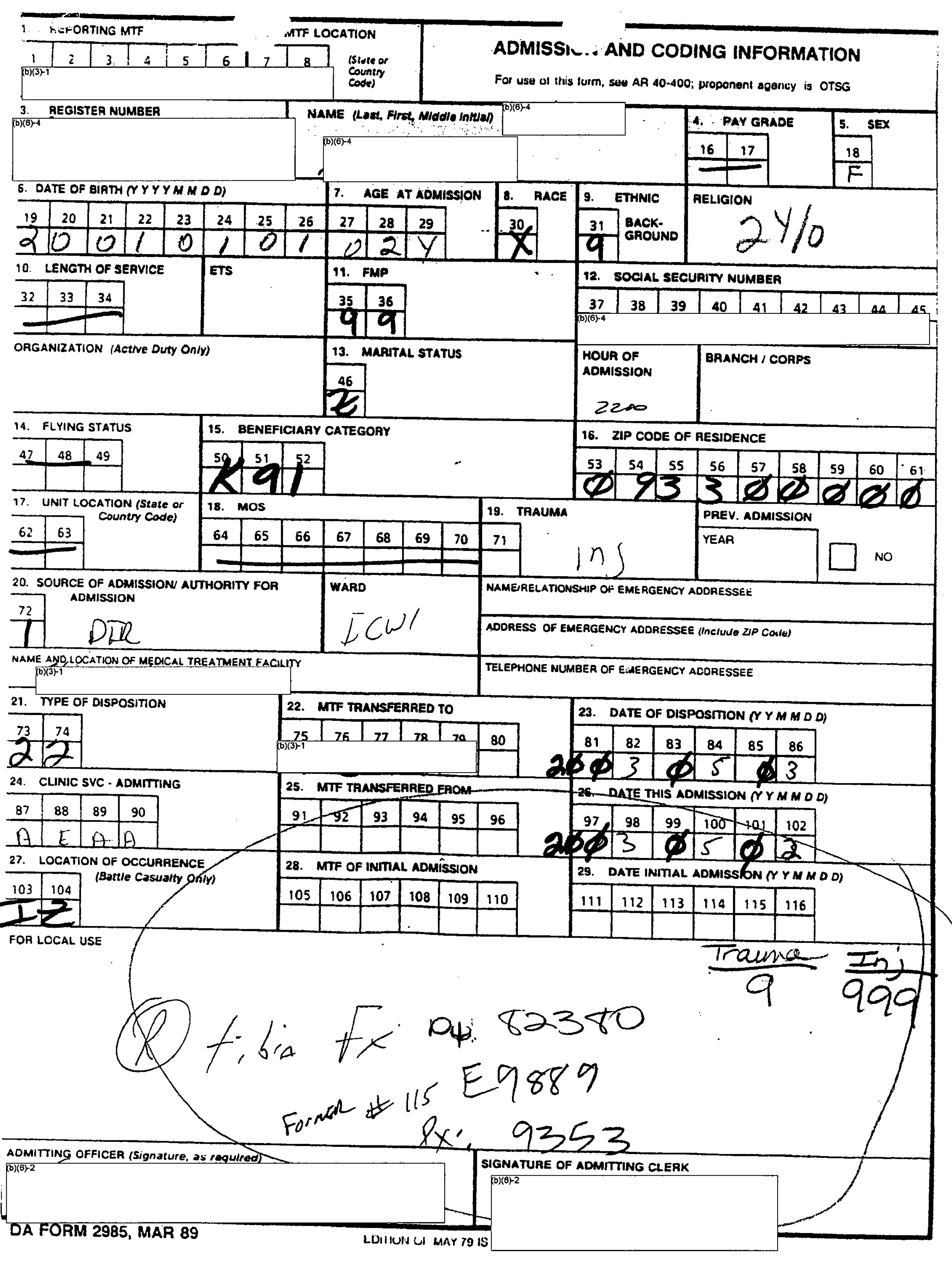
Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 5 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/2/03	(b)(6)-2	admit ICW	5/2/03	2100	2100	(b)(6)-2
5/2/03		stable	5/2/03	2100	2100	
5/2/03		xray (R) leg tonight	5/2/03	2100	2100	

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

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 4491

ACLU-RDI 1244 p.229



ADMISSI... AND CODING INFORMATION

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

1. REPORTING MTF (b)(3)-1 | MTF LOCATION (State or Country Code)

3. REGISTER NUMBER (b)(6)-4 | NAME (Last, First, Middle Initial) (b)(6)-4 | 4. PAY GRADE — | 5. SEX F

6. DATE OF BIRTH (YYYYMMDD) 2001010 | 7. AGE AT ADMISSION 02Y | 8. RACE X | 9. ETHNIC BACKGROUND 9 | RELIGION 24/0

10. LENGTH OF SERVICE — | ETS | 11. FMP 99 | 12. SOCIAL SECURITY NUMBER (b)(6)-4

ORGANIZATION (Active Duty Only) | 13. MARITAL STATUS Z | HOUR OF ADMISSION 2200 | BRANCH / CORPS

14. FLYING STATUS — | 15. BENEFICIARY CATEGORY K91 | 16. ZIP CODE OF RESIDENCE Ø9335ØØØØ

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 1 DIR | WARD ICW1 | 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 22 | 22. MTF TRANSFERRED TO (b)(3)-1 | 23. DATE OF DISPOSITION (YYMMDD) 2003Ø5Ø3

24. CLINIC SVC - ADMITTING AEAA | 25. MTF TRANSFERRED FROM | 26. DATE THIS ADMISSION (YYMMDD) 2003Ø5Ø2

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

FOR LOCAL USE

Trauma 9 Inj 999

(R) tibia Fx Dx: 82380

Former #115 E9889

Px: 9353

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

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS

MEDCOM - 4492

ADMISSI... AND CODING INFORMATION

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

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

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

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

4. PAY GRADE 16 17

5. SEX 18 F

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

7. AGE AT ADMISSION 27 28 29

8. RACE 30

9. ETHNIC BACKGROUND 31

RELIGION

10. LENGTH OF SERVICE 32 33 34

ETS

11. FMP 35 36

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS 46

HOUR OF ADMISSION
2200

BRANCH / CORPS

14. FLYING STATUS 47 48 49

15. BENEFICIARY CATEGORY 50 51 52

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

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

18. MOS 64 65 66 67 68 69 70

19. TRAUMA 71

PREV. ADMISSION
YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72
DIR

WARD
ICW1

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

22. MTF TRANSFERRED TO 75 76 77 78 79 80

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

81	82	83	84	85	86
0	3	0	5	0	3

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM 91 92 93 94 95 96

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

97	98	99	100	101	102
0	3	0	5	0	2

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

28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D) 111 112 113 114 115 116

FOR LOCAL USE

(R) tibia Fx

Former # 115

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

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

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4493

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: (b)(3)-1
2. NAME (Last, First MI): (b)(6)-2 (b)(6)-4
3. GRADE:
4. SEX: F
5. AGE:
6. RACE: I
7. RELIGION: IRAQI
8. LENGTH OF SVC:
9. ETS:
10. PREVIOUS ADMISSION:
11. FMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION:
14. WARD: ICW 1
15. FLYING STATUS: NO
16. RATING/DSG:
17. DEPT./BEN:
18. BRANCH/CORPS:
19. UIC/ZIP:
20. TYPE CASE:
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct
22. HOURS OF ADMISSION: 2230
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
25. TYPE DISPOSITION: TRANS
26. DATE OF DISPOSITION: 10 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION: 2 MAY 03
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

☐ Check if Continued on Reverse

33. CAUSE OF INJURY:

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW to buttocks

~~E969~~

877.0
808.0
44320

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
8	8				8

36. Total Days All Facilites

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

(b)(6)-2 OFFICER MD (b)(6)-2 MAJ MC SIGNATURE (b)(6)-2

EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4462

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: (b)(3)-1
2. NAME (Last, First, MI): (b)(6)-4 (b)(6)-4
3. GRADE:
4. SEX: F
5. AGE:
6. RACE: I
7. IRAQI
10. PREVIOUS ADMISSION
11. EMP: 99
12. SSN: (b)(6)-4
13. ORGANIZATION
14. WARD: ICW1
15. FLYING STATUS: NO
16. RATING/DSG
17. DEPT/BEN: K78
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct
22. HOURS OF ADMISSION: 2230
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION: TRANS
26. DATE OF DISPOSITION: 10 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION: 2 MAY 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

s/p GSW to buttocks

~~E969~~

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
8	8				8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING OFFICER: (b)(6)-2 MD (b)(6)-2 MAJ, MC

SIGNATURE OF: (b)(6)-2

EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4463

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 May 03	@2315hrs – Nursing Admission Note
	Pt received from (b)(3)-1 this evening. Pt speaking
	Arabic, but understands some simple English words.
	Pt alert and appears oriented. UTA orientation
	due to language barrier. PERRLA 2mm brisk. MAEW
	Heart – NSR, ø m/R/g noted. ø edema, brisk cap
	refill. ø MIVF infusing, ø heplock. Lungs CTA (B),
	↓ bases bilat. ø cough or SOB noted. Abdomen
	large, rounded, soft and tender near incision.
	Midline abdominal incision with dressing intact –
	ø drainage noted. LLQ colostomy with scant
	amount of soft stool in it. ø N+V noted. Pt has not
	voided since admission – UTA @ this time. Ⓛ buttock
	c̄ dressing intact – ø drainage noted. All pulses
	palpable +2. Pt denies pain at this time. USS.
	Will continue to monitor. (b)(6)-2 CPT, AN
2345 HRS 2 MAY 03	VS 7 BP 120/76 – P-109 – RR-20 – Temp 98.7 (E) SpO2 95% (b)(6)-2
3 MAY 03 0350	Pt c/o Ⓛ Hip pain, medicated c̄ #(2) Percocet PO as ordered.
	ø other complaints noted @ this time. (b)(6)-2
3 MAY 03 0600	Informed that pharmacy does not carry Zosyn 500mg IVPB, Physician paged, dose held @ this time for 0600 HRS. (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)*

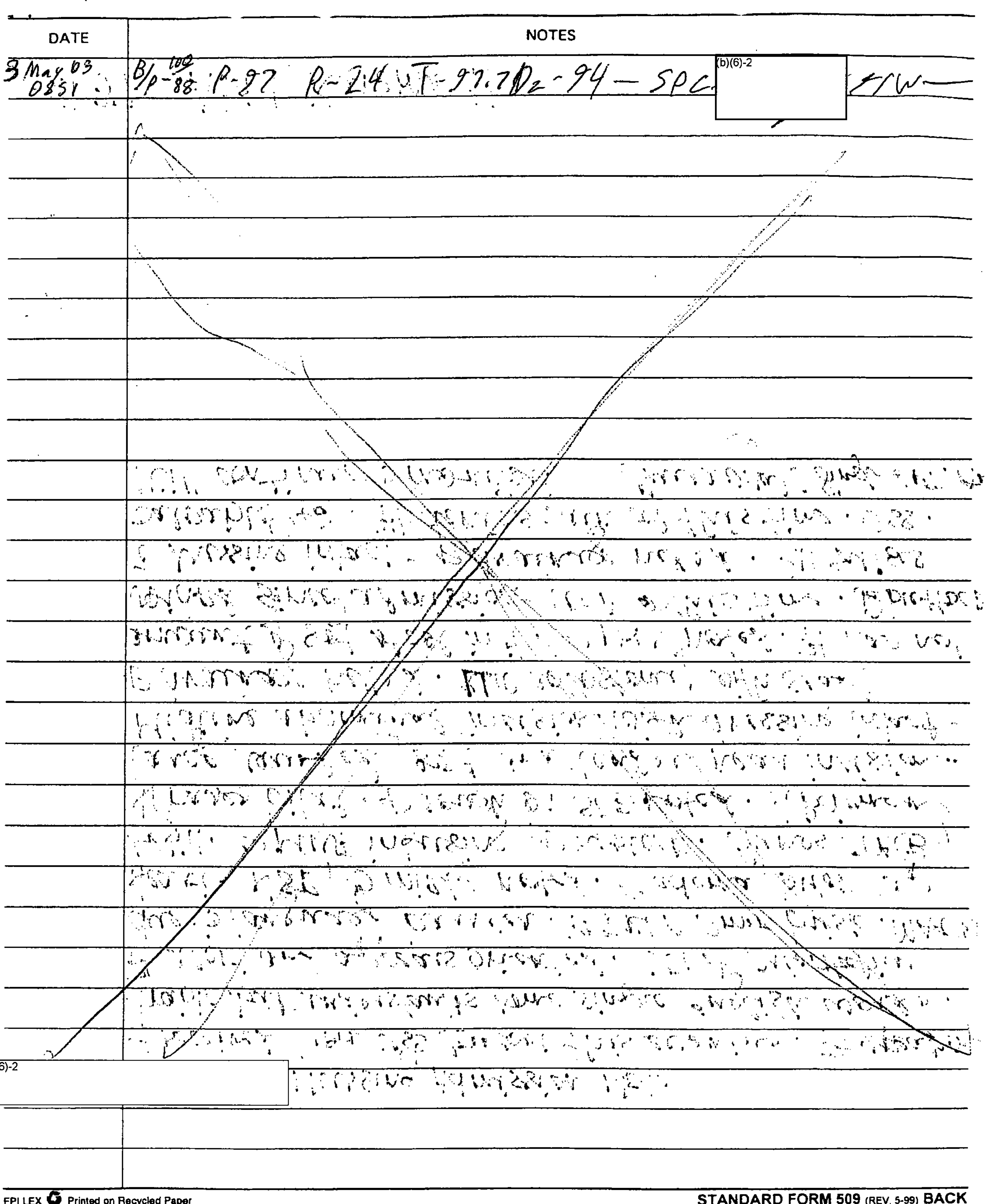
(b)(6)-4

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)

MEDCOM - 4464



DATE	NOTES
3 May 03 0851	B/P 100/88 P-97 R-24 T-97.7 O2-94 — SPC (b)(6)-2 —

(b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4465

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	PT NOTE
5-3-03	(S) Pnt seen on ward per Dr. (b)(6)-2 Request for consult
	s/p GSW to (L) buttocks, (L) acetabular fx and
	diverting colostomy - No interpreter
	(O) NAD, laying supine
	- (I) bed mobility → min assist x1
	- Mod assist x 1 for transfers
	- Ambulates c̄ crutches - FWB (L) s̄ distress -
	tentatively c̄ SBA x 1
	(A) Functionally doing well - ambulates FWB c̄ Stand-by
	assist -
	(P) Nursing supervision/ encouragement for ambulation
	TID → Ad Lib for LOS (b)(6)-2 MPT, ATC
5-3-03	D/W Dr. (b)(6)-2 - Ortho about WB precautions for (L)
	Acetabular fx - Recommends TTWB (L) LE only -
	will instruct through interpreter this pm regarding
	TTWB and completion — (b)(6)-2 PT
3 May 03	Pt seen by Surg this am for dsg Δ to midline
1210	Abd, incl. Δ'd Abx c̄ question on dosage ordered
	N.T. by MD. Pt seen by PT for ambulation
	will require f/u c̄ translator for instruction c̄
	U.S. team. (b)(6)-2 SSG LPN ———

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

MEDCOM - 4466

DATE	NOTES
05-03-03	PT
1410	- Pat seen this PM and was able to Ambulate TTWB
	(R) LE ≈ 20 feet c SBA. Cont TID ~ Ad Lib c
	Nursing supervision for LOS (b)(6)-2 PT
3 MAY 03 1545	Pt c/o pain in buttocks area. Pt given two Vicodin. A+Ox3.
	Resps even + unlabored. Skin W&D. BS x 3. Colostomy
	in place with small amt of stool. Picc line in (L) AC
	place Ø S+S of infection. Pt resting on (L) side.
	SG7 (b)(6)-2
3 May 03 1600	130/88 98.3 109 - 18 SpO2 - 97% SG7 (b)(6)-2
2300 03 MAY 03	VS) BP - 128/90 P 91 R 16 T - 97.8 SpO2 98
03 MAY 03 2345 HRS	Pt resting quietly s complaints @ this time. A&Ox3. LS CTA in upper
	lobes & to bases b/lat. O2 sats 97-98%. Ø SOB noted. BS active
	x3, ~~Col~~ (b)(6)-2 ostomy bag to (L) side of ABD c small amounts of brown
	stool. Pt voiding s difficulty. Picc line to (L) AC, single lumen.
	Good blood return noted to Picc line, Flushed c NS prior to IV ABX.
	Midline ABD DRSG CDI @ this time. (L) Buttock c DRSG intact. Pt
	able to ambulate c crutches. (b)(6)-2
4 MAY 03 0400	Pt medicated c 2 Vicodin PO for c/o (L) Hip/Buttocks pain. Pt now
	resting quietly. (b)(6)-2
4 May 03 0814	B/P - 118/88 P-103 R-20 T-97.7 O2-98-SPO2 (b)(6)-2
1130	Pt A+Ox3 Heart RRR Lungs CTA Pts moist +
	intact. Colostomy bag c >100cc of fecal material
	pt c/o nausea c fluid intake. Bowl sounds x4
	(b)(6)-2 SSG (b)(6)-2
04 May 03	Pt VS c 103 PULSE AND 98 SPO2, BP 132/80, TEMP 98.7, AND RR-20. (b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4467

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
04may03	1520 - c/o pain to ABD. & (L) posterior hip
	Medicated c̄ Percocet ii PO pain [(b)(6)-2]
	1630 - attempted to get OOB [with] Pt. became weak
	& had to be put back to bed again. VSS around
	BP 130/76 - %Ox = 98% Pulse = 103. [(b)(6)-2]
	1700 - DRSG Δ to ABDomen. Assessment of ABD
	reveals: beefy red tissue c̄ deep opening & white
	necrotic edges - No unusual odor / No unusual
	drainage. Area irrigated c̄ NSS - wet to dry
	packing @ NSS. Covered c̄ Dry gauze & secured
	c̄ tape. TX to (L) posterior buttock done
	Assessment of area / reveals: clean wound c̄
	beefy red tissue & white necrotic edges & depth.
	Wet to dry TX c̄ NSS. Applied / covered c̄ gauze
	& secured c̄ tape. Tol. well. Colostomy bag
	has soft formed green color BM - small
	amt. & Emptied. Pt. sad as interpreted by
	interpreter - misses "baby". Assured she'd be
	better once she heals & feels better & returns
	home. [(b)(6)-2]
1800	- ate 25% supper & PO flds. Encouraged [(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)

MEDCOM - 4468

DATE	NOTES
2400 04 MAY 03	VS> BP 120/82 P 113 R 20 T-99.4 SpO2 99%
05 MAY 03 0015	Pt A&O x3, Resting quietly @ this time. Medicated for pain @ 2315 hrs denies pain @ this time. LS CTA in bilat ↑ lobes ↓ in lower lobes, O2 SATS 98-99% on RA. BS active x4, Colostomy bag in place c̄ small amounts of brown stool. Pt voiding s̄ difficulty. Single lumen Perc line to (R) AC flushing well c̄ good blood return. ABD DSG C/D/I, (L) Buttocks DSG C/D/I. Cap refill <3 sec in ext x4. Pt has not been OOB this shift. —— (b)(6)-2
0800 5 May 03	VS> 116/78 P=105 R=17 T=96.4 SP 98 (b)(6)-2
0945	Pt A+Ox3 Lungs CTA Heart RRR. Bowel sounds x4 Δ dsg midline Abd c̄ moist kerlex c̄ Dakins Wnd 10" long 2" deep c̄ deep sutures. Covered c̄ 4x4 & tape. Wnd (L) Buttocks 2" wide 1" deep packed c̄ 4x4 moistened c̄ Dakins covered c̄ 4x4 + tape. Emptied colostomy & irrigated bag c̄ NS. (b)(6)-2 556 [illegible]
1500 5 May 03	VS> 110/77 P=98 R=23 T=97.7 SP 98 (b)(6)-2
5 May 03	1515 — Facial grimacing but denies pain per Interpreter, asked interpreter to ask what can be done to make her comfortable. She told interpreter "not much". Pt assisted up in bed. Remove blanket & applied sheet. Mouth care c̄ lemon swabs. Faced wiped c̄ baby wipes. (b)(6)-2
050503	1700 - Husband visited. Pt ate 100% meal. (b)(6)-2
2000 5 MAY 03	VS> BP 112/88 P 103 R 20 T 99.3 SpO2 95%

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
050503	at 2000 – Husband here. Drsg Δ to Abdomen. Area is clean, pink – no unusual drainage/odor. Has even edges. Area cleansed c NSS. Apply NSS wet packing. Covered c dry gauze + secured c tape. (L) poster. buttocks drsg done. Area is clean, pink c white necrotic, even Edges – No unusual drainage/odor. Tol. well. Cleansed area c NSS, Applied wet drsg. Covered c dry gauze + secured c tape. Colostomy bag emptied – Dk. greenish semi-formed BM mod. Amt. Peri-care done per pt. (b)(6)-2
	2100 medicated for pain c ii Percocet. Effective (b)(6)-2
05 May 03 @ 2300	Received report from night shift. Pt resting c husband @ BS. HRR, clear breath sounds, ↓ bases, abdomen round, midline DRSG C/D/I. Single lumen PICC to (R) arm. Flushes well. Cap refill < 2sec. Pt denies pain. Colostomy to (L) side. Will continue to monitor – (b)(6)-2 91WMC
6 May 03 0300	VS> BP 122/90 P 105 R 19 T 96.4 (Ax) SP 98 (b)(6)-2 91W

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)

MEDCOM - 4470

DATE	NOTES
6 May 03 0930	Pt resting in bed this am - Husband at bedside. Pt c̄ 1 episode of emesis this am - no further c/o N/ at this time. Tol PO meds. Lungs CTA B/L - HRRR BS x4 Quads. Colostomy bag intact to LLQ draining semiformed brownish/yellow stool. ML ABD incision - open wound. DSG Δ'd at this time W-D c̄ 1/4% Dankins Soln. Wound is beefy red - healthy tissue. Sutures in place at bottom of wound. DSG Δ'd to (L) buttock. Packed c̄ 2 4x4 gauze fluffs. Wound is fairly deep as 1 gauze packed in wound. Pt tolerated dsg Δ s̄ c/o. PICC line to (R)AC patent. Pt not receiving IV ABX any longer. Pt encouraged to AMB. Will amb pt to BR when she has to urinate. Will cont to assess ——— (b)(6)-2 CPT AN
1030	DSG to (R) PICC line done. Old dsg soiled & falling off. PICC entry site red & slightly swollen. Will notify MD's on rounds. Site clean c̄ Betadine under sterile tech. ——— (b)(6)-2 CPT AN
1315	Pt amb to back vestibule to use BR. Pt urinated. Assisted in emptying colostomy bag. Pt began to perspire & felt faint. Pt assisted to vestibule floor. Pt's name called & opened eyes. Pt helped up to chair by myself & husband. Pt amb back to bed c̄ crutches. Pt sitting up in chair at this time. Will cont to assess ——— (b)(6)-2 CPT AN
1445	MD's round on pt. [struck through] removed ML dsg. DSG repacked W-D c̄ 1/4 Dankins. PICC line removed - tip intact (b)(6)-2
06 May 03 @ 1950	Pt resting. Colostomy bag emptied, semiformed stool. Pt has DRSG to Abd CDI & buttocks CDI. No IV access. HRRR, clear equal breath sounds, good cap refill, A&Ox3, pain denies pain, c/o nausea 25m Meclizine given. Will continue to monitor. (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 MAY 03	VS > BP 132/76 P 100 R 20 T 99.1 SpO2 99
07 May 03 @ 0500	Δ'd Drsg to buttocks. Area deepened. Ø signs of infection. (b)(6)-2 91WM6
	Δ'd colo (b)(6)-2 Emptied colostomy bag.
	Soft brown stool. (b)(6)-2 91WM6
7 May 03 0800	VS > BP = 124/78 P = 103 R = 18 T = 96.9 SP = 98 (b)(6)-2
7 May 03	ate 100% breakfast. C/O pain in ABD. Medicated c Percocet tabs ii PO. ABD drsg intact at this time. Colostomy s drainage [illegible] at this time (b)(6)-2
0800	Does not like MVI - Says it makes her feel sick (nauseated) (b)(6)-2
0915 -	Sitting in chair at BS. Tol well. (b)(6)-2
1030 -	Back to bed. Resting Quietly (b)(6)-2
1600 -	Husband present. Drsg Δ to ABD. Area is pink + moist inside wound c even edges, no unusual odor/drainage. Cleansed/irrigated c NSS. Applied wet NSS packing. Covered c ABD. Pad - Secured c (b)(6)-2 Tape. Tol. well. Δ'd Drsg to (L) posterior thigh, area has tunneling depth even Edges - no unusual odor/drainage →

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)

MEDCOM - 4472

DATE	NOTES
07May03	1600 cont'd. Cleansed c̄ NSS. Applied NSS Gauze packing covered c̄ dry gauze - Secured c̄ tape. Tol well. Δ'd Colostomy bag - Has mod - Amt Semi formed fecal matter. Tol. well. (b)(6)-2
7 MAY 03 @ 2000	VS> BP 128/98 P 96 R 18 T 98.3 Ax SpO2 94% RA DRSG Δ to ABD. No unusual odor/drainage. Irrigated c̄ NSS Applied wet NSS packing. Covered c̄ ABD pad. Tolerated well. DRSG Δ to Ⓛ post. thigh. No unusual odor/drainage. Even edges on tunnel, moist & pink. Applied wet NSS packing, covered c̄ 4x4 s. Tolerated well. Emptied colostomy bag - has semi-formed brown stool. Tol. well. (b)(6)-2 (b)(6)-2 91WM6
@ 2030	Pt resting c̄ husband @ bedside. c/o difficulty sleeping will comedicate c̄ Benadryl. (b)(6)-2 91WM6
@ 2200	BP 120/78 (b)(6)-2 91WM6
8 May 03 0800	VS> BP-118/[illegible] P-90 R-18 T-98.3 Ax SP-96 [illegible] (b)(6)-2
8 May 03	0830 - Husband present. AM Care done by Pt + husband. Assessment reveals - Good mood - Smiling. ate own food for breakfast + some of our food (about 10%). Denies pain at this time. Lungs clr c̄ No Cough/congestion - BS + all Quads. Colostomy bag intact (b)(6)-2
12N	Pt Resting Quietly (b)(6)-2
1300	Ambulated to Bath - urinated + Colostomy bag emptied. (b)(6)-2
1600	Medicated for pain c̄ 2 percocet (b)(6)-2
1710	TX'S done to Abd, (2) posterior hip - (b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4473

ACLU-RDI 1244 p.243

DOD 010952

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08 May 03	Received report from day shift. Pt resting c̄ husband
@ 1930	@ bedside. [illegible] Drsg to ABD. Area is red c̄ ∅ infection
	[illegible] Drsg to Buttock no signs of infection. Pt is
	taking care of colostomy care. HEEL, Clear equal
	bilat breath sounds. Stool from colostomy is semi-
	formed brown. Pt c/o pain, will medicate c̄
	Percocet. Also pt c/o of difficulty sleeping, 10 mg
	of ambien given —— (b)(6)-2 91WM6
@ 2000	PO2 98% HR 100 BP 128/70 RR 20 Temp 98.2
9 May 03 0800	VS> BP 120/72 P-100 R-18 T-97(Ax) SP-98 Orozco N.W. ——
9 May 03	medicated c̄ percocet ii PO for pain at ABD &
	(L) buttocks. Resting Calmly at this time.
	Husband present. (b)(6)-2
9 May 03	1615 - Ambulating in Hall of NSG unit c̄ Husband -
	c/o "leg cramping" which subsided. (b)(6)-2
9 May 03	1800 - No C/o's voiced. Lungs Sound CTA, NO C/O s̄
	SOB. No warmth at Leg cramp site Left lower
	leg. Continue to monitor & encourage pt. to walk
	as much as possible. (b)(6)-2
@ 2000	VS> BP 118/88 P 107 R 18 T 98.9 SpO2 98

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)

MEDCOM - 4474

DATE	NOTES
09 May 03 @ 2030	Received report from day shift. Husband @ BS. Pt up walking c crutches & assistance from husband. HRRR, ↓E/B Breath sounds. Pt is performing colostomy care, emptied this shift. Pt has ABD dressing to midline CDI, & to (R) buttocks, CDI. Will continue to monitor for pain & infection —— (b)(6)-2 SN WMC
0820- 10 May 03	Pt A&Ox3, resting in bed, (B) 03 CTA, HRR, (+) BS, cap refill <3sec, (+)DS signal, drsg to midline dsd CDI, drsg to buttock intact, colostomy intact, pt s c/o discomfort @ this time will cont to monitor —— (b)(6)-2 LPN
10 May 03 0800	VS BP - 116/84 R-18 P-100 T-97.5 SA - 98 (b)(6)-2
10 May 1200-	Pt D/C / transferred to AW/surgical via bed/wheelchair, pt left floor ambulatory c family - VSS, afebrile - proper supplies c pt. —— (b)(6)-2 LPN

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4475

ACLU-RDI 1244 p.245

PT # (b)(6)-4

(b)(6)-4

SPECIMEN/LAB RPT

HEMATOLOGY

URGENCY: [X] ROUTINE, [ ] TODAY, [ ] PRE-OP, [ ] STAT

PATIENT STATUS: [X] BED, [ ] AMB, [ ] OUTPATIENT, [ ] NP, [ ] DOM

SPECIMEN SOURCE: [X] VEIN, [ ] CAP, [ ] OTHER (Specify)

PATIENTS MED

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO (b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2

REPORTED BY: Sgt (b)(6)-2 (b)(6)-2

MD DATE: 3 MAY 03

LAB. ID. NO.

REMARKS: 1+ Basophillia/Stippling
CBC – 1+ Polychromasia

549-107

TEST(S)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH	PLATELET COUNT	Retic	Lyt
RESULTS	3.89	10.4	32.8	84.8	26.7	31.7	6.3	Increased PLATELETS / remarks	562	24.2	1.5

Column headers also printed: DATE, SPECIMEN TAKEN, TIME, A.M. P.M., REQUESTED (X), IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC, SED. RATE, RETICULOCYTE COUNT, CLOTTING TIME, BLEEDING TIME, PTT CONTROL, PATIENT, CONTROL, PATIENT, % ACTIVITY, RATIO, SICKLING TEST

HEMATOLOGY
STANDARD FORM 549 Rev. 7-78
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505

SPECIMEN/LAB. RPT. NO.

PT # (b)(6)-4

(b)(6)-4

CHEM I

URGENCY: [X] ROUTINE, [ ] TODAY, [ ] PRE-OP, [ ] STAT

PATIENT STATUS: [X] BED, [ ] AMB, [ ] OUTPATIENT, [ ] NP, [ ] DOM

SPECIMEN SOURCE: [X] BLOOD, [ ] OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: D. (b)(6)-2

REPORTED BY: Sgt (b)(6)-2 (b)(6)-2

MD DATE: 3 MAY 03

LAB. ID. NO.

REMARKS: Chem 7

546-107

TEST(S)	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO2	HCT	HGB
RESULTS	92	9	1.2		136	3.1	97		32	11

Column headers also printed: DATE, SPECIMEN TAKEN, TIME, A.M. P.M., REQUESTED (X), PHOSPHATE, CALCIUM, TOTAL PROTEIN, ALBUMIN, GLOBULIN, ALKALINE PHOSPHATASE, ACID PHOSPHATASE, SGOT, LDH, CPK, BILIRUBIN (TOTAL), BILIRUBIN (DIRECT), CHOLESTEROL, TRIGLYCERIDES, AMYLASE, LIPASE, PROFILE (Specify)

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

(b)(6)-4

SF 546

MEDCOM - 4476

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT: ICW-1 | ROOM NO. | BED NO.: 5

DATE OF ORDER: 2 MAY 03 | TIME OF ORDER: 2210 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW1
2. DX: GSW (L) BUTTOCKS c (L) ACETABULAR FX
   DIVERTING COLOSTOMY
   c/B WOUND DEHISCENCE / NEC FASCIITIS
3. COND STABLE
4. VS PER ROUTINE
5. ACT: AD LIB - CRUTCHES @ BEDSIDE

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT: ICW-1 | ROOM NO. | BED NO.: 5

DATE OF ORDER: ↓ | TIME OF ORDER: ↓ HOURS

6. ALL: NKDA
7. DIET: REGULAR
8. IV (PICC LINE) HL - FLUSH PICC QD
9. LOVENOX, 30 MG SQ BID
10. IMIPENEM, 500 MG IVPB Q6'
11. ZANTAC 150MG PO BID
12. MULTIVITAMIN T PO QD

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT: ICW-1 | ROOM NO. | BED NO.: 5

DATE OF ORDER: ↓ | TIME OF ORDER: ↓ HOURS

13. MECLIZINE, 25 MG PO BID PRN NAUSEA
14. VICODIN OR PERCOCET, 1-2 TAB PO Q4-6 HR PRN PAIN
15. MOTRIN, 800 MG PO TID WM PRN PAIN
16. CBC, CHEM 7 IN AM
17. CONSULT PT

(b)(6)-2 MD

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER

noted. (b)(6)-2

CPT [illegible]

5/2/03 @ 2315 hrs

NURSING UNIT: ICW-1 | ROOM NO. | BED NO.: 5

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

MEDCOM - 4477

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: 03MAY03 TIME OF ORDER: 0958 HOURS

LIST TIME ORDER NOTED AND SIGN

1) if Imipenem unavailable then: Timentin 750mg IV Q6°
2) 1/2 strength DAKINS solution to BEDSIDE
3) BID damp-to-dry dressing changes c̄ 1/2 strength DAKINS
4) Ambien 5-10mg PO QHS prn

(b)(6)-2

(b)(6)-2 3 May 03 1350

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 03MAY03 TIME OF ORDER: 1814 HOURS

1) Δ Timentin to 3.1gm IV Q6°

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 4 MAY 03 TIME OF ORDER: 1300 HOURS

1) Transfer to (b)(3)-1
2) D/C Timentin
3) Rx on chart for D/C (no others)

(b)(6)-2

(b)(6)-2

noted 4 May 03 1300

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4478

ACLU-RDI 1244 p.248

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 6 May 03 TIME OF ORDER 1430 HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	1	D/C PICC line	(b)(6)-2
		V.O. Dr. (b)(6)-2 / (b)(6)-2 CPT AN	
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.			

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.

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

MEDCOM - 4479

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. May Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2MAY03	(b)(6)-2	VS @ Shift	08	(b)(6)-2													
	-----		16														
	-----		24														
2May03	(b)(6)-2	Activity: AD Lib c̄	08														
	-----	Crutches @ bedside	16														
	-----		24														
2May03	(b)(6)-2	Diet: Regular	08														
	-----		16														
	-----		24														
2May03	(b)(6)-2	IV: PICC LINE Flush	06	(b)(6)-2													
	-----	QID	12														
	-----		18	(b)(6)-2													
	-----		24	(b)(6)-2													

Died 6 May 03

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to Ⓛ buttocks c̄ Ⓛ Acetabular fracture; Diverting Colostomy

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

PATIENT IDENTIFICATION:
(b)(6)-4 (b)(6)-4
(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.
MEDCOM - 4480

ACLU-RDI 1244 p.250

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 May	(b)(6)-2	Admit ICW-1	2May03	2210	2230	(b)(6)-2
2 May		Condition Stable	2May03			
2 May		Chem 7, CBC in AM	3May03	0600	0600	
2 May		PT Consult	3May03	1000		
4 May 03		Transfer to (b)(3)-1				
4 May 03		Rx on chart for D/C (no orders				

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

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 4481

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 May Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	2	3	4	5	6	7	8	9	10	11	12	13	14	15
2May03	(b)(6)-2	Lovenox 30mg SQ BID	08	(b)(6)-2													
			20	(b)(6)-2													
2May03	(b)(6)-2	Imipenem 500mg IVPB Q6°	06	(b)(6)-2													
			12		D/C'd Roo 3 May 03												
			18														
			24														
2May03	(b)(6)-2	Zantac 150mg PO BID	08	(b)(6)-2													
			20	(b)(6)-2													
2May03	(b)(6)-2	Multivitamin i tab PO QD	08	(b)(6)-2													
3May03	(b)(6)-2	Timentin 3.1gm IV Q6°	06		(b)(6)-2												
			12		(b)(6)-2	D/c'ed 4 May 03							(b)(6)-2				
			18														
			24														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW (L) Buttocks ē (L) Acetabular fx; Diverting Colostomy

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

PATIENT IDENTIFICATION:
Bed #5
(b)(6)-4
(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. May Yr. 2003

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3 May	(b)(6)-2	1/2 strength DAKINS solution to BS	3 May	—		(b)(6)-2
6 May		D/C PICC line	6 May	done		
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
2 May	(b)(6)-2	Meclizine 25mg PO BID PRN - nausea	6 May 0315 (b)(6)-2; 06 May 2000 25mg (b)(6)-2
2 May		Vicodin 1-2 Tab PO Q4-6 HR PRN-Pain	2 PO 0310 3 May; 2 PO 1515 3 May; 2 PO 2100 3 May; 4 May; 4 May 2315; 5 May 0900; 5 May 2100; 08 May 0600; 8 May 1600; 09 May 0200; 9 May 2400; 10 May 0630 [(b)(6)-2 initials]
2 May		Percocet 1-2 Tab PO Q4-6 HR PRN-Pain	3 May 0830; 4 May 1530; 5 May 2 PO; 6 May 0315 2 tab; 6 May 1045; 06 May 2100; 07 May 0440; 07 May 0840; 07 May 1930; 07 May 2330 [(b)(6)-2 initials]
2 May		Motrin 800mg PO TID c meals PRN-Pain	
.....	.....		
3 May	(b)(6)-2	Ambien 5-10mg PO	08 May 2003 1800; 9 May 2345 10mg PO (b)(6)-2
.....	.....	QHS prn	
2 May	(b)(6)-2	Percocet 1-2 tabs	8 May 1630 ii PO (b)(6)-2; 9 May 0800 ii PO (b)(6)-2
.....	.....	PO Q 4-6 PRN Pain	
.....	.....		
.....	.....		
.....	.....		
.....	.....		

USAPA V1.00

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

MEDCOM - 4483

ADMIS[illegible] AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
MTF LOCATION (State or Country Code): IZ

3. REGISTER NUMBER: (b)(6)-4

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

4. PAY GRADE: —

5. SEX: F

6. DATE OF BIRTH (YYYYMMDD):

7. AGE AT ADMISSION:

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION:

10. LENGTH OF SERVICE: —

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: 2

HOUR OF ADMISSION: 2230

BRANCH / CORPS:

14. FLYING STATUS: —

15. BENEFICIARY CATEGORY: K91 78

16. ZIP CODE OF RESIDENCE: 093300000

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA: INJ

PREV. ADMISSION: YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 Direct

WARD: ICW1

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: 26 TRANS

22. MTF TRANSFERRED TO: (b)(3)-1

23. DATE OF DISPOSITION (YYMMDD): 2003 05 10

24. CLINIC SVC - ADMITTING: ABAD

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYMMDD): 2003 05 02

27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYMMDD):

FOR LOCAL USE

DX: 8081 GSW to buttocks
8771
86350
E9912

~~E969~~

Trauma 9
Inj 569

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

MEDCOM - 4484

ACLU-RDI 1244 p.254

DOD 010963

7-06(

ADMISSION AND CODING INFORMATION

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

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

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

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

4. PAY GRADE: 16 17

5. SEX: 18 — F

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 — I

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: 2230

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

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

WARD: ICW1

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 — TRANS

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

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 5 1 0

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A D

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 5 0 2

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

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

GSW to buttocks

~~E969~~

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

MEDCOM - 4485

ACLU-RDI 1244 p.255

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	
ADMISSION REMARKS	
4. SEX	F
5. AGE	
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	ICW3
15. FLYING STATUS	NO
16. RATING DSG	
17. DEPT BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	Direct
22. HOURS OF ADMISSION	2205
23. CLINIC SERVICE	ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	
26. DATE OF DISPOSITION	8 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	2 MAY 03
ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	
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

S/P GSW Ⓡ Neck, Carotid Dissection

874

443.21

874.8
443.21
344.1
344.2

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
6	6				6

36. Total Days All Facilites

a. ABSENT SICK DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

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

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

DA F[redacted] EDITION OF 1 AUG[redacted]

MEDCOM - 4434

ACLU-RDI 1244 p.256

DOD 010913

USNS COMFORT , (b)(3)-1 Date of Admission: 4/10/2003

CH Name: (b)(6)-4 copy Date Transfer:

(b)(6)-4 Age: 18 Gender: M

History:

18 y/o Iraqi Woman, with GSW vs shrapnel to right side of neck, injury reportedly occurred 12 days ago, with exploration to
neck 10 days ago at original (b)(3)-1, then transferred to (b)(3)-1 4/9/03, arrived to (b)(3)-1 4/10/03,for neuro eval and possiblesepsis

Hospital Course:

Admitted to ICU3 for close monitoring. Broad spectrum abx for presumed sepsis. Will require collar for 12 weeks.
NEUROLOGY: Greenflield filter placed 21 APR due to excess risk of DVT

Diagnoses:

GSW vs Shrapnel Right side Neck, with C-6 Spine injury with paralysis of all extremities except LUE., Rt. Parietal lobe stroke, Rt. Common Carotid traumatic aneurysm; Right vertebral and Right internal jugular occlusion

Surgeries/Treatment:

CT scan head/Neck 4/10/03; Head/Neck Angio 4/10/03; IV antibiotics, ,

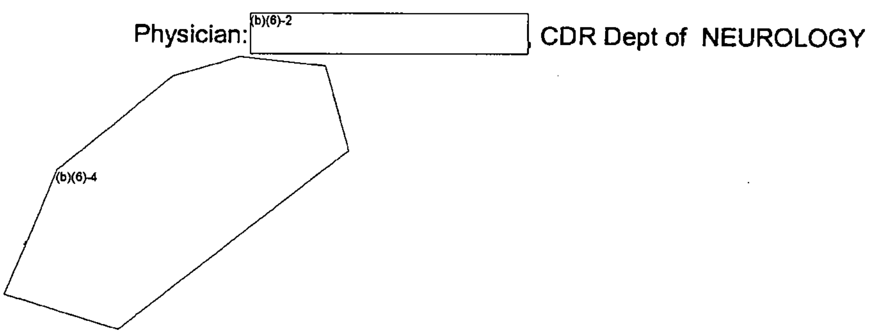
Recommendations:

Keep in C collar for now, may sit up. No surgical intervention required for c-spine. NEUROLOGY: Maintain on Low dose Coumadin (2 mg/day) for 3 mos due to Carotid dissection. Priorities are mobilization, rehab, optimize function r arm

Special Needs:

Prognosis: Guarded

Physician: (b)(6)-2 CDR Dept of NEUROLOGY 4/24/2003



MEDCOM - 4435

ACLU-RDI 1244 p.257

DOD 010914

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	
4. SEX	F
5. AGE	
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	ICW3
15. FLYING STATUS	NO
16. RATING DSG	
17. DEPT. BEN	K78
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	Direct
22. HOURS OF ADMISSION	2205
23. CLINIC SERVICE	ABAM
24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	
26. DATE OF DISPOSITION	8 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	2 MAY 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	
30. DATE OF INTIAL ADMISSION	
32. UNITS OF [illegible] COMPONENT	

ADMISSION REMARKS

33. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on [illegible]

34. CAUSE OF INJURY

35. DIAGNOSES OPERATIONS AND SPECIAL PROCEDURES

S/P GSW (R) Neck, Carotid Dissection

874

443.21

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	
6	6				6

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

SIGNATURE OF A[illegible] (b)(6)-2

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

DA F[illegible] EDITION OF 1 AUG[illegible]

MEDCOM - 4436

ACLU-RDI 1244 p.258

DOD 010915

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 May 03 2355	PT arrived to unit and placed in bed. VS 99.8 120, 20 128/86 94%. PT c̄ C-Collar, has bilat AFO to LEs. PT has sensation to LE but none movement or tone. PT c/o generalized pain x 3 during exam — MSO4 4mg IV — PT has foley — emptied 450cc of clear yellow urine. Lungs c̄ bilat crackles to bases, BS x4 normoactive. (b)(6)-2 MAJ AN
2355	2200 Elavil & Tegretol given @ 2355. (b)(6)-2 MAJ AN
3 May 03 0600	PT requested pain medication x 2 for remaining portion of shift. See med sheet. Currently pt resting quietly. 200cc urine emptied from foley. (b)(6)-2 MAJ AN
3 May 03 0835	REQUEST "MORPHINE" FOR PAIN. GIVEN MSO4 4mg IVP. RESTING IN BED — DID NOT DESIRE TO EAT @ MEAL (b)(6)-2
3 May 03 1000	VS- BP 152/70 - P -110, R - 20, T - 99.0, Pt asleep when arrived on shift, pt responds to verbal stimuli, able to move upper extremities upon command, Lungs CTA, ⊕ BS, Foley to gravity draining amber color urine, Pt c/o of "(b)(6)-4" pt given 4mg Morphine per IVP Maj (b)(6)-2, — (b)(6)-2 LPN
3 May 03 1200	Consulted c̄ anesthesia about pain control, fentanyl order, see medication sheets. (b)(6)-2
3 May 03 1400	pt started on Fentanyl, pt > 10, pt sat 91-96 on RA, pt took total of 150 fentanyl, pt had some relief, able to turn pt on side, will continue to

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

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

PROGRESS NOTES

DATE	
3 May 03 1400	monitor for changes.
3 May 03 1500	Pass on to 3-11 shift to give Morphine q 2hr on schedule, Fentanly right before turns. (b)(6)-2
3 May 03 1530	T - 101.5, pt given 2 tylenol. (b)(6)-2
3 May 03 1600	T - 100.3, will continue to monitor for changes (b)(6)-2
3MAY03 1925	Pt c/o pain. Given 4 mg MSO4 IV. (b)(6)-2
1939 3MAY03	VS T 98.5 / R 24 / P 108 / 115/80 (b)(6)-2 9IW
2045 03MAY03	pt had I.V changed from (L) ac area to (R) hand. pt said the IV was painful, IV was Red and irritated. pt has not complained of pain that much. pt was moved at 19:39 and didnt require any fentanyl. (b)(6)-2 9IW
3 May 03 2345	PT resting in bed c BM - Linen Δ'ed PT, Turned — MSO4 4mg given for movement p c/o pain. VS: 144/86 100.4, 118, 18, IV (R) Hand LR @ 125/hr, C-Collar in Place. PT has Sensation but No movement to LEs b/lat 2° to Injury. (b)(6)-2 MAJ AN
0600	Held PO Reglan 2° NPO for Procedure - PT was Nauseated — given Zofran 4mg IV. (b)(6)-2 MAJ AN
04 May 03	OP Note
1016	Preop D(x): Urinary retention; EBL = 35cc; IVF = 800cc. Post op D(x): above; Procedure: Suprapubic catheter. Surgeon: (b)(6)-2; complications: none

☆U.S. GPO:1995-397-405 (b)(6)-2 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4438

ACLU-RDI 1244 p.260

DOD 010917

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Physical Therapy Note | **PROGRESS NOTES**

DATE	NOTES
	(S) Pnt - 18 yo ♀, GSW to (R)
5-3-03	Side of neck, C-6 Spine injury c̄ paralysis of all extremities x̄
	(L) UE - Rt. Parietal Stroke, Rt Common Carotid traumatic
	aneurysm, Rt vertebral and Rt internal jugular occlusion
	(O) Resting in supine - asleep
	(R) UE Flaccid
	(L) LE Flaccid c̄ trace toe ext
	(R) LE Flaccid and painful to touch - movement
	(L) UE 3+/5 Biceps, 3/5 triceps, 3+/5 wrist ext, Finger
	flexion 2° to wrist ext. FF of Shoulder to shoulder
	height
	- No Bed mobility
	- unable to sit edge of bed 2° to (Rt) LE leg pain
	- Theraex of manual resistance - (L) Biceps, triceps
	and PROM of (R) UE, (L) LE
	(A) Poor functional prognosis, may overtime be able to
	assist c̄ basic ADLs such as feeding, hygiene.
	Likely require max care in future.
	Cont. ROM and attempts of sitting edge of Bed -
	probable d/c tomorrow per Nursing staff.
	d/w c̄ Physician about (R) LE pain. (b)(6)-2 , PT, ATC

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)

MEDCOM - 4439

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 May 03 to 0945	HR - 136, 98%, 123/85, RR 17, 98.5 (A)
0950	HR - 105, 97%, 120/86, RR 20, 98.7 (A)
0955	HR - 115, 98%, 118/85, RR 20. Administered 50 mcg Fentanyl IV
	for c/o pain. Will continue to monitor. —— (b)(6)-2 1LT, AN
1000	Patient returned from OR @ 0945 c̄ PM suprapubic cath in place.
	Emptied 300ml of bloody drainage c̄ large clots. ST c̄ HR 130's. Lung
	sounds CTA bilaterally, sating >95% on RA. Pupils 2mm / sluggish.
	Patient alert @ this time. Weak palpable pulses x 4. (L) fingertips slightly
	cyanotic. Will continue to monitor. —— (b)(6)-2 1LT, AN
1015	142 (HR); 98%, 125/88, 21-RR, 99.1 (A). Administered 3TSP Aceta
	Childrens Tylenol Suspension. Will continue to monitor. (b)(6)-2 1LT, AN
1030	HR 152, 97%, 134/84, RR-31, Temp 101.1 (A). Applied cold packs to
	under arm, Administered 25mg Demerol for c/o pain. Suprapubic cath c̄
	100ml of bloody output s̄ clots and clearing some. IVF currently
	@ 165ml, will continue to monitor. —— (b)(6)-2 1LT, AN
1056	HR 153, 96%, 112/70, RR 20, 102.5. Encouraged patient to
	drink fluids, applied more ice packs, notified Anesthesia — no interventions ordered
	at this time. Pt remains ST c̄ HR 140-150's, BP 90/40's. Administered
	500 ml bolus. Will continue to monitor. —— (b)(6)-2 1LT, AN
1120	HR 152, 97%, 104/51, 20's, T-100.9. Patient c̄ c/o pain to surgical site.
	Holding pain meds @ this time until bolus complete to monitor pressures. (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.

(b)(6)-4

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

MEDCOM - 4440

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4-May 03 1300	Pt recieved from OR via stretcher, pt placed in bed, A&O x3, responds to verbal stimuli, able to squeeze hand c̄ LUE hand, unable to squeeze hand c̄ RUE hand, responds to tactile stimuli on feet bil. Able to move toes on LLE, unable to move toes on RLE, Lungs CTA, cap refill > 3sec, Faint BS x4 quad, (+) pedal pulses bil. Pt c/o of " (b)(6)-4 ", pt given 4mg morphine per Dr's order, will monitor pt. for changes, V/S BP 122/65, P-131, R- , T-100.4, Sat 94% - 97% on Ra c̄ encouragement of C&DB, Foley to gravity draining bloody urine. (b)(6)-2
4 May 03 1330	Pt RUE dusky, unable to move hand, PT/OT worked c̄ pt, Dr aware, no further orders except therapy & work on getting pt to Hospital in Austria or Saudi Arabia for rehab (b)(6)-2
4 May 03 1400	T-101.4, pt given 2 tylenol will monitor pt. for changes. (b)(6)-2
4 May 03 1445	T-100., will continue to monitor for changes. (b)(6)-2
4 May 03 1505	BP 123/71 SpO2 98, P 144, Temp 100.3 (b)(6)-2
	pt complained of pain and was given 50 mcgs at 1820. of fentanyl. pt was positioned on her left side and was given another 50 MCG of fentanyl at 18:23 (b)(6)-2
2000	Pt c/o bladder pain, has suprapubic catheter that is not putting out urine. Dr (b)(6)-2 at bedside, attempted to flush

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4441

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 May 03 2006 cont.	Suprapubic catheter, 16 Fr 3 way catheter inserted in urethra c̄ 1000 cc bloody urine output. HR-124 R-14 SaO_2 96. Pt resting more comfortably now (b)(6)-2 CPT A
2300	VS: T-98[8] P-139 R-16 BP 118/80 SaO_2 96% Pt awake c/o lower extremity and lower abdominal pain, given Fentanyl 50 mcg. Pt in C-collar c̄ AFD devices on bilaterally. PIV in LFA infusing D5 ½NS c̄ 20 mEq KCl @ 125 cc/hr. Suprapubic catheter to BSD, Foley catheter to BSD c̄ bloody colored UOP. Pt given Zofran 4mg IV for nausea (b)(6)-2 CPT
0600	Pt resting quietly - Foley UOP - 1100 cc dark hematuric urine Suprapubic UOP - 100 cc blood-tinged urine
5 MAY 03	Urology - SP tube initially draining well then able to flush but not withdraw - performed antegrade cystogram that showed extraperitoneal extravasation - attempted to manipulate back into bladder but unsuccessful and D/c'ed SP tube Plan: cont levoflox, change hematuria cath over to soft foley tomorrow re-attempt SP tube when appropriate equipment available - EVAC thru international red cross.

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

(b)(6)-2

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

MEDCOM - 4442

DATE	NOTES
5 May 03	1230. Pt given 4mg MSO4 IV for c/o pain [(b)(6)-2] LTRN
5 May 03 0900	V/S – 128/60, 86, 18, 98.9, Sat 98% on RA, Pt Lungs CTA, ⊕ BS ⊕ pedal pulses, OT worked c pt on RUE, P.T. supposed to make splint or cast for pt.
5 May 03 1400	Pt given 4mg Morphine per Dr's order will continue to monitor pt. for changes. [(b)(6)-2] LPN
5 May 03 1400	Dr wrote orders for D/C to red cross, no hospital available to send pt yet. [(b)(6)-2]
5 May 1645	VS. 120/74, p 133, SpO2 96, R. 18. Temp 100.9. P.T. did put splint on pt's Ⓡ wrist & forearm. pt. is eating. pt was in pain and was given 4mg of MSO4. [(b)(6)-2] 91WLPN
1655.	pt was running a fever at 100.9. will monitor for changes. [(b)(6)-2] 91WLPN
1700.	pt voided. 400 mL of dk Brownish colored urine it was dumped out of foley bag. [(b)(6)-2] 91WLPN
1716.	pt feeling nauseated will monitor and give phenergan if needed [(b)(6)-2] 91WLPN
2200	pt recieved ancef at 2240 [(b)(6)-2] 91WLPN
2340	Assumed pt care @ 2245hrs. Pt has D5½NS c 20K @ 125 to LFA PIV. IV site shows ∅ signs of infiltration. Pt has on c-spine collar. Pt has bilateral AFO footies. Good circulation to Blat LE. Pt drsg to suprapubic area C/D/I. Pt has foley to gravity draining dark amber urine. Pt has splint c ace to Ⓡ arm. ⊕BS, x4, Lungs CTA. VS – 98.9, P-85, 125/68, 97% RA, R-20. Will continue to monitor pt throughout shift. [(b)(6)-2]

FPI LEX Printed on Recycled Paper

(b)(6)-4

MEDCOM - 4443 [illegible]99) BACK

MEDICAL RECORD	PROGRESS NOTES

DATE	
6 May 03 0745	Pt A&O x3, Lungs CTA, (+) BS, Abd, soft, tender, (+) pedal pulses. Pt c/o of pain given 4mg morphine per IV per RN. (b)(6)-2
6 May 03 0800	V/S 122/72, 100, 20, 99.0, Sat 99% on RA
6 May 03 1300	T - 99.5
6 May 1430	Pt resting in bed Ø Changes, will continue to monitor for changes. (b)(6)-2 LPR
6 May	Pt incontinent of Feces, loose, brownish color, Pt cleaned up, will continue to monitor pt for changes (b)(6)-2
6 May 03 2300	T 100' P 125 R 16 BP 118/70 SpO2 97%
Foley 1200cc	Assumed pt care @ 2245 hrs. Pt has foley to gravity draining sufficient amounts of yellow urine. Pt has AFO boots to bilateral feet. Pt has drsg to suprapubic area C/D/I. Pt has C-collar on w/out any complaints. (R) arm drsg C/D/I. Pt has IV to (L) FA, D5 1/2 NS c 20 KCl infusing @ 125cc/hr. Pt verbalized pain to bilateral LE. 50mcg Fentanyl administered. Will continue to reassess pain status and patient throughout shift. (b)(6)-2 1LT AN
	(+) BS x4, lungs CTA.

(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.
(b)(6)-4		

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

MEDCOM - 4444

ACLU-RDI 1244 p.266

DOD 010923

PROGRESS NOTES

DATE	
6 May 03 2200	LATE ENTRY: Slept most of shift in bed. Δ'd medicated x2 for pain & x1 for nausea, Husband attentive @ bedside. Splint in place on (R) hand. Neuro V's WNL. ∅ significant Δ's in status. (b)(6)-2
7 May/0530	800cc's of blood tinged urine drained from foley. (b)(6)-2
7 MAY/0900	O.T. NOTE: Pt seen initially 4 MAY 03 for edema and (-) ROM of the (R) UE and digits. Today she was provided with retrograde massaging to reduce swelling, ROM to the digits and wrist, and coban wrapping of digits and wrist. Splint is in place and keeps hand/wrist in a functional position. Staff instructed on keeping the hand elevated to assist w edema control. Will re-check splint 8 MAY 03. (b)(6)-2 SFC, COTA
7 May 03 0935	4mg MSO4 IVP pain (b)(6)-2 [illegible]
1220	4mg MSO4 IVP pain (b)(6)-2 [illegible]
7 May 03 0900	VS 122/80 - 80, 20, 98.5, Sat 99% on RA, A&O x3, (+) BS, ↑ pain, pt given pain medication per Dr's order, see medication sheet. (b)(6)-2
2355	Assumed pt care @ 2245 hrs. Pt has splint c̄ ace band to (R) arm. Pt has AFO footies to bilateral LE. Suprapubic drsg C/D/I. Pt has 20g to (L) FA c̄ D5½NS c̄ 20 KCl @ 125cc/hr.

(b)(6)-4

☆U.S. GPO: 1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4445

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
	Pt lungs CTA. (+)BS x4. Pt has foley draining to gravity. Pt medicated ē 4mg IV Morphine @ 2350 hrs prn pain. Will continue to monitor pt throughout shift. (b)(6)-2
8 May / 0000	VS - 98', 110/68, 97% RA, P 85, R 18. (b)(6)-2
0100	Pt sitting up in bed dryheaving c/o nausea and pain. 50mg Fetanyl, 4mg IV Zofran administered. Will continue to access pt throughout shift. (b)(6)-2
8 May 0830	Pt asleep in bed ē eyes close, no discomfort noted, will continue to monitor pt for any changes. (b)(6)-2
8 May 1150	Emptied 900ml of dark amber urine.
8 May 1200	Pt A+O X3, Lungs CTA, (+) BS x4, (+) Pedal Pulse, VS - T 99.5, 80, 20, 98% on RA, pt assisted ē am care. (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)*

(b)(6)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 4446

(THIS FORM IS SUBJECT TO THE PRIVACY AC[illegible] 974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[illegible]

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
0920	0920	1035	4 MAY 03
TOTS	SURG START	DRESSING	OR NO
0925	0945	1025	2L

OPERATION PERFORMED: Suprapubic Cath Placement

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

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [x] NPO SINCE MN
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Valium	5mg	IV	

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [ ] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

AGENTS

Agent	O2 30	1000		30		TOTAL
Robinul	.3					.3mg
Valium	5mg					5mg
Ketamine mg	100-50		50			200
MSO4	5	5				10mg
Esmolol		10				10mg
Fentanyl		50	50	50		150mg
N2O L/min						
O2 L/min	FM 4	4	4	4	RA	

FLUIDS

Urine

EBL

MONITORS

EKG	ST	ST	ST	ST	ST
% O2 Inspired	7.21	7.21	7.21	7.21	7.21
O2 Saturation	100	100	100	100	100
End Tidal CO2					
Temperature					
PNS					

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 2L & EQUIP. CHECKED
- [x] NON-INV. B/P
- [x] CONT. EKG
- [ ] ESOPH. STETH.
- [x] PULSE OXIMETER
- [ ] END TIDAL CO2
- [x] TEMPERATURE Axil
- [ ] WARMING BLANKET
- [ ] AIRWAY HUMIDIFIER
- [ ] N/G TUBE
- [x] IV(s) 20g R WRIST
- [ ] PNS
- [ ] V LEAD EKG
- [ ] PRECORD STETH.
- [ ] O2 ANALYZER
- [ ] MASS SPEC.
- [ ] FLUID WARMER
- [ ] O/G TUBE
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL
- [ ] REGIONAL
- [x] LOCAL / MAC
- [ ] NERVE BLOCK
- [ ] TIVA

INDUCTION

- [ ] PREOXYGENATION
- [ ] RAPID SEQUENCE
- [ ] INTRAVENOUS
- [ ] INHALATION
- [ ] INTRAMUSCULAR
- [ ] RECTAL

AIRWAY MANAGEMENT

- [ ] INTUBATION [ ] ORAL [ ] NASAL
- [ ] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [ ] STYLET USED
- [ ] ATTEMPTS x ___ [ ] BLADE ___
- [ ] ETT SIZE ___ [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [ ] CUFFED ___ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [ ] ETT SECURED AT ___ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE
- NATURAL

TIME / VITAL SIGNS

PRE-OP VALUES

- B/P: 140/91
- P: 130
- R: 16
- SAT: 94
- H/H:

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

RESP

Tidal Volume

Resp Rate

Peak Pressure

Symbols for Remarks: SV SV SV SV SV

Position: Supine

SYMBOLS: X ANESTH; ⊙ OPERAT; ∨ ∧ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS R; ASSISTED RESP; CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID F; E BLOOD

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

Tourniquet Time:

RECOVERY

TIME IN PACU	CONDITION
1030	Stable

B/P	PULSE	RESP	02 SAT
113/81	127	16	97

REMARKS

TEMP 98

REPORT TO: McKeown

PARRS:

FLUIDS TOTALS

IN	OUT
Crystalloid: LR - 1000 cc	EBL 100
	Urine 100
	Gastric 0
Blood	

(b)(6)-2

MAJ/CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 2

MEDCOM - 4447

Iraqi National ... ?

NAME:

SURGEON: (b)(6)-2

Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE: 25 | M F (F circled) | HEIGHT | WEIGHT

PROPOSED OPERATION: Suprapubic cath

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

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 (circled), 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 (b)(6)-2 ... DATE 4 MAY 03

PHYSICIAN ______ DATE ______

POST ANESTHESIA VISITS

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

DATE: ______

SIGNED: ______ TIME: ______

ACLU-RDI 1244 p.270

DOD 010927

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: ______ litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 100 cc/hr, bolus ________ cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 20 mg		
4	DEMEROL: 50 mg IV q 5-10 minutes PRN pain. MAX dose of 100 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 _______ or greater		
9	Call Anesthesia for any questions or concerns		
	Fentanyl 50 mcg IV prn pain MAX dose 200 mcg		
	(b)(6)-2		
	SIG		
	MAJ/CRNA		

PATIENT IDENTIFICATION

(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: (b)(6)(4)

DATE OF ORDER: 2 MAY 03 TIME OF ORDER: 2305 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICW #3 - Gen Surg (b)(6)-2
2. S/P GSW (R) neck, carotid dissection, CVA
3. Stable
4. VS per routine
5. NKDA
6. Regular Diet / Sustacal TID c̄ meals
7. IV → heplock
8. C-collar @ all times, may sit up
9. Foley → gravity
10. Have PT see patient in AM for ROM / strength evaluation c̄ daily care
11. Vicodin i PO q 4-6° PRN pain
12. Colace 100 mg PO TID
13. Coumadin 2.5 mg PO QD
14. Tegretol 300 mg PO TID
15. Elavil 75 mg PO qhs
16. MSO4 2-4 mg IV q 1-2° PRN severe pain
17. Phenergan 25 mg IM/PO q 6° PRN nausea
18. Benadryl 25 mg IM/IV q 8° PRN pruritis
19. Dulcolax supp i PR PRN for BM
20. Fleets enema i PR q 3-4 days PRN for no BM
21. Notify MD for T>101.5 P>120 <60 SBP>170 <100 sats < 93%
22. AFO splints (B) LE

(b)(6)-2 MD

(b)(6)-2 MAJ, MC

[Margin:] Noted (b)(6)-2 MAJ 2 MAY 03 2350

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: 1994--363-710

MEDCOM - 4450

MSO4 @ 2230 4mg

MEDCOM - 4451

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1052 TIME OF ORDER: 03May03 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

1) NPO at midnight
2) @ midnight LR @ 125 cc/h
3) Levoflox 500mg po q24
4) Reglan 10mg po tid.

SSS (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1235 TIME OF ORDER: 3 MAY 03 HOURS

1) Fentanyl 50mcg IV prn breakthrough pain; may repeat if RR>10, max dose 150mcg in 2hrs
2) Zofran 4mg IV prn N/V; may repeat x1 max dose 8mg in 12hrs.

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 04May03 TIME OF ORDER: 1010 HOURS

1) Post op S/p S-P catheter
 - resume pre-op orders.
2) Levoflox 500mg po QD for 2 days
3) D5 1/2NS c 20KCl @ 125cc/h

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 04May03 TIME OF ORDER: 1030 HOURS

1) Advance diet as tol.

(b)(6)-2

Noted 4 May 03 1330 (b)(6)-2

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

MEDCOM - 4452

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 DOWN.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5 MAY 03 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Δ Levo Flox to Levofloxacin 500 mg PO QD – stop on 11 MAY 03
2) on 6 MAY 03 – change foley catheter.
3) change dressing on SP tube site QD
4) Can D/C to red crescent / red cross when able

(b)(6)-2

(b)(6)-2

Noted 5 May 03 1400

06 May 03 / 0130 hrs 24° chart check done (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

– 24° chart check done 7 May 03 0600 – (b)(6)-2

DATE OF ORDER TIME OF ORDER

– 24° chart check done 8 May 03 / 0000

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 MAY 03 TIME OF ORDER 0830 HOURS

(1) Transfer to 28th CSH
- See Transfer Summary from USS Comfort

(b)(6)-2

0840 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4453

ACLU-RDI 1244 p.275

DOD 010932

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. 05 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8
2May03	(b)(6)-2	Vital Signs per routine	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
2May03	(b)(6)-2	Diet Regular c̄ Sustacal	D	(b)(6)-2						
		TID c̄ Meals	E	(b)(6)-2						
			N							
2May03	(b)(6)-2	Heploc IV	D	/	(b)(6)-2					
			E	/						
			N	(b)(6)-2						
2May03	(b)(6)-2	C-Collar at All Times	D	/	(b)(6)-2					
		(may sit up)	E	/						
			N	(b)(6)-2						
2May03	(b)(6)-2	Foley To Gravity	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
2May03	(b)(6)-2	MD Notification: Temp > 101.5	D	/	(b)(6)-2					
		Pulse > 120 < 60 O2Sat < 93%	E	/	(b)(6)-2					
		SBP > 170 < 100	N	(b)(6)-2						
		AFO Splints (B) LE	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
				/						
4May03	(b)(6)-2	Advance diet as tol.	D	/	/	(b)(6)-2				
			E	/	/	(b)(6)-2				
			N	/	/		(b)(6)-2			
5May03	(b)(6)-2	Change dressing on SP Tube site Q.D.	1600	/	/	/				

ALLERGIES ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) Neck, Carotid Dissection, CVA

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

MEDCOM - 4454

ACLU-RDI 1244 p.276

DOD 010933

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	Mo		Yr	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2May03	(b)(6)-2	Admit FCW #3 General Surgery / (b)(6)-2	Now	Now	2315	(b)(6)-2
2May03		DX: s/p GSW (R) Neck, Carotid Dissection, CVA	Now	Now	2315	
2May03		Condition: Stable	Now	Now	2315	
2May03		Have PT see patient in AM for ROM/	3May03	AM	done	
2May03		Strength evaluation and Daily Care	3May03	AM	done	
3May03		NPO at MIDNIGHT (PLAN	4MAY03	0001	done	
		SUPRAPUBIC CATHETER INSERTION)	~~3MAY03~~	NOW	done	
4 May	(b)(6)-2	Post op SP catheter, resume	4May03	ASAP	1330	
		previous orders.				
5 May	(b)(6)-2	on 6 May 03 - Change Foley	6May03	ASAP	—	
		Catheter				
7May03	(b)(6)-2	Can D/C to red crescent/	ASAP			
		red cross when able				
8 May	(b)(6)-2	Transfer to (b)(3)-1	8May	ASAP		
		See transfer summary from				
		(b)(6)-4				

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

USAPA V1

MEDCOM - 4455

~~ACLU-RDI 1244 p.277~~

DOD 010934

CL... CAL RECOR... | TH...APEUTIC DOCUMENTATION ... PLAN ... EDICATIONS)

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

VERIFY BY INITIALING

Mo. 05 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				2 3 4 5 6 7 8
2 May 03	(b)(6)-2	Colace 100mg PO TID	08	(b)(6)-2
			16	
			23	
2 May 03	(b)(6)-2	Coumadin 2.5mg PO QD	09	(b)(6)-2
2 May 03		Tegretol 200mg PO TID	07	
			14	
2 May 03	(b)(6)-2	Elavil 75mg PO q HS	22	(b)(6)-2
			22	
3 MAY 03		REGLAN 10mg PO TID	06	(b)(6)-2
			14	(b)(6)-2
			22	
3 MAY 03	(b)(6)-2	LEVOFLOX 500mg PO q HS	22	(b)(6)-2 D/C 4 May 03 New Order
3 May 03	(b)(6)-2	LR @ 125 cc/hr when NPO	07 15 23 23	(b)(6)-2 D/C 4 May 03 New Order
4 May 03	(b)(6)-2	Levofloxin 500mg PO QD x 2 days	22	Δ 5 May 03
4 May 03		D5½ c̄ 20 KCL 1 liter @ 125 cc/h	07 15 15 23 23	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW (R) neck, Carotid Dissection, CVA

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4456

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. MAY 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
2May03	(b)(6)-2	Vicodin i PO Q 4-6° PRN Pain	10 03May; 2025; 0415; (b)(6)-2
2May03	(b)(6)-2	MSO4 2-4mg IV q 1-2° PRN Severe Pain	4mg 2255 2May; 4mg 0300 03May; 0835 2May; 4mg 1630 3May 740; 4mg 2200; 2200 4mg 03May; 2400 3May 4mg; 0100 4May 4mg; 0200 4mg; 0300 4mg; 4May 0715 4mg; 1305 4mg; 3 1015 4mg; (b)(6)-2
2May?	(b)(6)-2	Phenergan 25mg IM/PO Q6° PRN Nausea	3May 1100; 2May 2130; (b)(6)-2
2May03	(b)(6)-2	Benadryl 25mg IM/IV Q8° PRN Pruritis	2May 2330; 2May 2330; (b)(6)-2
2May03	(b)(6)-2	Dulcolax Supp i PR PRN - For BM	
2May03	(b)(6)-2	Fleets Enema i PR q 3-4 Days PRN For No BM	

MEDCOM - 4457

ACLU-RDI 1244 p.279

DOD 010936

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION (PLAN — MEDICATIONS)

For use of this form, see ...0-407; the proponent agency is the Office of the Surgeon General.

Mo. MAY Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11
5 May 03	(b)(6)-2	Δ Levoflox to	22	(b)(6)-2						
		Levofloxin 500mg								
		po QD stop on								
		11 May 03								

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓡ Neck, CVA, ~~[illegible]~~

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN

(MEDICATIONS)

Mo. MAY Yr. 03

Verify by Initialing: 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
3 May 03	(b)(6)-2	FENTANYL 50mcg IV PRN BREAKTHROUGH PAIN - MAY REPEAT IF RR>10 - MAX DOSE 150mcg IN 2 HRS	3 May 50mcg 1400; 3 May 50mcg 1445; 4 May 0330 50mcg; 4 May 1445 50; 4 May 1815; 4 May 50; 5/4/03 100mcg 2115; 5/4/03 50mcg 2245; 5/5/03 100mcg 0030; 5/5/03 50mcg 0100; 5/5/03 100mcg 0300; 5/5/03 50mcg 0340; 5/5 50mcg 0520; 5/6 not given 0500
3 May 03	(b)(6)-2	ZOFRAN 4mg IV PRN N/V MAY REPEAT x1 MAX DOSE 8mg IN 12hrs.	3 May 4mg 1335; 3 May 4mg 2030; 4 May 4mg 0600; 4 May 4mg 2244; 5 May 4mg 1725; 6 May 4mg 1745; 7 May 1442 50mcg; 7 May 1446 4mg; 7 May 4mg 2125; 8 May 4mg 0100
4 May 03	(b)(6)-2	MSO4 2-4mg IV q1-2° PRN Severe pain (transcribed from previous order)	5 May 0330 4mg; 5 May 0400 4mg; 5 May 1225 4mg; 5 May 1600 4mg; 5 May 4mg 1640; 6 May 2105 4mg; 6 May 2240; 6 May 0730 4mg; 6 May 1600 4mg; 6 May 1915; 6 May 2330; 7 May 0130 4mg; 7 May 0600 4mg; 7 May 1500 4mg; 7 May 1830 IV 4mg
3 May	(b)(6)-2	Fentanyl 50mcg IV PRN breakthrough pain, may repeat if RR >10. max dose 150mcg in 2h	6 May 1310 50mcg; 6 May 1700 50mcg; 6 May 1800 50; 6 May 2330 50mcg; 7 May 1442 50mcg; 8 May 0100 50mcg; 8 May 1808 50mcg
7 MAY	(b)(6)-2	MSO4 2-4mg IV q 1-2° PRN SEVERE PAIN (transcribed from Above)	7 MAY 1930 4mg; 7 May 2040 4mg; 8 May 0400 4mg; 8 May 1330 4mg
7/May	(b)(6)-2	MSO4 2-4mg IV q1-2	7 May 2330 4mg

MEDCOM - 4459

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF 1 2 3 4 5 6 7 8 — 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 16 17 —

5. SEX 18: F

6. DATE OF BIRTH (Y Y Y Y M M D D) 19–26: 1985 0101

7. AGE AT ADMISSION 27 28 29: 18 Y

8. RACE 30: X I

9. ETHNIC BACKGROUND 31: 9

RELIGION

10. LENGTH OF SERVICE 32 33 34: —

ETS

11. FMP 35 36: 9 9

12. SOCIAL SECURITY NUMBER 37–45: (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS 46: 2

HOUR OF ADMISSION: 2008

BRANCH / CORPS

14. FLYING STATUS 47 48 49: —

15. BENEFICIARY CATEGORY 50 51 52: K 9 1 K78

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 65 66 67 68 69 70: —

19. TRAUMA 71: 9 INS

PREV. ADMISSION YEAR — NO

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

WARD: ICW3

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 73 74: 2 1

22. MTF TRANSFERRED TO 75–80: A 1 1 D 1

23. DATE OF DISPOSITION (Y Y M M D D) 81–86: 2003 Ø5 Ø8

24. CLINIC SVC - ADMITTING 87–90: A B A A

25. MTF TRANSFERRED FROM 91–96

26. DATE THIS ADMISSION (Y Y M M D D) 97–102: 2003 Ø5 Ø2

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

28. MTF OF INITIAL ADMISSION 105–110

29. DATE INITIAL ADMISSION (Y Y M M D D) 111–116

FOR LOCAL USE

DX: 8749 S/P GSW (R) neck, carotid dissection
95205
90001
9001
(4432)
04320
3LfcfCO
09639

TRAUMA 9 — COI 799

ADMITTING [...] (Signature, as req[...]) (b)(6)-2

PX: 5717
9763

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

DA [...]35, M[...] — EDITION OF MAY 79 IS [...]

MEDCOM - 4460

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

1 2 3 4 5 6 7 8

(b)(3)-1

ADMISSIO.. AND CODING INFORMATION

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

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

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

4. PAY GRADE: 16 17

5. SEX: 18 F

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 I

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: 2208

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 Direct

WARD: ICW3

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: 73 74

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

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 5 0 8

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 5 0 2

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

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

S/P GSW Ⓡ neck, carotid dissection

AD (b)(6)-2

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

EDITION OF MAY 79

MEDCOM - 4461

1.

[redacted]ENT TREATMENT RECORD COVE[redacted]

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

1. REGISTER NUMBER (b)(6)-4	2. (b)(6)-4	3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	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 1C01
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 Direct	22. HOURS OF ADMISSION 0005	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION Trans	26. DATE OF DISPOSITION 21 apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 11 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 L chest ~~E922.3~~

DX: 86130
8603
8911
7990
E9654

PPX: 5411
331
3404

Trauma 1

Injury 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
					10

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 MAJ, MC

SIGNATURE (b)(6)-2 R

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

MEDCOM - 4381

pre-op ws

DOCTOR'S ORDERS *(Date and sign all orders)*

Admit to ICU
Dx: S/P ex-lap, thoracotomy, chest tube x 2
Cond: Good c̄ chest tubes
Vitals q 4°
Activities - bed rest
Tx 2 units PRBC (Done)
IVF NS @ 125 cc/hr (Done)
Meds MSO4 10 mg IV q 2-3° PRN
Tylenol 650 mg po q 4° Temp ≥ 101
phenergan 25 mg IV q 6° PRN
Ancef 1 gm IV q 8° x 2 (Done)
NGT if emesis (Done)
CXR in a.m.
Albuterol Inhaler q 4°

(b)(6)-2

TEMPERATURE - PULSE - RESPIRATION

DATE AND TIME	T	P	R	STOOLS	WEIGHT	
0530	99.2	110	20	123/77	96% @ 6L	
						1 unit PRBC 2045 08 APR 03
						1 unit PRBC 2140 08 APR 03
						1gm Ancef IV [X] [X] [X]
						3mg MSO4 @ 0530
						1400 cc UOP

10 55820 10 55942

V1.00

MEDCOM - 4382

08-APR 03

VS 2300 130/73 22RR HR116 92% ON 6L

Patient received 2 units PRBC, CT #1 & #2 to LCS, T 99.4

received [illegible] Ancef IV, PA inserted subclavian line, patient

No other problems noted @ this time —— (b)(6)-2 [illegible]

MEDCOM - 4383

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
08Apr03	Brief Op Note
0915Z	Preop Dx: ① thoracoabdominal GSW
	② ⓛ hemothorax
	③ Acute Abdomen
	Postop Dx: ① Same
	② GSW to ⓛ lower lobe of lung & ⓛ hemothorax
	Procedure: Expl lap, exploratory thoracotomy
	Findings ① No intraperitoneal or retroperitoneal abdominal injury. Diaphragm intact
	② GSW to ⓛ lower lobe of lung c̄ round embedded in ⓛ lower lobe.
	Bullet not removed. Heart & mediastinal structures s̄ injury.
Surgeon	(b)(6)-2
	EBL: 200 cc
	Fluids: 3.5 l crystalloid, 1 unit of albumin.
	Specimens: ∅
	Complications: ∅
	Disposition: to RR stable. (b)(6)-2
	(b)(6)-2 MAJ, MC, USA General Surgeon (b)(3)-1

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

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

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

(b)(3)-1

MEDCOM - 4384

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

8 apr, 2003, 0920 Recover fm O.R. w/ CRNA & Surgeon, S/P Thoracotomy, CT in place, pt shivering, F/c w/ 1500 in bag, monitor w/ WRONG TIME!

wrong time is charted per monitor setting.

Time	HR	SAT	BP	RR	O2	Notes
0304	130	72	133/57			pt moving air well,
0310	115	80	135/67	35	6L MASK	but poor O2 saturation
0315	115	80	134/67	35	↓	per monitor, checked
0320	118	82	147/63	41		@ different sites eg.
0325	111	84	159/71	40		ear & fingers.
0330	100	88	154/70	28	←	40 mg Lasix given
0335	102	89%	143/70	26		Peripheral pulses weak,
0340	91	92%	150/69	24		cap refill <3 sec, pale skin.
0345	92	94%	142/71	21	↓3L	space blanket applied.
0350	92	94%	141/69	23	RA	IVF @ 40cc/° bilat.
0355	98	82%	120/60	21	↑5L	
0400	94	93%	133/66	21		
0405	98	94%	122/63	22		PER CRNA - Rec.d
0410	100	96%	126/64	22		3000 IVF &
0415	98	96%	128/65	26	↓3L	100 ALBUMIN w/
0420	100	95%	120/62	30	↓2L	1600 OUT VIA F/C & EBL
0430	↑ mg MSO4	94%	23			
0430	102	98%	125/63	22		0430 - PACU 400 FC
0445	109	97%	127/62	22	RA	
0500	115	90%	133/64	23	2L	2mg MSO4 IVP
0540	104	99%				1500 Out Via foley.

pupils +2 & reactive

IV sites (R) AC & Lt AC. patent 18 gauge.

RT LS CTA, w/ good air movement

Lt LS w/ WNO, diSQ

COI, CTube draining 10 cc so far,

as of 0430 "monitor time" = to 1030Z, pt not tolerating <3L N/C.

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES

Medical Record

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

MEDCOM - 4385

ACLU-RDI 1244 p.288

DOD 010864

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1/8/03	Male Iraqi brought to (b)(3)-1
2129	S/P E. lap + (L) thoracotomy c (L) chest
	tube. Pt presented hypotensive tachycardic
	tachypneic c ↓'d (L) BS. ABD. flat + soft
	c dry dressing. Pt improved c 2ND
	thoracostomy tube. Now he remains
	tachycardic + appears pale.
	Imp S/P E lap / thoracotomy, chest
	tube x 2. Critical.
	Plan ICU
	Pt to ICU ARBC
	O2 mask
	Mon for.
	CXR in a.m.
	(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.

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

MEDCOM - 4386

934th FST

DOCTOR'S ORDERS (*Date and sign all orders*)

2150 Midline dressing changed, healing well, chest tube draining to air seal with intermittent suction. Requires O_2 @ 6L sats at 96. Urine output QS, VSS. — (b)(6)-2 LPN

0330 - VSS, moaning sleeps [illegible] pain received 4mg MSO4 IV with good results sleeping quietly, O_2 >90% no other problems currently noted — (b)(6)-2 [illegible]

TEMPERATURE - PULSE - RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	~~STOOLS~~ BP	~~WEIGHT~~ SaO2	MEDICATION AND NURSE'S NOTES
09 9 APR 03 2130	99.2	101 / 101	26 / 21	126/73	98 / 5LPM	R Ancef [illegible] Last Dose
				131/70	96(5L)	1320 1000ml URINE OUTPUT
0600 10 APR 03	100.6	92	20	143/78	91@2L	U/O 07 - 900cc = 400cc ———— 2200
						600cc U/O
						MSO4 - 4mg 1700
						MSO4 - 4mg @ 2030
						MSO4 4mg 0350
						1200 cc U/O
						Inhaler. D/C to PRN by RN
						PT Respiratory status improved
10 APR	99.01	100	24	130/73	92/2L	— Albuterol q 4

USAPPC V1.00

MEDCOM - 4387

See next page 04

ACLU-RDI 1244 p.290

DOD 010866

MEDICAL RECORD	PROGRESS NOTES

DATE	
10 APRIL 03	General Surgery [illegible]
1600	3 y/o Iraqi Male EPW transferred from (b)(3)-1 after GSW Left chest 08 Apr 03. He was hypotensive w/ evolution to exp thoracotomy and laparotomy w/ neg. exp lap. Findings of injury to Left lower lobe not req. intervention.
	PMH/PSH ∅ NKDA
	Tubes: ① CT ×1 Lines: Left subclavian central
	Foley cath.
	CT – functioning; minimal output — CXR – lungs up – thoracotomy tube placed. No A/F level.
	Labs reviewed – H/H 8.1/25
	O: T-100.1 P-96 R-12 129/72
	① CT in place – Dsg intact
	Lungs – Shallow breaths. No crackles.
	Heart – RRR S (?)
	Abdomen – Dsg intact ↓BS, no guarding or rigidity.
	A: POD 2 Exp Thoracotomy / Laparotomy – Hemo Stable
	P: ① Agree w/ Plan
	② Would not pull CT as the pt will leave via air ambulance for 86th CSH soon. ③ Leave to [illegible] after CT change
	(b)(6)-2 (b)(6)-2 MAJ, MC GEN Surgeon

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

Start 1014 end 1155

MEDICAL RECORD — **INTRAOPE[RATIVE] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 08 Apr 03 TIME PATIENT ARRIVED IN SUITE 1000

4. PATIENT IN ROOM TIME 1000 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SSG (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: Pubic area & abdomen

PREP SOLUTION *(Specify)*
SITE: Nipple line to Mid thigh BY WHOM: SSG (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
		C = Correct I = Incorrect				
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☒ Yes ☐ No		C	C		
Other	☐ Yes ☐ No					

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

(b)(6)-4

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

☐ ESU NO: Valleylab REM Polyhesive II
GROUND PAD: BRAND
LOT NO: 55808

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLAC[ES DA] FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOL[ETE]

MEDCOM - 4389

ACLU-RDI 1244 p.292

DOD 010868

Start 1019 end 1155

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 08 Apr 03 TIME PATIENT ARRIVED IN SUITE 1000

4. PATIENT IN ROOM TIME 1001 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SSG (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: Pubic area & abdomen

PREP SOLUTION *(Specify)*

SITE: Nipple line to mid thigh BY WHOM: SSG (b)(6)-2

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☑ Yes ☐ No		C	C		
Other	☐ Yes ☐ No					

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

(b)(6)-4

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

☐ ESU NO: Valleylab REM Polyhesive II

GROUND PAD: BRAND

LOT NO: 55808

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES FORM 5179-1 (TEST), DEC 83 WHICH IS OBSOLETE

MEDCOM - 4390

13. PROSTHESIS, IMPLANTS ☐ YES ☐	IF YES NAME: ID NUMBER	UFACTURER

14. MEDICATIONS/ORDERS (b)(6)-2

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
NaCl	2		Irrigation		

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN (b)(6)-2 (b)(6)-2 MAJ, MC, USA

15. X-RAY YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐			
TYPE/SIZE	1. 32FR Thoracic Tube	2.	3.
SITE	1. (L)	2.	3.

19. ADDITIONAL INFORMATION

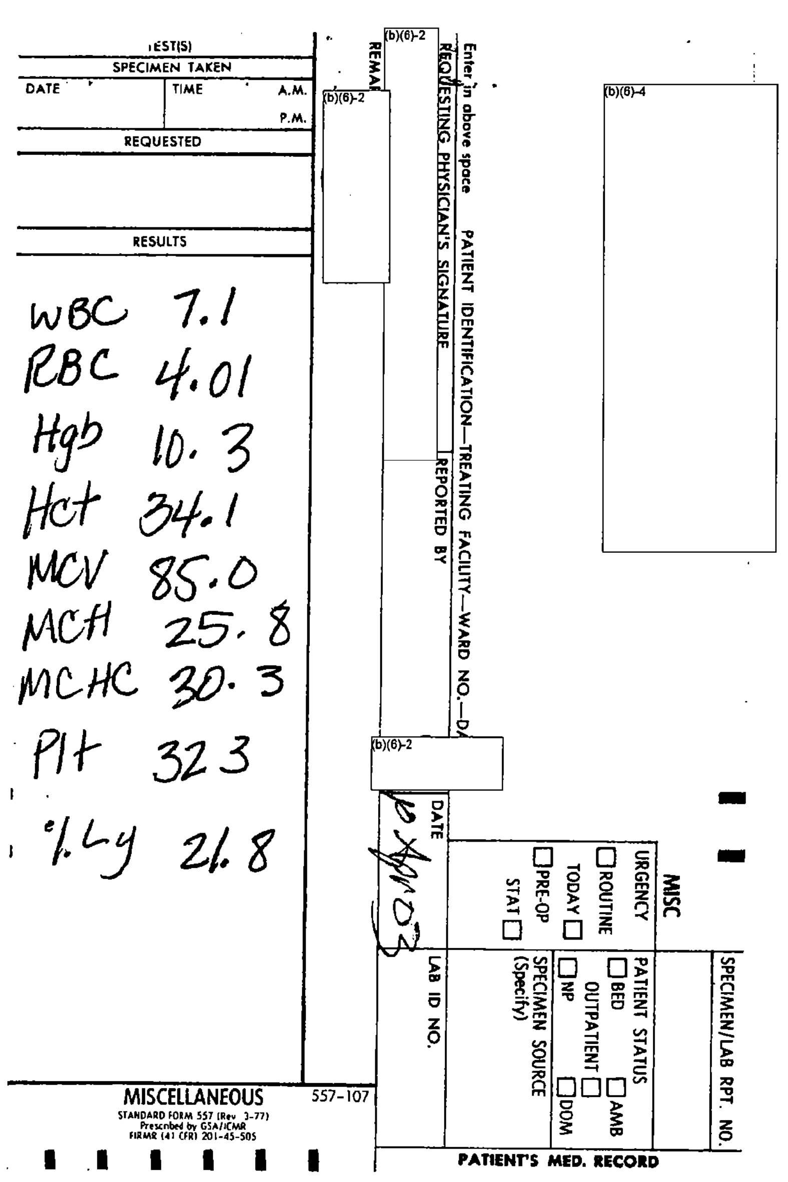
Exploratory laparotomy, exploratory (L) thoracotomy

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
Recovery	1200	litter

22. REGISTERED NURSE SIGNATURE

REVERSE OF DA FORM 5179-1, C MEDCOM - 4391 *U.S. GPO: 1996-404-613/40449



TEST(S)

SPECIMEN TAKEN

DATE | TIME | A.M. P.M.

REQUESTED

RESULTS

WBC 7.1
RBC 4.01
Hgb 10.3
Hct 34.1
MCV 85.0
MCH 25.8
MCHC 30.3
Plt 323
%Ly 21.8

MISCELLANEOUS

557-107

STANDARD FORM 557 (Rev 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

REMARKS

(b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

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

(b)(6)-4

DATE

(b)(6)-2

LAB ID NO.

MISC

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MEDCOM - 4392

ACLU-RDI 1244 p.295

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
08Apr	0310 RR		
	s/p expl lap, appl. @ thoracotomy		
0905	Condition: Fair		
	Vitals q1°	(b)(6)-2	
	IV q[illegible]	0930	
	Call for SBP < 90 RR > 30, SaO2 < 92%		
	O2 to keep SaO2 > 95%, UOP < 50cc/2°		
	Foley to gravity		(b)(6)-2 0930
	NGT to gravity		(b)(6)-2 0930
	[illegible] IVF NS @ 80 cc/h		
	MSO4 2-4 mg IV q2-3° prn pain		
	NPO		
	Logs to follow IV on arrival to RR.		(b)(6)-2 0930
	(b)(6)-2		

PATIENT IDENTIFICATION

(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) [illegible] 99 PREVIOUS EDITIONS ARE OBSOLETE

MC V1.00

DOCTOR'S ORDERS *(Date and sign all orders)*

TEMPERATURE - PULSE - RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	~~STOOLS~~ BP	~~WEIGHT~~ SaO_2	MEDICATION AND NURSE'S NOTES
10 APR 03	99.4	80	20	134/70	96% 2.5L NC	

USAPPC V1.00

MEDCOM - 4394

ACLU-RDI 1244 p.297

DOD 010873

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: 10 APR 03 — TIME OF ORDER: ______ HOURS — LIST TIME ORDER NOTED AND SIGN

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER ______ HOURS

13. PCXRAY q AM/QOD
14. IVF NS/ LR/ D5NS/ D51/2NS To run @100 cc/hr.
15. Ancef 1 GM IV Q 8 hrs
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs.
18. O2 titrate to keep SPO2 > 93%
19. Versed gtt 1-10mg/hr IV titrate to

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

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 2-4 MG IV q/2 HR PRN Pain
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.

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDE

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. 04 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11
10 Apr 03	------	IVF NS (LR) D5NS D5 1/2NS To run	07	/	(b)(6)-2
	------	@ 100 cc/hr	19	(b)(6)-2	
10 Apr 03	------	Ancef 1 GM IV q 8 HRs	06	/	
	------		14	/	
	------		22	(b)(6)-2	
	------	Gentamycin IV Q			

	------	Cefoxitin 2 gm IV q 8hrs			

	------				
10 Apr 03	------	02 titrate to keep SPO2 > 93%	07	/	(b)(6)-2
	------		19	(b)(6)-2	
	------	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: GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

(b)(6)-4

Treatment Facility: (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

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

MEDCOM - 4397

Verify by Initialing		THERA. EUTIC 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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
10 Apr 03	(b)(6)-2	Morphine Sulfate 2-4 mg IV q 1-4 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~~	

USAPA V1.00

MEDCOM - 4398

ACLU-RDI 1244 p.301

DOD 010877

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 10	11
10 Apr 03	......	Vital signs q hr / (q 2hr) / q6h4 / q8hr /	07	/	(b)(6)-2
	......	q shift	19	(b)(6)-2	
10 Apr 03	......	Cardiac Respiratory Monitoring	07	/	(b)(6)-2
	......		19	(b)(6)-2	
10 Apr 03	......	Diet: (NPO) / Regular / Soft / Clear	07	/	(b)(6)-2
	......	Liquid	19	(b)(6)-2	
10 Apr 03	......	Activity: Ad Lib / (Strict BR) / BR with	07	/	(b)(6)-2
	......	BSC / NWB R or L LE	19	(b)(6)-2	
10 Apr 03	......	(HOB up 30 Degrees)	07	/	(b)(6)-2
	......		19	(b)(6)-2	
10 Apr 03	......	Nursing I/O, (CDB) / NG to LIS / LCS	07	/	(b)(6)-2
	......		19	(b)(6)-2	
	......	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		
	......				
	......				
	......				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

Treatment Facility: (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

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

Verify by Initialing		THERAPEUTIC 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
	.....	Admit Patient to ICU				
	.....	Diagnosis: GSW Chest				
10	.....	Condition: (Stable) / Serious / Critical	10			(b)(6)-2
	.....	Allergies: NKDA				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

MEDCOM - 4400

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: 15	16	17	18	19	20	21
15 Apr	(b)(6)-2	Diet: Regular	B	/ (b)(6)-2						
			L	/						
			D							
15 Apr	(b)(6)-2	√ SaO2 q shift	07	/						
			15	/						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	Incentive Spirometer	07	/ (b)(6)-2						
			15	/						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	VS: q 4°	03	/						
			07	/ (b)(6)-2						
			11	/ (b)(6)-2						
			15	/						
			19	(b)(6)-2						
			23							
15 Apr	(b)(6)-2	Activity - up ad lib	07-19	(b)(6)-2						
			19-07							
17 APR 03	(b)(6)-2	AMBULATE	07-19	/ (b)(6)-2						
			19-07	/						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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. MEDCOM - 4401

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														
				11	12	13	14	15										
3-Apr 03	(b)(6)-2	LR @ 125 cc/hr HL	4	(b)(6)-2														
		WHEN TOLERATING PO FLUIDS	16	(b)(6)-2														
		Ancef 1gm IVPB	4	/	(b)(6)-2				DC'd									
		q 8°	12	/														
			20	(b)(6)-2														

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex lap / (L) thoracotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4402

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

Order 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													
11 Apr 03	(b)(6)-2	MSO4 1-2 mg IV q 1-2° prn pain	2 mg [illegible] 1030	2 mg [illegible] 1700	4/13 2 mg 2007	4/14 2 mg 1920										
			(b)(6)-2													

*U.S. GPO: 1996-454-110/95216

MEDCOM - 4403

ACLU-RDI 1244 p.306

DOD 010882

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)
EPW 1

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

DIAGNOSIS
DIAGNOSTIC
GSW (L) LUNG

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 BAGAGE: 218254

DESTINATION / DESTINATION: 212

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)
Chest tube to suction

SIGNATURE OF (b)(3)-1
SIGNATURE DU

DATE / DATE: 10 APR 03

REGULAR DIET / RÉGIME NORMAL

SPECIAL DIET (Describe) / RÉGIME SPÉCIAL (Description): NPO

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

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 / CATÉGORIE DE PERSONNEL
N/A	N/A	EPW

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT / DATE DÉPART
218254	10 APR Ø3

DESTINATION / DESTINATION	ARRIVAL DATE / DATE ARRIVÉE
(b)(3)-1	10 APR Ø3

EMBARKATION TAB – FICHE D'EMBARQUEMENT

MEDCOM - 4404

12. REASSESSMENT / REASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE			
TIME / HEURE				
BP / PS				
PULSE / POULS				
RESP / RESP				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

0830 Vitals unable
BP - 2° wounds
D-90
IV - unable to start 2° wounds
Ancef 1 gram 8:40

15. PROVIDER / OFFICIER: (b)(6)-2
DATE / DATE (YYMMDD): 030407

16. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- BAPTISM / BAPTISÉ
- ANOINTING / ONCTION
- CONFESSION / CONFESSION
- PRAYER / PRIÈRE
- COMMUNION / COMMUNION
- OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

---

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: IRAQ
RANK / GRADE
[X] MALE / HOMME
FEMALE / FEMME
SSN / NUMÉRO MATRICULE
SPECIALTY CODE / GPM
RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M
NATIONALITY / NATIONALITÉ
BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE
FRONT / DEVANT | BACK / ARRIÈRE
- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

multiple schrapnel wounds.

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
- [X] ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS: N
TIME / HEURE

6. TOURNIQUET / GARROT: [X] NO / NON | YES / OUI
TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON | [X] YES / OUI
DOSE / DOSE
TIME / HEURE: 7:45

8. IV / IV
TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRÉSENTE MEDICATION / ALLERGIES / ANTIDOTES

[crossed out]

10. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- [...]ÉDÉ

TIME / HEURE
DATE / DATE (YYMMDD)

(b)(6)-2

[...]ditions [...] 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 4405

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi POW transferred from (b)(3)-1 for further care. He underwent ex lap + thoracotomy 8 Apr ō GSW to LLL of lung c/b hemothorax, found left in LLL, CT x2 placed, ⊖ ex-lap. He also has shrapnel wound to Ⓛ ankle. Has been stable.

PHYSICAL EXAMINATION VS T 100.1 P 100 BP 136/46 O2SAT 91-93% on 2LPM NC

Gen: Iraqi EPW in no acute distress
ENT: PERRLA
Neck: supple
Lungs: BS equal bilaterally, Ⓛ SCV line
Cor: regular, ⊘ m/r/gallop
Abd: soft ⊖ BS ē guarding 6U- Foley in place
Ext: shrapnel wound Ⓛ ankle

104 | 4 | 97 ; 4.3 | 24 | 1.0
11.7 > 8.1 / 25 < 182
Alb 3.0
AST 63
ALT

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

A/P 1) S/P GSW Ⓛ thorax c/b hemothorax; CT placed; ⊖ ex lap
pain control, pulm toilet, IVF
2) evac to (b)(3)-1

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	10 Apr		

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

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 4406

ICAL RECORD - SUPLEMENTAL MI ... DATA

r use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon Gene...

OTSG APROVED (Date)

EPORT TITLE

TRAUMA FLOWSHEET

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: 11 Apr 03 Arrival Time: 0550 Sex: (M) F Age: ______ Wt: ______

llergies: NKDA Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint: GSW chest

MH: Medications:

reatments PTA:

ITAL SIGNS: BP: 131/73 P: 88 RR: 20 TEMP: SAO2: 89

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: # DPL ☐ POS ☐ NEG
HEST TUBE ☐ R ☐ L CM H20

R L L R
FRONT BACK

A - Abrasion
AP - Amputat
AV - Avulsion
B - Burn
C - Contusion
D - Deformity
E - Evisceration
OF - Open Fr
CF - Closed F
G - GSW
L - Laceration
PW - Puncture
S - Stab Wound
O - Other

(Continue on ...

REPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC 399th CSH | DATE

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

(b)(6)-4

(b)(3)-1

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

MEDCOM - 4407

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11APR03	Gen Surg Admit
	~35 y/o Iraqi ♀ s/p GSW (L) chest s/p (-) Ex lap /
	(L) thoracotomy for LLL lung injury @ FST on
	8 APR 03 HD stable c̄ (L) CT. ϕ other injuries
	PE: P89 BP 131/78 RR 20 sats 89% (RA)
	A&O, GCS 15
	HEENT - wnl
	neck - supple
	CV - RRR ϕ rubs
	lungs - ↓BS (L), CTA (R) (L) CT ϕ leak min output
	abdom - soft, ND, clean midline wound, appropriate
	TTP, ⊕BS
	GU - Foley intact
	Rectal ϕ blood
	Ext - ϕc/c/e, (L) ankle cutdown site c/d/open c̄
	granulation
	Neuro - nonfocal
	A/P: s/p GSW (L) chest s/p (-) Ex lap / (L) thoracotomy
	- Admit ward - Ancef - Foley
	- CT to suction - pulm toilet

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR
		(b)(6)-2 ...surg

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. (b)(6)-2

WARD NO. MAJ, MC

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4408

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Apr 03 1335	Pt arrived from EMT. A&O x3. Breathing s̄ any diff on room air. Has chest tube to (L) side on low cont suc. bulky drsg to (L) chest wall dry & intact. Small drsg to (L) ankle dry & intact. IV started to (R) arm. Has LR running @ 125/hr. DC'd cordis per Dr order. Has foley drng clear yellow urine.
	(b)(6)-2 SSG 91WM6 30
11 Apr 1650	Pt. s/s Ex Lap c̄ staples C/D/I. has (L) thoracotomy c̄ CT to suction VSS. Pt alert x3. Minimal c/o pain. On prn. Receiving Antibiotics IV. Will cont to monitor. (b)(6)-2
12APR03	PT AOX3. COMPLETE BED BATH GIVEN. ORAL CARE PROVIDED. PT TOLERATE WELL VSS. PERRL. NEURO INTACT. LUNGS CLEAR IN ALL (R) LOBES DIMINISHED IN (L) BASES, LL. CARDIAC RRR. SATS ≥95% ON RA. ACTIVE BS IN ALL 4 QUADS NON DISTENDED NONTENDER ABD. MIDLINE STAPLES INTACT. IODINE APPLIED TO STAPLES. (L) CHEST TUBE IN PLACE AND DRAINING SANGUINOUS FLUID TO 20cm SUCTION. CXR COMPLETED. PT DENIES CHEST PAIN AND SOB. FOLEY TO GRAVITY DRAINING CYU QS. 600cc OUT @ 0600. (L) ABOVE THE ANKLE SHRAPNEL WOUND CLEANED AND W/D DRSNG APPLIED (2cm x 2cm). PT TOLERATED 12OZ OF WATER WELL AND PROGRESSED TO 6 BISQUET CRACKERS. NO C/O N/V. WILL CONT ABX TX AND TO MONITOR THE PT. (b)(6)-2
	1330 D/C Foley to gravity 1100cc OUT THIS SHIFT (b)(6)-2
	1340 POST FOLEY VOID / INCONT x1 (b)(6)-2

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

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

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

MEDCOM - 4409

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12APR03	1700 - CHEST TUBE (L) CHEST TO WATER SEAL - DRESSING DRY AND INTACT,
	SMALL DRESSING LOWER (L) EXTREMITY - DRY AND INTACT, IV - LR @
	125cc/HR INFUSING IN (R) FOREARM, LUNGS CLEAR (R) LOBES - DIMINISHED (L)
	LOWER LOBES, MIDLINE AND STAPLES INTACT, BOWEL SOUNDS PRESENT IN ALL
	QUADRANTS. SGT (b)(6)-2 - 91WM6 2230 - PT. VOIDED 300cc URINE
	SGT (b)(6)-2 91WM6 Ø330 - PT. VOIDED 350cc (L) CT Ø OUTPUT.
	SGT (b)(6)-2 - 91WM6
	@0634z pt had 2 oz of urine output SPC (b)(6)-2 91W10 (b)(6)-2
13Apr03	Nutrition - Patient w/ chest tube s/p GSW to chest s/p Ex Lap. Patient
1008z	now on leg Diet. Consuming crackers, poptart, tang, Jello.
	Patient needs more protein for wound healing. Will
	Arrange shakes & Ensure. Will follow tolerances
	(b)(6)-2 MAJ [illegible] RD
1830 Z	Report received - pt resting in bed [illegible] complaints, lungs [illegible] ETA noted
	BS + x4 quads. CT - (L) chest intact, Drsgs D+I, [illegible] → [illegible] H2O seal
	pt voided 300 c u/r, mid Abd incision noted c staples intact edges well
	approximated. IV infusing well in (R) FA s s/s infiltration or infection. Drsg to
	(L) LE D+I. MAEW x4 cleared [illegible] 3+ x4 - (b)(6)-2 91WM6 [illegible]
0300 Z	Pt resting comfortably in bed CT → (L) chest intact - Drsg D+I - CT Drained 160 cc
	Serous drainage. CXR done - Pt voided 1000 cc urine [illegible] slips - IV infusing
	well s s/s infiltration or infection - assessment remains unremarkable - (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4410

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0945 14APR03	Patient had chest tube removed c 0830. X-ray completed c results pending. Lung sounds CTA, Sating 94-96% on RA. NSR c HR 80's, BP 120's/70's c good cap refill. Pt alert, PERL 2-3mm. Hypoactive BS x 4 quads c no BM @ this time. Patient resting @ this time. Will continue to monitor. (b)(6)-2 — 1LT, AN
15APR03	Ø300 - PT. VOIDED X 1 BP 115/74 P 105 R 18 T 99.2 POX 93% ON RA. SGT (b)(6)-2 91WM6
4-15-03	Tol reg diet, pen, lungs CTA, (b)(6)-2
15Apr03 0638	97.7 79% RA eve - deep breaths - breathing shallow HR 120 R 40 98/58
0640Z	pt received - assessment completed - pt denying Ø major distress but O2 Sat @ 75% - RR 32 - lungs sounds are clear in (R) lobes and crackles to all (L) lobes - no relief - pt put on O2 face mask (non-rebreather) O2 Sat ↑ to 88% on 6L - pt O2 ↑ to 8L O2 Sat ↑ 90% - pt (L) flank tender to touch - dressing CDI - pt has wound to (L) scapula area - midline abdominal incision c staples CDI - bowel sounds hypoactive - pt requested to sleep - HOB in semi fowlers - (b)(6)-2
4/15/02 1535	Patient c tachypnea and DESATS to 73% RA RR - 32-40 lungs ↓ BS (L) base otherwise clear P - 122 CV - TACHY Ø (m) ... - Ø swelling Ø clonus / Evidence of DVT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
A / TACHYPNEA	/ DESATS		

SPONSOR'S NAME	SSN/ID NO.	RELATION TO SPONSOR
Consider (PE / PNEU		mottled ... / Retained hemothorax

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.

Pneumonia / Effusion

P) ① Lovenox 100mg SQ now
② CXR (PA/LAT)
③ FIO2 to keep SaO2 > 90%
④ Transfer to 86 CSH ✓

CHRONOLOGICAL RECORD OF [MEDICAL CARE]
Medical Reco[rd]

STANDARD FORM 600
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-
(b)(6)-2

MEDCOM - 4411

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21APR03 1023	Pt given discharge teaching for dressing change and I.S. Pt discharge to SGT (b)(6)-2 c̄ 320TH MP CO at 1025. — (b)(6)-2 CPT AN

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

MEDCOM - 4412

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1627	Admit Note: (b)(6)-4
15 April	2003
	S/P laparotomy, chest tube
	transferred to minimal area today
	RA S_aO_2 71% RR 30-40
	returned to EMT area for evaluation
	GCS 15
	Chest ↓ BS (R) base
	(L) sided chest tube dressing
	Abdomen soft, healing incision
	no pedal edema
	CXR - some ↑ fluid (L) base
	IMP: hypoxia
	- doubt PE
	- no evidence pneumonia
	- some [illegible] volume loss
	PLAN: Supplemental O2 (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.

(b)(6)-4

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

MEDCOM - 4413

DATE	NOTES
16 APR 03	Pt A&O x3. VS 100.5 107 20 116/74 O2 SAT 92% 5L NC.
2100	Resting in bed s̄ c/o pain or discomfort. IV HL to (R) FA
	flushing well s̄ s/s infection/infiltration. Instructed on
	use of IS. verbalized/demonstrated understanding. (b)(6)-2
	——— (b)(6)-2
17 APR 03 0750	Pt VS P 99 SPO2 93 T 99.0 BP 117/68 SPC [illegible]
17APR03 1123	Pt VS SPO2 93% ON ROOM AIR, P105, RR20, BP 110/70. CV: RRR,
	TEMP 100.3, CAP REFILL <5 SECONDS, Pt A&O x3 (+) BS THROUGHOUT,
	MIDLINE STAPLES INTACT, AND STAPLES ON (L) MIDDLE
	CHEST INTACT, s̄ DRAINAGE. Pt ambulated for 10 MIN and O2 SP 92%
	ON ROOM AIR. (b)(6)-2 [illegible]
16:18	VS BP 122/74, SPO2 93 [illegible] 18 T 98.7
17APR03 1843	Pt SPO2 is 92% on room air and VSS. Pt c̄ 1 BM AND 1 [illegible];
	OOB TO bathroom. Pt midline and (L) staple sites open to air.
	CXR completed this AM. Pt A&O x3 and s̄ c/o and ate all
	3 meals s̄ c/o (95%). PT AMBULATED TO CXR PROCEDURE [illegible]
17 APR 03	Pt A&O x 3. VSS. uneventful night. O2 Sats 91-92% RA
0630	Abd inc. well approx healing well. Lat inc open to
	air healing well. c/o neck discomfort. medicated c̄
	Tylenol 650 mg PO. c̄ good results. slept thru night.
	continue to monitor ——— (b)(6)-2
18 Apr. 03	B/P - 120/78 P - 90 R - 16 Temp - 99.3 O2 S - 97
1125	— SPC (b)(6)-2 9/W
18 Apr. 03	1430 B/P - 116/56 P - 99 R - 16 O2 S - 96 Temp. 98.9
18APR03 1635	Pt A&O x3 given ii TYLENOL for non specific neck pain, patient expressed relief in 30 min p̄ medication given. Pt O2 SP 96-97% ON ROOM AIR. Pt c̄
	wound (L) UPPER BACK 1/2 X 3/4 IN PINK c̄ DRESSING CHANGE AND BACITRACIN.
	Pt c̄ WOUND (L) LOWER LEG c̄ OLD BLOOD; CHG DRESSING c̄ BACITRACIN [illegible] (b)(6)-2

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4414

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15 APR 03 2200	Pt Rcvd in ward. A&O x3. VS 99.8 111 20 122/79 97% on O2 10L NRB mask. Δ'd to NC @ 6L sats Holding @ 94-95%. Abd Inc well approx healing well. IV HL to Ⓡ FA ṡ s/s of infection/infiltration flushing well. ø c/o pain/discomfort @ this time. continue to monitor (b)(6)-2 [illegible] LPN
16APR03 1115	Pt received A&OX3. He speaks limited English and responds well to commands. Pt has a midline ABD INC c̄ staples that is s̄ drainage and healing well. IV HL Ⓡ FA s̄ S/S of infection (C,C,Firm, dry, and flushed well). Pt c̄ a wound on his upper Ⓛ back. The wound is the size of two ~~quarter~~ quarters approx. The wound is without drainage and DR. (b)(6)-2 is aware of the patient's wound. Pt BP 130/85, P98, RR 27, T 99.2, and SpO2 94% c̄ 6L of O2 via NC. Pt able to bathe at bed side and wash his face (brush his teeth). Pt has an order to D/C anef, but the is no order to start it. (b)(6)-2 CPT AN
16APR03 1810	Pt is A&OX3; OOB to void c̄ BM X1. Pt BP 110/70, HR 98, Temp 100.2, RR 24, and SpO2 92% c̄ 6L of O2. Pt s̄ c/o of pain. Pt c̄ is Voldyne 5000 at the bed side. (b)(6)-2 CPT AN

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4415

(b)(6)-4

ICW 1

DATE	NOTES
19 Apr 03	pt (b)(6)-4 – T 99.8° P 94 R 20 BP 112/74 O2SAT 98% RA
	pt A/O x3, LS clear encourage I.S. 10x hr while awake.
	BS x4, UOP dark clear urine. (L) ankle & back ulcers
	c̄ Bacitracin & redressed. midline incisional wound
	& (L) flank staples intact ø s/s infection noted, ø
	dihiscence noted. pt has ø IV site, (R) arm old IV
	site c̄ hardened quarter size area ø redness or
	infection noted (IV D/C'd 19 Apr 03). pt has minimal
	c/o pain, rested well throughout night and did
	not require pain meds. Continue to monitor. (b)(6)-2 CPT/AN
	pt did not ambulate this shift. (b)(6)-2 CPT/AN
20 Apr. 03	B/P 134/66 P-99 R-20 T-98.9 O2S-98-SPC (b)(6)-2 9/W
20 APR 03	Pt is A&O x3 and given 2 TYLENOLS FOR HA pt verbalized
	relief within 30 MIN. Pt (L) BACK AND (L) LEG (LOWER) DRESSINGS
	CHANGED BOTH c̄ PINK MEAT (FLESH) and old red blood
	on old ~~dressin~~ dressings. Pt educated on dressing changes for
	his leg and back and demonstrates correctly how to CHANGE
	the dressing for his leg. Pt is aware of pending dis-
	charge to EPW CAMP OR HOME p̄ CA INTERVIEW. PENDING
	PAD F/U c̄ CA FOR TRANSFER. Pt c̄ staples midline and
	(L) RIB CAGE AREA. STAPLES TO BE REMOVED BY NEXT
	NURSING SHIFT. (b)(6)-2 CPT AN
20 Apr 03	2200 – pt A/O x3, LS clear, BS x4, UOP WNL. ~~W/D dsg~~ dsg c̄
	bacitracin to back done; (L) ankle dsg Δ'd. Staples removed
	as ordered s̄ diff. ø s/s infection noted. ø c/o pain
	Continue to monitor. J Elsbury CPT/AN
21 Apr 03 0715	PT VS. P86 BP 119/70 SPO2 98 T 96.3 R 16 – SPC (b)(6)-2
21 APR 03 1004	Pt released to MP and will receive dressings Δ AT NEXT LOCATION. (b)(6)-2 CPT/AN

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Apr 03 2100 -	T 99.5° P 92 R 24 BP 122/76 Pox 98% RA A/O X 3, LS clear, BS X4, last BM 4/17. UOP ok. pain med prn. ulcer (L) back redressed c̄ bacitracin, (L) foot ulcer has 2 stitches dsg c/d/I. midline incision staples and (L) flank staples intact slight redness around site ∅ S/S infection (L) flank has scabbed quarter size area c̄ some sanguinous old drainage. O2 Sats 98% RA, pt resting comfortably. Continue to monitor. (R) FA 20g X 3 day d/c'd has hard area above site. Continue to monitor. Dsg Δ to back c̄ bacitracin [(b)(6)-2] CPT/AN
19 Apr. 03 0955	B/P 120/68 P - 89 R - 20 Pox - 96 Temp - 98.4
	SPC [(b)(6)-2] 9/W
19 Apr. 03 1407	B/P 102/68 P - 109 R - 20 O2S - 98 Temp - 98.7 SPC [(b)(6)-2] 9/W
19 APR 03 1844	Pt is A&O X3 P 99, R 20; O2 SP 97%. Pt wound (L) upper back 1½ X 3¼ IN c̄ PINK flesh; Pt wound (L) LOWER LEG c̄ pink and red flesh both dressings changed and BACITRACIN APPLIED TO the sites. Pt ambulated ~~the~~ throughout the ward X 5. Pt c̄ 1 BM and 1 VOID at 1620. Pt ambulated c̄ a steady gait. Pt midline and (L) wound staples removed every other, c̄ well healed edges. [(b)(6)-2] CPT, AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ...k/Grade)

[(b)(6)-4]

REGISTER NO.	WARD NO.
	ICW/

PROGRESS NOTES
Medical Record

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

MEDCOM - 4417

NSN 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 | **ARRIVAL**

STREET ADDRESS			DATE *(Day, Month, Year)* 10 Apr 03	TIME 1910
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

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

CHIEF COMPLAINT
SP [illegible] SP CT

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1910	TIME	1915				
☒ URGENT		BP	133/78				
	INITIALS (b)(6)-2	PULSE	89				
		RESP	16				
☐ NON-URGENT		TEMP					
		WT	85%				

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

ORDERS

☑ PULSE OX 85% on RA ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1915Z					

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶ TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.	

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

PATIENT'S SIGNATURE

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

(b)(3)-1

MEDCOM - 4418

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC		SUP 02	PH	P02	RESULTS	
	H/H		PCO2	SAT	OTHER		
	PLT		U/A DIP			EKG INTERPRETATION	
PT			U/A MICRO				
APTT	BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

31 yo EPW Tx'd @ EST/CSH from GSW (L) CHEST
S/P EX LAP / THORACOTOMY - 2 DAYS AGO.

PE: ABSENT BS (L) - PULSE OX 83%
DISCONNECTED CT - RECONNECTED + REEXPANSION
DRESSING INTACT → 91% RA

A/P: STABLE AFTER CT RECONNECTED
OBSERVE
GYDL

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

CODES

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

1. NAME (Last First Middle Initial) (b)(6)-4	SSN	3a. STATUS	3b. SE	4. PRECEDENCE	5. GRADE
		EPW		U / P ✓ / R	
6. AGE 31	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 10 APR 03	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY (b)(3)-1	16. # OF ATTENDANTS: 16a. MED Ø, 16b. NON-MED Ø
	14b. ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #3	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

GSW CHEST

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 10 APR 03 | 20b. TIME | 20c. ALLERGIES

20d. DIET X REG | Gm NA | CARDIAC | DIABETIC __ CALS
RENAL __ Cal __ Gm Na __ MagK __ mg PO4
TUBE __ TYPE __ cc/hr 1/2, 3/4 FULL STRENGTH
PEDIATRIC: AS __ OTHER (Specify)
TPN: Change to __ at __ cc/hr max of __ days
TUBE FEEDING __ at __ strength at __ cc/hr

NPO

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)

Central Line

OXYGEN: __ PERCENT __ 3 LITERS ROUTE: __
VENT SETTINGS

20g. ALTITUDE RESTRICTION: Yes / No __ feet

20h. RECORDS TO ACCOMPANY PATIENT

✓ OUTPATIENT RECORDS	X	XRAYS	OTHER:
Ø INPATIENT RECORDS		OB	
NARRATIVE SUMMARY		DENTAL	
FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Ancef 1gm IV Q 8°
O_2
~~Kelley~~ ...
MSO4 2-4mg Q1° PRN pain

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

	YES	NO	ISSUE		YES	NO	ISSUE
a.		✓	Hypertension	i.		✓	Bowel Problem
b.		✓	Cardiac Hx	j.		✓	Self-care
c.		✓	Diabetes	k.	X		Ambulatory
d.		✓	Respiratory	l.		✓	Ambulatory Aid
e.		✓	Ears/Sinus	m.		✓	Self-meds
f.		✓	Motion Sick	n.		✓	Adequate Supply of Meds
g.		✓	Vision Impaired	o.			Other:
h.		✓	Voiding Pr.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

GSW Chest
S/p ExLap / Thoracotomy
CT / Foley / Central Line

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

24. STAMP AND SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433

MEDCOM - 4420

511-118

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR / DAY	11 Apr	12 APR	13 Apr	13 APR	14 APR	15 Apr		20 Apr	
19 / HOUR	1700 0800	1200	1835 0245	1200	0800 1200	0800		2000	

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: 18 16 16 → 20 20 16

BLOOD PRESSURE: 132/75 | 127/77 | 130/78 | 132/82 → | 124/79 | 128/75 | 124/71 | 119/66

P-83 P-112 P-90

SpO2: 93% 94 | 92% 93% 92% → | 94% 94 | 94% 94% | 98%

HEIGHT: WEIGHT → 234

Intake: 1750 | 240 PO 1500 cc

Output — Urine: 3350 | 11 Apr 03 1900 200 | 12 Apr 03 130 2700 | 12 April 650cc | 13 Apr 03 12 oz.

CT: 92 12 Apr 03 0245 | 90 | [illegible]

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4421

MEDICAL RECORD		VITAL SIGNS RECORD
HOSPITAL DAY		1
POST-	DAY	
MONTH-YEAR	DAY	11
19	HOUR	48 12 48 12

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°	X	37.2°
	98.6°		37.0°
120	98°		36.7°
110	97°		36.1°
100	96°		35.6°
90	95°	O	35.0°
80			
70			
60			
50			
40			

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD		16
BLOOD PRESSURE		130/66
HEIGHT:	WEIGHT →	
Intake		
Output: CT / UOP		2000

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

*U.S. Government Printing Office: 1995 - 609-626

MEDCOM - 4422

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: 11 APR 03 TIME OF ORDER: 0605 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU # Gen Surg (b)(6)-2
2. Dx: S/P Ex lap / (L) thoracotomy / (L) CT
3. Stable
4. VS per routine
5. NKDA
6. LR @ 125 cc/hr
7. NPO
8. Foley → gravity
9. CT to -20 cm suction
10. D/C (L) cordis & place peripheral IV
11. OOB → chair BID
12. Ancef 1 gm IVPB q 8°
13. PCXR in EMT & q AM
14. MSO4 1-2 mg IV q 1-2° PRN pain (b)(6)-2
15. Encourage pulmonary toilet
16. Notify MD for T>101.5 P>120 <60 SBP>180 <100 UOP <250 cc/shift
17. O2 per FM/NC - wean/titrate to keep ≥ 95%

(b)(6)-2 MD (b)(6)-2 MAJ, MC

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 APR 03 TIME OF ORDER: 0445 HOURS

1. Reg Diet
2. Heplock IV once tolerating clears (b)(6)-2
3. CT → H2O seal
4. D/C Foley 1200 Z

(b)(6)-2 MD

4/1?/03 (b)(6)-2

1. Lovenox 40mg SQ Q 24° 3) FM O2 to keep SaO2 ≥ 90%
2. CXR (PA/LAT)

(b)(6)-2

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

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

MEDCOM - 4423

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

1624
15 April 2003
Admit ICW - temper
① VS - Q4h
② Incentive Spirometer
③ Heparin 5000 units sub Q Q 12h
④ regular diet
⑤ Spot check SaO2 Q shift
⑥ O2 per nasal cannula to keep SaO2 > 92%
⑦ Up ad lib
[(b)(6)-2]

Noted [(b)(6)-2] 2100 [illegible] 15 April @ 2050

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

4/14/03 ~~① Repeat CXR~~ error [(b)(6)-2]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

24° chart check 15 APR 03 2330 [(b)(6)-2]

24° ✓ 17 APR 03 0230 [(b)(6)-2] [illegible]

4/16/03 ① Bacitracin to wound on back TID
② D/C Ancef
③ D/C heparin

NO ANCEF FOUND ON [illegible]
[(b)(6)-2]
NOTED [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER [(b)(6)-2] HOURS

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: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4/17/03 TIME OF ORDER 0755 HOURS

LIST TIME ORDER NOTED AND SIGN

D/C O2

(b)(6)-2

(b)(6)-2

CPT, AN

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER TIME OF ORDER ______ HOURS

17 Apr 03 CXR

Ambulate

(b)(6)-2

24PV 4/19/03 0600

(b)(6)-2

CPT/AN

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

CPT AN

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4425

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
(b)(6)-4		4/18/03 [illegible]	
		① Tylenol 325 mg T-III	po
		q 4-6° prn	
		(b)(6)-2	
7N 4/19/03 0600 (b)(6)-2 CPT/AN			(b)(6)-2 (b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER 20 APR 03 / TIME OF ORDER 0730 HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	①	Remove staples	
	②	D/C to EPW Compound vs Home	
		Depending on status (b)(6)-2	MD
R 4° 4/21/03 0400 (b)(6)-2 CPT/AN		(b)(6)-2	
NURSING UNIT: ICW 1 / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	
(b)(6)-4			
NURSING UNIT: ICW 1 / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ____ HOURS	
(b)(6)-4			
NURSING UNIT: ICW1 / ROOM NO. / BED NO.			

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

☆ U.S. GOVT

MEDCOM - 4426

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 11	12	13	14	15
11-APR03	(b)(6)-2	US per routine	04	/	(b)(6)-2			
			12	(b)(6)-2				
			20					
11-Apr03	(b)(6)-2	~~NPO~~ REG DIET	4					
			16					
11-Apr03	(b)(6)-2	Foley → Gravity	4	(b)(6)-2		D/C		
			16					
11-Apr03	(b)(6)-2	CT to low cont Suction	4	(b)(6)-2		/DC		
			16					
11-Apr03	(b)(6)-2	OOB → Chair BID	04	(b)(6)-2				
			16					
11APR03	(b)(6)-2	CXR q AM	05	/	(b)(6)-2			
11-APR03		Encourage Pulmonary toilet	04	(b)(6)-2				
			16					
11-APR03	(b)(6)-2	Notify MD for T 101.5 P >120 <60, SBP >180 <100	04	(b)(6)-2				
			16					
11-Apr 03	(b)(6)-2	Urine op <250cc per shift	04					
		O2 per FM/NC - wean/titrate to keep ≥95%	16					
12APR	(b)(6)-2	CT → H2O SEAL	D	/	(b)(6)-2	D'CD 14 APR 03		
			N	/				

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P Exlap / Ⓛ thoracotomy

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ______ Yr ______	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 Apr 03	(b)(6)-2	Admit ICU #2			11 Apr 03 0730	(b)(6)-2
11 Apr 03		D/C (L) Cordis ; place peripheral IV			[illegible]	

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

USAPA V1.00

MEDCOM - 4428

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 15	16	17	18	19	20	21
15 Apr	(b)(6)-2	Diet: Regular	B	(b)(6)-2						
			L	(b)(6)-2						
			D							
15 Apr	(b)(6)-2	√ SaO2 q shift	07	(b)(6)-2						
			15	(b)(6)-2						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	Incentive Spirometer	07	(b)(6)-2						
			15	(b)(6)-2						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	VS: q 4°	03	/						
			07	(b)(6)-2						
			11	(b)(6)-2						
			15	(b)(6)-2						
			19	(b)(6)-2						
			23							
15 Apr	(b)(6)-2	Activity - up ad lib	07 19							
			19 07	(b)(6)-2						
17 APR 03	(b)(6)-2	AMBULATE	07 19	(b)(6)-2						
			19 07							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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.

MEDCOM - 4429

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 04 Yr 03

Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15 Apr	(b)(6)-2	Admit ICW-1 Temper	15 Apr	1624	1624	(b)(6)-2
		CXR —	17APR03	ASAP	1110	
20APR03	(b)(6)-2	REMOVE STAPLES	20APR03	~~400~~ 2210	2210	
		DC TO EPW COMPOUND VS HOME				
		PENDING ON STATUS				

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

★ U.S. GPO:1997-418-290/55267

MEDCOM - 4430

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	15	16	17	18	19	20	21
15 Apr 03	(b)(6)-2	O2 nasal cannula	07 19	/	(b)(6)-2	D/C				
		to keep SaO2 > 92%	19 07	(b)(6)-2						
15 Apr	(b)(6)-2	Heparin 5000 u subq	08	/	(b)(6)-2	D/C				
		q 12°	20	(b)(6)-2	/					
16 APR 03	(b)(6)-2	BACITRACIN TO	06	/	/		(b)(6)-2			
		WOUND ON BACK TID	14	/	(b)(6)-2					
			22	/						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 4431

ACLU-RDI 1244 p.334

DOD 010910

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. ______ Yr. ______

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
18APR03	(b)(6)-2	TYLENOL 325mg T-III PO Q 4-6° PRN	ii 1010 18 APR03	18APR 2100 3 (b)(6)-2	20 APR03 2 1618 (b)(6)-2	20 APR 3 2245 (b)(6)-2										

☆U.S. GPO:1998-432-786/85214

MEDCOM - 4432

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 7 8 (b)(3)-1

2. MTF LOCATION (State or Country Code.)

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

NAME (Last, First, Middle Initial) (b)(6)-4 (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 20 21 22 23 24 25 26: 1 9 7 2 0 1 0 1

7. AGE AT ADMISSION 27 28 29: 3 1 4

8. RACE 30 Arab

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 0605

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 IRS

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 A

WARD 1W1

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 D/C: Trans

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 2 1

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 4 1 0

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

GSW L Chest

DX: 86130
8603
8911
7990
E9654

PX: 5411
331
3404

Trauma
1
Injury
450

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

MAJ, MC

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

MEDCOM - 4433

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: **24 - HOUR COMPREHENSIVE CARE RECORD Part 1**

OTSG APPROVED (Date)

(b)(3)-1

DATE: 22 Mar 03

Preop DX: ① GSW to Ⓛ shoulder c̄ exit wound over Ⓛ scapula ② GSW to Ⓛ mid abdomen c̄ exit wound over Ⓡ UQ abdomen ③ shock

HOSPITAL DAY NO.

POST OP DAY NO.

ISOLATION DAY NO.

ALLERGIES: unknown

LAB STUDIES

TIME	2050	10
HCT	30 / Hb 10	
GLU	187	
pH	7.26	
PO2		
PCO2		
HCO3		
BE		
Na	149	
K+	3.6	
Ca	1.15	

TOTAL OUTPUT: 860; chest tube 325

TOTAL INTAKE: IV #1 2000; IV #2 120; IVPB 50; cumulative total intake 2170

TIME	TEMPERATURE
1533	96.6
1545	97.2
1600	
1630	98.1
1700	97.3
1730	97.4
1800	98.3
1900	
2000	98.7
2100	98.1
2200	98.7
2300	98.3
2400	98.3

TEMPERATURE (O) - ORAL (A) - AXILLARY (R) - RECTAL

VITAL SIGNS

PULSE ● = RADIAL ▲ = APICAL ∨ = SYTOLIC ∧ = DIASTOLIC

WEIGHT lbs.

RESPIRATIONS

BLOOD PRESSURE

SaO2

MISC

INTAKE: ORAL; TUBE FEEDING; IV NUMBER #1 LR; IV NUMBER #2 LR / Amiod; IVPB; CUMULATIVE TOTAL INTAKE

BLOOD; TOTAL # Units BLOOD Given

OUTPUT: URINE; NASOGASTRIC; EMESIS; CHEST TUBE; STOOL - LIQUID; CUMULATIVE TOTAL OUTPUT; BOWEL MOVEMENT

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE: 22 Mar 03

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

EPW (b)(6)-4

(b)(3)-1

DIAGNOSIS: Thru & Thru gastrotomy over greater curvature ② multiple [illegible] jejunum ③ Ⓡ lobe liver

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDCOM - 4373

24 - HOUR COMPREHENSIVE CARE RECORD Part 2

	0700-1900	1900-0700
ACTIVITY BR - D - AA - A		
BATH B - P - S		
FOLEY / PERI CARE		
ORAL CARE		
ENDOTRACHEAL TUBE CARE		
ORAL / ET SUCTION		
OXYGEN VIA AT LPM		
VENTILATOR		
Fi O2 21%		
RATE: 12		
TIDAL VLOUME 500		
PEEP Ø		
DIET:		
DRESSING CHANGE		

SIGNATURES	INITIAL
(b)(6)-2 MAJ/AN	(b)(6)-2
(b)(6)-2	

NEURO GUIDE
- ✓ Normal
- – Sluggish
- + Fixed
- C Eyes Closed by Swelling

PUPIL SIZE: 2 mm, 4 mm, 6 mm, 8 mm

		TIME	1530	1710	(b)(6)-2
PUPILLARY REACTION	RIGHT	SIZE			
		REACTION			
	LEFT	SIZE			
		REACTION			
COMA SCALE — EYES OPEN	SPONTANEOUS	4			4
	TO SPEECH	3			
	TO PAIN	2			
	NONE	1	1	1	
COMA SCALE — BEST MOTOR RESPONSE	EYE COMMANDS	6			
	PULLS TESTERS HAND AWAY WHEN PINCHED	5			5
	FLEXION WITHDRAWAL	4			
	DECORTICATE POSTURING	3			
	DECEREBRATE POSTURING	2			
	NONE (intubated)	1	1	1	
COMA SCALE — BEST VERBALE RESPONSE	ORIENTED	5			
	CONFUSED	4			
	INAPPROPRIATE	3			
	INCOMPREHENSIBLE SOUNDS	2			
	NONE	1	1	1	
	TOTALS				

BR - BEDREST D - DANGLE AA - AMBULATE WITH ASSISTANCE A - AMBULATORY | B - BED P - PARTIAL S - SHOWER

TIME	NARRATIVE NOTES
1530	Pt. received from OR. Intubated. Breath sounds clear bilaterally. (L) EJ IV c̄ LR @ TKO, IVF's LR @ TKO (R) AC. Sedated. Vent settings SIMV rate 12, FIO2 21%, TV 500. Midline abd incision c̄ intact drsg. Drsg to RUQ intact c̄ noted bloody drainage oozing to rt side. Drsg reinforced c̄ 4x4's. (R) lat CT site intact, Ø drainage noted, connected to low suction. Foley draining clear yellow urine. Oral ETT 26cm @ lip to (R) side. (R) NGT clamped. Temp 86.6. Pt covered c̄ five blankets. Will monitor for ↑'d temp. (b)(6)-2 MAJ/AN
1615	Pt. attempted to wake up. Biting ETT c̄ ↓'d O2 sat (80-85%). Temp remains @ 87.0 F. Given 5mg MSO4 + 3mg Versed IV per anesthesia. (b)(6)-2
1710	Pt. biting on ETT. Attempting to wake. Temp remains @ 87.4. Given 3mg MSO4 + 1.5mg Versed IV. Pt now less agitated. (b)(6)-2 MAJ/AN
1830	Pt extubated per anesthesia. Placed on FM @ 10L/min. Tolerating well. (b)(6)-2
2000	Pt. agitated & groaning. Attempting to turn over + pulling to lie side. Given 2mg MSO4 + 1.5mg Versed IV. (b)(6)-2
2200	Pt. continues c̄ moaning. Given 3mg MSO4 IV. Temp @ 89.3. Pt. continues with being covered c̄ multiple blankets. (b)(6)-2

ACLU-RDI 1244 p.338

DOD 010853

Initial Assessment (b)(3)-1 ICU OR

Date 23 MAR 03 Time 1615HRS

NEUROLOGICAL ASSESSMENT

Pupil size: 2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level of Consciousness
X Awake X Alert _ Drowsy
_ Restlessness _ Lethargic
_ Unconscious

Orientation:
X Time X Place X Person

Eyes Open:
X Spontaneous
_ To Speech
_ To Pain
_ No Response

Best Verbal:
X Oriented & Converses
_ Disoriented & Converses
_ Inappropriate Words
_ Incomprehensible Sound
_ No Response

Best Motor:
X Obeys Commands
_ Localizes Pain
_ Extension
_ No Response

Motor Ability & Strength:

	Strong	Weak	Absent
RA	✓		
LA	✓		
RL	✓		
LL	✓		

PSYCHOLOGICAL
X Calm _ Combative
X Cooperative _ Anxious

INTEGUMENTARY
Color: X Normal _ Pale _ Flushed _ Cyanotic _ Jaundiced
Skin: X Warm X Dry _ Diaphoretic _ Cool _ Clammy

RESPIRATORY
X Unlabored _ Labored

Breath Sounds:
_ Clear Bilaterally
_ Absent R L
X Rales (R L)
_ Wheezes R L

ABDOMINAL
_ Soft X Tender
_ Rigid _ Non-Tender
_ Distended _ Rebound

Bowel Sounds:
_ Active _ Hypoactive
_ Hyperactive _ Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial	+2	+2
Femoral		
Pedal	+2	+2
Edema		

0-Absent + 2-Normal
+ 1-Weak + 3-Bounding

Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
1615h	98.8	119	18	118/59	SpO_2 97% on 5L O_2 via Nasal canula
					Pt transported to (b)(3)-1 ICU Section via
					litter by FLA. VSS on arrival. Pt has chest
					tube to (R) side which is to low suction.
					Draining bloody red fluid at this time. NG
1830		113	20	112/59	tube to low suction draining dark red
					fluid. 18ga IV to (L) wrist saline locked.
					18ga to (R) AC infusing LR @ 150cc/hr.
					Δ'd dressings to (R) upper chest, back
					and (L) side with 4x4 & tape. Δ'd Chest
					tube dressing with 4x4's. Dressings to (R)
					abdomen and midline abdomen Δ'd c̄ Kerlix
					soaked in NaCl 0.9% irrigation solution.
					Foley catheter to gravity drainage c̄ clear
					amber urine at this time (b)(6)-2 [illegible]
1910					Interpreter explained pain scale to pt who verbalized
					understanding and gave his name and age. Pain level was 9/10.
					Pt medicated c̄ 5mg MSO4 (b)(6)-2 [illegible]

Allergies NKDA

Time	IV	MEDICATIONS (dose/route site)
1700		Cefotetan 2g IVPB in 100ml NaCl.
1645		5 mg MSO4 IVP
1700		5 mg MSO4 IVP
1900		5 mg MSO4 IVP 9/10 pain.
[illegible]		6 mg MSO4 IVP 9/10 (b)(6)-2

INTAKE/OUTPUT

Time	IV	Urine	Chest	Gastric
		300 (1930)		
Total:				

Pertinent Lab Values
1830 hrs.

pH 7.374	Na 138
pCO_2 44.4	K 4.8
PO_2 99	iCa 1.17
Base Excess +1	Hct 22
Bicarb. 26	Hbg 7
TCO_2 27	
SO_2 97	

(b)(6)-4

25 yrs old

S WORKUP SHEET DA FO 00 (b)(3)-1

MEDCOM - 4375

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 **24 - HOUR COMPREHENSIVE CARE RECORD Part 1**

OTSG APPROVED (Date)

DATE: 23 Mar 03
HOSPITAL DAY NO. 2
POST OP DAY NO.
ISOLATION DAY NO.
ALLERGIES

LAB STUDIES: TIME / TIME / HCT / GLU / pH / PO2 / PCO2 / HCO3 / BE

(b)(3)-1

TOTAL OUTPUT

TOTAL INTAKE

TIME	TEMPERATURE (O) - ORAL (A) - AXILLARY (R) - RECTAL	VITAL SIGNS / PULSE ● = RADIAL ▲ = APICAL V = SYTOLIC ^ = DIASTOLIC / WEIGHT lbs.	RESPIRATIONS	BLOOD PRESSURE / SaO2	TIME
2010	100.7	● 120, < , >	20	99	01
0020	99.7	● 120, < , >		99	02
0230	97.5	< , >	14	99	03

TIME	MISC	INTAKE	ORAL	TUBE FEEDING	I V NUMBER # 1 LR	I V NUMBER # 2	I V PB	CUMULATIVE TOTAL INTAKE	BLOOD	TOTAL # Units BLOOD Given	OUTPUT	URINE	NASOGASTRIC	EMESIS	CHEST TUBE ® side	STOOL - LIQUID	CUMULATIVE TOTAL OUTPUT	BOWEL MOVEMENT
01					↑													
02												100			13			
03					↑													

PREPARED BY (Signature & Title)
DEPARTMENT/SERVICE/CLINIC
DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)
EPW (b)(6)-4
(b)(3)-1

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

DIAGNOSIS: ① Thru & Thru Gastrostomy over greater curvature
② Multiple enterotomies proximal jejunum
③ ® lobe liver GSW

MEDCOM - 4376

ACLU-RDI 1244 p.340

24 - HOUR COMPREHENSIVE CARE RECORD Part 2

	0700-1900	1900-0700
ACTIVITY BR - D - AA - A		
BATH B - P - S		
FOLEY / PERI CARE		
ORAL CARE		0100
ENDOTRACHEAL TUBE CARE		
ORAL / ET SUCTION		
OXYGEN VIA ___ AT ___ LPM		
VENTILATOR		
Fi O2 ___		
RATE: ___		
TIDAL VLOUME ___		
PEEP ___		
DIET: ___		
DRESSING CHANGE		

SIGNATURES	INITIAL
(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2

NEURO GUIDE
- ✓ Normal
- − Sluggish
- + Fixed
- C Eyes Closed by Swelling

PUPIL SIZE
- 2 mm
- 4 mm
- 6 mm
- 8 mm

			TIME
PUPILLARY REACTION	RIGHT	SIZE	
		REACTION	
	LEFT	SIZE	
		REACTION	
COMA SCALE — EYES OPEN	SPONTANEOUS	4	
	TO SPEECH	3	
	TO PAIN	2	
	NONE	1	
BEST MOTOR RESPONSE	EYE COMMANDS	6	
	PULLS TESTERS HAND AWAY WHEN PINCHED	5	
	FLEXION WITHDRAWAL	4	
	DECORTICATE POSTURING	3	
	DECEREBRATE POSTURING	2	
	NONE	1	
BEST VERBALE RESPONSE	ORIENTED	5	
	CONFUSED	4	
	INAPPROPRIATE	3	
	INCOMPREHENSIBLE SOUNDS	2	
	NONE	1	
	TOTALS		

BR - BEDREST D - DANGLE AA - AMBULATE WITH ASSISTANCE A - AMBULATORY B - BED P - PARTIAL S - SHOWER

NARRATIVE NOTES

TIME	
0100	care continued from 22 Mar 03. Pt awake and very uncomfortable.
	Unable to communicate d/t language barrier, however pt. moaning. Given
	3 Mg MSO4 for pain. Will continue to monitor. Temp 1'd 90.7. (b)(6)-2
0200	2 Mg MSO4 IV

MEDCOM - 4377

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1 — LOCATION (State or Country Code): I Z

3. REGISTER NUMBER: (b)(6)-4

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

4. PAY GRADE: —

5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19780101

7. AGE AT ADMISSION: 25Y

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION:

10. LENGTH OF SERVICE: —

ETS:

11. FMP: 20 / 99

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 0920

BRANCH / CORPS:

14. FLYING STATUS: —

15. BENEFICIARY CATEGORY: K78 ~~K9~~ / K78

16. ZIP CODE OF RESIDENCE: 093300000

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA: INJ

PREV. ADMISSION YEAR: NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 DIR

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 05

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (YYMMDD): 030502

24. CLINIC SVC - ADMITTING: ABAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYMMDD): 030418

27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYMMDD):

FOR LOCAL USE

DX: 8631 GSW to R anterior & posterior chest - E969
8603 GSW to R Lower Quadrant of abdomen Trauma
86415
86339
9584
5180
99832
E9??
[illegible]
[signature]
450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 MD

SIGN (b)(6)-2

DA FORM 2985, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

X: 4562
5061
[illegible]

MEDCOM - 4378

1. REPORTING MTF						2. MTF LOCATION		ADMISSION AND CODING INFORMATION
1	2	3	4	5	6	7	8	(State or Country Code)
(b)(3)-1						I	G	For use of this form, see AR 40-400; proponent agency is OTSG

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

NAME (Last, First, Middle Initial): # (b)(6)-4 (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 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 0920

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

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

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AN(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

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

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

81	82	83	84	85	86
0	3	0	5	0	2

24. CLINIC SVC - ADMITTING:

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

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

97	98	99	100	101	102
0	3	0	4	1	8

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

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE
GSW to R anterior & posterior chest - E969
GSW to R Lower Quadrant of abdomen

(b)(6)-2

...uired)

MD

SIG (b)(6)-2

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4379

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y/N	32. UNDERLYING CAUSE OF DEATH / SEP
117	118	119	120	121
			N	

33. RESIDUAL DISABILITY		
122	123	124

34. DO NOT USE - DATA FILLER #1								
125	126	127	128	129	130	131	132	133

35. CAUSE OF INJURY		
134	135	136

36. FIRST DIAGNOSIS *(Principal Diagnosis)*							
137	138	139	140	141	142	143	144
	E	9	9	1		2	

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176

41. SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*							
201	202	203	204	205	206	207	208

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES	
265	266
0	1

53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES	
267	268

54. PRIMARY PROVIDER SPECIALTY CODE		
269	270	271

55. BLOOD USAGE Y/N
272

MEDCOM - 4380

INPATIENT TREATMENT RECORD COVE...

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

1. (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4	3. GRADE	ADMISSION REMARKS
4. M	RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP	12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD
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 Direct	22. HOURS OF ADMISSION 0920	23. CLINIC SERVICE ABAN
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION 02 MAY 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 18 APR 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ	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 to R anterior & posterior chest ~~E991.2~~
" to R lower Quadrant of abdomen

III: 879.2, 860.2, V58.3, E991.2

II: 880.00, 879.2, 785.50, 991.6, 860.2, 879.8, E991.2

11040, 32020, 47015, 44202, 47741

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
14	14				14

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

SIGNA... (b)(6)-2 | SIGNA... (b)(6)-2 ...CER

DA F...

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDCOM - 4310

INPATIENT TREATMENT RECORD COVE... ...ET

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 # (b)(6)-4		

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

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

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	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	0920	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		02 MAY 03

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW to R anterior & posterior chest ~~E991.2~~
" to R lower Quadrant of abdomen

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
14	14				14

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

S... (b)(6)-2 ...MD ... R

D... EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 4311

DEPARTMENT OF THE ARMY

(b)(3)-1

(b)(3)-1 IRAQ APO AE 09331

02 MAR 03

MEMORANDUM FOR Record

SUBJECT: Hospitalization for Patient # (b)(3)-1 (b)(6)-4 (b)(6)-4 (b)(6)-4

1. Patient (b)(6)-4 admitted on 23 March 2003 during the Operation Iraqi Freedom war to the (b)(3)-1, located at (b)(3)-1 Iraq. His injuries consisted of gun shot wounds to the right anterior and posterior chest and gun shot wounds to the right lower quadrant of his abdomen.

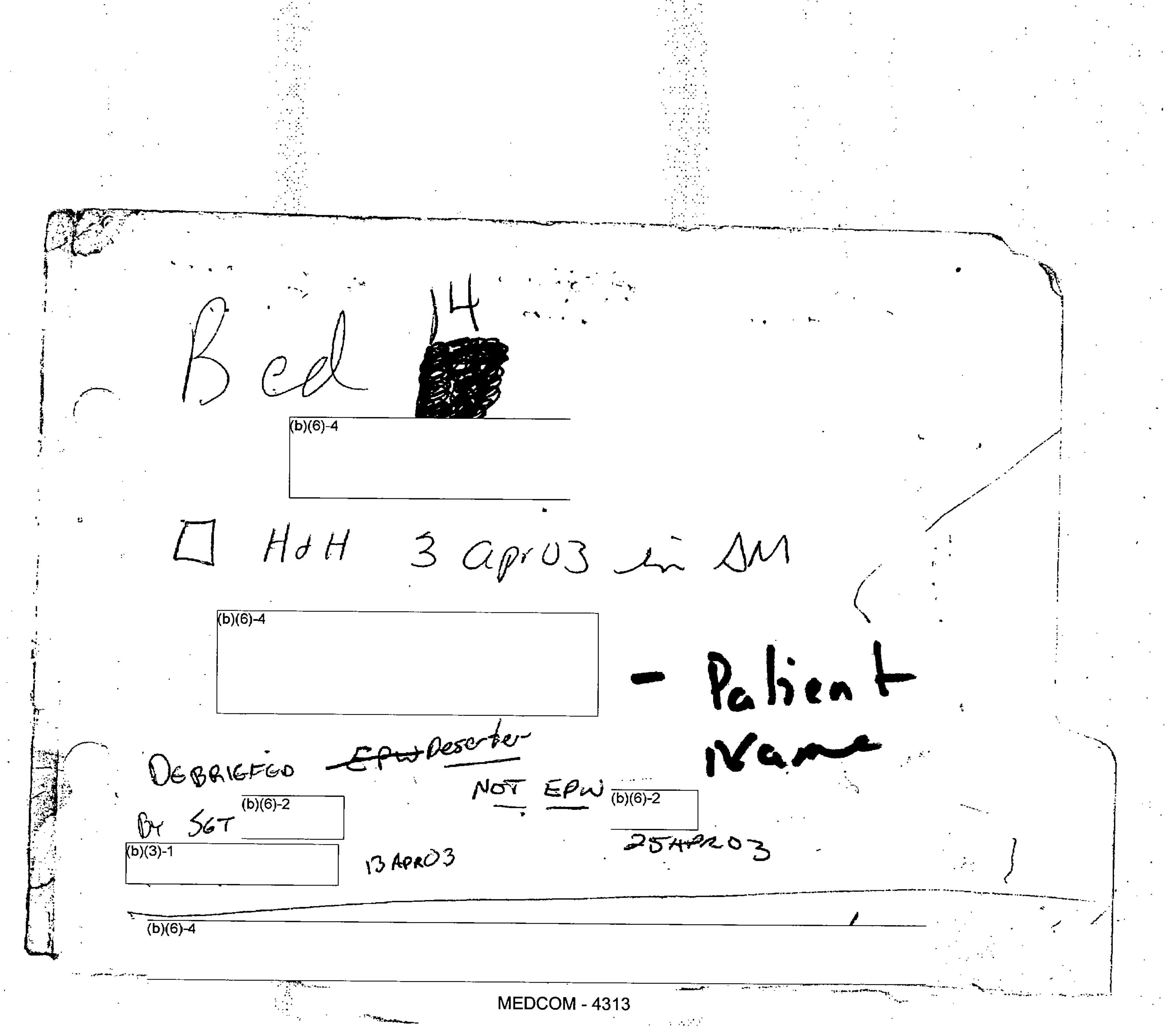
2. On 23 March 2003, Patient (b)(6)-4 received an exploratory laparatomy discovering a right liver fracture and repaired two gastrointestinal injuries. Surgeon noted a negative pericardial window and placed a right chest tube, naso-gastric tube, foley catheter and patient placed on oxygen per nasal cannula. These injuries occurred during his service with the Iraqi military unit assigned to protect (b)(3)-1.

3. On 18 April 2003, Patient (b)(6)-4 transferred to the (b)(3)-1 to the Intermediate Care Ward #2, under the care of LTC (b)(6)-2 staff. Patient's wounds cared for with wet to dry wound care twice each day that the nursing staff taught the patient to perform. Nursing staff assisted patient with his personal hygiene each day. The patient ambulated without assistance, but used crutches at times to provide support. He is being discharged on 2 May 2003 with Ibuprofen 800mg every 8 hours for pain. His wound today is clean, free of infection and healing nicely by secondary intention with bright red granulation tissue. Patient will receive 7-10 days worth of dressing supplies to care for his wound himself at his home.

4. Point of contact is the undersigned.

(b)(6)-2

(b)(6)-2
Lieutenant Colonel, Army Nurse
Head Nurse, Intermediate Care Ward #2
(b)(3)-1
(b)(3)-1 Iraq APO AE 09331



Bed 14
(b)(6)-4
☐ HdH 3 apr03 in AM
(b)(6)-4
- Patient Name
DEBRIEFED ~~EPW~~ Deserter
NOT EPW
(b)(6)-2
25APR03
By SGT (b)(6)-2
(b)(3)-1
13 APR03
(b)(6)-4
MEDCOM - 4313

EPWE

23 Oct 02 1721

Name:
SSN: (b)(6)-4
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE: 23Oct02
TIME: 1721

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** Multiple GSW to chest/Abdomen
3. Condition: VSI (SI) Stable
4. **Allergies:** Unknown
5. **VS:** ~~Q5min x 3; Q15 min x 3,~~ then Q1 hr; (Q2 hrs) Q4 hrs;
Notify MD for SBP: > ~~90~~ or < 90; DBP: > ___ < 50;
HR: > 130, < ___; RR: > ___, < ___; Temp: > ___
6. **IVF:** **IVF:** LR @ 150 cc/hr; NS @ ___ cc/hr;
Albumin @ ___ cc/hr; Hespan @ ___ cc/hr
7. Monitor: Cardiac; Pulse Ox; ~~Neuro~~ Q4h m/hr; A-line;
8. I&O: ~~Q1 hr~~; (Q 2 hrs)
9. ~~Drains~~: NG to Low/Cont suction; Foley to gravity q2h
10. (R) CT #1: 20 cm H2O suction, ~~H2O seal; Heimlich~~ record output q4h
11. CT #2: 20 cm H2O suction, H2O seal; Heimlich
12. **LABS:** ABG now ~~& Q1 hr~~; ~~Q2 hrs; Q ___ hrs;~~ PRN
Hct now & Q 24 hrs; Chem now & Q 24 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:
17. **MEDS:**
✓ Morphine 2, 4, or (6 mg) IVP Q 1 ~~min~~/hr prn Pain
Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
~~Zofran 2-4 mg IVP Q ___ 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 2gm IV q12h x2
Heparin 5000U SQ 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;

Additional Orders/Charting:

(1) W→D Kerlex q12h Abd + RLQ wnds
(2) HOB ↑ 45° @ all times
encourage deep breathing
(3) CXR @ earliest possible time
(b)(6)-2

24 Mar 8 AM
Δ VS + I+O to q4h
OOB ambulate c assist
labs
May be transferred to ward later.
(b)(6)-2

(b)(3)-1 Post-OP Orders, By CPT (b)(6)-2 as of 29 Nov 2001
(b)(6)-2 (b)(6)-2

MEDCOM - 4314

MEDICAL RECORD | PROGRESS NOTES

DATE
23 Mar 03

(b)(3)-1

1740 BP: 100/62
P: 125
R: 22
T: 98.8
O2 SAT: 96%
ALLERGIES
PMH:
PSH:

POD # (b)(6)-4 y-o EPW male S/P GSW to (R) ant + (R) posterior chest, S/P GSW to (L) abdomen → RLQ.
At surgery he underwent ex lap SBR with stable anastomosis control (R) liver fx, repair of GC gastrotomy x2, neg pericardial window and (R) side chest tube.
Clinically seriously injured with NG, foley, chest tube, open abdomen, and O2 [illegible] [illegible] [illegible] - Surgery performed 22 Mar 03 by (b)(3)-1

[illegible] 7/22
Pt awake, alert, much more comfortable after IV MSO4. NG with black bile, [illegible] Back wounds dressed. Lungs [illegible] clear. Heart tachycardic. Abdo wounds dressed. Abdo appropriately tender. Foley [illegible] Ext [illegible] edema Ø tenderness / Neuro moving all 4 ext, GCS 15.

Imp: Critically ill patient — will need ICU care. Multiple injuries GSW repair of multiple [illegible] + liver fx care

Plan: IV Abx. Chest tube care. IV fluid CXR in Am. ✓ labs. Watch fluids

(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. (b)(6)-2

WARD NO. 274 [illegible]

NAME: (b)(6)-4
SSN:
UNIT:

EPW (b)(6)-4

(b)(6)-2

MEDCOM - 4315

USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE

(b)(3)-1 Progress note

8Am

OPERATIVE NOTE

24 Mar 03 DIAGNOSIS: POD # (b)(6)-4 98²

VS: 116/62 P119 R16 SaO2 100

PROCEDURE: Tm Afeb VSS.

med: Afrefen
MSO4
SQ Heparin

I/O
UOP 50 - 150 cc/h.
CT 445 cc since 2pm. ø Airleak
SURGEON: NG 220 cc since 2p
FINDINGS: IVF @ 150.

GCS 15. Alert. Comfortable

Hgb 7
Hct 22
Na 138 K 4.8
iCa 1.17
ABG 7.37/44/99/26

NG + foley + CT functional
lungs clear, ̄x wheeze Ⓡ base
Heart tachycardic
FLUIDS: Abdo flat, soft ⊕BS. Wounds dressed, clean
CXR OK. sli pedal edema
A/P: POD#2 s/p R hemothorax. R liver fx. SBR, repair gastrotomy - Stable.
Hgb low

plan: transfer to holding ̄p review of am labs and CXR. OOB ambulate with assist
Vitals + I/O q4h. Deep Breathing
IVF NS @ 100 (Continue on reverse side)

(b)(6)-2

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

EPW # (b)(6)-4

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11- (b)(6)-2
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4316

9:15 Am
25 Mar 03

(b)(3)-1

PN

POD # (b)(6)-4

Tm 102.4 (12 hr) now 99.8
VSS. P 104 Bp 150/50 SaO2 100%
CT ⊘ air leak. 25cc/24h. → Waterseal.
foley 1500/24
NG 20cc/24h.

Labs
141 | 34
30 |
7/22
iCa 1.17

CXR: No PTX, pneumonia
RL plate atelectasis

uncomfortable this Am
lungs clear c̄ dli ↓ R base
Heart tachycardic, stable
Abdo ⊕ BS, tender.
Wounds clean + dressed. Edge of exit wound RUQ c̄ small medial rim of ischemic tissue.
foley intact. [illegible] ok (b)(6)-2

Imp: 1. GSW Ⓡ chest → plate atelectasis, ↓ CT output
2. GSW to abdo → Gastrotomy repair, SBO, control liver lac
- slow return of bowel function
NPO.

Plan: CT to Waterseal, prob pull in 24 hrs
Start Toradol 30 mg IV q6 x 4 days.
Continue MSO4 PRN
IVF keep @ 110.
OOB. Cough + deep

(b)(6)-2

(b)(6)-2

(b)(3)-1

PN

25 Mar 03
7:30 pm

Pt ambulatory. SaO2 96% RA
lungs clear c̄ a few crackles R base
Ⓡ CT ~~placed~~ removed. 30 mins post CT
SaO2 99% RA. Comfortable
plan: AP/lateral CXR in Am. Also V [illegible]
Do not [illegible] for 72 hrs (b)(6)-2

MEDCOM - 4317

ACLU-RDI 1244 p.352

MEDICAL RECORD	PROGRESS NOTES
26 Mar 03 2155	I agree with previous assessment. Morphine 4mg given for (R) arm pain. VSS. CTA (b)(6)-2 KT/AN
27 Mar 03	pt has (R) forearm phelibitis [illegible], pt c/o (R) arm [illegible]. Resp-16 pt given 25mg phenergan c 25mg Demerol followed by 5cc flush — Sgt (b)(6)-2
1420	pt lips soap with a sponge. Pt sleeping at this time (b)(6)-2
1530	V/S taken BP 140/70 P80 T 97.1
27 Mar 03 1700	Patient acting thirsty by gestures. IV continues, but conferred c Dr. (b)(6)-2 and now verbal given orders to start intake of clear liquids 100cc/[illegible] until reviewed by Dr. (b)(6)-2 (b)(6)-2 [illegible]
27 Mar 03 2359	4mg Morphine given x1. P 74, BP 137/78 R 20 T 96.2 No changes from last exam except pain level. Warm to touch also [illegible] KT/AW
28 Mar 03 0100	275 out urine, sleeping well (b)(6)-2 KT AN
28 Mar 03 0600	2100 urine out for shift (b)(6)-2 KT/AN
28 Mar 03	1000 - OSG Chux [illegible], open and draining well. Pt Afebrile [illegible], c/o pain to abdomen, [illegible] (b)(6)-2
28 Mar 03 1310	POD (b)(6)-4 s/p GSW to (R) ANT / (R) posterior chest s/p GSW to (L) ABD → RLQ s/p SBR s/p repair [illegible] AF/VSS GOOD UOP Rhonchi (R) base c ↓ BS wounds look good A/P / D/C IV Advance Diet as tolerated (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)

(b)(6)-4

REGISTER NO. | WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Mar 03 (b)(6)-2	274th FST PN [signature] (b)(6)-4
	Tm 99.7 VSS SaO2 100% → 98% RA
	UOP - diuresing
	IVF: 2500 } Currently SaO2 98%
	UOP 2800 pulse 9[illegible]
	CT out
	foley D/c'ed this AM
	c/o (R) sided CP esp deep Breathing
	Heart reg. lungs clear ↓ BS (R) base
	Abdo (+)BS. Wounds ok [illegible], [illegible]
	dressing change
	pt ambulatory
(Machine down)	CXR this AM (PA/LA) pending - ØPTX RLL atelectasis
	Imp: GSW (R) chest, s/p removal CT R lung, had RLL atel
	GSW to abdomen c SBR, repair gastrotomy
	Plan: please d CXR to R/O PTX
	keep O2 to keep SaO2 94%
	Start diet in 48 hrs (clear) (b)(6)-2
	Needs new IV site

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

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

REGISTER NO. | WARD NO.

(b)(6)-4 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)*
28 Mar 03	Surgery POD# (b)(6)-4
14^00	Pt [illegible] quiet [illegible]. [illegible]? Pain
	well controlled
	Wound clean...
	Plan advance diet to clear. (b)(6)-2
28 MAR 03	Pt (b)(6)-2
1520	Pt. ambulated well walk to end of tent and
	back. (b)(6)-2 [signature]
28 MAR	B/P 112/70 SaO2 - 97%
1615	P - 105 T - 98.3
	R - 20
28 Mar 03	Pt alert & requesting meds for sleep. Given 50mg Benadryl
1930	PO. S1 & S2 Audible. Lungs CTA from Apex to base anteriorly.
	Hyperactive Bowel Sounds x4 quads. Pt voided 750cc via urinal. Distal pulses
2 Tylenol 2230	present. Dssg C/D/I. (b)(6)-2 SSG/[signature]
29 Mar 03	Pt c/o H/A and PN, PN woke Pt up out of sleep after
0120	~~one motrin~~ II Tylenol / one Bendryl. Pt B/P 116/62 P 100 R16 T100
	Pt drank H^2O about .5L Pt also ate pastery. Pt also
	C/O PN on wound. SPC change dressing wet to dry.
	Wound look okay. Might need Bedside Debreivement
	a.m. Have Dr. (b)(6)-2 check wound on wound change SPC (b)(6)-2
29 Mar 03	BP - 1?0/60 RR - 20 Sats - 97% via RA
0530	P - 94 Temp - 99^3
29 Mar 03	1710. Pt. c/o (b)(6)-2 pain from wound. Dr. (b)(6)-2 gave
	verbal orders for Vicodin Tab I po now. Given (b)(6)-2
	Maj. [signature]

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

MEDCOM - 4320

PROGRESS NOTES

DATE	
29MAR03 0910	~~Upon~~ Upon assessment to PT
	PT c/o Tenderness c RN TU ABD &
	radiates to upper (B) Thighs.
	BP 110/64 100.8 P.95 97% RR 16
	(+) ABC's WNL (+) Pulses
29 March 03	1200 - Pt in Bed for dressing Δ on Mid line Abd incision. Wound open 1 in in width and about 12 in long. Little drainage of a clearish white appearance. No signs of infection, dressing Δ was sterile. Dressing change on open wound in upper right lateral thoracic region. No signs of infection. Dressing Δ on mid upper, Back no signs of infection. (b)(6)-2 2LT AN
29 March 03	1313 - Pt BS are Absent, did Digital Rectal check, no compaction present will continue to monitor. (b)(6)-2 2LT AN
29MAR03 1710	POD # (b)(6)-4 S/P GSW ABDOMEN - S/P (R) GSW Chest
	c SBR & gastrotomy repair
	Patient c/o ABDOMINAL pain
	T 100.8
	Lungs - ↓ BS (R) Chest
	(R) CT site - good
Belly:	ABD WOUND - ? NECROSIS deep in tissue
soft T	Midline incision - good
↓ BS but	Posterior (R) chest wound good
present	(P) D/W Surgery to R/O NECROSIS
	Pain control
	low threshold for Abx (b)(6)-2

★U.S. GPO:1995-397-405

MEDCOM - 4321

ACLU-RDI 1244 p.356

DOD 010800

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Mar 03 2009	no changes from previous exam. BP 92/46, p102, R 20, T ___. Fluids encouraged
	will continue to monitor (b)(6)-2 1LT/AN
29 Mar 03 2358	Vicodin 1 tab PO for c/o pain (b)(6)-2 1LT/AN
30 Mar 03 725	T = 96.2 F P: 94 O2 95 118/72 (b)(6)-2 91W
30 Mar 03 1017	Changed dressings on pt. abdomen, wet to dry. Dr. (b)(6)-2 looked at his wounds & said he needs debridement either today or tomorrow. Vicodin was given orally for pain. 1 tab SPC (b)(6)-2
30 MAR 03 1200	POD# (b)(6)-4
	S/P GSW ABD. S/P (R) GSW Chest c̄ SBR
	& gastrotomy repair
	AF/VSS
	ABD (R) UQ wound needs debridement
	Midline incision good
	Posterior (R) chest wound good
	(P) Surgery for Debridement — when?
	Pain Control (b)(6)-2
	Wound care
31 MAR 03 1440	115/50 RR 18 P. 118 POX 94 Temp 100.8 (b)(6)-2
31 MAR 1530	MSO4 4 mg IM @ 1530. CPT (b)(6)-2 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.

(b)(6)-4

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

MEDCOM - 4322

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 March 03	1515 - Pt Complains of Pain in Rt Shoulder, Give T Vicodin (b)(6)-2
30 Mar 03	1900 Pain uncontrolled. MSO4 4mg Im given. Prior to
	this patient up and ambulated [illegible] sat in chair for 20
	mins. (b)(6)-2 [illegible] FNP
30 Mar 03	Pt lying in bed awake c/o pain to midline incision. Given MSO4.
2140	Dsg CD+I. (b)(6)-2 SSG / LPN
31 Mar 03	Pt awake c/o pain, given 2mg of MSO4 to relieve
03:40	pain. Given water. (b)(6)-2 91W
31 Mar 03	BP - 100/48 RR - 20 Sats - 94% via RA
0625	P - 106 Temp - 100.4
31 March 03	0940 - Pt in Bed AtOx3, Breath Sound Clear Upper lobe, ↓ Lower, BSx4 Quadrants
	S1 S2 Present, All pulses Present (b)(6)-2 [illegible]
0954	B/P 115/45 P 102 R 16 SAT 95% T 99.2
31 March 03	2145 - Pt c/o pain 5 MG [illegible] Rt Deltoid per Dr. Verbal order (b)(6)-2
3/31/03	POD # (b)(6)-4
2145	GSW ABD / GSW (R) Chest
	s/p (R) CT s/p SBR / gastrotomy repair
	T - 100.4 P - 106 BP 100/48 RR 20 SaO2 94%
	Lungs: ↓ BS (R) base
	ABD: (R) UQ EXIT WOUND c NECROSIS EXTENDING
	to FASCIA.
	Mid-line incision c Necrosis @ epigastric
	area ⊕ Pseudomonas / colonization
	A: Debridement carried out at bedside
	P) W→D Δ's BID
	Vitals Q 6° - Low threshold for ABX
	Nutrition Consult (b)(6)-2
	AMBULATE BID
	PAIN CONTROL

MEDCOM - 4323

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Apr 03	BP 115/70 temp 97.7 Pulse 122 SpO2 99 RR 18-20 short shallow
	(b)(6)-2 91W10
4/1/03	POD # (b)(6)-4
1007	GSW ABD / GSW (R) Chest
	S/P (R) CT S/P SBR / gastrotomy repair
	T-97.7 BP 115/70 P 122 SpO2 99%
	Lungs ↓ (R) base
	ABD: Mid line incision / (R) UQ c̄ necrosis
	Bedside loose necrotic tissue removed
	P) ✓ H/H ? I - start
	W → D BID Δ's
	Pain Control
	Ambulate (b)(6)-2
	Nutrition cal
1 Apr 03	0930 zulu time - pt c/o pain GSW 2T3 (b)(6)-2
1 April 03	.2ml MS04 IM @ 1205Z (b)(6)-2
	91W10
1 April 03	1520z - Pt c/o Pain 4MG MS04 given (b)(6)-2
1APR03	1635z - Pt amb floor c/o pain & sleep 50mg Benadryl, 800mg Motrin PO per (b)(6)-2
	HR 106 RR 20 SpO2 95 TMP 99.6 100/50 (b)(6)-2 CPN, SGT

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

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

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4324

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2Apr03	Vitals = Temp 100.9, B/P 113/48 Pulse 110, SpO2 96% Resp 22 Given MRE @ 0619 Z
4/2/03 0710	POD# (b)(6)-4 GSW ABD/(R) Chest s/p (R) CT s/p SBR / gastrotomy repair Vitals: 100.9 BP 113/48 P. 110 SpO2 96% Lungs: ↓ BS (R) base ABD: [illegible] / (R) US wound ↓ necrosis [illegible] noted ? ✓ A/H AM 4/3/03 Ambulate TID EAT!!!! c Ensure Shakes (b)(6)-2 (b)(6)-2
2Apr03	Nutrition Note - will send Ensure shakes and more Dates to ↑ caloric intake (b)(6)-2 MAJ SP RD
2APR03 1915 temp 101.9 A	pt. c/o pain given 2 T3 for pain. Spc (b)(6)-2 took pt for a walk, would not walk for more than 5 minutes. Pt. states he wishes to die. Spc (b)(6)-2 also given an additional 325mg tylenol. Spc (b)(6)-2
2APR03 1500	B/P 112/38 Spc (b)(6)-2
2APR03 1630	B/P P 97 R [illegible] SAO2 95 T 110/56 99.7°, Pt ambulated floor x2 ∅ complaint of pain. (b)(6)-2 LPN, SGT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Apr 03 5:00Z	pt eating MRE - vitals → temp 95.8, SpO2 98%, pulse 98, 98/40 BP (RA), 20 resp, 90/40 BP (LA)
3 APR 03 0600Z	Pt DS'd Δ per MD. Bandage placed around chest. Pt ambulating this AM ~ problems. Lungs ↓ (B). — (b)(6)-2
3.	Nutrition — Patient agreed to drink 3 cans of Ensure a day, instead of getting a feeding tube. Translator explained that the IV did not have sufficient nutrition to heal his wounds. (b)(6)-2 MAJ SP RD
3 Apr 03 0930(Z)	Two Tylenol 3's administered per DR (b)(6)-2 order for pain management — SPC (b)(6)-2 91WM6
4/3/03	POD# (b)(6)-4 — Patient walking more!! Looks better!
	GSW ABD / GSW (R) Chest
	s/p (R) CT s/p SBR / gastrotomy repair
	T - 95.8 P - 98 BP 98/40 20
	Lungs ↓ (R) base
	ABD: scaphoid / soft / NABS
	wounds - dehiscence ↓ necrotic tissue
	H/H - 7/22

1) Continue care/wound

Ambulate

wound care

OAT!

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

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

MEDCOM - 4326

ACLU-RDI 1244 p.361

DATE	NOTES
4apr03	Vitals - 22rr, 97 Spo2, 92 pulse, 100.1 temp,
	100/60 BP (b)(6)-2 91W
4/4/03	DOD # (b)(6)-4
	GSW ABD / GSW (R) Chest
	s/p (R) CT s/p SBR / gastrotomy repair
	midline incision - Dehiscence
	c̄ necrosis
	T - 100.1 P - 92 RR 22 100/60 97% SaO2
	↓ BS (R) base
	Patient [illegible] looks worse than yesterday
	P) ① Locate Dobhoff [illegible] for TF's
	② Cont [illegible]
	③ Ambulate (b)(6)-2
	④ wound care
	⑤ Pain Control
4 April 03	1000 - NG Tube placed in Rt nostril, Aspirate Gastric Content
	for placement, placement Confirmed (b)(6)-2 2LT AN
	1020 - 240cc of Tube feeding Bolused, Received tube feeding from
	DeFact, Need to hang 240cc Bolus Q3 hrs. (b)(6)-2 2LT AN
	1030 - Pt up out of Bed, having Runny Bowel Movement, will continue to
	monitor and Tube Feedings Q3 (b)(6)-2 2LT AN
	1030 - Q3 Tube Feedings, check residuals before each TF, if ↑100cc
	hold feeding x 1 hr recheck residual until ↓100cc then Give TF 240cc
	Bolus (b)(6)-2 2LT AN

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STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 APR 03	Vitals: temp 101.3, 22 resp 100/56 BP, 97 SpO2, 115 pulse (b)(6)-2 9/W
4APR03 16:30	20RR 96 O2 114 HR 101.8° TMP 90/60. Pt sitting in bed, ate 1/4 jello cup.
4APR03 1650	650 Tynele for pain and Temp. (b)(6)-2 SGT, LPN
4APR03 1716	Drank 3/4 cup of Ensure. Note to watch if spitting out.
18:30	Pt drank 3/4 cup of Ensure. Pt request Potatos, Bread, vegtables, chicken and other solid items.
18:45	TMP 99.1 (b)(6)-2 SGT, LPN
22:42	TMP 98.4 (b)(6)-2 SGT, LPN
03:07	TMP 98.4° Aux pt asleep at this time (b)(6)-2 SGT, LPN
4/5/03	0420 - 99² - Aux, 100/62, 95, 97% (b)(6)-2 2LT AW
	0518 - Pt Received his cup of Ensure and is drinking (b)(6)-2 2LT AW
	0530 - Pt OOB to Latrine by himself, had a Bowel Movement (b)(6)-2 2LT AW
	0640 - Pt OOB to Ambulate, talk c other Pt, Looking More energetic, has more strength, moves and ambulate on his own. (b)(6)-2 2LT AW
(2)	changed pts dressing, wet to dry, [illegible] ace bandage, still very painful [illegible] (b)(6)-2 9/W

[illegible] 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)*
4/5/03	POD # (b)(6)-4 (b)(6)-4 D# (b)(6)-4
	GSW ABD/(R) Chest s/p (R) CT
	s/p SBR / gastrotomy repair
	Tmax: 101 (4/4/03 / 1630)
	Tc 98.2 100/62 95 97% RA
	Lungs ↓ BS (R) Base
	ABD: Scaphoid / Soft / NABS
	wound - looks better
	BM yesterday
	P) ① Cup ensure Q 3° while awake
	② Ambulate more
	③ [illegible] wound care (b)(6)-2
	④ Cont + [illegible] (b)(6)-2
4/5/03 0945	- Pt c/o Pain two T#3 Given PO (b)(6)-2
1000	Pt had 240 cc ensure by mouth (b)(6)-2
4/5/03	1230 - Pt Received 240 cc of Ensure and Drank it all, also
	saw pt ~~drinking~~ Eating MRE meal (b)(6)-2
1230	- Late Entry 0710 - Assisted c Dressing Δ, wound Red, appears
	more alive tissue, no debridement necessary, w-D [illegible]
	will continue to monitor (b)(6)-2
1350	Two T#3 Given for pain PO (b)(6)-2
5APR03 1630	T oral 98.9° HR 86 BP 94/68 O2 99 RA RR 20. Pt sitting up in bed
	eating crackers. Says stomach was hurting him a little bit. Lungs Clear x4
	Bowel active x4. (b)(6)-2 LPN, SGT

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

MEDCOM - 4329

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 APR 03 1205	Pt starts on ½ cup of Ensure. Pt spitts Ensure out of bed. Nurse strongly communicates to patient that he is wrong for it. Pt receives chucks to clean up. Interpreter talks c̄ pt and he downs the second cup of ensure. (b)(6)-2 LPN, SGT
23:10	97.5° oral pt complains of Abd pain. 80 mg Motrin (b)(6)-2 SGT, LPN
0306	Pt asleep
06 APR 03 0430Z	Vitals - temp 97.4, B/P 108/74, Pulse 90, SpO2 98% Resp 18 (b)(6)-2
0545	Pt Drank 240cc Cup of Ensure c̄ no problems, pt tolerated his ensure (b)(6)-2
06 APR 03 0730	POD # (b)(6)-4 LEVAQUIN D# 5
	GSW ABD / (R) CHEST s/p (R) CT
	s/p SBR / anastom repair
	T 97.4 108/74 90 98% SaO2
	Last Temp 101 (4/4/03 @ 1630)
	Midline incision looks good √ NEC 1095
	w→ A ∆ D
	P) Cont Tinsil
	Cont Levaquin
	Ambulation
	Pain Control

(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | ...OR'S ID NUMBER (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)

MEDCOM - 4330

DATE	NOTES
4/6/03	0900→ Pt Received 2nd Cup of ensure and drank all, pt c/o of pain and received 800mg Motrin PO. At 0600 Pt Drank 1st Cup of ensure and ambulated. At 0700 pt Dressing Δ done, wound Appeared red and well vascularized, no sign of infection or ↑ in Necrosis. Pt up to ambulate 2nd time. (b)(6)-2
1330	Pt Drinks 240cc Ensure, up + Ambulate. Pt eats little of dinner. (b)(6)-2
6APR03 1638	RR 16 98% 02 RA 99 HR TMP 98.3° oral 98/62
1721	Pt drank cup of ensure. Light complaints of pain in abd.
1900	50mg Benadryl for Sleep (b)(6)-2 LPN, SOT
0320	Pt Sleep through night s̄ complaint, still asleep at this time (b)(6)-2, LPN
7April03	0420 Temp 98.3 BP 100/30, HR 80, Resp 16 (b)(6)-2
	0530 - Pt in Bed, Given Ensure, doesn't want to drink, encouragement is working, Given Two T#3 for pain, ensure gone (b)(6)-2
4/7/03 0715z	POD # (b)(6)-4 Levaquin D#6 GSW ABD / (R) Chest s/p (R) CT s/p SBR / gastrotomy, repair AF/VSS (last temp 4/9/03) Midline incision - granulating well w/o D Δ's P) Cont Ensure Cont Levaquin Ambulate Pain Control (b)(6)-2
4/17/03	1030Z Admin 2 Tylenol #3 tabs (PO) per dr orders. Pt c/o of pain in abdomen (b)(6)-2 (b)(6)-2
4/17/03	1330z Pt eating apple. Ensure held at this time (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4/7/03	RR 20. HR 98 SPO2 99% RA TMP 98.1 oral BP 88/72 pt OOB AOB Flair
16:55	x3. Cleaned up AO c instruction. Mild pain to ABD (b)(6)-2 LPN, SGT
17:30	pt drank cup of ensure s difficulty (b)(6)-2 LPN, SGT
2335	Pt woke c abdominal PN, Pt given 500mg Tylenol — SPC (b)(6)-2
8 APR 03 0345	pt slep c little trouble (b)(6)-2 LPN, SGT
8 April 03 0430	VS obtained. O2 sat on RA 93%, P 77, RR 20, T 97.8°F, BP 92/50 — (b)(6)-2
4/8/03	POD# (b)(6)-4 LEVAQUIN D#7
	GSW ABD / (R) Chest s/p (R) CT
	s/p SBR / gastrotomy repair
	Tc 97.8 (Last Fever 4/4/03)
	Midline incision looks good
	P) Cont Ensure
	D/C Levaquin
	Ambulate
	Remove CT (b)(6)-2
0630 2010 8 Apr 03	PT recieved TT T3 (b)(6)-2
1030 Z 8 Apr 03	pt ambulated for 10 min. c/o pain gave TT T3 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) | 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)

MEDCOM - 4332

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09Apr03	(S) Pt admitted to MCW2 this AM from MCW I. Pt A+O x3
0740 Z	Assessment completed. BS are Hypoactive x4. All other assessments WNLs.
	(O) Pt Vitals are stable and present c̄
	Dx) GSW to Abdomen/(R) chest and S/p (R) CT
	- Mid line incision / wound on Abdomen. Beefy red tissue present. Wound vascularized, small amount of fibrinous (b)(6)-2 exudate noted in wound. Ø drainage noted. Ø eryth around wound
	- (R) GSW chest wound 6-7cm X 6-7cm, Red vascularized tissue present. Wound edges approximated. Ø S/S of infection
	(A) (P) - Continue Woundcare / Dressing Δ.
	- Treat pain as needed.
	- Continue Ensure feedings
	- Reinforce Walking (b)(6)-2 2LT AN
9Apr03 8:30	- Vitals - 185/70 B/P, 20 rr, 84 pulse, 99.2 temp. Cupta (b)(6)-2 91W
0940	FNP Note
	S/O S/P GSW. See 0740 note. No Δ in status. Drank 240cc Ensure @ lunch. Ambulating on own.
	A/P Continue to monitor nutritional status, Ø Δ in tx plan.
	(b)(6)-2 LTC, AN

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

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

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

(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	NOTES
09 Apr 03 1030	Patient given ii tabs of Tylenol 3 for pain (b)(6)-2 SLWMX
1130 z	Pt drank 240cc of Ensure and Ambulated. (b)(6)-2 2LT AN
1400 z	Pt had 240cc of Ensure and Ambulated. (b)(6)-2 2LT AN
1700 z	T 98⁵ P 85 R 18 BP 90/50 Pt alert for assessment & cooperative. Pt denies pain & is in no apparent distress. Lungs CTA. HRRR. bowel sounds hypo in LUQ & RUQ. active sounds in lower quads. Pt drank 240 cc ensure w/o difficulty (b)(6)-2 2LT AN
10 Apr 03 0505	Pulse 86, R-18 Temp 98.7, B/P 96/58 - Spc (b)(6)-2 SLWMSO
0630 z	Pt has Dressings taken down: Wounds x 2 to Midline ABD and GSW ® Chest. ABD midline wound is looking very good. Wound's is Red & beefy tissue that is well vascularized, small amt of fibrinous exudate noted. Edges approximated. No s/s of infection. R Chest GSW wound is 6 X 6 cm. Wound can be characterized as above except the fibrinous tissue noted. No s/s of infection (b)(6)-2 2LT AN
0950 Z	FNP PN S/O S/P GSW, See above notes re: Wound care et status. MAE. Ambulates s̄ assistance. ∅ s/s of infection. VSS.AF. A/P Wound improved, (1) Tylenol 650 to 1000mg PO q 4-6° prn pain. (2) Ibuprofen 800mg PO q 8° prn pain (3) Tylenol #3 PO q 4-6° prn pain ONLY if trying Tylenol et Motrin orders s̄ relief. (b)(6)-2 LTC, AN FNP
1000 z	Pt ambulated & drank ensure 240ml @ 0700 z. (b)(6)-2 2LT AN
1200 Z	Pt drank 240 mL Ensure (b)(6)-2 2LT AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10Apr03	V/S B/P = 94/58 P = 80 R = 16 = T = 98.1 P.T. dressing
19:52	clean + intact. P.T. setting in bed. talking with
	other P.T. P.T. was eat food —— (b)(6)-2 91WIO
11Apr03	2050 BP 110/70 P 68 R 16 T 97.1 (b)(6)-2
11Apr03	MD PN Pt c̄ GSW Abd & (R) chest POD # (b)(6)-4
0621	AFVSS
	Abd superior pole wounds beefy c̄ good granulation
	scant fibrinopurulent exudate.
	A/P (1) cont wound care, pain meds.
	(2) Cont to encourage feedings. (b)(6)-2
	MD
2045	BP 110/68 RR - 18
	T-97.8 P-76
	pt c̄ GSW Abd + (R) chest DRSG CDI. Pt c/o PN. Pt was given 500mg
	of tylenol —— (b)(6)-2
12Apr03 0445	P 82 RR 16 Temp 97.0 BP 100/50 Sgt [illegible]
12Apr03 - 0500	Abd. Dsg Δ'd - Wet to dry midline. Wound looks good
	and beefy, scant [illegible] on left border of wound, No c̄ change
	from previous day. Pt states pain R/T wound, pt received
	Motrin 800mg - SPC (b)(6)-2 91WM[——

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)

MEDCOM - 4335

ACLU-RDI 1244 p.370

DOD 010814

DATE	NOTES
12 Apr 03 - 0600	Pt drank ½ cup of ensure - [(b)(6)-2] 91WM6
1200.	Pt drank ½ cups of ensure - [(b)(6)-2] 91WM6
1700Z	T98⁵ P80 R16 BP 90/58 Pt Resting comfortably @ time of assessment. Pt w/ midline dressing which is C/D/I. Pt also has dressing to (R) chest wall C/D/I. All other systems WNL [(b)(6)-2] 2LT AN
13 Apr 03 5:20(Z)	Vitals = 96.8 temp, 18 R/R, 84 pulse [(b)(6)-2] 92/60 B/P [(b)(6)-2] 91W
05:55(Z)	Pt dressing removed. Wounds x2 to Midline abdomen and (R) chest. Wounds are healing very well, improvement every day, tissue is red and granulated, borders of wounds are closing. Dressing Δed W→D No c/o pain. [(b)(6)-2] 2LT AN
1625Z	T98² P90 R16 BP 90/55 Pt in bed @ time of assessment. Pt alert & denies pain. Dressing to midline abd & (R) chest wall C/D/I. All other systems WNL [(b)(6)-2] 2LT AN
14 Apr 03 0600(Z)	Pt dressing removed. Pt has wounds x 2. (1) Midline ABD wound is healing well. Noticable improvement on every exam. Beefy granulated tissue present some fib exudate in wound, ∅ necrotic ∅ erythe, W→D Δ done no s/s of infection present. (2) (R) chest GSW. wound is improving as well. above note on midline ABD applies to (R) chest, W→D Δ done no s/s of infection [(b)(6)-2] LT AN

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4336

ACLU-RDI 1244 p.371

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 April 03 06:15 zulu	• Nutrition note – patient been consuming 5 cups of ensure a day and crackers & rice. approximately 1,500 cal/Day, reccomend pt drinks 6-7 cups ensure a day. Wounds are healing very well, patient advancing well. SPC (b)(6)-2
2210	Pt w/injury to abd (midline incision) + (R) chest wall all dressings C/D/I. Pt resting comfortably, RR even & unlabored. Will continue to monitor (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)

MEDCOM - 4337

ACLU-RDI 1244 p.372

DOD 010816

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14apr03 7:13	Vitals = 98.6 temp, 18 rr, 88 pulse, 115/60 B/P (b)(6)-2 9W
14Apr03 2156	BP - 119/59 T - 98.5 P - 76 RR - 18
15apr03 5:25	Vitals = 98.2 temp, 18 R/R, 78 pulse, 115/60 B/P (b)(6)-2 9W
15Apr03 0600	Dsg d/c to Abd wound. Wound looks good & beefy pink, no exudate noted. Serosanguinous drainage on old bandage no odor noted, no significant change from previous assessment. Dsg CDI - W → D, No c/o pain. (b)(6)-2 SPC
2230	BP: 84/80 Resp: 18 P: 66 Temp: 99.0 — Sgt (b)(6)-2
16Apr03	0600 Pt slept most of shift w/o complaint. Dressing midline abd C/D/I, RR even & unlabored — (b)(6)-2 2LT AN
16Apr03 @ 0945	Pt dressing removed Pt has wounds x 2 ① Midline ABD wound. Wound is healing very well. Wound is 3cm @ widest point. Red beefy tissue present, wound edges closing. Ø necrotic Ø eryth. some Green drainage noted on dressing, though no pseudomonas noted in wound. ② (R) Chest wound. Note on ABD wound is consistant with this wound, Ø necrotic Ø eryth. — (b)(6)-2 2LT AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 4338

DATE	NOTES
16Apr03 8:46	Vitals = 97.8 temp, 18 R/R, 78 pulse, 100/55 B/P
	(b)(6)-2 9W
2,19	BP - 100/60 T - 98.6
	P - 80 RR - 18 (b)(6)-2
17Apr03 0856	BP 100/60 P. 80 RR 16 Temp 98.1 Spc (b)(6)-2
17Apr03	Pt dressing removed. Pt has injuries X2
1100	① Midline ABD wound. Wound is healing very well. No
	noticable closure from previous exam. Red, beefy,
	granulated tissue present. Edges are proximated,
	Ø necrotic Ø Eryth Ø s/s of infection. Wound
	care is W→D dressing Δ done.
	② Ⓡ Chest GSW: Wound is healing well 3cm x 3cm.
	ABD assessment is accurate for this wound and
	comparable. W→D dressing Δ done.
	(b)(6)-2 2LT AN
1436	BP - 100/60 T - 98.2
	P - 52 RR - 16 (b)(6)-2
18Apr03	Pt dressing Removed. Pt has injuries X2.
0905	① Midline ABD wound. Wound is begining to heal rapidly
	Wound red, beefy & granulated tissue. Wound edges
	closing. Dressing removed had some green discharge
	possibly ⊕ for psudemonas. Ø necrotic Ø Eryth Ø
	s/s of systemic infection. W→D dressing Δ done.
	② Ⓡ Chest GSW: Wound assessment of ABD is
	congruent with this wound. W→D dressing
	in place. (b)(6)-2 2LT AN
18APR03	Vitals: Temp 98.3 Pulse 96
0910	Resp 16, BP 105/65 (b)(6)-2 9W

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Apr 03	@1600 pt received to ward ambulatory via MD. Report given @ bedside per Dr (b)(6)-2 pt c̄ abdominal dressing midline + Ⓡ small dressing midaxillary line wet to dry. Dressing clean dry + intact. neuro intact. VSS BP 110/60 P 68 R 18 T-98.8 pt smiling. language barrier present. will continue to monitor (b)(6)-2
18 Apr 2035 BP 96/ P-78 R-18 T-98.2 Sat-100%	Nsg. Shift assessment completed, VSS. Dsg to abdominal midline - CD&I; dsg to Ⓡ upper chest CD&I. Patient is comfortable. Continue to monitor (b)(6)-2
18 Apr 2300	Nsg. W→D dressing done of midline abdominal incision on Ⓡ upper chest. Tissue c̄ good granulation no s/s of infection. (b)(6)-2
19 Apr 0530	VS BP 92/48 P-65 R-14 T-96.7 SaO_2-100% on RA
19 APR @ 0830	shift report received. VSS B/P-98/50 P-70 R16 T-97.0 pt resting quietly in position of comfort c̄ equal + even respirations. will continue to monitor. (b)(6)-2
19 APR 03 @	1040 pt dressing changed wet to dry. Edges well approximated beefy red tissue present c̄ ⊕ granulation. no odor noted. pt tol procedure well. pt NAD. Will cont to monitor. (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)

DATE	NOTES
	Nsg.
19 Apr 03	Shift assessment completed. No c/o @ this time.
2115	Will Δ dressing to mid abdomen (W→D). Abd,
	lungs CTA (B); BS (+), voiding per urinal. HR-70.
	RRR. Will monitor (b)(6)-2 cm
2300	W→D dsg done. No s/s of infection (b)(6)-2 cm
20 Apr 03	VS
0600	BP 96/48 P-80 R-16 T-97.2 SaO2-100%
20APR03@	0830 VS B/P-88/49 P-75 R-16 T-97. pt OOB to ambulate to BSC. pt ambulates c̄ steady
	gate. no c/o pain at this time. will continue to monitor. (b)(6)-2 2LT/AN
20APR03@	1145 wet to dry dressing change completed. midline abd incision (+) granulation c̄ beefy red
	granulated tissue. Edges well approximated. midaxillary wound healing well. LSCTA, (+) BS
	will continue to monitor. pt c̄ no c/o of pain. NAD. (b)(6)-2 2LT/AN
20 April	Nsg:
@1920	VS 95/48 P-78 R14 T-98.6 SaO2-97%
	Shift assessment completed, VSS, ⊘ pain. Dressing
	to mid abd line Δ'd. No s/s of infection. Lungs CTA (B)
	abd - BS (+), voiding spontaneously clear yellow urine.
	Continue c̄ current plan of care (b)(6)-2
21 Apr	VS BP 102/54 P-74 R-16 T-97.3 SaO2-100% on RA
0500	
21APR03@	0720 VS B/P-94/53 P-85 R-16 T-97.6 pt resting in position of comfort c̄ equal + even respirations.
	Dressing CDI. will continue to monitor (b)(6)-2 2LT/AN
21APR03@	1030 dressing Δ to midline incision (+) Beefy red granulation tissue present. Edges continuing
	to approximate well. LSCTA (+) BS x 4 quads. pt c̄ no complaint of pain. will cont. to monitor.
	(b)(6)-2 2LT/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Apr 03 2000	Nsg. Pt spent beginning of shift outside the ward. Ambulatory, stable. Dressing to mid-abdomen Δ'd, Ø any granulation, Ø any s/s of infection. Encouraged po/supplement intake. (b)(6)-2 [illegible]
21 APR 03 @ 0920	VSS see VS flowsheet. pt LSCTA, ⊕ BS x 4 Quads. Dressing CDI. Dressing removed midline incision c̄ ⊕ beefy red tissue. Edges continuing to approximate well. pt medicated c̄ motrin c̄ good relief. will continue to monitor. (b)(6)-2 [illegible]
22 Apr 03 2010	Nsg. Dressing Δ'd done. No s/s of infection noted. Pt is stable. BS+, urinating per urinal. Pain - 0/10. Plan continue c̄ drsg Δ BID (b)(6)-2
23 Apr 03 @	Dressing change ⊕ granulation no significant changes from prior assessment. Will D/C when arrangements made PAD involved. will cont to monitor. (b)(6)-2 [illegible]
23 Apr 03 2115	Shift assessment completed. Drsg Δ to mid-abd area. No s/s of infection (b)(6)-2 [illegible]
24 apr 03 @ 1300	VSS afebrile Dressing CDI ⊕ BS x 4 Quads. midline incision Beefy red c̄ ⊕ granulation no other significant changes from last assessment. wound healing well. Will cont to monitor. (b)(6)-2 [illegible]
24 Apr 03 2250	Dressing Δ done. No s/s of infection. VSS. No other c/o @ this time (b)(6)-2 [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

MEDCOM - 4342

DATE	NOTES
25 Apr 03 @	1010 VSS pt dressing Δ teaching initiated, Sterile technique used. pt receptive to teaching.
	wound healing well. ⊕ granulation; beefy red color. will reinforce teaching in AM. no other
	significant changes. —— (b)(6)-2 ZCT/AN
25 Apr 03 2000	Assumed care of patient. Pt sitting in bed in NAD. Ambulates
	freely on ward. See VS Flowsheet for further —— (b)(6)-2 SSG 91WM6
26 Apr 03 0540	Slept quietly all night. ∅ c/o. ∅ pain meds. Voiding spontaneously.
	Tolerating PO. —— (b)(6)-2 SSG 91WM6
26 APR 03 @ 1500	VSS pt able to complete DSG Δ c̄ assistance. wound healing well. no other sig changes
	—— (b)(6)-2 ZCT/AD

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2200	Nursing Note: Pt A&O. OOB s̄ difficulty. ~~Tol~~ Tolerating diet well. DRSG Δ to abdomen pt completed c̄ minimal assistance ~~to~~ site s̄ s/s of infection. VSS. No distress Noted @ present. —— (b)(6)-2 CPT/AN
27APR03 0545	Pt rested well tonight. c/o pain around 0300 → Ibuprofen 800 mg PO c̄ good effect. Voids spont. via urinal. Ambulates on ward. Drsg C/D/I. VSS. afebrile (b)(6)-2 SSG, 91WM6
27APR 03 1400hrs	A&Ox3 ↑ OOB to outside Drsg Δ c̄ staff assistant. Meals consumed s̄ c/o N/V. Resting well —— (b)(6)-2 91WM6 SSC
27APR03 1817	Noted what appeared to be a fungal rash on pt's R side of neck white & brown circular patches. Dr (b)(6)-2 ordered lotrimin BID which pt was instructed on how to apply. Pt able to demonstrate how to properly apply —— (b)(6)-2 CPT
27 APR03 2335	Assumed care of pt. Pt s̄ c/o @ this time. VSS afebril Voiding per urinal —— (b)(6)-2 SSG 91WM6
28APR03 0540	Slept quietly throughout the shift. ∅ c/o. (b)(6)-2 SSG 91WM6
28APR03 1400	All vitals stable & Dressing Δ'd this shift, wounds absent of signs of infection. Pt currently w/out complaints —— (b)(6)-2 91WM6

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)

MEDCOM - 4344

DATE	NOTES
29 APR 03 0035	Pt resting quietly. Awakens easily. ∅ c/o pain. Drsg C/D/I. VSS Afebrile. Continue to monitor —— (b)(6)-2 SGT 91WM6
0535	Slept all shift s̄ c/o. Cont to monitor —— (b)(6)-2 SSG 91WM6
29APR03 0900	Pt assisted w/ dressing Δ wounds absent of s/s of infection. premedicated w/ 800mg Motrin. Pt ate all of breakfast & currently w/out complaints. ——→ (b)(6)-2 91WM6
30 Apr 03 0540	Rested well this shift. ∅ c/o pain —— (b)(6)-2 SSG 91WM6
1030	Per charge nurse CID informed to re-evaluted Pt's status for possible transfer to EPW Camp. Drsg Δ'd c̄ Pt assistance, limited staff assist. Medicated cream → neck area. ↑OOB → Outside s̄ complaint. — (b)(6)-2
30 APR 03 1730	Nursing Note: Pt A+O on arrival to shift OOB. continue to encourage pt to stand erect and ~~for~~ (b)(6)-2 independant care. Pt completed dressing Δ to abdomen c̄ minimal assistance. Medicated x1 for pain wound sites s̄ s/s of infection. Tolerating reg diet well. VSS. No distress noted @ present.
	(b)(6)-2 CPT/AN
1 May 03 0545	∅ significant Δ's tonight. ∅ c/o. Rested well (b)(6)-2 91WM6
1 MAY 03 @ 1420	∅ A+O ×3 VSS-afebrile. Drg Δ completed by pt. Wound beefy red c̄ granulation. ∅ s/sx of infection. Pt resting t/o day. —— (b)(6)-2 [illegible]
1 May 03 2116	Nursing Note: Pt able to demonstrate dressing Δ to include handwashing before & p̄ procedure. Pt also able to complete dressing Δ s̄ assistance. Wound sites s̄ s/s of infection. Tried to communicate to pt he will do his own dressing Δs when he is d/c to home and he will have to see a Doctor for follow-up. Will reinforce when interpreter present (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
MAY ~~02APR03~~	Pt slept quietly throughout night w/out complaints. (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)

MEDCOM - 4346

(b)(3)-1

Intraoperative Documentation

1. Patient Identification:
EPW - name unknown (IRAQ)

2. Assigned Scrub: SSG (b)(6)-2 / SSG / PFC

3. Assigned Circulator: CPT

4. Position and Positional Aids:
Supine (circled) Prone Lateral - Right Side Up Left Side Up
Comments: see #6

5. Skin Preparation:
Hair Removal - Yes No (circled)
Razor Clip
Prep Solution - Betadine Paint
Site: ABDomen
By CPT (b)(6)-2
Comments:
Comments: No pooling noted

6. Location of External Devices:
armboard <90° ; Prep ; Bottles straight out in front uncrossed. ; Bovie Pad ; armboard <90°

7. Counts: C = Correct I = Incorrect

	First	Final	Other
Sponge	C	C	
Needle/Sharp			
Instrument	N/A Emergency Case		

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

8. Implants Yes No (circled)

9. Electrosurgery Device Yes (circled) No
ESU # SN 2026073R ① 2nd Valleylab
Ground Pad — Brand Valleylab E7507
Bovie pad site clear Postop — Lot # 62382 Exp 2004-07
Cut 30 Coag 30
Cut 70 Coag 70

10. Medications/Orders

Medications	Dosage	Time	Method	Prepared By	Given By
Surgicel	QS	Intraop	Topical	MFR	(b)(6)-2

Wound Irrigation: .9% NaCl

Other Orders:	Time	Carried Out By

11. Additional Information
To OR ē Foley and chest tube

12. Dressing/Immobilization
(b)(6)-2
~~4x8's, Tape~~ Skin not closed. Wound Packed ē moist 4x8's. 4x8's and Tape on Top.

13. Operation Performed
Exploratory Laparotomy
Segmental Enterectomy
Gastrotomy Repair x 2
Cholecystectomy

14. PT Transferred To	Time	Method
44th CSH ICU	see Anes record	Litter

15. Registered Nurse Signature (b)(6)-2 CPT/AN

16. Physicians Signature (b)(6)-2 (b)(6)-2

(see back page)

ACLU-RDI 1244 p.382

DOD 010826

Op Note

PreOp Dx: 1) GSW to (R) shoulder c̄ exit wound over (R) scapula
2) GSW to (L) mid-abdomen c̄ exit wound over RUQ abdomen
3) Shock

Post Op Dx: 1) Thru & thru gastrotomy over greater curvature
2) Multiple enterotomies of proximal jejunum
3) (R) lobe liver GSW fracture

Surgery: 1) Exp lap 2) segmental enterectomy c̄ 1° stapled anastomosis 3) Control of bleeding of (R) lobe liver
4) Repair of gastrotomy x 2 (handsewn double layer c̄ 3° silk
5) Negative pericardial window

Surgeons: (b)(6)-2 / (b)(6)-2
Anesthetist: (b)(6)-2 / (b)(6)-2 → 6 ETA
EBL: 1200 cc   Fluid: 4400cc crystalloid, 2u PRBC

Specimen: Jejunum (to disposal)

Drains: Ø
Complications: Extreme hypothermia c̄ core temp 31°C
TO ICU / recovery intubated to be re-warmed.
(b)(6)-2 MD
(b)(6)-2

MEDCOM - 4348

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS
For use of this form, see AR 40-66; the proponent agency is the OTSG

WARD (b)(3)-1 ICU

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

DATE 24 Mar 03

	PATIENT'S NAME Katum	BP	HR	RR	SpO2	IVF	U/O	Pain/Temp
0800	Chest X-ray done VS	116/62	119	16	100%	NS @ 150		98.2
	Dsging Δ by Dr. Cavity							
0830	MSO4 4mg IVP	120/60	120	15	100	↓NS @ 110	-110cc/hr	(b)(6)-2
0845	Labs via i-STAT	Na 138	K 4.4	Cl 98	Bun 15	Glu 99	Hct 24	(b)(6)-2
1000	VS →	114/60	110	12	100	NS @ 110		
1030	VS pre Transport	115/61	119	14	100	SL	100	(b)(6)-2

DA FORM 3950, JUN 91 — Previous editions are obsolete. — USAPA V1.01

MEDCOM - 4349

ACLU-RDI 1244 p.384

DOD 010828

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	27 Mar	31 Mar 03					
POST- DAY							
MONTH-YEAR / DAY							
19 / HOUR		2100 0600					

PULSE (0) — Systolic BP ✓ — Diastolic BP ∧

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

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

Output 700

Input - PO

IV -

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.

Put EPW

VITAL SIGNS RECORDS

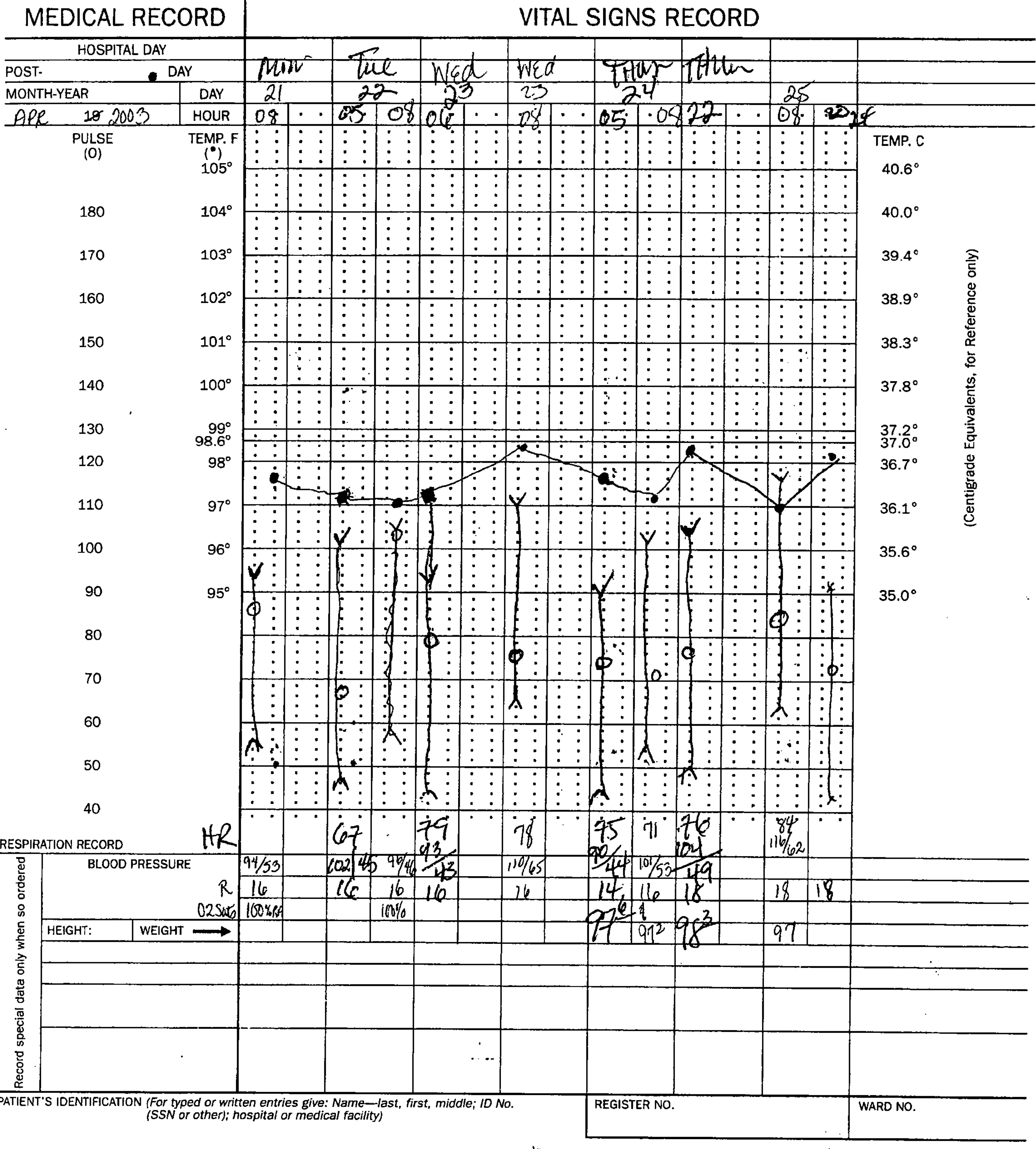
Medical Record

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

MEDCOM - 4350

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD



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

REGISTER NO.

WARD NO.

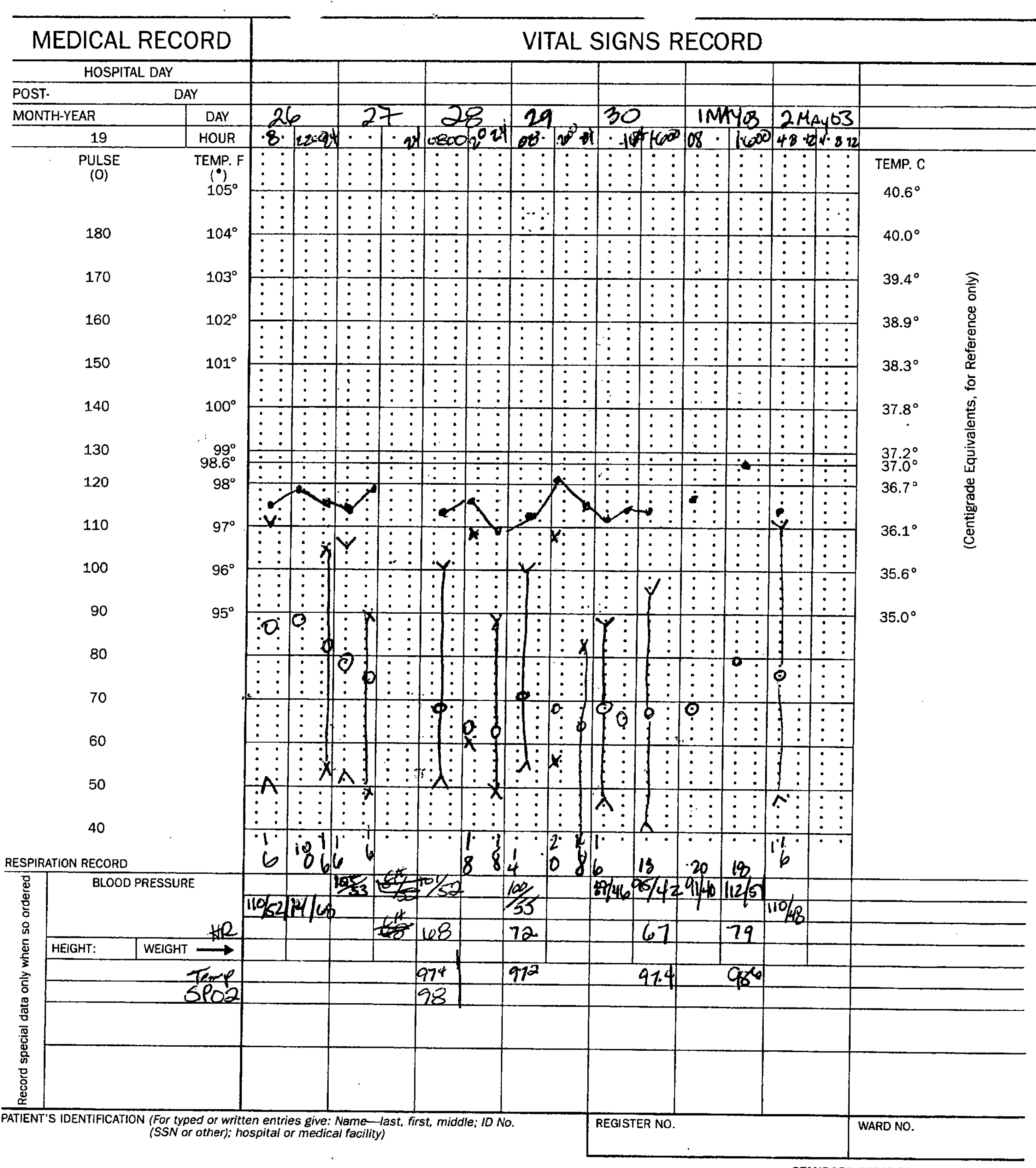
(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4351



MEDICAL RECORD | **VITAL SIGNS RECORD**

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	26	27	28	29	30	1 MAY 03	2 MAY 03	
19 / HOUR	8 · 1200 24	· · 24	0800 20 24	08 · 20 24	· 10 1600	08 · 1600	48 12 4 8 12	

PULSE (O) / TEMP. F (•): 180 – 104°; 170 – 103°; 160 – 102°; 150 – 101°; 140 – 100°; 130 – 99°, 98.6°; 120 – 98°; 110 – 97°; 100 – 96°; 90 – 95°; 80; 70; 60; 50; 40; 105° at top

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 | 10 | 16 | 16 | 6 | 18 | 18 | 14 | 20 | 18 | 16 | 18 | 20 | 18 | 16

Record special data only when so ordered

BLOOD PRESSURE: 110/62 | 121/60 | 105/53 | 64/53 | 110/52 | 100/55 | 89/46 | 96/42 | 91/40 | 112/51 | 110/48

HR: 68 | 108 | 72 | 67 | 79

HEIGHT: | WEIGHT →

Temp: 97.4 | 97.2 | 97.4 | 98.6

SPO2: 98

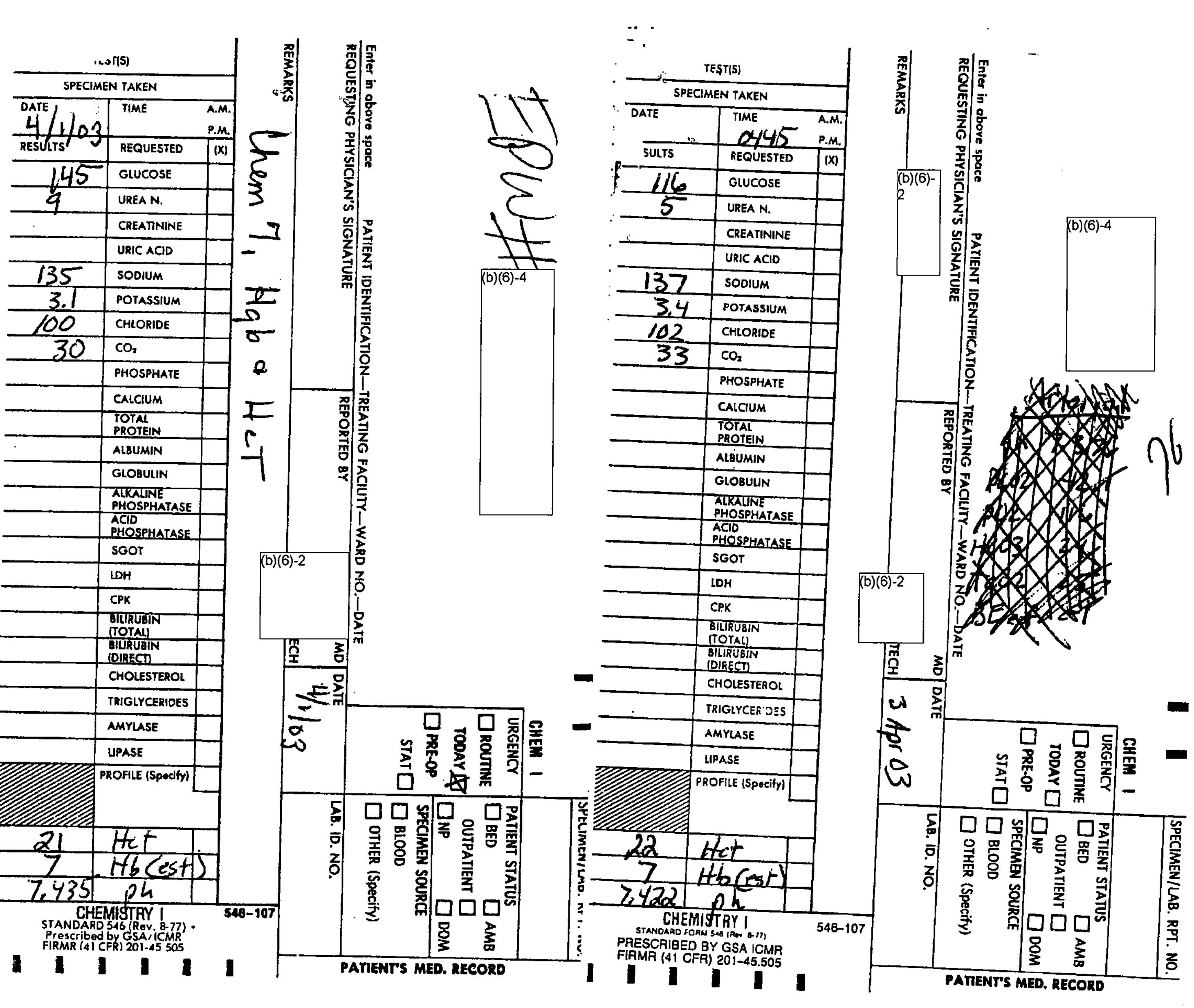
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)* | REGISTER NO. | WARD NO.

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

MEDCOM - 4352

ACLU-RDI 1244 p.387

DOD 010831



CHEMISTRY I — STANDARD FORM 546 (Rev. 8-77) — Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505 — 546-107

RESULTS	REQUESTED	(X)
145	GLUCOSE	
9	UREA N.	
	CREATININE	
	URIC ACID	
135	SODIUM	
3.1	POTASSIUM	
100	CHLORIDE	
30	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)	
7.435	ph	

TEST(S) — SPECIMEN TAKEN — DATE: 4/1/03 — TIME — A.M. / P.M.

REMARKS: Chem 7, Hgb & HcT

REQUESTING PHYSICIAN'S SIGNATURE — Enter in above space

REPORTED BY (b)(6)-2 — TECH — MD — DATE 4/1/03

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE (b)(6)-4

CHEM I — 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

CHEMISTRY I — STANDARD FORM 546 (Rev. 8-77) — PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505 — 546-107

RESULTS	REQUESTED	(X)
116	GLUCOSE	
5	UREA N.	
	CREATININE	
	URIC ACID	
137	SODIUM	
3.4	POTASSIUM	
102	CHLORIDE	
33	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)	
22	Hct	
7	Hb (est)	
7.422	ph	

TEST(S) — SPECIMEN TAKEN — DATE — TIME 0445 — A.M. / P.M.

REMARKS (b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE — Enter in above space

REPORTED BY (b)(6)-2 — TECH — MD — DATE 3 Apr 03

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE (b)(6)-4

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

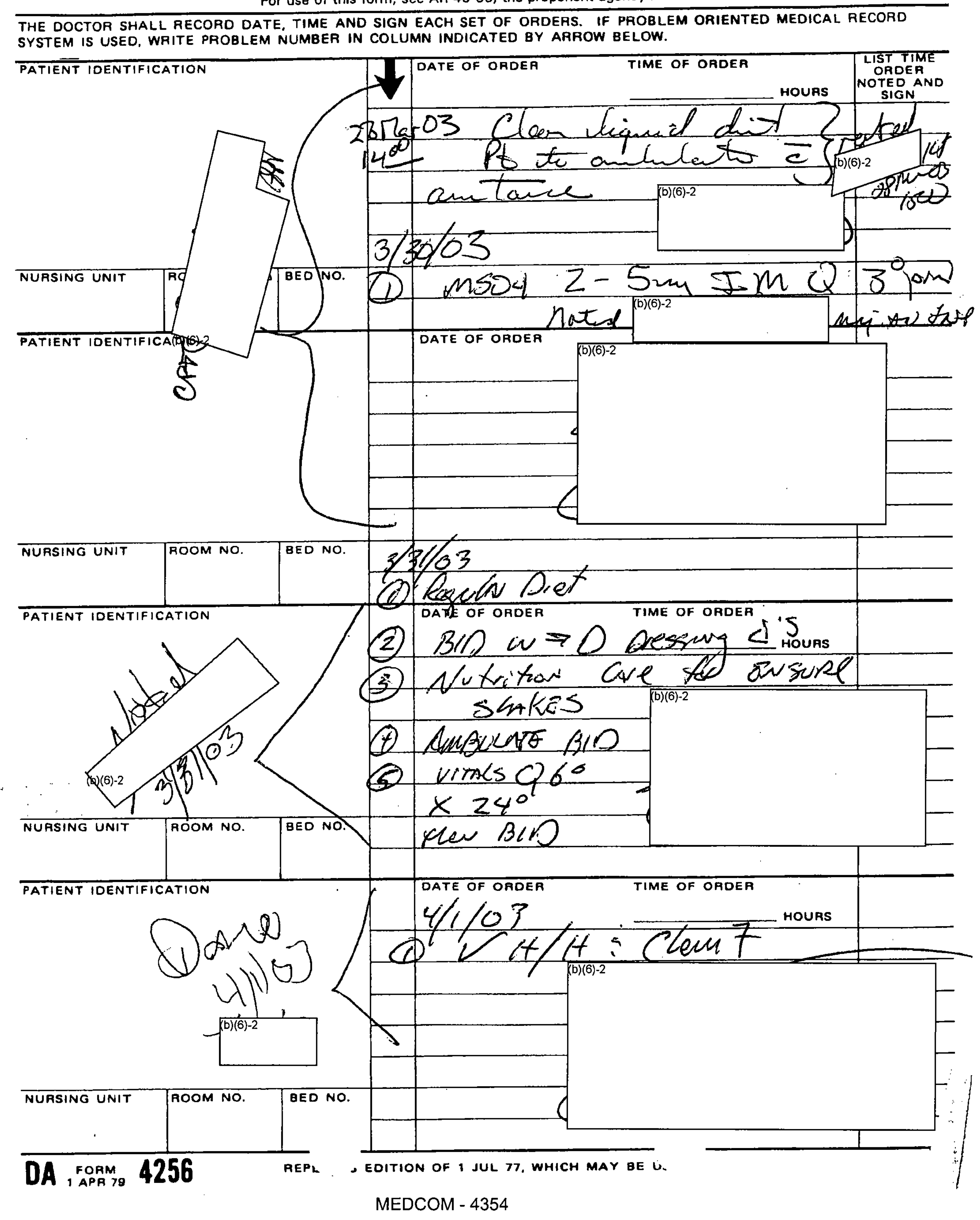
LAB. ID. NO. — SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

MEDCOM - 4353

ACLU-RDI 1244 p.388

DOD 010832



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

28 Mar 03 1400 Clear liquid diet. Pt to ambulate c assistance (b)(6)-2 — Noted (b)(6)-2 1400 28 Mar 03

3/30/03
① MSO4 2-5mg IM Q 3° prn
Noted (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICA(b)(6)-2 | DATE OF ORDER

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

3/31/03
① Regular Diet
② BID w→D dressing Δ's
③ Nutrition care for ENSURE SHAKES
④ AMBULATE BID
⑤ VITALS Q6° X 24°
Flex BID

(b)(6)-2

Noted 3/31/03 (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

4/1/03
① ✓ H/H : Chem 7

(b)(6)-2

Done 4/1/03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4354

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/03 0825Z	MD ORDERS
	① ✓ H/H AM 4/3/03
	② AMBULATE TID (b)(6)-2
	[illegible]
4/2/03 1530Z	MD ORDERS
	① LEVAQUIN 500mg po Q day
	② Don't forget the H/H in AM (4/3/03)
	(b)(6)-2
4/2/03 1535Z	pt given Levaquin 500mg. [illegible] (b)(6)-2
4/02/03 1555Z	Vitals – B/P 116/52, temp 99.4 axillary, Pulse 102, SpO2 96%
	resp 20 [illegible] (b)(6)-2 [illegible]
3APR03 0120Z	Pt c/o pain T=99.7 HR 100 RR 26 102/60, Tylenol 650mg
	PO given. (b)(6)-2
3Apr03 0103	L/E Pt drank 170ml of Ensure @ 1930-2000 [illegible] (b)(6)-2
3Apr03 0410Z	H/H drawn ① FA c̄ 18g sent to lab (b)(6)-2 [illegible]

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

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

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

MEDCOM - 4355

ACLU-RDI 1244 p.390

DOD 010834

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 APR 03 0420Z	Pt Lungs [illegible] (B). Heart RRR, ↓BS (B) Midline DSG intact ē visible sign of drainage. POC is for (B) Pt to ambulate [illegible] TID, push PO fluids use IS. (b)(6)-2 [illegible]
	ORDERS ...
3Apr03 1930	Pt states he has alot of PN on Abdomin Inscision. Also spinal PN below intrence wound. Pt given ī T3's. Pt wound on back ī·ī also dressed. Pt given Ensure Plus to drink. B/P 98/52 P 109 R10 SAO2 96 Temp - 101.0 Pt needs ~~spinal~~ (b)(6)-2 wound and spine evaluated a.m tomarro by Dr (b)(6)-2 SPC (b)(6)-2
	Pt would no drink Ensure. So I gave Pt Strabeny and vanallia shake c̄ 7.25L of H2O. SPC (b)(6)-2
	Pt states he has has PN while eating andrinking liquids other than water. Pt states PN is against abdominal wall. Pt states no previous surgerys or injurys to abdomin at any age before current injury — SPC (b)(6)-2
2235	Pt awaken c̄ PN 650mg Tylenol, 50mg Benadryl PO given SPC (b)(6)-2
2240	Levaquin is to be on day shift. (b)(6)-2 LPN, SGT
4/4/03 0900Z	- Gave Pt Levaquin (b)(6)-2
4 Apr 03 0435 Z	Orders (1) Ensure 240 cc q 3°
	(2) Insert NG for tube feeding (Dobhoff unavailable)
	(b)(6)-2 LTC, AN FNP

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

MEDCOM - 4356

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	MD ORDERS
	DO NOT WRITE NOTES HERE
	(1) Ensure 1 cup Q 3° (located ICU #2)
	(2) Do not feed between 2100Z and 0300Z
	(Allow patient to sleep)
	(3) If refuses Ensure then Restrain patient
	and drop Dobhoff
	and feed 250cc Ensure Q 3°
	(b)(6)-2
~~4/5/03 0710~~	~~(1) KUB film flat/upright~~ ERROR (b)(6)-2
	(b)(6)-2
4/8/03 @ 0445	(1) D/C Levaquin p today's dose

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

(b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

4/8/03 @ 1500
Transfer to ICW #3

(b)(6)-2
MEDCOM - 4357

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
	Medical Orders
10 Apr 03	
0950Z	Rx ① Acetiminophen 650mg to 1000mg PO q 4-6 hours prn pain.
	② Ibuprofen 800mg PO q 8° prn pain
	③ Tylenol #3 PO q 4-6° prn pain only
	p̄ trying Acetaminophen and/or Ibuprofen
	(b)(6)-2

Noted (b)(6)-2 0958 10 Apr 03

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)

MEDCOM - 4358

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	MD ORDERS
	(b)(6)-2
	D/C to EPW Compound.
	MD
	2) Lotrimin cream Apply to area BID — Noted 1816 27APR (b)(6)-2 (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

MD ORDERS

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

MEDCOM - 4359

CLIN... ...RD

THE...APEUTIC D...CUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the pro...onent agency is the Office of The Surgeon General.

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED				
				04	05	06	07	08
4APR03		Ensure 1 cup Q 3°	03			(b)(6)-2		
		If refuses then restrain	06					
		and use NSG (Dobhoff)	09					
		@ 250cc ensure Q 3°	12 15 18 21	2 2				
4APR03		Leviquin 500mg Qd	09	/	(b)(6)-2			D/C

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

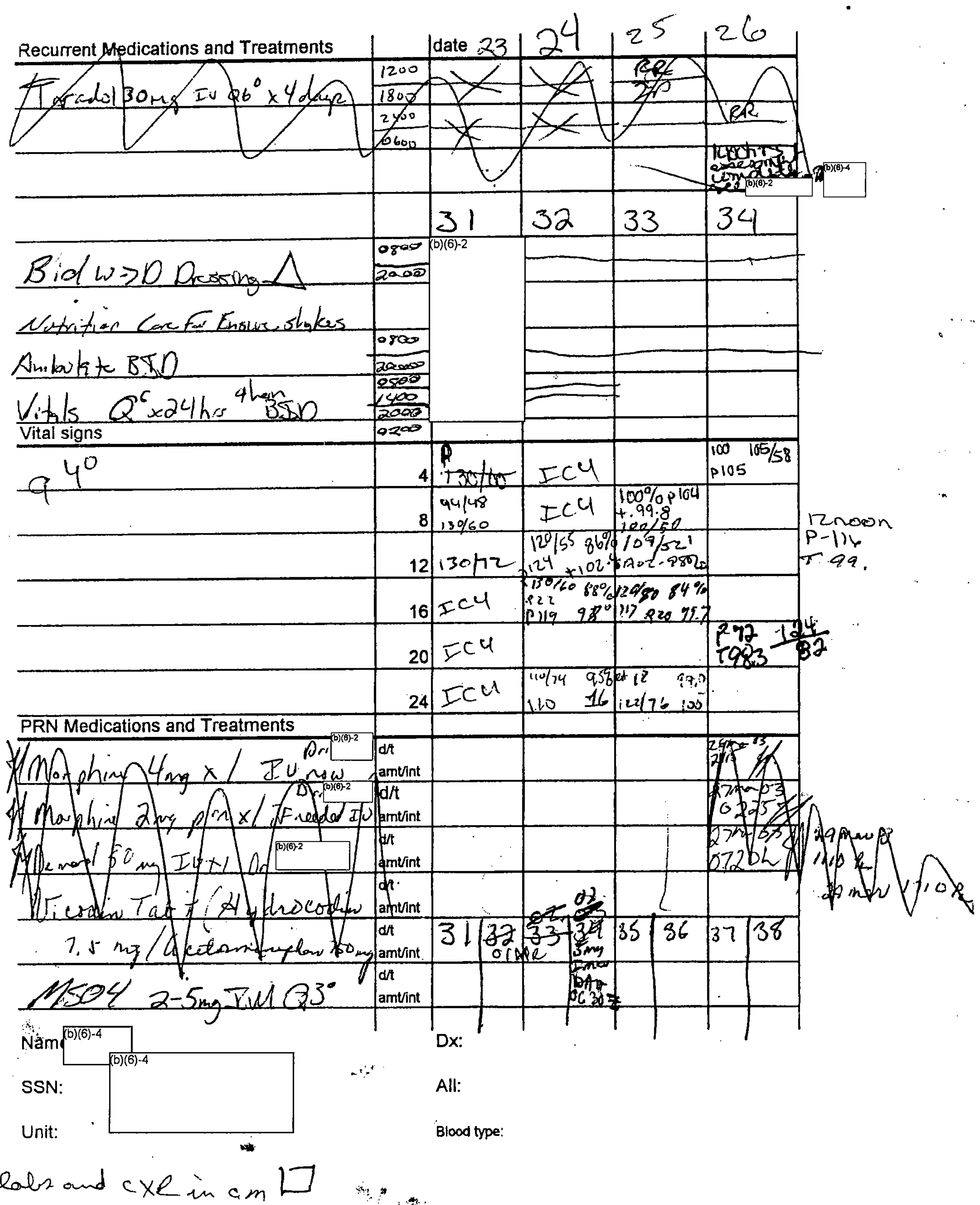
DA FORM 4677, 1 OCT 78 MEDCOM - 4360 USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE [illegible]N
(NON-MEDICATION)

Mo ____ Yr ____

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLU[M]N FOLLOWING COMPLETION — TIME/D[ATE] COMPLETED
10Apr03	(b)(6)-2	Acetiminophen 650mg to	
-----	-----	1000mg PO q 4-6h -	
-----	-----	prn for pain	
10Apr03	(b)(6)-2	Ibuprofen 800mg	
-----	-----	PO q 8hr prn pain	
16Apr03	(b)(6)-2	Tylenol #3 PO q4-6hr	
-----	-----	prn pain only p̄	
-----	-----	trying acetaminophen or	
-----	-----	Ibuprofen	
-----	-----		



Recurrent Medications and Treatments		date 23	24	25	26
Toradol 30mg IV Q6° x 4 days	1200 1800 2400 0600				
		31	32	33	34
Bid W->D Dressing Δ	0800 2000	(b)(6)-2			
Nutrition Care for Ensure shakes					
Ambulate BID	0800 2000				
Vitals Q° x 24hrs 4hrs BID	0800 1400 2000 0200				

Vital signs					
q 4°	4	130/100	ICU		100 105/58 P105
	8	94/48 130/60	ICU	100% P104 T 99.8 100/50	
	12	130/72	120/55 86% 124 T102.4	109/52 Apoz-98%	
	16	ICU	130/60 88% R22 P119 98°	124/80 84% 117 R20 99.7	P72 124/82 T98.3
	20	ICU			
	24	ICU	110/74 95% 110 16	12 122/76 100	

12noon P-116 T 99.

PRN Medications and Treatments					
Morphine 4mg x1 IV now Dr (b)(6)-2	d/t amt/int				
Morphine 2mg prn x1 Toradol IV Dr (b)(6)-2	d/t amt/int				
Demerol 50mg IV x1 Dr (b)(6)-2	d/t amt/int				
Vicodin Tab (Hydrocodone 7.5mg / Acetaminophen 750mg)	d/t amt/int	31 32 OTMR	33 34	35 36	37 38
MSO4 2-5mg IM Q3°	d/t amt/int				

Name: (b)(6)-4

SSN: (b)(6)-4

Unit:

Dx:

All:

Blood type:

labs and CXR in am

MEDCOM - 4362

ACLU-RDI 1244 p.397

DOD 010841

23 March 03
~~I+O of 24 March 03~~

IVF	Time	amount	Total		
~~LR NS@110 cc/hr~~ 800 @ 1100					

Hourly Input and Output		IV		CT	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600			100	
	0700				
	0800				
8 hour totals				100	
	0900	~~800~~			500
	1000				
	1100				
	1200				
	1300				
	1400			275	
	1500				
	1600	800			250
8 hour totals		800		275	750
	1700				
	1800				
	1900				
	2000	ICU			
	2100				
	2200				
	2300				
	0000				
8 hour totals					
24 hour totals					

Total input:
Total output:
Balance:

27 Mar 03 0230 1000 cc NS

MEDCOM - 4363

ACLU-RDI 1244 p.398

DOD 010842

I&O 24 Mar 03

25 March 03
Out 700cc urine
0522
0949 700cc
1412 800
26 March
1300cc 0501
300cc 2350

IVF	Time	amount	Total		
NS @ 110cc/hr ICU					
NS @ 110cc/hr 800TC 1100	1800	750	750		
NS @ 110cc/hr 1800	02	900	160		
NS @ 110cc/hr 500T @ 0630	0630				

Hourly Input and Output		IV	NG	CT	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100				
	1200				
	1300				
	1400				
	1500				
	1600				500
8 hour totals			0		500
	1700				
	1800				
	1900				
	2000		15		
	2100				300
	2200				
	2300				
	0000		5		
8 hour totals			20		300
24 hour totals			20	25	800

Total input:
Total output:
Balance:

ACLU-RDI 1244 p.399

DOD 010843

Recurrent Medications and Treatments		date			
Vital signs					
	4	S 79 BP 148/89 P 122 T 98.7			
	8				
	12				
	16				
	20				
	24				
PRN Medications and Treatments					
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: Dx:

SSN: All:

Unit: Blood type:

Recurrent Medications and Treatments		date 3/30	3/31	1	2	3	4	5
Tylenol #3			1700 x2 (b)(6)-2					

Vital signs								
2 apr03 Ambulated TID	4	/	/	/				
EAT - Ensure shakes	8	/	/	/				
	12							
	16							
	20							
	24							

PRN Medications and Treatments								
MSO4 2-5mg IM q3°	d/t	1900/3/30	1830 31 Mar					
	amt/int	4mg (b)(6)-2	4mg (b)(6)-2					
pain prn	d/t		1915 31 Mar					
	amt/int		2mg (b)(6)-2					
	d/t							
	amt/int							
	d/t							
	amt/int							
	d/t							
	amt/int							
	d/t							
	amt/int							

Name: (b)(6)-4

SSN:

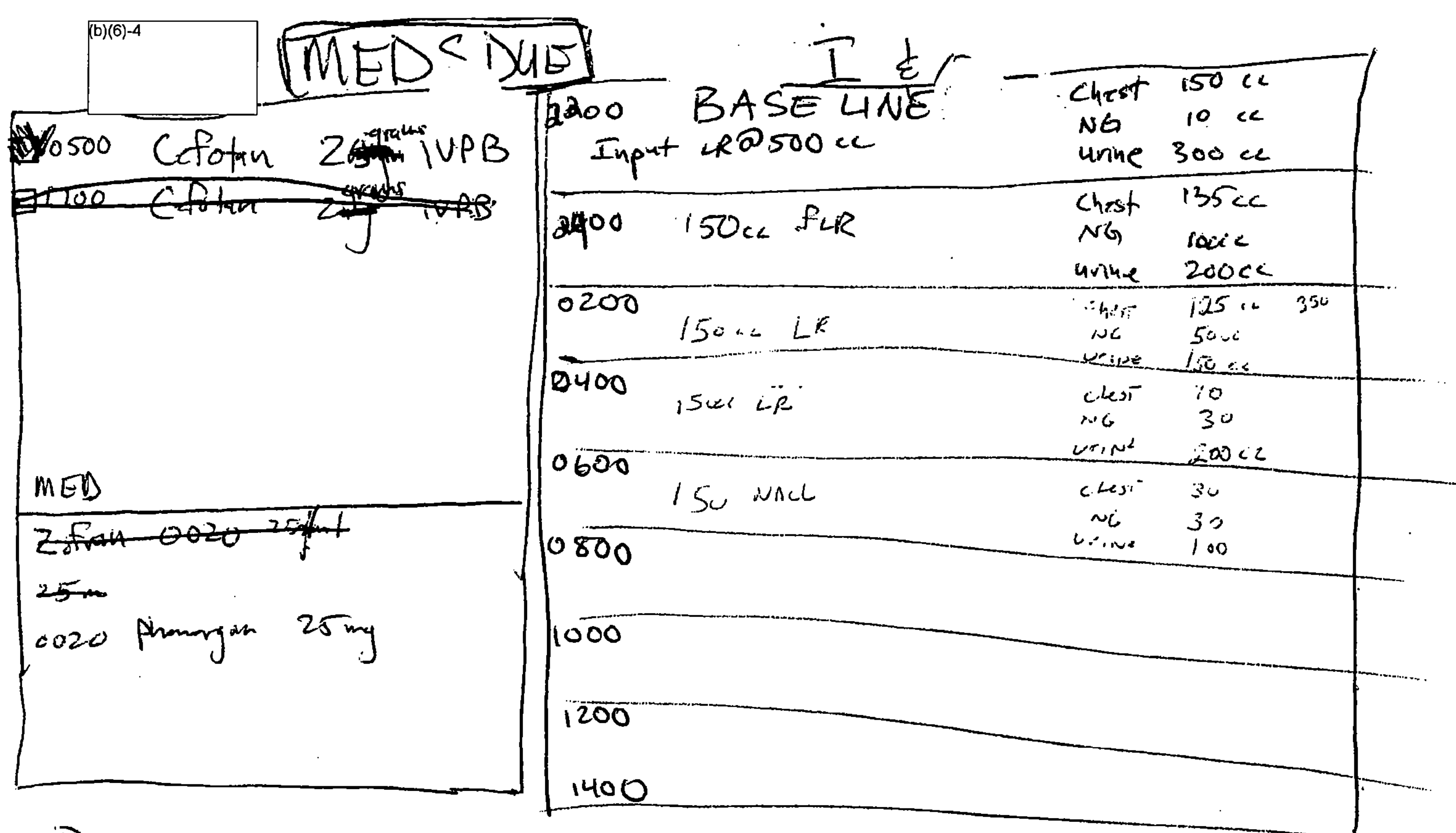
Unit:

Dx:

All:

Blood type:

MEDCOM - 4366



PAIN Management

1445	5 mg	MsO4	IVP
1700	5 mg	MsO4	IVP
1900	5 mg	MsO4	IVP
2230	6 mg	MsO4	IVP
0130	2 mg	MsO4	IVP

Progress NOTE

2200) Pt. resting ē HOB ↑ @ 45°, NG tube is in place. IV in (R) AC @ 150cc/h s̄ complications, (L) IV FA (L) wrist locked & patent. Foley secure. Chest tube in place as per X-ray. Dressing remain CDI. Note Chest tube ē NG tube @ continuous low suction (80 mm Hg.)

Zofran 0020
25mg/mL

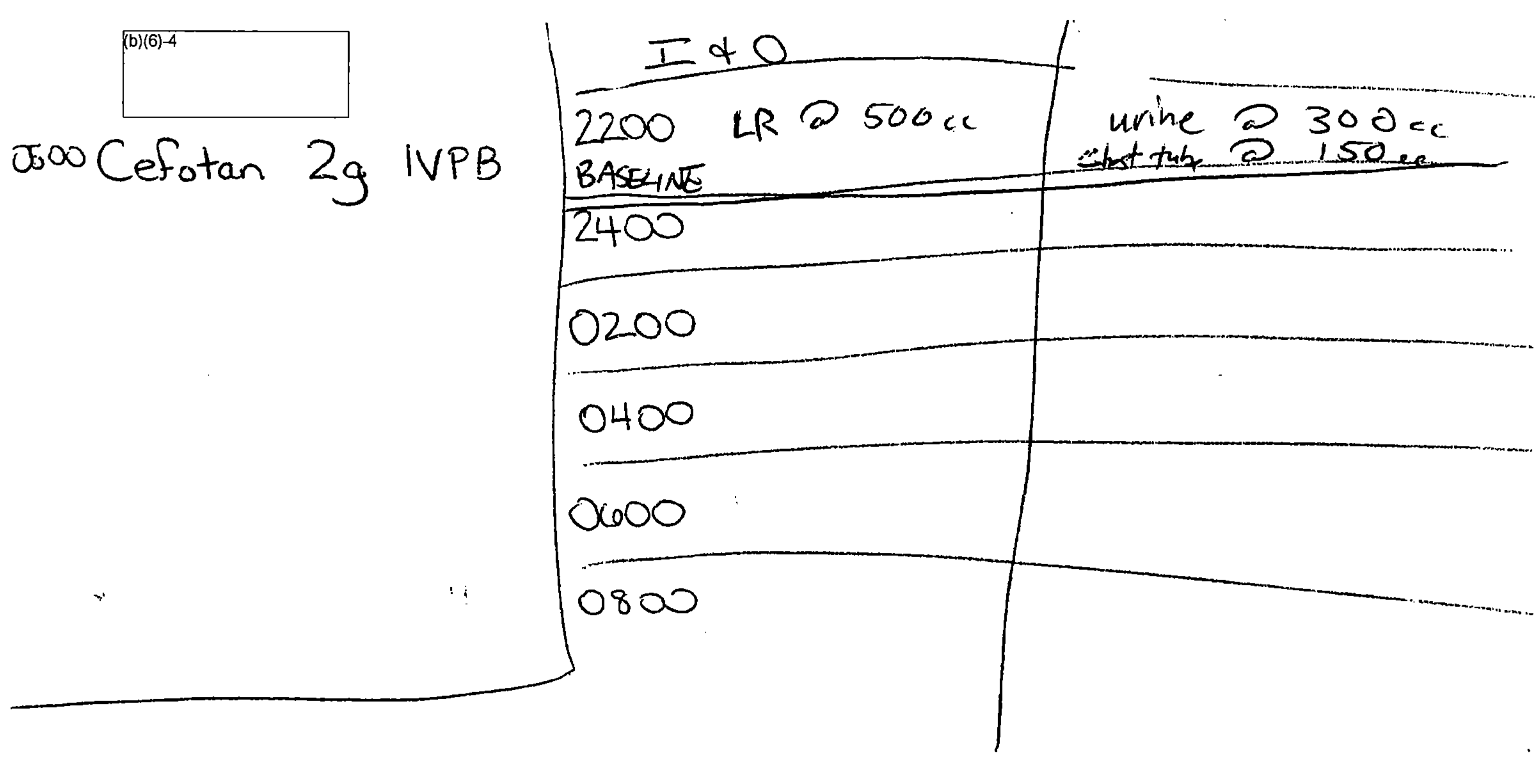
Vital Signs

TIME	BP	HR	SPO2	RR	Pain
2240	111/57	107	98	14	8
2300	116/63	110	99	14	sleep
2400	120/62				
0100	119/60	119	99	25	4
0200	124/61	117 / 119	98	18	
0300	122/61		100	22	
0400	112/55	115 / 121	100	11	
0500	114/62	127	100	11	
0600	116/62	133	96	19 / 23	
0700	113/61				
0800	110/60	117	100	9	sleep
0900	110/61	116	100	10	
1000		111	100	10	sleep
1100					
1200					

MEDCOM - 4367

ACLU-RDI 1244 p.402

DOD 010846


(b)(6)-4
0500 Cefotan 2g IVPB
I & O
2200 LR @ 500cc
BASELINE
urine @ 300cc
chest tube @ 150cc
2400
0200
0400
0600
0800

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 18	19	20	21	22	23	24	25	26	27	28	29	30	1
18APR03	(b)(6)-2	nurse initiated	07 19	(b)(6)-2													
		VS	19 07														
		Diet Regular + supplement	15										(b)(6)-2				
		c̄ Ensure															
18APR03		Dressing Changes BID	10	(b)(6)-2													
		Wet to dry	22														
18APR03		ambulate BID	10	(b)(6)-2													
			22														
27APR		Lotrimin cream apply	10	/	/	/	/	/	/	/	/	/	(b)(6)-2				
	-----	to area BID	22	/	/	/	/	/	/	/	/	/	(b)(6)-2				

	-----	Rewritten	5/2/03														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p GSW ABD (R) chest
s/p SBR / gastrotomy repair

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4369

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
18APR03	(b)(6)-2	Admit to minimal care ward				
		S/P GSW to Ⓡ ant + Ⓡ posterior chest; GSW to Ⓛ abd → RLQ				
		Condition stable				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
			TIME/DATE DISPENSED													
18APR03	(b)(6)-2	Ibuprofen 800 mg po with food	D 18 APR03 T 1945		20 APR03 1325		21 apr03 1740	21 APR03 0900		23 Apr 0230 800mg (b)(6)-2	24 apr 1300 (b)(6)-2	27 Apr 0300 (b)(6)-2	28 APR 1120 (b)(6)-2	29 Apr 03 0900	29 Apr 2300	30 apr 1700
		po Q 8 prn pain	(b)(6)-2													
			1 MAY 1700 (b)(6)-2													
		Rewritten 5/2/03														

*U.S. GPO: 1996-454-110/95216

MEDCOM - 4370

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. 5 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5										
18APR03	(b)(6)-2	Nurse initiated	07	(b)(6)-2													
		vital signs	19														
18APR03		Diet: Reg. & Supp.	15														
		w/ Ensure	/														
18APR03		Dressing change BID	10														
		WET-DRY	22														
18APR03		Ambulate BID	15	(b)(6)-2													
			22														
27APR03		Lotrimin cream apply	10														
		to area BID	22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW ABD/Ⓡ chest
S/P SBR

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

BED # (b)(6)-4

pt # (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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
6[illegible]	.....	Ibuprofen 800 mg po														
.....	.....	Q 8h PRN pain														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 4372

I[illegible] [illegible]ENT TREATMENT RECORD COVER [illegible]

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

1. (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4	3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	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 1
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 Direct	22. HOURS OF ADMISSION 2203	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION 29 APR 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 12 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 L Chest

E991.2

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
13	13				13

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 MD MAJ MC

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

[illegible] Y 79 EDITION OF 1 [illegible]

MEDCOM - 4187

USAPPC V1.10

ACLU-RDI 1244 p.408

DOD 010666

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
(Name)	(b)(6)-4
3. GRADE	
ADMISSION REMARKS	
4. SEX	M
5. AGE	
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	ICW1
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	Direct
22. HOURS OF ADMISSION	2203
23. CLINIC SERVICE	ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	
26. DATE OF DISPOSITION	29APR03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	12APR03
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

GSN L Chest
E991.2

III
879.2

II
879.2
864.01
47562
44320
47350

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
13	13				13

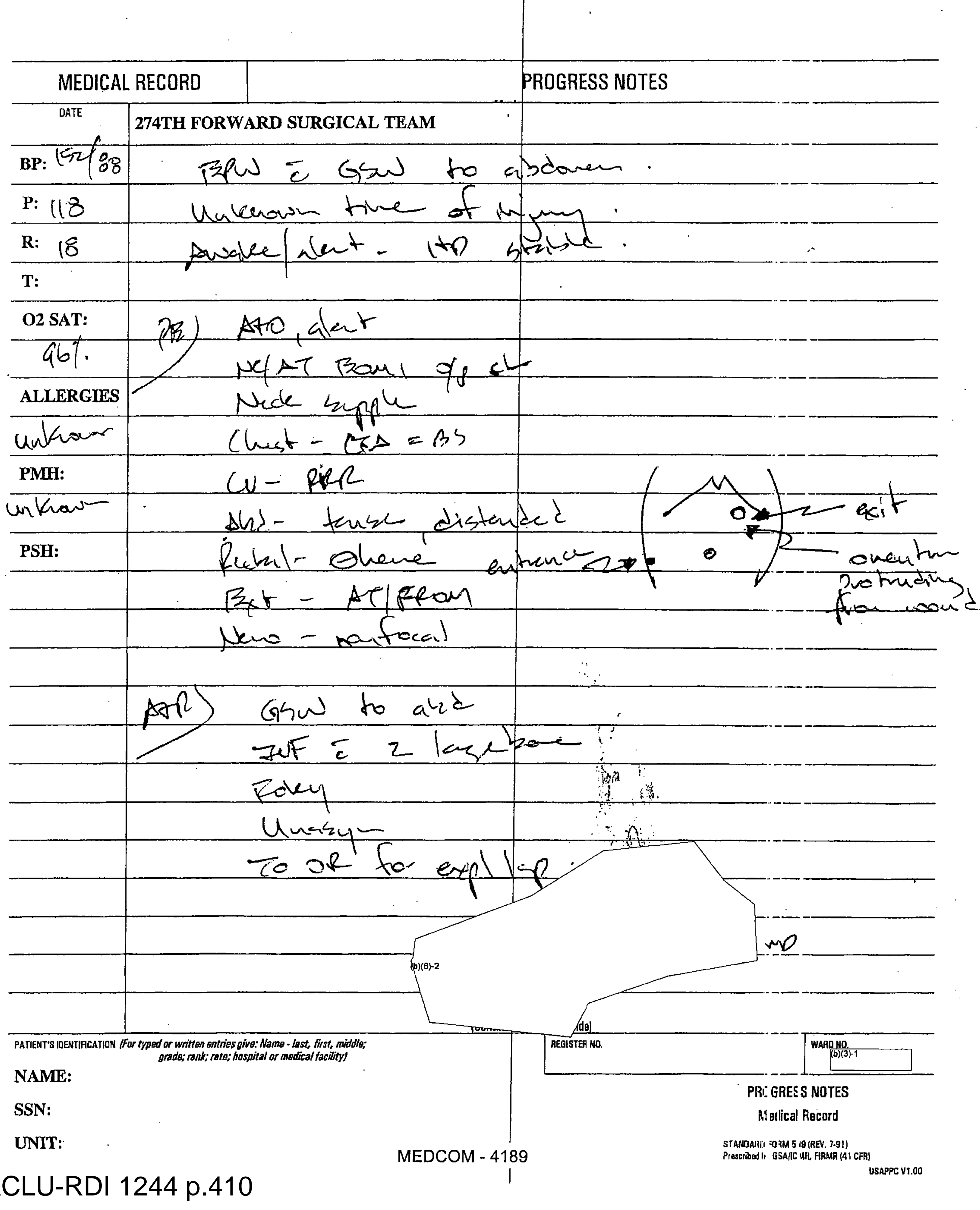
36. Total Days All Facilites

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 MD MAJ MC

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

DA ... Y 79 MEDCOM - 4188 USAPPC V1.10



MEDICAL RECORD | PROGRESS NOTES

DATE	274TH FORWARD SURGICAL TEAM
BP: 152/88	BPW c GSW to abdomen.
P: 118	Unknown time of injury.
R: 18	Awake/alert - HD stable.
T:	
O2 SAT:	PE) A+O, alert
96%	NC/AT PERRL, o/p clr
ALLERGIES	Neck supple
unknown	Chest - CTA = BS
PMH:	CV - RRR
unknown	Abd - tense, distended
PSH:	Rectal - heme'
	Ext - AT/FROM
	Neuro - nonfocal
	A/P) GSW to abd
	IVF c 2 large bore
	Foley
	Unasyn
	To OR for expl lap
	MD

(b)(6)-2

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

NAME:

SSN:

UNIT:

REGISTER NO.

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

MEDCOM - 4189

MEDICAL RECORD | **PROGRESS NOTES**

DATE

23 MAR 03 Surgery

OPERATIVE NOTE

DIAGNOSIS: GSW to abd.

PROCEDURE: Expl lap / Repair liver fracture / cholecystectomy / tr colon resxn c colostomy + Hartman's.

SURGEON: (b)(6)-2

FINDINGS: Fractured liver, contused GB, transverse colon injury. ⊖ retroperitoneal hematoma ⊖ duod. injury ⊖ CBD injury ⊖ stomach injury.

FLUIDS: 9 L crystalloid EBL: 750 cc

U/O: 3 L U/O.

JPs x 2 / NGT / Foley

To ICU, stable, intubated (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.

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

MEDCOM - 4190

ACLU-RDI 1244 p.411

DOD 010669

24 MAR 03

Surgery POD # 1

S/P expl lap / liver repair / cholecystectomy / colon rsxn

2° GSW

Comfortable but tachycardic / tachypnic

Afeb 136/80 120 20

Chest ↓ BS (B)

CV - RRR

Abd - soft, distended, min tender

Dressing - saturated superiorly

Colostomy - pink / patent

$)^{36}$ $)^{40}$

CXR ↓ lung volumes

A/P) - stable postop

Tachycardia ~ afeb / sats ok / but stable

Δ dressing

↓ fluids

Chest PT

Cont abx

(b)(6)-2

MD

25 MAR 03

Surgery POD # 2

S/P GSW to abd.

Comfortable

↓ HR ↓ tachypnea good pressure U/O good JPs ↓ing

Chest still junky

Abd soft, NT, ND

Incis c/d/i ostomy pink

A/P) less hyperdynamic c̄ toradol

Unasyn → Cefotetan

D/C NGT

Ambulate

Cont deep breath / cough

(b)(6)-2

MD

PROGRESS NOTES

DATE	
27 Mar 03	2100 - ⊖ stool from ostomy x 8°, ⊖ BS, T 101.8 F
	⊕ Tend ⊕ guarding ⊕ firmness MD aware + orders written.
	7X Shorter Rocephin given will monitor —— (b)(6)-2
27 Mar 03 2350	No changes from previous exam. sleeping well. (b)(6)-2 1LT/AN
28 Mar 03 0650 L	VS - 118/84, P 115, R 24, SpO2 91% T 97.4 (b)(6)-2 1LT/AN
28 Mar 03 0657	LE 0600 colostomy bag change, output moderate (b)(6)-2 1LT/AN
28 March 2003	
0715	stool, mg, temp low
	Abdomen softer
	will offer diet (b)(6)-2
	(b)(6)-2
28 Mar 03 1000	Given MSO4 5mg ⊕ result — (b)(6)-2 1LT
28 March	1t. (b)(6)-2 (b)(6)-2 drained 40cc dark red
	fluid. colostomy bag emptied. no signs of infection
	around colostomy site. —— (b)(6)-2 [illegible]
1200	Given Rocephin 1gm and Clindamycin 900mg — (b)(6)-2
28 Mar	(b)(6)-2
	JP #1 pulled.
	Will get pt up and ambulate
	to improve pulmonary toilet (b)(6)-2
28 MAR 03	
1630	P - 119 B/P - 134/78
	R - 21 SaO2 90%
	T - 101.5 Acetaminophen 325 mg po tabs X 2 given 1640 PO

(b)(6)-2 maj AN (b)(3)-1

ACLU-RDI 1244 p.413

DOD 010671

PROGRESS NOTES

DATE	
27 Mar 03	2100 - ⊖ stool from ostomy x 8°, ⊖ BS, T 101.8 F
	⊕ Tend ⊕ guard ⊕ firmness MD aware & orders written.
	ZX Shortened Rocephin given will monitor [redacted] 662
27 Mar 03 2350	No changes from previous exam. sleeping well. (b)(6)-2 ICU/AN
28 Mar 03 0650 L	VS - 118/84, P 115, R 24, SpO2 91% T 97.4 (b)(6)-2 ICU/AN
28 Mar 03 0651	LE 0600 colostomy bag change, output moderate (b)(6)-2 ICU/AN
28 March 2003	
0755	stool/ring, temp low
	Abdomen softer
	will offer diet (b)(6)-2
28 Mar 03 / 1000	Given MSO4 5mg ⊕ result — (b)(6)-2 ICU
28 March	H (b)(6)-2 drained 40cc dark red
	fluid. colostomy bag emptied. no signs of infection
	around colostomy site. (b)(6)-2 ICU
1200	Given Rocephin 1gm and Clindamycin 900mg — (b)(6)-2
28 Mar	(b)(6)-2
	JP#1 pulled.
	Will get pt up and ambulate
	to improve pulmonary toilet (b)(6)-2
28 MAR 03	
1630	P - 119 B/P - 134/78
	R - 21 SaO2 90%
	T - 101.5 Acetaminophen 325 mg po tabs X 2 given 1640 PK

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

(b)(6)-2 maj AN (b)(3)-1

MEDCOM - 4193

MEDICAL RECORD	PROGRESS NOTES

DATE	
27 Mar 03	0900 - Pt resting, states minimal abd pain via interpreter.
	ABD dsg C+D+I, stoma red [illegible] ⊕ output. JP x2
	with 15 serosang and 7.0 mL serous drainage. Mild erythema
	at JP site. ⊕ BS, ST 100-110 pulse ↓ x4. Extreme difficult
	maintain colostomy collection. Voids per urinal 450mL
	amber concentrated urine T 97.1 HR 120 R 21 - (b)(6)-2 /LT
	1030 Pt c/o pain to abdm. adm T3 x II - (b)(6)-2 /LT
1430	pt arrive in new location ate some food. urinated 400cc
	pt alert and oriented. (b)(6)-2
1540	V/S taken 130/70 P 90 T 96.9 - (b)(6)-2
2020	Dressing was changed @ 2000. Ax temp 101.8 (b)(6)-2 SG
2045	IV started Ⓡ wrist (b)(6)-2 SGT
#	
27 March 2003	General Surgery
2100	S/P repair liver laceration, colostomy
	23 March 2003. Has been having good
	colostomy output until today. No stool
	no flatus; abdomen now distended.
	temp 101.8 HR 120.
	Acknowledge only small amount of pain
	PE: Does not appear septic
	↓ BS Ⓡ side
	Abdomen quiet, distended
	Imp: Prob [illegible] will re-examine 28 March 03

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. (b)(6)-2 WARD NO. (b)(6)-2

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

MEDCOM - 4194

DATE	NOTES
4APR03 1905	Tmp 98.7 (b)(6)-2 LPN, SGT
22:50	TMP 97.3 Erythromycin 500mg PO LPN SGT
01:35	Pt colostomy ruptured, leaked all over, started cleaning ē No problems.
	when cut shirt away pt removed cigarett & matchs from pocket.
	and attempted to hide. I SGT (b)(6)-2 started to retrieve and,
	pt grabed my wrist to stop me. I continued to rech for
	pack showing unprusdented restraint in handling the situation. After
	taking he was ~~finished~~ (b)(6) cleaned and given a new shirt. No
	shorts were to be found so his were cut from him, at the
	area of soilage. Pt attempted to get out of bed to
	retreive cigreets told him no when he started up. I
	called the MP Guard and in and the pt went to wash
	basin and washed hand's and returned to bed. Denied assistance
	with bed. He arowsed other pt's wich became disruptive. I
	talked with ~~other~~ the interpreter earlier in the day and he
	stated that the pt was being the leader for the others. (b)(6)-2 SGT, LPN

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
06APR03	Δ OF SHIFT ASSMT COMPLETE. PT A&O. LUNGS CTA. DIMINISHED BASES. PT ON
1705	O2 NON-REBREATHER MASK - 15L. SaO2 @ 100%. PT ENCOURAGED TO USE PULMONARY
	TOILET & INSTRUCTED ON USE OF INCENTIVE SPIROMETER. PT HAS DRESSING TO ABD
	ML. CDI. PT HAS FOLEY TO GRAVITY. (b)(6)-2 SGT/LPN
07 APR03 0145.	HEMATURIA NOTED IN FOLEY BAG. MD SAW BAG EARLIER IN SHIFT & STATED IT WAS FINE
	500 cc DARK RED COLORED URINE EMPTIED FROM FOLEY. PT T - 100.5 A. WILL CONTINUE TO
	MONITOR (b)(6)-2 SGT/LPN
07 APR 03 0700Z	Pt VSS. Ronchi in upper lobes, lower lobes sound CTA. Bowel sounds
	absent x4 quadrants. abd. tender, soft to palpate. Dressing Δ'd, no
	signs of infection. repacked wet to dry. urine pink in color. Urine
	dip stick to be done. Pt on 9L O2 via face mask stating 93%.
	Pt A+O x3, neuro in tact. PERRLA bilat. cap refill <2 sec. skin
	turgor good. Pt uses IS q h°. (b)(6)-2 9/LVN MG
07 APR 03	1600Z Pt. had episode today when SaO2 stats went
	down to 85%. Pt is on 10L NR stating 93% now.
	Pt had episode when attempting to get out of
	bed. Emptied 700 cc of green liquid from NG tube.
	Urine ~~output~~ LKL 07APR03 output was 750cc urine yellow with
	tinge of pink. (b)(6)-2 9/[illegible]

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

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

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

(b)(6)-4

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 R

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7apr03	1630 PT A&O x3, Pupils PERRLA, Resp shallow, diminshed in bases c̄ wheezing upon expiration, PT SaO2 92%-94% on 10L via concentrater & NR, had PT use incentive spirometer, During use SaO2 droped to 85%, PT became agitated & showed signs of dypsnea. HR Tachycardic from 110-130 elevated upon agitation all distal pulses +3. Diet NPO c̄ BS non-active not passing flatus, Foley to gravity QS Urine is blood-tinged. Status Post X-Lap. Dressings CDI, PT moves all ext independently. (b)(6)-2 SPC LPN
7apr03	1800 PT running a/temp 101.3 wet towels applied to forehead & chest wool blanket removed
	(b)(6)-2 SPC LPN
8apr03	0230 - PT slept most of night without complaint, temp down from to 100.7 (b)(6)-2 SPC LPN
8apr03	0435 - PT Urine contines to be blood tinged, dark & concentrated. (b)(6)-2 SPC LPN
8APR03 0615	PT started 2u PRBC's initial VS T 100.4 P 122 B/P 123/72, 5 min VS 118/70, 124, 100.4, 15 min VS HR 122 BP 117/67, T. 100.7, 45 min VS HR 122 B.P. 116/68, T. 100.6, 1 Hour VS 112/65 HR 118, T 100.5 /1st Set VS 1st unit BP 116/70, 117 HR, T. 100.3
	556 (b)(6)-2 94MC

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

RT./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8APR03 0750z	2nd unit PRBC's started. Initial VS are T 100.3 BP 116/70 P 117, 5min VS BP 121/72, P116, T. 100.4, 15min VS 122/76 HR 119 T. 100.4 1hour VS BP 123/72 P 114 T. 100.5 last set VS BP 126/74 HR 116 T 100.7 No reactions noted. ——— 556 (b)(6)-2 91WM6
8APR03 1030z	PT. resting comfortably. C/o some pain @ midline incision. Dsg Δ done to midline. Wet to dry done. No foul smell or discharge noted. Appears to be healing well. Abd. is slightly distended. No gas or BM yet noted. New IV started in ® hand. 2u PRBC's given. H+H 25-9, pre PRBC's. No reaction noted to PRBC's. NG to LIS c̄ some greenish drainage. Foley to gravity c̄ 45 u/o. Clearing from blood tinge to clr. yellow. 10L O2 given per face mask. O2 Sats 92-93%. PT ambulated s̄ O2 and Sats dropped to 67%. PT. gets very weak quickly but ambulated well. Vital Signs Stable. ——— 556 (b)(6)-2 91WM6
8APR03 1132z	I Stat done — H+H 30/10. ——— 556 (b)(6)-2 91WM6
8APR03 @ 1550z	PT output 600 urine, 500 NG tube greenish in color. ——— 556 (b)(6)-2 91WM6

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 Apr/03	(b)(6)-4 Alert & Oriented x 3 PT Pleasant.
0353	PT Sclera appears to be somewhat Jaundice in nature.
	PT Skin color also appears out of text with Race. PT has
	NG to left nares connected to low Intermittent Suction.
	PT on NRB @ 40% with sats in 94-95% range. PT
	Lung sounds coarse and wet. PT Position of Comfort is at
	HOB @ 45% but pt displays a decreased angle by not
	staying at proper angle in bed. PT Has Midline Dressing
	to Abdomin. PT has PIV to Rt Forearm. PT has LR Infusing
	@ 140 cc HR. PT continues to be on Cipro IV and Unasyn IV, as well
	as ZANTAC. PT had one Temp spike during the night. DR (b)(6)-2
	present and 650mg of Tylenol was ordered and given P.O.. Low Inter-
	mittent Suction turned off. PT HAS Foley draining dark Amber colored
	Urine. PT was encourage to ambulate, but Refused. PT TEAching was
	conducted on Pts condition and what helps and worsens Pt's
	Condition. PT STATED That he would Try to Ambulate sometime this
	AM. PT did Receive MSO4 PRN for Pain x 3 doses during the
	night. No additional problems to work. (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)

MEDCOM - 4199

DATE	NOTES
11APR03 1200	PTS O_2 @ 83% RA Sup O_2 Non Rebreather at 6L/M 96%
	Pt Given 2.5mg Neb
	HR 110 120/70
1800	101.2° Aux wait an hour till next dose of vicodin (b)(6)-2 CRN, SOT
1910	Pt complaining of 1/2 pain in Abd.
	vicodin PO ii for pain. Ciprofloxin 500mg PO, Augmentin 875mg PO
	amitriptyline 25mg PO (b)(6)-2 CPN, SOT
12 April 03	0430 BP 110/70 P 72 R 24 T 99.0 (b)(6)-2
4/12/03 0455	Pt c/o Ⓡ posterior back (upper) pain
	Has been febrile, tachycardic; O2 requiring
	On Augmentin / Cipro for ? etiology
	Lungs - upper airway noises Ⓡ base posteriorly
	CXR (4/7/03) Ⓡ ML/LL opacification
	A) Pleural Effusion vs Pneumonia
	P) > Repeat CXR / need decubitus films
	> Cont Abx
	> If layers will need to perform
	thoracentesis - ? if able to perform such
	procedure here; if no layering ? loculated
	> D/W Surgery (b)(6)-2
	(b)(6)-2
12April03 0600	3mg MSO4 for pain (b)(6)-2 92W20
12April03	0600 Dressing Dcd Midline Incision, dressing is saturated c̄ serosanguous
	drainage and bowel. Site appears healing well on lower half, upper half is
	leaking Bowel, Dehiscing, Dr. Notified @ Bedside, going back to surgery. Repacked
	wound c̄ W->Dry, 4x4, + Tape. Open wounds Lt + Right of midline [illegible]

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MEDCOM - 4200

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10Apr 03 1600	Recieved, pt resting in bed, HOB 50° Pt wearing ~~simple face~~ non-rebreather mask at 11 O_2 consintrator. Lungs have expiratory rales SaO_2 95%. Pt has White coating on tounge. $S_1 S_2$ NSR. Abdominal dressing c/D/I. +2 radial & pedal pulses. @ 2000 pt refused med, c/o nausia. 12.5mg phenergan given 2030 ~~pt~~ medication crushed & mixed with water pt took only one sip, pt refused the rest. [signature]
11APR03 0618	RT Notes: Pt received HHN via MP c̄ 0.5cc Proventil / 110 Atrovent / NPC 110-114 RR-24 BS: ā + p̄ tx bilateral insp + exp wheezes throughout. NPC SpO_2 97% on NRB. NAR @ this time [signature] 91W20
0640	[illegible]
0830 Z	Pt admitted to MCU #1. VS obtained: BP 102/68, P126, T 100.0, 32 RR, O_2 sat 88% on RA, 92% on 3L O_2 [signature] 2LT [illegible]
0840Z	PT A&O×3, PERLA, receiving O_2 via non-rebreather @ 5L/min, Δ dressing to abdomen wet to dry draining moderate amounts of serous sanguinous fluid, Lungs sounds rough in all lobes, PT. c/o pain in abdomen given ii vicoden, has ⊕ pulses in all extremities. [signature] SGT 91WM6

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)

MEDCOM - 4201

DATE	NOTES
12APR03	OP NOTE
0830Z	PREOP: WOUND DEHISCENCE
	POST OP: SAME
	PROCEDURE: REVISION OF FASCIAL CLOSURE
	RETENTION SUTURES
	SURGEONS: KAPLAN MD AND BURANDY MD
	EBL < 50cc
	FLUIDS:
	COMPS: Ø
	FINDINGS: FASCIAL BREAKDOWN
	Ø EVIDENCE OF SUCCUS OR
	SOMATIC Ø PUS
	TAKEN TO ICU IN STABLE CONDITION
	(b)(6)-2 MD
0900	STABLE. c̄ pain 5mg of MSO4 given followed by another 5mg after 10 minutes. B/P 148/86, SATS 90% c̄ 10L/min FM and nebulizer TX in place now. Lungs mildly coarse upper lobes, Ø BS, good pulses / capillary refill x4, A&Ox3 P. 119, T° 99.7
0930	5mg of MSO4 given IV per abdominal pain (b)(6)-2
0935	75mg of Demerol given IV (b)(6)-2
1000.	V.O. of Dr. Chapman 2.5mg of Valium x2 then reevaluate (b)(6)-2
1100	Urinated 600cc of clear / yellow urine (b)(6)-2
	Sleeping comfortably now (b)(6)-2
1245	300mg of Vanc, 30mg of Toradol given c̄ 5,000 units of Heparin SQ

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 Apr 06	[illegible] appear healing c̄ vascular tissue [illegible] drainage (b)(6)-2
12 Apr 03	[illegible] Staff Note
0700	On rounds, Pt noted to have wound breakdown to
	include partial fascial separation
	Pt POD 5 s/p colostomy takedown
	T 99.
	On Cipro
	Imp: Wound breakdown POD 5
	Risk factors malnourishment, O2 requirement, [illegible]
	Plan: Retention sutures in OR (b)(6)-2
13 Apr 03	Nutrition - Patient with poor intake for last 2 wks due to surgery for s/p GSW.
0829	patient on J-tube feeding @ 10cc hr provides 264 calorie day estimated needs
	2400 per day goal rate for Ensure 90 cc/hr. (b)(6)-2
	MAJ SP RD

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

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

MEDCOM - 4203
509-114

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
13 APR 03	Brief Op Note:
	Preop Dx: Anastomotic breakdown S/P colocolostomy
	Postop Dx: same
	Procedure: Ex lap / End Ileostomy / mucous Fistula / J-tube / Drainage
	Surgeons: (b)(6)-2
	Anesthesia: GETA
	EBL: 250 UOP: 250
	Fluids: 4100 cc crystalloid
	Findings: Anastomotic disruption c̄ retraction (both ends), stool in peritoneum ā intense inflammatory rxn, fecal necrosis
	Drains: ET, NG, Foley, Penrose x 2 (at colonic openings), J-tube
	Complications: ∅
	Counts: correct x2
	Disposition: To ICU / Fair / intubated

Penrose
old colostomy site
mucous fistula
end ileostomy
Penrose
(b)(6)-2
MAJ, MC (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 4204
509-114

DATE	NOTES
16APR03 1150	RT Notes: Pt extubated approximately 1035 and placed on NRB @ 12 lpm. Pt received HHN via aerosol mask c̄ 0.5cc Albuterol/2.5cc NS. HR 120-121 RR 28-23 BS: Coarse Rhonchi throughout c̄ mild wheezes in apices bilaterally. SpO_2 98%. Pt stable @ this time. Will continue to monitor pt's status —— (b)(6)-2 91W20
16Apr03 2000	

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4205

DATE	NOTES
13 APR03	Pt sedated, intubated from OR s/p ex lap ~~colostomy revision~~ (wa error)
1830 Z	Foley draining clear, yellow urine, VS: Sinus tach, Hypotensive 161/97,
	RR: 23, Vent settings SIMV, 14, 700, 50%, J-tube to gravity, NG to
	LIWS, Colostomy bag empty at this time lungs: CTA(B), ⊖
	BS. Abdominal dressing is C/D/I. Pt has 2 IV sites, Running
	D5NS @160cc/hr + TKO in other IV. Received IV MSO4 + Versed
	as pt became agitated + began to pull on dressings, tubes. Pt also
	attempted to spit out bite block/ET tube. RT called,
	pt sedated. All secure. B/P returning to normal levels: 134/66.
	Pt suctioned x 2 s̄ result, ∅ ~~secretions~~ secretions. (wt)
	(b)(6)-2 , 91C3H
13 Apr 03	Resp Care Note: pt. on mech vent as ordered, all settings
1900z	checked + set properly. All alarms set + working. Ambu @ bedside.
	BBS fairly clear c̄ dim bases. Vent settings SIMV, RR 16, V_T 700, Peep
	5 cmH_2O, I:E 1:2, PIP 31 cmH_2O Mean 13 cmH_2O, High pressure 50
	cmH_2O, Low Pressure 5 cmH_2O. (b)(6)-2 91W3N
2145z	Resp Care Note: Vent settings SIMV RR 16 V_T 700, peep 5, FIO_2 100%
	I:E 1:2, High Press 50 cmH_2O, Low Pressure 5 cmH_2O, PIP 30, Mean 14.
	(b)(6)-2 91W3H
14 Apr 03	Resp Care Note: vent settings, SIMV, RR 16, V_T 700, peep 5 cm H_2O
00:05	FIO_2 100%, I:E 1:2, PIP 31, Mean 12, S_pO_2 100%, High Press 50
	Low Pressure 5. [redacted] 91W3H b6-2
14 APR 03 0500	Patient report recvd, sedated, PERLL, MAE when stimulated, lungs CTA, Vent
	SIMV 16-700-1.0+5 RR 16/16. Patient becomes very anxious when aroused. Abd soft tender
	given MSO4 for pain, Haldol started, Versed for sedation. Abd dressings soiled c̄
	serosanguinous drainage. J tube Δd. from drainage to 10cc F8 Ensure, w/ burg 10 w/
	residuals of 0. ETT 26 cm @ teeth mouth guard in place. NG to LIS
	Green clear bile like secretion. foley draining dark amber (b)(6)-2 500 ml 38 ml

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STANDAR(b)(6)-2 9 (REV. 5-99) BACK

MEDCOM - 4206

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1300	Cipro 400mg and Augmentin 875mg given per PO, resting in bed now c FM at 8L/min
1600	T 102.0, P-130 B/P-126/73, sats 97%, no changes in physical condition, lungs CTA, ↓ BS, AxOx3 resting in bed now (b)(6)-2
1630	Pt A+OX3, lungs little wheezing on exhale, Pt having some difficulty breathing, Perrla, bowl sounds active, Pulses x3, Pt has dressing on Abdomen some drainage, IV (R) AC, Pt stats @95% via NR at 8/min (b)(6)-2 9W
0300	Drained 400cc clear yellow fluid out of foley
0700 z 13APR03	Pt is resting c some c/o pain. Pain meds given c good relief. Ambulated to BR. Midline incision covered c bulky drsg & drsg Δ this AM. Large amount of brownish drainage from abd wound. IV (L) arm patent s s/s of infx. Lungs CTA apex to base Bilat c ↓ air intake. O2 @ 7L sats 92-95%. VS stable. Bowel Sounds hypoactive. 556 (b)(6)-2 9W
1500 z 13APR03	PT started to leak stool through midline incision. Drs notified. PT. O/C for OR @ this time. T. 102.3 AX 3gms Unasyn given @ 1800z. 556 (b)(6)-2 9W

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		ICW 1

PROGRESS NOTES
Medical Record

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

MEDCOM - 4207

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14 APR 0500	(continued) VSS, IV (L) Hand 16ga infusing s̄ s/s of compromise IV (R) ... s̄ s/s [illegible].
	Pulses +2/+2 ... Patient restrained [illegible] for protect airway.
0500	[illegible] Plane. [illegible]
	[illegible] (R) colostomy [illegible] pink [illegible] (b)(6)-2 [illegible]
	(L) Fistula pink
0800	Urine output still dark. Dr Kaplan here - report given. (b)(6)-2 [illegible] (b)(6)-2
0810	4mg of VERSED GIVEN IV PER AGITATION
14 Apr 03	RT Note: Vent settings SIMV RR 16 VT 700, Peep 5, FIO2
0915Z	100%, I:E 1:1.5, PIP 32, Mean 12, VT exhaled 700ml / SpO2 100% b6-2
	High Pressure 55 Low Pressure 5. BBS Clear c̄ dim bases. [redacted] 91W14
14 APR 1000	Patient tolerating bolus via Tube feeding s̄ residual. Urine output ↑ p̄ bolus. Versed [illegible] for sedation.
	[illegible] c̄ RT ↓ FIO2 but Dr [redacted] reports he wants ∅ vent Δ's (b)(6)-2
	b6-2
14 Apr 03	Resp Care Note: Vent settings SIMV RR 16, VT 700, peep 5, FIO2
1220Z	100%, I:E 1:1.5, VT exhaled 700ml, PIP 31, Mean 15, SpO2 100%.
	(b)(6)-2 [illegible] 91W34
14 APR 03 1300Z	Patient became extremely agitated s̄ violently pulling against staff. Broke
	Bite Block in place. Patient given MSO4 / Versed / Haldol s̄ effect. Vecuronium
	used to paralyze patient & prevent [illegible] extubation. HR went to 165
	s̄ decline. Dr (b)(6)-2 notified of Patient's condition - New order [illegible] - Valium
	10mg IVP slow over 5 min. now @ 1310 patient still awakening & struggling against
	ventilator - Lungs CTA Bilat. Breath Sounds ETT in place s̄ compromise (b)(6)-2
14 APR 03 1430	Patient finally settled down, HR 138, Sat 100% Resting. ETT advanced back to 26cm
	@ Teeth. [illegible] patient had pushed is out to 23cm @ Teeth. NGT continues to put
	out bile like secretion. HOB 30° Ostomy c̄ 50cc secretion. (b)(6)-2 [illegible]
1530	Colostomy remains pink, patient calm, sedation continues
1630	Assumed care of pt. T 100.3 (A) P 126 R 18 BP 113/67 SaO2 100.
	Pt sedated. LS have crackles in upper lobes. Pt

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
	(b)(3)-1	

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)

DATE	NOTES
(cont)	currently on a vent, PEEP 5. SIMV, RR 16, V_T 700,
	NGT in place to to suction. Draining dk green bile.
	Oral tube in place. Lg abd dressing that is
	dry and intact. IV in (L) hand s̄ redness or
	swelling. Colostomy draining brown liquid stool.
	Red Robin off dressing c̄ 60cc syringe in place.
	FC draining clear yellow urine. — (b)(6)-2
4/14/03 1220	Resp Care Note: Vent settings SIMV RR 16 V_T 700, peep 5
	FIO_2 100%, I:E 1:1.5, PIP 30, Mean 9, Exhaled V_T 696 ml, High pressure Alarm
	55 cm H_2O Low Pressure 5 cm H_2O, SpO_2 100%. BBS fairly clear (b)(6)-2
14 APR 03 0400	while checking pt pulses distal to restraints discovered
	edema in (L) arm worsened by wrist band cutting off
	circulation cut wrist band off. (b)(6)-2 SPC LPN —
14 APR 03 0400	PT had episode of fighting ventilator twice
	during night (b)(6)-2 SPC LPN —
15 APR 03 0500	Pt. is on vent c̄ set vent settings @ 16 BPM, 700ml, 100% O_2 on A/C. Lungs
	are wet apex to base. No output from suctioning. NG to LIS putting out
	green liquid of about 200cc per 12°. Foley to gravity c̄ qs output. Vital signs
	stable. HR ↑ 110-120s. low grade temp 100.5 avg. Bowel sounds absent. Colostomy
	LLQ c̄ ø output. Incision midline open c̄ red rubberbands as sutures.
	Drsg in place. Penrose x2. Wet to dry done c̄ copious amounts of leakage
	from incision. Some foul smell noted. IV (R) arm @ TKO s̄ s+s of
	infx. IV (L) hand s̄ s+s of infx or infiltration. Peg tube LLQ flushed
	c̄ 10cc H_2O QS. Morphine + Versed given Q1° for sedation. No edema
	noted on extremities. — SSG (b)(6)-2 91WM6

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15APR03 1930	Δ OF SHIFT ASSMT COMPLETED. PT AROUSABLE BY VERBAL STIMULATION. LUNGS SOUND CONGESTED & WET THROUGHOUT. PT ON VENT. SETS @ 16 BPM, 700 ml 100% O2 SATS ON A/C. HEART @ SINUS TACH - 109 BPM. BULKY DRSG TO ABD. C/D/I. BS ARE ABSENT. OSTOMY TO RLQ. ϕ OUTPUT IN BAG. PT HAS NGT TO LIS. ϕ OUTPUT NOTED. FOLEY CATH. TO GRAVITY. CLEAR YELLOW AS URINE. PT HAS 2 PENROSE DRAINS s̄ DRAINAGE. PEG TO LLQ. PERIPHERAL IV TO Ⓡ ARM. ϕ S/SX INFILTRATION IV TO Ⓛ HAND ϕ S/SX INFILTRATION. WILL CONT. TO MONITOR PT. (b)(6)-2 [illegible]
4-16-03 1300	Pt extubated 1145 o/o per DR (b)(6)-2, pt [illegible] - on [illegible] at 10 Lpm. HR 118, 108/69, RR 24, [illegible]%, T - 99.5 Sx large amounts of thick [illegible] secretions. [illegible] - pt responsive to simple commands, [illegible], R - Lungs coarse rhonchi [illegible] after cough clears up, CV - [illegible] Trach [illegible], ⊖ edema, GI - TF start at 10cc/hr per DR (b)(6)-2 ↓ BS, [illegible] intact [illegible] AL ABD [illegible] changed [illegible] removed [illegible] GU - foley to gravity [illegible] 98. Skin warm dry. [illegible] 1. [illegible] Ⓡ AC - D5 ½ NS at 180/hr (b)(6)-2
4-16-03 1600	Nutrition - patient started on J-tube feedings of 10 cc/hr Ensure. Patient s/p exp lap now without vent. Patient's estimated energy needs 2400 calories per day. Currently getting 264 calories per day. Will stimulate & sustain enterocytes. Advance as tolerated to goal TF

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

MEDCOM - 4210

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Nutrition Continued
4-16-03	rate of 90 cc/hr or Diet advancement to regular.
4-16-03	pt resting comfortably s/p extubation [redacted] 6-2 MAJ SRRD
	at 1180 today. 1x confused tried to get out of bed,
	pt reoriented. 1x with T.T to 103 reported to (b)(6)-2
	[illegible] to pt. Ice pack to groin armpits. now temp
	99.6 (R). B/S 87/47, HR [illegible], sats 100, RR 22, T 99.8
	[illegible] (b)(6)-2
4/16 2015	Report received initial assessment complete no c/o of
	pain SOB pt extubated w/ 1 BO O2 non-rebreather sats
	92-93%. Pt alert to verbal and tactile stimulate
	Will continue to (b)(6)-2 [illegible]
4/17/03 0700	Report received, PT in bed IV in (R) AC position, running very slow [illegible]
	flushed c some difficulty - New IV [illegible] inserted in (L) wrist 18 g - Tube feeding
	infusing in J Tube. Foley -> BSD noted - Dk yellow urine. O2 NRB mask
	in place. Abd dsgs intact c small amount of drainage noted
	lungs auscultated, Diminished B/S Bil Bases noted - rest of assessment unremarkable
	[illegible] (b)(6)-2 [illegible]
	PT's mother & cousin in to visit PT - PT repositioned in bed. c/o Pain
1230	medicated c MSO4 4mg IVP (b)(6)-2 [illegible]
1420	Dsgs D'd To Abd wounds, c old dsgs Noted c Serous liquid from incisions
	Penrose drain noted on each side of Abd. J-Tube in place c drainage noted - New
	wet Kerlix gauze placed, covered c 4x4 Abd Pads c Tape. PT tolerated Dsg D
	c minimal c/o Pain [redacted] 6-2 91WM6K - Colostomy emptied of 400cc Brown liquid
	(b)(6)-2
1500	PT appears to be asleep, NAD Noted SAO2 94% (b)(6)-2
1655	Medicated c MSO4 2mg IVP for c/o Pain - Foley emptied of 2000 cc Drk yellow (b)(6)-2
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4211

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible] 1508	medicated c MSO4 2mg IVP [redacted] b6-2
1500	colostomy emptied of 300 liquid stool
1700	Pt given 4mg MSO4 for pain SPC (b)(6)-2 [illegible]
17 APR 03	[illegible] CTA [illegible] O2 @
1920	[illegible]
	[illegible]
	[illegible] IVPs ↑ —
	(b)(6)-2
	Cont IVPs ↑ 2130, [illegible] @ 2110 — (b)(6)-2
	4mg MSO4 for ↑ pain @ 2134 — (b)(6)-2
2130 —	Drsg D'd Pt awake - requesting pain med - 2mg MSO4 given
	emptied 2000 from foley - clear urine - (b)(6)-2
18 APR 0100	Unasyn IVP ↑ @ 0100
0420	4mg MSO4 IVP for ↑ pain (b)(6)-2
0600 —	See VS sheet T 100.5 AX
0615 —	4mg MSO4
0700	Unasyn IVPB @ 0630
	Foley 1200cc out
0730	Received report on pt. Pt resting in bed no c/o pain. Will monitor (b)(6)-2
	0815 Ostomy appliance leaking. Emptied bag. Reinforced seal
	and cleaned pt. 200cc watery dark green fluid emptied. Pt
	tolerated juice w/o c/o N/V. Pt c/o pain 2mg MSO4 given. (b)(6)-2
	(1000) Δ ABD DRSG. Premedicated pt w/ 1mg Versed & 2mg MSO4.
	PT tolerated procedure well. Tissue around area pink. No
	strong or foul odor noted from wound. Ostomy appliance
	changed 2/2 leakage from around area. Stoma care done.
	Stoma pink and moist. (b)(6)-2 91WM6
	(1415) Gave pt 2 tabs Tylenol 325mg PO for temp 100.9 Axillary (b)(6)-2 [illegible]
	(1630) Pt c/o pain in abdomen 3mg MSO4 given (b)(6)-2 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-800/50618

MEDCOM - 4212

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DOD 010691

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17APR03	1930 - ABD DRESSING DRY AND INTACT, COLOSTOMY (R) SIDE OF ABD,
	ENSURE FEEDING @ 20cc/HR PER PEG TUBE, FOLEY TO GRAVITY
	IV - D5NS @ 60cc/HR INFUSING IN (L) HAND, EXPIRATORY WHEEZING
	IN ALL LOBES, PT. ON 10L O2 VIA NON-REBREATHER MASK - POX 92%
	SGT (b)(6)-2 91WM6 2115 - T. 101.9 (A) RN NOTIFIED AND 650mg
	TYLENOL GIVEN PER FEEDING TUBE, FOLEY OUTPUT - 1100cc CLEAR
	YELLOW URINE, SGT (b)(6)-2 91WM6 2200 - BP 122/69 P121 R22
	POX 92% ON 10L O2 VIA NON-REBREATHER SGT (b)(6)-2 - 91WM6
	0630 - FOLEY OUTPUT - 2000cc AND COLOSTOMY 100cc OUTPUT. T. 103.5 (A)
	650mg TYLENOL SUPPOSITORIES GIVEN, SGT (b)(6)-2 91WM6
18APR03 0730	0700 meds given, T 101.5(A) - SAO2 96% - Tube feeding infusing well @ 20cc/hr. IV
	infusing well into (L) hand. Lungs CTA c ↓ BS Bil Bases. BS +. Abd round softer
	than yesterday. Abd Drsg intact. O2 12-15L/m via NRB. PT c/o Pain + Being
	cold, explained to PT that he is cold D/T ↑ Temp & he was medicated less
	than an hour ago — (b)(6)-2 91WM6H
0830	Dr [redacted] b6-2 in - orders received - PT's Am care done. Foley care done. pt tolerated c
	minimal complaint - (b)(6)-2 91WM6H
0930	PT's J-Tube clamped off per Dr (b)(6)-2 order (b)(6)-2 91WM6H
1130	Foley emptied of 700 drk yellow urine - (b)(6)-2 91WM6H
1140	PT placed on litter & readied for transport - (b)(6)-2 91WM6H
1400	PT NOT being transferred - Drsg Δ c Dakin solution - Pre medicated c MSO4 4mg IVP
	Versed 4mg IVP - PT tolerated Drsg Δ - Then c/o Pain p placed back to bed (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.

(b)(6)-4

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

MEDCOM - 4213

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 APR Ø3	(1345) Δ ABD DRSG w/ Dakens solution. Patient premedicated
	w/ 4mg MSO4 & 4mg Versed. Pt tolerated procedure
	well. (1515) pt voided 300 cc yellow urine.
	Pt resting in bed. (b)(6)-2 91WM6
	1630 75cc dark green water stool emptied from bag.
	Pt voided 300cc clear yellow urine. (b)(6)-2 91WM6
1934	recieved report from offgoing staff, pt. care assumed.
	pt. walked up and back down hallway. Assessment
	done, no significant changes noted. pt c/o pain b6-2
	4mg MSO4 given IV. Pt. resting at this time. 91WM6
2343	dressing Δ on abdomen completed. pt. medicated
	but continues to c/o pain (b)(6)-2, 91WM6
21 Apr 0548	95/54 hr 92 97 SpO2 FM 8LO2 97.3 T. pt resting,
	Ø c/o pain, Ø signs of distress. Ø significant changes in
	condition. (b)(6)-2 91WM6
0715	Received report on pt, assessment done. No sig. changes.
	P 110 Pox 95% T 99.2 ⓞ. Pt resting in bed w/ NO c/o
	pain. (0930) Drsg Δ by physician. Commented not
	as much oozing of fecas from wound. tissue around
	wound looks good. Stoma care done. Pink & moist.
	Did drsg w/ NS instead of Dakens per MD instruction.
	Pt given 4mg MSO4 IV. DRSG Δ complete (b)(6)-2
	(1415) Pt voided 350cc dark yellow urine. Pt.
	ate pear and orange w/ Ø c/o N/V. (b)(6)-2 91WM6
	(1730) Emptied 100cc green liquid w/ some formed
	stool. Pt ate 30% of dinner w/ Ø c/o N/V.
	C/o pain. 3mg MSO4 given (b)(6)-2 91WM6
	2045 - PT. VOIDED 400cc URINE. (b)(6)-2 91WM6

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50818

MEDCOM - 4214

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 APR 03	1645 750 cc clear yellow urine emptied (b)(6)-2 91WM6
	1720 Pt OOB to chair. Tolerated w/ no SOB or c/o
	pain. Pt ate banana and drank water w/ no N/V.
	Pt in chair looking at magazine (b)(6)-2 91WM6
	1800 Foley clamped for bladder training (b)(6)-2 91WM6
	~~2000~~ 1930 - IV RESTARTED 18G (L) WRIST - D5½ NS @ 160 cc/HR. 2000 -
	ABD. DRESSING DRY AND INTACT, COLOSTOMY (R) SIDE OF ABD - 125cc
	SEMI FORMED STOOL OUTPUT, LUNGS CLEAR IN ALL LOBES, POX 92% ON
	9L O2 VIA NON-REBREATHER MASK. 2100 - PT. c/o URGENCY TO VOID -
	FOLEY UNCLAMPED - 500cc URINE OUTPUT AT THAT TIME. SGT (b)(6)-2 91WM6
	Ø500 - ABD. DRESSING CHANGED WITH DAKINS WET TO DRY DRESSING
	COLOSTOMY OUTPUT 175cc SEMI FORMED STOOL. SGT (b)(6)-2 91WM6
	Ø615 - FOLEY OUTPUT 850cc SGT (b)(6)-2 91WM6
20 APR 03	[illegible] + [illegible] [illegible] ↑ (b)(6)-2
Mo	0730 - received report on Pt. Assessment done - drsg
	on ABD CDI. Foley clamped for bladder training. IV in
	(L) hand. Ostomy draining dark watery stool. (b)(6)-2 91WM6
	0740 Foley DC'd. (b)(6)-2 91WM6
	0915 150 cc dark green watery stool emptied from bag. (b)(6)-2
	1000 PT voided 350 cc clear dark yellow urine. Pt c/o pain
	in abdomen. 3mg MSO4 given. (b)(6)-2 91WM6

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.

6

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)
23 APR 03	Pt sick w/ bed medicated ? Smoking [illegible] for sleep +
0410	↓ agitation (b)(6)-2
0400	Unasyn IVPB ↑
0400	Pt c/o pain – refused Motrin po
0430	⊕ emesis 300cc GRN with undigested food – medicated c (b)(6)-2
	12.5g phenergan IVP
0550	⊕ small emesis 100cc grn
0600	total Intake – IV = 2400 600cc po = 240cc [illegible]40cc (b)(6)-2
	Output = emesis = 400cc voided SW = 800 cc
	VS BP 107/61 P 103 R 28 T 98.7 AX (b)(6)-2
0700	↑ Unasyn + Zantac IVPB (b)(6)-2
0800	800g Motrin po
4-23-03	AM dressing Δ'ed wounds red pink ⊖ foul smell, colostomy
[illegible]	draining, G-Tube intact. ρ-HL IV, ambulate, ensure TID,
	Percocet for pain. (b)(6)-2
4-23-03	Throughout day pt agitated frequently, ambulated 2x today
	sat outside, colostomy leaking clear green fluids. Pt ate
	apple 1x today but appetite ↓. (b)(6)-2
23 APR 03	Assessment completed – Abd Dg c/d/i, colostomy intact c
1912	mod liquid green stool. stoma surf red, HL capped - syringe
	removed – retaped - reopsited. Pt c/o pain (b)(6)-2
2015	1 Vicodin po for ↑ pain
	voided 80cc urine
2100	Cover 30g – SQ – Zantac 150g po
2200	Pt refused bedtime – c/o pain
2330	Drsg Δ'd – ⊕ liquid stool – 50cc w/ colostomy (b)(6)-2
	stool coming from mid abd wound & lateral wound – (b)(6)-2
	2 NS – Abd drsg applied + Montgomery straps secured – 10g [illegible]

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

MEDCOM - 4216

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22APR03	0005- ABD. DRESSING CHANGED WITH DAKINS WET TO DRY
	DRESSING, COLOSTOMY BAG CHANGED - 100cc SEMI FORMED STOOL,
	PT. VOIDED X 1. SGT (b)(6)-2 -91WM6 0230 - PT. VOIDED
	cc URINE. SGT (b)(6)-2 91WM6
22 APR03	0705 Received report on pt. Pt in bed c/o pain. Told time had
	not passed to get more medicine. Zantac ↑. (b)(6)-2 91WM6
	0815 Pt given 800mg motrin per MD order for c/o pain. 0915
	ABD DRSG Δ - bacitracin applied to areas irritated by
	tape. Drainage noted by eptube. Lovenox given (b)(6)-2 91WM6
	1145- Pt OOB to chair outside. NO c/o pain. Episode
	of emesis x1 50cc. 12.5 phenergan given. (b)(6)-2 91WM6
	1335 Pt resting in bed c/o pain told too early to
	medication. Chewing ↑. (b)(6)-2 91WM6
	1715 IV infiltrated, 16' restarted Ⓡ AC. Pt at 40% of
	dinner and drank juice w/ Ø c/o N/V. (b)(6)-2
22 APR 03	Assessment completed - Pt sleeping - [illegible] abd drsg
1900	c/d/i - colostomy draining yellow formed - liquid stool - (b)(6)-2
2000	Medicated pt 2 [illegible] [illegible] (b)(6)-2
23 APR 03 2400	Drsg (Abd) Δ'd & colostomy Δ'd X2 - Bed Changed
	while pt w/ DS Chair - Bacitracin applied to irritated [illegible]
	area from tape application. Medicated 2 [illegible] Mag [illegible] Drsg Δ [illegible]
	(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.
(b)(6)-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4217

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 Apr 03	1 Tab Vicodin for ↑ pain po — (b)(6)-2
0300	Pt continues to refuse to drink. Cont. ... — (b)(6)-2
0600	VS - BP 98/61 P 103 R 22 T 98.2 (O)
	Intake - po 720 total. Output voided = 300 GG = 300 ... 100 total = 700
	Colost - loose ... - ... colostomy — (b)(6)-2
0900	Dsg Δ'd and minimally debrided. Yellow stool noted
	at Penrose sites. Wound bed beefy red c̄ areas of pale fibrous
	... aspect. G Tube intact c̄ small amount purulent
	drainage at insertion site. Retention sutures intact. Covered
	c̄ ABD pads and ... c̄ Montgomery straps. Tol well c̄ 5 mg Diazepam
	ABD soft and appropriately tender. Stoma intact and beefy red
	draining mod amount liquid green stool. Some difficulty experienced with
	adhering colostomy bag. — (b)(6)-2
1000	Pt ambulated throughout hosp. Tol well but fatigued at
	end of walk. Pt returned to bed — (b)(6)-2
1600	Emptied 450 ml liquid stool with bits in it. Ambulated about hospital,
	became fatigued in 5 min. Pt c̄ ≈ 500 po intake but denies need
	to urinate. Will cont to monitor — (b)(6)-2
1700	Pt consumed 75% of dinner and ambulated again. Tol well. Cont
	with good PO intake. 240 c̄ dinner — (b)(6)-2
1720	Pt colostomy again unattached. Cleansed skin at site which is
	somewhat abraded. Applied Benzoin to skin ... — (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

MEDCOM - 4218

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 April 03	1730 - VS T 97.4 P 115 SPO2 95 RA R 20 BP 108/68
	Pt tol meal s̄ emesis or nausea. Takes 400 UOP
	this shift, Dark Amber ST to 115, +2 x 4 Reg Pulse
	Lun clear upper & diminished bases. addit 200 output
	per colostomy bag ——— (b)(6)-2 [illegible]
	1820 - Pt C/O Pain even Vicodin ī. Pt continues to
	Hotly refuse ensure drink. Offer anti emetic & pt decline
	and refused drink ——— (b)(6)-2 [illegible]
	1830 D/C pt dressing. wound unchanged from AM assessment
	Flushed G-Tube. Prior to dsg Δ - admin Vicodin x1 tablet
	Pt declined valium prior to dsg Δ ——— (b)(6)-2 [illegible]
2036	Pt. c/o pain, gave 500mg Motrin.
	Pt. wanted ~~MSO4~~ MSO4 (hand signals). no Pt. is
	now sleeping. S,S. Lung sounds diminished.
	Dark Amber urine @ 350cc (spilled onto
	floor). (b)(6)-2 -[illegible] 2100 @ 300 cc of colostomy output
	0430 Pt. c/o pain Gave ī of Vicodin.
	Heplock came out/blown upon flushing
	0500 Drsg change done. Bright red, no
	heavy oozing. Flushed G-tube w/ 10cc water.
	Tol. drsg change well. T 97°, BP 83/50
	P 92 R 22 96% O2 - (b)(6)-2 [illegible]
	0600 - Pt. doesn't want Ensure
25 APR 03	0715 Received report on pt. Pt resting in
	bed w/ ∅ c/o pain. 0630 am care provided. PT
	OOB to chair. (b)(6)-2 [illegible]
	1215 ABD DR (b)(6)-2 - MD noticed that wound appears
	deeper. Pt tolerated procedure well. (b)(6)-2 [illegible]

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

MEDCOM - 4219

ACLU-RDI 1244 p.440

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
25 April 03 1710	Nutrition Note - Per nursing, pt having emesis after meals ~ 10-15 min. Pt appears to have problems c spicy foods. Ø problems c fruits & liquids. Refuses to drink vanilla Ensure. Will try chocolate Ensure and carnation instant breakfast 4 oz @ time. Will send pt bland diet to possibly help ↓ vomiting. Will continue to monitor. CPT (b)(6)-2 RD, LD
1830	PT VOIDED TOTAL of 1050 cc dark yellow urine this shift. Encourage pt to drink H_2O. Pt had emisis x1 after dinner ≈ 200 cc emisis. Ambulated in the ward before returning to bed. No further complaints of N/V. Patient had c/o pain @ 1730 and received 1 Vicodin. (b)(6)-2 [illegible]
25 Apr. 2020	Report received initial assessment complete pt has colostomy. Pt has vicodin 1-II tabs for pain resting quietly ambulates ad lib Will contin to monitor (b)(6)-2 [illegible]
	Drsg Δ, colostomy Δ @ 0500 Will contin to monitor (b)(6)-2 [illegible]
26 Apr 0600	Pt. VSS minimal c/o of pain and SOB received Vicodin T po last dose @ 05^{45} (b)(6)-2 [illegible]
0730	VS P 102, SpO2 94% RA, BP $\frac{102}{64}$ R16 T 97.0 oral. Pt resting quietly in supine position. Lungs clear upper c ↓ bases R > L. ⊕ output from colostomy (b)(6)-2 [illegible]

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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.)*

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

MEDCOM - 4220

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1000	Δ'd dsg + Colostomy bag. Stoma beefy red c̄ surrounding skin improving in condition wound bed meaty red s̄ foul odor, some fibrous tissue noted at infer aspect. Lung sounds to R middle + lower lobes very diminished c̄ musical 'squeak' noted to RLL. Pt ambulated in hall briefly + ret to bed. b6-2 Pt somewhat combative. Consumed one appl + tol well s̄ N/V (b)(6)-2
1230	Pt tol meal s̄ N/V. Ambulated about hospital and outside tol well. Pt refuses encour. (b)(6)-2
1600	Pt ambulate in halls, tol well. Colostomy bag in place s̄ leaks (b)(6)-2
1645	Pt tol dinner s̄ N/V (b)(6)-2
1935	Strong S.S.s. Lung sounds diminished on bases x2. Pt drank juice for me @ 180cc. Colostomy bag intact. Will cont. to monitor (b)(6)-2 AUWMG
	2035 Pt ambulated outside to smoke a cigarette, drank @ 60cc fluid, ate a banana. (b)(6)-2 AUWMG
2200	Drsg change done. Green sanguenous fluid oozing out of bottom abd. & wound w/foul odor. Wound under (L) Penrose has green d/c w/foul odor. (R) Wet to dry. 10cc flushed in G-tube. (b)(6)-2 AUWMG

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4221

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
0745 27 April 2003	Received patient @ 0700, without complaints of pain or discomfort. VSS, afebrile. PERLA/3mm/reactive. NSR, S1-S2 auscultated. Capillary refill ~~>3 sec~~ [redacted] b6-2 < 3 seconds, skin warm to touch. Colostomy bag in-tact c̄ small amount of liquid stool. Midline abdominal dressing C/D/I at this time. Patient consumed 60-70% of breakfast s̄ complications. OOB x 1 to smoke. Pt in bed resting at this time, will continue to monitor. (b)(6)-2 -125,AN
0845 27 April 03	Administered 10mg Valium and Vicodin tab prior to dressing change. Dressing Δ completed s̄ c/o pain. Wound healing appropriately per Dr. [redacted] b6-2 (b)(6)-2 14T,p
1700	Pt's family member came in and ate dinner together @ 752. Took (ambulated) pt. outside to smoke, & to say goodbye to family member. 1735 Drsg. Δ done. Foul odor coming from wound, and drsg. (foul odor) from bottom of penrose drain. Put wet-to-dry drsg. on. [redacted] b6-2 Emptied colostomy bag @ 300cc of urine output. 1844 OOB to smoke. ~~with~~ Pt. ate meal brought in by family member (b)(6)-2 [signature]

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

MEDCOM - 4222

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2103	Pt. OOB x1 to smoke.
2237	Got New colostomy bag changed.
	more Formed stools, non-liquid. (b)(6)-2 [illegible]
27 Apr	Pt: resting s c/o's of pain or SOB [illegible]. Colostomy c semi-formed
2301	stool well. continue to monitor pt (b)(6)-2 [illegible]
28April	0900 - Dsg Δ'd + wound observed by Dr (b)(6)-2. Wound healing
	well. Colostomy bag coming off - Δd. Pt Void 350 ml med (b)(6)-2
	yellow s sediment. Ileostomy Stoma Beefy red with med output
	of soft pudding text green output. Pt ambulated to outside
	tol well. Consumed food that was brought from home. Lungs c
	[illegible] in upperfields cn ↓ bases (b)(6)-2 [illegible]. Pt
	neuro intact. (b)(6)-2 [illegible]
1700	Dsg Δ done. Wet-to-dry. No changes.
	Colostomy bag emptied - colostomy
	intact Family member by side.
	Tol. dsg Δ well w/ Vicodin tab at
	@1600. Ate meal @ 75%. OOB x2.
	Will cont. to monitor. (b)(6)-2 [illegible]
	2000 OOB x1 outside. 2100 Meds
28 APR	given. (b)(6)-2 [illegible]
2300	PT IS RESTING IN BED c HOB @ 30° PT HAS NO C/O PAIN. AOX3. LUNGS CTA. ACTIVE
	BS IN ALL 4 QUADS, NON TENDER, NON DISTENDED ABD. DRSNG C/D/I. COLOSTOMY DRAINING
	COPIOUS AMOUNTS OF SEMI-FORMED STOOL, VSS. WILL CONT TO MONITOR PT (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 APR 03	PT HAD C/O GENALIZED PAIN, 1 TAB VICODIN ADM. NO ESSENTIAL Δ'S
0330	FROM PREVIOUS ASSESSMENT. COLOSTOMY CONTINUED TO DRAIN SEMI-FORMED
	STOOL, PT CONSUMED 120cc OF WATER, REFUSED ENSURE SUPPLEMENT,
	WILL CONTINUE TO MONITOR THE PT. —— (b)(6)-2 RT/AN
0730	Δ'd Pt Abd dsg. Midline Incision 1" wide 1/2-3/4" deep
	c̄ healthy wound. Min fibrous exudate at inferior aspect. Sem[illegible]
	green drainage noted from old dsg unchanged from yesterday.
	[illegible] beefy red wound @ (R) exit of [illegible] (+) fecal stool/pus
	drainage unchanged from yesterday. [illegible] small amount drain at insertion
	flushed easily though pt complain of irritation with flushing.
	Colostomy bag c̄ small amt green liquid to semisoft
	stool —— (b)(6)-2 [signature]

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(b)(6)-4

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4224

I + O Sheet

MEDICAL RECORD | **PROGRESS NOTES**

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DATE	NOTES	NG OUT	J Tube ~~out~~ OUT / INTAKE	Foley OUT	IV IN	PO IN
13APR03	1600 – 0400	100	200 output	300	2080	∅
14 APR 03	04–1600	350	100 output / 70	350/325 (400)	500+300 / 1920+50	∅
14apr 03	1600–0400	200cc	∅	1250 cc	1920 cc	∅
15APR03	04 – 1600	∅	∅	1150 cc	1400	∅
15APR03	1900 - 0700		∅			
15 Apr 03	0025		∅	350	40	∅
	0100	∅	∅	100	650	∅
	0200	∅	∅	100	150	∅
	0300	∅	∅	150	~~350~~ 350	
	0400	∅	∅	100	180	
	0500	∅	∅	125	180	
	0600	∅	∅	100	180	

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 (b)(3)-1 ICU-1 | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

14 / 160 / 12 / 320 / 30

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

MEDCOM - 4225

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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 #3
	s/p GSW abd
	Comfortable
	HR 110 RR 20 130/80 Sat 93% JP (b)(6)-2 (b)(6)-2 Sanguinous
	Abd soft, NT Good u/o. ø bile.
	Dres c/d/i
	Ostomy p/p/p
	A/P) Cont aggressive pulmon toilet
	Dressing
	Ambulate
	Clear liquids → adv diet as tolerated.
	Wound care (b)(6)-2
	NP
1900 26 MAR	pt assessed - BP 130/90 - HR 100-118 - pt voided 150 (peach color urine) abd dressing CDI - makeshift colostomy in place of drainage set - 5mg MSO4 given ⊕ thigh - pt told to stay in bed (b)(6)-2
26 mar 03 2000	Late entry - ABD wound edges well approximated, staples intact, ø drainage ø erythema, Dsg WNO Δ'd by Dr (b)(6)-2. Stom red ō and watery to serosanguin discharge. ⊕BS. ⊕ Flatus. Lung sound CTA bilat ō ↓ bases. Strong min proud cough, Pt AXO, Ambulate ō assist. Voids per urinal (b)(6)-2

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(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 MAR 2100	[pt received @ 1900 - assessment completed @ that time] - (@ 2100 NOW)
	pt make shift ostomy bag in place - VSS - (b)(6)-2
2130	150 urine out put - (b)(6)-2
2220	100 cc urine out - 3mg MSO4 given (b)(6)-2
2310	7mg MSO4 IM given (R) thigh - (b)(6)-2
27 MAR 0100	Urine output - 400 - (b)(6)-2
27 MAR 0400	Pt C/O Pain ↑ given 3mg MSO4 IM (L) arm, VS T. 100.4 P120 BP 119/74
	650mg Tylenol given PO. No other complaints @ this time (b)(6)-2
0600	T-98.8 - HR 112 - RR 24
27 MAR 03 0815	POD #4 S/P GSW to ABD
	Pt comfortable
	P-120 T-98.8 RR 24 Tmax 100.5 (last night)
	Voiding urine well
	JP's c̄ serosanguinous drainage ? amount last 24°
	JP's drainage is less RBD and appears to be
	↓ output
	Lungs - Improved Breath Sounds
	ABD - ↑BS soft NT/ND
	Difficult maintaining colostomy
	(due to) aqueous output
	Midline incision inspected yesterday
	Bandages C/D/I → granulating well
	ext - ∅ swelling ∅ tenderness
	A) POD #4 S/P GSW ABD - Stable
	P) Should temp ↑ will add Triple Abx c̄ Amp Cleo Tobra
	Advance diet as tolerated
	Wound care / Pulmonary toilet / Ambulate
	(b)(6)-2

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

MEDCOM - 4227

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 March 03	1230 - Pt Voided 250cc, Reddish Yellow ——— (b)(6)-2 [illegible]
29MAR03 / 1730	POD #6
	S/P X-LAP / Liver Repair / Cholecystectomy
	Colectomy
	Abx: Rocephin / Clinda x 2 days
	T max 101.5 yesterday
	JP x 1
	Ostomy c̄ copious output
	Emesis x 1 tonight
	generally good po intake
	P) Cont. Abx
	JP pulled
	Staples out tomorrow
	Cont wound care
	(b)(6)-2
29 mar 03	Pt c/o N+ Dizziness, given 25mg Phenergan IM to (R) Shoulder @ 2105.
2115	A'd Abd Dssg, wound bed pink. (b)(6)-2 SSG/LPN
2249 →	Pt awakened + pulled off col ostomy bag. Bag replaced, Pt given 50mg
	Benadryl PO for sleep. ——— (b)(6)-2 SSG/LPN ———
30 Mar 03 @ 7:15	B/P = 127/84 P ~~93~~ 104 O2 sat 92 T = 99.2
	——— (b)(6)-2 91W10

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

MEDCOM - 4228

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1837 28Mar03	Pt was given IV, Pt ripped out the IV - (b)(6)-2 561/91W
1847	T - 98.6 (0) [illegible]
2204	Pt temp 98.9. Pt colostomy bag had about 300-350cc with some form in it. Bag was drained and put valve in it to drain it. Pt c/o PN to ABdomin. Pt was given 800mg motrin 50mg of Benudral. Pt also had 800cc of urin output. SPC (b)(6)-2
29Mar03 0415	Pt took colostomy bag off. Pt recieved last colostomy bag. SPC (b)(6)-2 clean wound and placed last colostomy bag. SPC (b)(6)-2
29 Mar 03 0540	BP - 110/80 RR - 24 Sats - 94 P - 97 Temp - 98
29MAR03 0852	initial assessment of PT WNL (+)ABC's PT has colostomy output of 100cc colostomy site appears not infected. incision site to be dressed + clean no other apparent injurys (b)(6)-2 B/P 130/78 P = 115 T = 99.1 O_2 = 94 R = 16
29 March 03	1000 Dressing Δ on mid line Abd incision, site appears c̄ staples in the middle and open on the top and Bottom about 1in. No signs of infection dressing Δ was Sterile. Small open incision on left upper quadrant, packed Sterilely and no signs of infection (b)(6)-2 91W
29 March 03	1030 - 60 cc Drainage from Colostomy 91W

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(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4229

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1925 30 Mar 03	T-99.5 (o) reported to Dr. (b)(6)-2 [illegible]
30 Mar 03 21:08	800mg Motrin given. P.T awake sitting up on
	bed. (b)(6)-2 91W10
30 Mar 03 21:16	P.T vomites (b)(6)-2 91W10
30 Mar Ø3	Midline + LLQ Dssg's D'd. Colostomy bag D'd. mild pain
213Ø	noted c̄ dssg removal. Wound bed pink c̄ minimal sangeous fluids.
	See Flowsheet for meds. (b)(6)-2 SSG/LPN
31 Mar Ø3	BP- 118/64 RR- 16 Sats- 98% via RA
Ø622	P- 92 Temp- 98.7 (b)(6)-2 SSG/LPN
31 March 03	1140 Pt A&Ox3, LS clear Bilaterally, Move All Extremities, [illegible] Pulses x4, VSS, Dressing
	Δ no sign of infection staples in place Colostomy drain 60cc + 250cc from
	0900 (b)(6)-2 2LT [illegible]
3/31/03 1200	POD#8
	S/P X-LAP / Liver Repair / Cholecystectomy / colostomy
	Rocephin / Cleocin x4 days
	AF x 2 days
	Lungs: IMPROVED BS (R) base
	ABD: ostomy - beefy red / stool in bag
	Mildly DISTENDED ↓ BS
	Mild TENDER TO PALPATION (B) LQ's
	P) ① Cont. Abx
	② TO OR 02 APR 03 (Reanastomosis)
	③ BID W→D Δ's
	④ ostomy care
	⑤ Pain Control (b)(6)-2
31 MAR 03 1438	1[illegible]/48 RR 22 P. 113 POX 96 Temp 100.2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4230

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 March 03	1200 - Give pt Meds Rocephin 1Gm IM and Clindymycin 900mg
	IM Lt Buttocks —— (b)(6)-2 SGT AN
30 March 03	915 P.T. dressing change in ABD wound looks
	good wet to dry. —— (b)(6)-2 91W
30 MAR 03	POD #7 s/p x-lap / hw repair / cholecystectomy
1200	? colectomy
	Abx: Rocephin / Clinda x 3 Days
	AF/VSS
	CV: TACHY 116
	Lungs ↓ BS (B) base otherwise clear
	Ostomy c good out put
	Belly soft
	Wound look good
	P) Cont Abx
	Staples out soon
	Cont ostomy / wound care
	Re anastomosis in 3 days
	(b)(6)-2
30 Mar 03 / 2145	÷ Vicodin given for pain per Dr (b)(6)-2 MA (b)(6)-2 SGT 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.

(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 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/1/03	POD #9
1030	GSW ABDOMEN S/P EXLAP / Liver repair /
	cholecystectomy / colectomy
	Rocephin / Cleocin X 4 days
	AF X 3 days 139/78 P-113 RR 22
	T- 100.2
	Lungs - Better BS (R) Base
	ABD - Ostomy - Beefy Red / Stool in bag
	wound care incision granulating well
	P/ Cont Abx
	NPO P MN
	Q Day Dressing Δ's WTD
	Ostomy Care
	Reanastomosis 4/2/03
4/2/03	POD#10
0730	GSW ABDOMEN S/P EXLAP /
	Liver repair / Cholecystectomy / colectomy
	Rocephin / Cleocin X 5 days
	AF X 4 days 100/70 P-100 T 96.4 RR 26
	Lungs : cont (R) base improvement
	ABD - ostomy - beefy RED / Stool in Bag
	mid line / lung areas healing well
	P) D/C Abx
	Regular Diet
	Transfer Soon?
	Reanastomosis ?

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; S... Date of Birth; Rank/Grade.)*

(b)(6)-2

(b)(6)-2

...D NO.

...AL CARE

MEDCOM - 4232

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4/3/03 1015	POD #11 S/P GSW ABD S/P EX-LAP / Liver Repair / Cholecystectomy / colectomy
	VITALS / 98.1 99 98/60 98% SaO2 (RA)
	LUNGS - CTAB mildly ↓ (R)
	ABD: Soft / mildly distended / wound looks good / ostomy looks good
	Stool in Bag
	P/ ① Clears Liquids Diet
	② Begin Erythromycin 500g Q 4° (total 2 gms) on 4/4/03
	1st Dose @ 1100 Z
	2nd Dose @ 1500 Z
	3rd Dose @ 1900 Z
	4th Dose @ 2300 Z
	③ NPO P MN (4/4/05)
	④ 3gm Unasyn (IV) on call to OR (4/5/03)
	⑤ Take Down on 4/5/03
	⑥ 1 gm Emycin @ 0500 zulu (4/5/03)
	(b)(6)-2
4/3/03 1641	SpO2 93 HR 98 Tmp 98.2 RR 20 102/76 Pt sitting in bed. Amb Ø ~~[redacted]~~ 66.2 pain. Translator talked to about doing selfcare + needing to cooperate. 1) Noted clear diet 2) Meds + remainder of above Note ↑ (b)(6)-2 SGT, LRN
3APR03	50 mg benadryl for sleep (b)(6)-2 LRN / SGT

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

MEDCOM - 4233

ACLU-RDI 1244 p.454

DOD 010712

3apr03 | vitals - 93 SpO_2, 99 pulse, 98.1 temp, 98/60 BP RA,
5:25z | 25rr (b)(6)-2 g/W

MD ORDERS

4/3/03 ① Clear Liquid Diet (Push Fluids)
② Erythromycin 500mg po Q 4° (Total 2 gms)
1st dose @ 1100 zulu (4/4/03)
✓ 2nd dose @ 1500 zulu "
✓ 3rd dose @ 1900 zulu "
✓ 4th dose @ 2300 zulu "
③ ~~E-mycin 1 (one) gram po @ 0500 zulu (4/5/03) c̄ sip H_2O~~
④ Unasyn 3gm IV on call to OR (4/5/03)
⑤ Surgery on 4/5/03

(b)(6)-2

4/4/03 - Soap suds enema until clear

(b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/1/03 1635	MD ORDERS
	o NPO p MN
	o ON CALL TO OR - Reanastomosis 4/2/03
	(b)(6)-2
1APR03 1650	TMP 99.1°
	HR-102 SPO2=93 100/60 RR 28 Bag Ø Leak no Pain site Red throbbing (b)(6)-2 LPN SGT
2100z	900mg/6ml clindamycin
2Apr03 629(2)	Vitals= 92% SPO2, 100 pulse, 26 RR, 96.4 temp, 100/70 BP
4/2/03 0730	D/C (b)(6)-2 (b)(6)-2
	Regular Diet
	Noted (b)(6)-2 CPT/N
4/2/03 1620z	SpO2 93 HR 105 BP 110/80 RR 24 TMP 98.7 Pt sitting and talking when
	Started shift. states will not walk with full colostomy bag. (b)(6)-2 LPN SGT
1813	Ate 2½ MRE But No meat (Pork) just broth & Candies
0241z	Pt awoke and informed of need of Colostomy Δ' drained & cleaned at
	bedside for pt teaching. Attempted to Tell That he will do next Δ. (b)(6)-2 LPN, SGT

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.

Doctor's Order

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)*
5APR03 1130	MSO4 6 mg IV for Abd incisional pain (b)(6)-2
5APR03 1200	Resting [illegible] MSO4 for pain, Fluid bolus [illegible]/1000 VSS
	Abd dsg C&I, Abd soft, O2 4L -> Sat 94% [illegible]
	125 mg IV q[illegible] (b)(6)-2
1345	PT HAD 6mg of MSO4 FOR PAIN
1500	Patient c/o Abd pain increased, Abd soft, dsg [illegible] serous fluid stains. MSO4 6mg
	IVP given. NGT scant secretion. Foley output 25cc/hr x 4 hours, (b)(6)-2
	notified. [illegible] continue LR @ 140cc/hr No new orders
5APR03	Recieved pt resting in bed. Lungs CTA. S_1S_2
	Tachycardia. Bowel sounds absent. Large abdominal
	dressing intact. IV infiltrated. New IV started
	in (L) forarm, no s/s of infitration. +2 radial
	pedal pulses. Urine output to Foley 150cc at 2359,
	dark Amber urine. (b)(6)-2
6APR03	[illegible] @ 0315 100cc dark amber urine
6APR03 0500	Patient alert oriented x3, asking for PO intake. NGT [illegible] scant output Ø
	Bowel sounds. Midline dsg serous soaked to [illegible] Abd [illegible] - [illegible]
	drains [illegible] Notified of ↓ U.O. [illegible] LR bolus started Lungs CTA
	[illegible] 130's, Sats 92% c O2 supplied (b)(6)-2
6APR 0700	[illegible] A [illegible] Abd Well looking [illegible] midline. Packing w/D all wounds
	c (RLQ) entry/exits wounds packed (b)(6)-2
LAB	140 / 106 / 20 ; 4.6 / 25 / [illegible] < 165 ; 14 / 40 ; ph 7.322
6APR 0930	Patient c ↓ Sat ↑ RR, Temp 101.0 Ax, IS taught through interpreter c (b)(6)-2
	minimal ability. [illegible] Short puffs = 500ml on IS. Lungs c rhonchi & diminished
	bases (b)(6)-2
6APR03 1200	Patient response to [illegible] lasix c 850cc urine. Febrile 101.6 Ax sats
6APR 1300	only 90% c 10L/FM, (b)(6)-2 CPT & back, poor cough [illegible] Labs [illegible]
	PO_2 ↓ 62. (b)(6)-2 CPT, (b)(6)-2 Still requires O2 10L/FM NRB (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4236

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5APR03	Brief Op Note:
	Preop Dx: S/p Diverting colostomy for GSW to abdomen
	Postop Dx: Same
	Procedure: Colocolostomy (end → side)
	Surgeon: (b)(6)-2
	Anesthesia: GETA
	EBL: 250 UOP: 100cc
	Fluids: 2700
	Findings: Diffuse anterior adhesions, viable stump, viable stoma
	Drains: Foley, NG tube
	Complications: ∅
	Disposition: To ICW // stable
	(b)(6)-2 MD
	MAJ, MC
5APR 03 0800	Patient arrived from OR, O2 tapered down to RA c Sats. Follows commands,
106/68 - 97.9	Good cough reflex c NGT (L) Nare. Midline & (R) of midline dsg CDI.
14 - 110 102 FM - 99%	Lungs CTA, IV X ga (R) AC infusing w/o S/s of compromise. One Episode
	of emesis scant amt. Foley draining Clear yellow urine scant amt. (b)(6)-2
0845	Pain medication MSO4 2mg IV x2 for pain.
1135	Un output ↓, IV bolus 1 liter per (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 (b)(3)-1

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4237

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 APR 03	PT. ambulated x 3 today. Approx 200' each way. Tolerated
@ 11:45 z	well. Did have some low sats. 76-86% Room Air. Face
	mask @ 10 L's sats are 95% resting. Abd. midline open.
	Drsg Δ done. ∅ foul smell. Some small grey liquid
	drainage noted. Medicated c̄ MSO4 x2 today for
	pain to abdomen. Bowel sounds non active. Tongue
	looks better p̄ 24° of thrush. Thrush treated yesterday.
	Foley DC'd @ 0500z. PT. has not voided yet.
	NG DC'd @ 0500z. Abdomen is distended, but not as much
	a yesterday. IV Ⓡ forearm c̄ LR @ 140/hr. ∅ infiltration
	or infx noted @ IV site. I+S used and enforced. —
	SSG (b)(6)-2 91WM6
10 APRIL 03	Pt A+O x 3, NAD, O_2 @ 6 L/min via O_2 concentrator
0100 Z	via non-rebreather. Sats 93-94%. Pt used IS x 2
	this shift, also ambulated to BS commode + chair.
	PAO_2 drops to 81-85% c̄ RA. C/O pain to abdomen.
	Dressing is C, D, I. No BS noted, pt not passing flatus.
	Abdomen is distended, tender to shallow palpation. (b)(6)-2 91B?

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.

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

MEDCOM - 4238

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Apr 03	0515 Patient alert & oriented / language barrier. Requires O_2 via NRB to keep Sat > 92%. Lungs coarse throughout. (+) BM & void. W→D dressing, D'd to midsection, (-) purulent drainage. Ambulates c̄ steady gait. Skin color appropriate for ethnicity. IVA (L) hand infusing LR @ 140cc/hr (-) redness or edema. (b)(6)-2 1LT / AN

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

MEDCOM - 4239

MEDICATIONS

Allergies:

Time	Pair 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1841		25mg Succhinylcholine	IV			CPT ALLISON
1905		12.5mg Succhinylcholine	IV			CPT ALLISON
1944		5mg MSO4	IV			[illegible]
2236		2mg MSO4	IV			[illegible]
2330		2mg MSO4	IV			[illegible]

NEUROVASCULAR

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

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

C-SECTIONS

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

DRESSINGS

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

PACU OUTPUT

Time	Source	Color/Appearance	Amount
1849	foley	Pale yellow	1450 mL
1930	foley	Pale yellow	200 mL
2200	foley	yellow	700 mL
2230	JP		100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(b)(6)-2

23MAR03 1824- Pt received from CPT (b)(6)-2 s/p ex lap, colostomy & repair of liver laceration (b)(6)-2 cholecystectomy. Pt unresponsive x 0, alert to pain, intubated @ 25 depth 02 lips. Vent set @ 12 BPM, I:E 1:4.0, SIMV, 21% O2 with supplemental O2 added & 700 mL. BS present, clear & equal all quadrants. IV's running 0.9% NaCl (L) wrist & (R) wrist. Strong pulses @ radial & carotid, weak pedal bilaterally. Foley draining to gravity (b)(6)-2

1841- Pt starting to buck the vent & convulse, med given by CPT (b)(6)-2 noted above. (b)(6)-2

1846- Pt relaxed, (b)(6)-2

1847- IV (L) wrist shut off, IV removed

1900- Dressings to mid abdomen have old blood underneath, no new seepage noted.

1911- 60 cc Diprovan syringe started @ 25 mcg/kg/min into (L) IV site using syringe pump VS 109 HR 127/76 12 RR 100% SpO2 (b)(6)-2

1939- Vent malfunction, bag pt manually while corrected. Pt back on vent 1946 12 BPM 1:4.0 IE 21% w/ supplemental O2 VS returning to baseline (b)(6)-2

1945- Vent settings switched to CPAP, 21 100% SAO2

1957- Diprovan drip stopped per Anesthesia in preparation for extubation. CONT DA 3950 (b)(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_______________ **Output:**_______________
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

ACLU-RDI 1244 p.461

DOD 010719

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED *(Date)*

Date: 23 Mar 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In:
Allergies: OR Intake: Crystalloid Colloid
Pre-op V/S: OR Output: UOP EBL
Procedures: Meds/Times:
ex lap colostomy cholecystectomy

Pre Op Meds History

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

Airway: Nasal, Oral, ETT, Trach, Other

Time	1824	1829	1834	1849	1904	1919	1934	1949	2004	2019	2034	2049	2050	2120	2130	2140
SaO2	100	100	99	100	99	100	100	97	100	98	99	98	96	97	95	97
FIO2																
Methods	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	RA	RA	RA	RA	RA	RA	RA	RA
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	15	16	21	12	21	12	11	16	24	23	23	26	27	25	18	14
T																

Time								
Pain (0-10)								
LOS								

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1900	0.9 NaCl	700	RA	IV	
2100	0.9 NaCl	600	RA	IV	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	/	1	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	/	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	/	1	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	/	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	/	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	/	7 (b)(6)-2	

Codes

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE

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

(b)(6)-4

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

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

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY 546 Ambulance

2. PATIENT IDENTIFIED, RECORD AND PROCEDURE VERIFIED BY (b)(6)-2

3. DATE 23 MAR 03 — TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1345 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Translator present pt. cooperative

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:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR
☐ CLIP
COMMENTS: DR. (b)(6)-2

PREP SOLUTION *(Specify)*
SITE: Beta/Abd & Chest BY WHOM: Cpt (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

Prep

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

C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				(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;)*

(b)(6)-4

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

☐ ESU NO: F1048
GROUND PAD: BRAND Valleylab
LOT NO: 156870

☐ 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.

MEDCOM - 4242

OPERATION REQUEST AND WORKSH[illegible]

For use of this [illegible], see AR 40-407; the proponent agency is the Offi[illegible] he Surgeon General

SECTION A — REQUEST FOR SURGERY

1. PATIENT'S NAME (Last, First, MI) (Print)	2. STATUS	3. AGE	4. RELIGION	5. REGISTER NO	6. SSN (with Family Member Prefix)
(b)(6)-4	OD	N45			

7. PREOPERATIVE DIAGNOSIS: S/P Colostomy for colon injury
8. NURSING UNIT (from - to): MCU
9. OPERATION PROPOSED: Colo-colostomy
10. REQUESTING SERVICE: Gen Surg

11. DATE OF SURGERY	12. TIME OR CASE NO	13. SCHEDULE PRIORITY (check one)	14. BLOOD REQUIRED (Unit)	15. SEPTIC
5APR03	1ST	☐ EMERGENCY ☐ SEMI-EMERGENCY ☐ ROUTINE	Ø cc	II

16. SURGEON	17. ASSISTANT(S)	18. POSITION OF PNT	19. PREP REQUIRED
(b)(6)-2	(b)(6)-2	Low Lith	Beta

20. NURSING STAFF	21. ANESTHETIST(S)	22. ANESTHESIA
	~~GETA~~	GETA

23. SPECIAL INSTRUCTIONS AND REMARKS
Intestinal set
Silver bullet

24. REQUESTING OFFICER (Printed Name and Signature): (b)(6)-2 MD (b)(6)-2 MAJ, MC

SECTION B — OPERA[TIVE ...]

25. OPERATING ROOM NO	26. TIME OR CASE NO	27. SEPTIC	28. FLUIDS (other than blood)	29. BLOOD ADMINISTERED
			NS	Ø

30. SURGEON	31. ASSISTANT(S)	32. ANESTHETIST(S)	33. ANESTHESIA TIME (Began and Ended)
		PITCHER	0810 / 1109

	AGENT	TECHNIQUE	
34. INDUCTION ANESTHETIC	Propofol	RSI ē CP	37. AIRWAY: 7.0 ETT
35. PRIMARY ANESTHETIC	Forane	GETA	38. RELAXANTS — INTUBATION: Succinylcholine; OTHER:
36. SECONDARY ANESTHETIC			

39. SPECIAL PROCEDURES (Anesthesia):

40. NURSING TIME (Began and Ended)	41. SCRUBBED PERSON(S)	42. CIRCULATING PERSON(S)
0730	Jey	(b)(6)-2

43. OPERATION DATE	44. OPERATION TIME (Began and Ended)	45. DRAINS	46. SPONGE COUNT	47. LABORATORY SPECIMEN
5 April 03	0838 / 1655	Foley	Correct	Ø

48. OPERATIVE DIAGNOSIS

49. OPERATION(S) PERFORMED ☐ EPISODES OF SURGERY

50. COMPLICATIONS (Continue on reverse, if more space is required)

51. DICTATOR'S NAME, SERVICE & PHONE EXT | RECORDED IN REGISTER (Initials)

DA FORM MAR 82 4107 EDITION OF 1 JUN 73 MAY BE USED.

MEDCOM - 4243

Name:
SSN:
DOB:
Unit:
Nationali

(b)(6)-4

HT:
WT: lb
WT: kg

DATE: 23 MAR 03
TIME: 1900

Additional Orders/Charting:

24 MAR 03 1500
1) Δ Unasyn to
3gm IVB Q6H
2) Albumin 5%
250cc boluses
x 2 over
20-30 minutes.
(b)(6)-2
24 MARCH 03 [illegible]
i) Toradol 30mg IVP now V.O. (b)(6)-2
24 MARCH 03 2040 hrs (b)(6)-2
i) Δ Toradol to 30mg IVP
Q6hrs. - V.O. (b)(6)-2
(b)(6)-2
25 MAR 03
1) Continue toradol
30mg IVB Q6H
2) D/c Unasyn
3) Cefotetan 2 gms
IVB Q12H
4) Colostomy bag today
5) Ambulate today.
6) D/C NGT
7) D/C Foley if ambulatory

(b)(6)-2

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** s/p ex lap for GSW
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: > 160 or < 90; DBP: > 100 < 50;
HR: > 120, < 60; RR: > 20, < 10; Temp: > 102
6. **IVF:** IVF: LR @ 80 cc/hr; ~~NS @ 75~~ 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 [illegible] empty + record Q4H
~~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 6 hrs; Chem now & Q 6 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: 700; RR: 12; Fio2: 21%; PEEP
ABG Q 1 hrs;
~~16.~~ X-Ray:
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
✓ ~~Propofol 25 [illegible]~~ = OFF DC'd [illegible]
✓ Unasyn 1.5gm IVB (b)(6)-2
~~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 30-60 min
Notify MD for Mental Status changes
20. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;
274th FST Post-OP Orders, By CRT [redacted] as of 29 Nov 2001

(b)(6)-2

MEDCOM - 4244

ACLU-RDI 1244 p.465

DOD 010723

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS
For use of this form, see AR 40-66; the proponent agency is the OTSG

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

WARD (b)(3)-1 ICU

DATE 24 Mar 03

PATIENT ID NAME (b)(6)-4

Time		BP	HR	RR	SpO2			Out
0700	Labs ABG: pH 7.337,	PCO2	37.6,	PO2 65	HCO3	20 TCO2 21		BE -6
	i-STAT #7 → Na	150,	K 3.1	Ca 0.92	Hct 36	Hgb 12	— (b)(6)-2	
	i-STAT #6 → Na	148	K 3.3	Cl 118,	Bun 10	Glu 120	Hct	40
0745	IV Fluid changed to	LR	@ 80 cc/hr				(b)(6)-2	
0900	MSO4 3mg IVP c/o Thr pain	128/76	131	22	94		(b)(6)-2	
0900	Unasyn 1.5g IVPB	given				(b)(6)-2		
1000	Dsg Change —		JP drains 1 & 2			65cc total		55
1020	MSO4 3mg IVP	125/71	121	20	100		(b)(6)-2	
1200	MSO4 4mg IVP	128/74	140	37	94		(b)(6)-2	
1245	Urine Output		141	20	96	→		600cc output
1245	JP drains marked #1 & 2		#1	output 60cc	#2 20cc			(b)(6)-2
1245	IVF LR @ 80cc/hr		via dial-a-flo				(b)(6)-2	(b)(6)-2
1315	Temp 101.0 HR	140-146;	Albumin			25% 100 ml mixed		
	with 400 cc of LR →		250 cc/hr →				(b)(6)-2	
1410	VS - output.	120/74	133	21	93%	100 cc u/o		(b)(6)-2
1430	i-STAT - Lab #6	Na 139	K 3.5	Cl 108	Bun 11	Glu 118	Hct 38	
1507	VS, pt resting in bed	120/74	146	29	94%		(b)(6)-2	
1530	Δ'd unasyn to 3g IVPB and started albumin 5% 250cc bolus per MD						(b)(6)-2	
1600	Pt c/o pain and became restless HR ↑150 4mg MSO4 given IVP						(b)(6)-2	
1600	Zantac 50mg IVPB							
1700	400cc dark urine from foley catheter		(b)(6)-2					
1730	Unasyn 3g IVPB						(b)(6)-2	
	Pt sleeping. Vitals	124/71	138	20	90%			
1800	Pt resting	120/68	137	23	91%			
1900	Pt sleeping. Vitals —	115/70	140	22	91%			

DA FORM 3950, JUN 91 — Previous editions are obsolete.

MEDCOM - 4245

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD (b)(3)-1

ICU

- *This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.*

DATE

PATIENT'S NAME (b)(6)-4		T	P	R	BP	SPO2		
1930	Drained JP's #1 yielded 75cc	#2 yielded 25cc						(b)(6)-2
1930	4mg MSO4 IVP For 8/10	pain. Encouraged PT to sit up in bed and cough.						
2000	30mg Toradol slow IVP for fever per MD	101.8	139	22	121/72	90%		
2030	Rechecked temp	100.4						
1230	4mg MSO4 IVP for pain	99.0	122	25	120/65	93%		
0030	Unasyn 3.0mg IVPB							
0100	500cc clear dark yellow urine							
0100	Zantac 50mg IVPB							
0300	Pt asleep HOB↑ no T pt asleep		125	28	139/85	92%		
0730	30mg Toradol slow IVP for pain							
0730	4mg MSO4 IVP for pain							
0745	DC'd NG Tube ~~10ml~~ 5ml of	return ~~da~~						
0800 ~~0745~~	JP drain 75 ml ~~of of~~ out of	drain 1	20ml drain	2 dark	Sero Sanguinous		fluid (b)(6)-2	(b)(6)-2
0800	foley drain 700cc dark	yellow	urine clear					(b)(6)-2
~~0900~~	Pt resting comfortably	NTK	133	21 ~~133~~	114/65	91		(b)(6)-2
0905	ZANTAC 50mg IVPB.							
0910	Δd Unasyn 3g Q6h to Cefotan 2g IV	q 12 hrs. per MD. Gave Cefotan 2g IV						
0930	6mg MSO4 IVP prior to dsg Δ.							
1000	Placed colostomy bag on patient.							
1030	Ambulated patient to front door and return.	Pt tolerated this well. D/C'd foley on return						
	to room. Pt c/o pain 5mg	MSO4 IVP given.	250ml dark yellow urine in foley.					(b)(6)-2
1215	Vitals. Pt resting in bed.	99.7	135	22	109/63	87% on 5L Nasal Cannula		(b)(6)-2
1300	Toradol 30mg IV. Vitals		132	20	132/73	87% on 5L Nasal Cannula		(b)(6)-2
1420	4mg MSO4 IVP. Transferred PT to holding via litter.							(b)(6)-2

DA FORM 3950, JUN 91 — Previous editions are obsolete. — USAPA V1.01

MEDCOM - 4246

ACLU-RDI 1244 p.467

DOD 010725

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD (b)(3)-1

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

DATE 23MAR03

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

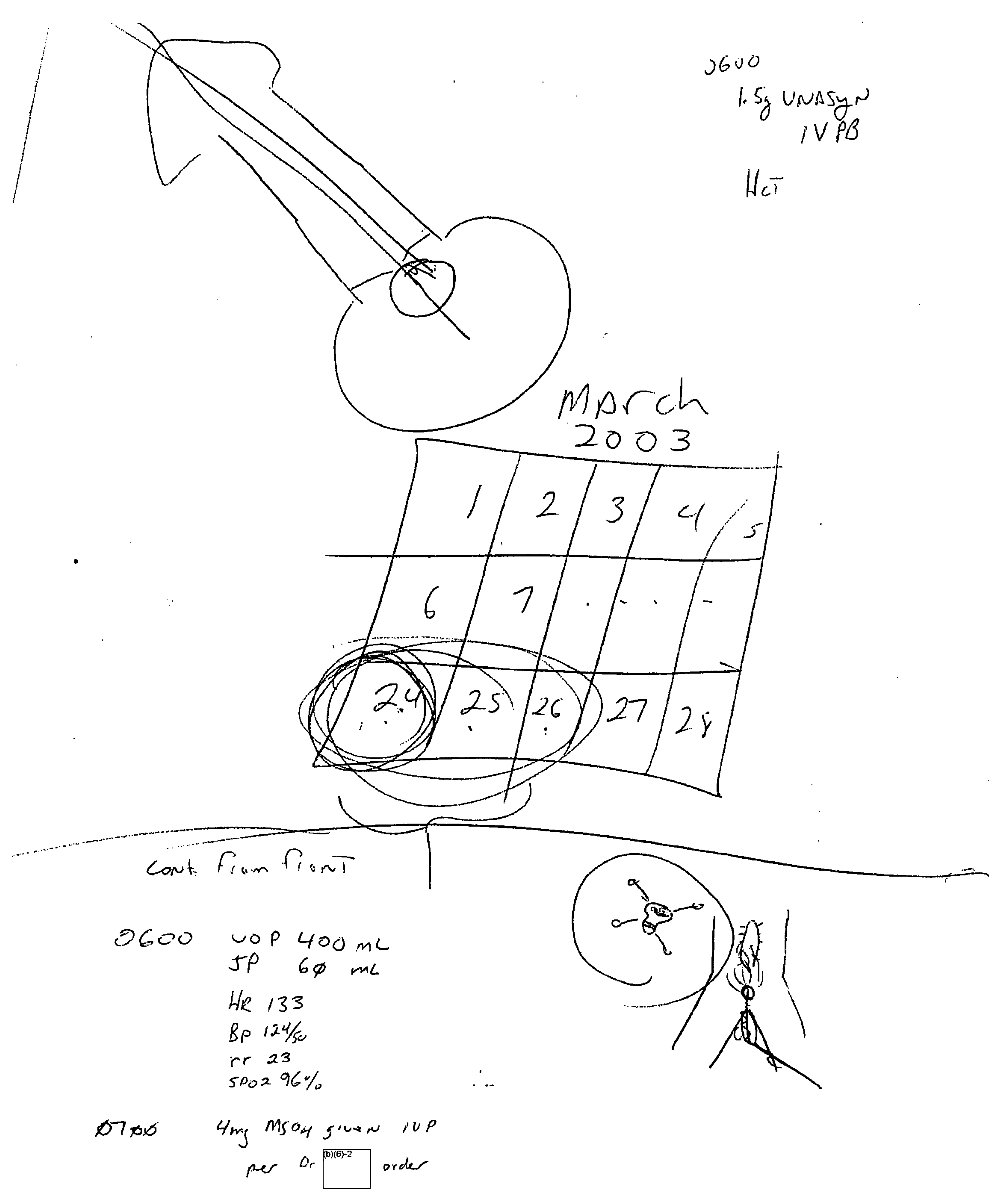
Time	Notes
2034	Dressing to UL quad seeping, order to reinforce — (b)(6)-2
2104	Pt started to wake up, c/o pain
	"A LOT" per translator. 2mg IV — (b)(6)-2
	MSO4 given, pt relaxing at this time
2340	↑1000ml NaCl — (b)(6)-2
2350	JP drain out 75 ml — (b)(6)-2
2400	1.5g Unasyn Q6h per order — (b)(6)-2
	1st Dose Now
0015	4mg IVP Zofran — (b)(6)-2
0048	Pane 6- Drawn for ISTAT: NA 143
	K 3.9 Cl 111 Bun 9 Glu 150
	HcT 42; Dr notified — (b)(6)-2
0100	VS; HR 128 rr 21 BP 143/77
	SAO2 96, Anterior chest/abd dressing
	seeping serosanguinous fluid,
	reinforced — (b)(6)-2
0200	VS: HR 128 BP 130/79 rr 26 SaO2 96
	UOP 500cc NG 40 JP 46
0300	VS: HR 133 BP 127/79 rr 31
	SaO2 93 NC
0402	VS HR 132 BP 145/91 rr 34 SpO2 92%
	UOP 150 ml JP 30
0500	VS HR 132 BP 141/78 rr 32
	SAO2 93%

DA FORM 3950, JUN 91 — Previous editions are obsolete. — USAPA V1.01

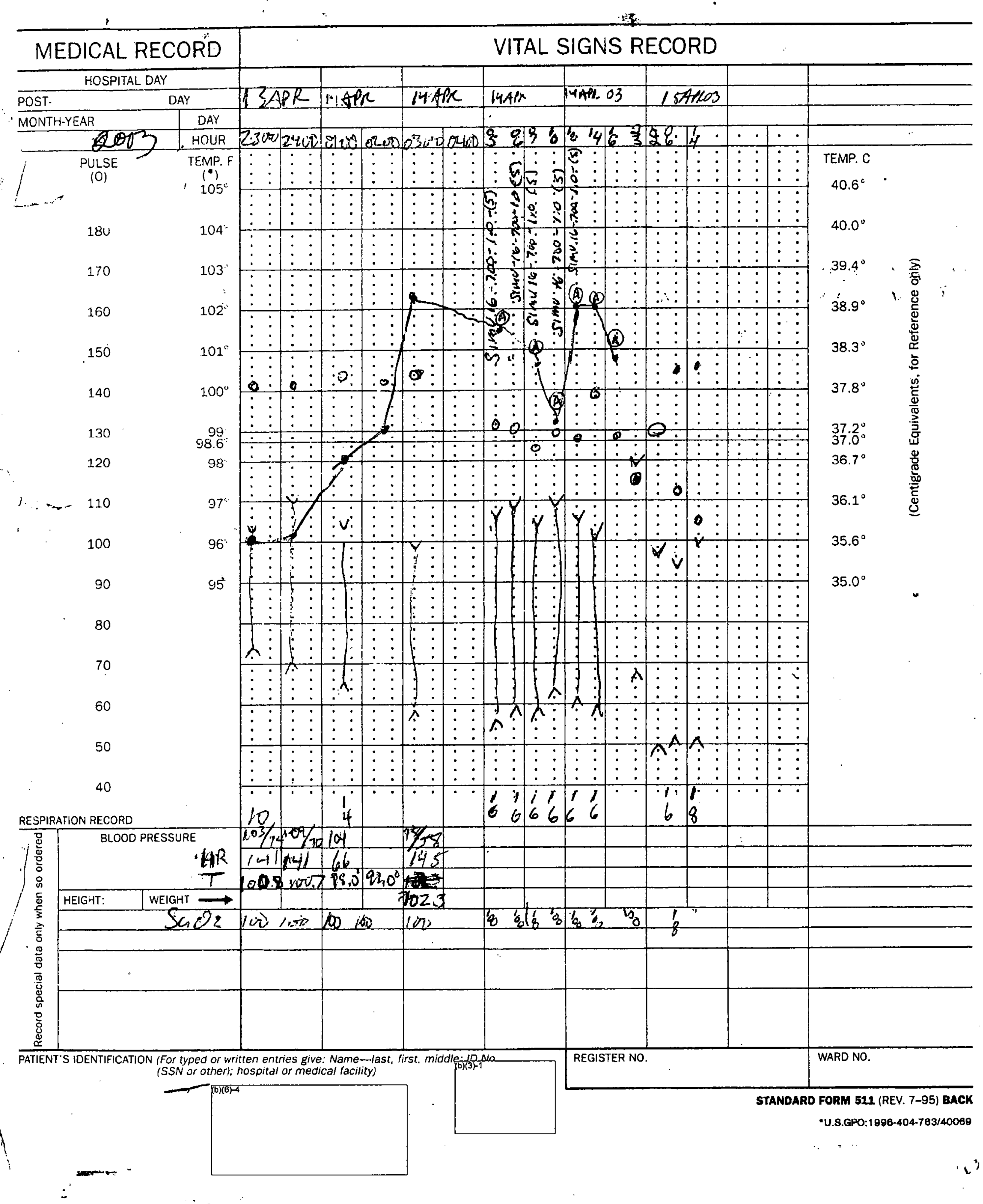
MEDCOM - 4247

ACLU-RDI 1244 p.468

DOD 010726



MEDCOM - 4248



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

(b)(3)-1

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

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

MEDCOM - 4249

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	10 Apr 03	11 APR	12 APR 03	13 April	13	13	13	
APRIL 19 2003 / HOUR	1200, 1630	0100, 2	1630	0800, 1000	1415	1430, 1600	2000, 2100	2300

PULSE (O) — TEMP. F (•) — TEMP. C

SYSTOLIC BP V

DIASTOLIC BP Λ

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)

RA Sats 89% 4 Lpm 02

RESPIRATION RECORD: 34, 28, 126

BLOOD PRESSURE: 124/66, 118/54, 71, 105/67, 108/59, 118/66, 121/70, 179, 153, 139, 179, 116/79

R m Air SATS 98/40, 95, 95%, 98%, 98, 94, 94

HEIGHT: WEIGHT

Output: X 7 total

Intake -PO

100% SIMV 700, 14, 50%, 5

100% SIMV 700, 14, 50%, 15

SAT - PAO2

VENT Settings

NG

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.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4250

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	
DAY	
MONTH-YEAR / DAY	27 APR 03 / 28 Apr / 29 APR
19 / HOUR	2030 / 0130 / 0430 / 2230 / 0500

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	102/72	12?/78	98/56	100/46	57/52
P	72	84	68	102	110
R	14	20	18	18	18
HEIGHT: / WEIGHT →	RA		RA	RA	RA
SPO_2				96	98%

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

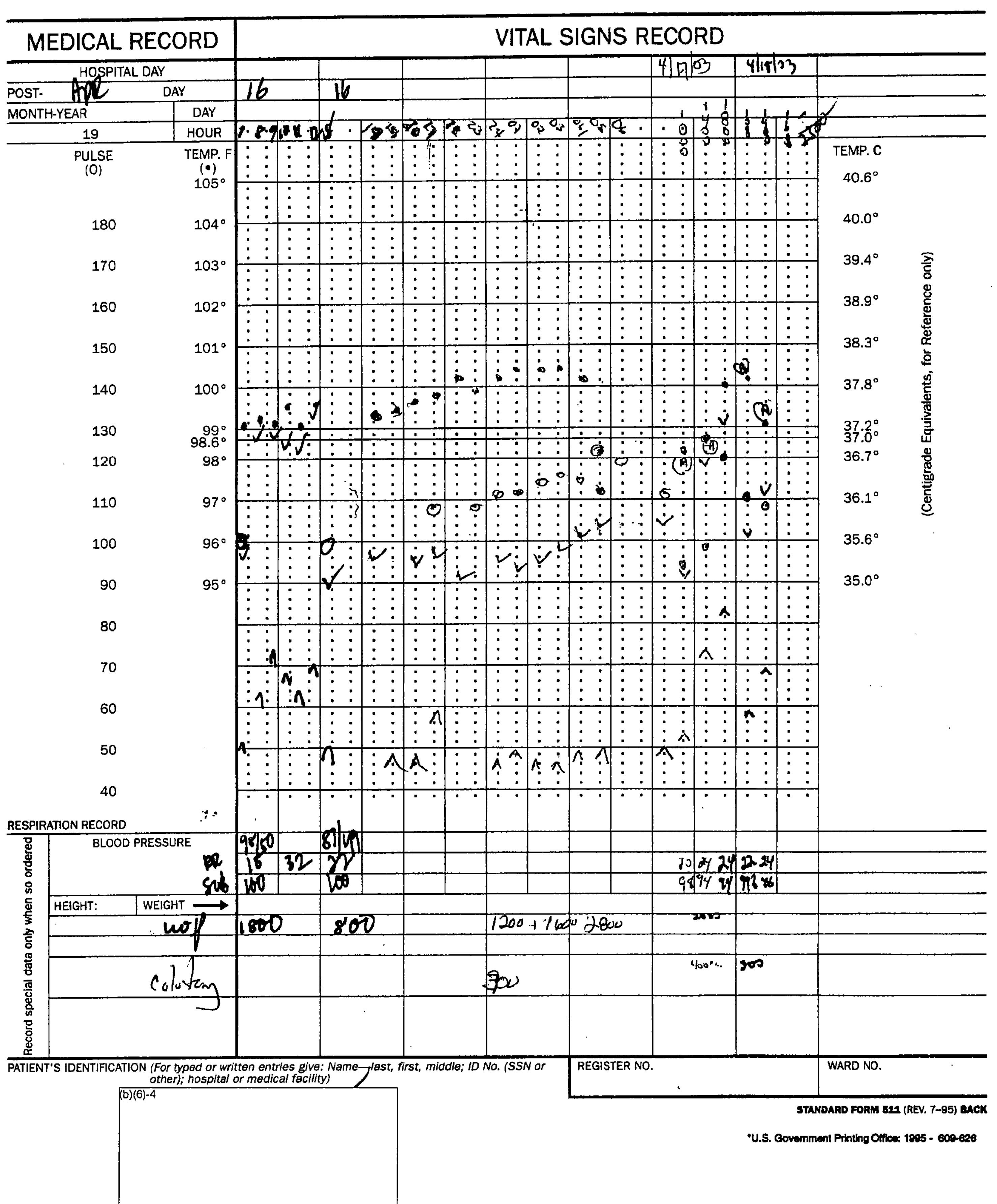
REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-628

MEDCOM - 4251



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY
19 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-826

MEDCOM - 4252

ACLU-RDI 1244 p.473

DOD 010731

511-118

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 19 Apr, 20 Apr, 21 Apr, 22 Apr

19 | HOUR: 06, 1030, 1415, 1820, 06, 1000, 1415, 1810, 0546, 1015, 1400, 06, 1000, 1400

PULSE (O) | TEMP. F (•)

105° / 180 104° / 170 103° / 160 102° / 150 101° / 140 100° / 130 99° / 98.6° / 120 98° / 110 97° / 100 96° / 90 95° / 80 / 70 / 60 / 50 / 40

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 26, 22

BLOOD PRESSURE: 100/58, 105/56, 104/60, 109/58, 107/60, 109/61, 112/61, 106/63, 95/54, 102/60, 104/61

114, 109, 105, 112, 110, 108, 111, 92, 98, 104

1046 95%, 94%, 94%, 96%, 95%, 95%, 97%, 96, 95, 95, 96

HEIGHT: | WEIGHT → 10.3 AY, 99.4, 99.2, 97.3

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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4253

MEDICAL RECORD		VITAL SIGNS RECORD							
HOSPITAL DAY									
POST-	DAY	22 APR	25 APR	27 Apr					
MONTH-YEAR	DAY								
19	HOUR	1800	1930	0600					

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

	22 APR	25 APR		27 Apr
BLOOD PRESSURE		94/57	99/56	98/56
SPO2 %		94%		94%
HEIGHT: / WEIGHT →				

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

REGISTER NO.

WARD NO.

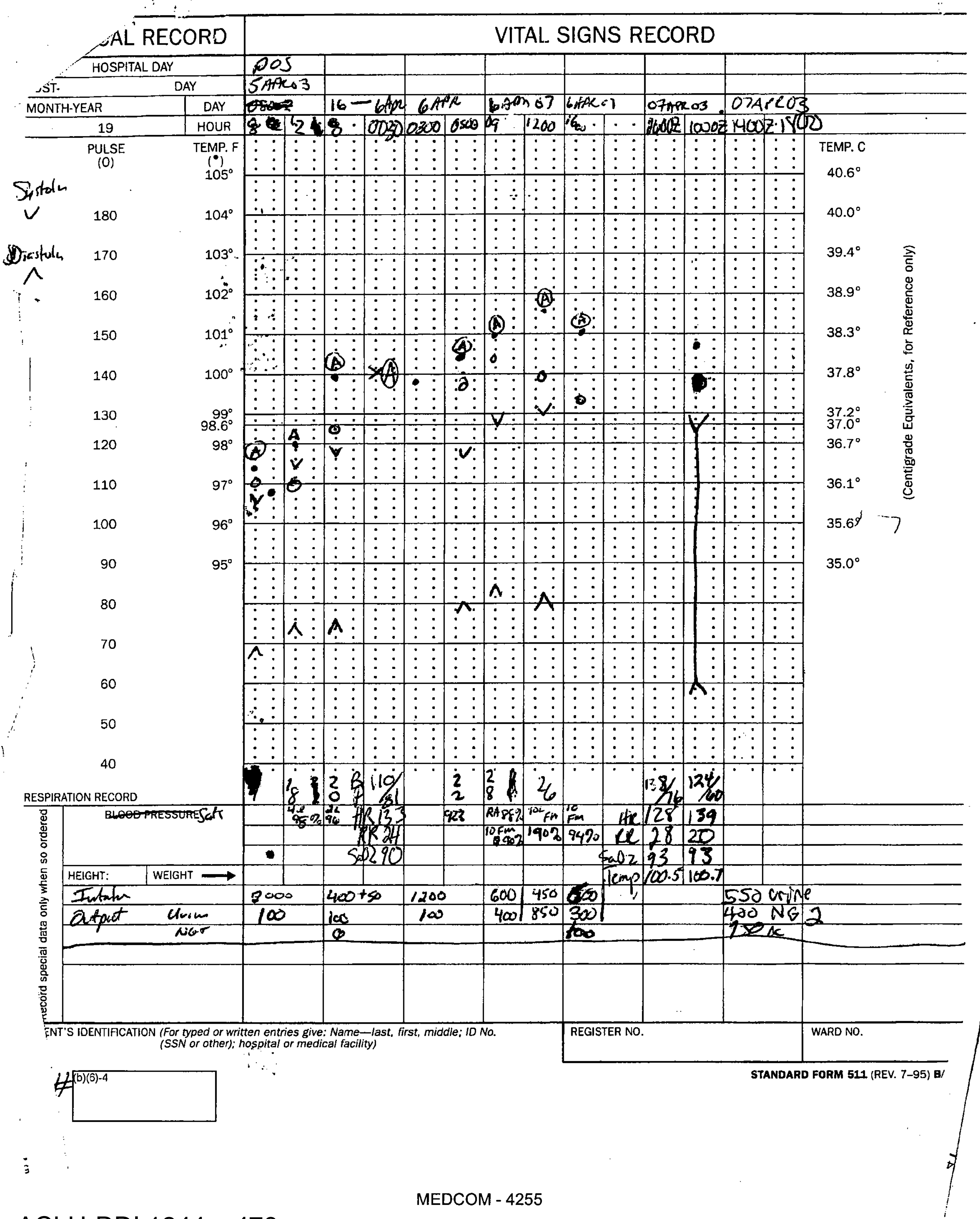
STANDARD FORM 511 (REV. 7-95) **BACK**

*U.S. Government Printing Office: 1995 - 609-626

OD

(b)(6)-4

MEDCOM - 4254



...AL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	ØOS
...ST- DAY	5APR03
MONTH-YEAR / DAY	16 — 6Apr · 6APR · 6APR 03 · 6APR 03 · 07APR03 · 07APR03
19 / HOUR	0700 · 0300 · 0500 · 09 · 1200 · 1600 · 1600Z · 1000Z · 1400Z · 1900

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)

Systolic V
Diastolic Λ

RESPIRATION RECORD

~~BLOOD PRESSURE~~ SaO2

HR 133
RR 24
SaO2 90

HR 128 · 139
RR 28 · 20
SaO2 93 · 93
Temp 100.5 · 100.7

BP 138/76 · 124/60

HEIGHT: WEIGHT →

Intake	3000	400+50	1200	600	450	650	550 urine
Output Urine	100	100	100	400	850	300	400 NG
NGT		Ø				100	150 cc

Record special data only when so ordered

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

REGISTER NO. | WARD NO.

STANDARD FORM 511 (REV. 7–95) **B/**

(b)(6)-4

MEDCOM - 4255

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY			8APR03	9APR03	9APR03	9APR03	10 APR03	
MONTH-YEAR / DAY	7APR03	8APR03	8APR03 0430Z	9APR03 [illegible]Z	0320	0430Z	0213Z	
19 / HOUR	1830	0200						

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		119/66	116/65	106/71	120/69	96%	3/4
BLOOD PRESSURE	115/65	[illegible]	65	71	69		120
T	101.3	100.3	93%	101.0	99.3		69
R	22	21	113	22			24
HEIGHT: / WEIGHT →			24				
P	132	119	100.3	120	111		
SPO2	94%	91		93	95		

Record special data only when so ordered

NG 200cc OUTPUT / INPUT 1,750cc IV
Urine 700cc

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

MEDCOM - 4256

Initial Assessment
Date ______ Time ______

(b)(3)-1

ICU ____
OR ____

NEUROLOGICAL ASSESSMENT

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
X 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
X 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
X Cool
_Clammy

RESPIRATORY
_Unlabored X 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
1352		128		167/86	Pt to FST from FLA awake c̄ GSW to Ⓛ chest. Pt restless has spontaneous resperations. bleeding controlled. Lungs CTA Ⓑ. entrance wound to Ⓡ flank - exit Ⓛ chest. Abd distended. Pt being induced to surgery. Translator @ bedside.

Allergies

Time	IV	MEDICATIONS (dose/route site)

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric	Pertinent Lab Values
	Total:					

(b)(6)-4

35 y/o ♂
EPW

ATLS WORKUP SHEET
MEDCOM - 4257

DA FORM 4700 274th FST OP 1

13. PROSTHESIS, IMPLANTS ☐ YE[S] ☐ NO	NAME: ID NU[MBER]	MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

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. 10Fr JP x 3	2.	3.
SITE	1. Abd	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4X8 Fluffs 4X4 Silk Tape

19. ADDITIONAL INFORMATION

DR. (b)(6)-2

DR. (b)(6)-2

DR. (b)(6)-2

Anes - Maj (b)(6)-2 - Gen

20. OPERATION(S) PERFORMED

Exploratory Laparotomy

21. PATIENT TRANSFERRED TO ICU | TIME | METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

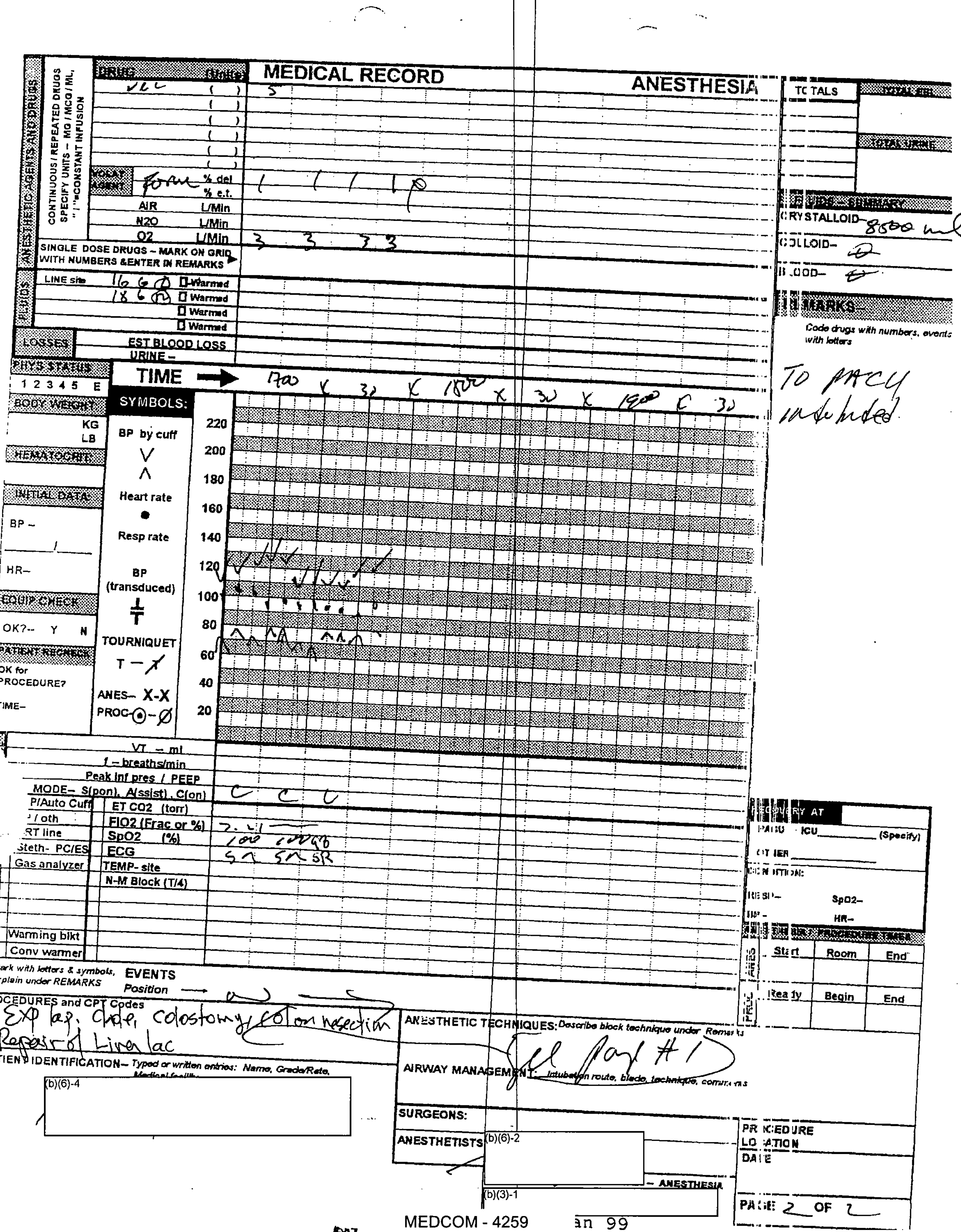
REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDCOM - 4258

ACLU-RDI 1244 p.479

DOD 010737



MEDICAL RECORD — ANESTHESIA

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

DRUG (Units): vec — 5

VOLAT AGENT: Forane % del / % e.t. — 1 1 1 1 Ø

AIR L/Min
N2O L/Min
O2 L/Min — 3 3 3 3

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

FLUIDS — LINE site: 16 G Ⓛ ☐ Warmed; 18 G Ⓡ ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE –

TOTALS — TOTAL EBL; TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID – 8000 ml; COLLOID – Ø; BLOOD – Ø

REMARKS — Code drugs with numbers, events with letters

To PACU intubated

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 → 1700 X 30 X 1800 X 30 X 1900 X 30

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE– S(pon), A(ssist), C(on): C C C

P/Auto Cuff; ET CO2 (torr)
/ oth; FIO2 (Frac or %): 2.41
RT line; SpO2 (%): 100 100 100
Steth- PC/ES; ECG: SR SR SR
Gas analyzer; TEMP- site
N-M Block (T/4)
Warming blkt
Conv warmer

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

RECOVERY AT: PACU ICU ____ (Specify); OTHER; CONDITION; RESP– SpO2–; BP– HR–

ANES / PROCEDURE TIMES: Start, Room, End; Ready, Begin, End

PROCEDURES and CPT Codes: Exp lap, Chole, colostomy, colon resection, Repair of Liver lac

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA per #1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

(b)(6)-4

SURGEONS:

ANESTHETISTS (b)(6)-2

— ANESTHESIA (b)(3)-1

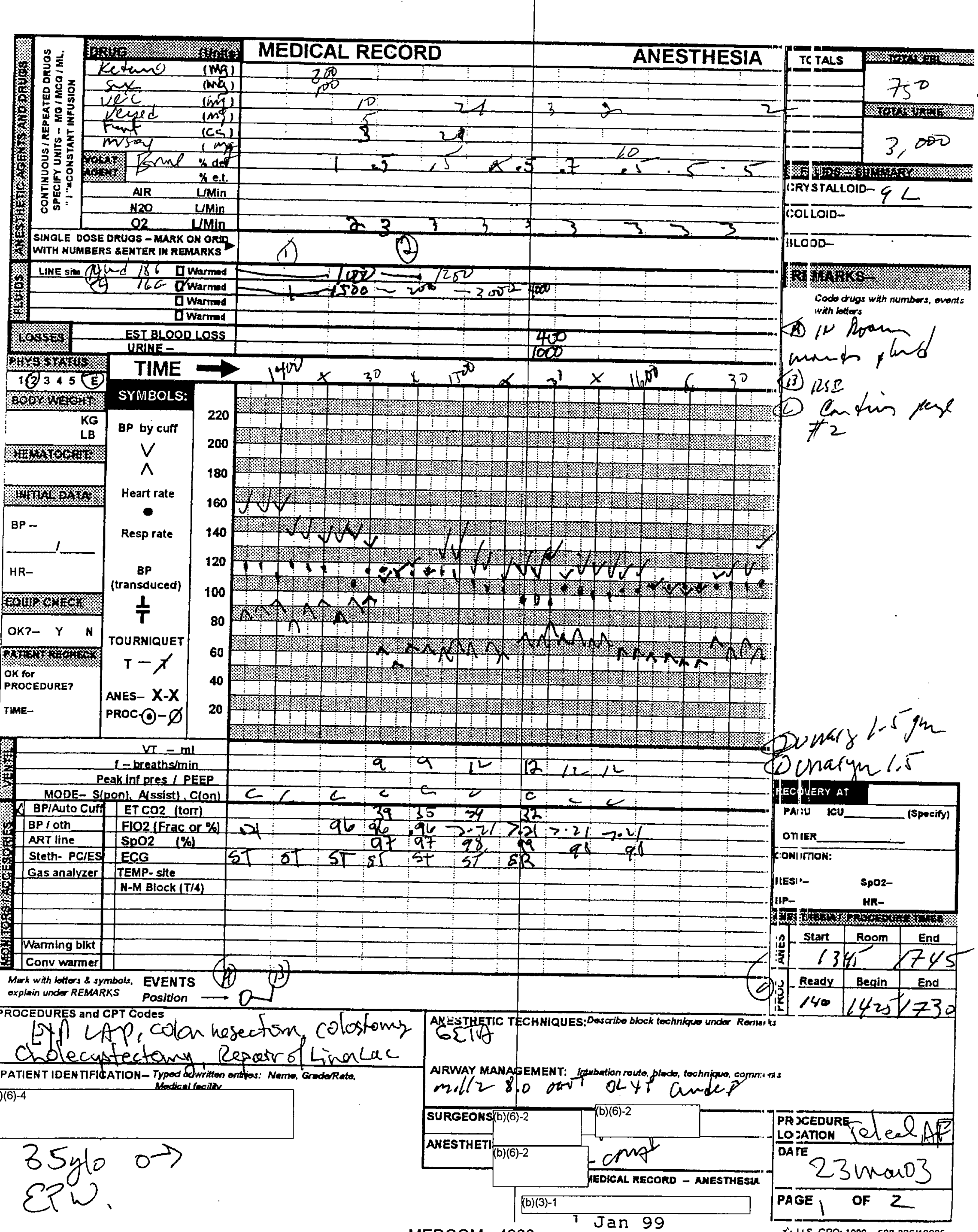
PROCEDURE
LOCATION
DATE

PAGE 2 OF 2

MEDCOM - 4259 Jan 99

ACLU-RDI 1244 p.480

DOD 010738



MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)									
Ketamine	(MG)	200								
Sux	(MG)	100								
Vec	(mg)		10	2	1	3	2			2
Versed	(mg)		5							
Fent	(cc)		3	2						
MSO4	(mg)						10			
VOLAT AGENT Forane	% del / % e.t.		1	.5	.5	.5	.7	.5	.5	.5
AIR	L/Min									
N2O	L/Min									
O2	L/Min		2	3	3	3	3	3	3	3

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ① ②

FLUIDS: LINE site ① Lt hd 18 – 1000 → 1250; ② 16G – Warmed – 1500 – 2000 – 3000 – 4000

LOSSES: EST BLOOD LOSS 400; URINE – 1000

PHYS STATUS 1 ② 3 4 5 Ⓔ

TIME → 1400 x 30 x 1500 x 30 x 1600 x 30

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

BODY WEIGHT KG LB; HEMATOCRIT; INITIAL DATA: BP – / HR–; EQUIP CHECK OK?– Y N; PATIENT RECHECK OK for PROCEDURE? TIME–

VENT: VT – ml; f – breaths/min 9 9 12 12 12 12; Peak insp pres / PEEP; MODE– S(pon), A(ssist), C(on) C C C C C C C C C

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

ET CO2 (torr)			39	35	34	32		
FIO2 (Frac or %)	.21	96	96	.96	7.21	7.21	7.21	7.21
SpO2 (%)			97	97	98	99	91	91
ECG	ST	ST	ST	ST	ST	ST	SR	
TEMP- site								
N-M Block (T/4)								

Mark with letters & symbols, explain under REMARKS — EVENTS Ⓐ Ⓑ Ⓒ; Position → O

TOTALS: TOTAL EBL 750; TOTAL URINE 3,000

FLUIDS – SUMMARY: CRYSTALLOID– 9 L; COLLOID–; BLOOD–

REMARKS– Code drugs with numbers, events with letters
Ⓐ in Room monitors placed
Ⓑ RSI
Ⓒ Continue page #2
① Unasyn 1.5 gm
① Unasyn 1.5

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____ CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES: ANES Start 1345 Room End 1745; PROC Ready 1400 Begin 1425 End 1730

PROCEDURES and CPT Codes: Exp LAP, colon resection, colostomy Cholecystectomy, Repair of Liver Lac

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — mil 2 8.0 ott OLT Under P

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

35 y/o
EPW.

SURGEONS (b)(6)-2 (b)(6)-2
ANESTHETI (b)(6)-2 – cmd
MEDICAL RECORD – ANESTHESIA
(b)(3)-1

PROCEDURE LOCATION Tel Afar
DATE 23 Mar 03
PAGE 1 OF 2

1 Jan 99
MEDCOM - 4260
☆ U.S. GPO: 1999 – 528-336/10085

ACLU-RDI 1244 p.481
DOD 010739

Iraqi national, no translator available

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE | M F | 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

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 tendencies, 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 (b)(6)-2 MJ, CRNA DATE 5 APR 03

PHYSICIAN ______ DATE ______

POST ANESTHESIA VISITS

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

DATE: ______

SIGNED: ______ TIME: ______

IVI / (b)(6)-2 ... 0815

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

ANESTHESIA RECORD

Page 1 of 1

START	IN OR	ANES. END	DATE
	0815	1109	5 APR 03
TOTS	SURG START	DRESSING	OR NO
0820	0838	1055	

OPERATION PERFORMED: Ostomy take down

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [ ] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 3 & EQUIP. CHECKED
- [x] NON-INV. B/P
- [x] PNS
- [x] CONT. EKG
- [ ] V LEAD EKG
- [ ] ESOPH. STETH.
- [ ] PRECORD STETH.
- [x] PULSE OXIMETER
- [x] O2 ANALYZER
- [x] END TIDAL CO2
- [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [ ] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [x] N/G TUBE
- [ ] O/G TUBE
- [x] IV(s) 18g @ forearm
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [x] O.R. [ ] FLOOR
- [x] EYE CARE taped
- [ ] PRESSURE POINTS CHECKED / PADDED

AGENTS

Agent											
Versed mg	2										
Propofol mg	180										
Succinylcholine mg	100										
Fentanyl ml	3 2										
MSO4 mg			5 5			10					
Vecuronium mg		3		2			3				
Neostigmine mg										5	
Robinul mg										.8	
FORANE	2.3	2.0	2.2	2.2	2.3	2.3	1.5	1.8	1.8	1.5	X
N2O l/min AIR											
O2 l/min	5-2	2	2	2	2	2	2	2	2	2	2.5 — X

FLUIDS

NS	1000 — 2000 — 2700
Urine	100
EBL	200 — 250

MONITORS

EKG	ST	SR	SR	SR	SR	ST	SR	SR	SR	SR	ST
% O2 Inspired	.86	.77	.77	.78	.78	.77	.78	.78	.78	.79	
O2 Saturation	100	100	100	100	100	100	100	100	100	100	
End Tidal CO2	41	40	42	42	32	34	34				
Temperature											
PNS	0/4 4/4	0/4	0/4	3/4	4/4	1/4	3/4	4/4 4/4	1/4		4/4 sustained tetany

TIME: 0815, 30, 0900, 30, 1000, 30, 1100, 30

VITAL SIGNS

PRE-OP VALUES: B/P 107/59; P 101; R; SAT; H/H

RESP

Tidal Volume		830	730	750	1200	1200	1150	1420	750	760	
Resp Rate	14	10	12	12	14	10	10	9	12	12	
Peak Pressure		25	24	24	26	28	26	28	24	24	18
	SV/AV	CMV	CMV	CMV	AV	AV	AV	AV	CMV		SV

Symbols for Remarks

Position: supine

ANESTHETIC TECHNIQUE

- [x] GENERAL
- [ ] LOCAL / MAC
- [ ] REGIONAL
- [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION
- [ ] INHALATION
- [x] RAPID SEQUENCE
- [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS
- [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE Miller 2
- [x] ETT SIZE 7.0 [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED ↑ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT ____ CM
- [x] BREATH SOUNDS equal
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

REMARKS:
- [ ] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

Tourniquet Time: N/A

RECOVERY

TIME IN PACU	CONDITION
1104	STABLE

B/P	PULSE	RESP	O2 SAT
104/68	119		96

REMARKS

TEMP

REPORT TO: PARRS:

FLUIDS TOTALS

IN	OUT
Crystalloid	EBL
	Urine
Blood	Gastric

(b)(6)-2 MJ CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; ● PULSE; O SPONTANEOUS RESP; ASSISTED RESP; CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID F; B BLOOD

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 29 MAR 99) Page 1 of 2

MEDCOM - 4262

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF ' - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22C

ANESTHESIA RECORD

Page | of

START	IN OR	ANES. END	DATE
18	0959	1145	12 APR 03
TOTS	SURG START	DRESSING	OR NO
1026	1030	1125	188

OPERATION PERFORMED: REV. ABD WOUND PERISERVICES

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug | Dose | Route | Time

Pre-Anesthetic State: [x] AWAKE [ ] CALM [ ] SEDATE [x] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N / G TUBE [ ] O /G TUBE
- [x] IV(s) INO-R. 1 Kg (R) AC
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE MAC 3
- [x] ETT SIZE 7.0 [ ] DOUBLE LUMEN
- [x] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 3 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [x] ETT SECURED AT 22 CM
- [x] BREATH SOUNDS = (B)
- [x] AIRWAY [x] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS / FLUIDS / MONITORS

Times: 18 x 30 x 11 x 35 x 17

								TOTAL
Versed	2.5				2.6			5 mg
Fentanyl	100		50, 50		50			250 mcg
Propofol	150				30			180 mg
Sux	100							100 mg
Vecuronium	2	3	2	2				9 mg
Neostig						3		3 mg
Forane	1.5	1.8	2	2	2	off		
~~N2O~~ L/min AIR	2	2	1	1	1	off		
O2 L/min	1	1	.4	.4	.4			
.9NS	1000		1000					
Urine								
EBL								
EKG	ST	SR	ST	ST	ST	ST	ST	
% O2 Inspired	.95	.43	.37	.31	.49	.50	.50	
O2 Saturation	100	100	97	97	99	98	99	
End Tidal CO2	(+)	42	40	35	33	33	(+)	
Temperature	–	–	–	–	–	–	99.3	
PNS	4/4		4/4		4/4	–	4/4	

VITAL SIGNS

PRE-OP VALUES: B/P 137/82; P 130; R 18; SAT RA 93; H/H –

(Graph: 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20)

RESP							
Tidal Volume	730	725	850	870	880	SV	SV
Resp Rate	8	10	10	12	12	18	18
Peak Pressure	26	29	29	34	35	(+)	(+)
1:6	1:2	→	→	→	→	→	→

Symbols for Remarks

Position

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

NO IV IN PRE-OP

Tourniquet Time:

RECOVERY

TIME IN PACU	CONDITION
1143	TRE-HYPNOTIC CONGESTED

B/P	PULSE	RESP	O2 SAT
155/92	111	26	

REMARKS | TEMP

REPORT TO: PARRS:

FLUIDS TOTALS

IN	OUT
Crystalloid .9NS	EBL
	Urine N.M.
Blood	Gastric

MAJ (b)(6)-2 CRNA, LDOR, AN

PHYSICIAN / CRNA

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

NAME: (b)(6)-4 SURGEON: (b)(6)-2 / (b)(6)-2 Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE: 40's | (M) F | HEIGHT: 5'9" | WEIGHT: ~175#

PROPOSED OPERATION: REV. ABD WOUND DEHISCENCE / S/P COLOSTOMY TAKEDOWN

PREOPERATIVE VITAL SIGNS: B/P 137/82 P 130 R 16

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE
Expl. Lap. S/P GSW → ABD (23MAR03) Colostomy Takedown

CURRENT MEDICATIONS ☐ NONE
Cipro 500mg PO BID
Augmentin 875mg PO BID
Motrin 800mg PO q L-8° prn
Albuterol/Atrovent Nebulizer Tx q6°

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☑ NEGATIVE

ALLERGIES ☑ NKDA
NKDA

AIRWAY / TEETH / HEAD & NECK: Intact dent.; FROM neck supple; ØTMJ MP2

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. (B) pulmonary infiltrates ?	Chest X-ray / Pulmonary Studies: Ordered for today post-op.
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) low back pain, 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
- Sepsis / Infection, potential for
- Skin integrity, alteration of
- Fluid / electrolyte imbalance, pot. for
- Alt. in patterns of elimination, pot. for
- Gas exchange / resp. patterns, alt. of

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: ________

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 74 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22(

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
1927	1940	2220	13 APR 03
TOTS	SURG START	DRESSING	OR NO
1848	1955	2210	

OPERATION PERFORMED: Ex-lap

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug | Dose | Route | Time

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [ ] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 3 & EQUIP. CHECKED
- [x] NON-INV. B/P
- [ ] PNS
- [x] CONT. EKG
- [ ] V LEAD EKG
- [ ] ESOPH. STETH.
- [ ] PRECORD STETH.
- [x] PULSE OXIMETER
- [x] O2 ANALYZER
- [x] END TIDAL CO2
- [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [x] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [x] N / G TUBE
- [x] ~~O / G TUBE~~
- [x] IV(s) 16g (L) Hand, 18g (R) AC
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [ ] O.R. [x] FLOOR
- [x] EYE CARE taped
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL
- [ ] REGIONAL
- [ ] LOCAL / MAC
- [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION
- [x] RAPID SEQUENCE
- [ ] INTRAVENOUS
- [ ] INHALATION
- [ ] INTRAMUSCULAR
- [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION
- [x] ORAL
- [ ] NASAL
- [x] DIRECT VISION
- [ ] BLIND
- [ ] AWAKE
- [ ] FIBER OPTIC
- [x] STYLET USED
- [x] ATTEMPTS x 1
- [x] BLADE Miller 2
- [x] ETT SIZE 8.0
- [ ] DOUBLE LUMEN
- [ ] STRAIGHT
- [ ] RAE
- [ ] ANODE
- [x] CUFFED 7 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [x] ETT SECURED AT 24 CM
- [x] BREATH SOUNDS equal
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE
- [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA
- [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS

Agent											TOTAL
Versed mg	Versed 2.5										2.5 mg
Propofol mg	150										150 mg
Succinylcholine mg	100										100 mg
Fentanyl mcg	2 3	3		2				5			150 mcg
Vecuronium mg	10			10			10				30 mg
Forane	2.8	2.5	2.5	2.5	2.5	2.0	2.0	1.5	1.6		
~~N2O~~ L/min AIR	1	1	1	1	1	1	1	1X			
O2 L/min	5-.4	.4	1	1	1	1	1	1-2	2	2	

FLUIDS

Fluid								
LR	700	1500	2400	3000	4000	4100		
Urine			200		250			
EBL	150		250	300				

MONITORS

EKG	SR	SR	ST	ST	ST	ST	ST	ST	ST	ST
% O2 Inspired	.98	.40	.50	.50	.55	.56	.55	.57	.99	1.0
O2 Saturation	100	98	97	98	99	98	98	98	100	100
End Tidal CO2	38	34	37	35	37	36	37	36	38	40
Temperature										
PNS	4/4	0/4	0/4	1/4	0/4 0/4	0/4	0/4	0/4	0/4	0/4

TIME: 1945, 2000, 30, 2100, 30, 2200, 30, 2300

VITAL SIGNS

PRE-OP VALUES: B/P 139/71; P 136; R 18; SAT 94; H/H

RESP

Tidal Volume	830	880	890	740	730	720	740	720	560	560
Resp Rate	12	12	12	14	14	14	14	14	15	18
Peak Pressure	30	31	30	30	29	29	30	30	30	
	SV/CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV

Symbols for Remarks

Position: supine

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

Tourniquet Time: N/A

SYMBOLS: X ANESTH; ⊙ OPERAT; V Λ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; • PULSE; O SPONTANEOUS RESP; Ø ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION
2213	STABLE INTUBATED

B/P	PULSE	RESP	O2 SAT
/	133	14	97

REMARKS | TEMP

REPORT TO: PARRS:

FLUIDS TOTALS

IN		OUT	
Crystalloid	4100	EBL	300
		Urine	200
Blood		Gastric	

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

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDCOM - 4265

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 29 MAR 99) Page 1 of 2

ACLU-RDI 1244 p.486

DOD 010744

Iraqi national, no interpreter available -

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE ~48 | (M) F | HEIGHT 70" | WEIGHT ~100 Kg

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

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY: Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes ___ Pack/Day for ___ Years	Chest X-ray / Pulmonary Studies
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☐		EKG
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☐	Ethanol Use: ☐ No ☐ Yes Frequency ___	LFTs
NEURO/MUSCULOSKELETAL: Arthritis, DJD, 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	☐		Urinalysis / Thyroid / FBS
OTHER: Anemia, Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, 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 (b)(6)-2 MAJ CRNA DATE 13 APR 03

PHYSICIAN ___ DATE ___

POST ANESTHESIA VISITS

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

DATE: ___

SIGNED: ___ TIME: ___

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: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 100 cc/hr, bolus ______ cc x 1		
3	MORPHINE: 2 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 ______ or greater		
9	Call Anesthesia for any questions or concerns		
(10)	Phenergan 25 mg IV PRN N/V may repeat once -		
	SIGNED (b)(6)-2 MAJ, CRNA.		

PATIENT IDENTIFICATION

(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

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 8 Apr 03

DATE AND HOUR REQUIRED 0600

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

DATE VERIFIED

TIME VERIFIED

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
N/A	N/A

PREVIOUS RECORD CHECK: [ ] RECORD [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 8 Apr 03

REMARKS:

Exp 15 Apr 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

(b)(6)-2

AT *(Hour)* 0600 ON *(Date)* 8 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

2nd VERIFIER *(Signature)* (b)(6)-2 S/W/M6

PRE-TRANSFUSION

TEMP. 106.3 PULSE 117 BP 116/70

DATE OF TRANSFUSION

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 8APR03 0938Z

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	100.7	116	121/74

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 (b)(6)-2 9/W/M6

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

(b)(6)-4

(b)(6)-4

SEX M

WARD ICU 1

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 - 4268

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) ______ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 8 Apr 03

DATE AND HOUR REQUIRED: 0600

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify): N/A

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: Ex-lap

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

DATE VERIFIED

TIME VERIFIED

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
N/A	N/A

- [x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 8 Apr 03

REMARKS:

PREVIOUS RECORD CHECK: [ ] RECORD [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2 15 Apr 03

PRE-TRANSFUSION DATA

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

AT (Hour) 0600 ON (Date) 8 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

2nd VERIFIER (Signature) (b)(6)-2 9/4/MG

PRE-TRANSFUSION

TEMP. 100.4 | PULSE 122 | BP 123/72

DATE OF TRANSFUSION: 8 Apr 03

TIME STARTED: 09

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1U ML

TIME/DATE COMPLETED/INTERRUPTED: 8 Apr 03 @ 0738Z

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE 100.3 | PULSE 117 | BLOOD PRESSURE 116/70

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 (b)(6)-2 9/WMG

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

(b)(6)-2

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

SEX: M

WARD: ICW

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 - 4269

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA CARE UNIT ORDERS		(b)(6)-2 1105
1	OXYGEN: 2 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-4 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		✓
	(b)(6)-2 MAJ, CRNA, [illegible]		

PATIENT IDENTIFICATION

(b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages. S/P Colostomy takedown

Diagnosis: S/P expl. lap w/ wound dehis.

Height: 5'9" Weight: 175# Diet:

Allergies: NKDA

Nursing Unit	Room No.	Bed No.	Page No.

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

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

07 APR 03
UA Ø715Z
Glucose = (−)
Bili = Small
Ketones = (+) 5 trace
SG = 1.030
Blood = moderate
PH = 7.5
protein = 30+
Urobilinogen = .2 normal
Nitrate = (−)

CHEMISTRY I (546-107)

TEST(S) / SPECIMEN TAKEN — DATE: — TIME: 0640

RESULTS	REQUESTED	(X)
100	GLUCOSE	
10	UREA N.	
	CREATININE	
	URIC ACID	
135	SODIUM	
4.5	POTASSIUM	
103	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)	
35	Hct	
12	Hb (est)	
	Ph	

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

TEST(S) / SPECIMEN TAKEN — DATE: 6 Apr 03 — TIME: 1300

RESULTS	REQUESTED	(X)
164	GLUCOSE	
16	UREA N.	
	CREATININE	
	URIC ACID	
140	SODIUM	
4.1	POTASSIUM	
104	CHLORIDE	
27	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)	
35	Hct	
12	Hb (est)	
7.441	ph	

REMARKS: 1-66-2

Arterial
ph 7.444
PCO2 39.2
PO2 62
HCO3 25
BEecf 1

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY — DATE: 6 Apr 03

LAB. ID. NO.

CHEM I

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

LABORATORY FILE

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.

404525 Labs

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

MEDCOM - 4271

13. PROSTHESIS, IMPLANTS ☐ YE NO IF YES NAME: ID NU MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

☆U.S.GOVERNMENT PRINTING OFFICE 1996-404-755/40008

NSN 7540-00-181-8358

TEST(S)		
SPECIMEN TAKEN		
DATE	TIME	
RESULTS (first form)	RESULTS (second form)	REQUESTED
111	106	GLUCOSE
12	11	UREA N.
		CREATININE
		URIC ACID
143	142	SODIUM
3.5	3.6	POTASSIUM
103	105	CHLORIDE
33	32	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)
25	30	Hct
9	10	Hb (EsH)
7.495	7.56	ph

REMARKS

Dr (b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

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

REPORTED BY (b)(6)-2

TECH MD DATE 8 Apr 03

LAB. ID. NO.

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

546-107

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD) 03 MAR 23 — TIME OF ARRIVAL / HEURE D'ARRIVÉE 1000

TIME / HEURE		1020	1115	1212
BP / PS	130/70	140/120	120/60	125/100
PULSE / POULS	120	108	108	110
RESP / RESP				

DATE / TIME DATE / HEURE — 13. CLINICAL COMMENTS / DIAGNOSIS INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

GSW to R flank c LUQ exit wound.
3L IVF
2mg morphine
(b)(6)-2 Stable
... time

15. (b)(6)-2 (b)(6)-2 DATE / DATE (YYMMDD)

16. DISPOSITION — L'UNITÉ — TIME / HEURE
EVACUATED / EVACUÉ
DECEASED / DÉCÉDÉ

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
BAPTISM / BAPTISÉ — PRAYER / PRIÈRE
ANOINTING / ONCTION — COMMUNION / COMMUNION
CONFESSION / CONFESSION — OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

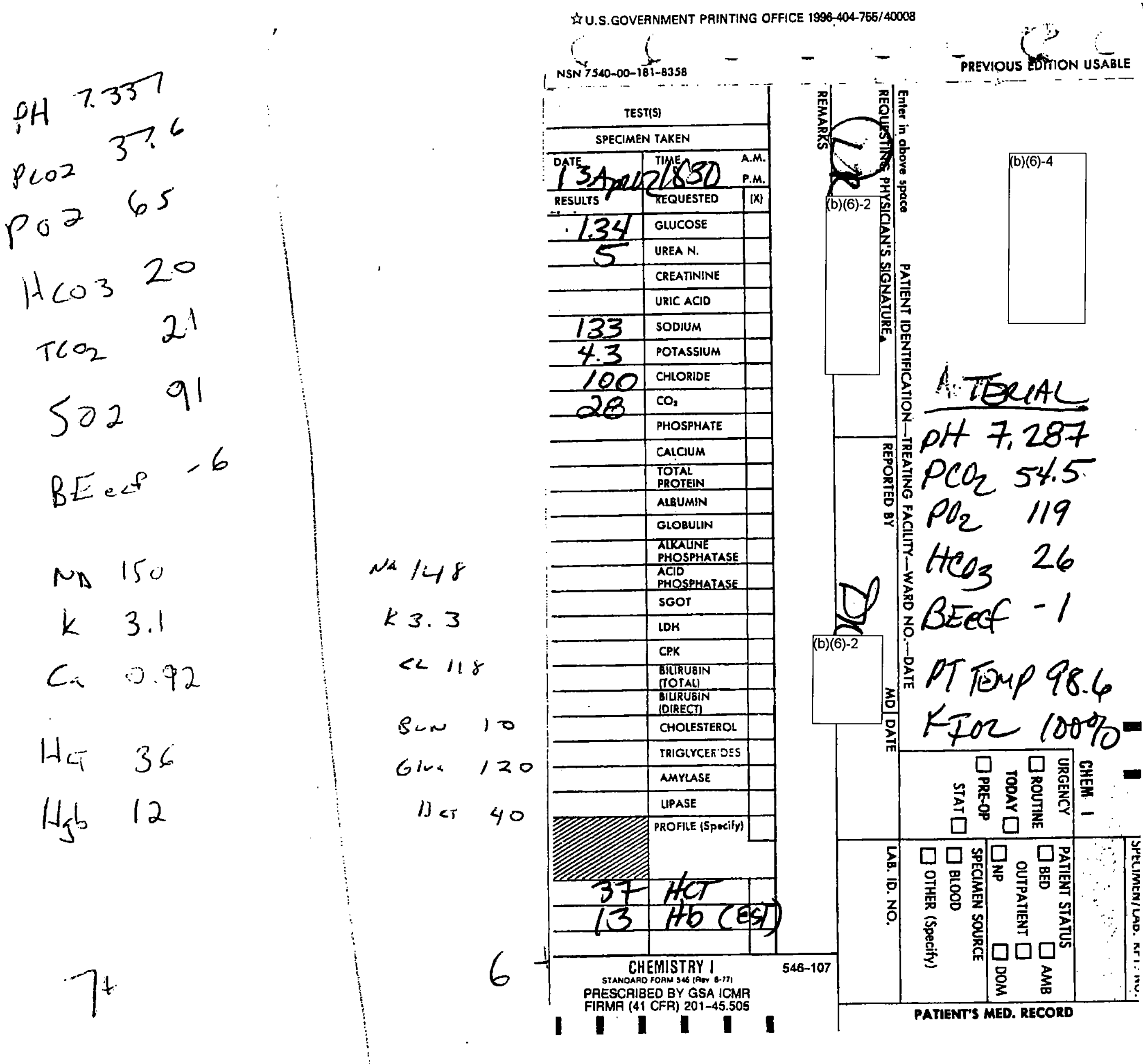
20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO TIME

22. REGISTERED NURSE SIGNATURE

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 388-733/23952



☆U.S.GOVERNMENT PRINTING OFFICE 1996-404-765/40008

NSN 7540-00-181-8358

PREVIOUS EDITION USABLE

TEST(S)		
SPECIMEN TAKEN		
DATE 13 April	TIME 1830	A.M. P.M.
RESULTS	REQUESTED	(X)
134	GLUCOSE	
5	UREA N.	
	CREATININE	
	URIC ACID	
133	SODIUM	
4.3	POTASSIUM	
100	CHLORIDE	
28	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)	
37	HCT	
13	Hb (EST)	

REMARKS

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

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

(b)(6)-4

REPORTED BY (b)(6)-2 MD DATE

ARTERIAL
pH 7.287
PCO_2 54.5
PO_2 119
HCO_3 26
BEecf -1
PT TEMP 98.6
FIO_2 100%

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

LAB. ID. NO.

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. REF. NO.

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

PATIENT'S MED. RECORD

pH 7.337
PCO_2 37.6
PO_2 65
HCO_3 20
TCO_2 21
SO_2 91
BEecf -6

NA 150
K 3.1
Ca 0.92

Hct 36
Hgb 12

7+

NA 148
K 3.3
CL 118
BUN 10
Gluc 120
Hct 40

6

MEDCOM - 4273

ACLU-RDI 1244 p.494

DOD 010752

CLINICAL RECORD - DOCTOR'S ORDERS

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

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
	27 March 2003		
	2100	① CBC, I-stat	
		AM 28 March 2003	
	done (b)(6)-2	② Rocephin ? gm IV q24	
	(b)(6)-2	③ Clindamycin 900mg IV q8	
NURSING UNIT / ROOM NO. / BED NO.	noted	④ NPO (b)(6)-2	

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
	28 March 2003		(b)(6)-2
		Dietary to [illegible]	28 Mar 03 - 1500
		(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
	28 Mar	Pt to be up and	[illegible]
	1350	ambulating (b)(6)-2	28 Mar 1530
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
		3/30/03	
		Diet: Clears start 70 4/1/03	
		NPO p̄ 2359 hrs 4/1/03	
		(b)(6)-2 MD	
NURSING UNIT / ROOM NO. / BED NO.		(b)(6)-2	

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

MEDCOM - 4274

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: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 90 cc/hr, bolus ——— cc x 1		
3	MORPHINE: 2 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 _______ or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 25mg IV PRN N/V may repeat once		
	SIGNE (b)(6)-2, MAJ, CRNA		

PATIENT IDENTIFICATION

(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 - 4275

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

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

0800 ZULU 4/5/03

To ICU
S/P Takedown colostomy
Stable
VS per routine
NKDA
Activity ad lib
NG to suction

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

(b)(6)-2 0843Z (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER ____ HOURS

Foley to gravity
W-D to all wounds daily
Call MD for low urine output
fever or hypotension.
NPO
D5LR @ 140cc/hr
MSO4 6mg 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
Unasyn 3.0g IV Q6°
Zantac 50mg IV Q12°
✓ O2 2LNC
✓ H&H, Chem-7 in am.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 5 APR 03 | TIME OF ORDER: 1145 HOURS

(1) Give 1 Liter LR Bolus IVF now
Verbal Order (b)(6)-2 (b)(6)-2

(b)(6)-2 Noted 1145 5 Apr 03

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4276

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 (b)(6)-4		DATE OF ORDER: 6 APR 03 — TIME OF ORDER: 0850 HOURS	
	1	LR ī L bolus	6 APR 03 0850 Z (b)(6)-2
		(b)(6)-2 MD	
NURSING UNIT: ICU-1 / ROOM NO. / BED NO.		pH 7.322 140/4.6 106/25 165	
PATIENT IDENTIFICATION		DATE OF ORDER: 6 APR 03 — TIME OF ORDER: 1046 Z HOURS	(b)(6)-2
	1	LASIX, 20 mg IV x 1	6 APR 1050 Z
		(b)(6)-2 (b)(6)-2 MD (b)(6)-2	
NURSING UNIT: ICU-1 / ROOM NO. / BED NO.: 2			
PATIENT IDENTIFICATION pH 7.44 8L FM 1300 hrs pCO2 39.2 (39.2 pO2 62 BE +1 HCO3 25 TCO2 26 Sat 90% 12 / 35 140/4.1 104/27 164 4/6/03 1230		DATE OF ORDER: 6 Apr — TIME OF ORDER: HOURS H+H, ABG, Chem 7 now (b)(6)-2 (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.		6 April 2003 Chart ✓ (b)(6)-2 2000 (b)(6)-2	
PATIENT IDENTIFICATION		DATE OF ORDER: 7 APR 03 — TIME OF ORDER: 0445 HOURS	
	1	D/C IVF to LR	
	2	UA dip now	
	3	Ambulate TID	
4/7/03 0800		Cipro 400 IV q12° (b)(6)-2 MD	
NURSING UNIT / ROOM NO. / BED NO. (b)(6)-2		1st dose now (b)(6)-2 (b)(6)-2 (b)(6)-2	

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

MEDCOM - 4277

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 (b)(6)-4		8 April 2003	0450 Z HOURS	
	✓	Istat 8	(b)(6)-2	0502 9 APR 03
		(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		8 April 2003	0605 Z HOURS	(b)(6)-2
		Transfuse c 2 unit Blood		8 APR 03 0615 Z
			(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION (b)(6)-4		DATE OF ORDER	TIME OF ORDER	
		8 April 03	1600 HOURS	
		Tylenol 650 mg PO x 1 Dose now please.		(b)(6)-2 8 Apr 03 @ 1610
		V.O. Dr. (b)(6)-2	(b)(6)-2	
NURSING UNIT: ICU 1 / ROOM NO.: ICU 1 / BED NO.: 2				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		9 APR 03	0440 HOURS	(b)(6)-2
	①	D/C NG		(b)(6)-2 9 APR 03 @ 0450
	②	D/C Foley		
	③	Ambulate TID		
		(b)(6)-2	(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.				

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

MEDCOM - 4278

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: 11 April 2003 TIME OF ORDER: ______ HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Have RT to try weaning off vent

(2) Continue to ambulate QID

NURSING UNIT: ICU 1 ROOM NO.: BED NO.: 2

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 16 APR 03 TIME OF ORDER: 0955 HOURS

1) Δ Antibiotics to Cipro 500mg PO BID ē Augmentin ~~500mg~~ 875mg PO BID

2) D/C IV ē D/C Zantac IV

VO: Dr. (b)(6)-2 /LT (b)(6)-2 1LT/AN/BSN/[illegible]

NURSING UNIT: ROOM NO.: BED NO.:

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: ______ HOURS

1 Vicodin i-ii PO q 4-6° PRN pain

2 Amitriptyline 25mg PO qHS

VO: Dr. (b)(6)-2 /LT (b)(6)-2 [illegible] (b)(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

PATIENT IDENTIFICATION

DATE OF ORDER: 10 APR 07 TIME OF ORDER: 1600 HOURS

1) Ketorolac 30mg IM x1 Now done (b)(6)-2

TO: Dr. (b)(6)-2 / LT (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.

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MEDCOM - 4279

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

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

DATE OF ORDER: 11 April 2003 | TIME OF ORDER: 0545 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ Istat 8 (b)(6)-2

(b)(6)-2 137/97/6 | 3.5/32/ | 38 | 13

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 April 2003 | TIME OF ORDER: 0550 HOURS

~~Nebs c albut & atro t q4h~~

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 April 2003 | TIME OF ORDER: 0605 HOURS

1. Transfer to min care tent
2. Dx: S/P GSW to abdomen
3. O2 @ FiO2 20% by (b)(6)-2
4. IVFS — hep lock

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

5. Vicodin I-II tabs po q4h prn pain
6. Nebs c albut & atrovent QID

(b)(6)-2

DA FORM 4256, 1 APR 79 | REPLACES EDITION OF 1 JUL 77, WHI...

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 11 April 2003 TIME OF ORDER 0745 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Transfer to med care (Continued orders)
2. Cipro 500mg PO BID (b)(6)-2
3. Augmentin 875mg PO BID (b)(6)-2

NURSING UNIT 1 | ROOM NO. | BED NO.

4/11/03 / 0835

1. AMBULATE TID

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

2. w→ D & L's Q Day
3. Nutrition Consult
4. O2 TO keep SaO2 >90% (FM/NC) (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted 12 Apr 03 (b)(6)-2

DATE OF ORDER 4/12/03 TIME OF ORDER 0445 HOURS

1. CXR (PA/LAT) TODAY ? R L Decubiti Plus
2. IV INCENTIVE SPIROMETRY / Pulmonary Toilet
3. MOTRIN 800mg po Q6-8° prn (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 APR 03 TIME OF ORDER 0840 Z HOURS

1. CONTINUE ALL PREOP ORDERS
2. NPO
3. ~~READ~~ ADMIT TO ICU → (b)(6)-2 (b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 APR 03 — TIME OF ORDER: 1220 Z HOURS

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2 12 APR 03 1300

1. Toradol, 30 mg IV TID PRN Pain
2. Heparin, 5000 u SQ BID

(b)(6)-2 MD

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 APR 03 — TIME OF ORDER: 1450 Z HOURS

1. NPO
2. Unasyn 3.0 gm IVPB now
3. Prepare for OR

(b)(6)-2 MD

MAJ, MC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

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

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MEDCOM - 4282

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)-2

DATE OF ORDER: 4/13/03 | TIME OF ORDER: 18 00 zulu HOURS | LIST TIME ORDER NOTED AND SIGN

✓ To ICU
✓ S/P Ileostomy/mucous fistula
✓ Condition critical
✓ VS Q1°
✓ NKDA
✓ Bedrest c̄ HOB 30°
✓ Strict I/On

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ___ HOURS

✓ NG to suction
✓ Foley to gravity
✓ J-tube ~~to suction~~ gravity
✓ Penrose ×2 in place
✓ Wet to dry dressing changes all wounds daily
✓ NPO

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ___ HOURS

✓ D5NS @ 160cc/hr
✓ MSO4 1-4mg IV Q1° prn pain
✓ Phenergan 12.5mg IV Q4° prn ~~pain~~ nau (b)(6)-2
✓ Versed 1-4mg IV Q1° prn sedation
✓ Unasyn 3.0g IV Q6°
✓ Gentamycin ~~360~~ mg IV Qday
✓ Zantac 50mg IV Q12°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ___ HOURS

✓ Tylenol 650mg PR Qday
✓ Vent 700/14/50%/+5
✓ Chem-7, ABG, H&H now
✓ Heparin 5000 U SQ BID (b)(6)-2 4/14/03
Flush J-tube c̄ 10cc H2O q̄ shift (b)(6)-2
✓ PCXR in AM + ABG in AM

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. MEDCOM - 4283 710

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

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

PATIENT IDENTIFICATION (b)(6)-4

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

4/14/03 0420 NS 500cc bolus over 30 min
Haldol 2mg IV ... sedation
... (b)(6)-2
(Cursive)
Noted 14 Apr 0430 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 14 APR 03 TIME OF ORDER 0830 HOURS
(1) NS bolus 500cc
V.O. Dr (b)(6)-2 / (b)(6)-2 ...
(b)(6)-2 14 Apr 0830 (b)(6)-2

14 APR 03 1300
(1) Valium 5-10mg IVP q4-6° prn agitation.
Verbal Order Dr (b)(6)-2 / (b)(6)-2
(b)(6)-2
Noted. 1330 14 APR (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 14 APR 03 TIME OF ORDER 1330 HOURS
(1) Hold Tube Feeds
(2) Valium 10mg IV now, done 1340 (b)(6)-2
Verbal order Dr (b)(6)-2 / (b)(6)-2
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

14 April 2003 Chart (b)(6)-2 CPT AN

PATIENT IDENTIFICATION

DATE OF ORDER 15 Apr. TIME OF ORDER HOURS
Valium 5mg IV now
V.O. (b)(6)-2 / Dr (b)(6)-2
(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 - 4284

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: 4-16-03
TIME OF ORDER: 0900 HOURS

1. TF 10cc/HR cont.
2. aggressive weaning

V/O DR (b)(6)-2 (b)(6)-2 mb

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER
TIME OF ORDER HOURS

1. VO TF ↑ 20cc/h

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER: 17 Apr 03
TIME OF ORDER: 0840 HOURS

1. Lovenox 30 mg SQ BID
2. Δ VS to Q4°

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

9/LWMBH 4/17/03 0845

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)-4

DATE OF ORDER: 18 APR 03
TIME OF ORDER: 0830 HOURS

1. M→D Dressing Δ c̄ Dakin's solution BID
2. Clamp G-tube
3. Clears → Advance as tolerated
4. Tylenol i - ii PO q 4-6° PRN T>101

(b)(6)-2 MD

(b)(6)-2 9/LWMBH 19 APR 03 0920

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 4285

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: 22 Apr 03 TIME OF ORDER: 0710 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

1) MVI ī PO QD
2) D/C MSO4 & Versed (b)(6)-2
3) NS dressing Δ s (b)(6)-2
4) Motrin 800 mg PO 4° (b)(6)-2 p pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Apr 03 TIME OF ORDER: 0810 HOURS

1) Zantac 150 mg PO BID
2) Vicodin 1 tab PO Q6° prn
3) Stop all ABX
4) D/C IV zantac
5) Heplock IV
6) MVI i tab PO QD (b)(6)-2
7) Wean off O2 (b)(6)-2 94%.
8) Ensure ī can PO TID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 4/29/03 TIME OF ORDER: 0720 HOURS

Discharge to (b)(3)-1

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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☆U.S. MEDCOM - 4286 3-710

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
5 APR	(b)(6)-2	H&H, Chem 7 in AM	06 APR	0400	0500	(b)(6)-2
5 APR		Stable condition	5 APR	0811	0815	
07 APR 03		UA dip	07 APR	0700	0715	
8		I Stat	8 APR	0530	0530	
8		Transfuse c 2 units Blood	8 APR	0600	0615	
9		DC foley	9 APR	0449	0449	
9		DC NG	9 APR	0449	0449	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
5 APR	(b)(6)-2	Call MD for low urine	
		output, fever, hypotension	

MEDCOM - 4287

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 5	6	7	8	9	10	11
5APR03	(b)(6)-2	VS per Routine q 4°	04/16	(b)(6)-2						
5APR03		NGT to Low Int. S[illegible]	04/16							
5APR03		VS per Routine q 4°	04/16	(b)(6)-2						
			16/04	(b)(6)-2						
5APR03		NGT to Low Int. S[illegible]	04/16					DC'd 9 APR03		
			16/04							
5APR03		Activity [illegible]	04/16							
			16/04							
5APR03		Foley to Gravity	04/16					DC'd 9 APR03		
			16/04							
5APR03		Wet Dry Drsg Δ's to all wounds q Day	06	/	/	(b)(6)-2	/			
5APR03		O_2 @ 2 L NC	04/16	(b)(6)-2						
			16/04							
5APR03		Ambulate T/D	04/16			(b)(6)-2				
			16/04							

TREATMENTS

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS:
S/p Colostomy [illegible]

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

PATIENT IDENTIFICATION:
(b)(6)-4

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 4288

CLINICAL RECORD

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

Mo. ___ *Yr.* ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29
22APR03	(b)(6)-2	NS Dressing Δ's TID	08	(b)(6)-2							
			16								
			24								
18APR	(b)(6)-2	CLAMP G-Tube, Flush 10cc H2O qs. CLD Adv as TOL	D								
			N								
13APR	(b)(6)-2	VS q shift	D	/	(b)(6)-2						
			N	/							
13APR	(b)(6)-2	HOB 30°	D	/							
			N	/							
13APR	(b)(6)-2	Ambulate TID	08	/							
			16	/							
			22	/							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p colostomy Repeat 2° colostomy takedown

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

MEDCOM - 4289

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4-23	(b)(6)-2	Wean off O^2	4-23	0900	0900	(b)(6)-2
4-23		↓ IV	4-23	0900	0900	

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

USAPA V1.00

MEDCOM - 4290

Recurrent Medications and Treatments		date 3/25	26	27	
~~Zantac 50mg IV Q8°~~	1600				
	2400				
	0800				
~~Toradol 30mg IVP Q6°~~	1900				
	0100				
	0700				
~~Cefotetan ii gms IV Q12°~~	1800				
	2400				
SEE New times					

Vital signs					
	4	99.6 110/65 P125		100.4 P120 112/74	
	8				
	12				
	16	120/70 133 98.6			
	20				
	24		133 99.8 902 117/70 26		

PRN Medications and Treatments					
Morphine 4mg Q30mins PRN	d/t amt/int	25 mar 03 1720 2.5mg [illegible]	25 march 03 1705 (b)(6)-2	26 March 0400 (b)(6)-2	27 march 0 march 3mg [illegible]
~~Morphine 2.5mg~~	d/t amt/int				
Lasix 10-20mg IV prn wheezing	d/t amt/int	25 march 03 15mg 1700	25 march 03 2115 [illegible]		
Vicodin 325-650mg PO Q4-6° prn	d/t amt/int		1	TT @ 0115	
Motrin	d/t amt/int	27 MAR 03 2008 IGU			
	d/t amt/int				

Name: (b)(6)-4 Dx:

SSN: All:

Unit: Blood type:

(b)(6)-4

MEDCOM - 4291

IVF	Time	amount	Total		
LR @ 75cc/hr					

Hourly Input and Output		IV			UOP
	0100				
SP x 1	0200				
SP x 2	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100				
	1200				
	1300				
	1400				
	1500				
	1600				
8 hour totals					
	1700				450
	1800				
	1900				
	2000				
	2100				
	2200				
	2300				
	0000				
8 hour totals					

24 hour totals
Total input:
Total output:
Balance:

Recurrent Medications and Treatments		date 3/26	27	28	29	
Zantac 50mg IV Q8°	08 / 14 / 22	(b)(6)-2				
Toradol 30mg IVP Q6°	1200 / 1800					
Cefotetan 2gms IV Q12°	1200 / 2400	(b)(6)-2			(b)(6)-2	D/C'd 2apr
~~Rocephin 1Gm IM q24~~					1200	
~~Clindamycin 900mg IM q8h~~	1200 / 2000 / 0400					D/C'd 2Apr03
start 2apr03 Regular Diet						

Vital signs					
	4	99.6 110/65 P125			
	8	P T			
	12				
	16				
	20				
	24				

PRN Medications and Treatments					
Motrin 800 mg PO PRN	d/t amt/int	1500 (b)(6)-2			
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: (b)(6)-4

SSN:

Unit:

Dx:

All:

Blood type:

MEDCOM - 4293

Recurrent Medications and Treatments		date March 30	31	April 1	2
~~Rocephin 1 Gm IM q 24~~	~~1900~~ (b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	
~~Clindamycin 900mg IM q8h~~	~~0500~~ (b)(6)-2		(b)(6)-2		
	~~1600~~ 1300			(b)(6)-2	
	~~2400~~ 2100	(b)(6)-2			

} D/C'd 2 April

Vital signs					
Regular Diet	4				(b)(6)-2
	8				
	12				
	16				
	20				
	24				

PRN Medications and Treatments					
Motrin 800mg Po PRN Pain	d/t amt/int				
Phenergan. 25mg IM PRN N/V	d/t amt/int	30 mar 04 2130 25mg (b)(6)-2			
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: (b)(6)-4

Dx:

SSN:

All:

Unit:

Blood type:

MEDCOM - 4294

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
				5 6 7 8 9 10 11 12 13
5APR03	(b)(6)-2	DSLR @ 140cc/hr	04/16	(b)(6)-2 D/C
			16/04	(b)(6)-2 (b)(6)-2
5APR03		Zantac 50mg IV q 12°	03	
			15	(b)(6)-2
5APR03		Unasyn 3.0 Gm IV q 6°	05	(b)(6)-2
	-----		11	(b)(6)-2
	-----		17	D/C
	-----		23	
07APR03	(b)(6)-2	IV fluids LR 140cc/hr	04/16	(b)(6)-2
			16/04	
07APR03		AMBULATE TID	04/16	D/C
	-----		16/04	
7APR03	(b)(6)-2	Ciprofloxacin 400mg IV q 12° 1st dose Now	08	(b)(6)-2 D/C
			20	(b)(6)-2
10APR		Ciprofloxacin 500mg PO BID	08	(b)(6)-2
			20	(b)(6)-2
10 APR		Augmentin 875 PO BID	08	(b)(6)-2
			20	(b)(6)-2
10 APR		Amitriptyline 50mg PO qHS	19	(b)(6)-2
11APR		Albuterol/Atrovent Nebulizer Tx q4°	04/08	(b)(6)-2
	-----		12/16	(b)(6)-2
	-----		20/24	
12APR03	(b)(6)-2 -	HEPARIN 5000 U	0?	(b)(6)-2
	-----		18	

ALLERGIES: ☐ YES ☒ NO — NKA

PRIMARY DIAGNOSIS: S/P Colostomy Takedown 5APR

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:
(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 4295

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5 Apr	(b)(6)-2	NS 1 liter IV Bolus now	5 APR	now	1145Z	(b)(6)-2
6 APR		LR 1 liter Bolus	6 APR	now	0500Z	
6 APR		Albuterol Nebulizer Tx 0.5ml / 2.5cc NS now	6 APR	now	0955Z	
6 APR		Lasix 20mg IV X 1	6 APR	now	1050Z	
8 Apr		Tylenol 650mg PO X1 DOSE.	8 Apr 03	NOW	1615	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
5 APR	(b)(6)-2	MSO4 6mg IV q 1° prn pain	5 APR 1000; 5 APR 1140; 6 APR 1345; 6 APR 1500; 6 APR 1700; 6 APR 2030; 6 APR 2200; 6 APR 2335; 8 APR 0550; 8 APR 0640; 6 APR 0925; 6 APR 1630; 6 APR 1845; 6 APR 2320; 10 APR 2330; 11 APR 0320; 5 APR 1855 (b)(6)-2
5 APR	(b)(6)-2	Phenergan 12.5mg IV q 4°	
6 APR 03		MSO4 6mg IV q 1° PRN PAIN	6 APR 03 2300; 6 APR 1145; 5mg 0600Z; 10 APR 1145Z; 7 APR 1535; 7 APR 1000Z; 8 APR 0530; 8 APR 0910; 8 APR 2000; 8 APR 2200; 8 APR 0630; 13 APR 0930; 13 APR 0800; 13 APR 1350; 10 APR 4mg 0155Z (b)(6)-2
10	[illegible]	Vicodin 1-2 PO q 4° prn pain	11 APR 1500; 2040; 13 APR; 13 APR 0130
12 APR	[illegible]	Toradol 30mg IV TID PRN PAIN	1245 12 APR 2005; 13 APR 0430 (b)(6)-2

*U.S. GPO: 1998-454-110/95218

MEDCOM - 4296

TX'S

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	13	14	15	16	17
13APR03	(b)(6)-2	VS Q1°	04 / 16		(b)(6)-2			
13APR03		BR: HOB @ 30°	16 / 04 / 16					
13APR03		Strict I/O's	16 / 04 / 16					
13APR03		NG to suction	16 / 04 / 16					
13APR03		Foley to gravity	16 / 04 / 16					
13APR03		J-tube to gravity	16 / 04 / 16		D/C 14 APR			
13APR03		Wet to dry dressing Δ all wounds daily	06					
13APR03		NPO	04 / 16					
13APR03		Flush J-tube c̄ 10cc H2O Q Shift	04 / 16					
14 APR		Tube Fed via J Tube Ensure @ 10cc/hr	04 / 16 / 10		Hold			

Yellowed out 13 Apr 03 See New Sheets

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Colostomy Repair 2° Colostomy Takedown c̄ Dehiscence 13APR

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. ______

PATIENT IDENTIFICATION: (b)(6)-4

Treatments

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4297

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
13APR03	(b)(6)-2	To ICU, S/P Ileostomy/mucous-fistula, condition critical	13APR03	1900	1900	(b)(6)-2
		NKDA, Penrose x 2 in place	13 APR03	1900	1900	
13APR03		chem 7, ABG, H+H now	13APR03	1900	1900	
13APR03		PCXR in Am.	14APR03	0200	0330	
13APR03		ABG in AM	14APR03	0300	0330	

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

*U.S. GPO: 1996-454-110/95216

MEDCOM - 4298

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 13	14	15	16	17
13 APR03	(b)(6)-2	D5NS @ 160 cc/hr	04 16	/	(b)(6)-2			
			16 04	(b)(6)-2				
13APR03		Unasyn 3.0 gm IV Q6	03	/	(b)(6)-2			
	------		09					
	------		15					
	------		21	/	(b)(6)-2			
13APR03	(b)(6)-2	Gentamycin 500mg QD IV	19					
13APR03		Zantac 50mg Q12°	03	/	(b)(6)-2			
			15	/	(b)(6)-2			
13APR03		Tylenol 650 mg PR QD	07	/	(b)(6)-2			
13APR03		Heparin 5000u SQ BID	03	/				
			15	/	(b)(6)-2			
~~13APR03~~ error		E						

Yellowed out 15APR03 See New Sheet

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Colostomy 13 MAY 2° Takedown/Behrscena/Leakage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL - CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4299

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. APR Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14 APR	(b)(6)-2	NS 800 Bolus IV over 30	14 APR	now	0430	(b)(6)-2
14 APR		NS Bolus 500ml IV	14 APR	now	0845	
14 APR		Valium 10mg IV now	14 APR	now	1340	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
13APR03	(b)(6)-2	MSO4 1-4mg IV Q1° prn pain / See below	13APR 1930 3mg; 2030 4mg; 2130 4mg; 2215 4mg; 2315 4mg; 0015 4mg; 0115 4mg; 0215 4mg; 0300 4mg; 0420 4mg; 0520 4mg; 1200 4mg; 14APR 1323 4mg; 14APR 1530 4mg; 1630 4mg; 1730 4mg; 1830 4mg; 1930 4mg; 2045 4mg; 2140 4mg; 2320 4mg; 0100 4mg; 0330 4mg; 0430 4mg; 0530 4mg; 0630 4mg (b)(6)-2
13APR03		Phenergan 12.5mg IV Q4° prn nausea	15APR 150 12.5mg (b)(6)-2
13APR03		Versed 1-4mg IV Q1° prn sedation	13APR 1900; 2010; 2100; 2130; 2230; 4mg; 4mg; 0130; 0230; 0300; 0350; 0430; 14APR 1005; 14APR 1210; 1310; 1700; 1800; 1950; 2045; 2140; 2320; 0100; 0330; 0430; 2530; 0628 4mg; 15APR (b)(6)-2
14APR		Haldol 2mg IV q 2° prn Sedation	14APR 0630; 14APR 1200 (b)(6)-2
14APR		Valium 5-10mg IV prn q4-6° prn agitation/restlessness	14APR 10mg 1340; 14APR 1840; 15APR 0100 (b)(6)-2
15		MSO4 1-4mg IV Q1° prn pain	15APR 0130; 4mg; 1700 4mg; 15APR 1800 4mg; 2100; 4mg; 2300 (b)(6)-2

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

MEDCOM - 4300

ACLU-RDI 1244 p.521

DOD 010779

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 ... PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23
13APR	(b)(6)-2	D5LR/NS @ 160/hr	07	(b)(6)-2								
	------		19									
	------		19									
13APR	(b)(6)-2	Unasyn 3.0gm IV Q6	07	(b)(6)-2								
	------		13									
	------		19									
	------		01									
13APR	(b)(6)-2	Gentamycin 500 QD IV	21	(b)(6)-2								
13APR		Zantac 50mg Q12°	07	/	(b)(6)-2							
	------		19	(b)(6)-2								
[illegible]	(b)(6)-2	Tylenol 650mg PR QD	[illegible]	(b)(6)-2								
[illegible]		Hep 5000 BID	[illegible]	(b)(6)-2								(b)(6)-2
			19									
16APR		TF at 10cc/hr	D	/	(b)(6)-2							
			N	/	(b)(6)-2							
[illegible]		TF at 20cc/hr	D	/	/	(b)(6)-2						
			N	/	(b)(6)-2							
17APR03		Lovenox 30mg SQ BID	09	/	/	(b)(6)-2						
			21	/	/							
22APR		MVI T PO QD	10	/	/	/	/	/	/	/	(b)(6)-2	

MED SHEET

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Colostomy 2° Takedown (revision) Leakage 13APR03

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4301

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. ____ Yr. ____

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		[illegible]				
		[illegible]				
	(b)(6)-2	[illegible]				
		[illegible]				

Order Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
13 APR	(b)(6)-2	[illegible]	4mg 1330; 4mg 1430; 1530; 1145; 1000; 1415; 2000 4mg; 2100 4mg; 4mg; 4mg 4/17; 4/17 4mg; 4/17; 2200 4mg; 4/17 2345 4mg; 4/17
			(b)(6)-2
			4/18 0310 4mg; 4/18 0410 4mg; 4/18 4mg; 4/18 0045 2mg; 4/19 0800 2mg; 4mg 1000 2mg; 3mg; 19APR 4mg; 19APR 2100; 4/19 2330 4mg; 4/20 0045 4mg; 4/20 0400 4mg; 4/20 0500 4mg; 4/20 1930 4mg; 4/20 4mg 2245
13 APR	(b)(6)-2	Phenergan 12.5mg IV Q4° prn nausea	(b)(6)-2; 4/23 0400
			(b)(6)-2
13 APR		Versed 1-4mg IV Q1° prn sedation	15APR 4mg 1330; 15APR 1430; 15APR 4mg 1530; 15APR 1145; 15APR 1800; 15APR03 1915 4mg; 15APR03 2000 4mg; 15APR03 2100 4mg; 4/15 2400; 4/16 4mg 0100; 4/17 4mg 2345; 4/17 0110 4mg; 4/18 1010 4mg; 4/19 2335 3mg; 4/20 0045 2mg
			(b)(6)-2
13 APR		Haldol 2mg IV q2° prn sedation	
13 APR		Valium 5-10mg IVP Q4-6° prn agitation	4/22 3300; 4/23 0000; (b)(6)-2
18 APR 03	(b)(6)-2	Tylenol I-II PO Q4-6° PRN T 101	

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

MEDCOM - 4302

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 ... PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17 18 19 20 21 22 23
13APR	(b)(6)-2	V.S [redacted] Δ'd To Q4°	07 19 19 07	(b)(6)-2
13APR		BR: HOB 30°	07 19 19 07	(b)(6)-2
13APR		Strict I+O's	07 19 15 07	(b)(6)-2
[illegible]		[illegible]		(b)(6)-2 [illegible]
13APR		Foley to Gravity	07 15 17 07	(b)(6)-2 DC'd 20 APR
[illegible]		[illegible]		(b)(6)-2 [illegible]
13APR		Flush T-tube c̄ 10cc H2O Q shift	07 19 19 07	(b)(6)-2
14APR03		W-D Drsg Δ c̄ Dakin's Sol BID	10 20	(b)(6)-2 } DC'd 22APR
14APR03		Clamp G-Tube. Clears → advance as tolerated	07 19	(b)(6)-2 (b)(6)-2 (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Colostomy Repeat 2° Colostomy / Takedown

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4303

CLINICAL RECORD

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

Mo.____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED						
				23	24	25	26	27	28	29
22 APR	(b)(6)-2	LOVENOX 30mg SQ BID	09	(b)(6)-2						
			21							
22 APR		MVI T PO QD	09							
23 APR		ZANTAC 150mg PO BID	09	(b)(6)-2						
			21							
23 APR		ENSURE 1 CAN PO TID	08							
			16							
			23							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4304

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. ________ Yr. ______

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
13APR	(b)(6)-2	MSO4 1-4mg IV Q1° PRN	4/21 2100 4mg; 4/21 2245 4mg; 4/21 2345 4mg; 4/22 0045 4mg; 4/22 0230 4mg; 4/22 0630 4mg; (b)(6)-2 } DC'd 22 APR 03
13APR		VERSED 1-4mg IV Q1° PRN SEDATION	4/21 2245 1mg; 4/22 0230 4mg; (b)(6)-2 } DC'd 22 APR 03
22APR		~~MVI I PO Q1~~ CL	
22APR		Motrin 800 mg Q8 PRN pain	22APR 0830; 22APR 1745; 4/23 0730; 4/24 [illegible]; 4/25 2139; 4/27 [illegible]; 28Apr 1400; (b)(6)-2 (b)(6)-2
13APR		Phenergan 12.5mg IV q4°	27Apr [illegible] IM 12.5; (b)(6)-2
13APR03		Valium 5-10mg IVP q4-6° prn Agitation	4/23 [illegible]; 24Apr [illegible]; 27APR 10mg [illegible]; (b)(6)-2
18APR03		Tylenol I-II PO q4-6° prn T>101	
13APR03		Haldol 2-4 IV q 2° prn sed	
23APR		Vicodin I TAB q6° prn	4/23 AM 1400; 4/23 [illegible]; 24Apr I Tab [illegible]; 24Apr I Tab 1815; 4/25 0425 I Tab; 25APR 1030; 23 Apr 2205; 26 Apr 0552; 26Apr 2[illegible]; 27APR 0800; 27Apr 1700; 28Apr 0512; 28APR [illegible]; 29APR 0333; (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

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

MEDCOM - 4305

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: 1991-301-765

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)*
		Other Detainee-(Iraqi)

DIAGNOSIS
DIAGNOSTIC
S/P Colostomy 2° Takedown / Revision

CLASS–CLASSE Litter		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 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)*
D5NS @160/hr – J-tube flush Q shift
Unasyn 3.0gm IV Q6 (19,01,07,13) – 10L O2 via simple mask
Gentamycin 500 QD IV (21)
Zantac 50mg Q12° (07,19)
Lovenox 30mg SQ BID (09,21)

SIGNATURE OF MEDICAL OFFICER
SIGNATURE DU MÉDECIN
(b)(6)-2 MD (b)(6)-2 MAJ, MC

DATE
DATE

REGULAR DIET
RÉGIME NORMAL
⊗

SPECIAL DIET *(Describe)*
RÉGIME SPÉCIAL *(Description)*
Clear lqd - advance as tolerated

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 - 4306

1. REPORTING MTF | 2. LOCATION (State or Country Code)

1 2 3 4 5 6 | 7 8
(b)(3)-1 | I (?)

ADMISSION AND CODING INFORMATION

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

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

NAME (Last, First, Middle Initial) EPW (b)(6)-4
(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 20 21 22 23 24 25 26

7. AGE AT ADMISSION 27 28 29

8. RACE 30

9. ETHNIC BACKGROUND 31

RELIGION

10. LENGTH OF SERVICE 32 33 34

ETS

11. FMP 35 36

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS 46

HOUR OF ADMISSION 2203

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 AA INJ

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 D+R

WARD MCW1

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

22. MTF TRANSFERRED TO 75 76 77 78 79 80

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

81	82	83	84	85	86
0	3	0	4	2	9

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM 91 92 93 94 95 96

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

97	98	99	100	101	102
0	3	0	4	1	2

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

28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D) 111 112 113 114 115 116

FOR LOCAL USE

GSW (L) chest

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

MEDCOM - 4307

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP

117	118	119

31. AUTOPSY Y / N

120
N

32. UNDERLYING CAUSE OF DEATH / SEP

121

33. RESIDUAL DISABILITY

122	123	124

34. DO NOT USE - DATA FILLER #1

125	126	127	128	129	130	131	132	133

35. CAUSE OF INJURY

134	135	136

36. FIRST DIAGNOSIS *(Principal Diagnosis)*

137	138	139	140	141	142	143	144
	E	9	9	1		2	

37. SECOND DIAGNOSIS

145	146	147	148	149	150	151	152

38. THIRD DIAGNOSIS

153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS

161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS

169	170	171	172	173	174	175	176

41. SIXTH DIAGNOSIS

177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS

185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS

193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*

201	202	203	204	205	206	207	208

45. SECOND PROCEDURE

209	210	211	212	213	214	215	216

46. THIRD PROCEDURE

217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE

225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE

233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE

241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE

249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE

257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES

265	266
0	1

53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES

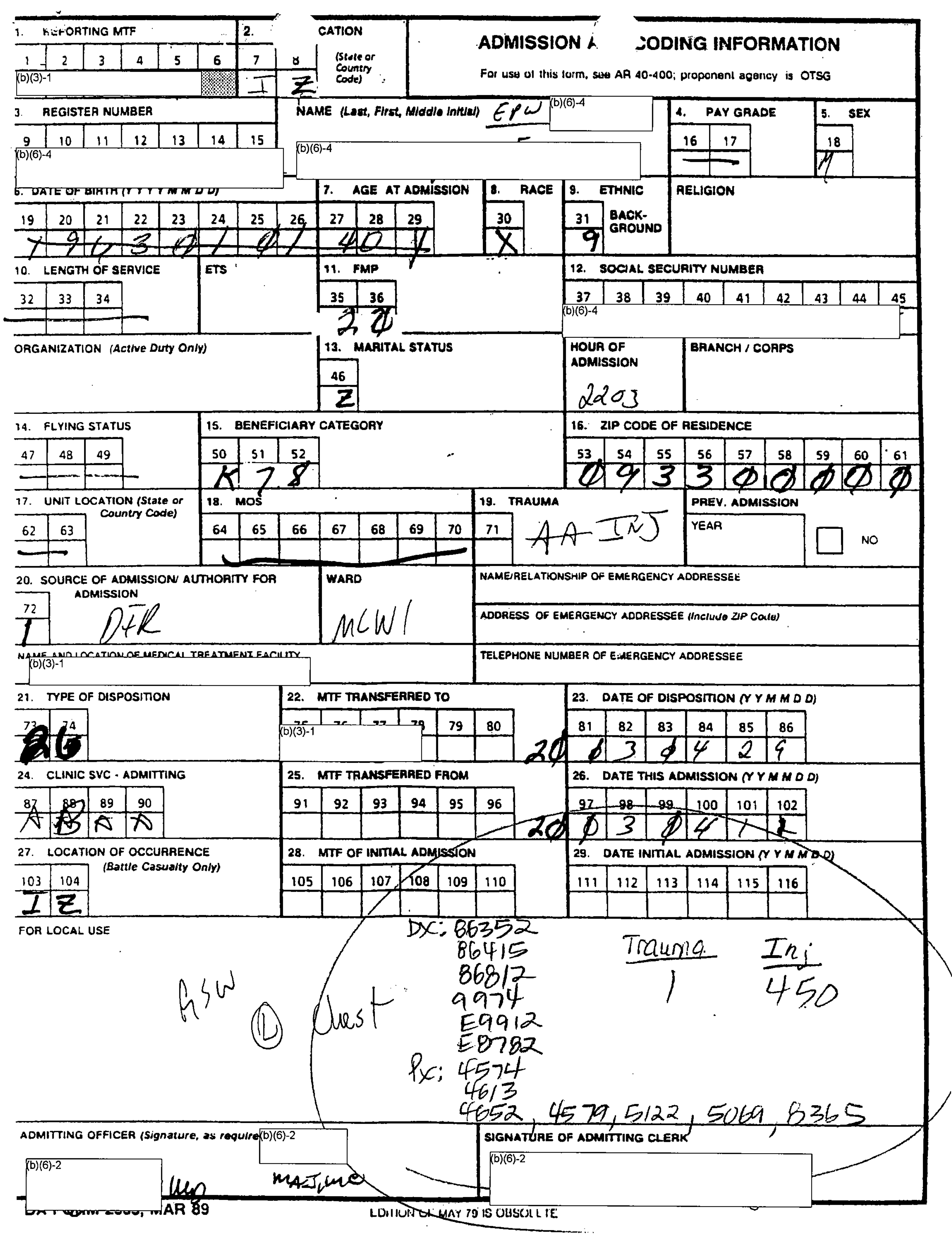
267	268

54. PRIMARY PROVIDER SPECIALTY CODE

269	270	271

55. BLOOD USAGE Y/N

272



ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. LOCATION (State or Country Code): I Z
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): EPW (b)(6)-4 (b)(6)-4
4. PAY GRADE: —
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19630101
7. AGE AT ADMISSION: 40 Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION:
10. LENGTH OF SERVICE: —
ETS:
11. FMP: 20
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 2203
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: AA INJ
PREV. ADMISSION: YEAR / NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 DFR
WARD: MCW1
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: 26
22. MTF TRANSFERRED TO: (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 20 030429
24. CLINIC SVC - ADMITTING: ABAA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 20 030411
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

GSW (L) Chest

DX: 86352, 86415, 86812, 9974, E9912, E8782

Px: 4574, 4613, 4652, 4579, 5122, 5069, 8365

Trauma: 1 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

MEDCOM - 4309

Verify by Initialing	THERAP... IC 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
11	(b)(6)-2	MSO4 5mg IM x1	11	09:20	09:20	(b)(6)-2
11		Tetanus 0.5 ml IM	11	11:00	11:00	
13Apr03		Cincef 1gm IVPB q8° x48 then keflex 250 QID.	Noted			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
11	(b)(6)-2	Morphine Sulfate 2-8 mg IV q 4 hr PRN pain	1210 3mg	1700 3mg IV	1930 11Apr	2315 11Apr	12Apr 5:30	12Apr 10:03	12Apr 1640	12Apr 05-16						
11		~~Phenergan 12.5-25mg IV q 4-6 hrs prn N/V~~		MF	3mg IV	4mg	8mg	8mg	4mg	8mg						
-----		MOM 30cc PRN Gastric Upset														
-----		NS / LR bolus X ____ liters														
-----		T #3 i-ii PO q4-6hr PRN pain	1945 ii T3 11Apr	/	/	2300 ii 11Apr	1340 ii 12Apr 03	1815 ii 12Apr 03	13Apr 0126 2tabs	13Apr 0930? ii PO 1030	13Apr 1600 ii	13Apr 2110 ii	14Apr 0100? ii			
12		Motrin 800mg PO PRN Breakthrough pain	12Apr 1900 i	13Apr 1830 i	13Apr 2345 i											
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 4173

ACLU-RDI 1244 p.531

DOD 010652

NOFORN

CLINICAL RECORD	T[illegible]PEUTIC DOCUMENTATION CARE PL[illegible] [illegible]DICATIONS) For use of this form, see AR 40-40[illegible] the proponent agency is the Office of The Surg[illegible] [illegible]eneral.	Mo.____ Yr.____

VERIFY BY INITIALING — [illegible]TIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	20	21	22	23	24	25	26	27	28	29	30
20 Apr 03	(b)(6)-2	vitals signs routine	07 09 19	(b)(6)-2										
4/23/03 20 Apr 03	(b)(6)-2	regular diet	07 14						(b)(6)-2					
4/23			19 07											
4/23/03	(b)(6)-2	Wet to Dry drsng Δ to	07/19	/	/	/	/	(b)(6)-2						
		Ⓡ thigh + Ⓛ heel BID pin	19/07	/	/	/	/							
		care BID												
4/23/03	(b)(6)-2	V.S. Q 4 Hours	7/19	/	/	/	/							
			19/7	/	/	/	(b)(6)-2							
4/23/03	(b)(6)-2	Activity Up Ad lib on	7/19	/	/	/								
		crutches Wt. bearing AS	19/7	/	/	/								
		tol'd on Ⓛ LE												
4/23/03	(b)(6)-2	Nursing: Up on Crutches	7/19	/	/	/	(b)(6)-2							
		BID	19/7	/	/	/								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓛ segment femur fx; Ⓛ heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 4174

ACLU-RDI 1244 p.532

DOD 010653

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN NON (MEDICATIONS)				Mo. Yr.
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Heplock IV	19 Apr 03	ASAP	1630	(b)(6)-2
		NPO p̄ midnight	19 APR 03	2359	2359	
20Apr03	(b)(6)-2	Heplock IV c̄ good po	20 Apr 03			
		Admit patient to ward				
23Apr03		Admit to ICW3	23Apr03			
		Dx (R) open femur fx				
		Cond: Stable				
		Nursing: Up on crutches BID				
		VS q4°				
		Diet: REG				
		Activity: Up Adlib on crutches wt.				
		bearing as tol'd on (L) LE				

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

MEDCOM - 4175

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

ACLU-RDI 1244 p.533

DOD 010654

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16											
13Apr03	(b)(6)-2	Keflex 250mg p.o. QID	06	/	/	/												
			12	/	/	/												
			18	/	/	/												
			24	/	/	/												

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Ⓡ Femur fracture, Ⓛ heel wound

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4176

ACLU-RDI 1244 p.534

DOD 010655

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21Apr03	(b)(6)-2	Restoril 15-30g PO q HS prn	1840 [illegible]	2050 [illegible]												
21Apr03		Demerol 50-100mg po q 4° prn														
21Apr03		Dilaudid 2-4mg PO q 4° prn														
21Apr03		Benadryl 25-50mg IV q HS prn	2300 [illegible]													

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

MEDCOM - 4177

ACLU-RDI 1244 p.535

DOD 010656

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 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14 Apr 03	(b)(6)-2	Heparin 5000u SQ BID	10	/	(b)(6)-2												
			22	(b)(6)-2													
14 Apr 03		Ancef 1gm q8 IV x 72h	06														
	-----		14							DC							
	-----		22														
14 Apr 03	(b)(6)-2	Gentamycin 300mg IV q24	10								(b)(6)-2			D/C		D/C	
17 Apr 03		Lovenox 30mg SQ BID	10	/	/	/	(b)(6)-2									D/C	
	-----		22	/	/	/	(b)(6)-2									D/C	
17 Apr 03	(b)(6)-4	Ancef 1gm q8° IV	06	/	/	/											
	-----		14	/	/	/											
			22	/	/	/											
20 Apr 03	(b)(6)-2	Ancef 1g IV q8°	06	/	/	/	/	/	/	/	(b)(6)-2						
	-----		14	/	/	/	/	/	/	/							
	-----		22	/	/	/	/	/	/	(b)(6)-2							
20 Apr 03	(b)(6)-2	Heplock Flush Q8shift	07 19	\	\	\	\	\	\		(b)(6)-2						
			19 07	\	\	\	\	\	\								
21 Apr 03		Ancef 1g IVPB Q8°	06	/	/	/	/	/	/	/	/	/	/	/	/	/	
			14	/	/	/	/	/	/	/	/	/	(b)(6)-2				
	-----		22	/	/	/	/	/	/	/	/	/					
4/23/03	(b)(6)-2	Gentamycin 400mg IV QD	10	\	\	\	\	\	\	\	\	\					
4/23/03		IVLR @ 125 : heplock when tol'g PO meds	7/19	/	/	/	/	/	/	/	/	/	(b)(6)-2		D/C		
			19/7	/	/	/	/	/	/	/	/	/					
4/23/03		Colace 100mg Cap PO BID	0800	/	/	/	/	/	/	/	/	/	/	(b)(6)-2			
			2000	/	/	/	/	/	/	/	/	/	(b)(6)-2				
4/24/03		Flush Heplock Q shift	7/19	/	/	/	/	/	/	/	/	/					
	-----		19/7	/	/	/	/	/	/	/	/	/					

Margin notes: 3; 23 APR; "Transcribed to new med sheet 26APR03 1? (b)(6)-2"; "Transcribed to new med sheet 26APR03 (b)(6)-2"

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓡ femur fx; Ⓛ heel [illegible]

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. ______ Yr. ______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19 Apr	(b)(6)-2	~~Heplock IV~~ ERROR	19 Apr		1600	(b)(6)-2
19 Apr		~~NPO after midnig~~ ERROR (b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
14Apr03	(b)(6)-2	MSO4 2mg IV q4-6h prn pain	[illegible]
14Apr03		Tylenol #3 po ī-ĪĪ q4-6h prn for pain	[illegible]
14Apr03		Motrin 800mg po TID	15Apr 0805; 16Apr 1325; 17Apr 0800; 21Apr 1615
		Phenergan 25mg IV	2000
17Apr03		Vicodin 1-2 po q4°	NOT AVAILABLE
17Apr03		~~MSO4 2-4mg IV q2°~~ prn	17Apr 1300 4mg; 17Apr 1900 3mg; 17Apr 2250 4mg; 18Apr 0115 4mg; 18Apr 4mg; 18Apr 1445 4mg; 19Apr 0950 4mg; 19Apr 1225 4mg; 20Apr 0100 4mg; 20Apr 0300 4mg
18Apr03		Ambien 10mg po HS prn	18Apr 0050; 18Apr 2030; 19Apr 0036; 19Apr 2205
18Apr03		T-3 1-2 po q4° for prn	18Apr 1600; 19Apr 1325; 19Apr 0600; 19Apr 2205
20Apr03		T-3 ī-ĪĪ po q4° prn pn	20Apr [illegible]
20Apr03		Percocet ī-ĪĪ po q4° pn	20Apr 1110 ĪĪ; 20Apr 1600 2tab; 21Apr [illegible]; 21Apr [illegible]
20Apr03		MSO4 2-4mg IV q2° pn	20Apr 1415 4mg; 20Apr 1800 4mg; 21Apr 0130 2mg; 22Apr 0510 4mg; 22Apr 0848 2mg
20Apr03		Phenergan 12.5-25mg IM q6° prn	25mg 2000; 25mg 2300
21Apr03		Percocet ī-ĪĪ po q4° prn	21Apr 1315; 22Apr 0050 ĪĪ; 22Apr 1315; 22Apr ĪĪ; 23Apr 1102

RECOPIED (SEE bottom of SHEET)

*U.S. GPO: 1996-454-110/95216

MEDCOM - 4179

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 23	24	25	26	27	28	29	30
23Apr03	(b)(6)-2	Diet: Reg	7/19	(b)(6)-2							
			19/7								
23Apr03		VS Q4°	7/19	(b)(6)-2				D/C			
			19/7								
23Apr03		Wet to dry drsng Δ to Ⓡ thigh + Ⓛ heel Bid pin care BID	7/19								
			19/7								
23Apr03		Activity: Up Adlib on crutches wt. bearing as tol'd on LLE	7/19	(b)(6)-2							
			19/7								
23Apr03		Nursing: Up on crutches Bid	7/19	(b)(6)-2							
			19/7								
24Apr03		VS Q8°	7/19								
			19/7								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓡ segment femur fx; Ⓛ heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4180

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
4/23/03	(b)(6)-2	Admit to ICW3	23Apr03			(b)(6)-2
4/23/03		Dx (R) open femur fx	23Apr03			
4/23/03		Cond: Stable	23Apr03			
4/23/03		Heplock IV when tol's PO meds	23Apr03			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23Apr	(b)(6)-2	MSO4 2-10mg IVP 3-6° PRN	23APR 1600 4mg	23APR 1930 3mg	24APR 0230 [illegible]mg	24Apr 4mg 0840	24Apr 10mg 1150	24Apr 2mg 1450	24APR 4mg 2000	24APR 4mg 2300	25Apr [illegible] 0233	25APR 4mg 1445	25APR 6mg [illegible]			
23Apr		Restoril 15-30mg PO QHS PRN sleep	2030 30 PO	24Apr 30 PO 2100	25APR 2300								Transcribed to new med sheet			
23Apr		Phenergan 12.5-25mg IV Q6° PRN Nausea	23APR 25mg [illegible]										26 APR 03. (b)(6)-2			
23Apr03		Percocet I-II PO Q4° PRN	2030 II 23APR	0550 II 4/24	1250 I 4/24	24APR 1635	[illegible]	25APR 0900 II	25APR 1300 II							

☆ U.S. [GOVERN]MENT PRINTING OFFICE: 1993 342-027/70450

MEDCOM - 4181

CLINICAL RECORD

TH..APEUTIC DOCUMENTATION CA[ ] AN[ ] EDICATIONS)
For use of this form, see A[ ] 7; the proponent agency is the Office of T[ ] 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													
				26	27	28	29	30									
23APR03	(b)(6)-2	Ancef 1gm IVPB Q8°	06	(b)(6)-2													
			14														
			22														
23APR03		Gentamycin 400mg IV QD	10														
23APR03		Colace 100mg Cap PO BID	08														
			20														
23APR03		Flush Heplock Q shift &	07														
		PRN	19														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
Ⓡ femur fx
Ⓛ heal wound

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 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4182

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23APR	(b)(6)-2	MSO4 2-10mg IV Q3-4H PRN Pain	26APR 0955 5mg	26 Mar 03 1410 5mg [illegible]		26APR 2015 [illegible]	27APR 0530 10mg	27APR 0715 5mg								
23APR	(b)(6)-2	Restoril 15-30mg PO QHS PRN Sleep														
23APR	(b)(6)-2	Phenergan 12.5-25mg IV Q6H PRN nausea														
23APR	(b)(6)-2	Percocet i-ii PO Q4H PRN	26APR 1120	26APR 1530	26APR 1610	27APR 0715										

(b)(6)-2

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

MEDCOM - 4183

MSP''

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. S.	4. PRECEDENCE U / P / R X	5. GRADE
6. AGE	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	15a. DESTINATION FACILITY	16. # OF ATTENDANTS 16a. MED / 16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER Tent#3 558 (b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS
① (R) Femur fracture
② (L) Foot soft tissue injury

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.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			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	20b. TIME	20c. ALLERGIES
4 APR 03	1500	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	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE
① (R) femur fx
② (L) foot soft tissue injury

20i. MEDICATIONS / TREATMENTS
① (R) Femur I&D + EX FIXATION
② (L) foot I&D

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

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

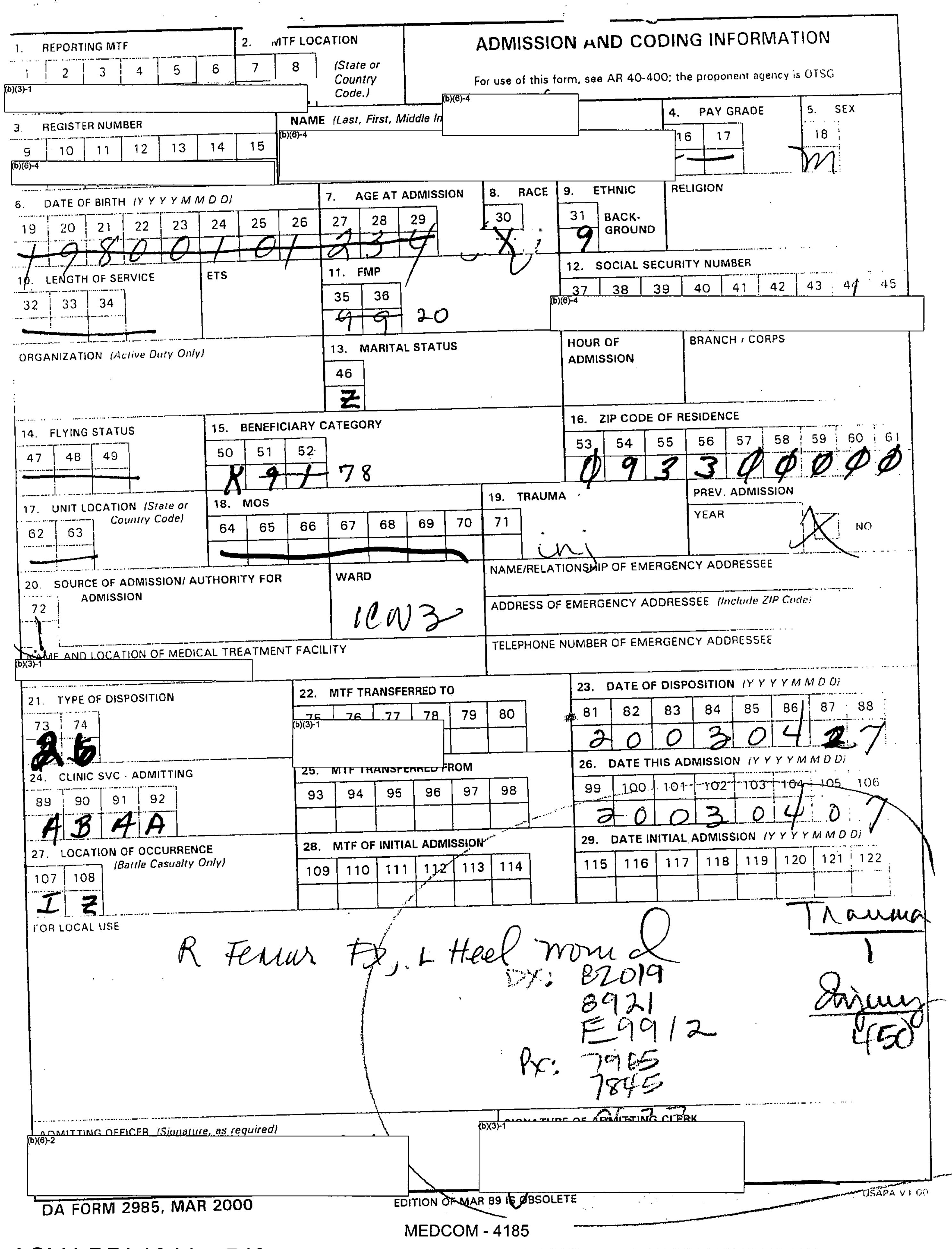
25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel v...

MEDCOM - 4184

ACLU-RDI 1244 p.542

DOD 010663



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 In — (b)(6)-4 — (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 20 21 22 23 24 25 26 — 1 9 8 0 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 2 3 4

8. RACE: 30 — X

9. ETHNIC BACKGROUND: 31 — 9

RELIGION

10. LENGTH OF SERVICE: 32 33 34 — —

ETS

11. FMP: 35 36 — 9 9 20

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46 — Z

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 48 49 — —

15. BENEFICIARY CATEGORY: 50 51 52 — K 9 1 78

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 — —

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 — 1

WARD: 1CW3

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: 73 74 — 2 6

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 2 7

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B 4 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 4 0 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108 — I Z

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 Femur Fx, L Heel wound

DX: 82019
8921
E9912

Px: 7965
7845

Trauma 1
Injury
450

ADMITTING OFFICER (Signature, as required) — (b)(6)-2

SIGNATURE OF ADMITTING CLERK — (b)(3)-1

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

MEDCOM - 4185

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)-2

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

4. PAY GRADE: 16 17

5. SEX: 18
M

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

7. AGE AT ADMISSION: 27 28 29

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

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
IRS

PREV. ADMISSION: YEAR — NO X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72
A

WARD: ICW 3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

(b)(3)-1 ... LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74
D/C: Trans

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

23. DATE OF DISPOSITION (YYYYMMDD): 81 82 83 84 85 86 87 88
2 0 0 3 0 4 2 7

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 (YYYYMMDD): 99 100 101 102 103 104 105 106
2 0 0 3 0 4 0 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 (YYYYMMDD): 115 116 117 118 119 120 121 122

FOR LOCAL USE

R Femur Fx, L Heel wound

... OFFICER (Signature, as required) (b)(6)-2

... ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF M... USAPA V1.00

MEDCOM - 4186

ACLU-RDI 1244 p.544

DOD 010665

PA[illegible]IENT TREATMENT RECORD COV[illegible] [illegible]HEET
F[illegible] 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	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE [illegible]	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. SMP 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD ICW3
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE IN
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct	22. HOURS OF ADMISSION	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION Trans	26. DATE OF DISPOSITION 27 Apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 7 Apr 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

R Femur Fx ; L Heel wound
~~821.00~~ ~~892.0~~

I&D / EXT FIX ~~79.95~~
~~79.14~~

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
	20			20	20

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

SIG[NATURE] (b)(6)-2 SIGNATURE (b)(6)-2

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

MEDCOM - 4127

[I]PATIENT TREATMENT RECORD CO[VER] [S]HEET

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

Field	Entry
1. REGISTER NUMBER	(b)(6)-4
2. NAME	(b)(6)-4
3. GRADE	
ADMISSION REMARKS	
4. SEX	M
5. AGE	
6. RACE	Iraqi
7. RELIGION	
8. LENGTH OF SVC	
9. ETS	
10. PREVIOUS ADMISSION	0
11. FMP	99
12. SSN	(b)(6)-4
13. ORGANIZATION	
14. WARD	ICW3
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	Direct
22. HOURS OF ADMISSION	
23. CLINIC SERVICE	ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	Trans
26. DATE OF DISPOSITION	27 Apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	7 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

R Femur Fx ; L Heel wound
~~821.00~~ ~~892.0~~

I&D / EXT FIX ~~79.95~~
~~79.99~~

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
					20

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

SIGN[ATURE] (b)(6)-2

SIGNATU[RE] (b)(6)-2

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

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4/4/03	OP NOTE
1320(?)	Preop Dx: (R) femur fx, open &
	(L) foot soft tissue injury
	OP: (R) femur I&D & ex. fixator
	(L) foot I&D
	Dr CHO / Dr ALARCON
	Fluid: 1L LR
	GETA
	Ø comps
	To ICW → 86

(b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

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 - 4129

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

ACLU-RDI 1244 p.547

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)
11 April 03	Admitted to ICW 3 from FST. Temp 99.3°F, HR - 91 bpm
	BP 122/64, O2 sat 99% Awake. MAE. No neuro-
	-vascular deficits. BBS CTA, Abd-soft, +BS. (R) LE
	c traction, dsgs changed. (L) ankle & heel
	wound needs debridement. c/o pain Medicated
	with MSO4. Abx. given. Awaiting OR. (b)(6)-2
11 Apr 03	Pt Received from OR via gurney c O2 BP 140/86 pulse 106
1345	Temp 97 (A) SPO2 100% Resp 20 c +3 DP+PT to Rt leg drsg to
	(Rt) Femur c X Fix to limb. Will continue to monitor (b)(6)-2
1400 11Apr03	BP 148/89 Resp 20 HR 95 SPO2 100% Temp 97.2 (A)
1415 11Apr03	BP 138/87 Resp 20 HR 90 SPO2 100% Temp 97.4
1430 11Apr03	BP 152/72 Resp 20 HR SPO2 Temp
11APR03 1900	PT RECEIVED RESTING IN BED. REPORT RECEIVED FROM CPT
	(b)(6)-2 RESP CTA CV S1S2 +3 pulse u/L Extremities. GI:
	BS (+) x4. No complaints of pain. Will continue to monitor (b)(6)-2
12APR03 0100	BP 137/75 HR-103 RR 16, SpO2 100% RA T-98' oral. (b)(6)-2
Voided 400cc	
c 1330/12Apr03-	BP 105/66 HR 104 RR 16 POX 98% RA Temp 36°C.
	pt given T3 ii PO for pain @ 1330. pt alert & dealing
	c pain. lungs CTA & DB well, HS normal S1S2 & BS
	present x4 quads, moves extremities well +3 pulses
	to all extremities. UOP >600cc clear yellow urine, ate
	some meal & did well (b)(6)-2 CPT AN

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

(b)(6)-4

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 **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 4130

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1815Z/12Apr03	- pt resting well. pain controlled c̄ MSO4 + Tylenol #3. able to take PO well & tolerate. UOP >800cc clear yellow urine. (b)(6)-2 CPT AN.
1950	800 motrin PO for pain - (b)(6)-2 CPT AN —
13Apr03 0300 BP 147/64 P78 SpO2 99% RA R:18	Nsg: Pt easily aroused c̄ verbal stimuli to perform a.m. washing. Currently denies pain or discomforts, (speaks english a little) VSS. Refused a.m. meal. P.E. unremarkable. RLE has a very pungent odor, dsg is soiled c̄ blood (area marked c̄ blk pen) ⊕ distal pulse ⊕ Tactile sens - BLE's. GU: voiding a/dsg clean yellow urine. Tol po fl. well 18g (R) AT ⊖ wrist flushes well ⊘ edema (b)(6)-2 S. SSG (b)(6)-2
4/13/03 0620(Z)	OP NOTE Preop: S/P (R) femur ex fix & I&D (L) foot OP: Washout (R) femur, open & (L) foot Δ CHO Fluids: 400 LR MAC ∅ Comps (b)(6)-2
13 April 03 124/64 80 99.4 20	Post-op Nsg Note: Pt returned lying supine asleep ∅ suppl. O2 SpO2 96%, transferred from gurney to bed c̄ drawsheet s̄ incident. VSS, Pt easily aroused c̄ verbal stimuli. Dsg post-op marked by Nsg ~ C.D.I. Pt s̄ (c/o) pain. ⊕ Distal pulses ⊕ WD skin ⊕ Tactile sensation. WCTM (b)(6)-2
1200Z/13Apr03	- pt doing well p̄ surgery. Alert and O x3 follows commands, pain controled well. lungs CTA, HS normal S1 S2, BS x4 quads, V.S. 122/62 P 103, RR 16 POX 98% on RA temp 98.8
+3	pulses to all extremities - (R) ext fix to femur & draining c̄ serous fluid (b)(6)-2 CPT [illegible]

'U.S. Government Printing Office: 1993 — 300-892/60148 STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 4131

ACLU-RDI 1244 p.549

DOD 010610

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2210/13Apr03	O - 800cc yellow urine } pt doing well,
	I - 600cc H_2O (b)(6)-2
~~13~~ 14 APR03	VS/ BP: 120/67 P: 105 R: 18 T: 98.1° O_2 SAT: 98% R/A
	PT A+OX3 FOLLOW COMMANDS. PT HEART SOUNDS STRONG S1 + S2
	PRESENT. LUNG SOUNDS CLEAR ALL FIELDS BS (+) X4 ABDOMEN
	SOFT TO TOUCH (R) LEG BULKY DRESSING c̄ DRAINAGE Δ x48 HRS. LAST
	CHANGED 13 APR @ 1300HR. ALSO BULKY DRESSING (L) ANKLE
	NO DRAINAGE. PT CAN WIGGLE TOES ON BOTH FEET.
	PULSES STRONG + BILATERAL (b)(6)-2
14 APR 03	VSS Pt s̄ c/o pain/discomfort. Pt informed through interpreter of x̄ to
BP 110/74 P100 R: 16 T 99.0	different facility. Has tolerated p.o. well. ø drsg Δ per MD's order.
	(b)(6)-2 [illegible]
0620	GIVE ii T35 FOR PAIN (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

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 **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 4132

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Admit Note MASH
14 Apr 03 0955 Z	ID 23 y/o Iraqi ♂. Transfer from FST
	CC s/p (R) Femur Fx., (L) soft tissue wound left foot.
	HPI See medical record — stapled together.
	PE Lungs - CTA. CV - RRR. Abd — BS x 4 Quadrants
	LUQ + RUQ — tender to light palpation (McBurney's). —
	(? constipation). Skin — w/D. LE — (R) femur c external
	Fixator — dry drng on dressing. (L) foot — dry drng →
	dressing. X-ray — ∅ Fx or shrapnel in (L)
	foot (R) Femur Fx — since reoperated on.
	A (R) Femur I+D and ext fixation
	(L) foot I+D
	P Admit to MCW2
	Condition: Stable
	Diet as tolerated.
	VS BID
	Meds — MSO4 5mg IM/IV Q 4-6° prn pain.
	Tylenol #3 PO i - ii Q 4-6° prn pain
	Motrin 800mg PO TID
	Heparin 5000 u SQ BID

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)

MEDCOM - 4133

DATE	NOTES
26 APR 03	VS 132/76, 88, 18, 98.7 CBX Neurovasular √'s To (R) LE ē Ext Fixa-
1943	ator, WNL Drsg D+I, Neurovascular √'s To (L) Foot + Drsg WNL
	Pt Has (L) FA PCV - good flush. (b)(6)-2 MAJ AN
2000	C/O Pain MSO4 10mg - (R) Ext Fixation. (b)(6)-2 MAJ AN
2350	PT Resting quietly. (b)(6)-2 MAJ AN
27APR03	R12 SpO2 99% P82 T98.0 BP 98/50 LS-CTA BS present X4 ~~distal~~
	Abd soft ~~&~~ without tenderness A+O X3 capillary refill < 3 sec skin
	is warm dry + intact has 18G IV to (L) forearm patent gave 10mg MSO4
	IV and flushed heplock gave Percocet ī PO @ 0715 Drsng to (R) thigh
	& pin care done pt received 0800 colace was transported
	to local hospital in Al Nasiryah Drsng to (L) heal still dry and
	intact, (b)(6)-2 91WID SPC

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14 Apr 03	Vitals = 99.(4) temp, SpO2 = 97, pulse 120, B/P 120/70 RR 22
9:32(2)	(b)(6)-2 91W
0932Z	Pt to MCW #2 via A/E. External fixator to (R) femur in place. (+) pedal pulse (B) LE. Drsg to (L) heel/ankle c dried drainage. Pt states he has pain to (R) femur. Pt given water per request [redacted] (b)(6)-2
14 Apr 03 1000Z	Pt given MSO4 5mg IV for pain in (R) extremity. (b)(6)-2
14 Apr 03 1057	Pt recieved 1g Ancef VIA IV (b)(6)-2
14 Apr 03 1410	PT recieved Tylenol #3 x II VIA PO (b)(6)-2
2051	BP - 132/74 T - 98.9
	P - 100 RR - 20 (b)(6)-2 91W20
2120	Pt w/injury to (R) femur (+) ext fixator in place. Copius amts of serosang drainage noted. Chux placed under leg. Pt w/injury to (L) ankle. Dressing intact w/old drainage noted. Pt able to wiggle toes bilat. Both ↓ ext warm to touch cap refill <3 sec. All other assessments WNL. Pt w/ IV access to (L) wrist & is patent. Pt c/o pain to (R) ↓ ext. Given 5mg MSO4 for pain. Will continue to monitor (b)(6)-2
15 Apr 03	Pt c/o pain given 5mg MSO4 IV (b)(6)-2

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 4135

DATE	NOTES
0200	Pt awake + moaning c/o pain. Pt given 2 tylenol #3 + 25mg phenergan IV. (b)(6)-2
0230	Pt given 2mg MSO4 IV for breakthrough pain (b)(6)-2 24/AN
15Apr03 0500	Temp - 99.1, Pulse - 100, Resp - 18, B/P 118/58 - Spc (b)(6)-2
0600(2)	Pt dressing removed from (L) ankle. Presents c wounds x3
	(1): Fx (R) Femur. Pt c ext Fixator in place. Dressing intact c large amt of serosanguinous drainage noted. Dressing reinforced, wound awaiting x-ray.
	(2)+(3): (L) Ankle wounds x 2
	- Entrance wound 5x2cm and 3cm deep. Wound is vascularized c little drainage noted. Wound is (+) for fibrinous tissue. Ø necrotic noted Ø eryth. Wound is located center of Heel.
	- Exit wound is 8x6cm 3cm deep located on Lateral ankle. Wound is vascularized with moderate ~~amount~~ amount of fibrinous exudate noted. Wound has possible necrotic tissue present. Ø eryth noted. no s/s of infection. (b)(6)-2 24/AN
2040(4)	Pt w/above wounds. All dressings C/D/I. Pt w/IV access to (R) wrist + is patent. Pt c/o pain MSO4 5mg IV given. Pt has (+) feeling, movement + cap refill <3 sec. Pt will be NPO p MN + oncall to OR in AM (b)(6)-2 24/AN
2152	BP 122/76 T - 99.4 P - 84 R - 18 (b)(6)-2 2W 20
2152	

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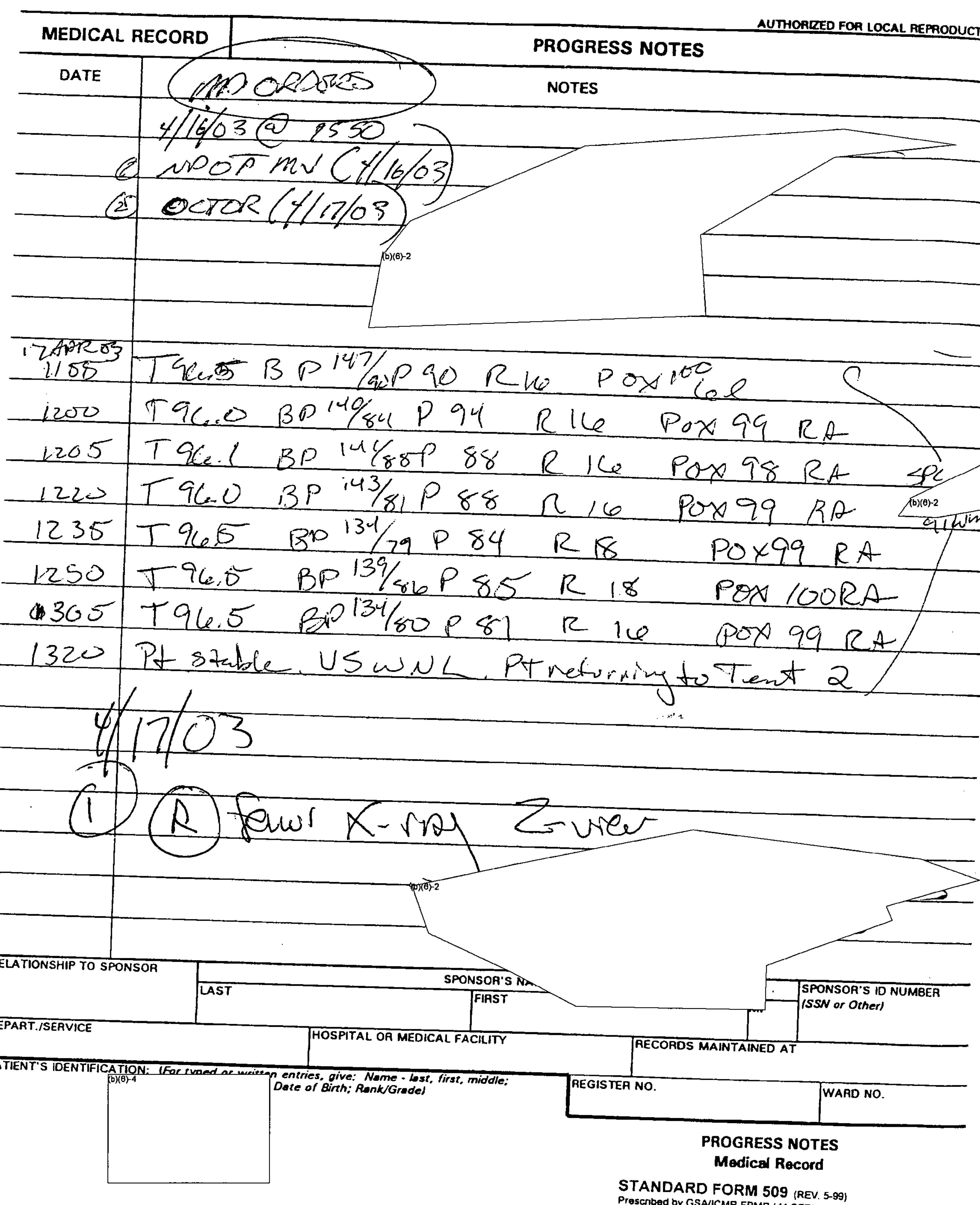
STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4136

~~ACLU-RDI 1244 p.554~~

DOD 010615



MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCT

DATE	NOTES
	MD ORDERS
	4/16/03 @ 1550
	① NPO P MN (4/16/03)
	② OCTOR (4/17/03)
	(b)(6)-2
17 APR 03 1155	T 96.5 BP 147/90 P 90 R 16 POX 100 (?)
1200	T 96.0 BP 140/84 P 94 R 16 POX 99 RA
1205	T 96.1 BP 144/88 P 88 R 16 POX 98 RA
1220	T 96.0 BP 143/81 P 88 R 16 POX 99 RA
1235	T 96.5 BP 134/79 P 84 R 18 POX 99 RA
1250	T 96.5 BP 139/86 P 85 R 18 POX 100 RA
1305	T 96.5 BP 134/80 P 81 R 16 POX 99 RA
1320	Pt stable. VS WNL. Pt returning to Tent 2
4/17/03	
	① Ⓡ Jaw X-ray 2 view
	(b)(6)-2

SPC (b)(6)-2 91Wm

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST | 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; 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)

MEDCOM - 4137

DATE	NOTES
4/23/03	Op Note
1220	Preop Dx: (R) open femur fx (L) heel wound
	Postop Dx: same
	Proc: (1) D&I (R) thigh & (L) heel
	(2) Partial closure (R) thigh wounds
	Surg: Nilsson Anes: IV sed
	EBL: Min Comp: ∅ Drains ∅
	Plan: wet to dry dressg Δs to (L) heel
	and (R) thigh. D/C when bed adequate
	and can self care. (b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4138

DATE	NOTES
4/17/03	Post Op Note
1100	Pre/post op dx ① segmental Gr III Aopen Ⓡ femur fx - extends to 1cm below lesser troch
	② GSW Ⓛ heel mid foot
	Procedure I+D, Ⓡ ex fix revision
	Findings - mod amt necrotic tissue from thigh wound - debrided
	~~x~~ distal prox pin loose - replaced c̄ more prox pin through greater troch → lesser - hopefully
	through + through GSW to med Ⓛ ankle c̄ tract through heel 9 X 8cm med wound, 3X4cm heel pad wound.
	~~—~~ tibial artery prev tied off
	Plan ~~x~~ return 72°
	(b)(6)-2
4/20/03	Post Procedure Note
0930	Pt to be evac'd today, was scheduled for I+D but did dressing Δ c̄ sedation to allow transport
	wounds c̄ good granulation tissue ∅ gross purulence
	c/o difficulty c̄ urination so UA sent - pending
	rec F/U c̄ urination issues
	also rec repeat I+D 48°
	will need definitive treatment of femur fx, possible cover [illegible] ankle/heel
	(b)(6)-2
20APR03	VS 0945 B/P 122/75, 103P, 13R, T97.1 SaO2 98%
Post-Op	0950 B/P 119/72, 99P, R-14 SaO2 99%
	0955 B/P 112/69, 103P - SaO2 100%, R-20 1000 B/P 114/..., P-91, SaO2 99% R-18

(b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4139

ACLU-RDI 1244 p.557

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16Apr03	Vitals = 98.7 temp, 18 rr, 120/75 BP, 78 pulse
8:30	(b)(6)-2 91W
16 Apr 03 0910	Pt received ÏÏ Tylenol #3 PO By Spc (b)(6)-2
16Apr03 11:20	pt received 5,000 units of heparin (b)(6)-2 91W
13:45	gave pt 2 #3 for pain (b)(6)-2 91W
1415	Pt given 4mg MSO4 for pain (b)(6)-2 2LT AN
18:30	Pt. given ÏÏ T3 for c/o allum !! 2LT AN
1945	T 98.6 P 80 R 16 BP 120/85
2030	Pt c/o pain to (R) thigh given 5mg MSO4 & 25 mg phenergan IV (b)(6)-2 2LT AN
0655	Pt has been NPO since MN. Pt has IV access in (b)(6)-4 (R) FA w/ LR ↑ @ TKO. Pt w/ (R) LE fixator & dressing is soiled & foul smelling. Pt on call to OR (b)(6)-2 2LT AN
17Apr03	Vitals = 98.0 temp, 18 R/R, 84 pulse, 120/70 BP
7:50	(b)(6)-2 91W

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)

MEDCOM - 4140
509-114

DATE	NOTES
18 Apr 03 1200 hr	Pt tried to walk but didn't get very far out of bed. Need
	to find out when pt is able to so we can let him know.
	Pt did not complain of any pn when he got up. SPC (b)(6)-2 91W
18 Apr 03 2025	PT C/o Not being able to sleep i 10mg of Ambien given.
19 Apr-03 0025	PT C/o of pain in (R) Leg repositioned Leg and gave
	ii t-3. (b)(6)-2 SGT 91WB20
0130	Pt sleeping (b)(6)-2 SGT 91WB20
0600	Pt woke c/o pain in (R) leg gave 2 tabs tylenol #3
	VS BP 102/50 T-98.7 R 16 P 83
0815	Pt tolerates reg diet, restarted IV (R) AC. pt
	received ancef at 0830. Pt c/o pn, gave pt 800mg motrin
	to help relieve. pt vs. 110/62 R 16 T 98.2 P 74. SPC (b)(6)-2
1830	Pt had BM, feels better. Pt also cleaned self up. SPC (b)(6)-2
19 Apr 03 2030	VS. Bp 110/52 T-98.6 R 16 P 81, PT resting comfortably + talking
	with other pts. (b)(6)-2 SGT 91WB20
19 Apr 03 2205	Pt C/o pain and not being able to sleep. gave Pt ii t-3 and
	i ambien. Pt resting now. (b)(6)-2 SGT 91WB20
20 Apr 03	0755 Pt resting good VSS @ B/P 114/60 p 60 R 16 T 98.5 SPC (b)(6)-2 91W
20 Apr 03 0815	received pt sleeping @ 1600. Gave Ancef 1gm @ ~~1445~~ (Error) 1445 pt went
	outside to commode via litter, had BM and slept till 1800. ate
	dinner and had ~~2~~ (Error) percocet ii po tolerated well no c/o N/V or alarm
	The ~~rest~~ (Error) rest of the shift. percocet was given at 1600 also
	pt had morphine 4mg at 1500 and 1145. (b)(6)-2 SPC USA 91W
	pt heplock'd 1830 (b)(6)-2 AMRO SPC USA

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4141

ACLU-RDI 1244 p.559

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4/17/03- 1300	Pt returns from OR - Pt stable, ® LE Drsg CDI, no complaints of pain. Pt recieves Ancef & gen IV — SPC (b)(6)-2 91W
1715	Pt recieved from mcw about 1630 hrs. Pt recieved Ancef at 1400 hrs, gent at 1700 hrs. Pt was given morphine 4mg for pn at 1710 hrs. Pt has external fixation to ® femur, dressing looks good, no soaking. Pt has GSW to Ⓛ heal dressing looks good. Vital signs are B/P 126/82, P 60, R16, T 98.2. Pt will let you know when in pn. SPC (b)(6)-2 91W
4/17/03 1930	Pt Complain of pain in ® Leg gave 3mg MSO4. SGT (b)(6)-2 91W
2030 17 Apr03	BP 122/60 T 99.3 P 100 R16 Dressing C/D/I pt. s̄ c/o pain or discomfort at this time will continue to monitor (b)(6)-2 SGT
2200 17 Apr03	PT given Lovenox. (b)(6)-2 SGT 91W
2250 17 Apr03	PT c/o Pain and not being able to sleep given 4mg of MSO4 + ii Tylenol #3. PT Sleeping. SGT (b)(6)-2 91W
18Apr03 0115	4mg of MSO4 given for pain. (b)(6)-2 SGT 91W
18Apr03 0400	4mg of MSO4 given for pain. (b)(6)-2 SGT 91W
0740	Pt had problem sleeping last night. Vital signs stable at B/P 108/48 P 84 R 16 T 98.8. SPC (b)(6)-2 91W

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)

MEDCOM - 4142
509-114

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Apr 03 2030	Pt c/o Pain IN (R) Leg + Not being able to sleep.
	Pt given ii Percocet PO + 25mg of Phenergan. Pt now
	resting. (b)(6)-2 SGT 91W20
21 Apr 03 0130	Pt c/o Pain IN (R) Leg, PT given 2mg MSO4. (b)(6)-2 SGT 91W20
21 Apr 03 0200	VS. Bp 112/60 R-16 T 98.8 P 78 (b)(6)-2 SGT 91W20
21 Apr 03	VS Bp 110/52 R 14 T 98.8 P 86 pt c/o pain tolerated percocet ii po
	@ 0840 stated they don't help he needs injections because the
	pain makes him not be able to sleep. Dr. (b)(6)-2 ordered
	restoril 15-30g po q HS had no other complaints pt is now
	sleeping received his Gent 300 mg IV @ 1000 and Lovenox 30 mg SQ
	@ 1000. (b)(6)-2 91W10
1845	pt asking for sleep meds gave 30 mg tab of Restoril
	(b)(6)-2 91W10
21 Apr 03 2000	Pt Sleeping. CKNG added benadryl 25-50mg IV to PRN
	Meds. (b)(6)-2 91W20
2300	Pt c/o of upset stomach gave pt 25 mg Phenergan. (b)(6)-2 SGT 91W20
22 Apr 03	V.S. Bp 105/58 R 15 T 98.8 P 87 (b)(6)-2 91W20
0500	Pt awoke c/o Pain in (R) Leg. 4mg MSO4 given. Pt now
	Resting. (b)(6)-2 91W20

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)

MEDCOM - 4143

ACLU-RDI 1244 p.561

DATE	NOTES
22Apr 0945 ~~094~~	VS 85/40 T 98.5 P85 R32 92% pt c/o of pain has been given 2mg MSO4 IV and T-3 ii po since shift Δ. ate all of breakfast received. Ancef flushed IV and stabilized it with coverspong (b)(6)-2 Ⓡ external fixator to Ⓡ femur clean, dry intact no drainage noted. Drsng to Ⓛ ankle clean, dry intact ∅ drainage. (b)(6)-2 SPC 91W10
22Apr03 1850	pt ambulated via crutches 10 steps voided 500cc ate all of meals hasn't had any complaints received 06 ancef. D/C'd old IV replaced with 18g to Ⓛ forearm is patent & intact. (b)(6)-2 91W10 SPC
2030 22Apr	Pt returned from outside c/o Pain Ⓡ Leg. Pt given i Restoril & ii Percocet. Pt Now resting (b)(6)-2 SGT 91W20
	VS BP 95/41 T 98.10 P101 R14 (b)(6)-2 SGT 91W20
0300	Pt c/o not being able to sleep, Pt given 50mg Benadryl IV. (b)(6)-2 SGT 91W20
23Apr03 0700	BP ~~110/50~~ 110/50 SpO2 98 T 98.2 P76 R16 ~~pt consumed all of first~~ (error) pt waiting to go to OR Did AM care ambulated via litter and crutches to bathroom gave Gentamycin 300mg IV @ 1000 and Lovenox 30mg SQ @ 1000 IV is patent & intact a little positional D rsng to Ⓡ thigh & Ⓛ heel clean dry & intact no drainage. (b)(6)-2 91W10
(b)(6)-2 ~~1315~~ 1415	received pt from post-op still sleep ~~easily aroused~~ (error) not easily aroused T95.4 P83 SPO2 98% R16 BP 124/84 drsng to Ⓡ thigh & Ⓛ heel clean dry intact, no drainage. IV LR @ 125cc/hr in Ⓛ forearm. gave ancef 1gm @ 1400 (b)(6)-2 91W10 SPC
1430	pt awake + oriented c/o dizziness ∅ N/V can wiggle toes all of them has good pedal pulse in Ⓡ leg and popliteal. (b)(6)-2 91W10 SPC

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4144

ACLU-RDI 1244 p.562

DOD 010623

98.7

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1938 23APR03	Pt is alert and oreintated x3. Pt c/o pain in (R) leg recieved 3mg MSO4 prn pain. Lung sounds CTA. RR 20, SPO2 98%, HR 92 RRR, BP 100/58, BS active in all 4 quadrants. Pulses +2 in all extremities, Pt has urinal at bedside. Ø output since 1900, Pt has (R) femur ext. fixator c̄ badage c/D/I. (L) foot dressing C/D/I. Pt resting comfortably in bed will continue to monitor. —— SPC (b)(6)-2 91D
24APR 1030	R 18 SPO2 99 P 87 T 98.6 BP 116/56 pt c/o pain gave 4mg MSO4 IV and percocet ii po @ 0850 received his 1000 Gentamycin IV is patent & intact. pt A ~~x~~ (Error) + O x 3 drsng to (R) thigh is intact wrapped with ace bandage Drsng to (L) heel has bloody + serosanguineous ~~fluid~~ (Error) drainage just reinforced doctor's want to start Δ Tomorow 4/25 Also received colace 100 mg @ 0840. —— (b)(6)-2 SPC 91W10
1240	pt given 10mg MSO4 ambulated to latrine c/o dizziness when he sits up. Ambulated via crutches to chair also Had BM no c/o pain —— (b)(6)-2 SPC 91W10
1250	pt c/o pain gave percocet i po. (b)(6)-2 91W10 SPC
24APR03 @ 1637	Pt given ii tabs po Percocet for c/o leg pain. Resting in bed. —— (b)(6)-2 1LT RN

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

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

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

MEDCOM - 4145

DATE	NOTES
24 Apr 03 2000	Pt after returning from outside complained of pain in (R) Leg
	Pt was given 4mg MSO4. (b)(6)-2 SGT 91W
24 Apr 03 2100	Pt C/O not being able to sleep. He was given 30mg
	Restoril PO. (b)(6)-2 SGT 91W
24 Apr 2130	VS BP 109/54 T 99.1 P 94 R 14. PT resting in bed (b)(6)-2 91W
25 Apr 0233	PT C/O Pain given 6mg MSO4 (b)(6)-2 SGT 91W
25 Apr 03 0945	SpO2 99% P 96 T 98.5 BP 126/60 IV leaked restarted 18g in (L) forearm
	Drsng to (R) thigh Δ'd pincare done Drsng to (L) heel Δ'd. LS clear
	pt c/o tightness in chest started to hyperventilate then quickly
	recovered. SpO2 was 100% HR 133 R 30. HOB↑ gave water and a cool
1400	towel then let him rest and was fine afterwards. Received his
	Gentamycin @1000 + Ancef @1400. pt ambulated via crutches to
	bathroom. Is a smoker. c/o pain received percocet ii po
	@1300 has good pedal pulse in (R) leg foot (error) can wiggle toes. is
	warm + dry. Abdomen soft ∅ distention bs present x4 received
	colace 30mg @0800. is NPO after midnight. (b)(6)-2 spc 91W
1830	R18 SpO2 98 P 96 T 99.2 BP 112/42 pt hasn't c/o pain ambulated to
	bathroom by self with crutches (b)(6)-2 91W spc
2000	VS 98.6, 88, 18 100/58 CBx: (R) Femoral Low External Fixator Drsg D+I
	good Neurovascular V's, (L) Heel Drsg D+I Neurovascular V's wnl. (L) FA IV
	good Flash/Flush. PT resting, ∅ c/o pain Txed c 6mg MSO4 PO
	(b)(6)-2 MAJ AN
5 APR 03 @ 0740	VSS @ 118/68, HR 85, RR 18, T 98.1°F. Pt sitting up to eat. HEENT, RRR, CTA, +Circ, +CMS. Pt c/o
	feeling cold from AC. Pulled up wool blanket. (b)(6)-2 1LT RN
6 APR 03 @ 0955	Pt given 5mg IV MSO4 for c/o pain to a dressing Δ. (b)(6)-2 1LT RN

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4146

~~ACLU-RDI 1244 p.564~~

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

EPW s/p GSW (R) thigh and (L) foot. Treated by FST. Sustained (R) open femur fx with considerable soft tissue loss and large open (L) heel wound. Wounds debrided by FST and traction splint placed (R) leg.

Chest - BS clear

Abd - soft, ND/NT

Ext - open fx (R) lateral thigh (large defect), debrided
Open medial (L) heal wound

A/P - GSW to (R) thigh, (L) heal.
(1) Admit ICU
(2) Possible OR for ex-fix.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

CODES

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

(b)(6)-4

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

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

BT1 BL2

MEDICAL RECORD — LRMC INTR[illegible]TIVE DOCUMENT

For use of this form, see AR 40-4[illegible]; [illegible]oponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY: (b)(6)-2

2. PATIENT IDENTIFI[illegible] AND PROCEDURE VERIFIED BY: (b)(6)-2 — MAJ TAN

3. DATE: 11 APR 03 TIME PATIENT ARRIVED IN SUITE: 1200 Z

4. PATIENT IN ROO[M] TIME: 1200 Z NUMBER: 81

5. PREOPERATIVE EMOTIONAL STATUS

[X] 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)*

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

COMMENTS: (R) LEG IN TRACTION c̄ COBAN WRAPS X 2

8. SKIN PREPARATION

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

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

9. LOCATION OF EXTERNAL DEVICES

PREP AREA

LEGEND X Ground Pad MB -- Safety Strap MS --- Tourniquet NA

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No					
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

(b)(6)-4

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

[X] ESU NO: OR 082 @ 30/30
GROUND PAD: BRAND: VALLEYLAB
LOT NO:

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

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA F[illegible] E MCEUL OP 358, 2 Mar 00 USAPA V1.00

MEDCOM - 4148 MRRC apprvl - 3 Feb 00

ACLU-RDI 1244 p.566

DOD 010627

13. PROSTHESIS, IMPLANTS	[X] YES	[ ] NO	IF YES NAME: ID NUMBER; MANUFACTURER
HowMedica Ultra-X Ex Fix #5129-9-135 cot# 8929869			

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
(b)(6)-2		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
Fluffs
Kerlix
Acewrap

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: Patient/guardian Surgeon Anesthesia Operating Room Nurse

20. OPERATION(S) PERFORMED

Ex Fix (R) Femur
D & I (L) Foot

21. PATIENT TRANSFERRED TO ICU 3	TIME 1330	METHOD LITTER

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

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY LTC (b)(6)-2

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

3. DATE 13 Apr 03 TIME PATIENT ARRIVED IN SUITE 0550 Z

4. PATIENT IN TIME 0550 Z NUMBER /

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta/Beta
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

Prepped area

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				SPC (b)(6)-2 91D	(b)(6)-2 CPT
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 4150

ACLU-RDI 1244 p.568

DOD 010629

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): .9NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
fluffs
Kerlix

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
D+I Right thigh, Left foot

21. PATIENT TRANSFERRED TO
ICU 3

TIME Sep [illegible] METHOD litter

(b)(6)-2 [SIGNA]TURE
CPT [illegible]

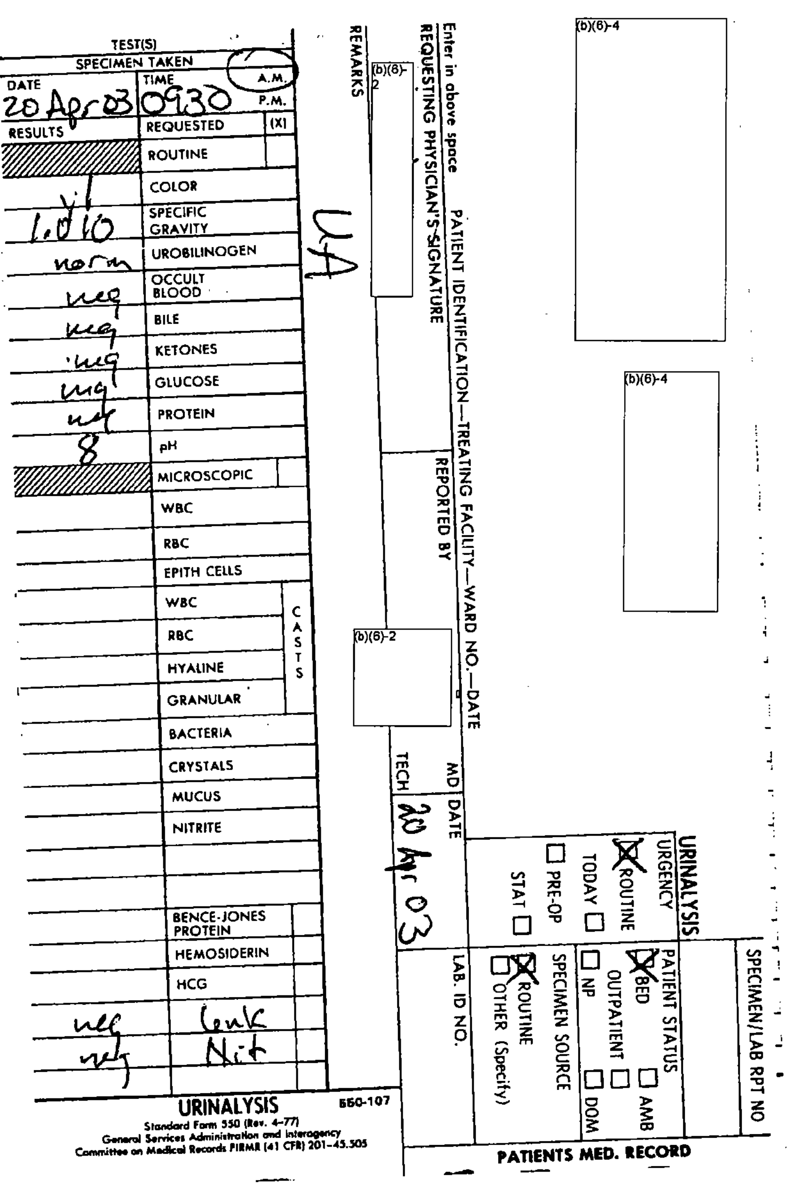
REVERSE OF DA FORM 5179-1, [illegible] 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDCOM - 4151

ACLU-RDI 1244 p.569

DOD 010630



TEST(S)

SPECIMEN TAKEN

DATE	TIME	
20 Apr 03	0930	A.M. (circled) / P.M.

RESULTS	REQUESTED	(X)
	ROUTINE	
yl	COLOR	
1.010	SPECIFIC GRAVITY	
norm	UROBILINOGEN	
neg	OCCULT BLOOD	
neg	BILE	
neg	KETONES	
neg	GLUCOSE	
neg	PROTEIN	
8	pH	
	MICROSCOPIC	
	WBC	
	RBC	
	EPITH CELLS	
	WBC (CASTS)	
	RBC (CASTS)	
	HYALINE (CASTS)	
	GRANULAR (CASTS)	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	
neg	Leuk	
neg	Nit	

REMARKS: UA

(b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

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

REPORTED BY

(b)(6)-2

TECH

MD

DATE 20 Apr 03

LAB. ID NO.

URINALYSIS

URGENCY: [X] ROUTINE [ ] TODAY [ ] PRE-OP [ ] STAT

PATIENT STATUS: [X] BED [ ] AMB [ ] OUTPATIENT [ ] NP [ ] DOM

SPECIMEN SOURCE: [X] ROUTINE [ ] OTHER (Specify)

SPECIMEN/LAB RPT NO

URINALYSIS 550-107

Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505

PATIENTS MED. RECORD

(b)(6)-4

(b)(6)-4

(b)(6)-4

MEDCOM - 4152

NAME: (b)(6)-4 RGEON: (b)(6)-2 Planned Surgery Date: 11 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

A 3 | M (circled) F | HEIGHT | WEIGHT 70 Kg

PROPOSED OPERATION: (R) femur ext fixator

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS [X] NEGATIVE

CURRENT MEDICATIONS [X] NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS [ ] NEGATIVE

ALLERGIES [X] NKDA

AIRWAY / TEETH / HEAD & NECK: class I

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY: Asthma, Bronchitis, COPD, Dyspnea, Pneumonia, Productive Cough, Recent cold, SOB, Tuberculosis	[X]	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	[X]		EKG
HEPATO/GASTROINTESTINAL: Bowel obstruction, Cirrhosis, Hepatitis, Hiatal Hernia, Jaundice, N&V, Reflux/Heartburn, Ulcers	[X]	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	[X]		
RENAL/ENDOCRINE: Diabetes, Renal failure/Dialysis, Thyroid disease, Urinary retention, Urinary tract infection, Weight loss/gain	[X]		Urinalysis; Thyroid; FBS
OTHER: Anemia, Bleeding tendancies, Hemophilia, Pregnancy, Sickle cell trait, Transfusion history	WNL		Hgb / Hct / CBC; Lytes

PROBLEM LIST / DIAGNOSES: Healthy 23 y/o ♂

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 (b)(6)-2 MAJ / CRNA DATE 11 APR 03

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

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

DATE: ____

SIGNED: ____ TIME: ____

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

ANESTHESIA RECORD

Washout (L) heel

Page | of

ANES. START	IN OR	ANES. END	DATE
1136Z	1200Z	1340	11 APR 03
TOTS	SURG START	DRESSING	OR NO
1205	1240	1325	

OPERATION PERFORMED: (R) femur ext fixator

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

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [x] NPO SINCE 2400
- [x] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1155

Pre-Anesthetic State: [ ] AWAKE [x] CALM [x] SEDATE [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

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

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [ ] BLADE 4 MAC
- [x] ETT SIZE 8 [ ] DOUBLE LUMEN
- [x] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 10 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [x] ETT SECURED AT 21 CM
- [x] BREATH SOUNDS BBS x 4
- [x] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS / FLUIDS / MONITORS

	1200	15	30	45	1300	15	TOTALS
Fentanyl mcg	2			0.5	0.5		
Sux mg	120						
Propofol	100						
Forane % ET	0.8	1.3	1.4	1.3	1.2	X	
~~N2O L/min~~ Air	2	1	1	1	1	7	
O2 L/min	1	0.8	0.8	0.6	0.6	3	
LR	1000	LR 2	1400				
Urine							
EBL							
EKG	SR	SR	SR	SR	SR		
% O2 Inspired	.9	.9	.9	.50	.43		
O2 Saturation	100	100	100	100	100		
End Tidal CO2	48	40	37	53	53		
Temperature	unavailable		"	"	"		
PNS							

Time scale: 1200, 15, 30, 45, 1300, 15, 30, 45, 1400

VITAL SIGNS

PRE-OP VALUES: B/P 110/60; P 102; R 16; SAT 98%; H/H

Tidal Volume	700	650	600
Resp Rate	12	12	12
Peak Pressure	25	22	24

RESP: SV, MV, MV, SV, SV, SV

Symbols for Remarks

Position: Supine

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

RECOVERY

TIME IN PACU	CONDITION		
1335	stable		
B/P	PULSE	RESP	O2 SAT
140/86	100	16	100

REMARKS RA TEMP 98

REPORT TO: PARRS:

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [x] Significant changes from preop plan / evaluation.

1330 opens eyes lifts head oropharynx suctioned ext c (+) pressure

Tourniquet Time:

FLUIDS TOTALS

IN	OUT
Crystalloid 1500 LR	EBL
Blood minimal	Urine
	Gastric

(b)(6)-2

MAJ / CRNA

PHYSICIAN / CRNA

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

NAME (b)(6)-4 SURGEON: (b)(6)-2

Planned Surgery Date: 13 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

A	
(M) / F	
HEIGHT	
WEIGHT	70kg

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P 147/64 P 78 R 18 99%

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE	CURRENT MEDICATIONS ☐ NONE
(R) femur ex-fix 11 APR 03 } GA → ∅AC (L) heel washout	Ancef Heparin 5000U SQ BID motrin PRN T3 PRN MSO4 PRN

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE	ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK
MP 2, TMD 4 FB Oro App 3 FB FROM

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: (B) CTA ∅ R/R/W
CARDIOVASCULAR: Angina, Arrhythmia, CHF, Exercise Tolerance, Hypertension, MI, Murmur, MVP, Pacemaker, Rheumatic fever	☒		EKG: RR S1S2, ∅m
HEPATO/GASTROINTESTINAL: Bowel obstruction, Cirrhosis, Hepatitis, Hiatal Hernia, Jaundice, N&V, Reflux/Heartburn, Ulcers	☒	Ethanol Use: ☐ No ☐ Yes Frequency ___	LFTs: NPO since MN.
NEURO/MUSCULOSKELETAL: Arthritis, Back problems, CVA/Stroke, DJD, Headaches, Loss of consciousness, Neuromuscular disease, Paralysis, Paresthesia, Syncope, Seizures, TIAs, Weakness	☒	(R) femur Fx (L) heel wound	
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	PREOPERATIVE MEDICATIONS ORDERED
	(1) 2 3 4 5 E	

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 13 APR 03

POST ANESTHESIA VISITS

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

DATE: ___

SIGNED: ___ TIME: ___

MEDCOM - 4155

(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 1

ANES. START 0530 | IN OR 0547 | ANES. END | DATE 13 APR 03

OPERATION PERFORMED: WASHOUT LFt Foot Lt Thigh

SURGEON(S)

TOTS 0555 | SURG START 0600 | DRESSING 0620 | OR NO 2

PREOPERATIVE

- [x] IDENTIFIED
- [ ] ID BAND
- [ ] QUESTIONING
- [ ] CHART REVIEWED
- [x] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	[illegible]	IV	540
Robinul	[illegible]	IV	540
Fentanyl	50 mcg	IV	541

Pre-Anesthetic State:
- [ ] AWAKE
- [ ] CALM
- [ ] SEDATE
- [ ] APPREHENSIVE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

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

ANESTHETIC TECHNIQUE

- [ ] GENERAL
- [x] 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
- [ ] BLADE
- [ ] ETT SIZE
- [ ] DOUBLE LUMEN
- [ ] STRAIGHT
- [ ] RAE
- [ ] ANODE
- [ ] CUFFED ___ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [ ] ETT SECURED AT ___ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [x] NATURAL
- [ ] MASK CASE
- [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA
- [ ] SIMPLE O2 MASK
- [x] LMA SIZE - NRFM.

AGENTS / FLUIDS / MONITORS

Times: 45 | 00 | 15 | 30 | 45 | 700

Agents				
Fentanyl		50	50	
Propofol		30	20	20
Atropine				
Versed			1	
Ketamine	25		25	
N2O L/min				
O2 L/min	NR. FM		5	5

Fluids: LR 1000

Urine

EBL

Monitors			
EKG	ST	ST	ST
% O2 Inspired	RM		FM
O2 Saturation	100	100	100
End Tidal CO2	+	+	+
Temperature			
PNS			

TIME

PRE-OP VALUES

B/P | P | R | SAT | H/H

200 180 160 140 120 100 80 60 40 20

RESP: Tidal Volume 50 50 52 52

Resp Rate

Peak Pressure

Symbols for Remarks

Position

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

RECOVERY

TIME IN PACU 0624 | CONDITION Alert oriented

B/P 131/84 | PULSE 94 | RESP | O2 SAT 99

REMARKS | TEMP 97

REPORT TO: | PARRS:

REMARKS:
- [x] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

~~Induced intubated~~ ~~Eyes taped~~ ~~[illegible]~~

0547 12 Room

0624 OO OR

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	1400	EBL	100
		Urine	
		Gastric	0
Blood			

(b)(6)-2 LTC

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED 29 M...) MEDCOM - 4156

(THIS FORM IS SUBJECT TO THE PRIVA[illegible] 'F 15 .S A CLINICAL RECORD FORM, IT IS COVERED BY DD 22C

ANESTHESIA RECORD

Page 1

ANES. START	IN OR	ANES. END	DATE
0953	1000	1143	17APR03
TOTS	SURG START	DRESSING	OR NO
1005	1021	1135	

OPERATION PERFORMED: I+D, Revise ExFix ® [illegible]

SU (b)(6)-2

TOTAL

PREOPERATIVE

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

Drug Dose Route Time

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

AGENTS

1000 x 30 x 1100 x 30

- Ketamine 100 50 50 50 100
- Midaz 2
- Fentanyl 100
- MSO4 5

N2O L/min

O2 L/min

FLUIDS

LR 800

Urine

EBL

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 ® AC
- ☐ ARTERIAL LINE
- ☐ CENTRAL LINE
- ☐ SWAN-GANZ
- ☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
- ☐ EYE CARE
- ☐ PRESSURE POINTS CHECKED / PADDED

MONITORS

EKG	SR	ST	ST	SR	SR	SR	SR
% O2 Inspired	RA	RA	RA	RA	RA	RA	RA
O2 Saturation	99	99	99	99	99	100	100
End Tidal CO2							
Temperature							
PNS							

ANESTHETIC TECHNIQUE

- ☐ GENERAL ☐ LOCAL / MAC
- ☐ REGIONAL ☐ NERVE BLOCK
- ☐ IV sedation

INDUCTION

- ☐ PREOXYGENATION ☐ INHALATION
- ☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
- ☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

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

VITAL SIGNS

TIME 1000 x 30 x 1100 x 30 x 1200

PRE-OP VALUES: B/P, P, R, SAT, H/H

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

RESP

Tidal Volume	SV	SV	SV	SV	SV	SV	SV
Resp Rate	12	14	12	14	12	16	16
Peak Pressure							

Symbols for Remarks

Position: Sup

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

SYMBOLS: X ANESTH; ⊙ OPERAT; ∨ ∧ B/P CU PRESSU; ⊥ T ARTER LINE PRESSU; ● PULS; C SPONTA OUS R; ₵ ASSIS RES; ☒ CONTRO RES; T TOURNI; F CRYS LOID F; E BLO

Tourniquet Time:

RECOVERY

TIME IN PACU	CONDITION		
1142	Stable		
B/P 144/72	PULSE 110	RESP 16	O2 SAT 100

TEMP

REMARKS

REPORT TO (b)(6)-2 PARRS:

FLUIDS TOTALS IN		OUT	
Crystalloid	800	EBL	Min
		Urine	NM
		Gastric	
Blood	∅		

(b)(6)-2

PHYSICIAN / CRNA

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

MEDCOM - 4157

MCEHL OP 100, APR 00 (Rev) (MRRC APPROVED: [illegible])

(THIS FORM IS SUBJECT TO THE PRIVAC ... 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
0905	0910		
TOTS	SURG START	DRESSING	OR NO
0915	0917	0933	

OPERATION PERFORMED: I+D ... Dressing ...

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

PREOPERATIVE

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

Drug Dose Route Time

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)
- ☐ 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

AIRWAY MANAGEMENT

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

AGENTS

Agent			TOTAL
Robinul	mg	.3	.3mg
Valium	mg	5	5mg
Ketamine	mg	100	100mg
Fentanyl	mg	50	50
Versed		2	2mg
N2O L/min			
O2 L/min			

FLUIDS

LR

Urine: Not measured

EBL

MONITORS

EKG	SR	SR
% O2 Inspired	RA	RA
O2 Saturation	96	98
End Tidal CO2		
Temperature	AVAIL	
PNS		

TIME 0900 0930 1000

VITAL SIGNS

PRE-OP VALUES

- B/P: 136/82
- P: 90
- R: 14
- SAT: RA 97
- H/H

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

RESP

Tidal Volume			
Resp Rate	12	14	15
Peak Pressure			
Symbols for Remarks	SV	SV	SV

Position: Supine

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

SYMBOLS: X ANESTH; ⊙ OPERAT; ∨ ∧ B/P CUFF PRESSURE; ⊥ T ARTERIAL LINE PRESSURE; • PULSE; ○ SPONTANEOUS RESP; ASSISTED RES; CONTROLLED RES; T TOURNIQUET; F CRYSTALLOID F; E BLOOD

RECOVERY

TIME IN PACU	CONDITION		
0935	Awake/Stable		
B/P 122/75	PULSE 102	RESP 18	O2 SAT 98

REMARKS

TEMP

REPORT TO: MAJ SLACK PARRS:

(b)(6)-2

Tourniquet Time:

FLUIDS TOTALS

IN	OUT
Crystalloid:	EBL:
	Urine: Ø I+O
	Gastric:
Blood: Ø	

PHYSICIAN (CRNA)

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDCOM - 4158

(THIS FORM IS SUBJECT TO THE PRIVAC[illegible] 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[illegible]

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1030	1045	1230	23 Apr 03

OPERATION PERFORMED: I & D of (R) femur + (L) heel; closure of (L) femur wound

SURGEON(S): N

TOTS	SURG START	DRESSING	OR NO
1050	1055	1213	

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE MN
- [ ] PRE-OP MEDICATION:

Drug | Dose | Route | Time

Pre-Anesthetic State: [x] AWAKE [x] CALM [ ] SEDATE [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

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

ANESTHETIC TECHNIQUE

- [x] GENERAL [x] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

Ketamine simple mask

INDUCTION SV

- [x] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

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

AGENTS / FLUIDS / MONITORS

TIME	1045	1100	30	1200	30	1300		TOTAL
Ketamine	<60>	140	<200>	<180>				
Versed	<2>		<2>					
MSO4	<2-3>		<5>					
Propofol	20	20	40-40	<100>				
Toradol						30		
Zofran								
N2O L/min								
O2 L/min FM	4	4	4	4	4	3 / RA		
Fluids: LR								
Urine								
EBL								
EKG	SR	ST	ST	ST	ST	SR	SR	
% O2 Inspired	.9	.9	.9	.9	.9	.9	.9	
O2 Saturation	100	100	100	100	100	100	100	
End Tidal CO2								
Temperature								
PNS								

VITAL SIGNS

PRE-OP VALUES: B/P 108/59; P 80; R ____; SAT ____; H/H ____

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

SV SV SV SV SV SV

RESP							
Tidal Volume							
Resp Rate	16	16	16	16	16	16	16
Peak Pressure							

Symbols for Remarks

Position

SYMBOLS: X ANESTH; ⊙ OPERAT; ∨ ∧ B/P CUFF PRESS; ⊥ T ARTERIAL LINE PRESS; • PULSE; ○ SPONTANEOUS RESP; Ø ASSIST RESP; ⊗ CONTROL RESP; T TOURN; F CRYSTALLOID F; E BLOOD

RECOVERY

TIME IN PACU: 1230

CONDITION

B/P: 103/65 | PULSE: 94 | RESP | O2 SAT: 99% RA

REMARKS

TEMP: On RA

REPORT TO: PARRS:

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

In RM @ 1045

To ICU #3 for recovery

Tourniquet Time:

FLUIDS TOTALS

IN	OUT
Crystalloid: LR 1000	EBL: min
	Urine
	Gastric
Blood	

(b)(6)-2

Maj, CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDCOM - 4159

ACLU-RDI 1244 p.577

DOD 010638

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	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

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 tendencies, 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)

Stable B/P - 103/65, P-87, RR 22
SATS 100% RA lungs CTA, VSS [illegible]
[illegible] ×4 (b)(6)-2

DATE: 04/23/03

SIGNED: (b)(6)-2 1LT/AN TIME: 1245

MEDCOM - 4160

ACLU-RDI 1244 p.578

DOD 010639

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 April 03 TIME OF ORDER: 1000Z HOURS

LIST TIME ORDER NOTED AND SIGN

1 Admit Patient to ICU
2 Diagnosis: (R) femur fx, (L) heel wound
3 Condition: Stable/Serious/Critical
4 Allergies: NKDA/
5 Vital signs q hr/q2hr/q6hr/q8hr/q shift
6 Cardiac respiratory monitoring
7 Diet: NPO / regular/ soft/ clear liquid

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER: when awake 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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

13 PCXRAY q AM/QOD
14 IVF NS/ LR/ D5NS/ D51/2NS To run @ 150 cc/hr.
15 Ancef 1 GM IV Q 8 hrs first dose now
16 Gentamycin IV Q
17 Cefoxitin 2gm IV q8hrs. D/C IVF when awake
18 O2 titrate to keep SPO2 > 92%
19 Versed gtt 1-10mg/hr IV titrate to

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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 1-2
22 MSO4 2-4 MG IV q 4 HR PRN Pain
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 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

(b)(6)-2

MEDCOM - 4161

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 11APR03 TIME OF ORDER ______ HOURS LIST TIME ORDER NOTED AND 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

28 tetanus 0.5ml SQ IM

29 Heparin 5000 units SQ BID

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 4/11/03 TIME OF ORDER 1330 (Z) HOURS

1 NO DRESSING Δ UNTIL 13 APRIL 2003

1400

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11APR03 TIME OF ORDER 1530 HOURS

1 heplock IV

2 T#3 i-ii p.o. Q6 PRN pain

NOTED 11APR03 1900

(b)(6)-2

1535

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 4/13/03 TIME OF ORDER 0800 HOURS

1 ✓ Resume previous orders

✓ Reg diet

✓ D/C IVF when tol po well

✓ IVF: LR @ 100 cc/hr

~~Keflex 250mg po QID~~

Ancef 1 gm IVPB q 8° x 48°

then Keflex 250 QID

NO DRESSING Δ FOR 48°

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 4162

~~ACLU-RDI 1244 p.580~~

DOD 010641

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Apr 03 — TIME OF ORDER: 0955 Z HOURS — LIST TIME ORDER NOTED AND SIGN

Admit to MCW 2
Condition Stable
Diet as tolerated
VS BID
Meds: MSO4 5mg IV Q4-6° prn pain
Tylenol #3 PO i-ii Q4-6° prn pain
Motrin 800mg PO TID

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

Heparin 5000U SQ BID
Maintain Heplock

(b)(6)-2

14 Apr 03, 1030 LTC, AN FNP
Ancef 1gm Q8° IV x 72°

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

LTC, AN FNP HOURS

4/14/03
Gent 300g IV Q 24°

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 15 Apr 03 — TIME OF ORDER: 0555 Z HOURS

1. X-ray (R) femur
2. NPO tonight @ midnight - OR tomorrow
3. X-ray (L) foot/ankle (3 views)

(b)(6)-2

LTC, AN FNP

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

MEDCOM - 4163

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 (17APR03 1145)	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA CARE UNIT ORDERS		
1	OXYGEN: 8 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 150cc/hr, ~~bolus~~ cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 20mg		
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		
10	Phenergan 12.5mg IV q 6° PRN		
	SIGNED (b)(6)-2		

PATIENT IDENTIFICATION

(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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4/17/03 TIME OF ORDER 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ward
S/P I+D ex fix (R) forearm for I+D (L) heel wound
stable
Vitals routine
Act bed rest
Diet reg

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

D5½NS @ 70cc/hr heplock c good po
Meds ancef 1g IV q8°
Vicodin i-ii po q4° prn
MSO4 2-4mg IV q2° prn
Phenergan 12.5-25mg IM q6°
Lovenox 30mg SQ bid

[signature] SEARLE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18Apr03 TIME OF ORDER 08:10 HOURS

Ambien 10mg PO q HS PRN

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4/18/03 TIME OF ORDER HOURS

1) May substitute Tylenol #3 for Vicodin since pharmacy out of Vicodin

(b)(6)-2

(b)(6)-2 9 Apr 03 (b)(6)-2 CPT AN

(b)(6)-2 20APR03 (b)(6)-2 MAJ AN

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

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

MEDCOM - 4165

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER Admit to ward 4/20/03 TIME OF ORDER 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

(R) segmented femur fx, (L) heel wound
stable
Vitals routine
Act - ad lib
Diet reg
IV D5 ½ NS @ 80 cc/hr heplock = good
Meds T#3 i - ii po q 4° prn

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

Percocet i - ii po q 4° prn
MSO4 2-4 mg IV q 2° prn
Ancef 1 g IV q 8°
Phenergan 12.5-25 mg IM q 6° prn

(b)(6)-2

(b)(6)-2 MAJ AN NC

(b)(6)-2 1030 / 20 Apr 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 4/21/03 TIME OF ORDER HOURS

Percocet i - ii po q 4° prn
Restoril 15-30 mg po qhs prn
Dilaudid 2-4 mg po q 4° prn
Demerol 50-100 mg po q 4° prn

(b)(6)-2

D/4° chart checks done (b)(6)-2 0100/22 Apr 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 21 Apr 03 TIME OF ORDER HOURS

(1) Benadryl 25-50 mg IV qhs prn sleep

(b)(6)-2

CPT AN CRNA

- noted 0100/22 Apr 03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

MEDCOM - 4166

OTSG

CLINICAL RECORD - DO[illegible]

For use of this form, see AR 40-66, [illegible]

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF [illegible] [PRO]BLEM ORIEN[TED] [RECO]RD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATE[D] [illegible] [ARRO]W.

PATIENT IDENTIFICATION		DATE OF ORDER	[TIM]E OF ORDER	[NURSE'S SIGNATURE AND] TIME ORDER [NOT]ED AND [S]IGN
(b)(6)-4		22Apr03		
		Percocet 1/1 - 4/11 PO Q4° prN PAIN		
		NO Q8°		
			NO given by (b)(6)-2 to sp (b)(6)-2 9w10	
			Noted 23Apr03 (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION		DATE OF ORDER	[TIM]E OF ORDER	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION		DATE OF ORDER	[TIM]E OF ORDER	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION		DATE OF ORDER	[TIM]E OF ORDER	
NURSING UNIT	ROOM NO.	BED NO.		

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

☆ U.S. GOVERNMENT PRINTING O[FFICE] [illegible]

MEDCOM - 4167

ACLU-RDI 1244 p.585

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		23 APR 03	1930 HOURS	
	1	Colace 100mg Cap PO BID		
		(b)(6)-2		(b)(6)-2
			MJ	23 APR 03 2050
NURSING UNIT / ROOM NO. / BED NO.				

PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
		4/25/03	HOURS	
		NPO [illegible]		
			(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.				

PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
			HOURS	
NURSING UNIT / ROOM NO. / BED NO.				

PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
			HOURS	
NURSING UNIT / ROOM NO. / BED NO.				

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

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

MEDCOM - 4168

ACLU-RDI 1244 p.586

DOD 010647

CLINICAL RECORD - DOC[illegible] S

For use of this form, see AR 40-66, the [illegible] is OT[illegible]

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF [illegible] SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED [illegible] W.

PATIENT IDENTIFICATION | DATE OF OR[illegible] | TIME OF OR[illegible] | TIME [illegible] AND [illegible]

(b)(6)-4

① Heplock IV
② NPO after midnight
verbal Dr (b)(6)-2

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

noted 19 APR 03 @ 1612hr

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF OR[illegible] | TIME OF O[illegible]

4/27/03

Contin Gentamicin 400mg IV QD
Lovenox 30mg [illegible] [illegible]
~~[illegible] [illegible] [illegible]~~
NPO > MN.
MSO4 2-10mg IV Q 3-6° PRN.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF OR | TIME OF OR

4/23/03 1215

Admit to ward
Dx: Ⓡ open femur fx
Cond: stable
VS Q4°
Activity: up Ad Lib on crutches
WB bearing as tol'd on Ⓛ LE
Nursing: Up on crutches BID
Wet to dry dressing changes to Ⓡ thigh and Ⓛ heel BID
Pin care BID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF OR | TIME OF OR

Diet: Reg
IV LR @ 125; hep lock when tol'g PO
Meds: Ancef 1g IVPB Q8°
Gentamicin 400 mg IV QD
MSO4 2-10mg IV Q3-6° prn pain
Restoril 15-30mg PO QHS prn sleep
Phenergan 12.5-25mg IV Q6° prn nausea

Noted 23 Apr 03 1245 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 7[illegible] [illegible]SED.

☆ U.S. GOVERNMENT PRINTING [illegible]

MEDCOM - 4169

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 11	12	13										
11	(b)(6)-2	VS Q Shift	07	(b)(6)-2												
			19													
11		~~NPO~~	07			→ Reg Diet 12 Apr 03										
			19	(b)(6)-2												
11		Strict BR	07													
			19													
11		HOB up 30°	07													
			19													
12		Regular Diet	20	/	/	(b)(6)-2										
			10	/	(b)(6)-2											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur Fx - (L) heel wound

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.

MEDCOM - 4170

~~ACLU-RDI 1244 p.588~~

DOD 010649

Valuepre

Verify by Initialing		THERAPEUTIC 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
11	(b)(6)-2	Admit to ICU 3	11	09:40		(b)(6)-2
11		Dgn: (R) Femur fx, (L) heel wound	11	09:40		
11		Condition: Stable	11	09:40		
11		No dressing Δ until 13 Apr 03				
13 Apr 03		D/C IVF when tol. P.O.				

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

★ U.S. GPO:1997-418-290/55267

MEDCOM - 4171

ACLU-RDI 1244 p.589

DOD 010650

CLINICAL RECORD	[THER]APEUTIC DOCUMENTATION CARE [PLA]N (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	11	12	13	14	15								
11	(b)(6)-2	IVF NS (LR) D5NS D5 1/2NS To run	07	eu	> HL IM 11 Apr 03											
		@ ~~150~~ cc/hr Δ'd 100 cc/o	19													
11		Ancef 1 GM IV q 8 HRs x48°	02	(b)(6)-2		③	⑤	/	/	/						
		p̄ 48° 13-15 Apr start	10			③	⑥	/	/	/						
		PO Keflex. & DC Ancef.	18			④	⑦	/	/	/						
		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													
11	(b)(6)-2	~~Heparin 5000u SQ bid~~	06	(b)(6)-2	X	} Δ HL/mc										
			18	X	X											
11		Heparin 5000u SQ bid	10	(b)(6)-2												
			22													
11		HL IV q shift flush	00		>											
			12													
13Apr03		Keflex 250 mg QID														

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: (R) Femur Fx, (L) heel wound

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

Treatment Facility: (b)(3)-1

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

MEDCOM - 4172

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER	2.	3. GRADE	ADMISSION REMARKS
(b)(6)-4			

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

11. FMP	12.	13. ORGANIZATION	14. WARD
99	(b)(6)-4		8

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	1245	ABAA

24. NAME, RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Home	16 apr 03

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

29. N (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

R BKA

897

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
	9			9	9

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

(b)(6)-2

(b)(6)-2

EDITION OF

USAPPC V1.10

MEDCOM - 4097

.NPATIENT TREATMENT RECORD CC . SHEET

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

1. REGISTER NUMBER (b)(6)-4	(b)(6)-4	3. GRADE CIV	ADMISSION REMARKS
4. SEX M / 5. AGE / 6. RACE Iraqi	7. RELIGION / 8. LENGTH OF SVC / 9. ETS	10. PREVIOUS ADMISSION	
11. FMP / 12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD 8	
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 Direct	22. HOURS OF ADMISSION 1245	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 16 apr 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 7 apr 03	ADMITTING OFFICER
29. (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

R BKA

~~899~~

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
				9	9

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

(b)(6)-2

(b)(6)-2

EDITION OF 1

MEDCOM - 4098

USAPPC V1.10

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
9 Apr 03	S/O - Iraqi EPW evacuated s/p (R) BKA
BP: 115/53	Dressing in place
P: 130	Airway patent
T: /	Lungs CTA (B)
R: 24	Distal pulses nml, cap re-fill < 2 sec.
O2 Sat - 99%	Imp: s/p BKA - stable
ALLERGIES:	Plan: (1) Admit pt ward
	(2) Dx: (R) BKA
	(3) Cond: stable
MEDS:	(4) VS: Q shift
	(5) All: unknown.
	(6) IV NS @ 200 cc/h
MHx:	(7) Ancef 1 gm Q 12 hrs.
	(8) Toradol 30mg IV Q 4-6 h prn pain
	(9) Foley Catheter
SHx:	(10) Reg diet
	(12) Activity BR —— (b)(6)-2
	CPT, [illegible] - C
TOB:	
LMP:	

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

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 **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 4099

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 APR 05	Ortho Op Note OR
2056 Z	Dx: infected (R) BKA stump
(b)(3)-1	procedure (R) BKA stump I&D
	surgeon: Dr. (b)(6)-2, ortho
	anesthesia: MAJ (b)(6)-2, CRNA ((b)(6)-2)
	findings: purulence (R) BKA stump, tight
	sutures in layers - removed.
	necrotic fascia, fat and muscle removed.
	stump closed open c̄ myoplast flap and
	retention sutures (prolene).
	post-op plan: - IV antibx
	- repeat debridement in 48hr
	- keep stump open 2° infection
	(b)(6)-2, M.D.
	LTC, MC, USA
	ORTHOPAEDIC SURGERY
13 APRIL 05	Op Note
1205 (Z)	Preop: infected (R) BKA stump
	procedure: repeat I&D (R) BKA stump
	surgeon: Dr. (b)(6)-2, ortho
	anesthesia: MAJ (b)(6)-2, (General)
	findings: less purulence and necrotic burden.
	small pocket that tracked proximally on ant. tib.
	surface.
	post-op: IV antibx - no of p [illegible]
	- repeat debridement in 48hr. (b)(6)-2
	- ask-ems for [illegible] for further care M.D.
	LTC, MC, USA ORTHOPAEDIC SURGERY

*U.S. Government Printing Office: 1995 - 404-763/20

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 4100

ACLU-RDI 1244 p.594

DOD 010579

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 APR 03	1200 z		T: 97.2 BP: 147/77 HR: 130 RR: 27 SAT O2: 95
			PT A+O x3 AND COOPERTIVE HEART SOUNDS STRONG
			LUNGS CLEAR IV IN (L) AC PATENT FOLEY IN
			NO SIGNS OF IRRITATION DRAINING AUBURN CLEAR
			URINE, BKA SLIGHT DRAINAGE (b)(6)-2
11 APR 03	1200 z		5 mg MSO4 GIVEN FOR PAIN (b)(6)-2
11 APR 03	1220 z		2 gm CEFOXITIN IV GIVEN AS ORDERED (b)(6)-2
11 APR 03	1240 z		0.5 ml TETANUS GIVEN IM (L) ARM AS ORDERED (b)(6)-2
11 APR 03	1240 z		5000 u HEPARIN GIVEN SC RL QUAD (b)(6)-2
11 APR 03	1350 z		PT OUTPUT 825 cc URINE CLEAR AND AUBURN
11 Apr 03	1500 z		3 mg MSO4 for stump pain - IV (b)(6)-2
11 APR 03	1730 z		5 mg MSO4 FOR stump pain - IV (b)(6)-2
11 APR 03	2100 z		PT. RETURNED FROM OR @ 2100 Z
	2100 z		VS/ BP: 143/74 P: 125 R: 36 T: 102.7 °F
			HEART SOUND STRONG, S1 + S2 PRESENT LUNG SOUNDS
			CLEAR AND RISE AND FALL IS BILATERAL BS (+) x4
			LARGE BULKY DRESSING DRY + INTACT ON BKA
	2115 z		VS/ BP: 148/75 P: 136 R: 36 SAO2: 94 (b)(6)-2
	2130 z		VS/ BP 149/75 P 136 R: 35 SAO2: 98 (b)(6)-2
	2145 z		VS/ BP 157/77 P: 130 R: 30 SAT O2: 96 (b)(6)-2
			5 mg MSO4 GIVEN @ 2150 z FOR PAIN (b)(6)-2
	2200 z		VS/ BP: 134/79 P: 135 R: 34 SAT O2: 99
	2230		VS/ BP: 134/79 P: 133 R: 32 SAT O2: 96

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 4101

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12APR 0215 ē			Pt awake, alert + oriented in Ø acute distress and
			Responds appropriately and follows commands.
			Upper breath sounds clear + ↓ Ⓑ in bases. Bowel
			sounds present x4. Dressing to Ⓡ BKA clean, dry
			+ intact. Medicated ē MSO4 for c/o pain. T-102²
			BP-136/83 P-124 R-28 SAO2 90% on R/A. Placed
			on 2L O2/NC and medicated ē tylenol for fever
			(b)(6)-2
1130	IN 500IV 600PO 1100 in 750 out		T-101⁴ R-26 BP-132/68 P-120 SAO2 96% on R/A
			(b)(6)-2
1230			3mg MSO4 IV GIVEN FOR STUMP PAIN (b)(6)-2
12APR03			PT A+OX3 HEART SOUNDS S1 + S2 PRESENT
			BS ⊕ X4 BULKY DRESSING Ⓡ BKA CLEAN + INTACT.
			IV IN Ⓛ AC CLEAR + PATENT
1400			GAVE 2 TAB PERCOCETS FOR PAIN (b)(6)-2
1600			VS/ BP: 130/60 P:124 R:26 T: 101 SAO2: 97% RA
	IN 1,000cc OUT 1900cc		Clear yellow URINE (b)(6)-2
11APR03			GAVE 5mg MSO4 FOR PAIN @ 1900 (b)(6)-2
1950			GIVEN TWO TABS PERCOCET FOR PAIN (b)(6)-2
2230			GIVEN 5mg MSO4 FOR STUMP PAIN (b)(6)-2
0200			BP-117/65 P-111 R-26 T-99⁰ Medicated ē Percocet ii
			for c/o pain. Pt awake, alert + oriented & responds appropriately.
			Medicated ē percocet ii for c/o pain. Lungs clear but
			↓ in bases. Dressing to Ⓡ BKA intact ē moderate
0830 1850cc out			amt serous drainage. In Ø acute distress. (b)(6)-2
14APR03	1000		RESP 24, PULSE 123, SpO2 92%, TEMP 101.0 B/P 138/61 (b)(6)-2

*U.S. Government Printing Office: 1995 - 404-763/2006

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 4102

ACLU-RDI 1244 p.596

DOD 010581

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13 Apr 03	1745		5mg MSO4 IV for c/o pain — (b)(6)-2 CPT
	2010		c/o pain ii po percocet given (b)(6)-2
14 APR 03	0400		BP - 146/60 P-124 R-24 T-100.2 Pt awake, alert, +
			oriented. c/o moderate to severe pain @ (R) BKA.
			Pt. stable in ø acute distress. Dressing to (R)
			stump clean, dry + intact. — (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

(b)(6)-4

MEDCOM - 4103

MEDICAL RECORD | PROGRESS NOTES

14 APR 0930Z	pt received via stretcher – assessment completed – dressing
	CDI – pt given Tylenol 1000mg for pain (b)(6)-2
1800/1400Z	Vicodin i tab given (b)(6)-2
1400	1500cc urine output (b)(6)-2
MAR! 3 1519Z	T99°. Will Monitor (b)(6)-2
14 APR03 1930/1530Z	NEW IV START 16 guage IN (R) ForeArm NORMAL
	Saline hung KVO. ANCEF 1 gram given IVP (b)(6)-2 9KJ
1720Z 14 Apr 03	BP 120/64 T 98.9 P 120 R 22 (b)(6)-2 SGT 91W20M6
14 APR 03 1750Z/2100	Pt has IV to R FA @ 60cc/hr Pt stump has
	[illegible] drsg CDI, Pt unable to lift stump
	(R) leg is edematous Foley to gravity c̄
	dark yellow urine. (b)(6)-2 2LtA
14 APR 03 2100/1700Z	350 mg Gentimicin IV (b)(6)-2 5,000u
	heparin SQ to abd (b)(6)-2 2LtA
14 Apr 03 1900Z/2200	575 urine out (b)(6)-2 2LtA
14 APR 03 0000Z	ANCEF 1gm given (b)(6)-2 9KW
15 Apr 03 0555/0255	1gm Ancef IVP (b)(6)-2 2LtA
15 Apr 03 0300Z/0600	380cc out dark yellow urine (b)(6)-2 2LtA
0855/0455	BP 130/60 - HR100 - 28 - T99.6°
15 APR 03 0630Z	ii T3 given for c/o pain. (b)(6)-2 [illegible]
15 Apr 1350	Tylenol 1000mg given (b)(6)-2
15 APR 03 1734	ii T3 for c/o pain. (b)(6)-2 [illegible]

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

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

MEDCOM - 4104

PROGRESS NOTES

DATE	
15Apr 1845	Vicodin [illegible] (b)(6)-2
15Apr03 2000hrs	140/78 P 104 R 16 T 98.7 Pt keeping in bed c eyes closed Drug to (R) drainage CDT Rt leg is swollen Pt c/o pain (b)(6)-2 [illegible]
15Apr03 2142hrs	® MOTRIN 800mg PO for pain (b)(6)-2 [illegible]
15APR03 0001	pt c/o pain given 800mg motrin [illegible] (b)(6)-2 [illegible]
16Apr03 0219	® Vicodin PO for pain (b)(6)-2 [illegible]
16Apr03 0241	50mg Demerol, 12.5mg Phenergan IM to (R) Buttox (b)(6)-2 [illegible]
16Apr03 0600	® Vicodin PO for pain (b)(6)-2 [illegible]
0715	BP 132/68 - HR 88 - RR 16 T - 97.3
	[illegible] assessment completed - [illegible] (b)(6)-2
	pt wants to leave AMA - complications identified and
	explained through an interpreter - MD notified (b)(6)-2
4/16/03 0930	Patient requests to be released AMA. Patient counseled c assistance of Arabic-speaking interpreter that failure to receive proper medical care could result in life-threatening infection that could cause death or, at the very least, loss of function of the limb causing failure to fit for prosthesis. Patient voiced understanding of the risks of requesting to be released. Transportation arranged through civil affairs for movement to a local hospital. (b)(6)-2

(b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

☆U.S. GPO: 1995-397-405

(b)(6)-4

MEDCOM - 4105

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)* 11 April 03 | TIME

TRANSPORTATION TO FACILITY (b)(3)-1

SEX m

AGE 27

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 Old Healthy

ALLERGIES NKDA

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 S/P (R) BKA

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	10:15				
BP	147/90				
PULSE	107				
RESP	18				
TEMP	100.4				
WT	93 ½ m AA				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Ancef 1gm IV now	DWN	10:30		
	CBC	DWN			

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 10:29

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)*

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3796

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

17 y/o suffered traumatic amputation of (L) thigh [(b)(6)-2]

PMHx
No previous hospitalizations
NKDA
No meds

PE
Stable
Heart RRR
Lungs clear
Abd soft

(L) lower extremity traumatic amputation

A/P LLE traumatic amputation
To OR for amputation.

CONSULT WITH	TIME	ACTION

RESIDENT/N[(b)(6)-2]

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDCOM - 4107

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

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

3. DATE 11 apr 03 TIME PATIENT ARRIVED IN SUITE 1911z

4. PATIENT IN ROOM TIME 1911z NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (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:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* betadine
SITE: right BKA BY WHOM: Cpt (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

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

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

MEDCOM - 4108

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix ABD
Fluffs
Ace

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I&D Right BKA

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	2050	litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM ...

*U.S. Government Printing Office: 1995 — 388-733/23952

MEDICAL RECORD | LRMC INTR[...]ATIVE DOCUMENT
For use of this form, see AR 40-4[...] proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY MAJ (b)(6)-2
2. PATIENT (b)(6)-2 PROCEDURE VERIFIED B[Y] CPT AN
3. DATE 13 Apr 03 TIME PATIENT ARRIVED IN SUITE 1050 Z
4. PATIENT TIME 1050 Z NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Betadine
SITE: Right leg stump BY WHOM: CPT (b)(6)-2
SITE: BY WHOM:

COMMENTS: Ø poorly healed

9. LOCATION OF EXTERNAL DEVICES

prepped stump area

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

C = Correct I = Incorrect

10. COUNTS					Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[ ]	Yes	[X]	No					
Needle Sharp	[X]	Yes	[ ]	No		C	C	(b)(6)-2	(b)(6)-2
Instrument	[ ]	Yes	[X]	No					
Other	[ ]	Yes	[X]	No				SPC	

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

(b)(6)-4

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

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

13. PROSHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): .9 NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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 ______________ side.

Verified by: N/A
Patient/guardian Surgeon Anesthesia Operating Room Nurse

20. OPERATION(S) PERFORMED
I&D Left leg stump

21. PATIENT TRANSFERRED TO ICU3 | TIME See anes record | METHOD Litter

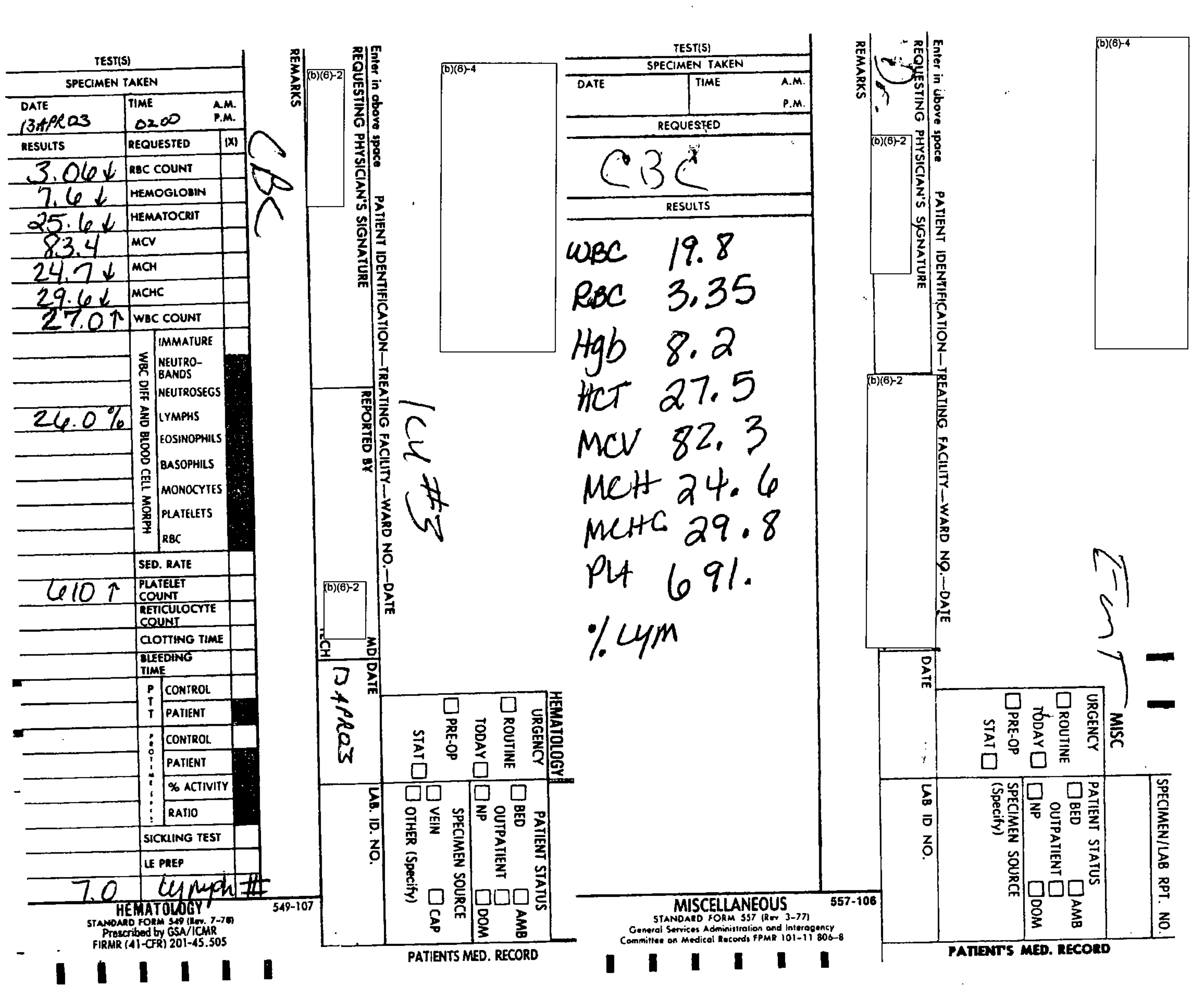
(b)(6)-2 CPT/

REVERSE OF DA FORM 5975-1, OCT 87

MEDCOM - 4111

M[illegible] IL OP 358, 2 Mar 00
M[illegible] apprvl - 3 Feb 00

USAPA V1.00



HEMATOLOGY
STANDARD FORM 549 (Rev. 7-76)

RESULTS	TEST
DATE 13APR03	TIME 0200
3.06↓	RBC COUNT
7.6↓	HEMOGLOBIN
25.6↓	HEMATOCRIT
83.4	MCV
24.7↓	MCH
29.6↓	MCHC
27.0↑	WBC COUNT
26.0%	LYMPHS
610↑	PLATELET COUNT
7.0	Lymph #

REQUESTED: CBC
ICU #3
DATE: 13APR03

MISCELLANEOUS
STANDARD FORM 557 (Rev 3-77)

REQUESTED: CBC

RESULTS:
WBC 19.8
RBC 3.35
Hgb 8.2
HCT 27.5
MCV 82.3
MCH 24.6
MCHC 29.8
Plt 691.
% Lym

MEDCOM - 4112

NAME: (b)(6)-4 SURGEON: Planned Surgery Date: 11 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

AGE: ~~19~~ 27 | (M) F | HEIGHT | WEIGHT: 80 kg

PROPOSED OPERATION: Washout (R) stump

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE
amputation (R) leg

CURRENT MEDICATIONS ☒ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☒ NEGATIVE

ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK
class 2 FROM 3FB

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY: Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☒	Tobacco Use: ☐ No ☐ Yes ___ Pack/Day for ___ Years	Chest X-ray; Pulmonary Studies
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☒		EKG
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☒	Ethanol Use: ☐ No ☐ Yes Frequency ______	LFTs
NEURO/MUSCULOSKELETAL: Arthritis, DJD, 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	☒		Urinalysis; Thyroid; FBS
OTHER: Anemia, Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC; Lytes

PROBLEM LIST / DIAGNOSES
Healthy 27 yo ♂

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 (b)(6)-2 CRNA DATE 11 APR 03

PHYSICIAN ______ DATE ______

POST ANESTHESIA VISITS

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

DATE: ______

SIGNED: ______ TIME: ______

MEDCOM - 4113

(THIS FORM IS SUBJECT TO THE PRIVA F AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1030Z	1050	1205Z	13 APR 03
TOTS	**SURG START**	**DRESSING**	**OR NO**
1056	1108	1150	

OPERATION PERFORMED: Washout (R) BKA

SURGEON(S): [redacted] 66(?)

PREOPERATIVE

- [X] IDENTIFIED [X] ID BAND [X] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE 0700
- [X] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1045
Fentanyl	50	IV	1045

Pre-Anesthetic State:
- [X] CALM [ ] AWAKE
- [ ] APPREHENSIVE [X] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

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

ANESTHETIC TECHNIQUE

- [X] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [X] PREOXYGENATION [ ] INHALATION
- [X] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [X] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

- [X] INTUBATION [X] ORAL [ ] NASAL
- [X] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [X] STYLET USED
- [X] ATTEMPTS x 1 [ ] BLADE 4 MAC
- [X] ETT SIZE 8 [ ] DOUBLE LUMEN
- [X] STRAIGHT [ ] RAE [ ] ANODE
- [X] CUFFED 10 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [X] 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

Times: 1045, 1100, 15, 30, 45, 1200 — TOTALS

	1045	1100	15	30	45	1200
Ketamine cc	50					
Propofol cc	170					
Sux cc	120					
Fentanyl cc		1	1	1		
Isoflurane % E	1.5	1.6	1.5	1.1	X	
~~N2O L/min~~ Air	1	1	1	1		
O2 L/min	5 / 0.8	0.6	1	1		
LR			100			
Urine						
EBL			100			
EKG	ST	ST	ST	ST	ST	
% O2 Inspired	.44	.37	.67	.51	.9	
O2 Saturation	99	99	98	100	100	
End Tidal CO2	37	37	55	46	42	
Temperature	unavailable		"	"	"	
PNS						

VITAL SIGNS

PRE-OP VALUES: B/P 121/95; P 101; R 16; SAT 98%; H/H

Tidal Volume	840	830				
Resp Rate	10	10				
Peak Pressure	30	29				
	SV / MV	MV	SV	SV	SV	

Symbols for Remarks

Position: supine

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

REMARKS:
- [X] Patient reevaluated. No change from preop plan / evaluation.
- [X] Significant changes from preop plan / evaluation.

1157 opens eyes lifts head oropharynx suctioned extubated c̄ (+) pressure.

Tourniquet Time:

RECOVERY

TIME IN PACU	CONDITION		
1155	stable		
B/P	PULSE	RESP	O2 SAT
	142	20	92

REMARKS RA — TEMP

REPORT TO: PARRS:

FLUIDS TOTALS

IN	OUT
Crystalloid LR 700	EBL 100
	Urine
	Gastric
Blood	

(b)(6)-2

MAJ / CRNA
PHYSICIAN / CRNA

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

MCEUH OP 100, APR 00(Rev) (MRRC / MEDCOM - 4114

NAME: (b)(6)-4 (b)(6)-2 SURGEON:

Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M F	HEIGHT	WEIGHT
27			80kg

PROPOSED OPERATION: Rt AKA washout

PREOPERATIVE VITAL SIGNS: B/P 134/83 P 124 R 28

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY: Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☑	Tobacco Use: ☐ No ☐ Yes ___ Pack/Day for ___ Years BBS =	Chest X-ray; Pulmonary Studies
CARDIOVASCULAR: Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☑	RRR	EKG
HEPATO/GASTROINTESTINAL: Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☑	Ethanol Use: ☐ No ☐ Yes Frequency ___	LFTs
NEURO/MUSCULOSKELETAL: Arthritis, DJD, 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	☑		Urinalysis; Thyroid; FBS
OTHER: Anemia, Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC: HCT ↓ 22.5; 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. (circled: General Anes.)
Other: ___
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ___ DATE ___

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 DATE 13 Apr 03

PHYSICIAN ___ DATE ___

POST ANESTHESIA VISITS

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

DATE: ___

SIGNED: ___ TIME: ___

ACLU-RDI 1244 p.609

DOD 010594

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 ORDERS NOTED AND 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

1151 11 APR 03 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11APR03 TIME OF ORDER 1245 HOURS

1. tetanus 0.5ml IM x1
2. Heparin 5000u SQ BID

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 14 APR 03 TIME OF ORDER 2055 Z HOURS

Resume previous pre-op orders.

(b)(6)-2 M.D.

LTC, MC, USA

ORTHOPAEDIC SURGERY

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 Aug 03. TIME OF ORDER 0940 Z HOURS

Cont. 35° up [illegible]

(b)(6)-2 M.D.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 April 03 TIME OF ORDER: 10:40 HOURS

LIST TIME ORDER NOTED AND SIGN

No.	Order
1	Admit Patient to ICU #7
2	Diagnosis: S/P (R) BKA ō [illegible]
3	Condition: Stable/Serious/Critical
4	Allergies: NKDA
5	Vital signs q hr/q2hr/q6hr/q8hr/q shift (q4°)
6	Cardiac respiratory monitoring
7	Diet: NPO X regular/ soft/ clear liquid

DATE OF ORDER / TIME OF ORDER ______ HOURS

No.	Order
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

DATE OF ORDER / TIME OF ORDER ______ HOURS

No.	Order
13	PCXRAY q AM/QOD
14	IVF NS/ LR/ D5NS/ D51/2NS To run @ 125 cc/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

DATE OF ORDER / TIME OF ORDER ______ HOURS

No.	Order
	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 2.5 MG IV q1-2 HR PRN Pain
23	Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24	MOM 30cc PRN Gastric upset

(b)(6)-2 11 APR 03 1145

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

MEDCOM - 4117

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 Apr 03 TIME OF ORDER: 1400 HOURS LIST TIME ORDER NOTED AND SIGN

VO Dr (b)(6)-2 / (b)(6)-2 CPT

Percocet tabs i or ii po q 4-6° PRN (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

1 Resume previous orders
2 No dressing Δ x 48° then w/d Δ 2 (STARTING 4/15) qd
(3) ANCEF 1 gm IVPB q8° x 48° then Keflex 500 q id (b)(6)-2 13APR03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 1217 HOURS

D/c ANCEF 13 APR 03. CHO

P/c dressing Δ order
Gent. 350mg IV q day. (b)(6)-2 13APR02

4/14/03 @ 1555z

1. ADMIT TO MCW3
2. Dx: INFECTED (R) BKA STUMP (b)(6)-2
3. CONDITION: STABLE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

[Stamp: ... MC USA ORTHOPAEDIC SURG...]

4. VITALS BID
5. Diet: NPO PMN tonight
6. IV LR @ 60cc/°
7. Ancef 1 gm IV Q 8°
8. GENT 350mg IV Q 24°
9. Heparin 5000 units SC Q 12°
10. Foley to gravity

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

DA FORM 4256, 1 APR 78 REPLA[CES] ... MEDCOM - 4118 ... [WHI]CH MAY BE USED.

Verify by Initialing		THERAPE[illegible]C DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 4 Yr 3	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
11 APR	(b)(6)-2	Morphine Sulfate 2-5 mg IV q 1-2 hr PRN pain	5mg 1220	3mg 1500 (b)(6)-	5mg 1730	(b)(6)- 5mg 2158	4/12 0215	12 Apr 9:50	12 APR 1115	12 APR 1230	12 APR 1850	12 APR 2230 5mg	13 APR 0700	13 APR 1245 5mg	13 APR 1505 5mg	13 APR 1745 5mg
-----	-----	Phenergan 12.5-25mg IV q 4-6 hrs prn N/V	[illegible]				SL 12 APR	5mg IV	3mg IV (b)(6)-	3mg (b)(6)-2	5mg (b)(6)-2	(b)(6)-2	4 [illegible] (b)(6)-2	IV (b)(6)-2	IV	IV
-----	-----	MOM 30cc PRN Gastric Upset														
-----	-----	NS / LR bolus X ____liters														
-----	-----															
-----	-----	Tylenol 650 PO	0230 12 APR													
-----	-----	for T > 101	SL (b)(6)-2													
-----	-----	PERCOCET 1-2 TAB 4-6 HR								12 APR 1400 (b)(6)- 2 tab	12 APR 1950 2 tab (b)(6)-2			13 APR 1340 II tabs (b)(6)-	14 APR SL 0045	
-----	-----	4-6 (b)(6)-2														
-----	-----															

USAPA V1.00

MEDCOM - 4119

ACLU-RDI 1244 p.613

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	DATE COMPLETED 11	12
11 APR	(b)(6)-2	Vital signs q ~~hr / q 2hr / q6h4 / q8hr~~ /	07	(b)(6)-2	
		~~q shift~~ Q 4°	19		
11 APR		Cardiac Respiratory Monitoring	07		
			19		
11 APR		Diet: NPO / Regular / Soft / Clear	07		
		Liquid	19		
11 APR		Activity: Ad Lib / Strict BR / BR with	07		
	......	BSC / NWB R or L LE	19		
	......	HOB up 30 Degrees	07		
	......		19		
11 APR	(b)(6)-2	Nursing I/O, CDB / NG to LIS / LCS	07		
			19		
11 APR		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		
	......				
	......				
	......				

ALLERGIES: [ ] YES [X] NO — NKDA

PRIMARY DIAGNOSIS: S/P BKA c̄ revision @ 2/2 — stable

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

Treatment Facility: (b)(3)-1

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

ICU #3

MEDCOM - 4120

ICAL RECORD SUPPLEMENTAL MED[illegible]
form, see AR 40-66; the proponent agency is the Offi[illegible] General

REPORT TITLE

POST ANESTHESIA CARE RECORD

OTSG APPROVED (Date)

Time in: 1202 Z | Procedure: Washout (R) BKA | ASA Grade (I – V):

Physician: | Anesthesia Provider: | Pre-Op Vitals: T= P=101 R=16 BP=[illegible] SaO2=

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

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

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

INTAKE: OR / PACU
Crystalloids 700cc / IE
Blood Prod ___/___
Colloids ___/___
Irrigations ___/___
Other ___/___

OUTPUT: OR / PACU
Urine ___/___
EBL 100cc /___
Drains ___/___
Emesis ___/___
Other ___/___

Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	Derm Level	N/V	Nurse action	OTHER			Init
1205z	141/85	101.1	140	16	90	—	2	2	2	1	2	9	10	(R) leg		⊖	AOB	RA			(b)(6)-2
1220z	139/80	99.4	136	16	89	—	2	2	2	1	2	9	10	"		⊖	"	"			
1235z	141/85	99.4	130	16	97	—	2	2	2	1	2	9	10	"		⊖	"	"			
1250z	147/81	98.7	130	16	98	—	2	2	2	1	2	9		"			"	"			
1305	145/86	98.7	116	16	98	—	2	2	2	2	2	10	10	(R) leg		⊖	"	"			
1335	146/79	98.3	119	16	95	—	2	2	2	2	2	10	10	(R) leg		⊖	"	"			
1405	98/33	98.3	119	16	96	—	2	2	2	1	2	9	10	(R) leg		⊖	"	"			
1505	142/84	98.6	110	16	98	—	2	2	2	1	2	9									
1605																					

VITAL SIGNS BP = blood pressure; P = pulse; R = respirations; T = temperature ax = axillary; SaO2 = 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

sxn = suction 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 PtT = patient teaching - see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow-by Other:

Quality Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp SL = sleeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:

Location 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 extremity Hd = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

TIME	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
1250z	5mg Morphine					

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | 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

DA FORM 4700, MAY 78

MCEUL OP 45(Rev), 19 Sep 01
MRRC apprvl - 02 Aug 01

MEDCOM - 4121

ACLU-RDI 1244 p.615

DOD 010600

RN ASSESSMENT

	ADMISSION ASSESSMENT TIME:	DISCHARGE ASSESSMENT TIME:
RESP	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:
CV	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:
NEURO	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes / No / N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes No/ N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:
GI/GU	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:
PSYCHO-SOCIAL	Affect: calm and appropriate / cooperative / other: Language: English / other: Interpreter present: Y / N / NA "Special Needs": N/A / identified: Other:	Patient informed of present condition: Yes / No Family updated on patient condition: Yes / No Other:
IV	None: Gauge: 18 Location: (L) Arm Condition: patent / no redness / no edema Other: Solution: LR Rate: 85 cc/hr Amount remaining: 100 ml	None: Gauge: Location: Condition: patent / no redness / no edema Other: Solution: Rate: Amount remaining:
DSG	None: Type: Coban Location: (R) leg Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:	None: Type: Location: Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:
SAFETY	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:
PEDS	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A
OTHER		
	RN Signature:	RN Signature:

PATIENT TEACHING IN PACU (circle all that apply)

Topic	Level of Involvement	D=demonstrated V=verbalized	INIT
Pulmonary Toileting: Importance of / Cough-deep breathing exercises / incentive spirometer / ABD splinting / Other:		D / V	
Wound care: ice compress / heat application / extremity elevation / signs of compartmental syndrome / Other:		D / V	
Pain management: Medications: type, dose, route, indications, side effects / positioning / activity restrictions / prn Rx requests on ward / Other:		D / V	
Surgeons and Anesthesia post-op orders		D / V	
Pediatric: safety: padded sides, IV armboard / monitoring equipment / staff-parent at BS at all times / pediatric post-op agitation vs pain / Other:		D / V	
Spinal anesthesia: use nursing assistance first time OOB, avoid pressure points while numb / Fundal massage / lochia and pad count / Other:		D / V	
Post cardiac cath: signs of bleeding / apply pressure over site when coughing, sneezing, or vomiting / lie flat with leg straight / use of sandbag / Other:		D / V	
MISC: Elevate HOB / avoid eye strain / wire cutter worn around neck / Oral intake restrictions Other:		D / V	

NURSING NOTES

DISCHARGE NOTE: This patient meets criteria for discharge from the PACU or has been cleared by the anesthesia provider indicated on MCEUL OP 501: Anesthesia Record.

Nursing Care Plans remain open: #

Report called to: ________ Ward: ________ Via: ________ At: ________ hours.

________ for ________

(RN Signature) ________ (Chief, Anesthesia Services)

 MEDCOM - 4122

MCEUL OP 45(Rev),19 Sep 01
MRRC apprvl - 02 Aug 01

ACLU-RDI 1244 p.616

DOD 010601

1. DATE AND TIME OF CAPTURE	2. SERIAL NO
08 APR 03	0205524 A
3. NAME (b)(6)-4	4. DATE OF BIRTH 1044 HIJRA
6. RANK N/A	6. SERVICE NO.
7 UNIT OF EPW	8. CAPTURING UNIT (b)(3)-1
9. LOCATION OF CAPTURE (Grid coordinates) MB 421870	

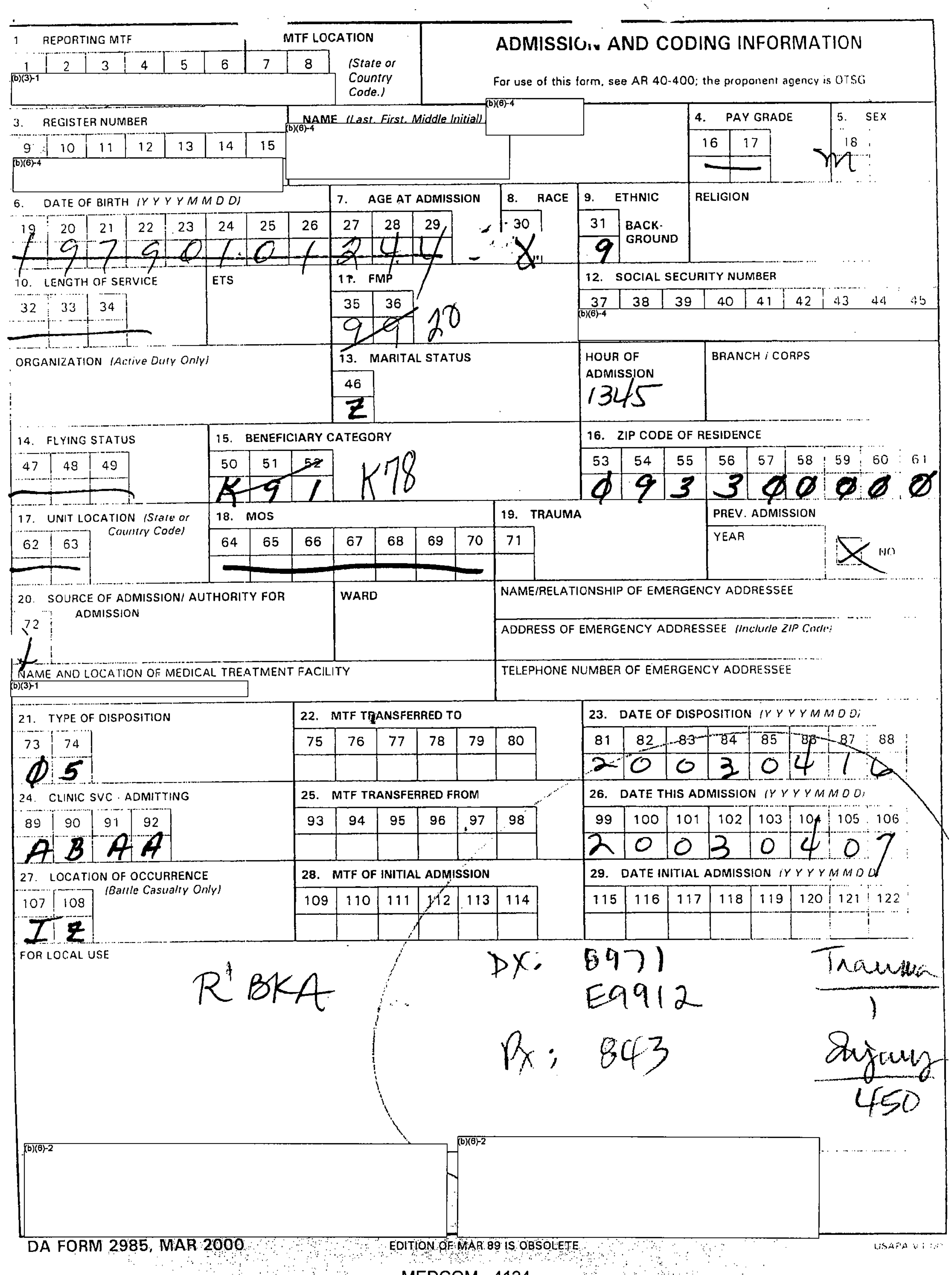
10. CIRCUMSTANCES OF CAPTURE	11 PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS
CHARGED U.S. VEHICLE WITH OWN VEHICLE	SEVERE GUNSHOT WOUND (R) LEG	NONE

DD FORM 2745, MAY 96

REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

MEDCOM - 4123

ACLU-RDI 1244 p.617



ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8) — (b)(3)-1
MTF LOCATION (State or Country Code.)

3. REGISTER NUMBER (9–15) — (b)(6)-4

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

4. PAY GRADE (16, 17): —
5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26): 1979 01 01
7. AGE AT ADMISSION (27–29): 24
8. RACE (30): X
9. ETHNIC BACKGROUND (31): 9
RELIGION

10. LENGTH OF SERVICE (32–34): —
ETS
11. FMP (35, 36): 99 20
12. SOCIAL SECURITY NUMBER (37–45) — (b)(6)-4

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 1345
BRANCH / CORPS

14. FLYING STATUS (47–49): —
15. BENEFICIARY CATEGORY (50–52): K91 K78
16. ZIP CODE OF RESIDENCE (53–61): 093300000

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
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): 05
22. MTF TRANSFERRED TO (75–80)
23. DATE OF DISPOSITION (YYYYMMDD) (81–88): 20030416

24. CLINIC SVC - ADMITTING (89–92): ABAA
25. MTF TRANSFERRED FROM (93–98)
26. DATE THIS ADMISSION (YYYYMMDD) (99–106): 20030407

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107, 108): IZ
28. MTF OF INITIAL ADMISSION (109–114)
29. DATE INITIAL ADMISSION (YYYYMMDD) (115–122)

FOR LOCAL USE

R BKA

DX: 8971
E9912

Px: 843

Trauma / Injury
450

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

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

MEDCOM - 4124

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

4. PAY GRADE: 16 17

5. SEX: 18 — CIV 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 — Iraqi

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

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

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 1345

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 — [X] NO

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

WARD: ICU

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

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	1	6

24. CLINIC SVC - ADMITTING: 89 90 91 92

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	4	0	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

R BKA ~~897~~

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

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

MEDCOM - 4125

ACLU-RDI 1244 p.619

DOD 010604

ADMISSION AND CODING INFORMATION

30. AGE AT DISP

123	124	125

31. AUTOPSY Y / N

126

32. UNDERLYING CAUSE OF DEATH / SEP

127

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	9	7				0	

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

42. SEVENTH DIAGNOSIS

191	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

50. SEVENTH PROCEDURE

255	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
0	0

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

ACLU-RDI 1244 p.620

DOD 010605

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 (b)(6)-4
3. GRADE	
ADMISSION REMARKS	
4. SEX	M
5. AGE	
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	NO
16. RATING/DSG	
17. DEPT./BEN	
18. BRANCH/CORPS	
19. UIC/ZIP	
20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	Direct
22. HOURS OF ADMISSION	1230
23. CLINIC SERVICE	ABAD
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	TRANS
26. DATE OF DISPOSITION	11MAY03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	3MAY03
ADMITTING OFFICER	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
30. DATE OF INITIAL ADMISSION	
32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED	
31. SELECTED ADMINISTRATIVE DATA	

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Head, facial, chest, & left arm burns, old with contractures 941.Ø
943.Ø
942.Ø

Proc
Ō

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
8	Ø			8	8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

SIGNATURE OF P[...] (b)(6)-2

DA FORM 3647, MAY 79 MEDCOM - 4663

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	99	IRAQI				

12. SSN	13. ORGANIZATION	14. WARD
(b)(6)-4		ICW2

15. FLYING STATUS	16. RATING DSG	17. DEPT. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	1230	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		11MAY03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION
		3MAY03

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION
(b)(3)-1	

ADMISSION REMARKS

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD COMPONENT TRANS

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Head, facial, chest, & left arm burns, old with contractures 941.0
943.0
942.0

Proc
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
8	0			8	8

36. Total Days All Facilites

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

SIGNATURE (b)(6)-2

SIGNATURE OF P (b)(6)-2

DA FORM 3647, MAY 79 MEDCOM - 4664

From (b)(6)-2 @hotmail.com]
Sent: Tuesday, April 22, 2003 4:09 PM
To: (b)(6)-2 @yahoo.com; (b)(6)-2 @earthlink.net; (b)(6)-2 MAJ; (b)(6)-2 @hotmail.com; (b)(6)-2 @hotmail.com
Cc: (b)(6)-2 @halliburton.com; (b)(6)-2 @state.gov; (b)(6)-2 @state.gov; (b)(6)-2 @state.gov
Subject: Re: Burned Baby Boy

(b)(6)-2

In addition to the humanitarian concerns in arranging badly needed treatment for this child, this is the type of case that can do wonders for public relations by reversing some on the negative publicity we have been receiving. However, I do not know if there is a simple solution. A regional solution should seriously be explored, However, if the USA is the final option that is decided upon, it probably is doable, but it will be a struggle to get all of the necessary documents/permissions in order.

First, the King Hussein Medical Unit has one of the best burn units in the Middle East. It is located in Amman, Jordan. I know that it treats burn victims from around the region. Currently, the Iraqi border with Jordan is closed, but I know from having worked in Jordan in the consular section from December 2002 through the beginning of the war in March 2003, that the Jordanian government is willing to work with the USG for special cases. The question would be whether the Shriners or other philantropic organization would cover costs in Jordan - they would be much less than in the USA. The Jordanians would ask for some type of guarantee that the family would depart Jordan following treatment.

Second, I assume from your comments that the Shriners would be willing to cover medical expenses if the family made it to the USA. However, it is not clear how the family would pay for travel to the USA and also for living expenses.

HAVE MEDICAL, TRAVEL AND LIVING EXPENSES DEFINITELY BEEN GUARANTEED?

ALSO, IS THE CHILD IN SUFFICIENT CONDITION TO UNDERGO A VERY LONG DAY OF TRAVELING ON A REGULAR AIRPLANE TO GET TO THE USA OR WOULD THERE HAVE TO BE A SPECIAL MEDEVAC FLIGHT?

There is no US visa processing from within Iraq. Therefore, the family would need to travel to a third country to start the visa processing. (There is a process for a parole - entry without a visa - but that entails a lot of red tape and several agencies. It is a possible, but not easy, operation to complete.) For visa processing, the parents would need to complete forms, pay the application fees and submit proof regarding the diagnosis and the arrangements for treatment and payment in the USA. The visa process cannot be preempted, done in abstentia or completed overnight. Even with special attention, the process could take several days if not more than a week to complete. The USG has imposed special visa processing requirements for all Iraqi adults. I know that this is a special case that requires immediate attention, but the necessary clearances would still have to be arranged from Washington - the clearance process includes a number of different agencies, it is not just the Department of State. There may also be the need for a passport waiver depending on the passport issue.

IF THIS FAMILY NEEDS TO GO TO A NEARBY COUNTRY TO DO THE VISA PROCESSING, WOULD IT NOT MAKE SENSE TO HAVE THEM SEEK AT LEAST THE INITIAL COURSE OF TREATMENT WITHIN THE MIDDLE EAST?

In short, I agree with your initial assessment that it might be prudent to further investigate treatment in the region before deciding that the USA is the answer. In any case, as you have already indicated in your e-mail, additional data is needed to determine the proper course of action. I have restated some of your initial questions above and also added a few. Let me know if you need something more. The additional addressees are people in the US Embassies in Amman and Kuwait City. (b)(6)-2

FYI, the USG has decided not to accept any Iraqi passports issued after March 19 for travel to the USA in that as of that date the USG does not believe that there was a recognized government inside Iraq. The unclassified cable on that topic is State 100462. There is a procedure, however, for an Iraqi with a passport issued after March 19 to get permission to travel to the USA - passport waiver and a special advisory opinion - but that lengthens the time involved in the processing. An April 22 meeting in the Kuwaiti Foreign Ministry indicated that Kuwait has made a similar decision.

>From (b)(6)-2
>To: (b)(6)-2
>CC: " (b)(6)-2
>Subject: Burned Baby Boy
>Date: Tue, 22 Apr 2003 04:43:44 -0700 (PDT)
>
>Through (b)(6)-2 of KBR, I have learned of the
>case of an infant boy in or near Talil, Iraq who was
>badly burned four months ago. The mother claims that
>the baby was burned by hot oil from a lamp that fell
>over during an American air strike.
>
>According to the Army physician on the scene, the baby
>needs proper medical care urgently. I understand from
(b)(6)-2 that the Shriners in the U.S. have been
>informed about this case and would like to help.
>
>I have no idea whether it will be possible to do
>something for this child, but it is worth trying. It
>seems to me that we need to start with the following:
>
>Major (b)(6)-2, (b)(3)-1 -- We will need the
>names of the child as well as of the mother and
>father. Is a medical diagnosis available? Where is
>the family now? What exactly are the Shriners
>prepared to do for the baby? Is care in the U.S.
>necessary? If adequate care could be given in this
>region, it might be simpler.
>
>Major (b)(6)-2 (b)(3)-1 -- I mentioned this case
>to General (b)(6)-2 when I called him to say goodbye. Do
>you have any advice on possible medevac procedures?
>
(b)(6)-2 -- As a consular officer, perhaps you
>could advise on how difficult it would be to send an
>Iraqi family to the U.S. in current circumstances.

>
(b)(6)-2 -- Since you will be here in Kuwait until
>next week, I would like to ask you to be the ORHA
>point of contact for action on this case.
>
>Dr. (b)(6)-2 t -- Do you think that the medical NGO with
>which we spoke yesterday might want to help in this
>case? I think you have their contact info.
>
>Everyone should include (b)(6)-2 on e-mails about this
>case. I would welcome any ideas on how to deal with
>this case.
>
>I attach the photos that I received. It is a sad
>case.
>
>(b)(6)-2
>Ambassador (ret.)
>Coordinator for Humanitarian Assistance
>(b)(3)-1
>
>
>____
>Do you Yahoo!?
>The New Yahoo! Search - Faster. Easier. Bingo
>http://search.yahoo.com
><< Burnedchild1.jpg >>
><< Burnedchild2.jpg >>
><< Burnedchild3.jpg >>

MSN 8 with e-mail virus protection service: 2 months FREE*

(b)(6)-2 TSgt 407 AEG/CP

From: (b)(6)-2 TSgt (b)(6)-2
Sent: Wednesday, April 23, 2003 4:34 AM
To: (b)(6)-2 @jrms.gov.jo'
Cc: (b)(6)-2 @webtv.net'
Subject: Burned baby from U.S. Troops stationed in Iraq near An Nasiria

Importance: High

To whom it may concern:

Atttached are photos of a 5 month old child that was burned approximately 4 months ago. We are desperately seeking advanced burn care and reconstructive surgery for this little boy. Medical services available in Iraq are non-existent for this type of severe burn. Without medical attention we are afraid this child will lose eye sight in the left eye because the eyelid is contracted, the right eye status is unknown. If a plastic surgeon could review these photos to see if your hospital could provide any help would greatly be appreciated. The attending U.S. Medical Doctor is COL (b)(6)-2 (b)(6)-2 M.D. from the (b)(3)-1 . Please respond to this email at the following address: (b)(6)-2 @9 (b)(3)-1 army.mil. Our U.S. Military phone number here in Iraq is 300-573-(b)(3)-1 (This is a DSN number not commercial) . Any help you could offer would be greatly appreciated!

Sincerely,
COL (b)(6)-2 M.D.

IMGP0064.JPG IMGP0065.JPG IMGP0066.JPG

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 May 03	H&P
	5 1/2 mo old c̄ 4 1/2 mo
	old extensive facial burn. Trying
	to arrange burn center care.
	PMH (b)(6)-2
	UCHD ō
	All ō
	Meds ō
	PE Severe facial burn, old
	Chest clear c̄ ant upper chest
	burn & (L) shoulder
	Heart faint RR
	Abd soft EXT: intact
	Plan: Admit for admin purposes
	(b)(6)-2 MD

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)

MEDCOM - 4669

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3May03@1445	- nsg note: Pt arrived on ward in NAD. VSS. Burn to face, head, and upper torso. W→D dsg Δ c̄ NS performed. Pt tol well. ⊕ PO intake - breastfeeding. ⊕ UO (x1 diaper). Parents @ bedside. Eye drops ordered QH for moisturizing. Explained to parents - parents verbalized understanding. Poss air evac in AM for tx to American Hospital. Pt sleeping @ this time. LSCTA, HR-NSR, ⊕ BS. ∅ diff breathing, retractions, SOB, hoarseness noted. Will continue to monitor. (b)(6)-2
3 May 03 2002	Nursing Note: Pt VSS. Pt breastfeeding s̄ difficulty. DRSG to ~~scalp~~ scalp c̄ minimal yellow drainage and a small amount of serous drainage. Parents continue to provide care for infant. Provided parents c̄ clothes & a rattle. No distress noted @ present. Continue to remind parent q hour to place eye drops. (b)(6)-2
4 May 03 @0120	pt resting quietly c̄ no sign of resp distress noted. afebrile. parents @ bedside. Will continue eye drops Q H throughout night per MD order. Will allow parents opportunity to rest + provide emotional support. Language barrier present. LSCTA, heart RRR, +BS ~~no other~~ small sign dressing to scalp s̄ drainage at this time. Will cont to monitor. (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)

MEDCOM - 4670

DATE	NOTES
4MAY03@1410	nsg note: VSS-afebrile. W/D dsg Δ c̄ NS. Pt tol well. Pt premed c̄ 100mg Children's Tylenol. Face & head c̄ granulation. Int'l Red Cross to coordinate for possible evac to United States. Awaiting finalization on plans for pt. Parents @ bedside. Tol PO diet well. Ø sig Δs. Pt resting quietly t/o day. (b)(6)-2
5MAY03 0400	PT SLEEPING COMFORTABLY AND HAS BEEN ALL SHIFT. (b)(6)-2 SPC/LPN
5MAY03@1400	- NSG NOTE: VSS-AFEBRILE. W/D DSG APPLIED TO HEAD c̄ NS. ⊕ GRANULATION NOTED. PT TOL PROC. WELL. LSCTA, ⊕BS, HR-NSR. Ø S/SX DIFF BREATHING NOTED. PT TOL BREASTMILK WELL. ⊕UO, ⊕BM t/o SHIFT. Ø OTHER SIG Δs. MOTHER @ BEDSIDE. FATHER TO RTN LATER TODAY. (b)(6)-2
6MAY03 0600	PT SLEPT FITFULLY THROUGH NIGHT. MOTHER AT BED SIDE, FED AND COMFORTED PT. (b)(6)-2 SPC/LPN.
6MAY03@1020	: nsg note. W/D dsg Δ completed c̄ NS. Head red c̄ granulation. ⊕PO intake, ⊕UO, ⊕BM. MD in to see pt. Awaiting sponsor for parents to go to US to have operation for pt. Ø further news at this time. Will continue to monitor. (b)(6)-2
6 May03 1909	Nursing Note: W/D drsg completed pt tolerated well site to scalp s̄ s/s of infection; Pt Alert, cooing & responding to sound. Pt breastfeeding s̄ difficulty. Pt's mother states the baby will not sleep @ present. Will continue to monitor. (b)(6)-2
6 May03 2100	Nursing Note: Noted pt Ⓡ eye weeping; small amount of yellow d/c. No redness noted @ present pt VSS. Will continue to monitor. (b)(6)-2
7MAY03 0600	PT SLEPT THROUGH NIGHT. MOTHER WOKE ONCE TO FEED. DRSG C/D/I. (b)(6)-2 SPC/LPN

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STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 MAY 03 [illegible]	VSS Has been resting c minimal crying. Mom has been doing all care except Drsg. changes. No resp. distress/difficulties noted. Mom is grateful for care, has no questions/complaints. Will continue to assess/Monitor (b)(6)-2 SSG [illegible]
7 May 03 2035	Pt Alert wetting diaper x2. Breast feeding s difficulty. Wound to scalp s s/s of infection W D drsg completed. Noted parents giving pt medicine. Parents communicated drops for gas. No distress noted @ present. Will continue to monitor. (b)(6)-2 CPT/AN
8 MAY 03 0600	PT AWOKE x 3 DURRING SHIFT. MOTHER AT BEDSIDE
DRSG C/D/I	FED AND COMFORTED. (b)(6)-2 SPC/LPN
8 May 03	Dr (b)(6)-2 wife & community in US to raise funds. Then family can go to Kuwait for visa application & hence to Duke Univ. via Air Force
	(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)

MEDCOM - 4672

DATE	NOTES
8 MAY 03 @0800hrs	Nursing: VSS, Drsg change done c W-D Kerlex drsg. Tan drainage noted on old drsg. WD/tissue Red, c small amount of bleeding noted p Drsg removed, stopped c clean drsg and light pressure. Mom assist c Drsg change. Eye's remain open when sleeping (contractures/swelling) Lung clear, Heart regular, rate/136. Active Bowel sounds throughout. Peripheral pulses palpable, cap refill <3 sec. No complications noted, will continue to assess/monitor. (b)(6)-2 CPT
8 May 03 2130	Nursing Note: Pt sleeping upon arrival to shift. Continue to remind ~~pt~~ parents of eye drops Q 1hr. Yellow discharge noted on (R) eye lid p awaking which mother cleaned. DRSG to scalp c small amount nickel size yellow drainage noted on left side of head. When drsg changed yellow dry crusted discharge noted along edges of wound. Pt tolerated dressing Δ well. Mother wanted to put cotton on wound instructed mother to only use the sterile supplies to clean around wounds ; she verbalized understanding. Pt seemed a little fussy before falling asleep. VSS. No distress noted @ present. (b)(6)-2 CPT/AN
8 May 03 @ 2340	pt resting quietly on ~~ISSC~~. VSS. parents @ bedside. pt NAD. LSCTA, heart RRR, resp equal + even. will cont to monitor (b)(6)-2 2LT/AN
9 May 03 @ 0250	pt awake + breastfeeding. Drsg ~~bo~~ env completed to head wet to dry. small amt of ~~drainage~~ brownish drainage noted to old dressing. (+) Red granulation tissue present. Ø odor noted. Eye drops administered @ 1 H to allow mother to rest. Drsg change teaching reinforced. mother assisted. Sterile technique used. pt tolerated procedure well. NAD. will continue to monitor. (b)(6)-2 2LT/AN
9 May	Fund-raising being initiated. Granulation tissue creamy s odor (b)(6)-2

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4673

ACLU-RDI 1244 p.631

DOD 011152

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 MAY 03 C	1015 - nsg note: Dsg to head Δ'd W/D c sterile H_2O. Mother assisted & performed dsg Δ c staff observation. Head red c granulation. Some milky colored drainage noted on dsg upon removal. MD notified. Ø Δ's to current regime made. VSS - afebrile. Mother @ bedside. Pt tol PO diet (breastmilk) well. ⊕ UO, ⊕ BM. Ø other sig Δ's. Awaiting funds to transfer family to U.S. Will continue to monitor. (b)(6)-2
9 May 03 1730	Nursing Note: A yellowish drainage noted on dressing a small amount of on Ⓛ side. Wound to scalp s foul odor noted. Ⓡ eyelid appeared unusually dry. Reinforced the ~~importance of~~ importance of the eye drops q 1'hr c Mother even when baby is sleeping regardless if the baby is a little fussy. Mother verbalized under standing. No other changes noted. Will continue to monitor. (b)(6)-2 CPT/AN
10 MAY 03	0630 PT Ⓡ EYE WAS DRY AND FILMED OVER AT SHIFT Δ (2300), IT LOOKS MUCH BETTER THIS AM (PINK & MOIST). (b)(6)-2 SPC/LPN
10 MAY 03 1200	Nsg Entry VS stable Afebrile (98.7) 32, 132 Drsg changed to head. Bleeding at the site (when taking the Drsg off). Small amount of Drainage at the site. M.D notified. PHYSICIAN ordered Silvadene c dressing changes (b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO. (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)

MEDCOM - 4674

~~ACLU-RDI 1244 p.632~~

DOD 011153

DATE	NOTES
10 May 03	Multiple hospital staff & others working on arrangements for reconstructive surgery
	(b)(6)-2
10 MAY 03 07 - 1500	Nsg Entry Mother at bedside nursing baby. No other problems ō the infant → (b)(6)-2 MAJ AN
10 May 03 2230	Nursing Note: VSS. DRSG Δ c̄ Silverdine. Wound site s̄ s/s of infection. ⊕ uo x 3. tolerating Breastfeeding well. No changes today. Ⓡ eyelid not as dry today. No distress @ present. → (b)(6)-2 CAPT AN
11 MAY 03 1400	Nsg Entry Drsg changed to head. No bleeding at the site. Baby didn't cry when changing the drsg. Wound site small trace of drainage. No odor detected. Mother at bedside breastfeeding infant s̄ any problems. Ⓡ eyelid healing slowly → (b)(6)-2 MAJ AN

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4675

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11 May 03	Humanitarian organization (Operation
1230	Blessing) taking child to Basra
	for plastic surgery
	(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)

MEDCOM - 4676

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY	3MAY03			4may	4may		5MAY03		6May03		6	7		
19 / HOUR	14	1600		3		2300	1400		1600	1930	2300	1400	1900	2300
RESPIRATION RECORD	46	48	36	45	36	38	38	32	36		34	36	40	32
BLOOD PRESSURE		98/51	/						94/48			132	97/59	
HR		133	136	128	127	130	128	126	140		136	[illegible]	147	128
T		97.3	97.0	95.5	98	97.9	98.5	98.6	99.2	98.4	98.9	98	98.2	98.0

PULSE (O) — TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

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		

Record special data only when so ordered

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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 4677

ACLU-RDI 1244 p.635

MEDICAL RECORD	VITAL SIGNS RECORD							
HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	8MAY03		9MAY		10MAY03			
19 / HOUR	0800 2000	23· 08·	1600		1600			

PULSE (0) / 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 Resp	40	42	38	28	32	30	32	36
BLOOD PRESSURE		100/59			107/41			
Pulse	136	112	134	120	134	132	132	136
Temp	99.1	98.0	98.4	97.1 (Ax)	97.9	97.8	97.7	98.7
HEIGHT: / WEIGHT →								

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

MEDCOM - 4678

ACLU-RDI 1244 p.636

DOD 011157

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
(b)(6)-4	3May03	100mg liquid Tylenol c̄ dressing changes per VO from Dr (b)(6)-2 and CPT (b)(6)-2 3May 1420	noted 3May03 @ 1445 (b)(6)-2
		24 hr chart check completed @ 0730 3May03	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	10May03	Silvadene c̄ dressing changes (b)(6)-2	(b)(6)-2 10MAY03 1455
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
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLA[CES ... WHI]CH MAY BE USED. MEDCOM - 4679

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

3 May 03 — noted

Please provide food & "bed" [redacted] pt. & family

Routine VS
Artificial tears q h (may give bottle to parents)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

Lacrilube ophthalmic oint OU q hs

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

3 May

Get photo's of baby with head dressing off. Use digital camera & give to Major (b)(6)-2 (in TOC)

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

3 May

Wet-to-dry dressings to head tid

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

3 May 03
0445

(b)(6)-2

DA FORM 4256, 1 APR 79 — REPLA[CES] ... [WHI]CH MAY BE USED. — MEDCOM - 4680

ACLU-RDI 1244 p.638

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. MAY 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 11 12 13 14 15 16
3 MAY 03	(b)(6)-2	Please provide food & bed for pt & family	07 15 15 23 23 07	(b)(6)-2
3 MAY 03	(b)(6)-2	Routine VS	07 15 23	(b)(6)-2
3 MAY 03	(b)(6)-2	Arti tears q hr (May give bottle to parents)		
3 MAY 03	(b)(6)-2	Wet-to-dry dressing to head TID		(b)(6)-2 — see below
3 MAY 03	(b)(6)-2	Lacri lube ophthalmic oint OU q hs	21	(b)(6)-2 (b)(6)-2
8 May 03	(b)(6)-2	Wet → dry dressing to head TID	02 10 18	Yes — time d/c'd
8 May 03	(b)(6)-2	Wet → dry dressing to head TID	02 10 18	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

MEDCOM - 4681

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				
			Mo May Yr 03			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3May03	(b)(6)-2	Get photo's of baby c̄ head dressing off. Use digital camera & give to Major (b)(6)-2 (in TOC)	3May03		Done @ 1050	(b)(6)-2

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

MEDCOM - 4682

USAPA V1.00

ACLU-RDI 1244 p.640

DOD 011161

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. MAY Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 May 03	(b)(6)-2	Artifical tears q h	06		(b)(6)-2												
		(may give bottle to	07														
		parents)	08														
			09														
			10														
			11														
			12														
			13	(b)(6)-2													
			14														
			15														
			16		(b)(6)-2												
			17														
			18														
			19														
			20														
			21														
			22														
			23	(b)(6)-2													
			24														
			01														
			02														
			03														
			04														
			05														
10 May 03	(b)(6)-2	Silvadine c dressing	02	X	X	X	X	X	X	X	X	(b)(6)-2					
		changes	10	X	X	X	X	X	X	X	X						
			18	X	X	X	X	X	X	X	X						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 4683

ACLU-RDI 1244 p.641

DOD 011162

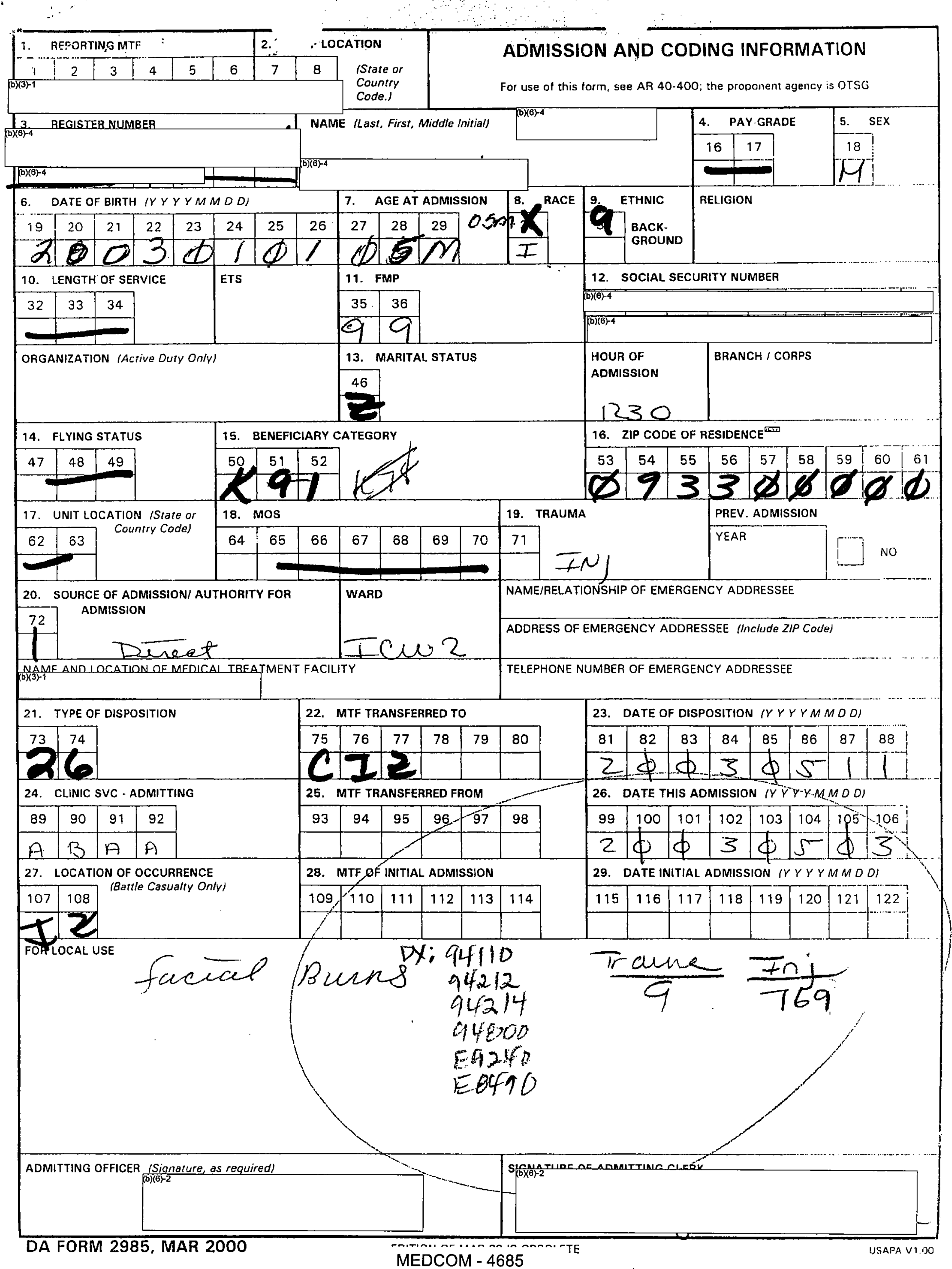
Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. ____ Yr. ____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
~~1888 3MAY03~~	(b)(6)-2	~~Tylenol elixer~~ : age														
.....	..... error	appropriate dose														
3 May03	(b)(6)-2	100mg liquid Tylenol	4 May03 @0900 100mg PO													
.....	.....	c̄ dsg Δ's	(b)(6)-2													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 4684



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.)

3. REGISTER NUMBER: (b)(6)-4 / (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 / (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): 2003 0101
7. AGE AT ADMISSION (27–29): 05M
8. RACE: X / I
9. ETHNIC BACKGROUND: 9
RELIGION:

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

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 1230
BRANCH / CORPS:

14. FLYING STATUS (47–49): —
15. BENEFICIARY CATEGORY (50–52): K91 K91
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): INJ
PREV. ADMISSION: YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1 Direct
WARD: ICW 2
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): 26
22. MTF TRANSFERRED TO (75–80): C I 2
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 2 Ø Ø 3 Ø 5 1 1

24. CLINIC SVC - ADMITTING (89–92): 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 5 Ø 3

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

facial Burns DX: 94110
94212
94214
94800
E9240
E8490

Trauma 9 Inj T69

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

DA FORM 2985, MAR 2000 EDITION OF MAR 80 IS OBSOLETE USAPA V1.00

MEDCOM - 4685

ACLU-RDI 1244 p.643

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: 7 8 (State or Country Code.)

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

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26
7. AGE AT ADMISSION: 27 28 29
8. RACE: 30 — I
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: 1230
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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — D Direct
WARD: ICW 2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 86TH CSH LSA ADDER, IRAQ
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — TRANS
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (YYYYMMDD): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 5 1 1

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 (YYYYMMDD): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 5 0 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108
28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (YYYYMMDD): 115 116 117 118 119 120 121 122

FOR LOCAL USE: Facial Burns

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

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

MEDCOM - 4686

~~ACLU-RDI 1244 p.644~~

DOD 011165