(b)(3)-1

...NT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	NA	NONE

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		NA	NA	NA	NA	NONE

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

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NONE	NA	K78	NA	NA	NA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0530	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
NA	XFER TO EPW HOLD	030713 1500

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
NA	NA	030705	(b)(6)-2 LT

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030705	NA

31. SELECTED ADMINISTRATIVE DATA

NA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX:MULTIPLE SHRAPNEL RIGHT LEG

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER

(b)(6)-2 LTC, MC

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

(b)(6)-2 SSG, NCOIC, PAD

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

19 Y/O IRAQI ♂, PW 2° ATTACKING US FORCES IN SAMARRA, C̄ RLE FRAGMENT WOUNDS. INITIAL (b)(3)-1 [redacted].
UNKNOWN Ⓡ RX @ BAS & GROUND EVAC'D TO
TOI UN[illegible] POINTED WEAPONS AT USF WHILE UNDER OBS.

UNKNOWN Ⓡ INITIAL EVAL 2° NO TRANSLATOR

PMH
PSH
MEDS
ALL
HABITS
NKS

PHYSICAL EXAMINATION

NAD TEENAGER
HEENT AT
NECK NT FAROM
CHEST CTA COR RRR S Ⓜ ABD SOFT NT C̄ NABS
EXT - BLE LLE ~~N~~ RLE C̄ MULT FRAG WOUNDS -
FEW POST & MED THIGH, MANY ANT-MED LLE ~~DISTAL~~ PULSES
INTACT & SYMMETRIC. APPARENTLY ANT. KNEE NT NOT
EFFUSION FAROM
XR NO FXS - NO INTRA-ART FB - MULTIPLE SM METALLIC

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

FRAGS ON TIBIAL SURFACE
A - FRAGMENT WOUNDS RLE
P - TD, ANCEF, WOUND EXCISION IN O.R.

(b)(6)-2 [redacted]

0635

LTC MC

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

OR

DATE	IDENTIFICATION NO.	ORGANIZATION
5 JUL 03		

PAT[redacted] ...r written entries give Name last, first, ...de; date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-4 [redacted]

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

(b)(6)-4 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 Jul 03 1800	Nursing Admission ~~Personnel~~ Pt. received from ER. VS 125/64, 88, 24, 99.9. NAD resp. distress. Drowsy. Desires h2o. Unable to understand that he is going to surgery. Pt prepared for Surgery [b)(6)-2] OPTAN
5 JUL 03 1330	OP NOTE PREOP Dx RLE (THIGH & LEG) FRAGMENT WOUNDS POST OP Dx SAME PROCEDURE DEBRIDEMENT RLE SURG ENCOUNTER ANES GETA MOD CUM FLUIDS 900 CC EBL MIN SPEC # DRAINS # COMPLICATIONS MULTIPLE FRAGMENT WOUNDS 0.3-3CM RLE. # KNEE OR ANKLE PENETRATION TO DEEP FOR NEUROVASCULAR INJURY SEARCH.
	[b)(6)-2] ORTHOPEDIC SERVICE
1800	Nursing assessment: At stance at this time. Sleeping, easily arousable oriented x3. PERRLA. Lungs CTA bilat. RSR. Abd soft, non-tender, bowel sounds active x4quads. Drsg to R. leg CDI. Brisk cap refill and strong pulses x4 extremities. Alive & well. Knee and FROM t

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

[b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
(Cont)	(R) toes. Eating 50% dinner. Using IS, able to raise one heel. Ø C/O pain. —— (b)(6)-2 [redacted] CA/RN
6 Jun 03	POD 1
	S/LING ARM
	Ø URBA
	FCT 36
	NVI DISTALLY
	DSG INTACT
	A DANG WRL
	P DAC 8 Jun 03
	(b)(6)-2 [redacted] (b)(6)-2 [redacted] TC, MC ORTHOPEDIC SERVICE
6 Jun 03 1600	Nursing: Shift note Pt with BS, clear + equal bilaterally, shallow breathing, BS @ 4 Quads, Voiding w/o difficulty. Pain x1 this shift. Ø significant changes this shift. Continue to monitor —— (b)(6)-2 [redacted] ERPN
06 Jun 03 1800	Nursing assessment: Pt awake at this time. AAOx3. ERRA. Mucous membranes pink moist intact. Neck supple, FROM. Lungs CTA bilat. NSR. Abd Soft, non-tender, bowel sounds active x4 quads. Ate 50% dinner, tolerate well. Voiding dark yellow urine to urinal, encouraging PO intake of fluids. Using IS encouragement Ø C/O pain at this time. Strong pulses and brisk cap refill x4 extremities. (R) leg dsg from toes to groin. Ø drainage noted to dsg. —— (b)(6)-2 [redacted] (b)(6)-2 [redacted] CA/RN
2245	IV ~~Ø~~ (L) AC infiltrated. 20g to (R) FA started (b)(6)-2 [redacted] CA/RN

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01July03 0030	Pt c/o pain to (R) leg. Percocet 1/1 tabs for pain. Will monitor [redacted] LT/SN
070715 July 03	Nursing Assessment: Pt awake, alert, O x 3. Airway intact, breath sounds clear and unlabored, LS clear to all fields (B). Abd soft, nontender, + distention. BS(+). Voids spontaneously. ROM and neurovascularly intact to (B) UE and (L) LE. (R) LE ROM limited 2° pain & drsg. Drsg c/d/i ACE wrap from ankle to mid thigh. (R) foot + edema but neurovascularly intact. Pt does not want to straighten (R) leg completely 2° pain. Will get interpreter & explain that he needs to maintain ROM. IV w/o (R) AC flushes + s/s infection / inflammation. — [redacted] SAV
7 Jul 03 0745	S LOCAL PAIN & STIFFNESS O VSSA NVI DISTALLY DSG INTACT A STABLE P DPT TO MORROW
7 Jul 03 @ 1717	Nursing Notes: Assumed care of Pt A+O Breathing intact & SOB or Labored Breathing Lung CTA. Pt tolerated Regular diet ate about 80% of meal. IV SL flushes well & S/S of infection at Site. Cont on Back — [redacted] LSN

LTC, MC
ORTHOPEDIC SERVICE

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)* [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 July 03	Abd Soft ø tender · Eyes PERRL. Cap Refl x4 brisk.
1717	(R) Leg elevated. ø drainage or foul odor noted.
	Will Continue to monitor Pt Status —— [redacted]
1745	Pt c/o Pain 4mg IV MSO4 given. Will Continue to
	monitor Status —— [redacted]
1930	Pt c/o pain 2 Percocet PO given. Will Continue to
	Monitor Status. 475 cc clear yellow urine Emptied
	from Bedside urinal —— [redacted]
2205	Pt Asleep —— [redacted]
0130	Pt C/o Pain Percocet II tabs PO given. Will Continue
	to monitor Pt's Pain Status —— [redacted]
08 1030 July 03	Nursing Assessment: Pt is awake, seen Ox3, alert. Airway intact, breathing even and
	unlabored. Lung sounds clear to all fields (B). Abd soft, nontender, s distention, BS⊕x4.
	Voids spontaneously. Neurovascularly intact to all extremities. (B) UE and LLE have FROM.
	(R) LE has gauze c ACE from ankle to mid thigh, (R) foot is swollen but pulses are palpable
	(R) foot is elevated but pt is somewhat non-compliant. Even after talking through interpreter, pt
	does not keep leg straight, to maintain extension capabilities. IV in (R) FA is tender but not
	red, swollen, and flushes well. Will attempt to restart IV. —— [redacted]
6 Jul 03	OP NOTE
1915	PREOP DX FRAG WNDS RLE
	POSTOP DX SAME
	PROCEDURE DEBRIDEMENT & DPC (R) LE FRAG WNDS.
	SURG [illegible] ANES [illegible] SCHRADER
	FLUIDS IL LR EBL MIN SPEC ø DRAINS ø CX ø
	FINDINGS CLEAN WNDS ø SIGN INFECTION. MIN
	GROSS DEBRIS, TO ICU FOR RECOVERY STABLE [redacted]
	LTC [redacted] ORTHOPEDIC SERVICE

*U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDICAL RECORD	PROGRESS NOTES
DATE 7 Jul 03	AOD, S NO C/O O VSSA NVI DSG INTACT A CLEAR P LOCAL WOUND CARE. 3D PROPHY ABX
9 Jul 03 1130	Nursing: Ambulation Pt up OOB to chair, learning to put best leg down first & pivoting. C/O pain ↑ 20 min. Received morphine ×2 this shift. Continue monitor [redacted] CPM
9 Jul 03 -	2030 AVSS, Resps, WNL CTA Bilat, S1-S2 clear & Regular, (+) BS ×4. Dsg to RLE C, D, I. Ambulates with crutch assistance. RLE elevated and neurovascular will continue to monitor [redacted] BCT, LPN
10 Jul 03 0600	Nursing Assessment: Pt sleeping, easily aroused. Flush ht's 5 difficulty. Lungs CTA, (+) BS ×4, abd soft, flat, HR 79 & reg. ~~2+ x +2 Pulse x4 extrem.~~, (L)LE c +2 Pulses & (R)LE +2 Pulses. (R)LE c brisk cap refill, warm, dry & mild edema. Dsg to (R)LE CDI — IV [redacted] Adv

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTES (Sign all notes) — OBSERVATIONS Include medication and treatment when indicated
8 Jul		2030	• ASSESSMENT - PT BACK FROM DEBRIDEMENT OF RLE. A&Ox3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, LAD RADIAL 2+3, PULSES PALPABLE IN ALL EXTREMITIES, WEAK IN RLE. PT CAN FEEL TOUCH TO RLE. DRSG TO RLE C,D,I LR 75cc/HR TO LUE. WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2 SGT, LPN
9 Jul 03	1118		Nursing: Shift assessment Pt. bright & alert Speech in Arabic/native tongue. Able to express pain thru gestures. Level unknown. O resp. distress, VSS, BS (+) Voiding clear yellow urine 730cc qs. (R) LE remain in bent shape, encouraged to wiggle toes & straighten leg. No other changes noted. Continue to monitor — (b)(6)-2 CPT
10 Jul 03	1709		Nursing: Assumed care of Pt A&O. Sitting up in bed. ∅ complain of pain. Eyes PERL, ~~Movement at bedside~~ IV SL flushes well ∅ S/S of infection at site. Abd soft and non tender. Pt able to move all extremities. Pt tolerated regular diet. Encourage Pt to stretch infused (R) Leg ∅ drainage or odors from site. Will Continue to monitor Pt. Status — (b)(6)-2 LCpl

(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 - 6272

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Jul 03		1916	Pt Ambulated to BR Pt Obs to void Spontaneously clear yellow Urine voided. Pt c/o pain after ambulation. Pt back in Restraints. (b)(6)-2 LLTAN
		2252	Pt c/o Pain in leg 2mg MSO4 IV given IV flushes DC. will continue to monitor Pain Status (b)(6)-2 LLA
		2311	Pt Asleep LLA
12 Jul 03	1118		Urine: Clear yellow Specimen

PROGRESS NOTES

DATE	
11 0955 July 03	Nursing Assessment: Assumed care of pt. Pt awake, alert, Ox3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ̄s distention. BS ⊕ x4. FROM and neurovascularly intact to (B) UE and LLE. RLE has limited ROM 2° pain and wraps. RLE is neurovascularly intact. Pt is doing a better job of keeping his RLE straight, improving ROM. Pt is up ̄c crutches ̄c standby assist. —— [redacted]
11 June 03	2150 - AAO x3, PERRLA, LUNGS CTA BILAT. S1-S2 STRONG AND REGULAR (+) BS x4. RLE DRSG C, D, I, ELEVATED, MOTOR + SENSORY SKILLS SLUGGISH BUT CAN FEEL, WIGGLE, PULSE PALPABLE [redacted] REG DIET. UP WITH CRUTCH ASSISTANCE —— [redacted]
12 Jul 03 1440	Nursing: Shift assessment Pt. alert, communicating in native tongue & non-verbal. VSS. no resp. distress BM x1 this shift. (R) Leg drsg. changed this shift. Sutures intact & explained by interpreter. Ambulated x2 this shift. Increasing pressure to (R) foot. Continue to monitor —— [redacted]
12 July 03 1719	Nursing Notes: Assumed care of Pt At O. Sitting up in bed. Pt tolerated regular diet OK. Ø c/o pain at this time. Breathing intact BS x4 quad Abd soft and non tender IV SL intact Able to move extremities OK. ~~Pt~~ Void spontaneously. Encouraged to keep (L) leg extended. will continue to monitor Pt status —— [redacted]
13 0600 July 03	Nursing Assessment: Pt awake, alert, Ox3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ̄s distention, BS ⊕ x4. Voids spontaneously. FROM to (B) UE, LLE, and neurovascularly intact. RLE neurovascularly intact, but ROM to knee limited by pain. Encouraged ROM exercises. Ø IV access. —— [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD [redacted] PROGRESS NOTES

DATE

13 JUL 03 ADMITTING & D/C DIAGNOSES

[redacted] FRAGMENT WOUNDS RIGHT THIGH & LEG

ADMITTED 5 JUL 03

DISCHARGED 13 JUL 03

PROCEDURES - WOUND DEBRIDEMENT 5 JUL 03

DELAYED PRIMARY CLOSURE 8 JUL 03

CLINICAL RESUME -

19 y/o IRAQI MALE SUSTAINED FRAGMENT WOUNDS (R) THIGH & LEG WHEN ENGAGED BY US FORCES AS HE ATTEMPTED TO ENGAGE THEM. WOUNDS OF LEG WENT TO PERIOSTEUM BUT NO FXS NOTED. HOSPITAL COURSE WAS UNREMARKABLE. ABX WERE D/C'D ON HD 7.

DISPOSITION: D/C IN NP CUSTODY

MEDICATIONS CONTAB 7.5 #20 1 PO Q 4° PRN

BLET NEG

ACT WBAT

FU SUTURES OUT AT BAS/ASMC IN 1 WK.

(Continue on reverse)

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

[redacted]

REGIST

WARD NO

[redacted]

LTC, MC

ORTHOPEDIC SERVICE

PROGRESS NOTES

Medical Record

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

USAPPC V1.00

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY: (b)(6)-4

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 5 July 03 | TIME: 0450

TRANSPORTATION TO FACILITY: Ambulance

SEX: M

AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES: ?

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Shrapnel wound (R) Lower leg

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0502	556			
BP	127/71	132/68			
PULSE	105	97			
RESP	99%/20	99%/26			
TEMP	97.4 oral	979			
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
526	ANCEF 1gm IV				
527	Tetanus				
634	Morphine 5mg				

DISPOSITION ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(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

MEDICAL RECORD | ***(Doctor)*** | 0500

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: ≈ 15 yo male c Ⓡ lower leg shrapnel wounds. Had been seen earlier - has sutures to one wound. Ambulated into CMT. Alert and cooperative. TOI 0000.

O: Pt is alert & cooperative
VSS
HEENT - WNL
Neck - WNL
Chest - CTA, no distress
Abd - BS Ⓝ
Pelvic - stable
Back - ~~fragments~~. atraumatic
Ext: mult frag to Ⓡ LE below knee to bone/foot. Ⓝ mult frags up p thigh to buttock
+ PP N/V, intact.
Rectal: Ⓝ Bld. NL Tone. NL PRs Guaiac Ⓝ.

XRay: mult frags to lower leg. Ortho's.

135 | 106 | 13
4.4 | 22 | 1.1 | 172
CK 619.
16 | 13 | 42
Tel, Clr 1.025 5.0
TAS 9/10.

Admitted to ICW - repeat grams - pt stable - transferred via litter [b)(6)-2] MAT MC

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
[b)(6)-2] [b)(6)-2] MAT, MC.

DIAGNOSIS
mult frag wounds to Ⓡ LE.

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

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY MAJ [redacted] CRNA
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY
3. DATE 20030705 TIME PATIENT ARRIVED IN SUITE 1215
4. PATIENT IN ROOM TIME 1215 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: A&Ox3. Consent ✓'d.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted], AN, 66E SGT [redacted], AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms abducted less than 90° on padded armboards. Amsco bed padded.

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

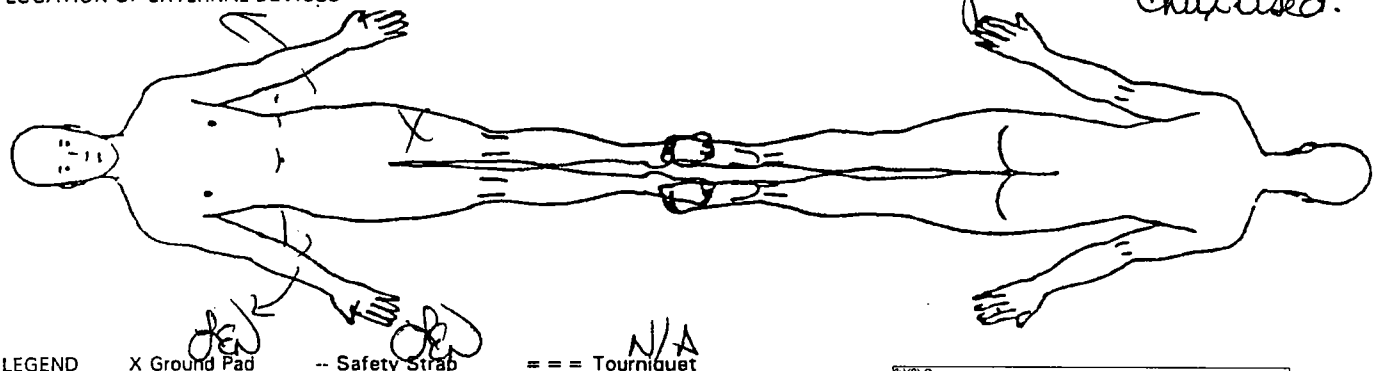
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadyne 7.5% + NSS / [redacted]
SITE: RLE to groin BY WHOM: [redacted], SGT
SITE: BY WHOM:
COMMENTS: No pooling noted. 1015U-drape + Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Out by [redacted]

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

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

[redacted]

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

☒ ESU NO: 000442
GROUND PAD: BRAND VL Polyhesive
LOT NO: EXP 05092, H9402-4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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): 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	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

Fluffs
Kerlix
Ace Wrap

19. ADDITIONAL INFORMATION

15/0, EBW 45 kg. NPO prior to arrival to EmT in a.m.

Transferred to ICU via stretcher. Drowsy, Bone pad site clear, dry, intact. Dressing CDI to RLE.

20. OPERATION(S) PERFORMED

Debridement, RLE wounds.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1325	Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM BY anesthesia
VIA: cart
TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFIED/RECORD REVIEWED AND PROCEDURE VERIFIED BY [b)(6)-2] LT/AN

3. DATE 8 July 03

4. PATIENT IN ROOM TIME 1745 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [b)(6)-2] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [b)(6)-2] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bump (R) hip

8. SKIN PREPARATION

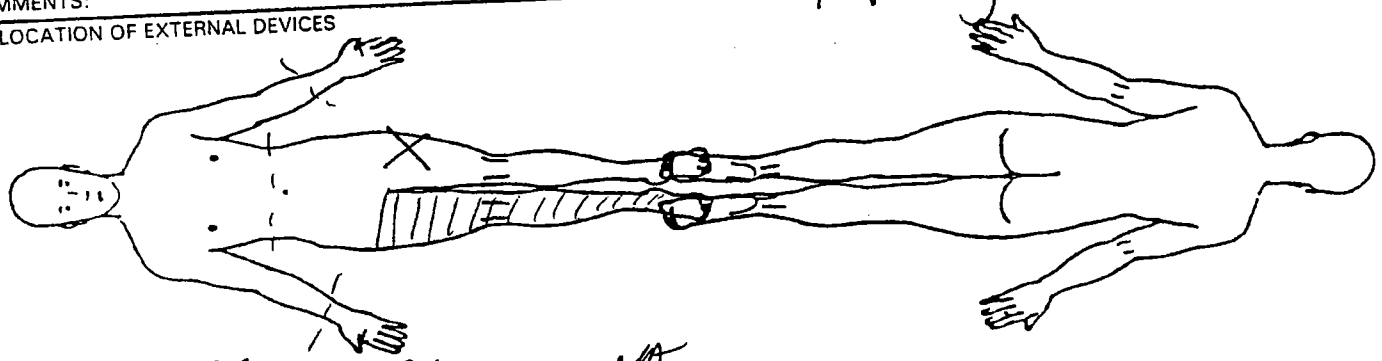
HAIR REMOVAL DONE BY: METHOD: ☐ YES ☒ NO ☐ OR ☐ DEPILATORY ☐ CLIP ☐ NURSING UNIT ☐ RAZOR

PREP SOLUTION (Specify) Beta / Brandt's Sol.
SITE: (R) leg - foot to groin BY WHOM: [b)(6)-2]
SITE: BY WHOM:

COMMENTS: ϕ pooling or irritation

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad csl -- Safety Strap csl = = = Tourniquet MA /// = prep

10. COUNTS

C = Correct I = Incorrect

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

SCRUB [b)(6)-2] CIRCULATOR [b)(6)-2]

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

[b)(6)-4]

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

☒ ESU NO: X 1 cut/coag: 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 6280

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):
NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Dr [b)(6)-2]

cpt [b)(6)-2] CRNA

20. OPERATION(S) PERFORMED

I+D of RLE wounds

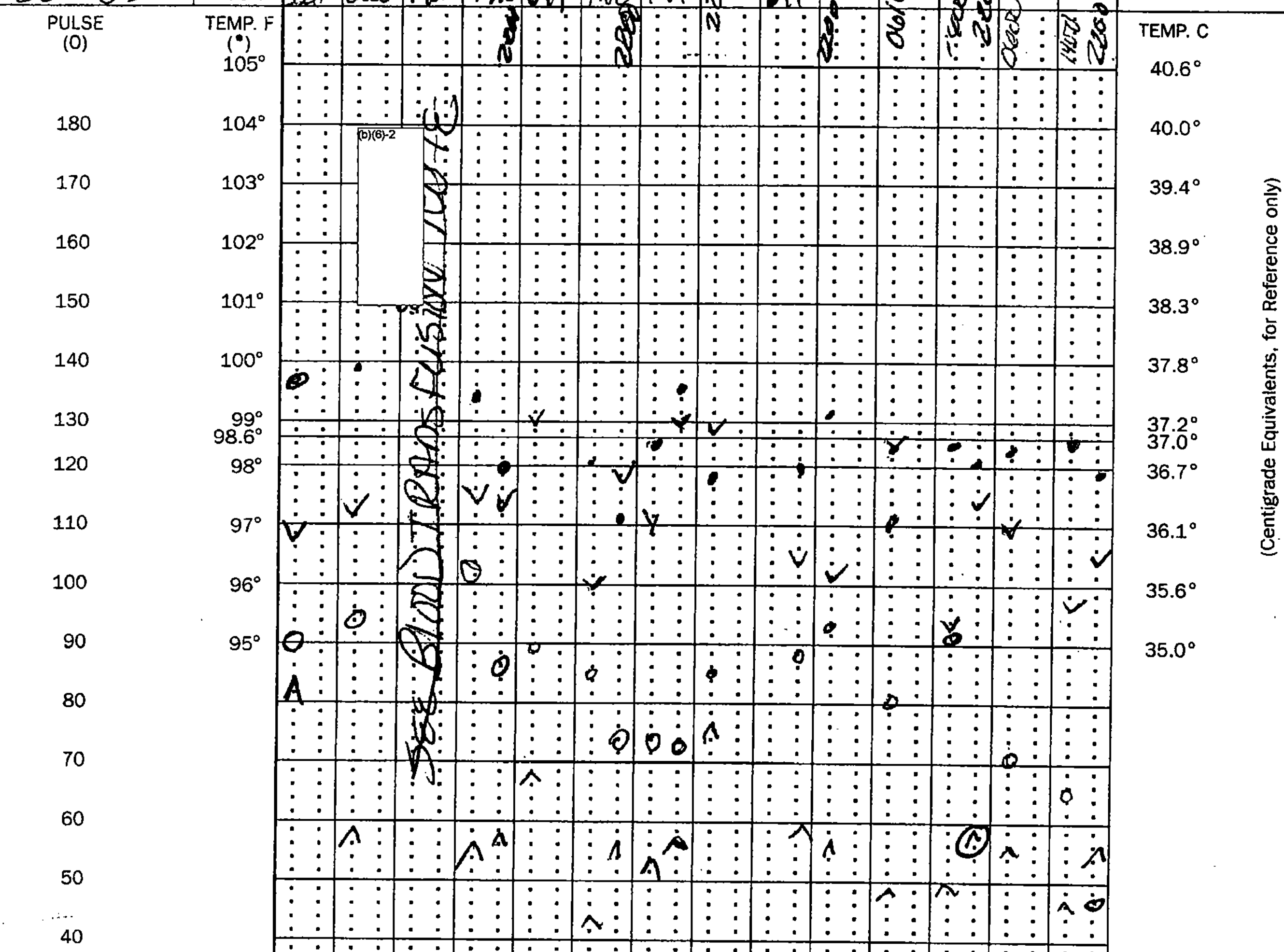
21. PATIENT TRANSFERRED TO TCU TIME 1920 METHOD litter

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1/2	2	3	4	5	6	7	
POST- DAY								
MONTH-YEAR / DAY	6	6	7	8	9	10	11	
20[illegible]03 / HOUR	0600	1400	[illegible]	[illegible]	[illegible]	0610	[illegible]	



RESPIRATION RECORD 18 20 18 20 18 18 18

Record special data only when so ordered		
BLOOD PRESSURE	113/58, 124/68, 118/56, 124/61, 128/76, 105/56, 112/58, 105/55	[illegible]
HEIGHT:	WEIGHT →	99% 99% 98% 97% 98% 99% 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.

(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 - 6282

MEDICAL RECORD		VITAL SIGNS RECORD
HOSPITAL DAY		8 · 9
POST-	DAY	
MONTH-YEAR	DAY	12 · 13
2019	HOUR	[illegible]

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	18	19	18	14	
BLOOD PRESSURE		160/[illegible]	100% / 121/61	116/56	
SpO2	96	97			
HEIGHT: / WEIGHT →		C9	100%	99	

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**

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

LAST, FIRST, MI (b)(6)-4 | DATE 5 July | TIME 0520 | SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	15.8	4.8-10.8 x 10^3
RBC	5.37	4.7-6.1 x 10^9
Hgb	12.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.3	42-52% (M) 37-47% (F)
MCV	78.8	80-94 fl (M) 81-99 fl (F)
Plt	422	130-500 x 10^3 verified
Lymph %	18.7	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.025	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

ESR

Cell Count		
Directigen		Negative

Coagulation Studies

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microbiology (urine)

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS: Type & Screen

REPORTED BY: (b)(6)-2 | DATE: 05 JUL 03 | LAB ID NO.:

Room 12

TEST	RESULT I-Stat	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT Met 8	REF. RANGE
GLU	172 #	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	619 #	39-380 u/l (M) 30-190 u/l (F)
NA+	135	128-145 mmol/l
K+	4.4	3.3-4.7 mmol/l
CL-	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 05 JUL 03

LAB ID NO.:

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	5 Jul 03	0710	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.4	4.8-10.8 x 10^3
RBC	5.25	4.7-6.1 x 10^9
Hgb	12.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	41.8	42-52% (M) 37-47% (F)
MCV	79.7	80-94 fl (M) 81-99 fl (F)
Plt	901	130-500 x 10^3 verified
Lymph %	11.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Other	

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh			

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2	05 Jul 03	

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	06JUL	0430	(b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.4	4.8-10.8 x 10^3
RBC	4.57	4.7-6.1 x 10^9
Hgb	11.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.2	42-52% (M) 37-47% (F)
MCV	79.2	80-94 fl (M) 81-99 fl (F)
Plt	326	130-500 x 10^3 verified
Lymph %	20.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 06 Jul 03	LAB ID NO.:

MEDICAL RECORD

ANES...

Drug	(Units)	Doses	Total
...rsed	(mg)	2	2 mg
...nt	(mg)	100 50,50,50	250 mg
...P	(mg)	200	200 mg
...nx	(mg)	100	100 mg
...SO4	(mg)	5	5 mg
...orodal	(mg)	30	30 mg
ISO	% del	X—1.5—1.2—X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	X-8—2—2—8	

...E DRUGS – MARK ON GRID
...RS & ENTER IN REMARKS

LR ☐ Warmed — 2 (300) — (900)

☐ Warmed

☐ Warmed

☐ Warmed

EST BLOOD LOSS

URINE –

TOTAL URINE 0

FLUIDS – SUMMARY

CRYSTALLOID– 900

COLLOID– 0

BLOOD– 0

REMARKS–

Code drugs with numbers, events with letters

1200 pt ID'd ! Med Records Reviewed

1215 In Rm Monitoring

1218-1222 RSI c̄ Cricoid pres

1320 pt s/x c̄ good TV pt Extubated c̄ pos. pres & suctioning

TIME ➡ 15 30 45 1300 15 30

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

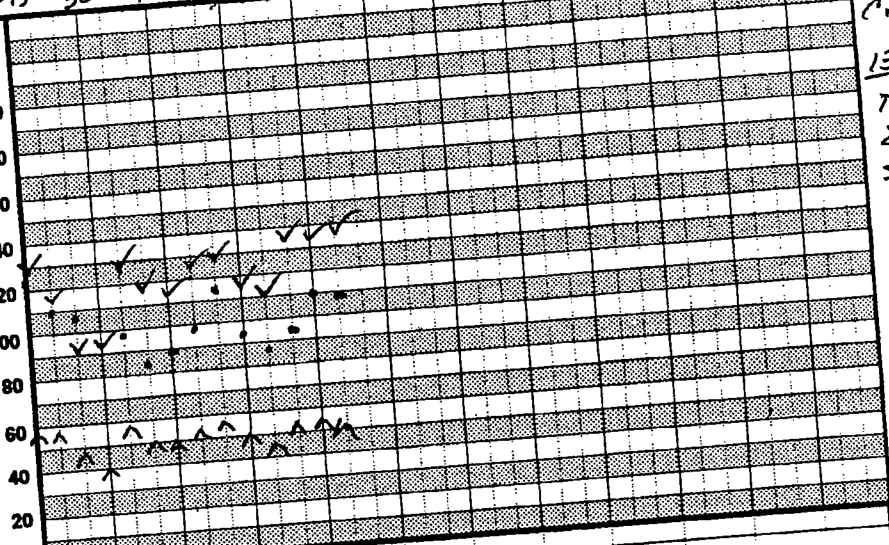
Resp rate

BP (transduced)

TOURNIQUET T—X

ANES– X-X

PROC-⊙-Ø



VT – ml	400				
f – breaths/min	8	18	21	18	
Peak insp pres / PEEP	21				
MODE– S(pon), A(ssist), C(on)	S/C	C	S	S	S
ET CO2 (torr)	(+)	38	52	54	60
FIO2 (Frac or %)	.87	.87	.86	.86	.86
SpO2 (%)	96	98	98	98	98
ECG	ST	SR	SR	SR	ST
TEMP- site					
N-M Block (T/4)	4/4	4/4			

P/Auto Cuff · ... / oth · ...RT line · ...teth- PC/ES · ...as analyzer · Warming blkt · Conv warmer

RECOVERY AT 1325

PACU (ICU) (Specify)

OTHER

CONDITION: stable

RESP–24 SpO2– 97

BP–116/56 HR– 114

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1200	1215	1330
	Ready	**Begin**	**End**
PROC	1225	1240	1310

...k with letters & symbols, ...lain under REMARKS — EVENTS Position → ...

...CEDURES and CPT Codes (R) lower leg Debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: intubation route, blade, technique, comments — DL x1 c̄ 3 MAC Visualized Cords ! Intubated c̄ 7.0 ETT to 21 cm @ lip, Bilat BS ! ETCO2 x5 waves, Eyes taped

...TIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, ...

(b)(6)-4

SURGEONS:

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

PROCEDURE LOCATION ISO 1-1

DATE 5 July 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

*U.S. GPO: 2002-729-180/40137

PATIENT RECORD

MEDCOM - 6288

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS — MG / MCG / ML, * | * = CONSTANT INFUSION

DRUG	(Units)		Dose
Versed	(mg)	1	1 mg
Fentanyl	(mcg)	25 75 … 25 50 50	250 mcg
STP	(mg)	250	250 mg
Succ /	(mg)	100	100 mg
MSO4	(mg)	2 2 2 2 2	10 mg
	( )		X

VOLAT AGENT	Sevo % del	2 2 2 1.5–2.3 — 2.2–1.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3–2–2–2–2–2–2–2 3 — RA

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

LINE site LR(cc) 18g LA	☐ Warmed	~300 ~700 (1000)
	☐ Warmed	
ANCEF 1g IVPB	☐ Warmed	X ——— X
	☐ Warmed	

LOSSES — EST BLOOD LOSS: —; URINE — No foley

TIME → 1745 1800 ψ 30 ψ 1900 ψ 30 ψ 2000 ψ 30

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: N45 KG / LB

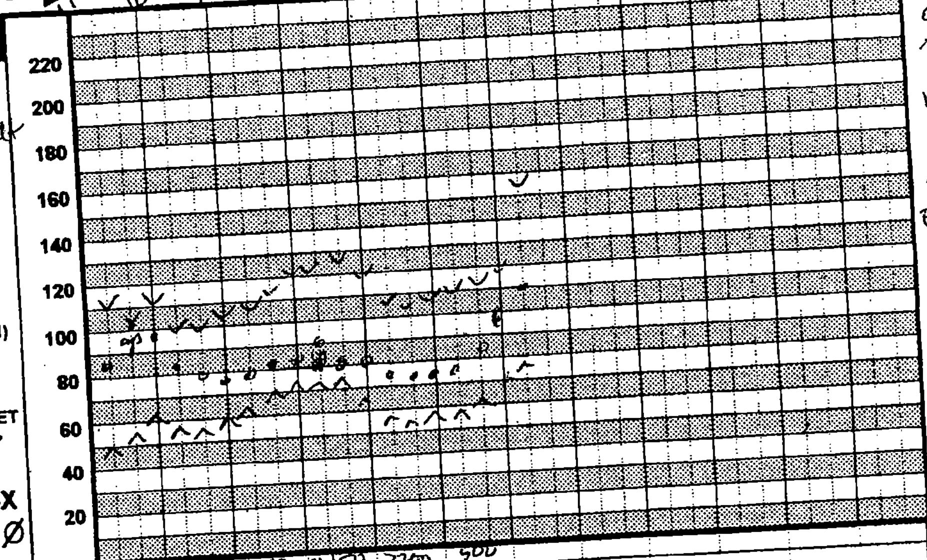
HEMATOCRIT: 36.2

INITIAL DATA: BP — 110 / 50; HR — 85

EQUIP CHECK: OK? — (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes; TIME — 1730

SYMBOLS: (R) arm BP by cuff; V Reg / Λ Adult; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T —✗; ANES — X-X; PROC ⊙—Ø



	VT — ml	>700 >700 >720 >750 >700 500
I:E = 1:2	f — breaths/min	16 10 10 25 17 22 20 22
	Peak insf pres / PEEP	18 19 — — —
	MODE — S(pon), A(ssist), C(on)	S C C S S/A S/A S/A S
✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕ 40 34 48 52 54 50 RA
BP / oth	✓ FIO2 (Frac or %)	.84 .83 .84 .84 .84 .83
ART line	✓ SpO2 (%)	100 100 100 99 99 99 98
Steth — PC/ES	✓ ECG	SR SR SR SR SR SR SR
✓ Gas analyzer	TEMP — site Axill	
	N-M Block (T/4)	4/4 ⊕ 4/4 ≥ST
Warming blkt		✓
Conv warmer		

EVENTS (Mark with letters & symbols, explain under REMARKS): Arms <90°, padded / secured → →

Position → O ←→ → → →

PROCEDURES and CPT Codes: Debridement + DPC RLE wounds

ANESTHETIC TECHNIQUES: (Describe block technique under Remarks) GETA (O2 / sevo)

AIRWAY MANAGEMENT: (Intubation route, blade, technique, comments) DL x1 c̄ Mac 3. Grade I view VC. 7.0 OETT placed et secured @ 22 cm @ teeth. ⊕ stylet ⊕ ETCO2 sustained ⊕ BBS = soft bite block placed

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

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 8 JUL 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

TOTAL URINE: N/A

FLUIDS — SUMMARY

CRYSTALLOID — LR 1,500 cc

COLLOID — X

BLOOD — X

REMARKS — Code drugs with numbers, events with letters

1700 → Pre op completed. Plan GETA. ⊕ ID. 18g IV patent LA.

1745 in OR 1-1. Monitors on. PreO2. IV induction. Eyes taped shut. See Airway note below.

1915 Resp even / Reg. Opens eyes. Airway reflexes intact. TV > 500. Oral suction. Extubated c̄ pos pressure breath. Spont resp ensue.

1920 To ICU for recovery via litter. VSS. Report to ICU staff.

RECOVERY AT 1920

PACU (ICU) (Specify)

OTHER T = 97.6

CONDITION: Stable

RESP — 22; SpO2 — 98%

BP — 153/74; HR — 110

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1700	1745	1925
	Ready	Begin	End
PROC	1753	1810	1915

*U.S. GPO: 2002-729-180/4013

ANESTHESIA PLAN OF CARE PREPROCEDURE

Age 12 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Wash-out (R) lower leg
SURGICAL SERVICE: ORTHO
NPO SINCE: ?

ASA Physical State (1) 2 3 4 5 E
WT: 45 (KG)/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: ?
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) Tet
( ) MSO4
( ) ____
( ) ____
( ) ____

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

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

135 | 106 | 13 (172
4.4 | 22 | 1.1

15.8) 12.9 < 422
42.3

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

UNKNOWN

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 135/64 HR 85 R ___ T 99.4
Pain Scale 0-10 ____
HEENT - Teeth ____ intact
Trachea ____ midline
TMJ/Neck ____ FROM
Oropharynx ____ MPI
Nares ____
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: MAEW
IV Access: #18 (L) Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: (b)(6)-2 Date: 7 July 03 Time: 0830 Hrs

Patient Identification: (Ward) ____

(b)(6)-4

SEDATION KEY:

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

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

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

SEX (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: ______
SURGICAL SERVICE: Ortho - (b)(6)-2
2400 7/7 NPO SINCE: Debridement & D/C RLE wounds

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: ?

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g q 8hr LD 1400
( )
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
6 Jul. HB/HCT: 11.8 / 36.2 plt 326
U/A: ______
OTHER: ______

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y — Unknown
- Bronchitis/URI N Y
- COPD N Y — Ø interpretor available.
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological:
- Pregnancy N Y

Other Significant Hx:
- N Y (R) LE shrapnel wounds
- N Y

Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Debride RLE SULL + GETA ?comp

PHYSICAL EXAMINATION 98% RA
BP 130/58 HR 72 R 18 T 99.9
Pain Scale 0-10 ______
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck FROM
Oropharnyx MPI
Nares Patent
CHEST: CTA (B)
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (L) A 18g.
Ulnar Filling:
BACK:
OTHER:

NPO Since 2400 7/7/03

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

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

The pati (b)(6)-2 o understand and agrees. Questions answered.
Signed: (b)(6)-2 CRNA Date: 7/8/03 Time: 1700 Hrs

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

Signed: ______ Date: ______ Time: ______ Hrs

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

Patient Identification: (Ward) ______

(b)(6)-4

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
R Leg (R) femur. Pelvic	M	W/S	(b)(6)-4	EMT	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* Dr (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2			MAT/AW	DATE REQUESTED 7 July 03

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

GSW/shrapnel to (R) Leg

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
7 July 03		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

[PATIEN]T IDENTIFICATION

[redacted]

	DATE OF ORDER / TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
	DATE OF ORDER 5 Jul 03 — TIME OF ORDER 0615 HOURS	[redacted]
①	Admit to ICW pre op.	Noted & transcribed
②	Dx mult frag wnds (R) leg.	
③	Cond Stable.	
④	VS q shift.	
⑤	CBC on arrival. done	[redacted]
⑥	NKDA.	
⑦	NPO pre op.	

[NUR]SING UNIT | ROOM NO. | BED NO.

[PAT]IENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
	DATE OF ORDER 5 Jul 03 — TIME OF ORDER 1315 HOURS	
✓	ADMIT TO EMANUELLE ICW	
✓	DX RLE FRAGMENT WOUNDS	noted 5 July 03 @ 1645
✓	COND STABLE	[redacted]
✓	VS ROUTINE	
✓	ACT - EPW STATUS - OOB ↑ TID c̄ APPROPRIATE GUARDING	
✓	NKDA	

[N]URSING UNIT | ROOM NO. | BED NO.

[P]ATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
	DATE OF ORDER — TIME OF ORDER HOURS	
✓	REG DIET	
✓	LAB - CBC IN AM	
✓	LR @ 75CC/HR, HEP LOCK WHEN PO OK	
✓	MEDS ANCEF 1GM IV q8°	
✓	MS 2MG IV q15' PRN UP TO 16MG in 4°	
✓	PERCOCET 1-ii PO q4° PRN	
	TYLENOL 650MG PO q4° PRN	
✓	IS q1° W/A	[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
	DATE OF ORDER / — TIME OF ORDER HOURS	[redacted]
	[illegible] chart check	
	06 July 03 [illegible] 24° chart check	

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

DA FORM 1 APR 79 4256

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	LIST TIME ORDER NOTED AND SIGN
7 JUL 03 0700	____ HOURS	(b)(6)-2
NPO PMN		
		(b)(6)-2
		(b)(6)-2
		7/7/03 0750
24° chart ✓ 8 July 03 @ 0334		(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
8 JUL 03 1930	____ HOURS
ADMIT CBC CMP ANTERIOR	
✓ DO NOT FRAGMENT WARFARIN	
✓ CONSULT SOCIAL WORK	
✓ VS ROUTINE	
✓ ACT FOR STATUS - UP 2 TID -	
WHAT'S P.T.	
NWA	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
✓ NPO DIET	____ HOURS
✓ NS @ 75cc/HR PRIOR WHEN PO D/C	
✓ ANCEF 1 GM IV Q8° x 9 DOSES	
✓ TYLOX / PERCOCET 1-2 PO Q 4-6° PRN PAIN	
✓ MS 2MG IV Q15' PRN UP TO 12 MG / 4HR	
✓ VS Q1° W/A	
✓ MS 6MG IV NOW ← done 0425	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	____ HOURS
24° chart ✓ 10 July 03 @ 0400	
3 JUL 03	
D/C IN AM tomorrow	
NKDA CONTRA #20	
FLY BAG FOR SUTURE REMOVAL IN	
1 WK	

NURSING UNIT | ROOM NO. | BED NO.

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

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. ___

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13	14
5July03	(b)(6)-2	LR @ 75cc/hr	06	✓	✓								
		Heplock w/ KCl & PO	14	✓	✓								
		Hydrated	22	(b)(6)-2									
5July03	(b)(6)-2	Ancef 1gm IV Q8	06		(b)(6)-2								
			14		(b)(6)-2								
			22		(b)(6)-2								
6 Jul 03	(b)(6)-2	Heplock flush Q8hrs	6	✓	(b)(6)-2								
			14	(b)(6)-2									
			22		(b)(6)-2								
8 July 03	(b)(6)-2	LR @ 75cc/hr	06	✓	✓	✓	✓	(b)(6)-2					
		PO intake	14	✓	✓	✓	✓						
			22	✓	✓	✓	(b)(6)-2						
9 Jul 03	(b)(6)-2	Heplock flush Q8	6	✓	✓	✓	✓	✓	(b)(6)-2				
			14	✓	✓	✓	✓	(b)(6)-2					
			22	✓	✓	✓	✓	✓	(b)(6)-2				

Heplocked See below

DCD

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

RLE Fragment 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.

USAPA V1.0

7

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. July Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Labs: CBC in A.M	6 July	0600	0400	(b)(6)-2
7	(b)(6)-2	NPO p MN	8 July	0001	done	(b)(6)-2
13		DC to MP custody: Meds Lortab #20. F/U	13 July	TOD		
		BAS for suture removal in 7 wk.				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
5 July	(b)(6)-2	MSO4 2mg	25 July 1244 7 July 1744 7 July 2030 8 July 2in 8 July 2in 8 July 2in 8 July 1144 0820 1200 0930 1030
		IV Q15min PRN	7 July 1744 (b)(6)-2 7 July 1744 (b)(6)-2 10 1045 (b)(6) 10 1140 (b)(6) 10 1155 (b)(6) (b)(6) (b)(6)-2
		up to 16mg in 4°	
5 July	(b)(6)-2	Percocet 1-2 tabs	Dawn PO 7 July 0030 7 July 0420 7 July 1930 8 July 0430
		PO Q4 PRN	PO 1845 (b)(6)-2
5 July	(b)(6)-2	Tylenol PO	Dawn 1845
		650mg PRN Q4	1½ (b)(6)-2
8 July	(b)(6)-2	Tylex 1-2 tabs PO	
		Q4° PRN	

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 July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED X	5	6	7	8	9	10	11	12	13
5 July 03	(b)(6)-2	Routine VS	06	/	(b)(6)-2								
			14	/	(b)(6)-2								
			22	(b)(6)-2									
5 July 03	(b)(6)-2	Activity: EPW	06	/	(b)(6)-2								
		status: OOB TID	14	/	(b)(6)-2								
		w/ guard.	22	(b)(6)-2									
5 July 03	(b)(6)-2	Reg Diet	06	/	(b)(6)-2								
			12	/									
			18	(b)(6)-2									
5 July 03	(b)(6)-2	IS: Q1° while Awake	06	/	(b)(6)-2								
			14	/									
			22	(b)(6)-2									

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: RLE Fragment 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. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr._____
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5Jul (b)(6)-2	Admit to ICW c/o Dr. Granville				(b)(6)-2
5Jul	Dx: RLE Fragment Wounds				
5Jul	Condition: Stable				

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

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

OTSG APPROVED *(Date)*

Date: 8 Jul 03 | Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1920

Allergies: NKDA | OR Intake: Crystalloid 1.2. 1000 | Colloid | Ancef 1gm @ 1748 1748

Pre-op V/S: 160/90 | OR Output: UOP 0 | EBL minimal

Procedures: Debridement sharp @ leg | Meds/Times: Img versed Succ 100mg 250mg Fent Morph 10mg in OR

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

Time	1925	1930	1935	1940	1945	2000	2015
SaO2	98%	100%	100%	99%	98%	98%	99%
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	26	28	20	18	16	20	18
T	97.8			98.4			
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1925	LR	1000cc	LFA	S. Smith	100ml

X-rays: | Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S: X = A-line BP; ' = Cuff BP; = Pulse

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

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

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

(Continue on reverse)

(b)(6)-2 | SFTPWM6 | DEPARTMENT/SERVICE/CLINIC: TCU | DATE: 8 Jul 03

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1925	8	6mg MSO4	IV	relief	E	[b](6)-2 IVT Tech

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	√	+	P	brisk	W	PK
15'	(R) leg	√	+	P	brisk	W	PK
30'	(R) leg	√	+	P	brisk	W	PK
45'							
60'							
90'							
D/C	R/leg	+	+	P	brisk	W	PK

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Gauze (R) leg	Kerlix	CDI T
30'	(R) leg	Gauze/kerlix	CDI I
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1925	NSR	no	

WAMC OP 173-E

NURSING NOTES

1925 Client from OR c CRNA & RN via litter and gurney - Pale ox 98% RA IVF infusing into (L) hand patent c S/Sx of infiltration 1 L/hr LR T 6mg MSO4 for pain - P MSO4 pt resting calm and cooperative. Lungs clear bilat, abdomen flat, hypoactive BS x 4 quads guarding when toe to right foot is touched, right pedal pulse weak but palpable. cap refill brisk. [b](6)-2

2000 client resting quietly. Pulse ox 96% on RA, pain to right foot DT. [b](6)-2 IVT

2020 Report given to SN [b](6)-2 in ICU [b](6)-2 IVT

2025 Transferred to ICU on litter c two assists [b](6)-2 IVT

Discharge Criteria:
Date: 8 Jul 03 **Time:** 2025 **PARS:** 10
BP: Sys: 100 ~~Dia:~~ **HR:** ~~RR:~~ **Sa02:** 96%
Pain Level at D/C (0-10):
Intake: 100 ml **Output:** 0
Additional Data:
Transferred To: ICU
Report Given To: SN [b](6)-2
Transferred Via: WIC / Litter / Gurney / Ambulance
Transferred By [b](6)-2 IVT
Cleared IAW Recovery Room SOP R-3
Charge Nurse Signature [b](6)-2 IVT

(b)(3)-1

Code.)

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

3. REGISTER NUMBER (b)(6)-4

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
1	9	8	4	0	1	0	1

7. AGE AT ADMISSION

27	28	29
1	9	4

8. RACE: 30 = X

9. ETHNIC: 31 = 9 (BACKGROUND)

RELIGION: UNKNOWN

10. LENGTH OF SERVICE: 32 | 33 | 34

ETS: NA

11. FMP: 35 = 9, 36 = 9

12. SOCIAL SECURITY NUMBER

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

ORGANIZATION (Active Duty Only): NA

13. MARITAL STATUS: 46 = U

HOUR OF ADMISSION: 0615 ~~0530~~

BRANCH / CORPS: NA

14. FLYING STATUS: 47 = N, 48 = A, 49

15. BENEFICIARY CATEGORY: 50 = K, 51 = 7, 52 = 8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
0	9	3	2	3	0	0	0	0

17. UNIT LOCATION (State or Country Code): 62 = N, 63 = A

18. MOS: 64 = N, 65 = A

19. TRAUMA: 71

PREV. ADMISSION: YEAR [ ] [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 = 0

WARD: ICW

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 = 2 4

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	7	1	3

24. CLINIC SVC - ADMITTING

89	90	91	92
A	A	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	7	0	5

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 | 108 = 1 2

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

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

FOR LOCAL USE

DX: MULTIPLE SHRAPNEL RIGHT LEG

DX 8901
E9912
Proc 8628
Trauma 1
FNJ 450 G9K

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

(b)(6)-2 LTC, MC

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

~~PFC, 91G~~

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

(b)(3)-1

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4					NO	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M						NO	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
99	(b)(6)-4					ICW	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
NO		K78				BI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0535	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TRANSFER	13 JUL 03

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

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

MULTIPLE SHRAPNEL WOUNDS AND GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX:RIGHT QUADDRICEP GSW

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER

(b)(6)-2 LTC, MC (b)(6)-2 (b)(6)-2 SSG, NCOIC PAD

DA FORM 3647, MAY 79 EDITIO USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

35 Y/O IRAQI ♂ ENGAGED @ MN BY US FORCES c̄ EXPLOSIVE DEVICE (? MK 19) WHEN POINTED WEAPONS WHILE UNDER OBSERVATION. INITIAL STABILIZATION @ ~~BAS~~. GROUND EVAC FROM SAMARRA. RCVD Td & ANCEF IN ED

PMH [illegible]
PSH
ALL NKDA
HABITS Ø
MEDS ZANTAC
ROS -

UNKNOWN @ INITIAL EVAL
2° NO TRANSLATOR

PHYSICAL EXAMINATION

NAD ♂ APPEARING ~~MID~~ 30'S
HEENT AT
CHEST CTA   NECK NT FROM   BACK NT Ø WOUNDS
COR RRR s̄ (M)
ABD SOFT NT c̄ MASS s̄ HSM OR MASS
EXT - BUE AT LUE AT RLE c̄ 2CM ~~POST~~-LAT THIGH WOUND. LARGE ANT THIGH WOUND (~15CM) c̄ EXTRUDED QUADRICEPS. DP & PT SYMMETRIC (B)
UNABLE TO COOP c̄ NEURO EXAM

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

XR Ø FX FEMUR c̄ SCATTERING METALLIC DEBRIS IN ANT SOFT TISSUES
A - FRAGMENT WOUND (R) THIGH
P - DEBRIDE IN O.R.

(b)(6)-2 [redacted]
LTC, MC
...OPEDIC SERVICE

(b)(6)-2	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	5 JUL 03		

(b)(6)-4 [redacted] ... or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-4 [redacted]

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

(b)(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 JUL 03	PREOP DX - HIGH ENERGY GSW/FRAG WOUNDS (R) QUADRICEP
1130	POSTOP DX SAME
	PROCEDURE DEBRIDEMENT (R) THIGH WOUNDS
	SURGEON CHANDLER
	ANES COSTA KEIBLER
	FLUIDS 1 L LR EBL 100 cc SPEC DENTATED MM
	DRAINS KCI VAC CX Ø
	FINDINGS ENTRY 2 CM UNDER LAT THIGH TOURN
	VL - LARGE EXIT TRACT VM - NEAR 100%
	TRANSECTION OF QUADRICEPS MOST GROSS
	DEBRIS - Ø FX
	TO ICU FOR MEDICAL STABLE
	PLAN - REDEBRIDE & CLOSE IN 72° - IV ABX
	CEFAZOLIN/GENT.
5 Jul 03	Nursing: Post-OP patient received from ICU. (+) BS, mag CTA,
1545	Verbalized no pain, drowsy, IV infusing w/o problem, foley d/c.
	drsg (R) leg from thigh to ankle, Ø drainage, intact. Contin to monito

(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.

PROGRESS NOTES
Medical Record

(b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6 July 03 1600	Nursing assessment: Pt stable at this time. Sleeping but arousable. PERRLA. Lungs CTA bilat. NSR. Abd soft, non-tender bowel sounds active x 4 quads. Strong pulses and brisk cap refill x 4 extremities. (R) leg dsg CDI. No complaints at this time. (b)(6)-2 WT/AW
6 JUL 03	S I'D PAIN. INFLAMMATION O VSSA DSG INTACT, NVI DISTALLY 138 Pt. 1109 100 28 9/1.0 115 7.0 Kg. 1 115 24.6
	A DOING WELL. HEMANGIOMA/AVM. P TRANSFUSE IN ANTICIPATION OF FURTHER BLOOD LOSS AT DEBRIDEMENT 8 JUL 03.
6 Jul 03 1600	Nursing: Shift Assessment Pt. with even clear resp. this shift, Shallow at time, encouraged IS, temp. peaked at 100.5 during blood transfusion which was not far from baseline. No ↑ in pulse rate or BP, BS (+), voided clear yellow >30cc per hour all shift. (R) leg with Dressing + Dcont amount of serous drainage, Dsg remains intact. Able to wiggle toes & feel sensation of (R) foot. (R) LE pulse pedal + dorsal intact. Transfused 2 units Wb w/o incident see SF518. Pain X this shift. Continue to assess for changes in temp., Pain, drainage at site (b)(6)-2 PT AW

STANDARD FOR ... BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
8 JUN 03	OP NOTE
1715	PREOP DX - (R) THIGH GSW C QUADRICEPS TRANSECTION - NEAR COMPLETE
	POST-OP DX SAME
	PROCEDURE - DEBRIDEMENT (R) THIGH GSW C QUADRICEPS REPAIR & IPC
	SURG GRANDVILLE
	ANES GEN ICOBLOCK
	FLUIDS 700 CRYST. EBL 50
	DRAINS JP (R) THIGH
	SPEC Ø CX Ø
	FINDINGS - CLEAN WOUND C NON NONVIABLE MUSCLE & GROSS DEBRIS - 90% DIVISION OF QUAD @ MID PORTION.
	TO ICU TO RECOVER STABLE

(b)(6)-2

[redacted] (b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

(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

(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

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 July 03	RN shift assessment: Pt came back from surgery
@ 0250	at approx 1800. Appeared somewhat
	sedated. Has leg bandage from upper
	(R) thigh to ankle which is CDI.
	VSWNL. Did not ask for pain meds
	during this shift. Has appeared to
	be asleep most of the shift. Resps
	even + unlabored + BS are clear — (b)(6)-2
0543	Addendum: JP has 8cc of red fluid —
	(b)(6)-2
9 JUL 2003	Nursing Assessment: Pt awake, ø C/O pain, hungry
0816	CTA, (R) BS X4. Pt had BM x 1 of soft brown stool. (L)LE
	T drsg CDI, JP intact T 3cc sero-sang. fluid. (R)ft
	T brisk cap refill, BLE cool to touch — ICT (b)(6)-2
9 JUL 03	POD 1
0940	S LOCAL PAIN
	O VSSA HCT 30
	JP MIN - DRIED Cr 0.7
	FOLEY D/C'D
	A STABLE
	STAPLES OUT SCD'S/TED'S & CAST ON POD 5
	(b)(6)-2 (b)(6)-2
	(Continue) ORTHOPAEDIC SERVICE

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

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
9 Jul 03	Nursing: JP drain removal: Pre-medicated pt c 2mg
1000	MSO4. Ø sutures holding JP. Remove bulb & pulled
	tubing. Tubing s cut across holes, MD verify tubing
	intact. ———— (b)(6)-2 [redacted] (b)(6)-2 [redacted] AN
9 Jul 03 1455	Nursing: Vitals. Pt temp ↑ to 101. bedside US IS
	IS. Will recheck pt temp ———— (b)(6)-2 [redacted] AN
9 Jul 03 1603	Nursing Tem. Pt temp remain 101.3 ↑ IS use. Will give
	tylenol † tab po & continue IS & fluids ———— (b)(6)-2 [redacted]
9 July	Nursing assessment: Pt stable at this time. AAOx3
1800	PERRLA. Lungs CTA bilat. NSR and soft, non-
	tender, bowel sounds active x4 quads. Pt
	eating well. Strong pulses and brisk
	cap refill x4 extremities. Moving (R) leg
	and toes well. Ambulated hall with
	PT using crutches. Voiding sufficient
	amts clear yellow urine to urinal. (b)(6)-2 [redacted]
2000	IV heplocked, tolerating po well. (b)(6)-2 [redacted]
10 0600 July 03	Nursing Assessment: Awake, alert, Ox3. Airway intact, breathing even & unlabored, LS clear
	to all fields (B). Abd soft, nontender, s distention. Voids spontaneously. (B) UE & (L) LE
	FROM and neurovascularly intact. (R) LE neurovascularly intact but ROM limited by splint
	c ACE. Drsg to RLE C/D/I. IV to (R) FA s s/s infection or infiltration. ~~Alt for OR 6~~ error
	(b)(6)-2 [redacted]
11 July 03	Nursing assessment: Pt has not c/o pain
0300	this shift, has spent the majority resting quietly
	or sleeping. Good cap refill to Rt toes. Still
	has difficulty adjusting self in bed. VS WNL
	resps even + unlabored ... to ...
	(b)(6)-2 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
11 Jul 03	POD 3 S NO C/O O VSSA WBC CV N HCT 29 NVI INTACT A STABLE P STAPLES OUT, STEINMANN, & CAST ON POD 5 OR 6 (b)(6)-2 (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE
11 Jul 03 1700	Nursing: Shift Assessment Pt alert this shift, Responding to verbal stimuli, 0 % pain this shift. @ leg dsg./ace dt.d. No S/S of infection. heplock in @ arm infiltrated, received new one. No major Changes. Lungs CTA, BS active, CONTD to monitor. (b)(6)-2 CPT
12 July 03 0030	NSG Shift assessment: Pt has spent majority of the shift resting/sleeping quietly in bed. Did not require pain meds this shift. IV area is CDI. Pt VS WNL (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.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
12 Jul 03 1438	Nursing: Assessment Pt. alert, quiet, use non verbals for communication. Required multi-sticks for blood draw this am. (R) arm tenderness from previous IV. Received pain med x2, IBM this shift. VSS. No resp. distress. Ambulated x2, apply slight pressure to (R) leg. C/o (L) leg/knee pain while interpreter was here. Will let physician know. No significant changes in (R) leg size, ∅ edema in (L) foot, able to wiggle toes. Continue to monitor. (b)(6)-2 CPT AD
12 Jul 03	-2100- ASSESSMENT A&O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR. ∅ COMPLAINTS OF PAIN. VSS - OOB AMBULATING ̄c CRUTCH ASSISTANCE. TOLERATED REG DIET. GIVEN ZANTAC 150mg PO. WILL CONTINUE TO MONITOR (b)(6)-2 SGT LPN
13 0600 July 03	NURSING ASSESSMENT: Pt alert, awake, or x3. Airway intact, breathing even and unlabored, LS clear to all (B). Abd soft, nontender, ̄s distention. BS ⊕ x4. Voids spontaneously. FROM to (B) UE and LLE. Neurovascularly intact to all extremities. (L) LE cast and gauze drsg to be changed to walking cast today. IV DC'd intact. (b)(6)-2 AN

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6310

MEDICAL RECORD	PROGRESS NOTES
DATE 13 JUN 03	NAR SUM ADMITTING & D/C DIAGNOSES- GSW (R) THIGH C QUADRICEPS TRANSECTION PVD PROCEDURES - 5 JUN 03 WOUND DEBRIDEMENT 8 JUN 03 QUADRICEPS REPAIR & DERMOFIX PRIMARY CLOSURE CLINICAL RESUME- THIS 35 Y/O IRAQI MALE SUSTAINED A HIGH VELOCITY GSW TO (R) ANT. THIGH BY US FORCES AS HE ATTEMPTED TO ENGAGE THEM. PE SHOWED 4CM LAT ENTRANCE & >15 ANT EXIT WOUNDS C TRANSECTION OF THE QUADRICEPS BUT NO FX. PMH SIGNIFICANT FOR PUD FOR WHICH HE TAKES ZANTAC HOSPITAL COURSE - UNDERWENT UNCOMPLICATED DEBRIDEMENT C QUAD REPAIR & DFC 3D LATER ABX D/C'D ON HD 7. STAPLES REMOVED & LONG LEG CAST PLACED ON DAY OF D/C. DISPOSITION D/C IN MP CUSTODY ACT - WBAT F/U - ORTHO FOR CAST REMOVAL 3wk MED - VICODIN 7.5 1 PO Q4° PRN ZANTAC 150 PO BI (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

(b)(6)-2

ES

(b)(6)-4

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR [illegible]
CFR)

USAPPC V1.00

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06July03 1800	Nursing assessment: Pt Stable at this time. AAOx3. PERRLA. Lungs CTA bilat. NSR. Abd soft non-tender, bowel sounds active x4 quads. IV to (R) bicep pt flushing easily. Ate 50% of meal, tolerated well. Encouraged PO fluids. IS used x10 qhrs while pt awake. Strong pulses and brisk cap refill x4 extremities. (R) leg w/ drsg from toes to groin. Old drainage noted and marked to drsg. Percocet effective for pain. Ø complaints. (b)(6)-2 ICU/AN
070650 July 03	Nursing Assessment: Pt is awake, alert, Ox3. Airway intact, breath even and unlabored, LS clear to all fields, Abd soft, non-tender & distended. Pt moves spontaneously, ROM and neurovascularly intact to (R) UE and (L) LE. (R) LE limited ROM 2° drsg & wound. (R) LE dressed c gauze & ACE from ankle to mid-thigh, CDI. Neurovascularly intact to RLE. IV to (R) bicep flushes well & is s/s of infiltration. (b)(6)-2 ICU/AN
7 JUL 03 0800	S NO C/O O VSS A HCT 28.4 WBC 10.7 Cr 0.8 DSG C SCANTY DRAINAGE NM DISTALLY A STABLE P DPC TO MORROW (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*
(b)(6)-4
(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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 July 03 @ 0130	RN shift assessment: Pt was OOB x 1 this shift (to bedside chair x 30 minutes), Pt appears to be in pain when moving. Denied any need for pain meds upon being put back into bed. Linen was changed. Pt tolerating PO well. Voiding w/ difficulties. Circulation to left foot is WNL. Will continue to monitor [redacted] (b)(6)-2
8 July 03 0800	PIV INFILTRATED, 20 ga PIV cath placed in (L) FA. Patency WNL. [redacted] (b)(6)-2 SPC/LRN
8 0830 July 03	NURSING ASSESSMENT: Pt is awake, alert, Ox3. Airway is intact, breathing even and unlabored, lung sounds clear to all fields (B). Abd soft, nontender, + bowel sounds. Pt NPO for OR. BSO x 4. Voids spontaneously. AROM and neurovascularly intact to (R) UE and (L) LE. (R) LE has splint & gauze and ACE wrap from ankle to mid thigh. Neurovascularly intact to (R) LE but ROM limited by splint & ACE. Dsg to RLE is CDI. IV to (R) FA flushes well & is s/s infection or infiltration [redacted] (b)(6)-2 SPC/LRN

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY: (b)(3)-1 Iraq
RECORDS MAIN

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M | AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

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

ARRIVAL

DATE *(Day, Month, Year)*: 5 Jul 03 | TIME: 0500

TRANSPORTATION TO FACILITY: Ground Evac

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (R) Femur Fracture

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0510

INITIAL: (b)(6)-2

VITAL SIGNS

TIME	0510	0540			
BP	126/75	131/72			
PULSE	74	69			
RESP	14	14			
TEMP	99.6	99.9			
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100%
☐ MONITOR
☐ ECG

TIME	ORDERS	BY	COMPLETED BY
0510	CBC, Chem 12, LFT	(b)(6)-2	(b)(6)-2
0510	FOley		
0510	UA		
0520	5mg Morphine		

TIME	PATIENT'S RESPONSE
0520	Tetanus 0.5cc (b)(6)-2
0530	Ancef 1g (b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(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

MEDICAL RECORD | **(Doctor)** | 0500

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

(S) EPW & clo GSW ® Femur Fracture, Injury was at approx. 12 midnight. Traction splint applied.

S: Pt is ~30 yo Iraqi EPW who threw did RPG + small arms attack vs US Forces then was PMAX? shot to ® thigh c ? explosive causing ↑ fragments to lat thigh

XRay: ⊖ fx mult Prox lat thigh frags.

O: WD WN Thin. mod dist x 2 to ® thigh injury.
HEENT: WNL
Lungs: ⊖CTA
Cor RRR ⊖⊖
Abd: ⊖BS. S. NT ND ⊖ dils
EXT: Smaller post–lat ® thigh entrance c Lg muscle herniation thru ant–® thigh 2+ Pedal pulses, warm. N/V intact.
GU: ⊖ injury
Back: ⊖ injury, Sm ® at abrasion.

23.5 / 9 / 30 / 321
Yel, Clr 1.030
all ⊖.
17 / .9 / 186
LFT WL.
B ⊕
~~Cults~~
~~Tetanus Toxoid~~

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
(b)(6)-2

DIAGNOSIS
GSW vs frag wnd to ® lat thigh.

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

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

VOL MEDICAL RECORD

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

1. AGE: N/A
HEIGHT: Unk N/A
WEIGHT: N/A

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

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

4. PROPOSED SURGICAL PROCEDURE: I+D (R) Thigh WD

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition (R) Thigh WD
Tobacco Unk ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH Unk Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment N/A 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g.. warm blanket. touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids N/A 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

(b)(6)-4

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