(b)(6)-4	28	B	Sore throat	cepacol
	23	B	H/A	tylenol
	21	B	diarrhea	Loperamide
	25	B	cough	cepacol
	19	B	H/A	tylenol
	65	B	H/A / swollen tear duct	tylenol
	21	B	sinus	Sudafed
	18	B	sinus / cough	sudafed
	58	B	H/A	tylenol
	51	B	B/P ✓ 133/80 / sinus	sudafed
	45	B	sinus	sudafed
	34	B	sinus	sudafed
	42	B	leg wound	cleaned + Dressed
	31	B	sinus	sudafed
(b)(6)-4	30	B	H/A	tylenol
	30	B	H/A	tylenol
	43	B	cough	cepacol
	50	B	Sore throat	cepacol
(b)(6)-4	45	B	cough	cepacol
	64	B	Back pain	IBU
	28	B	sore throat	cepacol
	30	B	Body pain	IBU
	23	B	H/A / Sore throat	tylenol / cepacol
	26	B	Heartburn	tums/ranitidine
	22	B	ankel dressing A	A
	60	B	Back pain / sinus	IBU / sudafed
	55	D	Back pain	IBU
	26	D	knee wound	cleaned + dressed

EXHIBIT 94

[redacted]

0204-04-CID259-80242

0008-04-CID149-80190

(b)(6)-4	3B	170	Dental	Tylenol (R)
	3B	170	Dental	Tylenol (R)
	3B	170	Sorethroat/(R) pain	Motrin/Cepacol
	3B	170	Ear infection	Z-Pak (M)
	3B	169	(R) ear pain	Motrin
	3B	169	Joint pain	Motrin
	3B	169	Dental	Aspirin (R)
	3B	169	"	" (R)
	3B	169	Sorethroat/dry lips	Cepacol
	3B	169	Sorethroat	Cepacol
	3B	169	Joint pain	Motrin
	3B	169	rash	Hydrocor.
	3B	168	rash	Allegra
	3B	168	Congestion	Sudafed
	3B	167	wound (R) knee	Bacitracin
	3B	167	Dental	Aspirin (R)
	3B	167	bug bites	Anusol
	3B	167	itchy eyes	eyedrops
	3B	167	HA	Motrin
(b)(6)-4	3B	167	Kidney pain	Motrin
	3B	176	back pain	Motrin
	3B	14	Constipation/wounds	bandage

For Official Use Only

(b)(6)-4

0109-04-C1076 0204-04-C10259-00242

7 Oct 03

HT 5' 6"

WT 167

Condition * GSW (L) upper leg. Bullet still in (L) upper leg (medial side)

Meds - gave motrin 600mg + P.O. Q 4-6 hrs PRN

* changed dsg (L) upper thigh. H_2O_2 solution used to irrigate wound. Betadine swabs x 3 to clean. DSD, Kerlex and tape. Told prisoner we will check daily AT Compound P his release from Medical Hold E-Compound.

** SEND TO E-Compound Medical Hold

0043-04-C10789

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

31 May 04 — S: 42 y/o ♂ DETAINEE referred by CIT for complete physical + history. Otherwise has BP was elevated today in clinic. He denies any current chest pain, headaches or visual changes.

CC4 Minor

BP - 198/110 / 174/114

P - 107

T - 99.1

R - 18

O) WNWD ♂ NAD VS ↑ BP AFEBRILE GAIT - NL

NECK CN II - CN XII, C4 - T1 MOTOR + C1 - S2 MOTOR GROSSLY INTACT

DTRs 2+

HEENT - NL

NECK - Supple, ↓ adenopathy or thyromegaly

HEART - RRR S MURMURS

Genital - 1 cm MASS on (-) testicle "painless" x 10 yrs
SICCC BROWN HOME ALE

Rectal - NL sphincter tone NO MASSES OR HEMORRHOID.

Prostate - smooth symmetrical neg for nodules

CVT - MOVES ALL extr also equal

integumentary - NL for acute scabs, ecchymoses or lacerations

A) 1. ↑ BP 2. Painless testicular mass x 10 yrs - probable CIC

3. Otherwise NL PE

P) 1. F/U on sickcall for numbers BP checks

2. case and plan discussed with pt through interpreter (b)(6)-2 (b)(6)-2 PAC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART SERVICE	MAINTAINED AT
SPONSOR'S NAME	SSN IC NO	RELATIONSHIP TO SPONSOR	

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

NAME: (b)(6)-4

RANK:

SSN

DOB:

UNIT

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

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 APR 04	(S) 33 y/o ♂ scheduled scans to (L) shoulder
B/P 156/98	and upper (R)(L) arms. Hx hypertension and
T 98.4	tachycardia probably circumstantial. Lungs
P 100	96% SpO2 clear and equal bilaterally.
R 16	No obvious external injuries present. Vital
	signs would indicate no internal injuries
	present. States he has no allergies or
	medical conditions for which he has
	been treated.
	SGT (b)(6)-2 (b)(6)-2 (b)(6)-2
	Concern about.
	(b)(6)-2
	CPT (b)(6)-2 SP, P.A.-C

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/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

Breathing: WNL

Circulation: WNL

Other:

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
		110		98		

Transfer Instructions:

NOTES: Fit for detention

Prepared By:

SPC (b)(6)-2 91W

Primary Survey

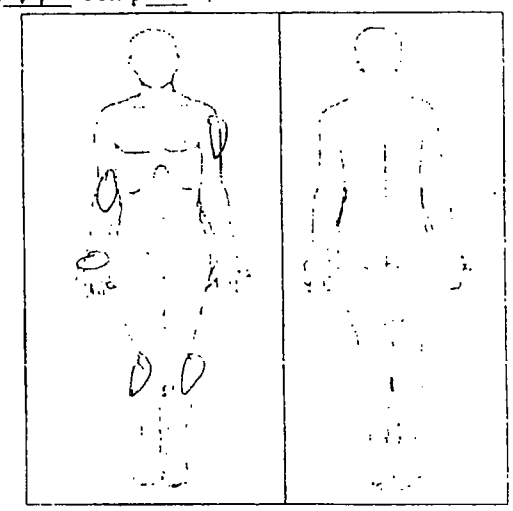
MHX: ∅
SHX: ↑ BP, Diabetic, Reflux
Meds: BP meds, Pepcid
Allergies: Hay fever

Airway: Patent / Mechanically maintained by
Breathing: Spontaneous / Assisted by
Circulation:
Pulse: Present / Absent CPR
Color: Normal / Abnormal
Cap refill: Normal / Delayed

Secondary Survey

Initial Vital Signs: b/p 84 / 125 pulse 98 Resp 18 Pulse Ox 97 Temp 98.9

HEAD ✓
NECK ✓
CHEST ✓
ABD ✓
PELVIS ✓
LEG ✓
FEMORAL ✓



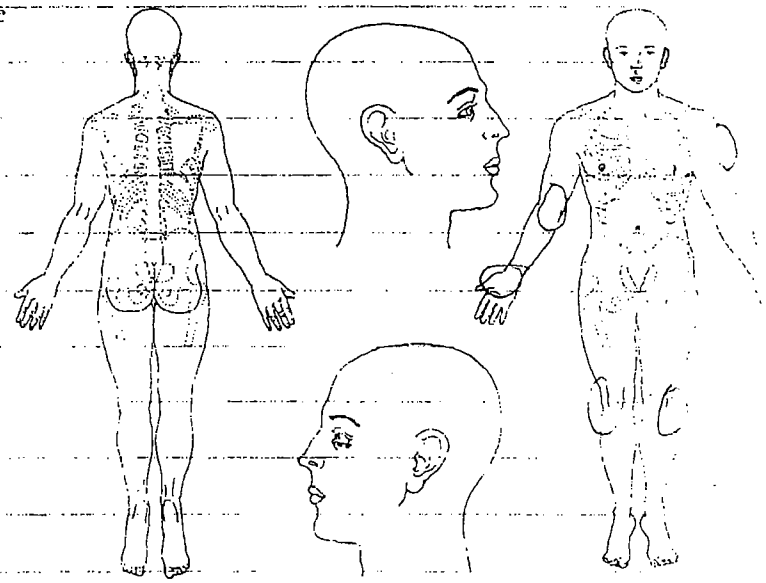
GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	15

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	12

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Apr 04	**REPORT OF DETAINEE MEDICAL SCREENING:**
(b)(6)-4	History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid D.
	Medication Allergies (NO) (YES) List -
	Current Medications: (Name/Dose/Frequency/Last Taken) (NONE) BP meds, Pepsid
	Recent Injuries: (NO) (YES) Describe - shrapnel scars to (L) shoulder upper (R) (L) Arms
	Exam Findings: BP: 184/125 Pulse: 98 Resp: 18 Pulse OX 97% T 98.9
	Utilize Diagram and Space Below to Indicate Examination Findings. If additional space required, continue on reverse



(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

Name/Rank/Unit of Screener

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART/SERVICE	RECORDS MAINTAINED
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

Detainee Name: (b)(6)-4
Last. First Middle

Control Number: 4-5 003

Date Time of Detention: 11 Apr 04

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. ...)
Prescribed by GSA/ICMR
FIRMR (41 CFR, 201-9.2...)

0232-01-C1D

Primary Survey

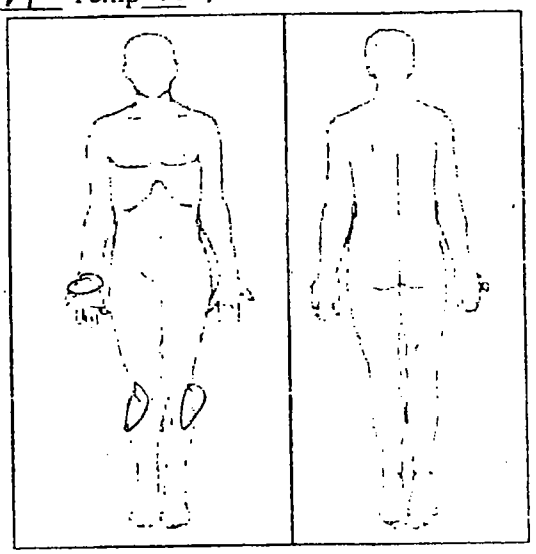
PMHX: ∅
PSHX: ↑ BP, Diabetic, Dell
Meds: BP meds, Pepsid
Allergies: Hay fever

Airway: Patent Mechanically maintained by
Breathing: Spontaneous Assisted by
Circulation:
Pulse: Present Absent CPR
Color: Normal Abnormal
Cap refill: Normal Delayed

Secondary Survey

Intial Vital Signs: b/p 84 / 125 pulse 98 Resp 18 Pulse Ox 97 Temp 98.9

GEN ✓
HEAD: ✓
NECK: ✓
HEART:
LUNGS:
CHEST:
ABD: Pain
PELVIS:
EXT:
RECTAL ✓
NEURO:



GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 min	3
	6-9 min	2
	1-5 min	1
	None	0
	TOTAL	12

70

Breathing: WNL

Circulation: WNL

Other:

Time				

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
	/					
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES: Fit for detention

Prepared By:

SPC (b)(6)-2, 91W

71

12

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE 0232-04-CRD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 APR 04	(S) 33 y/o ♂ scrapes/scars to (L) shoulder
B/P 156/98	and upper (B)(L) arms. Hypertension and
T 98.4	tachycardia probably circumstantial. Lungs
P 100 96% SpO2	clear and equal bilaterally.
R 16	No obvious external injuries present. Vital
	signs would indicate no internal injuries
	present. States he has no allergies or
	medical conditions for which he has
	been treated.
	SGT (b)(6)-2 (b)(6)-2 (b)(6)-2
	Concern about: (b)(6)-2
	CPT (b)(6)-2 SP, P.A.-C

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
USAPA V2.00

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MO:
HPI:

(b)(6)-4

C10919

Primary Survey

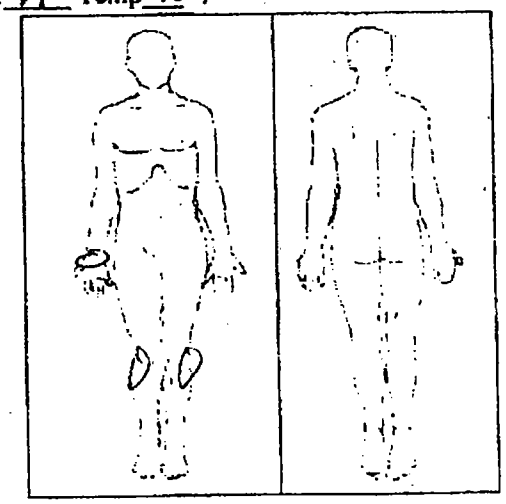
PMHX: ∅
PSHX: ↑ BP, diabetic, [illegible]
Meds: BP meds, Pepcid
Allergies: Hay fever

Airway: Patent / Mechanically maintained by
Breathing: Spontaneous / Assisted by
Circulation:
Pulse: Present / Absent CPR
Color: Normal / Abnormal
Cap refill: Normal / Delayed

Secondary Survey

Intial Vital Signs: b/p 84 / 125 pulse 98 Resp 18 Pulse Ox 97 Temp 98.9

GEN: ✓
HEAD: ✓
NECK: ✓
HEART:
LUNGS:
CHEST:
ABD: p-n
PELVIS:
EXT:
RECTAL: ✓
NEURO:



GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	12

Encl 4

56

0232-04-CID919

Time	Drug	Dose	Route	Initials

eathing: WNL

Circulation: WNL

Other:

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
	/					
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES: Fit for detention

Prepared By:

SPC (b)(6)-2 91W

Encl 4

Doc 57

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE 0232-04-CID919

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 APR 04	(S) 53 yro ♂ schrapnel scars to (L) shoulder
B/P 156/98	and upper (B) (L) arms. Hypertension and
T 98.4	tachycardia probably circumstantial. Lungs
P 100	96% SpO2 clear and equal bilaterally.
R 16	No obvious external injuries present. Vital
	signs would indicate no internal injuries
	present. States he has no allergies or
	medical conditions for which he has
	been treated. SGT (b)(6)-2 SFC A.
	Concur w above. (b)(6)-2
	CPT (b)(6)-2 SP, P.A.-C

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

USAPA V2.00

Encl 4

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0079-04-CID789

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 APR 04	(S) 33 yro ♂ scraped scars to (L) shoulder
B/P 156/98	and upper (B)(L) arms. Hypertension and
T 98.4	tachycardia probably circumstantial. Lungs
P 100	96% SpO2 clear and equal bilaterally.
R 16	No obvious external injuries present. Vital
	signs would indicate no internal injuries
	present. States he has no allergies or
	medical conditions for which he has
	been treated. SGT (b)(6)-2
	Concur above. (b)(6)-2
	CPT (b)(6)-2, SP, P.A.-C

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

USAPA v2.00

-12-

Enc 13

Time	Drug	Dose	Route	Initials

Breathing: WNL

Circulation: WNL

Other:

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
		110		98		

Transfer Instructions:

NOTES: Fit for detention

Prepared By:

SPC (b)(6)-2, 91W

(b)(6)-4

Primary Survey

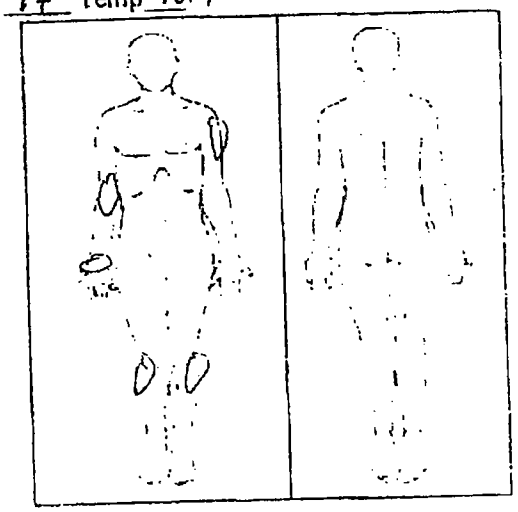
MHX: ∅
SHX: ↑ BP, Diabetic, Dell
Meds: BP meds, Pepcid
Allergies: Hay fever

Airway: Patent Mechanically maintained by
Breathing: Spontaneous Assisted by
Circulation:
Pulse: Present Absent CPR
Color: Normal Abnormal
Cap refill: Normal Delayed

Secondary Survey

Initial Vital Signs: b/p 84 / 125 pulse 98 Resp 18 Pulse Ox 97 Temp 98.9

HN ✓
HAD ✓
ECK ✓
HART ✓
LNGS ✓
HEST ✓
BD P—
ELVIS ✓
XT ✓
TOTAL ✓
NURO ✓



GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	15

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	12

For Official Use Only

Law Enforcement Sensitive

AUTHORIZED FOR REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Apr 04 @ 1108	**REPORT OF DETAINEE MEDICAL SCREENING:**

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz

Medication Allergies (NO) (YES) List -

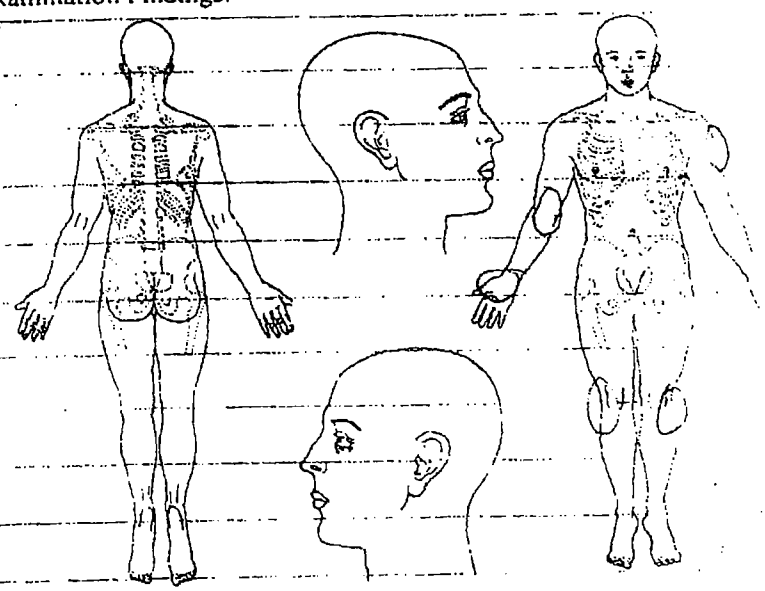
Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

BP meds, Pepsid

Recent Injuries: (NO) (YES) Describe - Shrapnel scars to (L) shoulder upper (R) (L) Arms.

Exam Findings: BP: 184/125 Pulse: 98 Resp: 18 Pulse Ox 97% T 98.9

Utilize Diagram and Space Below to Indicate Examination Findings.
If additional space required, continue on reverse



(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

Name/Rank/Unit of Screener

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART /SERVICE	RECORDS MAINTAINED
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

Detainee Name: (b)(6)-4
Last, First Middle

Control Number: 4-5 003

Date/Time of Detention: 11 APR 04

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

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Law Enforcement Sensitive

-11

Enc 3

0263-04, 0-0258-80294
0124-04-CID789

BHA MEDICAL SCREENING FORM

(b)(3)-1

CAMP CUERVO, BAGHDAD
Last Revised: 11 JUL 04

Name: (b)(6)-4
Age: 19
Date/Time of Exam: 28 July 2004
Type: Initial / Transfer / Release

HISTORY

Current illness: ∅

PMHX/Hospitalizations/Surgeries/TB: ∅

Allergies: ∅

Medicines currently taken: ∅

ETOH/Tobacco/Drug use: ∅

EXAM T: 98.8 P: 76 R: 12 B/P: 122/80

General: NAD WD/WN A/O x 3 VSS

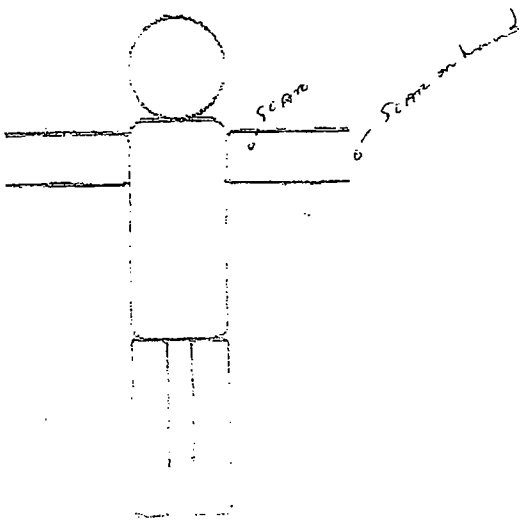
HEENT: NCAT; EOMI; PERRLA; TM mobile; Septum wnl; Throat clear

CX: CTA Bilat Lungs; Heart: RRR

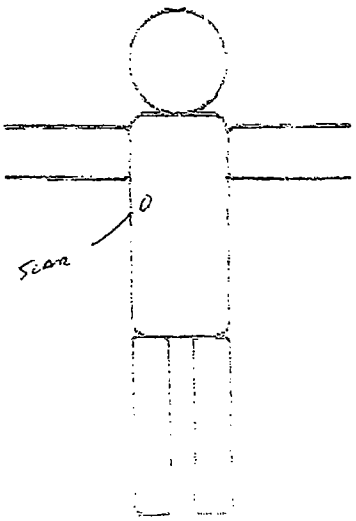
ABD: Benign

EXT: WNL

FRONT



BACK



Is this detainee fit for interrogation / transfer / release? YES / NO

Notes:

Signature: (b)(6)-2

BHA MEDICAL SCREENING FORM

(b)(3)-1

CAMP CUERVO, BAGHDAD

Last Revised: 11 JUL 04

Name: (b)(6)-4

Age: 72

Date/Time of Exam: 28 July 04 1815

Type: Initial / Transfer / Release

HISTORY

Current illness: Detainee complains of having a fever; SAYS he has no other symptoms. Detainee temperature was taken; ~~has not~~ is afebrile.

PMHX/Hospitalizations/Surgeries/TB: Ø

Allergies: Ø

Medicines currently taken: Ø

ETOH/Tobacco/Drug use: Ø

EXAM T: 98.6 P: 92 R: 14 B/P: 138/84

General: pt NAD WD/WN A&Ox3.

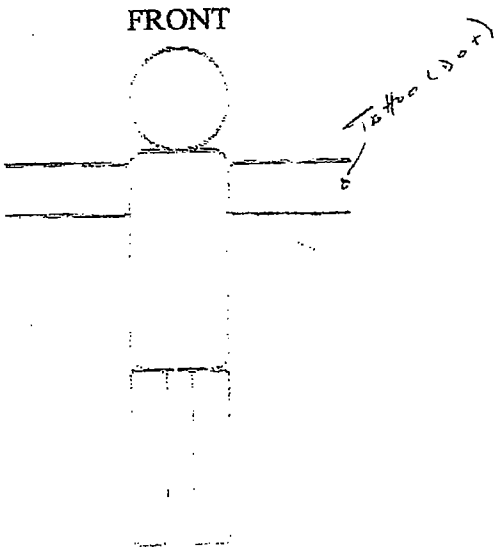
HEENT: NCAT; EOMI, PERRLA, TM mobile, septum WNL, throat clear

CX: Lungs: CTA Bilatx6; Heart - RRR

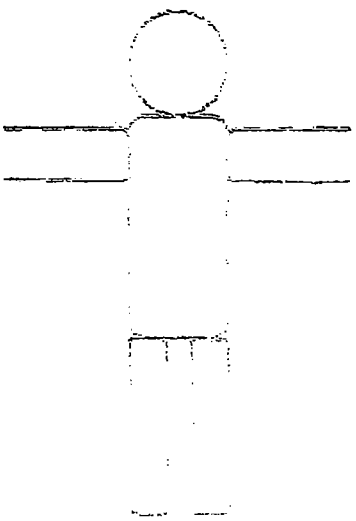
ABD: Benign

EXT: WNL

FRONT



BACK



Is this detainee fit for interrogation / transfer / release? YES / NO

History and Physical Exam Form 0262-04-CID-59-80254

Name: (b)(6)-4

Date: 30 Jul 04

ISN: (b)(6)-4

VS: BP: 135/93
Pulse: 89
Resp: 24
Temp:
Height: 5'7"
Weight:

DOB: 1930 AGE: 74

Gender: Male / Female

Complaint: Acute:

Chronic:

PMH: DM HTN STD TB
Hosp:
Surg: (R) [illegible] 1987

Medications:

Allergies: NKDA

SocHx: Tobacco Y / N ____PPDx____yrs

EtOH - NO

ROS: HEENT: → Pt reports he was struck
CV: in the (R) eye & in ABDM
PULM: he reports this was done
GI: by coalition force x 2 days
GU: ago
OB/GYN:
MS:
NEURO: Unremarkable
DERM:
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
____mm

Immunizations: (given at this time)

MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

(R) EYE (+) ecchymosis

HEENT:	Normal / Abnormal
CV:	Normal / Abnormal
PULM:	Normal / Abnormal
GI:	Normal / Abnormal
GU: NC	Normal / Abnormal
OB/GYN:	Normal / Abnormal / NA
MS:	Normal / Abnormal
NEURO:	Normal / Abnormal
DERM:	Normal / Abnormal
ENDO:	Normal / Abnormal
PSYCH:	Normal / Abnormal

Photograph

Comments / Findings:
in addition he reports being struck in the right thigh [illegible]

Impression: 1 Alleged abuse 2 Ecchymosis to (R) eye consistent
c possible trauma.

Plan: 1 Refer to ER 2 F/U PRN 3 [illegible]
Plan discussed @ length c pt through interpreter

Provider Signature: (b)(6)-2

Printed Name / Stamp: (b)(6)-2 PA-C
1LT, SP USA

Exhibit #6
59

History and Physical Exam Form

Name: (b)(6)-4

Date: 30 JUL 04

ISN: (b)(6)-4

VS: BP: 143/79
Pulse: 79
Resp: 14
Temp:
Height: 5'10"
Weight: 71K

DOB: 1984 AGE: 20

Gender: Male / Female

Complaint: Acute:

Chronic:

PMH: DM HTN STD TB
Hosp:
Surg: None

Medications: None

Allergies: None

SocHx: Tobacco Y/N
_____PPDx_____yrs

EtOH – None

ROS: HEENT: – Pt reports he was struck in the head with the butt of a weapon by coalition forces in addition he was kicked in the head.
CV:
PULM:
GI:
GU:
OB/GYN:
MS:
NEURO:
DERM:
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
_____mm

Immunizations: (given at this time)

MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

Posterior (L) ecchymosis on (L) temporal aspect

HEENT:	Normal / Abnormal	
CV:	Normal / Abnormal	
PULM:	Normal / Abnormal	
GI:	Normal / Abnormal	
GU: NE	Normal / Abnormal	
OB/GYN:	Normal / Abnormal	NA
MS:	Normal / Abnormal	
NEURO:	Normal / Abnormal	
DERM:	Normal / Abnormal	
ENDO:	Normal / Abnormal	
PSYCH:	Normal / Abnormal	

Photograph

Comments / Findings:

Impression: 1. Alleged Abuse 2. (L) ecchymosis on (L) temporal aspect consistent c Trauma

Plan: Ref to CID ? F/U PRN

Provider Signature: (b)(6)-2 PA C

Printed Name / Stamp: (b)(6)-2 PA-C
1LT, SP USA

EXHIBIT # 9 - 60

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

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

1 Apr 04
2040
2/12 CAV

REPORT OF DETAINEE MEDICAL SCREENING:

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz

c/o abd pain while walking ~~230 minutes~~ 200300 weeks

Medication Allergies: (NO) (YES) List - started 2-3 Days ago

Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

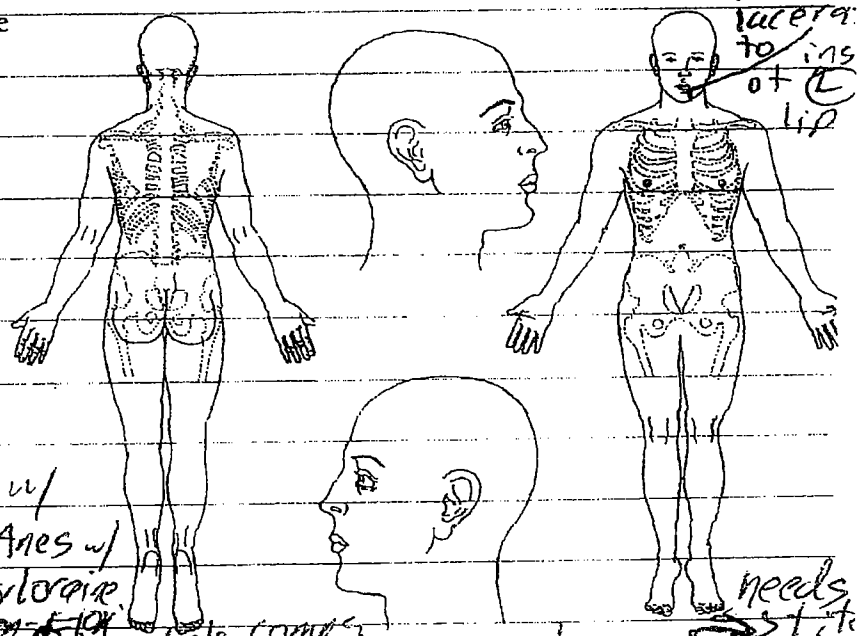
unknown med for abd pain

Ø translator available

Recent Injuries: (NO) (YES) Describe -

Exam Findings: BP: 120/100 Pulse: 88 Resp: 18

Utilize Diagram and Space Below to Indicate Examination Findings.
If additional space required, continue on reverse



.5 cm laceration to ins of L lip

4bd - S/NT/ND NABS

Procedure - sutured inner lip laceration w/ 4 stitches, 5-0 nylon. Anes w/ 2cc ~~lidocaine~~ 2% lidocaine. Sterilization - tap water + betadine. Immediate compression. Needs prescription for cauterization

needs stitches out

(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

SPC (b)(6)-2 (b)(6)-2 (b)(3)-1

Name/Rank/Unit of Screener (b)(6)-2 (b)(6)-2 CPT MC.

HOSPITAL OR MEDICAL FACILITY | STATUS | RECORDS MAINTAINED AT

PRISONER NAME | ISSMID NO | RELATIONSHIP TO SPONSOR (b)(6)-2

FOR IDENTIFICATION (For typed or written entries, give name, last, first, middle, if Navy SSN, Sex, Date of Birth) | REGISTER NO | WARD NO

Detained Name (b)(6)-4 Last Middle

Control Number

Date/Time of Detention:

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

HEALTH RECORD

DETAINEE PREINTEROGATION EVALUATION

DATE: 20 Apr 04

PATIENT COMPLAINT/INTEROGATER CONCERNS: PT is 56 yo O, was struck during arrest, broken front tooth + cut lip. Was taken to hospital, report filed

ALLERGIES: NKDA

MEDICATIONS: Ø

SOCHx: Tob: Ø ETOH: Ø

BP: 138/78

P: 69

R: 14

TEMP:

WEIGHT: 82 kg

O: GENERAL: Normal Abnormal

HEENT Normal Abnormal — healing laceration (L) lower lip, chipped (L) front tooth

NECK Normal Abnormal

LUNGS Normal Abnormal

CARD Normal Abnormal

ABD Normal Abnormal

EXT Normal Abnormal

PSHX: (–)

PMHX: (CIRCLE)

HTN (–)

DM (–)

TB (–)

CAD (–)

A/P: Dnl exam X as noted

Hep A, Hep B, MMR, Td: Given Patient Refused

(b)(6)-2

VMD, LT, USAF, FL

ISN: (b)(6)-4

SEX M

CAMP: Camp Cropper

DOB: 7/1/1947

STANDARD FORM 600 BACK (REV. 5-84)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

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

1 Apr 04
2040
2/12 CAV

REPORT OF DETAINEE MEDICAL SCREENING:

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz

C/O abd pain while walking ~~230 minutes~~ 200 minutes

Medication Allergies: (NO) (YES) List - started 2-3 Days ago

Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

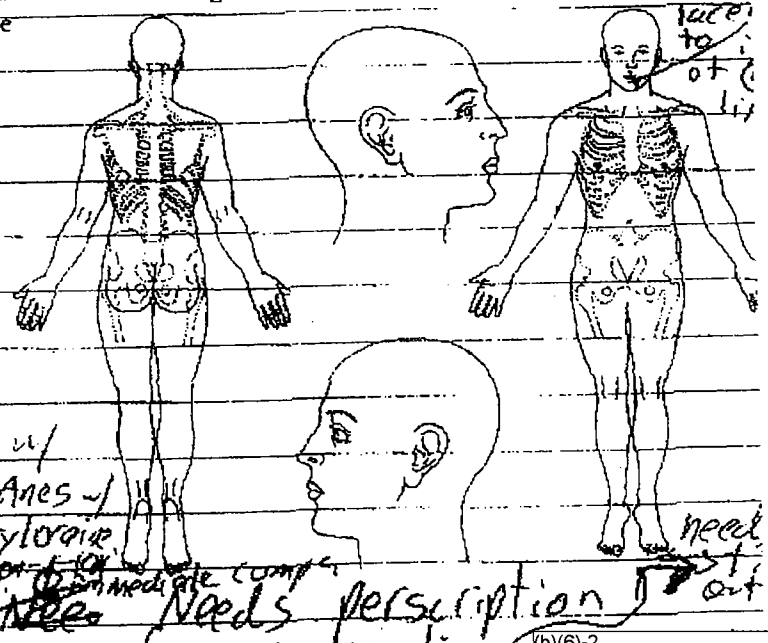
Unknown med for abd pain

Ø translator available

Recent Injuries: (NO) (YES) Describe -

Exam Findings: BP. 120/100 Pulse: 88 Resp: 18

Utilize Diagram and Space Below to Indicate Examination Findings.
If additional space required, continue on reverse



Abd - s/NT/ND NABS

Procedure - sutured inner lip laceration w/ 4 stitches, 5-0 nylon. Anes w/ 3cc 1% Xylocaine

(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

Needs perscription for cromolyn

(b)(6)-2 (b)(6)-2 (b)(3)-1 (b)(6)-2 (b)(6)-2

SPC

Name/Rank/Unit of Screener

CPT MC.

HOSPITAL OR MEDICAL FACILITY | STATUS | RECORDS MAINTAINED AT

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

Monitor for infxn

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

Detainee Information:

Name (b)(6)-4

~~Last~~ First ~~Middle~~

Control Number:

Date/Time of Detention

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

HEALTH RECORD	DETAINEE PREINTEROGATION EVALUATION

DATE: 20 Apr 04

BP: 138/78

P: 69

R: 14

TEMP:

WEIGHT: 82 kg

PMHX: (CIRCLE)

HTN (−)

DM (−)

TB (−)

CAD (−)

PATIENT COMPLAINT/INTEROGATER CONCERNS: PT is 56 yo O, was struck during arrest, broken front tooth + cut lip. Was taken to hospital, report filed

ALLERGIES: NKDA

MEDICATIONS: Ø

SOCHx: Tob: Ø ETOH: Ø

PSHX: (−)

O:			
	GENERAL:	(Normal)	Abnormal
	HEENT	Normal	(Abnormal) healing laceration (L) lower lip, chipped (L) front tooth
	NECK	(Normal)	Abnormal
	LUNGS	(Normal)	Abnormal
	CARD	(Normal)	Abnormal
	ABD	(Normal)	Abnormal
	EXT	(Normal)	Abnormal

A/P: (1) Int exam X as noted

Hep A, Hep B, MMR, Td: (Given) **Patient Refused**

(b)(6)-2

MD, US Army

ISN: (b)(6)-4

SEX: M

CAMP: Camp Cuci-6

DOB: 7/1/1947

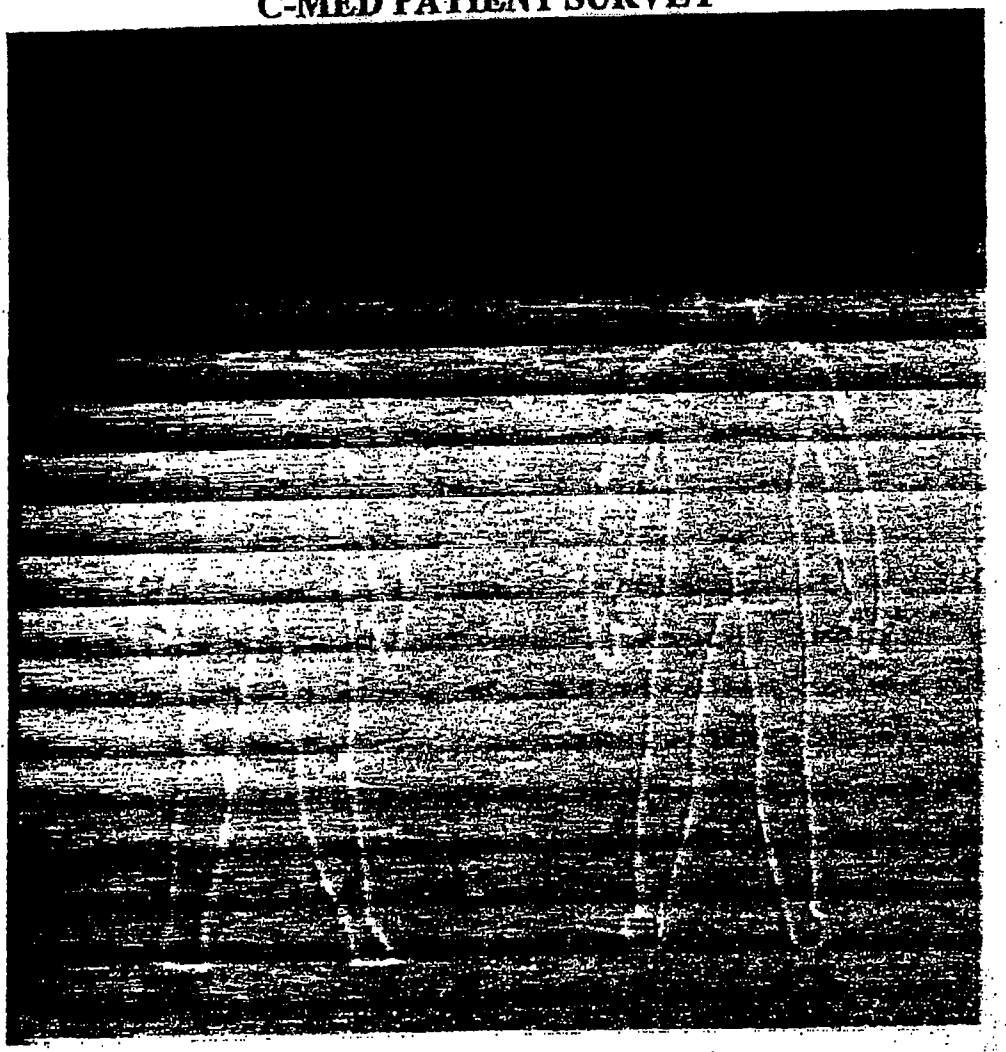
STANDARD FORM 600 BACK (REV 3-8

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

0249-04-CID259-80283
13285

0226-04-CID899-

C-MED PATIENT SURVEY



Description:

#1 - (R) wrist abrasions 2 erythema posterior/anterior
#2 - 3" linear scar @ LLQ
#3 - 1/2" linear abrasion @ scapula medial
#4 - 1/2" linear scar lateral patella
#5 - 1/2" linear scar inferior patella
#6 - 1 1/2" abrasion @ lateral ribcage ~ #4-5

SGT (b)(6)-2 91W20
Medic

(b)(6)-2 LT Pvt
MLVPA

Date/Time 07 July 04 - 1145

#7 - sm circular 1/2" x 1/2" abrasion top of nose between eyes on (L) lateral side

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
FOR OFFICIAL USE ONLY

EXHIBIT 3

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
Brigade Surgeon
(b)(3)-1

#28285
9-04-CID259-80283
0226-04-CID859

DETAINEE MEDICAL SCREENING FORM

DATE: 17 July 04 - 1145

NAME: (b)(6)-4 (b)(6)-4 AGE: 20 HEIGHT: 5'5" WEIGHT: 110 lbs

ALLERGIES: ☒ NO ☐ YES: nKDA

MEDICATIONS: none

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS DISEASES: none, ☐ OPIUM USE

SMOKER: ☒ YES ☐ NO

EXAM:

P: 88 BP: 122/82 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: PERRLA EOMI; OP clear CHEST: CTA

CV: RRR ABDOMEN: soft, nt, nD

MS: FAROM in all extremities ∅ deformities SKIN: dry, warm

DENTAL: ∅ oral trauma, teeth intact

GENERAL ASSESSMENT: Healthy male; aware of surroundings; Ready for questioning

SIGNED: SGT (b)(6)-2 91W20 (CLS, 91 W) MEDICAL OFFICER: 1LT (b)(6)-2 (MC, DC, MS)

SICK CALL:

DATE	COMPLAINT	DX/TX

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS DATE: _____

SIGNED: _____ (CLS, 91W) MEDICAL OFFICER: _____ (MC, DC, MS)

7 July 04 Pre-interrogation
530 Healthy male ∅ A's
GT (b)(6)-2 91W20
7 July 04 Post interrogation

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 3
14

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
Brigade Surgeon

284
F04-CID259-80283

(b)(3)-1

DETAINEE MEDICAL SCREENING FORM

DATE: 17 July 04 - 1114

NAME: (b)(6)-4 AGE: 34 HEIGHT: 5'5" WEIGHT: 193 lbs

ALLERGIES: ☐ NO ☒ YES: PCN

MEDICATIONS: ASA (children's), [redacted]

SGT - (L) Kidney Removed ~2 mo ago

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS DISEASES: _____, ☐ OPIUM USE GERD

(R) Kidney pt ~ 3 days

SMOKER: ☒ YES ☐ NO

EXAM:

P: 112 BP: 150/108 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: perrl, EOMI, MM dry, ∅ pharyngeal, bruising, ecchymosis, subconjunctival hemorrhage D.D. CHEST: CTA - ∅ dyspnea, good air x-Δ

CV: RRR ∅ mlg/r ABDOMEN: soft, (+) BS, (+) TTP generalized 2° being struck stab

MS: neck pt, FAROM c̄ minimal pt in UE SKIN: dry - see chart for integ assessment/scars

DENTAL: poor dentition c̄ numerous caries

GENERAL ASSESSMENT: 1) Multiple Abrasions, Contusions, Ecchymosis 2) Subconjunctival hemorrhage D. D. 3) Solitary Kidney - (R) 4) Volume depletion 5) GERD

SIGNED: SGT (b)(6)-2 91W2∅ (CLS, 91 W) MEDICAL OFFICER: 1LT (b)(6)-2 PAC, SP (MC, DC, MS) 17 JUL ∅4 1130 hrs

SICK CALL:

DATE	COMPLAINT	DX/TX

17 JUL ∅4 - ? initial assessment, with UA & initiate IV NS x 2 liters slowly - dx solitary kidney, volume depletion & multiple areas of ecchymosis. Rx: Tylenol 325 mg PO q 6 hrs, also Rx: Zantac 150 mg po QD ? Turns pcu - (b)(6)-2 PA
18 JUL ∅4 - 0730 hrs re-assessed pt - generalized discomfort 2° multiple contusions, started IV AP since yesterday - (b)(6)-2 PAC, SP

:25 21 July - MI (PR) DETAINEE IN GOOD CONDITION SP[redacted] Rx[redacted]
:05 21 July POST MI (NO CHANGE IN HEALTH STATUS

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS DATE: _____

SIGNED: _____ (CLS, 91W) MEDICAL OFFICER: _____ (MC, DC, MS)

Fu 04
Re-Int. - No change [redacted]
1st Int - No Change [redacted]

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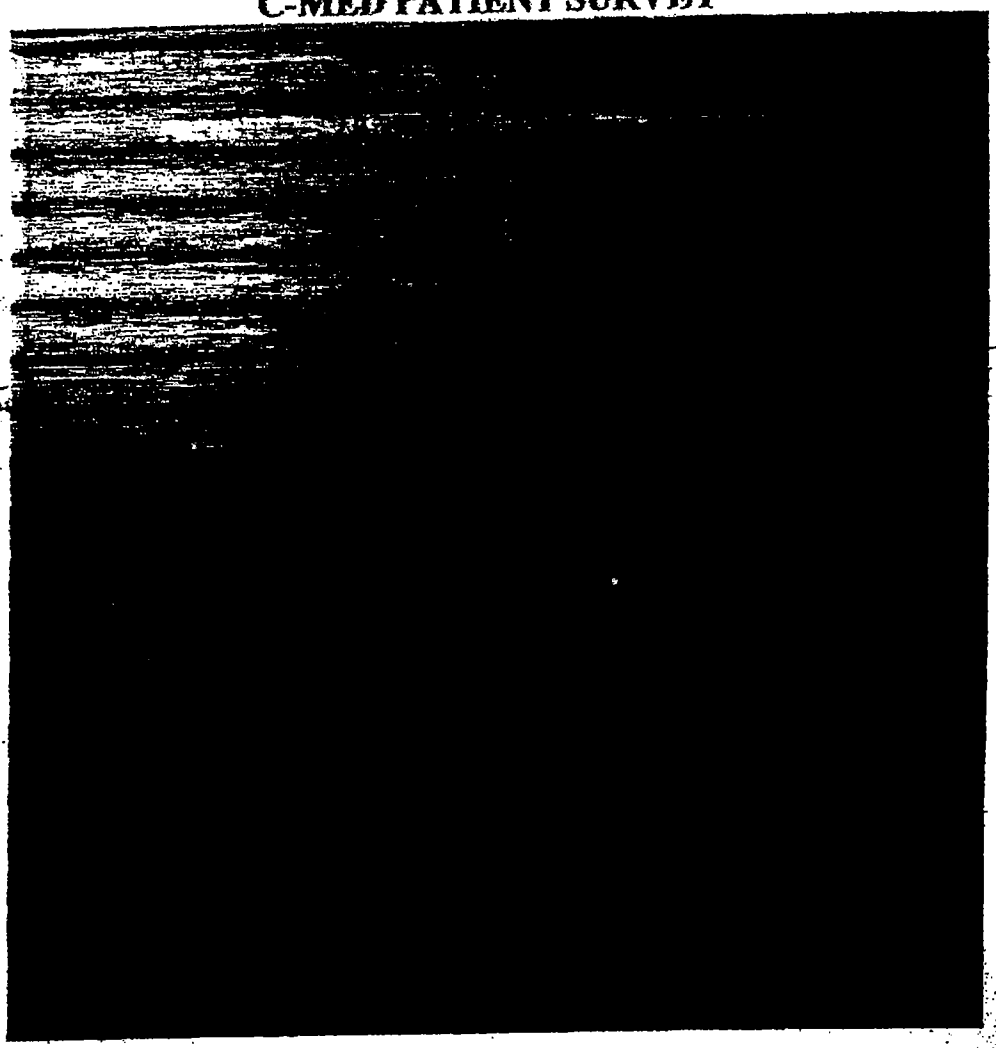
LAW ENFORCEMENT SENSITIVE
FOR OFFICIAL USE ONLY

EXHIBIT 4

24

C-MED PATIENT SURVEY



5

Description:
1 - ecchymosis of various stages of healing - remains more hyperemic
2 - along ≈ 2" dark blue/blk contusion - appears older than superior ecchymosis
3 - various shades of ecchymosis noted to (L) forehead, (L) periorbital, & nose
4 - healing superficial circular abrasions 3 surrounding erythema
5 - mod amt hyperemic ecchymosis/contusions over majority of posterior trunk
6 - ≈ 10-12" linear scar (L) flank to posteriorly - well healed - 2° removal of "bad" kidney 19/03
7 - ≈ 3" dark ecchymosis (L) buttock

SGT (b)(6)-2 9W20
Medic

1LT (b)(6)-2
MD/PA 17 Jul 04 1100hrs

Date/Time 17 July 04 - 1114

EXHIBIT 4

0217-04-CID259-80251
0117-C4-CID789

G-2

PRISONER IN PROCESSING MEDICAL SCREEN

NAME: (b)(6)-4 COMPOUND: ISN: (b)(6)-4
DATE: 30 Apr 04 DOB: 1982 AGE: 22
HISTORY BY TRANSLATOR: (YES) NO
NAME OF TRANSLATOR: Hannah

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW? Shot in (L) arm / hit repeatedly with rubber hose in bilat shins / shocked w electrical currents on (R) lower leg and bilat sides of torso X 15 days ago for 3 days ⇒ beaten by Kurdish, Iraqi linguist hung him — numbness in both legs from knees down

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN & HOW WERE YOU TREATED? No

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES (NO)
B) HAVE YOU BEEN COUGHING BLOOD? YES (NO)
C) HAVE YOU BEEN LOSING A LOT OF WEIGHT? YES (NO)

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE): none ⇒ [illegible] ago much stress he shot himself in (L) shoulder (suicidal) highly shot his brother. etc — x 1 yr ago

4) MEDICATION: unknown pill for mental disorder

5) ARE YOU ABLE TO WALK UNASSISTED? ~~YES~~ (NO)
6) ARE YOU ABLE TO FEED YOURSELF? (YES) NO
7) ALLERGIES: none

8) PULSE: 115 BLOOD PRESSURE: 116/84 RESPIRATORY RATE: 16

WEIGHT: 182 lbs HEIGHT: 5'10"

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO BN MD OR PA, UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTIONS 6 OR 7 ALSO REQUIRE MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE DATE: 4 MAY 04

ASSESMENT: Referred to SF 600 dated 4 MAY 04

RECCOMENDATIONS:

1043

PAGE 36

0217-04-CID259-80251
0117-04-CID789
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 MAY 04	S) 20 y/o ♂ A... referred by medic for evaluation.
	Pt reports he ... shot x 2 in R + L ARM. and
BP 143/83	was beaten ... Polish Army.
P 89	S - ↓ sleep
T 98.6	I
R 16	G (+) feelings ... guilt
	E - ↓ energy
	C - difficulty ... relation
PMH	A - ϕ
PSH - ϕ	P -
FH - single father	S - (+) suicidal ... tion x 1 yr with 1 attempt. He shot himself
SH - smoker	
MED -	O) GENERAL ♂ NAD INVABLE TO AMBULATE ⅋ assistance
Allergies - NKDA	NEURO: CN II GROSSLY INTACT (B)
	ARROM ... ⇒ QUADS ✱ ankle
	HEENT - NL ... - supple ⅋ adenopathy LUNGS - CTA (B)
	HEART - RRR ... - BENIGN GENITALS - NL MALE ↓ TESTES
	A) 1. Repression ... suicidal ideation
	2. ? R/S/y (B) ... OUT 2° TRAUMA
	P) 1. START ZOLOFT ... 3, CHASE AT ... PA-C
	2. F/U in 2 ... or ILT, SP OSA

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	DEPART./SERVICE	RECORDS MAINTAINED AT
Sooner ...		
SPONSOR'S NAME	RELATIONSHIP TO SPONSOR	

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

ISN: (b)(6)-4

COMPOUND: GANCI 2

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

2 of 3

0217-04-CID259-80251
0117-04-CID789
AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 MAY04	S) 22 y/o MALE ~~DETAINEE~~ here for F/U of B leg palsy. Hx reports much improvement
BP - 138/70	
P - 103	O) WNWD ♂ NAD VS STABLE AFEBRILE
T - 100.1	LOWER EXT - FASCS 6000 MS 4/5
R - 18	AND (+) P ROM ō PAIN NOG AROM
	A) 1 B leg palsy improving
	P) 1. Continue ō individual PT
	2. F/U in 2-3 wks
	(b)(6)-2 PA-C
	ICT, SP CLSA

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.

ISN # (b)(6)-4

COMPOUND # G2

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

2 of 3

G-2

PRISONER IN PROCESSING MEDICAL SCREEN

NAME (b)(6)-4 COMPOUND: ISN: (b)(6)-4
DATE: 30 Apr 04 DOB: 1982 AGE: 22
HISTORY BY TRANSLATOR: YES NO
NAME OF TRANSLATOR: Hannah

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW? numbness from both legs from knees down
Shot in (L) arm, hit repeatedly with rubber hose in bilat shins, shocked w electrical currents on (R) lower leg and bilat sides of torso x 15 days ago for 3 days ⇒ beaten by Kurdish, Iraqi linguist hung him

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN & HOW WERE YOU TREATED? No

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES NO
B) HAVE YOU BEEN COUGHING BLOOD? YES NO
C) HAVE YOU BEEN LOSING A LOT OF WEIGHT? YES NO

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE): none ⇒ ~~was under~~ so much stress he shot himself in (L) shoulder x 1 yr ago (suicidal) highly. Shot his brother. etc

4) MEDICATION: unknown pill for mental disorder

5) ARE YOU ABLE TO WALK UNASSISTED? YES NO
6) ARE YOU ABLE TO FEED YOURSELF? YES NO
7) ALLERGIES: none

8) PULSE: 115 BLOOD PRESSURE: 116/84 RESPIRATORY RATE: 16

WEIGHT: 182 lbs HEIGHT: 5'10"

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO BN MD OR PA, UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTIONS 6 OR 7 ALSO REQUIRE MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE

DATE: 4 MAY 04

ASSESMENT: refer to SF 600 dated 4 MAY 04

RECCOMENDATIONS:

0217-04-CID259-80251
0117-04-CID789
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 MAY 04	S) 20 y/o ♂ A[illegible] referred by medic for evaluation.
	Pt reports he [illegible] shot x 2 in R + L ARM. 2nd
BP 143/83	was beaten [illegible] Iraqish Army.
P 89	S - ↓ sleep
T 98.6	I
R 16	G (+) feelings [illegible] guilt
	E - ↓ energy
	C - difficulty [illegible] vibration
PMH	A - ∅
PSH - ∅	P -
FH - single father	S - (+) suicidal [illegible] tion x 1 yr with 1 attempt. He shot himself
SH - smoker	
MED -	O) GROOM ♂ NAD [illegible] UNABLE TO AMBULATE ⅋ assistance
Allergies - NKDA	NEURO: CN II [illegible] GROSSLY INTACT (1)
	AROM [illegible] → (1) COARSE ✱ ankle
	HEENT - NL [illegible] - supple ⅋ adenopathy LUNGS - CTA (B)
	HEART - RRR [illegible] - BENIGN GENITALS - NL MALE ↓ TESTES
	A) 1. Repression ⅋ [illegible] suicidal ideation
	2. ? Psy (B) [illegible] CBT 2° TRAUMA [illegible]
	P) 1. START ZOLOFT [illegible] 3, CHECK [illegible]
	2. F/U IN 2 [illegible] or [illegible] ILT, SP OSA

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	Sooner [illegible]	[illegible]US	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME		S[illegible] NO.	RELATIONSHIP TO SPONSOR	

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

ISN: (b)(6)-4

COMPOUND: GANCI 2

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

0217-04-CID259-80251
0117-04-CID789
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 MAY04	S) 22 y/o MALE DETAINEE here for f/u of
	(B) leg palsy He reports much improvement
BP - 138/70	
P - 103	O) WNWO ♂ NAD VS STABLE AFEBRILE
T - 100.1	LOWER EXT - FMCUT 6000 MS 4/5
R - 18	AM: (+) P ROM ō PAIN NO AROM
	A) 1 (B) leg palsy resolving
	P) 1. Continue ō adjunctive PT
	2. F/U in 2-3 wks
	(b)(6)-2
	PA-C
	1CT, SP CLSA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	...N/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.

ISN # (b)(6)-4

COMPOUND # G2

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

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0222-04-CID259-80256
0080-04-CID789

HEALTH RECORD

DETAINEE PRE-INTEROGATION EVALUATION

DATE: 20 June 04

PATIENT COMPLAINT / CONCERNS: 21 yo male c/o h/o anxiety d/o, h/o suicidal gesture. Pt c/o body.

ALLERGIES: NKDA

MEDS: Ø

Soc Hx: Tob: ETOH: Ø

PSHx:

BP: 118/62

P: 78

R:

WEIGHT: 94 kg

SaO2 96%

O:

GENERAL: Normal Abnormal

HEENT: Normal Abnormal Ø ecchymosis s. calvp, Ø TTP cranium

NECK: Normal Abnormal

LUNGS: Normal Abnormal

CARDIAC: Normal Abnormal

ABDOMEN: Normal Abnormal

EXTREMETIES: Normal Abnormal (F) healing abrasion (B) wrists (F) TTP (R) distal radius, (L) distal radius & prox 1st, 2nd MC (F) edema, ecchymosis, (F) TTP (L) mid anterior tibia

PMHX:
HTN: Y (N)
DM: Y (N)
TB: Y (N)
CAD: Y (N)

A/P:

Hep A, Hep B, MMR, Td: Given / Patient Refused

MA

anxiety d/o treated & valid prn.

(1) Pain (L) LE & (B) wrists
- X-rays ordered to r/o fx. Abrasions healing well.
- Motrin 400 mg q 4-6° prn pain

(2) Anxiety d/o
- Ativan 1 mg po BID prn anxiety

(b)(6)-2

(b)(6)-2

CAPT, USAF, MC

Family Practice Physician

ISN: (b)(6)-4

SEX:

CAMP:

DOB: 11/1980

STANDARD FORM 600 BACK (REV. 5-84)

...ing exam, physical finding on consult & they noted. PA states
had not made previous report of injuries, statement taken
5 Day.

0222-04-CID259-8025

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NSN 7540-00-634-4176

0080-04-CID789

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
20 June 04	
	Order
	(1) Atarax 1 mg po BID prn anxiety
	(2) Xray (L) LE, (L) wrist & hand, (R) wrist to rule out fracture.
	(3) Motrin 400 mg po q 4-6° prn pain
	(b)(6)-2 (b)(6)-2 CPT (b)(6)-2 MD

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

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial): (b)(6)-4

SEX: M

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION 10

DEPARTMENT/SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH 4/1/1980

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84) (EF-V1) (PerFORM PRO)
Prescribed by GSA and ICMR
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MEDCOM - 820

0080-04-CID789

AUTHORIZED FOR LOCAL REPRODUCTION

0222-04-CID259-80256

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Jan 04	DETAINEE IN-PROCESSING MEDICAL SCREEN
	SUBJECTIVE: AGE (M) / F DOB:
	ANY NEW MEDICAL ILLNESS OR INJURY? NO
	ANY HISTORY OF TB? YES / (NO) IF YES, WHEN AND HOW WERE YOU TREATED?
	COUGH > 2 WEEKS? YES / (NO)
	COUGHING UP BLOOD: YES / (NO)
	ANY WEIGHT LOSS? (YES) / NO IF YES, HOW MUCH AND IN WHAT TIME FRAME? 3 Kilo, 6
	ANY HISTORY OF HTN? YES / (NO)
	ANY HISTORY OF CAD? YES / (NO) IF YES, ANY HISTORY OF MI? YES / NO WHEN?
	ANY HISTORY OF DM? YES / (NO) IF YES, HOW LONG?
	ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / (NO)
	CURRENT MEDICATIONS: NO
	MEDICATION ALLERGIES: NKA
	ABLE TO WALK UNASSISTED? (YES) NO ABLE TO FEED YOURSELF? (YES) / NO
	ANY MISTREATMENT SINCE BEING DETAINED? YES / (NO)
	HISTORY OBTAINED THROUGH TRANLATOR? (YES) / NO NAME: (b)(6)-7

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		

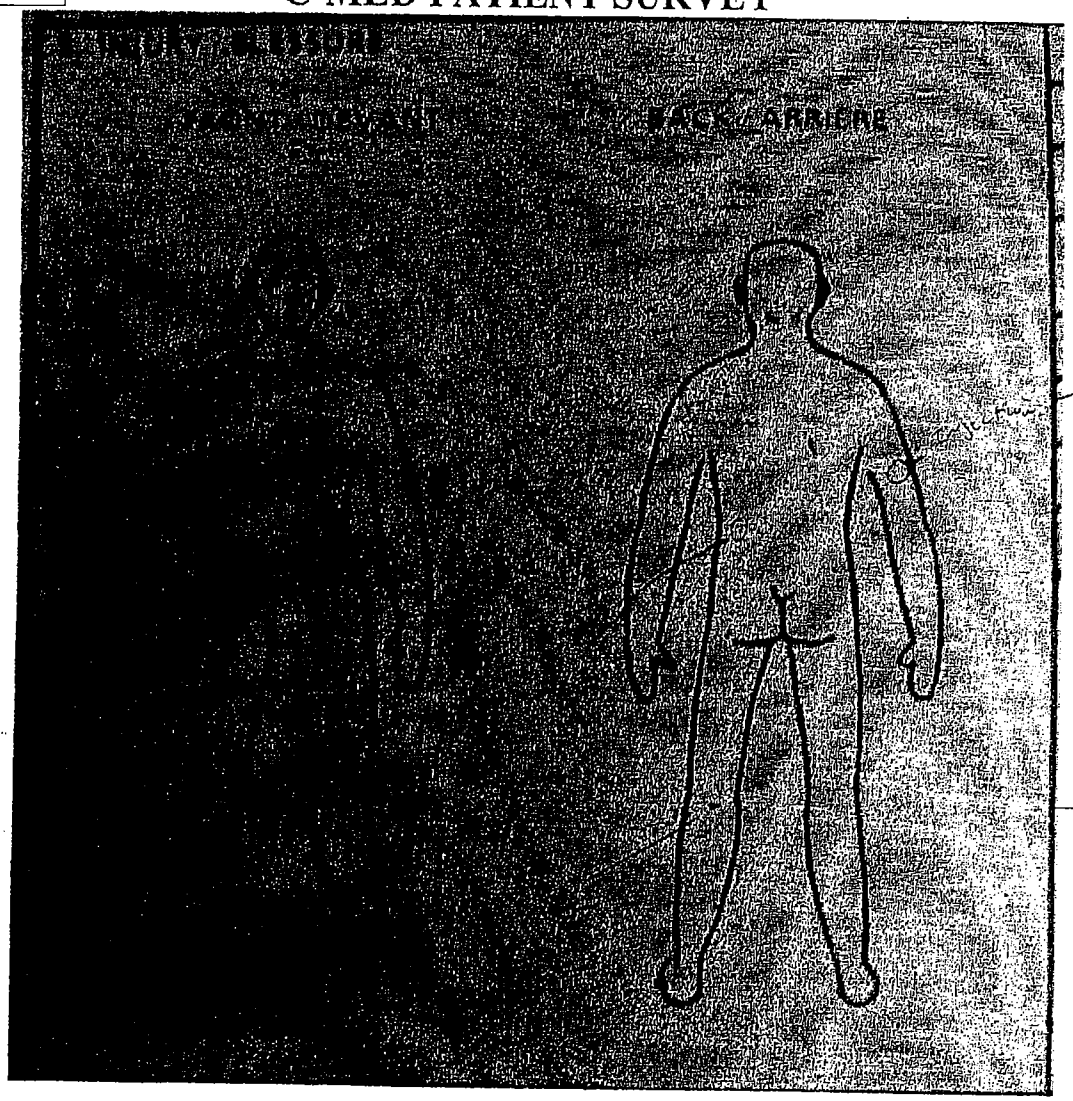
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	OBJECTIVE:
	HEIGHT: 66" WEIGHT: 178
	BP: 130/80 PULSE: 80 RESP: 18 O2%: TEMP:
	MEDICS SIGNATURE: (b)(6)-2 HM2 (b)(6)-2 HM2
	REFER TO PA OR MD IMMEDIATELY IF:
	CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS
	MD/PA REVIEW NOTE: Reviewed 19 JUN 04 (b)(6)-2

(b)(6)-4

C-MED PATIENT SURVEY



Description:

(1) 3 cm vertical scar on forehead just superior to (2) eye.
(2) old injection site on posterior (R) arm. 1' horizontal vertical on (R) scapula
3 old scar, circular, on (L) posterior thoracic region
4 old scar (circular)
5 ~~[illegible]~~ Recent scar (straight)
6 Bug Bite
#7 old scar (circular)
#8 Abrasion from hand cuffs

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

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

Date/Time 15 June 04 1413

(b)(6)-2 M.D.
CPT, MC

#9 Abrasion from handcuffs
SFC (b)(6)-2

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Plan:

Provider Signature: Printed Name / Stamp:

Routine Exam Form

Name: _____ Date: _____

ISN: _____ DOB: _____ AGE: _____

Chief Complaint:

HPI:

PMH:

MEDS:

Allergies:

Physical Exam:

VS:	BP	P	R	SaO_2	Weight

HEENT:	Normal / Abnormal
CV:	Normal / Abnormal
PULM:	Normal / Abnormal
GI:	Normal / Abnormal
GU:	Normal / Abnormal
OB/GYN:	Normal / Abnormal / NA
MS:	Normal / Abnormal
NEURO:	Normal / Abnormal
DERM:	Normal / Abnormal
ENDO:	Normal / Abnormal
PSYCH:	Normal / Abnormal

Comments / Findings:

Impression:

Disposition:

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4

EXHIBIT: 7

History and Physical Exam Form

Name: (b)(6)-4

Date: 15 June 04

ISN:

VS: BP: 125/72
Pulse: 84
Resp: 18
Temp:
Height: 66"
Weight: 180 lbs

DOB: 7-27-80 AGE: 23

Gender: Male / Female

Complaint: Acute:

Chronic: Asthma / Stomach Acid

PMH: DM HTN STD TB
Hosp:
Surg: AO Denies

Medications: Asthma inhs
Stomach Acid inhs

Allergies: NKDA

SocHx: Tobacco Y / N
_____PPDx_____yrs

EtOH no

ROS: HEENT: Perle EOMI
CV: RRR
PULM: CTA (3)
GI:
GU: SOFT NTTP
OB/GYN: NA
MS: FROM
NEURO: Intact
DERM: Clear
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
_____mm

Immunizations: (given at this time)

MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

HEENT:	Normal / Abnormal
CV:	Normal / Abnormal
PULM:	Normal / Abnormal
GI:	Normal / Abnormal
GU:	Normal / Abnormal
OB/GYN:	Normal / Abnormal /
MS:	Normal / Abnormal
NEURO:	Normal / Abnormal
DERM:	Normal / Abnormal
ENDO:	Normal / Abnormal
PSYCH:	Normal / Abnormal

Photograph

NA

Comments / Findings:

Impression: healthy male - STE

(b)(6)-2

CPT

(b)(6)-2

M.D.

CPT, MC

25

3

EXHIBIT: 7

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

STATEMENT OF (b)(6)-4 TAKEN AT Abu Ghraib DATED 20 June 04

9. STATEMENT *(Continued)*

PX states he was captured by American soldiers 6 days ago in Baghdad, hands & feet were tied then he was hit on head with rifle butt & kicked in leg with someone's boot. No loss of consciousness, Dr report had been made yet

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

INITIALS OF PERSON MAKING STATEMENT

PAGE 1 OF 1 PAGES

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PAGE 2, DA FORM 2823, DEC 1998

USAPA V1.00

EXHIBIT: 7

D214

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)
15 JUN 8	**PRE-TRANSFER MEDICAL ASSESSMENT**

**LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM

AGE: 23

(Y) (N)		(Y) (N)	
( ) (X)	Allergies	( ) (✓)	Recent illness/injury
( ) ( )	Dental Problems	(✓) ( )	History of psychological problems (Date) P
( ) (X)	HIV positive	(✓) ( )	Chronic health problems or infectious diseases Asthma
( ) (✓)	Previous Suicide Attempts (Date)	( ) ( )	Females only; Are you pregnant? N/A
( ) (✓)	History of alcohol abuse/treatment (Date)	(✓) ( )	Current medications
( ) (✓)	Current physical complaint(s)	1. Atrovent inhaler	
	1. Cough/Sputum Production	2. Albuterol inhaler	
	2. Rash	3.	
	3. Diarrhea/Vomiting		
	4. Night sweats		
	5. Pain		
	6. Exposure to TB		
	7. Lice/Other infestation		
	8. Contagious disease in the past 12 months?		
	8. Other:		

***** FOR MEDICAL PERSONNEL USE ONLY DETAINEE'S INITIALS (_____)

HIV/TUBERCULOSIS QUESTIONAIRE

Do you have a history or, or do you presently have any of the following symptoms or conditions:

(Y) (N)		(Y) (N)	
(✓) ( )	Persistent cough/shortness of breath	(✓) ( )	Cough with blood and/or dry cough
( ) (✓)	Unexplained weight loss/diarrhea X 2 weeks	(✓) ( )	Unexplained persistent fever
( ) (✓)	Night Sweats	( ) (✓)	Swollen glands/lymph nodes
(✓) (✓)	Prolonged fatigue or run-down feeling	( ) (✓)	Loss of appetite and or white patches in mouth
( ) (✓)	Recent exposure to someone with TB	( ) (✓)	Past abnormal X-Ray (Date)
( ) ( )	Hepatitis B series completed	( ) (✓)	Previous TB infection or treatment
( ) (✓)	Stomach surgery, Kidney failure, Blood disorders		
( ) ( )	Scars, birthmarks, tattoos: SEE DIAGRAM FOR DETAILS		
	1. Scar list	4.	
	2.	5.	
	3.	6.	

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT: >

(b)(6)-4

SEX: M

RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
	DETAINEE	

SPONSOR'S NAME	ORGANIZATION
	Shift -

DEPART/SERVICE	SSN/IDENTIFICATION NO.	DOB

(1) Pt still c/o shortness of breath
(2) Pt c/o of bruise on head (L) side when he was detained (did not happen here)

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EXHIBIT: 7

DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)			
	----------BELOW PORTION TO BE COMPLETED BY MEDICAL STAFF----------			
	PHYSICAL APPEARANCE			
	Clean, well groomed	(Y) (N)	Tremors, sweating	(Y) (N)
	Rashes, needle marks	(Y) (N)	Exposure to tuberculosis	(Y) (N)
	Body deformities	(Y) (N)	Infestations	(Y) (N)
	Cuts, bruises, lesions	(Y) (N)	Confinement Phys. Date: 15 Sep 04	
	VITAL SIGNS: Weight: 175 Height: 65" Temp: B/P: 128/72 Pulse: 84 Resp: 18			
	PPD given: N/A HIV drawn: N/A RPR drawn: N/A			
	Physical Exam: Within normal limits	(Y) (N)	See remarks for any (N) answers	
	Head	(✓) ( )		
	Lungs/Chest	(✓) ( )	LAB (If available) N/A	
	Back	(✓) ( )	CBC:	
	Heart	(✓) ( )	U/A:	
	Extremities	(✓) ( )	Chest X-Ray:	
	MENTAL STATUS			
	(Y) (N)			
	(✓) ( ) Alert, well oriented			
	(✓) ( ) Long and short term memory intact			
	( ) (✓) Experiencing hallucinations, delusions, or feelings of paranoia			
	(✓) ( ) Calm, cooperative			
	DISPOSITION			
	(Y) (N)		Prescriptions:	
	(✓) ( ) Cleared for basic transfer procedures			
	( ) ( ) Cleared for litter transfer procedures			
	( ) ( ) NOT medically cleared for transfer _____ (days/weeks)			
	Recommended type of confinement ( ) Normal ( ) Solitary ( ) Other -explain:			
	I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas. (SIG.)			
	Date/Time information transmitted to component surgeon's office			
	Infection Control recommendations		(1) Pt still c/o shortness breath	
	(✓) Standard Precautions		(2) Pt still c/o bruise on head (See diagram for details)	
	( ) Contact/Droplet Precautions			
	( ) Airborne Precautions			
	SCREENER (b)(6)-2			
	MEDICAL STAFF SIGNATURE (b)(6)-2		4/m 19 Sep 04 0950 PAC, SP	
	SCREENER		15 Jun 04	
	MEDICAL STAFF SIGNATURE			

EXHIBIT: 7

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Jun 04	DETAINEE IN-PROCESSING MEDICAL SCREEN
	SUBJECTIVE: AGE (M) / F DOB:
	ANY NEW MEDICAL ILLNESS OR INJURY? NO
	ANY HISTORY OF TB? YES / (NO) IF YES, WHEN AND HOW WERE YOU TREATED?
	COUGH > 2 WEEKS? YES / (NO)
	COUGHING UP BLOOD: YES / (NO)
	ANY WEIGHT LOSS? (YES) / NO IF YES, HOW MUCH AND IN WHAT TIME FRAME? 3 kilo, 6 m
	ANY HISTORY OF HTN? YES / (NO)
	ANY HISTORY OF CAD? YES / (NO) IF YES, ANY HISTORY OF MI? YES / NO WHEN?
	ANY HISTORY OF DM? YES / (NO) IF YES, HOW LONG?
	ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / (NO)
	CURRENT MEDICATIONS: NO
	MEDICATION ALLERGIES: NKA
	ABLE TO WALK UNASSISTED? (YES) NO ABLE TO FEED YOURSELF? (YES) / NO
	ANY MISTREATMENT SINCE BEING DETAINED? YES / (NO)
	HISTORY OBTAINED THROUGH TRANLATOR? (YES) / NO NAME: ACI

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 USAPA V2.00

EXHIBIT: 13

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	OBJECTIVE:
	HEIGHT: 66" WEIGHT: 178
	BP: 120/80 PULSE: 80 RESP: 18 O2%: TEMP:
	MEDICS SIGNATURE: (b)(6)-2 HM2 (b)(6)-4 HM2
	REFER TO PA OR MD IMMEDIATELY IF:
	CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS
	MD/PA REVIEW NOTE: Reviewed 19 JUN 04 PA [redacted]

EXHIBIT: 14

DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)
	----------BELOW PORTION TO BE COMPLETED BY MEDICAL STAFF----------
	PHYSICAL APPEARANCE
	Clean, well groomed (Y) (N) — Tremors, sweating (Y) (N)
	Rashes, needle marks (Y) (N) — Exposure to tuberculosis (Y) (N)
	Body deformities (Y) (N) — Infestations (Y) (N)
	Cuts, bruises, lesions (Y) (N) — Confinement Phys. Date: 15 Sept 04
	VITAL SIGNS: Weight: 175 Height: 65" Temp: B/P: 125/72 Pulse: 64 Resp: 18
	PPD given: N/A HIV drawn: N/A RPR drawn: N/A
	Physical Exam: Within normal limits (Y) (N) — See remarks for any (N) answers
	Head (✓) ( )
	Lungs/Chest (✓) ( ) — LAB (If available)
	Back (✓) ( ) — CBC: N/A
	Heart (✓) ( ) — U/A:
	Extremities (✓) ( ) — Chest X-Ray:
	MENTAL STATUS
	(Y) (N)
	(✓) ( ) Alert, well oriented
	(✓) ( ) Long and short term memory intact
	( ) (✓) Experiencing hallucinations, delusions, or feelings of paranoia
	(✓) ( ) Calm, cooperative
	DISPOSITION
	(Y) (N) — Prescriptions:
	(✓) ( ) Cleared for basic transfer procedures
	( ) ( ) Cleared for litter transfer procedures
	( ) ( ) NOT medically cleared for transfer _____ (days/weeks)
	Recommended type of confinement ( ) Normal ( ) Solitary ( ) Other -explain:
	I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas (SIG)
	Date/Time information transmitted to component surgeon's office
	Infection Control recommendations
	(✓) Standard Precautions — (1) Pt still c/o shortness of breath
	( ) Contact/Droplet Precautions — (2) Pt still c/o bruise on head (See diagram & detail)
	( ) Airborne Precautions
	SCREENER (b)(6)-2
	MEDICAL STAFF SIGNATURE (b)(6)-2
	SCREENER
	MEDICAL STAFF SIGNATURE

EXHIBIT:

15

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

PRE-TRANSFER MEDICAL ASSESSMENT

**LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM

AGE: 23

(Y) (N)		(Y) (N)	
( ) (X)	Allergies	( ) (X)	Recent illness/injury
( ) ( )	Dental Problems	(✓) ( )	History of psychological problems (Date) P
( ) (X)	HIV positive	(✓) ( )	Chronic health problems or infectious diseases 4th [illegible]
( ) (X)	Previous Suicide Attempts (Date)	( ) ( )	Females only, Are you pregnant? N/A
( ) (X)	History of alcohol abuse/treatment (Date)	(✓) ( )	Current medications
( ) (X)	Current physical complaint(s)	1. Atrovent inhaler	
	1. Cough/Sputum Production	2. Sertraline [illegible]	
	2. Rash	3.	
	3. Diarrhea/Vomiting		
	4. Night sweats		
	5. Pain		
	6. Exposure to TB		
	7. Lice/Other infestation		
	8. Contagious disease in the past 12 months?		
	9. Other.		

***** FOR MEDICAL PERSONNEL USE ONLY DETAINEE'S INITIALS (_____)

HIV/TUBERCULOSIS QUESTIONAIRE

Do you have a history or, or do you presently have any of the following symptoms or conditions

(Y) (N)		(Y) (N)	
(✓) ( )	Persistent cough/shortness of breath	(✓) ( )	Cough with blood and/or dry cough
( ) (✓)	Unexplained weight loss/diarrhea X 2 weeks	(✓) ( )	Unexplained persistent fever
( ) (✓)	Night Sweats	( ) (✓)	Swollen glands/lymph nodes
(✓) (✓)	Prolonged fatigue or run -down feeling	( ) (✓)	Loss of appetite and or white patches in mouth
( ) (✓)	Recent exposure to someone with TB	( ) (✓)	Past abnormal X -Ray (Date)
( ) ( )	Hepatitis B series completed	( ) (✓)	Previous TB infection or treatment
( ) (✓)	Stomach surgery, Kidney failure, Blood disorders		
( ) ( )	Scars, birthmarks, tattoos. SEE DIAGRAM FOR DETAILS		

1. Scar [illegible] 4.
2 5
3 6.

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT

(b)(6)-2

SEX M

SPONSOR | STATUS DETAINEE | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION Stryker

DEPART/SERVICE | SSN/IDENTIFICATION NO | DOB

(1) Pt still c/o shortness of breath

(2) Pt c/o of bruise on head (L) side when he was detained (did not happen here)

For Official Use Only
Law Enforcement Sensitive

EXHIBIT:

16

History and Physical Exam Form

Name: (b)(6)-4

Date: 15 June 04

ISN:

VS: BP: 125/72
Pulse: 84
Resp: 18
Temp:
Height: 66"
Weight: 180 lbs

DOB: 7-27-80 AGE: 23

Gender: Male / Female

Complaint: Acute:

Chronic: Asthma / Stomach Acid

PMH: DM HTN STD TB
Hosp:
Surg: Appy Dx

Medications: Albuterol inhaler
Stomach Acid tabs

Allergies: None

SocHx: Tobacco Y / N
_____PPDx_____yrs

EtOH no

ROS: HEENT: Poor teeth
CV: RRR
PULM: CTA (3)
GI:
GU: Gonorrhea
OB/GYN: NA
MS: Pelvic
NEURO:
DERM: Dry
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
_____mm

Immunizations: (given at this time)

MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

HEENT:	Normal / Abnormal
CV:	Normal / Abnormal
PULM:	Normal / Abnormal
GI:	Normal / Abnormal
GU:	Normal / Abnormal
OB/GYN:	Normal / Abnormal /
MS:	Normal / Abnormal
NEURO:	Normal / Abnormal
DERM:	Normal / Abnormal
ENDO:	Normal / Abnormal
PSYCH:	Normal / Abnormal

Photograph

NA

Comments / Findings:

Impression: healthy male - SIT [redacted]

CPT (b)(6)-2

(b)(6)-2 M.D.
CPT, MC

3

EXHIBIT:

17

Plan: _____

_____

Provider Signature: Printed Name / Stamp:

Routine Exam Form

Name: _____ Date: _____

ISN: _____ DOB: _____ AGE: _____

Chief Complaint:

HPI:

PMH:

MEDS:

Allergies:

Physical Exam:

VS: BP P R SaO_2 Weight

HEENT: Normal / Abnormal
CV: Normal / Abnormal
PULM: Normal / Abnormal
GI: Normal / Abnormal
GU: Normal / Abnormal
OB/GYN: Normal / Abnormal / NA
MS: Normal / Abnormal
NEURO: Normal / Abnormal
DERM: Normal / Abnormal
ENDO: Normal / Abnormal
PSYCH: Normal / Abnormal

Comments / Findings:

Impression: _____

_____

Disposition: _____

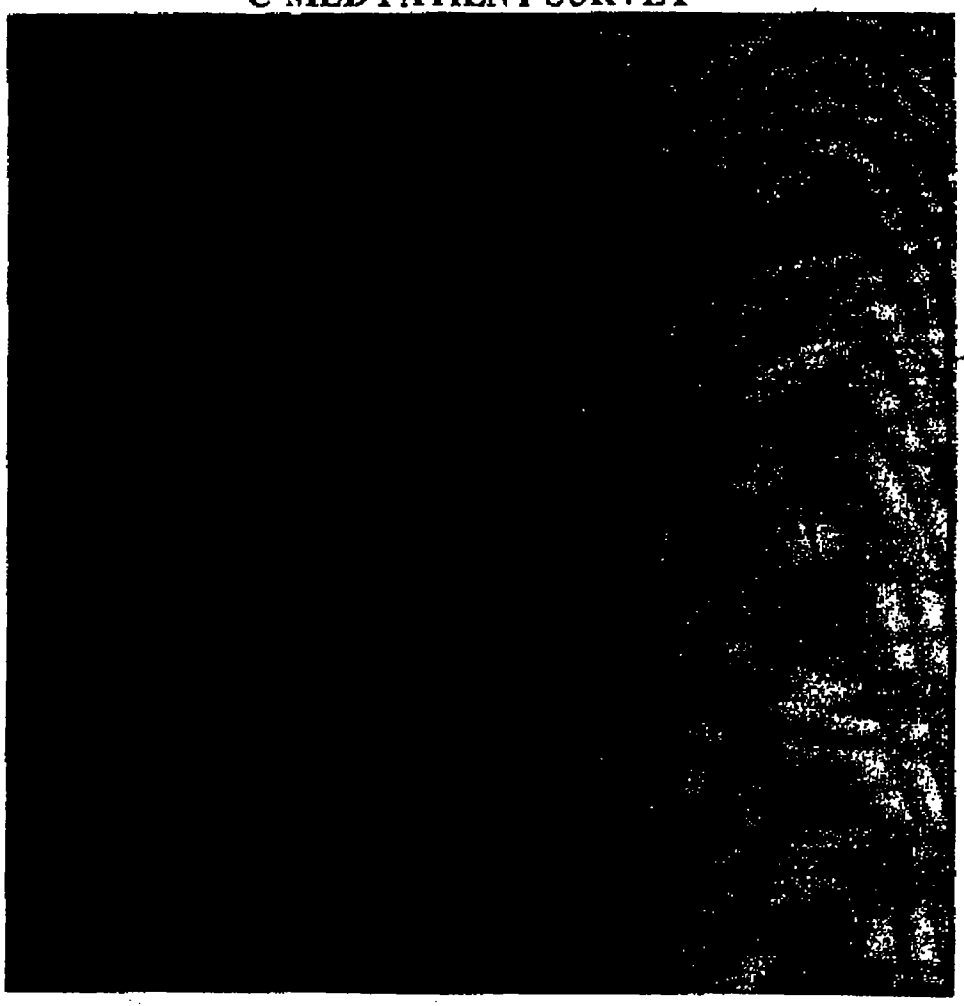
_____

EXHIBIT:

18

B214

C-MED PATIENT SURVEY



Description:

(1) [illegible]

(2) old [illegible] [illegible] (3) [illegible]

3 [illegible]

4 old scar (Crescent)

5 ~~[illegible]~~ Recent scar (straight)

6 Bug Bite

7 old scar (Crescent)

8 Abrasion from handcuffs

SGT (b)(6)-2

Medic

CPT (b)(6)-2

MD/PA

Date/Time 15 June 07 1400

(b)(6)-2 M.D.

CPT, MC

9 Abrasion from handcuffs,

S/C (b)(6)-2

EXHIBIT:

19

HEALTH RECORD

DETAINEE PRE-INTEROGATION EVALUATION

DATE: 20 June 04

BP: 118/62

P: 78

R:

WEIGHT: 94 kg

SaO2 96%

PMHX:

HTN: Y (N)

DM: Y (N)

TB: Y (N)

CAD: Y (N)

PATIENT COMPLAINT / CONCERNS:

& 24 year male c/o b/o anxiety d/o, b/o suicidal gestures. Pt ⊼ c/o today.

ALLERGIES: NKDA

MEDS: ∅

Soc Hx: Tob: ETOH: ∅

PSHx:

O:

GENERAL: (Normal) Abnormal

HEENT: (Normal) Abnormal ∅ ecchymosis scalp, ∅ TTP cranium

NECK: (Normal) Abnormal

LUNGS: (Normal) Abnormal

CARDIAC: (Normal) Abnormal

ABDOMEN: (Normal) Abnormal

EXTREMETIES: Normal (Abnormal)

(R) healing abrasion (B) wrists (R) TTP (R) distal radius, (L) distal radius & prox 1st, 2nd MC

(R) edema, ecchymosis, (R) TTP

(L) mild contusion tibia

A/P:

Hep A, Hep B, MMR, Td: (Given) / Patient Refused

MA

anxiety d/o - treated ⊼ Valium prn.

(1) Pain (L) LE & (R) wrists

- X-rays ordered to r/o fx. Bruises healing well.

- Motrin 400 mg q 4-6° prn pain

(2) Anxiety d/o

- Ativan 1 mg po BID prn anxiety

(b)(3)-1

(b)(6)-2

CAPT, USAF, MC

Family Practice Physician

ISN: (b)(6)-4

SEX:

CAMP:

DOB: 11/1980

STANDARD FORM 600 BACK (REV. 5-84)

For Official Use Only
Law Enforcement Sensitive

Enc 2

30

my exam, presented [illegible] Counsel [illegible] Coley notified. PA states had not made previous report of injuries, statement taken [illegible].

NSN 7540-00-634-4076

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT (TREATING ORGANIZATION (Sign each entry)
20 Jun 04	
	Order
	(1) Motrin 1 mg po BID prn anxiety
	(2) Xray (L) LE, (L) wrist & hand, (R) wrist to rule out fracture
	(3) Motrin 400 mg po q 4-6 prn pain
	(b)(6)-2 (b)(6)-2 (b)(6)-2 CPT MD

PATIENT'S IDENTIFICATION (Use reverse for Mechanical Injuries)

RECORDS MAINTAINED AT:

(b)(6)-4 (Last, First, Middle initial) | SEX: M

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

STATE/SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH: 7/1/1980

CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.506 — NSN VII (PerFORM PRO)

Encl 2

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0059-04-CID789-83991

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. Jun Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	3	4	5	6	7	8	9	10	11	12	13
3Jun04	(b)(6)-2	Cardiac Monitor	07	(b)(6)-2				Transfer to ICW					5Jun04	(b)(6)
			19											
			/											
3Jun04		Clear Liquids	07					Pt dcd 4Jun04						
			19											
			/											
3Jun04		Vitals q4hr	07											
			19											
			/											
3Jun		Bedrest elevate	07											
		HOB	19											
			/											
3Jun		IJO may anchor	07											
		Foley if needed	19											
			/											
4Jun		General Diet	07											
			19											
5Jun		Vital signs q 8°	07											
			19											
			/											
5Jun		activity as tolerated	07											
			19											
5 June 04		Restraints calm - q2h	07											
		+ document SIS of skin break	19											
5June04		weekly wt Thursday	08											Due

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
DX: CHF

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 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED

EX 4 7

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo Jun Yr 04
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3Jun	(b)(6)-2	Admit Monitored bed	3Jun	Now	2100	(b)(6)-2
3Jun		CBC, Lytes in am	4Jun	0600	2100	
[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	
5Jun		Transfer to ICU	5Jun	ASAP		

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

0059-04-CID785-83551

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 5	6	7	8										
5 June 04	(b)(6)-	Lasix 20mg ½ tab q a.m	08	(b)(6)-													

ALLERGIES: ☐ YES ☐ NO

PCN

PRIMARY DIAGNOSIS:

CHF

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

Ex 4 9

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													
		For Official Use Only / Law Enforcement Sensitive														

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Ex 4

0054-04-CID789-83491

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. Jun Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9							
3Jun	(b)(6)-2	Lasix 20mg IVP	04	/	(b)(6)-												
		q8hr	12	/	(b)(6)												
			20	/													
3Jun		IVNS @ KVO	07	/	(b)(6)-2												
			19	(b)(6)-													
3Jun		ASA 81mg po	08	/	(b)(6)-2												
		daily															
3Jun		Prinivil 20mg	08	/	(b)(6)-2												
		PO BID	20	/	(b)(6)-2												
3Jun		Isordil 20mg	06	/	(b)(6)-2												
		po TID	14	/	(b)(6)-2												
			22	(b)(6)-2													
3Jun		O2 2L per NC	07	/	(b)(6)-2												
	-----		19	/	(b)(6)-2												
4JUN.	-----	LABETALOL 100mg po BID	08	/													
4JUN	-----	Hold for SBP<90, HR<50	20	/													

4Jun	(b)(6)-	Metoprolol 25mg PO	12	/	(b)(6)-2												
	-----	BID - Hold SBP<90, HR<50	04	/	(b)(6)-2												

5Jun	(b)(6)-2	Zantac 150mg 1 tab	10	/	(b)(6)-2												
	-----	PO BID	22	/	(b)(6)-												

ALLERGIES: ☐ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: DX: CHF

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO. 1 of 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 — PREVIOUS EDITIONS OF DEC 72 WILL BE USED UNTIL EXHAUSTED

Ex 4 11

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 6 Yr. 04

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4JUN	(b)(	[redacted]	[redacted]			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
3Jun	(b)(6)-	MS 4mg IVP	D/T	4Jun 0500												
		q 2hr prn SOB	D/R	4mg EVA												
			I/D	RH												

12
Ex4

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

0059-04-CID 784-83951

Task Force Alcatraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4

SSN or ISN:

Diagnosis: CHF

Physician: (b)(6)-2

Ward: 3
Bed: /CV

STAT
X Routine

Specimen Date and Time:

Re (b)(6)-2

Date and Time: 5 Jun 04

Chemistry (i-STAT) / Green Top											
6+	7+	8+	Glu	Crea							
X	TEST	RESULT	REF. RANGE								
	Na		128-145 mmol/L								
	K		3.3-4.7 mmol/L								
	Cl		98-108 mmol/L								
	pH		7.35-7.45								
	PCO2		35-45 mmHg								
	PO2		80-90 mmHg								
	TCO2		18-33 mmol/L								
	HCO3		22-28 mmol/L								
	sO2		95-99%								
	BEecf		(-2) - (+3)								
	AGap		8-16 mmol/L								
	iCa		0.11-1.23 mmol/L								
	BUN		7-22 mmol/L								
	Glu		73-118 mmol/L								
	Creat		0.6-1.2 mmol/L								
	Hct		35.0-60.0%								
	Hgb		12.0-18.0 g/dL								
	Lactate		0.90-1.70 mmol/L								
	Urinalysis										
	Color		Straw/Yellow								
	Clarity		Clear								
	Glucose		Negative								
	Bilirubin		Negative								
	Ketone		Negative								
	SG		1.010-1.025								
	Blood		Negative								
	pH		5.0-8.0								
	Protein		Negative-Trace								
	Urobili		Negative								
	Nitrite		Negative								
	Leuko		Negative								
	Urine Microscopic										
	WBC		Epi								
	RBC		Mucus								
	Bacteria		Yeast								
	Casts:		Spermatozoa								
	Crystals:		Amorph Sed								
	Other:										

Chemistry (Piccolo Analyzer) / Green Top			
Chem 12	MetLyte8	BMP	Liver
X	TEST	RESULT	REF. RANGE
	ALB	3.4	3.3-5.5 g/dL
	ALP	91	53-128 U/L
	ALT	10	10-47 U/L
	AMY	67	14-97 U/L
	AST	19	11-38 U/L
	Tbil	2.5	0.2-1.6 mg/dL
X	BUN	9	7-22 mg/dL
	Ca	8.8	8.0-10.3 mg/dL
X	Chol	136	100-200 mg/dL
	CK	–	39-380 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
X	Creat	0.7	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	96	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.7	6.4-8.1 g/dL
	Na		128-145 mmol/L
	Misc Chemistry		
	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I		< 0.5 ng/mL
	Myoglobin		< 80 ng/mL
	RSV		Negative
	Microbiology		
	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

Hematology / Purple Top			
CBC	Malaria	H/H	
X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-50.0%
	LY#		0.7-4.3 x10(3)/uL
	Differential		
Segs			Mono
Bands			Eos
Lymph			Baso
Atyp Ly			Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%
	Malaria / Purple		
	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen
	Sed Rate / Purple Top		
	Sed Rate		1hr = 0-20 mm
	Coagulation (waiting for analyzer)		
	HCG		
	Urine		Negative
	Serum		Negative
	Blood Bank / Purple Top		
	ABO/Rh		
	T/C		

Other lab request to be sent out:

Ex H 13

Task Forc atraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST MI (b)(6)-4 | SSN (b)(6)-4 | DOB | RANK | UNIT

Pt (b)(6)-4 (b)(6)-2 | Ward: EMT | STAT / Routine | Specimen Date and Time: 3 JUN 04 1800 | Reported by: (b)(6)- | Date and Time: 3 JUN 04 1845

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	4.1	3.3-5.5 g/dL
	ALP	107	~~26-128~~ 26-89 U/L
	ALT	18	10-47 U/L
	AMY	62	14-97 U/L
	AST	36	11-38 U/L
	Tbil	2.2	0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	93	39-380 U/L
✓	CL	109	98-108 mmol/L
	TCO2	19	18-33 mmol/L
	Creat	0.8	0.6-1.2 mg/dL
	GGT	112	5-65 U/L
	Glu	90	73-118 mg/dL
✓	K	4.4	3.3-4.7 mmol/L
	TProtein	7.8	6.4-8.1 g/dL
✓	Na	127	128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I	<0.5	< 0.5 ng/mL
	Myoglobin		< 80 ng/mL
	RSV		Negative

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	5.2	4.8-10.8 x10(3)/ul
	RBC	5.87	4.2-6.1 x10(6)/uL
	Hgb	17.4	12.0-18.0 g/dL
	Hct	54.8	35.0-60.0%
	MCV	93.4	80.0-99.0 fl
	MCH	29.6	27.0-31.0 pg
	MCHC	31.7	33.0-37.0 g/dL
	Plt	205	130-400 x10(3)/ul
	LY%	59.1	15.0-50.0%
	LY#	3.1	0.7-4.3 x10(3)/uL

Differential

Segs	29	Mono	5
Bands		Eos	5
Lymph	61	Baso	
Atyp Ly		Immature cells	

RBC Morph: normocytic / normochromic

Plt verify:

Spun Crit 35-60%

Malaria (waiting for supplies)

Sed Rate

Sed Rate 1hr = 0-20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank

ABO/Rh

Ex 4. 14

Official Use Only / Law Enforcement Sensitive

0055-04-CID 778-85351

Task Force Alcatraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

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

SSN or ISN:

Diagnosis: CHF

Physician: (b)(6)-2
(b)(6)-2

Ward:
Bed:

STAT
Routine

Specimen Date and Time: 05 Jun 06 13

Reported by: (b)(6)-

Date and Time:

Chemistry (i-STAT) / Green Top

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dl.
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		Spermatozoa
Crystals:		Amorph Sed
Other:		

Other lab request to be sent out.

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	12	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	72	39-380 U/L
	CL	100	98-108 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	1.1	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	109	73-118 mg/dL
	K	4.1	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	132	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Troponin I	NEG	< 0.5 ng/mL
Myoglobin		< 80 ng/mL
RSV		Negative

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite
Chlamydia		Presumptive Negative
Strep A		Negative
Leishmania		Presumptive Negative

Hematology / Purple Top

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	8.6	4.8-10.8 x10(3)/uL
	RBC	6.16	4.2-6.1 x10(6)/uL
	Hgb	18.2	12.0-18.0 g/dL
	Hct	57.5	35.0-60.0%
	MCV	93.4	80.0-99.0 fl
	MCH	29.6	27.0-31.0 pg
	MCHC	31.7	33.0-37.0 g/dL
	Plt	202	130-400 x10(3)/uL
	LY%	35.7	15.0-50.0%
	LY#	3.1	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria / Purple

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank/ Purple and Red Top

ABO/Rh		
T/C		

FORM 67th CSHLAB-1 27 May 04

Official Use Only / Law Enforcement Sensitive

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Ex 4

0056-04-CID789-80551

CERTIFICATE OF DEATH

For use of this form, see AR 190-8; the proponent agency is DCSPER.

INTERNMENT SERIAL NUMBER

FROM:

TO:

ISN (b)(6)-4
Camp Bissonu

NAME (Last, First, MI)			GRADE	SERVICE NUMBER
NATIONALITY Iraqi	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE		
PLACE OF BIRTH				DATE OF BIRTH 01 JUL 1952
NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN				FIRST NAME OF FATHER
PLACE OF DEATH Abu Ghraib Hosp	DATE OF DEATH 10 June 04		CAUSE OF DEATH Cardiac Respiratory Arrest	
PLACE OF BURIAL				DATE OF BURIAL
IDENTIFICATION OF GRAVE				

PERSONAL EFFECTS *(To be filled in by Office of Deputy Chief of Staff for Personnel)*

___ RETAINED BY DETAINING POWER ___ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)* ___ FORWARDED SEPARATELY TO *(Specify)*

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS *(Doctor, Nurse, Minister of Religion, Fellow Internee)*. IF CREMATED, GIVE REASON. *(If more space is required, continue on reverse side).*

Patient arrived with CPR already under way, Cardiac Monitor showed Ventricular fibrillation, Despite CPR, Medications, and defibrillation attempts, pt ~~was~~ expired @ 2000 HRS either death declared by physicians.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE 6/18/04

(b)(6)-2

MEDICAL OFFICER

SIGNATURE OF COMMAN

WITNESSES

SIGNATURE (b)(6)-2 ADDRESS (b)(6)-2

SIGNATURE ADDRESS

DA FORM 2669-R, May 82 EDITION OF 1 JUL 63 IS OBSOLETE.

Ex 416

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL 0059-04-CD795-83551

Instructions - Medical Officer in attendance will:
Type, in one copy only, Items 1 through 10 and sign Item 11. *Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.*
or type entries.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*
SN: (b)(6)-4
BISSON L4

2. TIME OF DEATH *(Hour-day month-year)* 2100 6/10/04

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☒ NO

4. RELIGION Unknown

5. CHAPLAIN NOTIFIED ☐ YES ☒ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH
NA

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Cardio respiratory arrest	1 hour
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) Unknown	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
6/10/04	(b)(6)-2	(b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

USAPPC V2.00

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

17
Ex 4

0054-04-CID785-83651

PATIENT IDENTIFICATION

(b)(6)
-4

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

HOURS

Ex 18

0056-04-C10284-83551

Standard Form 504

CLINICAL RECORD	HISTORY—Part I

NATURE AND DURATION OF COMPLAINTS (*Include circumstance of admission*)

[illegible] 2 yo Male [illegible] previous MI [illegible] AS HD presents [illegible] 6 days ago
↑ cough SOB Tiring pedal edema ② Chest pain ④ Dyspnea on
exertion.
Pt [illegible] MI and HTN on HCTZ 25 day Prevacid 20 mg day
ASA 325 day Isordil 20 TID ①

HISTORY OF PRESENT ILLNESSES

HPI [illegible] as above
HEENT Clear
Chest [illegible] bilateral rales [illegible] on [illegible] PMI
① scattered wheezes
[illegible]
① Tiring pedal edema

A: DC HF
② Hx AS HD

P: ① [illegible]
② ACE
③ Diuretics
④ Beta blockers
⑤ Nitrates

(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.

HISTORY—Part 1
Standard Form 504

*U.S. Government Printing Office: 1991 — 281-782/20334

General Services Administration and
Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.5
October 1975 504-108

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Ex 4

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0056-04-CID785-83551

WEIGHT REGISTER

For use of this form, see AR 190-8; the proponent agency is DCSPER.

NAME (Last, First, MI) (b)(6)-4

INTERNMENT SERIAL NUMBER

WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE

DA FORM 2664-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE USAPPC V1.00

Ex 20

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0056-04-CID715-83551

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: 6/4/04 TIME OF ORDER: 0715 HOURS

(1) Begin Lovastatin 100 mg po BID first dose now

(2) Hold for SBP less than 90 or HR less than 50

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN: 6/4 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 6/4/04 TIME OF ORDER: 0730 HOURS

(1) Lipids, BUN, creat, pending Cholesterol in AM 6/5/04

(2)

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 6/4/04 TIME OF ORDER: 0810 HOURS

(1) DIC Labs (not stated)

(2) Metoprolol 25 mg PO BID

(b)(6)-2

Noted 0910 on 4 standard

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 6/4/04 TIME OF ORDER: 1610 HOURS

(1) General diet

(2)

(b)(6)-2

2000-4-[illegible]

(b)(6)-2

Noted 1610 on 4 standard

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

Ex 4 21

0055-04-CID 785-83551

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: 6/5/04 TIME OF ORDER: 0805 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICW
2. ~~NPO~~ D/C IV
3. Vital q 8hrs
4. Coughing to bedside
5. general diet
6. Zantac 150 mg PO BID
7. ASA 81 mg PO daily

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 6/6 TIME OF ORDER: HOURS

(b)(6)-4

8. Lopressor 25 mg PO BID
9. Procardia 20 mg ~~PO BID~~ daily
10. Lasix 20 mg PO qAM
11. Isordil 20 mg PO TID
12. PCN allergy
13. D/C [redacted]

NURSING UNIT: HPCC (b)(6)-2 | ROOM NO. | BED NO.: LPAU

PATIENT IDENTIFICATION

(b)(6)-4

DATE: 6/6/04 TIME OF ORDER: 1230 HOURS

1. Return to ward
2. ASA 81 mg PO daily
3. ~~Tenormin 50 mg~~
4. Lopressor 25 mg PO BID
5. Lasix 20 mg PO qAM
6. Isordil 20 mg PO TID
7. Procardia 20 mg daily

noted 6 June 04 1300

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: [redacted] HOURS (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

B 4

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0055-04-CID288-83551

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: 6/3/04 TIME OF ORDER: 2015 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit Monitored bed
2. Cardiac Monitor
3. O2 2LNC
4. Lasix 20mg IVP q8hrs
5. IV NS @ KVO
6. Clear liquids
7. Prinivil 20mg PO BID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: TIME OF ORDER: HOURS

8. ASA 81mg PO daily
9. MS 4mg IVP q 2hrs PRN SOB
10. CBC Lytes in AM 6/4/04
11. Isordil 20mg PO TID
12. I&O may catheterize foley if needed
13. Vitals q4hrs

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: TIME OF ORDER: HOURS

14. Bed rest elevate HOB

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 3/JUNE04 TIME OF ORDER: 2045 HOURS

VO:

1. Allergy to PCN
2. Dx: CHF

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

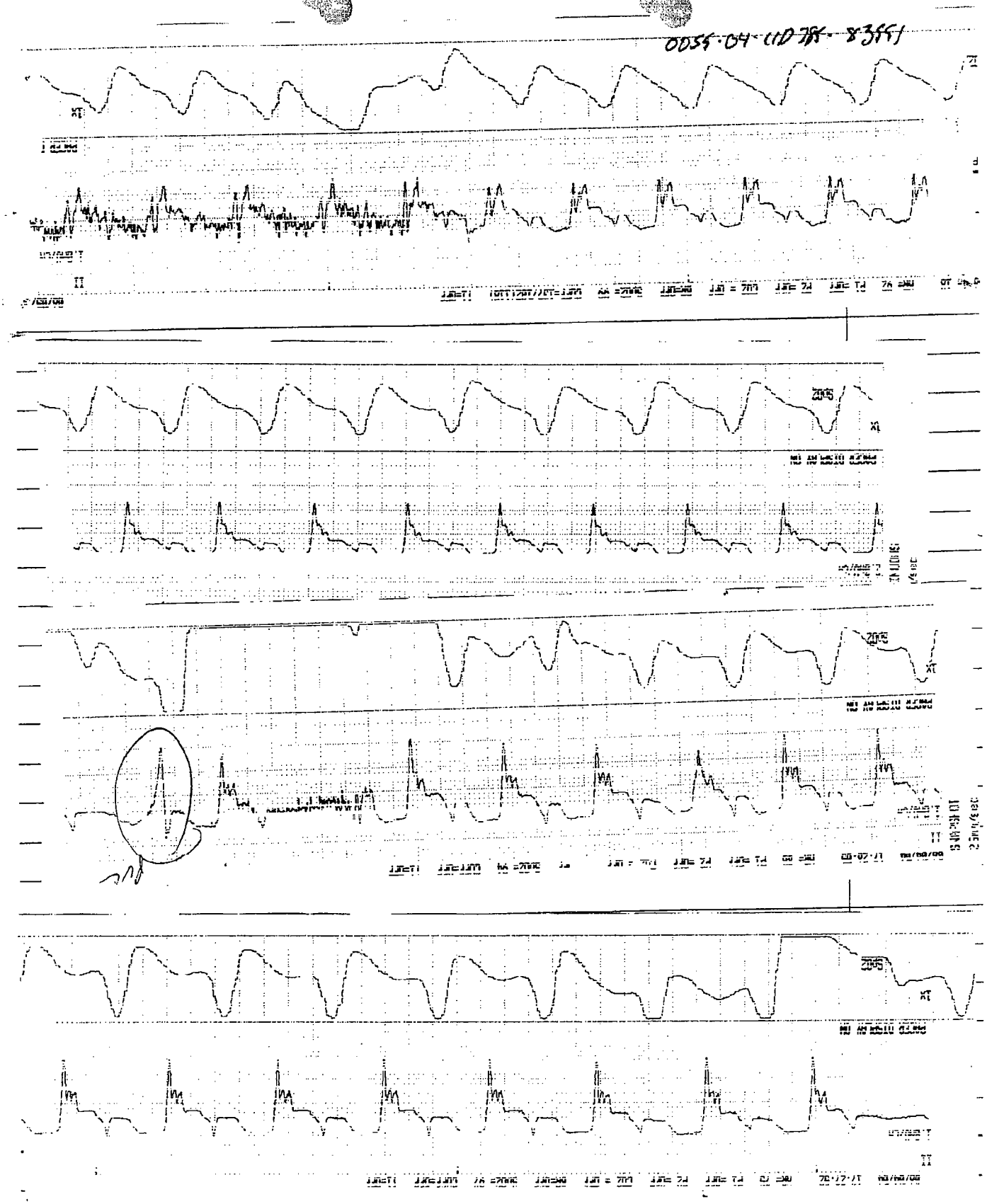
2yo chart 030 4Jun04 1452

(b)(6)-2

Noted 5Jun04 2030 (b)(6)

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

0055-04-CID 78-83551



Ex 4 24

BISON 4 (b)(6)-4 6055-04-00783-83(5)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO (b)(6)-2 | FROM: *(Requesting physician or activity)* | DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*
52 y/o ♂ C/O SHORT of BREATH, CHEST PAIN SINCE LAST NITE
Hx AT ATTACK. TAKES ~~CAPTOPRIL~~ (b)(6)-2 ISORDIN, ASA, ~~DIGOXIN~~ (b)(6)-2

HCTZ, ASA, ISOSORBIDE DIN, Prinzol

PROVISIONAL DIAGNOSIS
HT DISEASE

DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☒ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

BP - 116/90
P 92
R - 16
97% on RA

S) 52 y/o ♂ ACCEPTANCE REFERRED BY MEDICC FOR EVALUATION OF CHEST PAIN & SOB SINCE last Night. Pt presents with c/o SOB and was given 1 NITRO which resolved with nitro. Otherwise he has H/O HT AND IS ON HCTZ, ASA, ISOSORBIDE & Prinzol.

O) WNWD ♂ mild respiratory distress relieved after sublingual nitro
LUNGS - CTA B
HEART - RRR S1 S2 S4
ABD
? BONISH BRACH BLOCK

MH - RHEUM
MT

A) 1. UNSTABLE ANGINA

MED - ISOSORBIDE, NITRO, HCTZ, ASA 2 H/O MI
Allergies - PCN

P) 1. TRANSFER TO OASIS for further evaluation and recommendation
2. Care and plan discussed @ length to pt through interpreter

(Continue on reverse side)

SIGNATURE AND TITLE (b)(6)-2 SP USA | DATE 3 JUN 04

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

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

(b)(6)-4

BISON #4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

Ex 4
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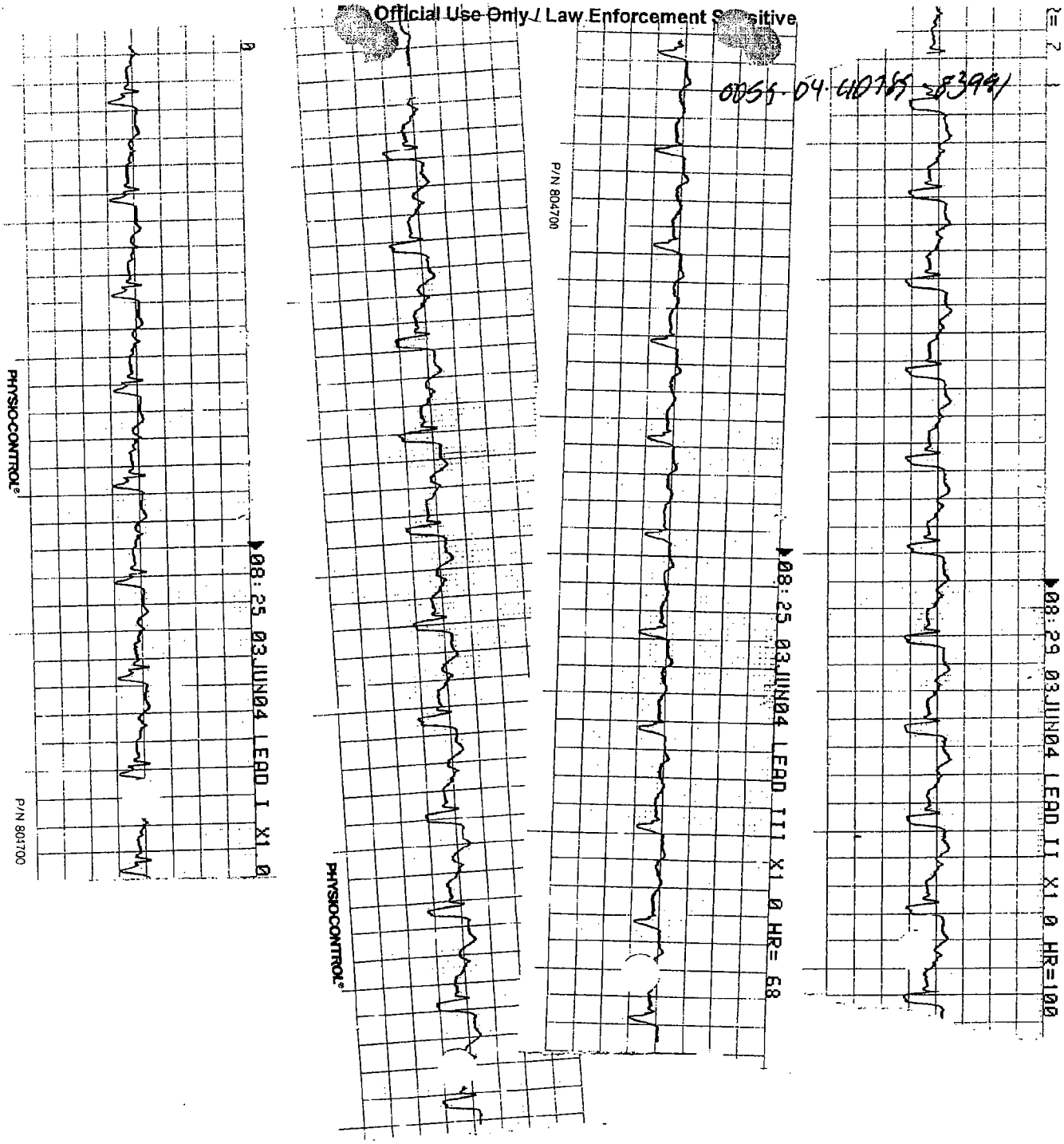
0054-04-40785-83991



SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	09					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA L FE. other	1 0					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	O					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 09		
ID band visible/legible	DG		
Orient to environment pm	DG		
Side rails (2/4) up	NA		
Bed position low	DG		
Call light within reach	NA		

OTHER

Review & post lab results	DG		
Notify MD abnormal labs	DG		
Incontinent urine/stool	DG		
Linen change pm	DG		
Turn/reposition q2h	DG		
ROM q2h if immobile	NA		
Antiembolic hose	–		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 100 %	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

INITIALS	SIGNATURE	SHIFT
(b)(6)-2		D

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

- Ex 4 27

0059-04-C10789-83991

SECTION III - INTERVENTIONS & TEACHING (CONT)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		None		

SECTION IV - NOTES

09 6 June 04 Pt up walking + sitting in chair. Denies dizziness, SOB + chest pain c̄ activity. Appetite fair. Tolerating meds well. Please refer to nursing assessment form medcom 689-R. (b)(6)-2 LTCAN

1300 Pt feeling good. VSS Tolerating medications well. Appetite good No chest pain. Discharge instructions reviewed c̄ pt + expresses understanding. (b)(6)-2 LTCAN

1400 Pt discharged accompanied by MP's. Condition stable. VSS. (b)(6)-2 LTCAN

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5 0234-04-CID78-93551

SECTION I - PATIENT ASSESSMENT

DATE: 6 JULY 2004 | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY: 3

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____ Anesthesia (*Specify*): _____

Total ER/RR/PACU time _____ Physician _____ B/P _____ P _____ R _____ T _____

Procedure/Diagnosis _____ Neurovascular checks _____

LOC _____ Tubes _____

Dressing/cast _____ Voided ☐ No ☐ Yes Amount: _____

Intake (IV, po) _____ Output (EBL, other) _____

Medication _____

Other _____ Received By _____

Report From _____

VITAL SIGNS

TIME:	0600	1300														
BP ARTERIAL LINE																
BP CUFF	115/88	123/94														
TEMPERATURE	97.7															
PULSE	82	93														
RESPIRATORY RATE																
OXYGEN (L/%)	—															
PULSE OXIMETER	98%	95%														
O_2 METHOD	RA															

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

PAIN

TIME:	09								
PAIN INTENSITY (10 / 5 / 0)	0								
MED ADMINISTERED (Y/N)	N								
RELIEF ACCEPTABLE (Y/N)	N								

SPECIAL NEEDS

	TIME: 09
*Skin breakdown prevention	(b)(6)-2
*Falls prevention protocol	
*Restraint protocol	
*Seizure precautions	
*Isolation precautions	

OTHER

TIME:									
FINGER STICK GLUCOSE	NA								
INSULIN (Y/N)	↓								

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

DIAGNOSIS: CHF

DRG: _____ ADMISSION DATE: 6-4-04-1CL

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: (b)(6)-2

ISOLATION REQUIRED (*Specify*): _____

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 09 INITIALS: (b)(	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ alert, oriented	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ HR + rhythm reg mild (+) foot edema periph pulses (+)	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ lungs clear	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ abd. soft. active bowel sounds	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ no reported urinary problems	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ Good strength all extremities	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ restraint sites - no redness / irritation	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ None	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ sl. anxious, wants to be released	☐	☐

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

TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____
IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____
IV site care provided: ____	IV site care provided: ____	IV site care provided: ____
IV tubing changed: ____	IV tubing changed: ____	IV tubing changed: ____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ____ / ____	IV Site #1: ____ / ____	IV Site #1: ____ / ____
IV Site #2: ____ / ____	IV Site #2: ____ / ____	IV Site #2: ____ / ____
Comments: NO IV access	Comments:	Comments:

Theater Trauma Registry Record

For use of this form, see AR 40-66; the proponent agency is OTSG 0055-04-CID785-83551

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine User" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION: BCOF
Number / TYPE:

CASUALTY NAME: (b)(6)-4

CASUALTY SSN: (b)(6)-4

Rank | Date of Birth | Gender ☒ Male ☐ Female | Unit

Arrive DTG: 1540 3JUN04

ARRIVAL METHOD:
- ☒ WALKED
- ☐ CARRIED
- ☐ Non-MED AIR
- ☐ OTHER
- ☐ Non-MED GND
- ☐ SHIP EVAC
- ☐ GND AMB
- ☐ DUSTOFF

Nation
- ☐ US DETAINEE
- ☐ Host Nation
- ☐ Enemy( )
- ☐ Coalition( )

Service
- ☒ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other

Wound DTG: N/A

WOUNDED BY:
- ☐ ENEMY
- ☐ FRIENDLY
- ☐ CIVILIAN (Host Country)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:
- ☐ UNK

N/A

PROTECTION: N/A

	Not Worn	Worn	Struck	Penetrated
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASCOW COMA SCALE (circle one)

3	8	12	15
UNC	STUPOR	LETHARGY	ALERT

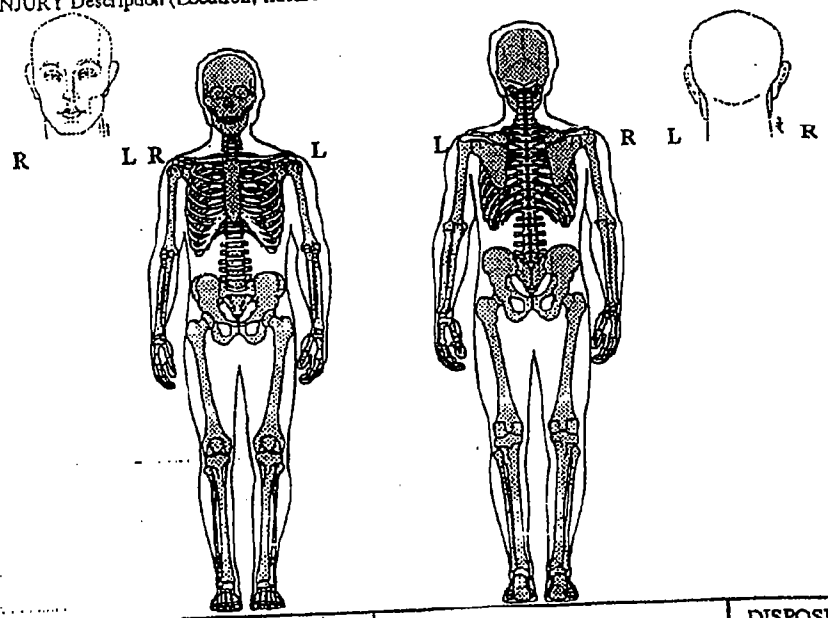
MECHANISM OF INJURY:
- ☐ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ MVC
- ☐ AIRCRAFT CRASH
- ☐ KNIFE/EDGE
- ☐ CBRNE
- ☐ BLAST
- ☐ BURN 1° 2° 3° _____ %TBSA
- ☐ CRUSH
- ☐ FALL
- ☐ IED
- ☐ OTHER

N/A

VITALS:

TIME	1540	1810	1850
Pulse	103	82	96
Temp	95.9		
B/P	144/103	119/80	112/61
Resp			
SpO_2	95%RA		0158

INJURY Description (Location, nature and size in cm. Be specific.)



TX & PROCEDURES:

SEDATED/ IMMOB	Y/N
INTUBATED	Y/N
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN 1545	Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
HBOC	ml
Fresh Whole Bld	Units

OR Start DTG: Stop DTG:
Vent On DTG: Off DTG:
ICU in DTG: Out DTG:

PROVIDER (b)(6)-2
SPECIALTY:
DATE:

DISPOSITION:
- ☐ RTD
- ☐ DECEASED

DTG: 2100 3JUN

EVACUATED to _____
- ☐ URGENT
- ☐ URGENT SURGICAL
- ☐ ROUTINE
- ☐ MINIMAL

TFR→ICU

MEDCOM Test Form 1381, OCT 2003

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EX 1

0059-04-C10789-83591

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

Observations/Notes (Holding, En route, etc)

TIME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
2005	116	89	88	21	92	A V P U	Aspirin	81 mg	PO	30JUN04-1805
						A V P U	Albuterol	0.5 mg	EH	30JUN-1430
						A V P U				
						A V P U				
						A V P U				
						A V P U				

NOTES: 1750 - 52 yr old brought to EMT c/o chest pain, seen 1 wk ago. 2 days before arrival. No chest pain on arrival. O2 @ 4L N/C (b)(6)-2 (b)(6)-2

MEDICATIONS:	LABS:	XRAYS:	PMH:
HCTZ 25mg qd ASA qd ISOSORBIDE BID PRINIVIL 20mg qd	lytes, Chem 12, CBC c diff Troponin > sent 1800	PA & Lat	"Clot in heart" Allergies: NKDA

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest: c/o SOB when coughing x 6 days some chest pain
SOB c exertion ⊖ chest pain

Abdomen: ⊖ fever ⊖ chills ⊖ sweating at night
① Losing 21 lbs
⊖ N/V

Upper: [illegible] clear
CTA bilateral rales scattered wheezes
O2 sat 94% 4L

Pelvis: Cx RN in ER on PIC
CXR bilateral

Lower: BKC ⊖ old injury and repaired MS
Tr edema
Full FA & pulses
⊖ clubbing or cyanosis

Skin: No albuterol nebulizer to 0.5 cc
Dorsal PIC
A ⊖ bruit [illegible]

(b)(6)-2

Cause of Death at _____

ANATOMIC:

☐ Airway ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Extremity (Upper/Lower) ☐ Other

PHYSIOLOGIC:

☐ Breathing ☐ CNS ☐ Hemorrhage ☐ Total Body Disruption ☐ Sepsis ☐ Multi-organ failure ☐ Other

0055-04-CID788-83551

MEDICAL RECORD - PATIENT ACTIVITIES FLOW SHEET

For use of this form see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 5 June 04 | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY: 2

TRANSFER

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

Time 1230 To ICW From ICU ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time ____ Physician (b)(6)-2 Anesthesia (Specify): —

Procedure/Diagnosis CHF BP 103/76 P 83 R 16 T 98.6

LOC Alert, oriented Neurovascular checks ____

Dressing/cast Ø Tubes Ø

Intake (IV, po) PO Output (EBL other) ____ Voided ☐ No ☐ Yes Amount: ____

Medication see flow sheet

Other ____

Report From (b)(6)-2 Received By (b)(6)-4 TCAN —

VITAL SIGNS

TIME:	1230	1400	1800	1830												
BP ARTERIAL LINE																
BP CUFF	103/76	107/81	103/72	103/70												
TEMPERATURE	98.6		97.7	97												
PULSE	83		74	81												
RESPIRATORY RATE	16		16	16												
OXYGEN (L/%)	—		—													
PULSE OXIMETER	95%		94%	94%												
O2 METHOD	RA		RA	RA												

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

PAIN

TIME:	1230	1945						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	N	NA						

OTHER

TIME:	NA							
FINGER STICK GLUCOSE	↓							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1230	1945
*Skin breakdown prevention	(b)(6)-2	(b)(6)-2
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		N/A
*Isolation precautions		

YESTERDAY'S WEIGHT: ____

TODAY'S WEIGHT: ____

WEIGHT CHANGE: ____

*Per hospital policy.

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

PATIENT IDENTIFICATION: (b)(6)-4

DIAGNOSIS: CHF

DRG: ____ ADMISSION DATE: 6-4-04

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: (b)(6)-2

ISOLATION REQUIRED (Specify): ____

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MEDCOM FORM 689-R (TEST) (MOFRS) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 4 pages MC V1.00

Ex 4

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0930 INITIALS: (b)	TIME: 1945 INITIALS: (b)(6)-2	TIME: INITIALS:
1. **NEUROLOGICAL:** Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ alert, oriented.	☑	☐
2. **CARDIOVASCULAR:** Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ Denies CP, SOB No edema. Periph pulses x4	☑	☐
3. **PULMONARY:** Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ Lungs clear	☑ CTA	☐
4. **G.I.:** Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ Abd. soft. active bowel sounds	☑	☐
5. **G.U.:** Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ no reported prob.	☑	☐
6. **MUSCULOSKELETAL:** Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ moves all extremities	☑ ambulates w/ difficulty	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ intact	☑	☐
8. **PAIN:** No complaints of pain discomfort. *(See page 3 for documenting pain intensity)*	☑ Denies	☑ no c/o pain voiced	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ cooperative	☑	☐

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

TIME: ____ INITIALS: ____	TIME: 1945 INITIALS: (b)(6)-2	TIME: ____ INITIALS: ____
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: No IV access	Comments: NO IV access	Comments:

0059-04-CID789-83551

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

Observations/Notes (Holding, En route, etc)

TIME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
2005	116	89	88	21	92	A V P U	Aspirin	81 mg	PO	3JUN04-1805
						A V P U	Albuterol	0.5 mg	EH	3JUN-1830
						A V P U				
						A V P U				
						A V P U				
						A V P U				

NOTES: 1750 - 32 yr old brought to EMTC c/o Chest Pain. Nitro 1 NTG SL given before arrival. No chest Pain on arrival. O2 @ 4L N/C

(b)(6)-2

(b)(6)-2

MEDICATIONS:
HCTZ 25mg qd
ASA qd
ISOSORBIDE BID
PRINIVIL 20mg qd

LABS:
lytes, Chem 12 CBC c diff
Troponin Sent 1800

XRAYS:
PA & Lat

PMH:
"Clot in heart"

Allergies:
NKDA

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest: No SOB when comfy x 6 days some [illegible]
SOB c exertion ⊖ chest pain

Abdomen: ⊖ fever ⊖ chills ⊖ sweating at night
⊖ Losing weight
⊖ N/V

Upper: Chest clear
Chest bilateral rales scattered wheezes
O2 sat 94% 4L

Pelvis: Cx RN in ER
Cx R bilateral

Lower: ⊖ KC ⊖ calf inflammation reported MS
Tender
Full f.b. + pulses
⊖ fleck in feet

Skin: No albuterol nebulizer 0.5cc
Donc RKS
A ⊖ bruised forehead

(b)(6)-2

Cause of Death at _____

ANATOMIC:
☐ Airway ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Extremity (Upper/Lower) ☐ Other

PHYSIOLOGIC:
☐ Breathing ☐ CNS ☐ Hemorrhage ☐ Total Body Disruption ☐ Sepsis ☐ Multi-organ failure ☐ Other

0059-04-010789-8398

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 09 INITIALS: (b)(	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ alert, oriented	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ HR + rhythm reg mild (+) foot edema periph pulses (+)	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ lungs clear	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ abd. soft. active bowel sounds	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ no reported urinary problems	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ Good strength all extremities	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ restraint wrists - no redness / irritation	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ None	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ sl. anxious, wants to be released	☐	☐

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

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments: no IV access	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1230	1945				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	R	R				
PASSIVE FLEXION	0	0				
PERIPHERAL PULSE	1	P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1230	1945
ID band visible/legible	(b)(6)-2	
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

Review & post lab results	(b)(6)-2	N/
Notify MD abnormal labs		/H
Incontinent urine/stool		N/
Linen change prn		
Turn/reposition q2h		
ROM q2h if immobile		
Antiembolic hose	—	/H

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Irregular
PERCENT CONSUMED: ICU	PERCENT CONSUMED: ICU	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: 1. Onset to ICU. Report S/S CP/SOB	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
(b)(6)-4	(b)(6)-2	(b)(6)-2 LTC AN MC SGT	(b)(6)-2

0054-04-CID789-83991

SECTION III - INTERVENTIONS & TEACHING (CONT)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	Ø	None		

SECTION IV - NOTES

5 June 04 1230 Received as transfer from ICU. Stable, VSS, please refer to nursing assessment form Medcom 689-R. (b)(6)-2 LTC AN
1800 No c/o chest pain, SOB. VSS. Appetite fair. Resting quietly and responds appropriately. Lungs clear, HR and rhythm regular. (b)(6)-2 LTC AN
1945 - Pt ambulating on ward w/o any difficulty. Pt w/o any dyspnea, no c/o chest pain. Will continue to monitor pt for any needs. 91WM6 (b)(6)-2 SGT
0030 Pt's B/P checked prior to 2400 meds. Pt denies any c/o c/p or dyspnea. Will continue to monitor pt for any needs. 91WM6 (b)(6)-2 SGT

0059-04-CID789-83991

SECTION III - INTERVENTIONS & TEACHING (CONT)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	Ø	None		

SECTION IV - NOTES

5 June 04 1230 - Received as transfer from ICU. Stable, VSS, please refer to nursing assessment form Medcom 689-R. (b)(6)-2 LTC AN

1800 No c/o chest pain, SOB. VSS. Appetite fair. Resting quietly and responds appropriately. Lungs clear, HR and rhythm regular. (b)(6)-4 LTC AN

1945. pt ambulating on ward w/o any difficulty. Pt w/o any dyspnea, no c/o chest pain. Will continue to monitor pt for any needs. 91WM6 (b)(6)-2 SGT

0030 Pt's B/P checked prior to 2400 meds. Pt denies any c/o c/p or dyspnea. Will continue to monitor pt for any needs. 91WM6 (b)(6)-2 SGT

NEUROLOGICAL ASSESSMENT

			HOURS 00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GCS	EYES OPEN	SPONTANEOUSLY 4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	3	3	3	3	3	3	3		3															
		REACTION	+	+	+	+	+	+	+		+															
	LEFT	SIZE	3	3	3	3	3	3	3		3															
		REACTION	+	+	+	+	+	+	+		+															
PUPIL SCALE			2		3		4		5		6		7 mm													
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record Separately if there is a Difference between the tow sides

+ + Brisk
+ Slow
No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

		HOURS 00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
↑ left	R	+	+	+	+	+	+	+	+	+	+	+	+	+											
	L	+	+	+	+	+	+	+	+	+	+	+	+	+											
↓ left	R	+	+	+	+	+	+	+	+	+	+	+	+	+											
	L	+	+	+	+	+	+	+	+	+	+	+	+	+											
edema ↑ left	R	–	–	–	–	–	–	–	–		–	–	–	–											
	L	–	–	–	–	–	–	–	–		–	–	–	–											
edema ↓ left	R	–	–	–	–	–	–	–	–		–	–	–	–											
	L	–	–	–	–	–	–	–	–		–	–	–	–											
	R	–	–	–	–	–	–	–	–		–	–	–	–											

+ + Normal
+ Weak
– Absent
D Doppler
R Right
L Left

For Official Use Only / Law Enforcement Sensitive

40 EX 4

0059-04-C-10289-83

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	/

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

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

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

ACTIVITIES OF DAILY LIVING											
	TIME	0700	1800								
	MOUTH CARE	(b)(6)-2									
	BATCH										
	SKIN CARE										
	FOLEY CARE										
	TRACH CARE										
	ROM EXERCISES										

TURN / SUCTION	TIME								
TURN									
	(b)(6)-2								
SUCTION									

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2
(b)(6)-2	

00041

0059-04-C10789-8577

POST-OP DAY Ø

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

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

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

ACTIVITIES OF DAILY LIVING											
TIME	0700	1800									
MOUTH CARE	(b)(6)										
BATCH											
SKIN CARE		(b)(6)-2									
FOLEY CARE											
TRACH CARE											
ROM EXERCISES											

TURN / SUCTION											
TIME	0700										
TURN	(b)(6)-2										
SUCTION											

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	
(b)(6)-4	

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Ex 4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2400	INITIAS (b)(	0730	INITIAS (b)(6)		INITIAS
	PUPILS	PERLA		PERLA			
	SENSORIUM	CAOX3		AOOX3, cooperative			
RESPIRATORY	RESPIRATION PATTERN	regular, unlabored		regular, unlabored			
	BREATH SOUNDS	Ausc all fields		CTA B			
	SECRETIONS	Ø		E, occasional dry cough			
SKIN	COLOR	WNL		WNL for race			
	INTEGRITY	WNL		WNL			
IV SITE	LOCATION	(L) FA		(L) FA			
	CONDITION	wnd, d s/sq infiltration or infiltration		patent, Ø s/sq infiltration or infiltration			
GASTRO	ABDOMEN	SNT (+) masses		S, slightly distended			
	BOWEL SOUNDS	(+) all 4 quads		(+) all, normoactive			
				[illegible]			
				stomach [illegible]			
GU	URINE	voiding c difficulty		voids c difficulty			
	COLOR/CLARITY	clear yellow		clear, yellow			
CARDIOVASCULAR	CARDIACRHYTHM	1° AV Block c		1° AV block c			
		IVCD & occasional		occasional PAC			
		PAC		E edema BUE			

LEGEND

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

(Continue on reverse)

(b)(6)-2 | ICU | DEPARTMENT/SERVICE/CINC ICU | DATE 5 Jun 00

PATIENT'S INDICATIONS (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)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

43

DATE 5-Jun-04 BY CHF HOSPITAL DAY 2

VITAL SIGNS	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
BP Arterial line																
BP Cuff	98/63	82/57	96/67	97/72	86/70	85/65	92/66	113/41	94/72	79/56	98/60	-	102/72			
Temperature	97.8	–	–	–		–	–	–	–	–	96.9		–			
Pulse	70	75	69	77	74	[illegible]	83	85	76	73	72		88			
Respiratory Rate	18	18	20	18	18	20	18	20	20	22	22		20			
pulse ox	97	97	98	97	97	95	97	99	99	96	97		99			

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF: Nacl	30	30	30	30	30	30	30	30	240	30	30	30	IV Nacl discont.	0				
PO						100			100	400	100	0	–	320				
TOTALS									340	430	130	30	0	320				

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR							1450		140	450	400		275					
	TOTAL							1450				850		1125					
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

DATE 5-June-04 px CHP HOSPITAL DAY 2

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial line																	
BP Cuff	98/63	87/57	96/67	97/72	86/70	88/65	97/60	112/41		94/72	79/56	98/60	–	102/72			
Temperature	97.8	–	–	–		–	–	–		–	–	96.9		–			
Pulse	70	75	69	77	74	75	83	85		76	73	72		88			
Respiratory Rate	18	18	20	18	18	20	18	20		20	22	22		20			
pulse ox	97	97	96	97	97	95	97	99		99	96	97		99			

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF: Nacl	30	30	30	30	30	30	30	30	240	30	30	30	IV d/c @1000	0				
PO						100			100	100	100	0	–	220				
TOTALS									340	430	130	30	0	220				

OUTPUT

URINE	HOUR																	
	TOTAL							1450/1450		140	450	400/850	275/1125					
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY —

ACUITY LEVEL CLASSIFICATION 0055-04-CID 789-82151

VITAL SIGNS	16	17	18	19	20	21	22	23
	76/43	71/51	78/53	105/74	79/46	88/61	88/62	87/65
	96.8	—	—	—	—	—	—	—
	75	76	72	77	75	91	69	74
	18	22	22	20	20	22	20	16
	94	96	94	95	94	94	98	96

INTAKE	16	17	18	19	20	21	22	23	8°T
I	30	30	30	30	30	30	30	30	240
	400	20	—					300	1020
K	430	50	30	30	30	30	30	370	1260

OUTPUT									
	X	650	X						1500

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

LABORATORY DATA	TIME	0615								
	GLUCOSE	109								
	Na/K	132/4.1								
	Cl/CO_2	100/21								
	BUN/Cr	12/1.1								
	WBC/PLATELET	8.4/267								
	Hct/Hgb	37.5/11.7								
	Troponin I	Neg								

ACTIVITIES OF DAILY LIVING	TIME	0720								
	MOUTH CARE	(b)(6)								
	BATCH									
	SKIN CARE	(b)(6)-								
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME									
	0720									
	(b)(6)-									
SUCTION										

24 HRS TOTALS

NURSE'S SIGNATURE

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	720	Urine	3570
Po	3170		
TOTAL	3960	TOTAL	3570
BALANCE	390		

(b)(6)-2

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Ex 4

NEUROLOGICAL ASSESSMENT

GCS		HOURS	00	02	04	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
EYES OPEN	SPONTANEOUSLY	4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓	✓
	TO SPEECH	3																					
	TO PAIN	2																					
	NO EYE OPENING	1																					
BEST VERBAL RESPONSE	ORIENTED	5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓	✓
	CONFUSED	4																					
	VERBALIZES	3																					
	VOCALIZES	2																					
	NO VOCALIZATION	1																					
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓	✓
	LOCALIZES PAIN	5																					
	FLEXION WITHDRAWAL	4																					
	ABNORMAL FLEXION	3																					
	EXTENSION TO PAIN	2																					
	NO RESPONSE	1																					
LIMB MOVEMENT: ARMS	NORMAL POWER		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓	✓
	MILD WEAKNESS																						
	SEVERE WEAKNESS																						
	ABNORMAL FLEXION																						
	ABNORMAL EXTENSION																						
	NO RESPONSE																						
LIMB MOVEMENT: LEGS	NORMAL POWER		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓	✓
	MILD WEAKNESS																						
	SEVERE WEAKNESS																						
	ABNORMAL FLEXION																						
	ABNORMAL EXTENSION																						
	NO RESPONSE																						
PUPILS: RIGHT	SIZE		3	3	3	3													3	3	3	3	3
	REACTION		+	+	+	+													+	+	+	+	+
PUPILS: LEFT	SIZE		3	3	3	3													3	3	3	3	3
	REACTION		+	+	+	+													+	+	+	+	+
PUPIL SCALE			2	3	4	5	6	7 mm															
ICP																							
CEREBRAL PERFUSION PRESSURE																							

LEGEND

C Closed by swelling

T Tracheostomy
S Stuttering
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record Separately if there is a Difference between the two sides

+ + Brisk
+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

	HOURS	00	02	04	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Leg	R	+	+	+	+	+	+	+	+	+	+							+	+	+	+	+
	L	+	+	+	+	+	+	+	+	+	+							+	+	+	+	+
Arm	R	+	+	+	+	+	+	+	+	+	+							+	+	+	+	+
	L	+	+	+	+	+	+	+	+	+	+							+	+	+	+	+
edema ↑	R																	–	–	–	–	–
	L																	–	–	–	–	–
edema ↓	R																	–	–	–	–	–
	L																	–	–	–	–	–

+ + Normal
+ Weak
– Absent
D Doppler
R Right

0059-04-C10789-8359

NEUROLOGICAL ASSESSMENT

HOURS: 00 02 04 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23

COMA SCALE

EYES OPEN	SPONTANEOUSLY	4
	TO SPEECH	3
	TO PAIN	2
	NO EYE OPENING	1
BEST VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	VERBALIZES	3
	VOCALIZES	2
	NO VOCALIZATION	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	ABNORMAL FLEXION	3
	EXTENSION TO PAIN	2
	NO RESPONSE	1

LIMB MOVEMENT

ARMS	NORMAL POWER
	MILD WEAKNESS
	SEVERE WEAKNESS
	ABNORMAL FLEXION
	ABNORMAL EXTENSION
	NO RESPONSE
LEGS	NORMAL POWER
	MILD WEAKNESS
	SEVERE WEAKNESS
	ABNORMAL FLEXION
	ABNORMAL EXTENSION
	NO RESPONSE

PUPILS

RIGHT	SIZE	3 3 3 3 3 3 3 3 3
	REACTION	H H H H H H H H H
LEFT	SIZE	3 3 3 B 3 3 3 3 3
	REACTION	H H H H H H H H H

PUPIL SCALE: 2 3 4 5 6 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND

C Closed by swelling

T Trach/Endo
S Stuttering
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record Separately if there is a Difference between the tow sides

++ Brisk
+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS: 00 02 04 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23

Leg	R	H H H H H H H H H H H H H H H H H H H H H H H H
	L	H H H H H H H H H H H H H H H H H H H H H H H H
Arm	R	H H H H H H H H H H H H H H H H H H H H H H H H
	L	H H H H H H H H H H H H H H H H H H H H H H H H
edema ↑	R	– –
	L	– –
edema ↓	R	– –
	L	– –

++ Normal
+ Weak
– Absent
D Doppler
R Right

Ex 4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA 0056-04-CID783-83551

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) OA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0800	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS		PERLA		PERLA			
	SENSORIUM		a&ox3, cooperative		CAOX3			
RESPIRATORY	RESPIRATION PATTERN		Regular, unlabored		regular & unlabored			
	BREATH SOUNDS		CTA B		Clear all fields			
	SECRETIONS		none					
			2 L/min O2 via NC					
SKIN	COLOR		WNL		WNL			
	INTEGRITY				WNL			
IV SITE	LOCATION		L FA		L FA			
	CONDITION		patent, good blood return; 0 s/s infiltration		WNL; 5 s/s of infiltration; infusion is complete			
			NS @ TKO					
GASTRO	ABDOMEN		S, NT, ND		SNT (-) masses			
	BOWEL SOUNDS		BS(+) x 4		(+) all 4 quad			
GU	URINE		Clear, yellow WNL intake		also voiding; difficulty			
	COLOR/CLARITY		Urinal		clear yellow			
CARDIOVASCULAR	CARDIACRHYTHM - electrode		NSR, Trace ectopy (B, Freq		PAC Bigeminy & trigeminy			
	ST WAVES		P wave ST 2/3 x 4		Ventricular ectopy			
			Cap refill < 3 sec x 4		ST ↑ & PACs			
			Chaman's sign (B/E)					

LEGEND

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

(b)(6)-2

(Continue on reverse)

PR

DEPARTMENT/SERVICE/CINC ICU

DATE 4 Jun 04

...typed or written entries give: Name Last, First, ...date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

49

DA FORM 1 MAY78 4700

WAMC OP 975 (Redesignated) 1 APR 90 (HSXC - NU)

Ex 1

HOSPITAL DAY 2

DATE 6-Jun | DX CHF

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial line																	
BP Cuff	127/85	101/68	93/61	93/63	123/90	136/100	85/62	86/59		84/53	87/59	89/61	96/66	97/44	112/70	83/56	75/41
Temperature	97.8					97.4					97.2			97.2			
Pulse	97	72	67	67	83	101	76	81	-	78	73	68	87	74	82	73	66
Respiratory Rate	24	22	22	24	22	24	22	20	-	20	20	18	18	20	18	20	18
O^2	94%	96%	97%	95%	96%	96%	94	94%	-	94	94	94	95	98	96	95	93

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS@30	30	30	30	30	30	30	30	30	240	30	30	30	30	30	30	30	30	240
po intake	200		200		200	200			800	150	150	0	200	250	200	200	200	1350
TOTALS									1040	180	180	30	230	280	230	230	230	1590

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		HOUR / TOTAL					400 / 400		420 / 820		830	475			275 / 750		500 / 1250			1250
URINE		SP gr																		
URINE		S/A																		
NG		OUTPUT																		
NG		PH																		
NG		GUAIC																		
EMESIS																				
STOOL																				
DRAINS																				

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HOSPITAL DAY 2

DATE 8-Jan DX CHF

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	SP Arterial line	—																	
	BP Cuff	127/85	101/68	93/61	93/63	123/90	136/100	95/62	86/51		84/53	87/59	89/61	96/66	97/64	117/70	83/52	75/41	
	Temperature	97.8	—	—	—		97.9	—	—	—	—	97.2	—	—	97.2	—	—	—	
	Pulse	97	72	67	67	83	101	76	81	—	78	73	68	87	74	82	43	66	
	Respiratory Rate	24	22	22	24	22	24	22	20	—	20	20	18	18	20	18	20	18	
	O^2	94%	96%	97%	95%	96%	96%	94	94%	—	94	94	94	95	98	96	95	93	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS@30	30	30	30	30	30	30	30	30	240	30	30	30	30	30	30	30	30	240
	po intake	200		200		200	200			500	150	150	0	200	250	200	200	200	1350
	TOTALS									1040	180	180	30	230	280	230	230	230	1590

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE						400/400		420/820		820	475			275/750		500/1250			1250
		SP gr																		
		SA																		
	NG	OUTPUT																		
		BILE																		
		GUAIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			

POST-OP DAY

PATIENT LEVEL CLASSIFICATION 0055-04-CID 785-83991

VITAL SIGNS	16	17	18	19	20	21	22	23	
						123/90	115/88	103/72	
						97.6			
						87	86	74	
						22	24	22	
						93	94	97	

INTAKE	16	17	18	19	20	21	22	23	8°T
						30	30	30	
						200		200	

OUTPUT	16	17	18	19	20	21	22	23	
				700/700					

RESPIRATORY DATA										
TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
A: pH										
A: PCO_2										
B: PO_2										
B: HCO_3										
B: SAT										
B: BASE										

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

ACTIVITIES OF DAILY LIVING										
TIME	21-									
MOUTH CARE										
BATCH										
SKIN CARE										
FOLEY CARE										
TRACH CARE										
ROM EXERCISES										
Incentive Spir	9									

TURN	TIME									
SUCTION										

24 HRS TOTALS

NURSE'S SIGNATURE

(b)(6)-2

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	90	Urine	700
Po	400		
TOTAL	490	TOTAL	700
BALANCE	210		

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EX 4

0059-04-00789-8395

NEUROLOGICAL ASSESSMENT

GCS		HOURS	21	23
EYES OPEN	SPONTANEOUSLY	4	✓	✓
	TO SPEECH	3		
	TO PAIN	2		
	NO EYE OPENING	1		
BEST VERBAL RESPONSE	ORIENTED	5	✓	✓
	CONFUSED	4		
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1		
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓	✓
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO RESPONSE	1		
LIMB MOVEMENT – ARMS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
LIMB MOVEMENT – LEGS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
PUPILS – RIGHT	SIZE		3	3
	REACTION		++	++
PUPILS – LEFT	SIZE		3	3
	REACTION		++	++
PUPIL SCALE				
ICP				
CEREBRAL PERFUSION PRESSURE				

LEGEND

C Closed by swelling

T Trach Tube
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record Separately if there is a Difference between the two sides

++ Brisk
+ Slow
– No Response

2 3 4 5 6 7 mm

+ Intact
– Abnormal

VASCULAR ASSESSMENT

	HOURS	21	23
Leg	R	++	++
	L	++	++
Arm	R	++	++
	L	++	++
	R		
	L		
	R		
	L		
	R		

++ Normal
+ Weak
– Absent
D Doppler
R Right

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NEUROLOGICAL ASSESSMENT

COMA SCALE	HOURS	21	23
EYES OPEN: SPONTANEOUSLY 4		✓	✓
EYES OPEN: TO SPEECH 3			
EYES OPEN: TO PAIN 2			
EYES OPEN: NO EYE OPENING 1			
BEST VERBAL RESPONSE: ORIENTED 5		✓	✓
BEST VERBAL RESPONSE: CONFUSED 4			
BEST VERBAL RESPONSE: VERBALIZES 3			
BEST VERBAL RESPONSE: VOCALIZES 2			
BEST VERBAL RESPONSE: NO VOCALIZATION 1			
BEST MOTOR RESPONSE: OBEYS COMMANDS 6		✓	✓
BEST MOTOR RESPONSE: LOCALIZES PAIN 5			
BEST MOTOR RESPONSE: FLEXION WITHDRAWAL 4			
BEST MOTOR RESPONSE: ABNORMAL FLEXION 3			
BEST MOTOR RESPONSE: EXTENSION TO PAIN 2			
BEST MOTOR RESPONSE: NO RESPONSE 1			
LIMB MOVEMENT: ARMS: NORMAL POWER		✓	✓
ARMS: MILD WEAKNESS			
ARMS: SEVERE WEAKNESS			
ARMS: ABNORMAL FLEXION			
ARMS: ABNORMAL EXTENSION			
ARMS: NO RESPONSE			
LEGS: NORMAL POWER		✓	✓
LEGS: MILD WEAKNESS			
LEGS: SEVERE WEAKNESS			
LEGS: ABNORMAL FLEXION			
LEGS: ABNORMAL EXTENSION			
LEGS: NO RESPONSE			
PUPILS: RIGHT SIZE		3	3
PUPILS: RIGHT REACTION		H	H
PUPILS: LEFT SIZE		3	3
PUPILS: LEFT REACTION		H	H
PUPIL SCALE		2 3 4 5 6 7 mm	
ICP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record Separately if there is a Difference between the tow sides

+ + Brisk
+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		21	23
Leg	R	H	H
	L	H	H
Arm	R	H	H
	L	H	H
	R		
	L		
	R		
	L		

+ + Normal
+ Weak
– Absent
D Doppler
R Right

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Ex 4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2100	INITIALS (b)(6)-		INITIALS		INITIALS
	PUPILS	Perrla					
	SENSORIUM	A&O x3					
RESPIRATORY	RESPIRATION PATTERN	regular					
	BREATH SOUNDS	crackles/wheezing BLL					
	SECRETIONS	none					
		O2 NC sats					
		97%					
SKIN	COLOR	normal for race					
	INTEGRITY	intact moist					
		warm					
IV SITE	LOCATION	(L) forearm					
	CONDITION	CDI patent					
		NS @ KVO					
GASTRO	ABDOMEN	soft nontender					
	BOWEL SOUNDS	active x 4					
GU	URINE	voiding					
	COLOR/CLARITY	yellow/clear					
CARDIOVASCULAR	CARDIACRHYTHM	NSR					
		massive cardiac x1					
		urgent					
		hypertension					

LEGEND

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

(b)(6)-2

(Continue on reverse)

PREPA[redacted] TMENT/SERVICE/CLINIC ICU DATE 3 Jun 04

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

55

0055-04-010781-83991

DATE		ON														HOSPITAL DAY			
VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff																		
	Temperature																		
	Pulse																		
	Respiratory Rate																		
	O^2																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS@TKO																		
	Po intake																		
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL																		
	URINE SP gr																		
	URINE S.A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		

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0059-04-C10789-83991

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff																		
	Temperature																		
	Pulse																		
	Respiratory Rate																		
	O^2																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS@TKO																		
	Po intake																		
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE																			
		SP gr																		
		S.A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			

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Ex 4

0059-04-0072K-83151

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Physician's PROGRESS NOTES

DATE	NOTES
6/3/04	Admitted for CHF see HPP (b)(6)-2
6/4/04	Pt alert breathing easily saturating 99% on 2L Chest clear bilaterally weakly [illegible] history of [illegible] edema gone A CHF P ① continue Diuretics ② Begin [illegible] (b)(6)-2
6/5/04	Still slightly hypotensive [illegible] with ACE and Beta blocker [illegible] some crackles at bases only Chest clear edema is gone A Pulmonary edema - improving (R) and (L) [illegible] HF P Continue to IV [illegible] and adjust meds (b)(6)-2

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

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

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0059-04-CID789-83

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/10/04	Ready for Discipline to corp

(b)(6)-2

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

Ex 4

Tl ter Trauma Registry Reco

For use of this form, see AR 40-66; the proponent agency is OTSG 61JSG-04-MD715-F3551

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION: Number CBCFH TYPE:	CASUALTY NAME: (b)(6)-4	CASUALTY SSN: (b)(6)-4

Arrive DTG: 10 June 2004 1940	Rank	Date of Birth 01 Jul 52	Gender ☒ Male ☐ Female	Unit Bisson L

ARRIVAL METHOD:
- ☐ WALKED
- ☒ CARRIED
- ☐ Non-MED AIR
- ☐ OTHER
- ☐ Non-MED GND
- ☐ SHIP EVAC
- ☐ GND AMB
- ☐ DUSTOFF

Nation
- ☐ US
- ☐ Host Nation
- ☒ Enemy (Victim)
- ☐ Coalition ( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other

Wound DTG: Unknown

WOUNDED BY:
- ☐ ENEMY
- ☐ FRIENDLY
- ☐ CIVILIAN (Host Country)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:
- ☐ UNK

N/A

PROTECTION: NA

	Not Worn	Worn	Struck	Penetrated
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASCOW COMA SCALE (circle one)

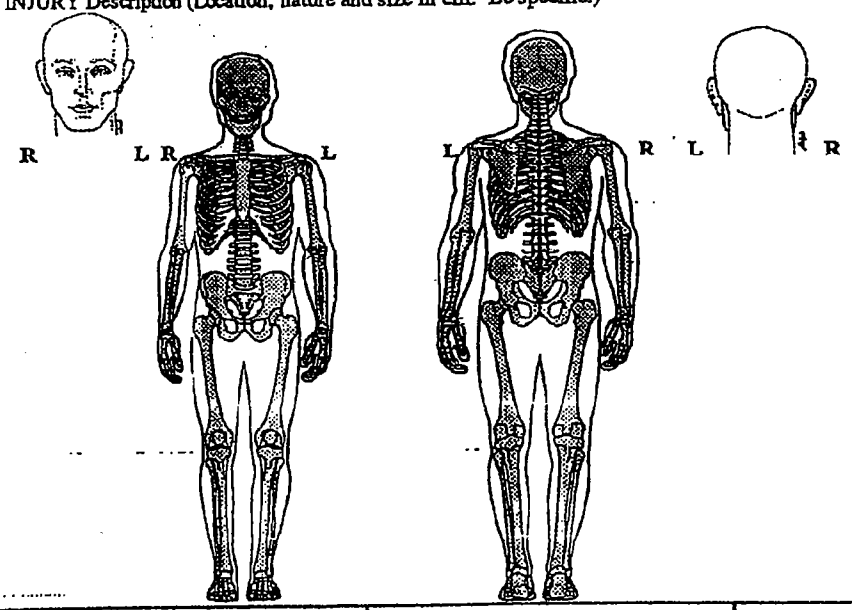
3	8	12	15
UNC	STUPOR	LETHARGY	ALERT

MECHANISM OF INJURY:
- ☐ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ MVC
- ☐ AIRCRAFT CRASH
- ☐ KNIFE/EDGE
- ☐ CBRNE
- ☐ BLAST
- ☐ BURN 1° 2° 3° _____ %TBSA
- ☐ CRUSH
- ☐ FALL
- ☐ IED
- ☒ OTHER Cardiac Resp arrest

VITALS:

TIME			
Pulse			
Temp			
B/P			
Resp			
SpO_2			

INJURY Description (Location, nature and size in cm. Be specific.)



TX & PROCEDURES:	
SEDATED/ IMMOB	Y/N
INTUBATED	Y/N
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN	Liters/min
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
HBOC	ml
Fresh Whole Bld	Units

OR Start DTG: Stop DTG:	Vent On DTG: Off DTG:	ICU in DTG: Out DTG:

DISPOSITION:
- ☐ RTD
- ☒ DECEASED DTG: 2000 HRS 10 JUN 04

EVACUATED to _____
- ☐ URGENT
- ☐ URGENT SURGICAL
- ☐ ROUTINE
- ☐ MINIMAL

PROVIDER (b)(6)-2 | SPECIALTY: ER | DATE: 6/10/04

MEDCOM Test Form 1381, OCT 2003

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Ex 4

0054-04-CID784-83991

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

Observations/Notes (Holding, En route, etc.)

TIME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
DTG:						A V P U				DTG:
						A V P U				
						A V P U				
						A V P U				
						A V P U				
						A V P U				

See Code Sheet

NOTES: Elderly Detainee down 25 min by EM attended by BTS within 8 min. Daff 3x 200J CPR 2 mg epi and 2 additional shocks ventilated and oxygenated intubation in the field and became pink after intubation. Presented to ER pulseless blue long ventilated

MEDICATIONS:	LABS:	XRAYS:	PMH:
See Code Sheet	Ø	Ø	Allergies: Unknown

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck: C collar long and CPR in ER intubation confirmed and breath sounds bilateral

Chest: occasional respiratory shocked c 200J and given high dose epinephrine 5 amp of EPI followed by 5 amp atropine and 1 amp of bicarb and defibrillated c 360J x 2

Abdomen: no rhythm or pulse was obtained CPR and respiration maintained through entire process TOD ~~1555~~ 2000 COD cardiorespiratory arrest

Upper:

(b)(6)-2

Pelvis:

Lower:

Skin:

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Cause of Death at _____

ANATOMIC:

Ex 4

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

Observations/Notes (Holding, En route, etc.)

TIME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
DTG:						A V P U				DTG:
						A V P U				
						A V P U				
See Code Sheet						A V P U	See Code Sheet			
						A V P U				
						A V P U				

NOTES: Elderly Detainee down 25 min before ER attended by BAS with 8 min Defib 3x200J CPR 2 mg epi and 2 additional shocks ventilated and esophageal intubation in the field and became pink after intubation & needed to ER pulseless blind bag ventilated

MEDICATIONS:	LABS:	XRAYS:	PMH:
See Code Sheet	Ø	Ø	Allergies: Unknown

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck: C collar, bag and CPR in ER intubation confirmed and quick look showed V fib on agonal rhythm shocked c 200J and given high dose epinephrine c 5 amp of EPI followed by 1 amp atropine and 1 amp of Bicard and defibrillated c 360J x 2 no rhythm or pulse so started CPR and respirations manual through entire process TOD ~~1555~~ 2000 COD cardiorespiratory arrest

Chest:

Abdomen:

Upper:

(b)(6)-2

Pelvis:

Lower:

Skin:

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Cause of Death at _____ For Official Use Only / Law Enforcement Sensitive

ANATOMIC:

Ex 4

EMERGENCY RESUSCITATION RECORD - PAI

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 10 June 2004

2. LOCATION OF RESUSCITATION EVENT
☐ MICU ☐ SICU ☐ CCU ☐ NICU ☒ ED ☐ PACU ☐ OR ☐ WARD: ____
☐ DIAGNOSTIC / PROCEDURE AREA: ____
☐ OUTPATIENT CLINIC: ____
☐ OTHER *(Specify)*: ____

3. WITNESSED ARREST?
☐ YES ☒ NO ☐ UNKNOWN

MONITORED AT ONSET?
☐ YES ☒ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) COMMENTS

☒ IV Access	☐ Time:	:	Inserted in field
☒ Endotrachael Tube	☐ Time:	:	Inserted in field
☐ Mechanical Ventilation	☐ Time:	:	
☐ Arterial Line	☐ Time:	:	
☐ Central Venous Line	☐ Time:	:	
☐ Pulmonary Artery Catheter	☐ Time:	:	
☐ Nasogastric Tube	☐ Time:	:	
☐ Pacing Device *(Specify type)*: ____	☐ Time:	:	
☐ Implantable Defibrillator / Cardioverter	☐ Time:	:	
☒ Other *(Specify)*: Suction	☒ Time: 1955	:	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*
☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☒ Other: Cardio-respiratory Arrest

6. RESUSCITATION ATTEMPTED
☒ YES *(Check all that were used)*
☒ Chest Compressions
☒ Defibrillation
☒ Airway Management
☐ NO *(Check one)*
☐ False alarm/arrest (BLS / ALS not needed)
☐ Do not attempt resuscitation (DNAR)
☐ Considered futile ☐ Found dead

7. INITIAL CONDITION
CONSCIOUS ☐ Yes ☒ No
BREATHING ☐ Yes ☒ No
PULSE ☐ Yes ☒ No
Site: ____

8. INITIAL RHYTHM
☒ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)
☐ Returned at: ____ : ____ ☐ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 19 : 58

WHY: ☐ ROSC ☐ DNAR
☐ Considered futile ☒ Death

9. EVENT TIMES
(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:		
CPR Started:		
1st Defibrillation:		
Airway Achieved:		
1st Dose Epinephrine:		

Code Team Called: ☒ Yes ☐ No Time: 19 : 40
Code Team Arrived: ☐ Yes ☐ No Time: 19 : 45

10. GLASGOW COMA SCALE (Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
(1) - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
(1) - No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
(1) - No movement

SCORE: 3

PATIENT DISPOSITION: CID

PATIENT IDENTIFICATION
ISN: (b)(6)-4
Camp Bissell

AGE: ____
GENDER: Male
HEIGHT (in): ____
WEIGHT (lbs): ____

MC V2.00

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE

0059-04-C10789-83991

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EMERGENCY RESUSCITATION RECORD PAGE

	TIME (Hr/Min):	1950	1957	1957									
VITALS	BLOOD PRESSURE												
	HEART RATE (* = CPR)	0*	0*	0*									
	RHYTHM	VF	VF	VF									
	PULSE PALPABLE (Y/N)	N	N	N									
	DEFIBRILLATION (Joules: 200, 300, 360)	1950 300	1957 360	1957 360									
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	~~1950~~ 200											
	PACING PERFORMED (✓)												
	RESPIRATIONS												
AIRWAY	BAGGED w / 100% O2 (✓)	✓	✓	✓									
	INTUBATED (✓)	✓	✓	✓									
	MASK (Specify type)	NRB	NRB	NRB									
	% OXYGEN	100	100	100									
	O2 SATS												
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	1 mg IV	1952 1mg	1953 1mg	1954 1mg								
	ATROPINE (0.5 -1 mg - IV / ET tube)	1955 1mg											
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
	1 AMP BICARB	1954											
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
ABGs	PH												
	pCO2												
	pO2												
	HCO3												

PHYSICIAN (Signature & Title) (b)(6)-2 MD

NURSE (Signature & Title) (b)(6)-2 SGT

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

2 epi
1 atr
1 bicar
prior to arrival

1950
200P

TOD: ~~1959~~ 2000 HRS

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Ex U

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EMERGENCY RESUSCITATION RECORD

	TIME (Hr/Min):	1950	1957										
VITALS	BLOOD PRESSURE												
	HEART RATE (* = CPR)	0*	0*	0*									
	RHYTHM	VF	VF	VF									
	PULSE PALPABLE (Y/N)	N	N	N									
	DEFIBRILLATION (Joules: 200, 300, 360)	1950 300	1957 360	1957 360									
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	1959 200											
	PACING PERFORMED (✓)												
	RESPIRATIONS												
AIRWAY	BAGGED w / 100% O2 (✓)	✓	✓	✓									
	INTUBATED (✓)	✓	✓	✓									
	MASK (Specify type)	NRB	NRB	NRB									
	% OXYGEN	100	100	100									
	O2 SATS												
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	1 mg IV	1952 1mg	1953 1mg	1954 1mg								
	ATROPINE (0.5 - 1 mg - IV / ET tube)	1955 1mg											
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
	1 AMP BICARB	1954											
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
ABGs	PH												
	pCO2												
	pO2												
	HCO3												

PHYSICIAN (Signature & Title) (b)(6)-2 MD

NURSE (Signature & Title) (b)(6)-2 EMT

MEDCOM FORM 679-R (TEST)(MCHQ) AUG 99, Book

QEPI
1 Atr
1 Bicarb
prior to arrival

1950
300

TOD: ~~1959~~ 2000 HRS

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Ex 4

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ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY REPORT

Name: (b)(6)-4
National Detainee Reporting System: (b)(6)-4
Date of Birth: 7 January 1952
Date of Death: 10 June 2004
Date of Autopsy: 19 June 2004
Date of Report: 22 September 2004

Autopsy No.: ME04-435
AFIP No.: 2931952
Rank: Iraqi civilian
Place of Death: Abu Ghraib, Iraq
Place of Autopsy: Baghdad, Iraq

Circumstances of Death: This 52 year-old male Iraqi civilian collapsed while speaking to other detainees while in US custody at the Baghdad Central Confinement Facility in Abu Ghruyeb, Iraq, and resuscitative efforts were unsuccessful.

Authorization for Autopsy: The Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Visual and documentation accompanying the body; fingerprints and DNA sample obtained

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease
   a. Severe coronary atherosclerosis with calcification
      i. Left main coronary artery, 50% luminal narrowing by fibrocalcific plaque
      ii. Total occlusion of proximal left anterior descending artery (LAD) with healed plaque rupture and organized thrombus; 75% narrowing of mid LAD by fibroatheroma; 65% narrowing of distal LAD by fibrocalcific plaque; total occlusion of ramus intermedius by healed rupture with fibrointimal thickening and smooth muscle proliferation
      iii. Total occlusion of proximal to mid left circumflex artery (LCA) by organized and recanalized thrombus; 70% fibrocalcific narrowing of distal LCA; 90% narrowing of obtuse marginal artery with fibrointimal thickening and smooth muscle proliferation
      iv. Right coronary artery (RCA), 25% narrowing of proximal RCA by fibrocalcific plaque; 40% narrowing of mid RCA by fibroatheroma; 70% fibrocalcific narrowing of distal RCA; 95% narrowing of posterior descending artery by fibroclcific plaque and smooth muscle proliferation
   b. Healed transmural myocardial infarction
      i. Involves anterior, septal and lateral left ventricle mid ventricle to apex
      ii. Microscopically, transmural fibrosis and fat replacement in anterior, septal and lateral walls of left ventricle
      iii. Aneurysmal dilatation
      iv. Epicardial fibrous adhesions at apex of left ventricle
   c. Cardiomegaly with biventricular hypertrophy
      i. Heart 666 gm (predicted normal value 343 gm)
      ii. Left ventricular cavity diameter 60 mm
      iii. Left ventricular free wall thickness 10 mm
      iv. Microscopically, biventricular myocyte hypertrophy with subendocaridal and perivascular interstitial fibrosis
   d. Moderate to severe atherosclerosis of the aorta
      i. Diffuse calcific intimal plaque formation
      ii. Focal plaque rupture with associated hemorrhage
   e. Pulmonary edema
      i. Right lung 965 grams
      ii. Left lung 818 grams

II. No evidence of any significant trauma
   a. Abrasion, 4 x 3 cm on back of right forearm
   b. Contusion, 7 x 4 cm on back of right hand

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Ex 5

AUTOPSY REPORT ME04-435
(b)(6)-4

III. Additional Findings
   a. Subcutaneous lipoma of anterior left side of neck
   b. Right renal calculus (kidney stone)
   c. Prostatic hypertrophy
   d. Symmetrically enlarged thyroid gland

IV. Medical Intervention
   a. Endotracheal tube in place
   b. Three adhesive EKG tabs on body

V. Early to moderate decomposition
   a. Diffuse marbling of body
   b. Corneal opacification

VI. Toxicology (AFIP)
   a. Volatiles: Heart blood and urine negative for ethanol
   b. Cyanide: Heart blood negative
   c. Drugs: Heart blood negative for screened medications and drugs of abuse

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EXTERNAL EXAMINATION

The body is that of a well developed, well-nourished male clad in a previously cut, white long sleeve shirt-dress ("dish dash") and white boxer shorts. The body weighs approximately 170 pounds, is 71" in height and appears compatible with the reported age of 52 years. The body is cold, the temperature that of the refrigeration unit. Rigor is waning. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure, and is especially pronounced on the face.

Early to moderate decompositonal changes are present, consisting of diffuse marbling and discoloration of the body and corneal opacification.

The scalp is covered with black and grey hair in a normal distribution, averaging 4 cm in length. Facial hair consists of a dark mustache and grey facial stubble. The irides appear dark, but are partially obscured by corneal clouding. The sclerae and conjunctivae are congested, especially on the left, with no petechiae. The earlobes are not pierced. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The lips are without evident injury. The teeth are natural and in good condition.

Examination of the neck reveals the trachea to be midline and mobile. There is a palpable 3 x 2 cm subcutaneous nodule on the anterior left side of the neck. The chest is symmetric and well developed. No injury of the ribs or sternum is evident externally. The abdomen is slightly protuberant and soft. The extremities are well developed with normal range of motion. There is a 4 x 1.5 cm scar on the upper anterior aspect of the right forearm, and there are irregular scars over the left knee. The fingernails are short and intact. No tattoos are noted, and needle tracks are not observed. The external genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable. There is an identification tag on the first toe of the left foot.

EVIDENCE OF THERAPY

There is an endotracheal tube in place secured with white tape around the head, and there are three adhesive EKG tabs on the body, two on the upper chest and one on the left thigh. There is a band-aid on the right antecubital fossa over a needle puncture mark with surrounding ecchymosis.

EVIDENCE OF INJURY

There is a 4 x 3 cm abrasion on the back of the right forearm and there is a 7 x 4 cm contusion on the back of the right hand. On external and internal examination of the body, there is no other evidence of trauma.

INTERNAL EXAMINATION

BODY CAVITIES:
The body is opened by the usual thoraco-abdominal incision, and the chest plate is removed. There is approximately 50 ml of serosanguinous fluid in each pleural space, and there are multiple pleural adhesions of the right chest cavity. No adhesions or abnormal collections of fluid are present in the peritoneal cavity. All body organs are present in the normal anatomical position. The subcutaneous fat layer of the abdominal wall is 4 cm thick. There is no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

HEAD: (CENTRAL NERVOUS SYSTEM)
The scalp is reflected, and there is no subgaleal hemorrhage or skull fractures found. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin and delicate. The cerebrospinal fluid is dark with decompositional change, most prominent over the occiput; however, there is no evidence of any subarachnoid hemorrhage. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. Coronal sections through the cerebral hemispheres revealed no lesions, and there is no evidence of infection, tumor, or trauma. Transverse sections through the brain stem and cerebellum are unremarkable. The dura is stripped from the basilar skull, and no fractures are found. The atlanto-occipital joint is stable. The brain weighs 1180 grams.

NECK:
On dissection of the soft tissue of the neck, there is a well-circumscribed yellow 3 x 2 cm nodule just under the skin on the anterior left side of the neck, adjacent to the thyroid cartilage. On sectioning, the nodule is uniformly fatty, consistent with a lipoma. Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, otherwise reveals no abnormalities. The anterior strap muscles of the neck are homogeneous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa and is unobstructed. The thyroid gland is large but symmetric and red-brown, without cystic or nodular change. There is no evidence of infection, tumor, or trauma, and the airway is patent. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury, hemorrhage, or fractures of the dorsal spinous processes.

CARDIOVASCULAR SYSTEM:
There are dense apical adhesions of the heart to the pericardial sac, and there is marked aneurysmal dilatation of the left ventricle. See "Cardiovascular Pathology Report" below. A moderate amount of epicardial fat is present, and the heart weighs 666 grams. The aorta and its major branches arise normally and follow the usual course. There is diffuse moderate to severe atherosclerosis of the aorta with extensive calcific intimal plaque formation and focal plaque rupture with associated hemorrhage. The venae cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi.

RESPIRATORY SYSTEM:
The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. There are scattered pleural adhesions of the right chest cavity. The pleural surfaces are otherwise smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is red-purple and edematous, exuding a moderate amount of bloody fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 965 grams; the left 818 grams.

LIVER & BILIARY SYSTEM:
The hepatic capsule is smooth, glistening and intact, covering dark red-brown, moderately congested parenchyma with no focal lesions noted. The gallbladder contains 5 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The liver weighs 1498 grams.

ALIMENTARY TRACT:
The tongue exhibits no evidence of recent injury. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 100 ml of dark fluid. The small and large bowel are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present and is unremarkable.

GENITOURINARY SYSTEM:
The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. There is a single dark calculus in the right renal pelvis. The calyces, pelves and ureters are otherwise unremarkable. White bladder mucosa overlies an intact bladder wall. The urinary bladder contains 50 ml of cloudy, yellow urine. The prostate gland is enlarged but symmetrical with lobular, yellow-tan parenchyma and no nodules or masses. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities. The right kidney weighs 207 grams; the left 235 grams.

RETICULOENDOTHELIAL SYSTEM:
The spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The spleen weighs 278 grams.

ENDOCRINE SYSTEM:
The pituitary and adrenal glands are unremarkable. The thyroid gland is symmetrically enlarged, but free of nodules or masses.

MUSCULOSKELETAL SYSTEM:
Muscle development is normal. No bone or joint abnormalities are noted.

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MICROSCOPIC EXAMINATION

Heart: See "Cardiovascular Pathology Report" below.

Selected portions of other organs are retained in formalin, without preparation of histologic slides.

CARDIOVASCULAR PATHOLOGY REPORT

Department of Cardiovascular Pathology, AFIP:

"**AFIP DIAGNOSIS: ME04-435**

1. **Severe coronary atherosclerosis with calcification, three vessel disease**
2. **Healed transmural infarction with aneurysmal dilatation, anterior, septal, and lateral left ventricle**
3. **Cardiomegaly with biventricular hypertrophy**

History: 52 year old male Iraqi detainee, 5'11", 170 lbs, found dead in bed
Heart: 666 grams (predicted normal value 343 grams, upper limit 453 grams for a 170 lbs male); focal epicardial fibrous adhesions at apex of left ventricle; closed foramen ovale; aneurysmal dilatation of left ventricle: left ventricular cavity diameter 60 mm, left ventricular free wall thickness 10 mm, ventricular septum thickness 10 mm; right ventricle thickness 4 mm; endocardial thickening in left atrium and left ventricle; unremarkable valves; healed transmural infarct, anterior and septal walls of left ventricle, mid ventricle to apex; subendocardial hyperemia, anterior and lateral walls of left ventricle; histologic sections show biventricular myocyte hypertrophy with subendocardial and perivascular interstitial fibrosis; transmural fibrosis and fat replacement in anterior, septal, and lateral walls of left ventricle.
Coronary arteries: Normal ostia; right dominance; severe calcific atherosclerois:

Left main coronary artery: 50% luminal narrowing by fibrocalcific plaque
Left anterior descending artery (LAD): Total occlusion of proximal LAD with healed plaque rupture and organized thrombus; 75% narrowing of mid LAD by thin capped fibroatheroma and 65% narrowing of distal LAD by fibrocalcific plaque; total occlusion of ramus intermedius by healed rupture with fibrointimal thickening and smooth muscle proliferation
Left circumflex artery (LCA): Total occlusion of proximal to mid LCA by organized and recanalized thrombus, 70% fibrocalcific narrowing of distal LCA; 90% narrowing of obtuse marginal artery with fibrointimal thickening and smooth muscle proliferation
Right coronary artery (RCA): 25% narrowing of proximal RCA by fibrocalcific plaque, 40% narrowing of mid RCA by thin capped fibroatheroma, and 70% fibrocalcific narrowing of distal RCA; 95% narrowing of posterior descending artery by fibrocalcific plaque and smooth muscle proliferation."

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EX5

ADDITIONAL PROCEDURES

- Full body radiographs are obtained and show no evidence of trauma.
- Documentary photographs are taken by OAFME photographers
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous fluid, heart blood, urine, and bile
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representative

OPINION

This 52 year-old male Iraqi civilian in US custody in Iraq died of atherosclerotic cardiovascular disease, with severe coronary artery disease and a healed myocardial infarction (previous heart attack), extensively involving the left ventricle. There is no evidence of any significant trauma.

The manner of death is natural.

(b)(6)-2

LtCol, USAF, MC, FS
First Chief Deputy Medical Examiner

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO ATTENTION OF

AFIP-CME-T

TO:

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

PATIENT IDENTIFICATION

AFIP Accessions Number	Sequence
2931952	01

Name (b)(6)-4

SSAN: **Autopsy:** ME04-435
Toxicology Accession #: 043003
Date Report Generated: June 30, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 6/10/2004 **Date Received:** 6/22/2004

VOLATILES: The **HEART BLOOD AND URINE** were examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

CYANIDE: There was no cyanide detected in the heart blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

DRUGS: The **HEART BLOOD** was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

(b)(6)-2 PhD
Certifying Scientist, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner

(b)(6)-2
PhD, DABFT
Director, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner

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0059-04-CID759-83991

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.

Jun 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	3	4	5	6	7	8	9	10	11	12	13
3Jun04	(b)(6)-2	Cardiac Monitor	07		(b)(6)-2			Transfer to ICW 5Jun04						
			19											
3Jun04		Clear Liquids	07					Order 4Jun04						
			19											
3Jun04		Vitals q4hr	07											
			19											
3Jun		Bedrest elevate HOB	07					ICW orders — Transferred to ICW 5Jun04						
			19											
3Jun		IvO mag anchor Foley if needed	07											
			19											
4Jun		General Diet	07											
			19											
5Jun		Vital signs q8°	07				(b)(6)-2							
			19											
5Jun		Activity as tolerated	07	X										
			19											
5 June 04		Restraint order - vg2h	07											
		+ document S+S of skin break	19											
6June04	(b)(6)	Weekly wt Thursday	08											

ALLERGIES: ☒ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: DX: CHF

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 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED

Ex 4

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0059-04-CID784-83551

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 5	6	7	8
Sjun 04	(b)(	Lasix 20mg ½ tab q a.m	08	(b)(6)-2			

ALLERGIES: ☐ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
CHF

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.

Ex 4

0054-04-CID789-83491

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. Jun Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9						
3Jun	(b)(6)-2	Lasix 20mg IVP	04	/	(b)(6)-2	(b)										
	-----	q 8hr	12	/												
	-----		20	/												

3Jun	(b)(6)-2	IVNS @ KVO	07	/		(b)(6)-2										
	-----		19	CW												

3Jun	(b)(6)-2	ASA 81mg po	08	/		(b)(6)-2										
	-----	daily														

3Jun	(b)(6)-2	Prinivil 20mg	08	/		(b)(6)-2										
	-----	PO BID	20	/		(b)(6)-2										

3Jun	(b)(6)-2	Isordil 20mg	06	/		(b)(6)-2										
	-----	po TID	14	/												
	-----		22	CW		(b)(6)-2										

3Jun	(b)(6)-2	O2 2L per NC	07	/		(b)(6)-2										
	-----		19	/												
4JUN.	-----	CABETALOL 100mg PO BID	08	/												
4JUN	-----	HOLD IF SBP<90, HR<50	20	/												
	-----															
4 Jun	(b)(6)-2	Metoprolol 25mg PO	12	/		(b)(6)-2										
	-----	BID - HOLD SBP<90, HR<50	24	/		(b)(6)-2										

4Jun	(b)(6)-2	Zantac 150mg IVP	16	/		(b)(6)-2										
	-----	TID	22	/												

ALLERGIES: ☐ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: DX: CHF

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1 of 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

Ex 4

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0059-04-CID789-83951

Task Force Alcatraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | SSN or ISN: | Diagnosis: CHF

Physician: (b)(6)-2 | Ward: 3 Bed: ICU | STAT / X Routine | Specimen Date and Time: | Reported by: (b)(6)-2 | Date and Time: 5 5.v04

Chemistry (i-STAT) / Green Top

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		

Other lab request to be sent out:

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	3.4	3.3-5.5 g/dL
	ALP	91	53-128 U/L
	ALT	10	10-47 U/L
	AMY	67	14-97 U/L
	AST	19	11-38 U/L
	Tbil	2.5	0.2-1.6 mg/dL
X	BUN	9	7-22 mg/dL
	Ca	8.8	8.0-10.3 mg/dL
X	Chol	136	100-200 mg/dL
	CK	–	39-380 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
X	Creat	0.7	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	96	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.7	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I		< 0.5 ng/mL
	Myoglobin		< 80 ng/ml
	RSV		Negative

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

Hematology / Purple Top

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-50.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Immature cells	

RBC Morph:

Plt verify:		
Spun Crit		35-60%

Malaria / Purple

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank / Purple Top

ABO/Rh		
T/C		

Ex 4

FORM 67ib CPHL AP 1.09 May 2004

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2004-04-010288-83551

Task Force Patriot
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST MI	SSN	DOB	RANK	UNIT
(b)(6)-2	(b)(6)-2			

Pt	Ward:	STAT / Routine	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	EMT	X /	3 JUN 04 1800	(b)(6)	3 JUN 04 1845

Chemistry (i-STAT): 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer): Chem 12, MetLyte8, BMP, Liver

X	TEST	RESULT	REF. RANGE
	ALB	4.1	3.3-5.5 g/dL
	ALP	107	36-128 U/L
	ALT	18	10-47 U/L
	AMY	62	14-97 U/L
	AST	36	11-38 U/L
	Tbil	2.2	0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	93	39-380 U/L
✓	CL	109	98-108 mmol/L
	TCO2	19	18-33 mmol/L
	Creat	0.8	0.6-1.2 mg/dL
	GGT	112	5-65 U/L
	Glu	90	73-118 mg/dL
✓	K	4.4	3.3-4.7 mmol/L
	TProtein	7.8	6.4-8.1 g/dL
✓	Na	127	128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I	<0.5	< 0.5 ng/mL
	Myoglobin		< 80 ng/mL
	RSV		Negative

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

Hematology: CBC, Malaria, H/H

X	TEST	RESULT	REF. RANGE
	WBC	5.2	4.8-10.8 x10(3)/ul
	RBC	5.87	4.2-6.1 x10(6)/uL
	Hgb	17.4	12.0-18.0 g/dL
	Hct	54.8	35.0-60.0%
	MCV	93.4	80.0-99.0 fl
	MCH	29.6	27.0-31.0 pg
	MCHC	31.7	33.0-37.0 g/dL
	Plt	205	130-400 x10(3)/ul
	LY%	59.1	15.0-50.0%
	LY#	3.1	0.7-4.3 x10(3)/ul

Differential

Segs	29	Mono	5
Bands		Eos	5
Lymph	61	Baso	
Atyp Ly		Immature cells	

RBC Morph: normocytic / normochromic

Plt verify:		
Spun Crit		35-60%

Malaria (waiting for supplies)

Sed Rate

Sed Rate		1hr = 0 20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank

ABO/Rh		

Ex 4
14

0056-04-CID188-83551

Task Force A. ..traz
Baghdad Central Detention Facility Hospital

..ATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4 | SSN or ISN: | Diagnosis: CHF

Physician: (b)(6)-2 | Ward: | Bed: | STAT | Routine | Specimen Date and Time: 0530 06 15 | Reported by: (b)(6)-2 | Date and Time:

Lytes

Chemistry (i-STAT) / Green Top									Chemistry (Piccolo Analyzer) / Green Top									Hematology / Purple Top								
6+	7+	8+	Glu	Crea					Chem 12	MetLyte8	BMP	Liver						CBC	Malaria	H/H						
X	TEST	RESULT	REF. RANGE						X	TEST	RESULT	REF. RANGE						X	TEST	RESULT	REF. RANGE					
	Na		128-145 mmol/L							ALB		3.3-5.5 g/dL							WBC	8.6	4.8-10.8 x10(3)/uL					
	K		3.3-4.7 mmol/L							ALP		26-84 U/L							RBC	6.16	4.2-6.1 x10(6)/uL					
	Cl		98-108 mmol/L							ALT		10-47 U/L							Hgb	18.2	12.0-18.0 g/dL					
	pH		7.35-7.45							AMY		14-97 U/L							Hct	57.5	35.0-60.0%					
	PCO2		35-45 mmHg							AST		11-38 U/L							MCV	93.4	80.0-99.0 fl					
	PO2		80-90 mmHg							Tbil		0.2-1.6 mg/dL							MCH	29.6	27.0-31.0 pg					
	TCO2		18-33 mmol/L							BUN	12	7-22 mg/dL							MCHC	31.7	33.0-37.0 g/dL					
	HCO3		22-28 mmol/L							Ca		8.0-10.3 mg/dL							Plt	202	130-400 x10(3)/uL					
	sO2		95-99%							Chol		100-200 mg/dL							LY%	35.7	15.0-50.0%					
	BEecf		(-2) - (+3)							CK	72	39-380 U/L							LY#	3.1	0.7-4.3 x10(3)/uL					
	AGap		8-16 mmol/L							CL	100	98-108 mmol/L							Differential							
	iCa		0.11-1.23 mmol/L							TCO2	21	18-33 mmol/L							Segs			Mono				
	BUN		7-22 mg/dL							Creat	1.1	0.6-1.2 mg/dL							Bands			Eos				
	Glu		73-118 mg/dL							GGT		5-65 U/L							Lymph			Baso				
	Creat		0.6-1.2 mg/dL							Glu	109	73-118 mg/dL							Atyp Ly			Immature cells				
	Hct		35.0-60.0%							K	4.1	3.3-4.7 mmol/L							RBC Morph:							
	Hgb		12.0-18.0 g/dL							TProtein		6.4-8.1 g/dL														
	Lactate		0.90-1.70 mmol/L							Na	132	128-145 mmol/L							Plt verify:							
	Urinalysis									Misc. Chemistry									Spun Crit		35-60%					
	Color		Straw/Yellow							Mono		Negative							Malaria / Purple							
	Clarity		Clear							RPR		Negative							Thin		No Plasmodium Seen					
	Glucose		Negative							HIV		Negative							Thick		No Plasmodium Seen					
	Bilirubin		Negative							Meningitis		Presumptive Negative							Sed Rate / Purple Top							
	Ketone		Negative							Legionella		Presumptive Negative							Sed Rate		1hr = 0-20 mm					
	SG		1.010-1.025							Troponin I	NEG	< 0.6 ng/mL							Coagulation (waiting for analyzer)							
	Blood		Negative							Myoglobin		< 80 ng/mL														
	pH		5.0-8.0							RSV		Negative														
	Protein		Negative Trace							Microbiology																
	Urobili		Negative							Source:																
	Nitrite		Negative							FecLeuk		Negative														
	Leuko		Negative							Gram Stain									HCG							
	Urine Microscopic									WetPrep		Negative							Urine		Negative					
	WBC		Epi							KOH		No Fungal Elements							Serum		Negative					
	RBC		Mucus							OccBld		Negative							Blood Bank/ Purple and Red Top							
	Bacteria		Yeast							O&P		No Ova/Parasite							ABO/Rh							
	Casts:		Spermatozoa							Chlamydia		Presumptive Negative							T/C							
	Crystals:		Amorph Sed							Strep A		Negative														
	Other:									Leishmania		Presumptive Negative														

Other lab request to be sent out:

FORM 67th CSHLAB-1 27 May ..04

Ex 4

..00 15

0056-04 CID 785-80551

CERTIFICATE OF DEATH

For use of this form, see AR 190-8; the proponent agency is DCSPER.

INTERNMENT SERIAL NUMBER

FROM:

TO:

ISN (b)(6)-4
Camp Bissonu

NAME (Last, First, MI)	GRADE	SERVICE NUMBER

NATIONALITY	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE
Iraqi		

PLACE OF BIRTH

DATE OF BIRTH: 01 JUL 1952

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN

FIRST NAME OF FATHER

PLACE OF DEATH	DATE OF DEATH	CAUSE OF DEATH
Abu Ghraib Hosp	10 June 04	Cardiac Respiratory Arrest

PLACE OF BURIAL

DATE OF BURIAL

IDENTIFICATION OF GRAVE

PERSONAL EFFECTS (To be filled in by Office of Deputy Chief of Staff for Personnel)

___ RETAINED BY DETAINING POWER ___ FORWARDED WITH DEATH CERTIFICATE TO (Specify) ___ FORWARDED SEPARATELY TO (Specify)

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS (Doctor, Nurse, Minister of Religion, Fellow Internee). IF CREMATED, GIVE REASON. (If more space is required, continue on reverse side).

Patient arrived with CPR already under way. Cardiac Monitor showed Ventricular fibrillation. Despite CPR, Medications, and defibrillation attempts, pt ~~[illegible]~~ expired @ 2[illegible] HRS either death declared by physician.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE: 6/18/04

(b)(6)-2

ICAL OFFICER

SIGNATURE OF COMM[illegible]

WITNESSES

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

(b)(6)-2

SIGNATURE ADDRESS

DA FORM 2669-R, May 82 EDITION OF 1 JUL 63 IS OBSOLETE.

Ex 4

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HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL: 0056-04-CD705-53551

Instructions - Medical Officer in attendance will:
Prepare, in one copy only, items 1 through 10 and sign item 11. Print or type entries.
Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*
SN: (b)(6)-2
BISSON 4

2. TIME OF DEATH *(Hour-day-month-year)*
2100 6/10/01

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☒ NO

4. RELIGION Lutheran

5. CHAPLAIN NOTIFIED ☐ YES ☒ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH
N/A

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Cardio respiratory arrest	1 hour
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) [illegible]	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
6/10/01	(b)(6)-2	(b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPPC V2.00

Ex 4
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0054-04-010713-8351

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
(b)(6) -4			[illegible]	[illegible] HOURS	
			[illegible]		
			[illegible]		
			[illegible]		
			[illegible]		
			[illegible]		
			[illegible]		
NURSING UNIT	ROOM NO.	BED NO.	[illegible]		
			[illegible]		

Ex 4

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MEDCOM - 915

0054-04-010789-83551

Standard Form 504

CLINICAL RECORD	HISTORY—Part I

NATURE AND DURATION OF COMPLAINTS (Include circumstance of admission)

[illegible]

HISTORY OF PRESENT ILLNESSES

HPI [illegible]
HEENT clear
Chest [illegible] bilateral rales ca. [illegible] PMI [illegible]
[illegible]
[illegible]
[illegible]

A [illegible]
[illegible] Hx AS HD

P [illegible]
[illegible] ACE
[illegible]
[illegible]
[illegible]

(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.

HISTORY—Part I
Standard Form 504

General Services Administration and
Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.5
October 1975

504-108

*U.S. Government Printing Office: 1991 — 281-782/20334

Ex 4

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WEIGHT REGISTER

For use of this form, see AR 190-8; the proponent agency is DCSPER.

NAME (Last, First, MI) (b)(6)-4

INTERNMENT SERIAL NUMBER

WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE

DA FORM 2664-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE USAPPC V1.00

Ex 4

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MEDCOM - 917

0036-04-0285-5551

0056-04-CID715-83551

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: 6/4/04 TIME OF ORDER: 0715 HOURS

(1) Begin Lovenox 100 mg po BID first dose now

(2) Hold for SBP less than 90 or HR less than 50

(b)(6)-2

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6/4/04 TIME OF ORDER: 0730 HOURS

(1) Lytes, BUN, creat, serum cholesterol in AM 6/5/04

(2)

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6/4/04 TIME OF ORDER: 0810 HOURS

(1) DLC Lovenox (not started)

(2) Metoprolol 25 mg Po BID

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER: 6/4/04 TIME OF ORDER: 1600 HOURS

(1) General diet

(2)

(b)(6)-2

2000 - 4 [illegible] in AM/CT

(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.

Ex 4

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0654-04-CID 785-83551

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: 6/5/04 TIME OF ORDER: 0805 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICW
2. D/C IV
3. Vital q 8 hrs
4. Catheter to bedside
5. general diet
6. Zantac 150 mg ÷ PO BID
7. ASA 81 mg ÷ daily

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24CC Pal-AL		LGRW

DATE OF ORDER: 6/6 TIME OF ORDER: _____ HOURS

1. Logesic 25 mg PO BID
2. Percocet 20 mg ÷ daily
3. Lasix 20 mg ÷ PO qAM
4. Isordil 20 mg ÷ PO TID
5. PCN allergy
6. LOS

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6/6 TIME OF ORDER: 1230 HOURS

1. Return to camp
2. ASA 81 mg ÷ PO daily
3. ~~Percocet 50 mg ÷~~
4. Logesic 25 mg ÷ PO BID
5. Lasix 20 mg ÷ PO qAM
6. Isordil 20 mg ÷ PO TID
7. Percocet 20 mg ÷ daily

noted 6 June 04 1300

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: _____ TIME: _____ HOURS

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

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

Ex 4

☆ U.S. GOVERNMENT PRINTING OFFICE: 1980—409-924

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0055-04-CD28-8255/

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: 6/3/04 TIME OF ORDER: 2015 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit Monitored bed
2. Cardiac Monitor
3. O2 2LNC
4. Lasix 20mg IVP q8hrs
5. IV NS @ PIV
6. Clear liquids
7. Prevacid 20mg PO BID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 6/4 TIME OF ORDER: HOURS

8. ASA 81mg PO daily
9. MS 4mg IVP q 2hrs PRN SOB
10. CBC Lytes in AM 6/4/04
11. Isordil 20mg PO TID
12. I&O may obtain foley if needed
13. Vitals q4hrs

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: TIME OF ORDER: HOURS

14. Bed not elevated HOB

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 3/JUNE04 TIME OF ORDER: 2045 HOURS

VOS

1. Allergy to PCN
2. Dx: CHF

(b)(6)-2

NURSING UNIT: 7th charlie | ROOM NO.: 030 | BED NO.: 4 Jun 04 1658

(b)(6)-2

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

Ex 4

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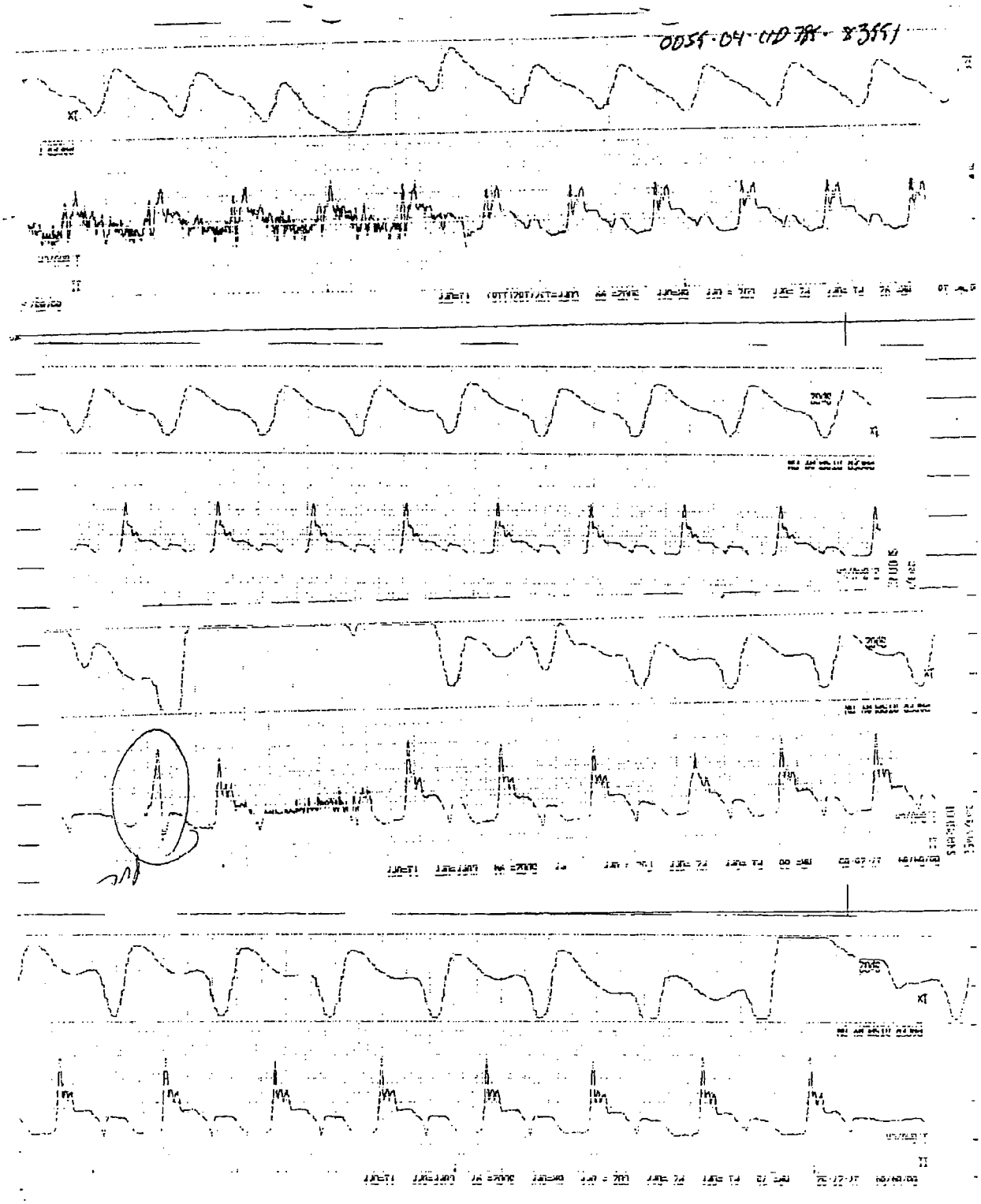

Ex 4

00024

BISON 4 (b)(6)-4

6035-04-00715-83(5)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: LT. (b)(6)-2

FROM: *(Requesting physician or activity)*

DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

52y/o ♂ C/O SHORT of BREATH, CHEST PAIN SINCE LAST NITE
Hx AT ATTACK. TAKES ~~CARDIZEM~~ ISORDIN, ASA, ~~DIGOXIN~~

HCTZ, ASA, ISORDIN BID, Prinzol

PROVISIONAL DIAGNOSIS

HT DISEASE

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ 72 HOURS ☒ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

BP - 116/90
P 92
R - 16
97% on RA

S) 52 y/o ♂ BOTTENEAU REFERRED By MOOTC FOR EVALUATION OF CHEST PAIN & SOB since last night. Pt presents with c/o SOB and was given 1 NITRO which resolved with intro. Otherwise he has H/O HT AND IS ON HCTZ, ASA, ISORDIN BID, PRINZOL.

O) WNWD ♂ mild respiratory distress relieved after sublingual nitro
LUNGS - CTA B
HEART - RRR S1 S2 S4

? BURNING BACK PAIN
ABN

NH - ASIAN
MM

HX - ISCHEMIC, ANGINA, HCTZ, ASA & H/O MI
Allergies - PCN

A) 1. UNSTABLE ANGINA

P) 1. TRANSFER TO CBNS for further evaluation and recommendations
2. Case and plan discussed @ length to pt through interpreter

(Continue on reverse side)

SIGNATURE AND TITLE (b)(6)-2 PA-C USN SP USN

DATE 3 JUN 04

HOSPITAL (b)(6)-2

RECORDS MAINTAINED AT

DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR

SPONSOR'S NAME *(Last, first, middle)*

SPONSOR'S ID NUMBER *(SSN or Other)*

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

REGISTER NO.

WARD NO.

(b)(6)-4

BISON #4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

Ex 4

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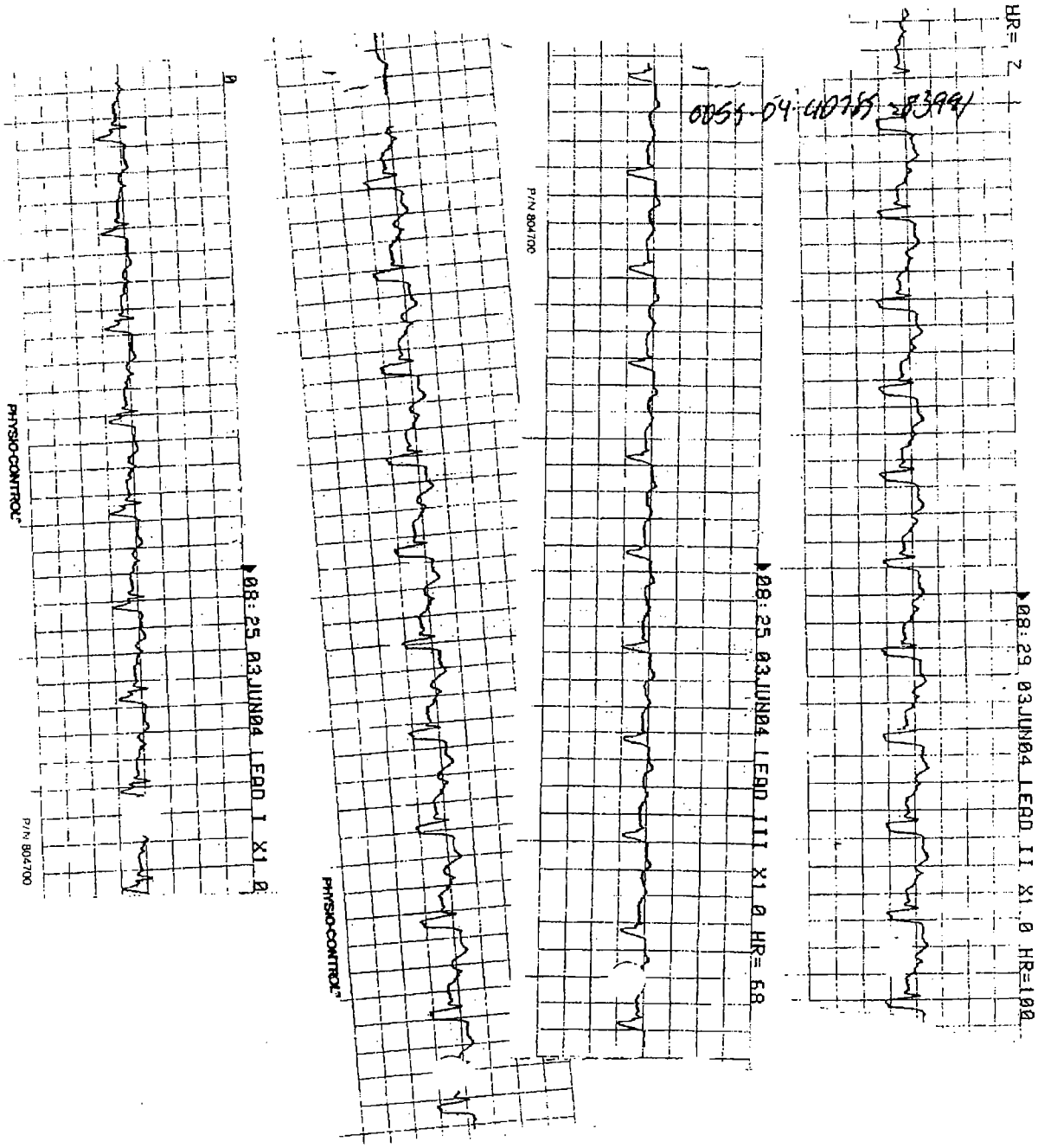
08:29 03JUN04 LEAD II X1.0 HR=100
08:25 03JUN04 LEAD III X1.0 HR= 68
08:25 03JUN04 LEAD I X1.0
PHYSIO-CONTROL
P/N 804700

Ex 4

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0059.04-CID 789. 20551

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	09					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA L FE other	1					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	O					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-6 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	09		
ID band visible/legible	DG		
Orient to environment pm	DG		
Side rails (2/4) up	NA		
Bed position low	DG		
Call light within reach	NA		

OTHER

Review & post lab results	DG		
Notify MD abnormal labs	DG		
Incontinent urine/stool	DG		
Linen change pm	DG		
Turn/reposition q2h	NA DG		
ROM q2h if immobile	NA		
Antiembolic hose	–		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Irregular	TYPE:	TYPE:
PERCENT CONSUMED: 100 %	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
(b)(6)-4	(b)(	(b)(6)-2 CTL AN	D
(b)(6)-4			

Ex 4

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MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5 0254-04-C1078-93551

SECTION I - PATIENT ASSESSMENT

DATE: 6 JUNE 2004 | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY: 3

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0600	1300														
BP ARTERIAL LINE																
BP CUFF	115/88	123/91														
TEMPERATURE	97.7															
PULSE	82	93														
RESPIRATORY RATE																
OXYGEN (L/%)	—															
PULSE OXIMETER	98%	95%														
O_2 METHOD	RA															

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

PAIN

TIME:	09							
PAIN INTENSITY (10 / 5 / 0)	0							
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	N							

OTHER

TIME:								
FINGER STICK GLUCOSE	NA							
INSULIN (Y/N)	↓							

SPECIAL NEEDS

TIME:	09		
*Skin breakdown prevention	(b)(6)-2		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: CHF

DRG: _____ ADMISSION DATE: 6-4-04-1CU

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: (b)(6)-2

ISOLATION REQUIRED (*Specify*): _____

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

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#2

Theater Trauma Registry Record

For use of this form, see AR 40-66; the proponent agency is OTSG 0035-64-CIDTR-53511

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION: BCOF
Number Type

CASUALTY NAME: (b)(6)-2

CASUALTY SSN: (b)(6)-2

Arrive DTG: 1540 3 JUN 04

Rank | Date of Birth | Gender ☒ Male ☐ Female | Unit

ARRIVAL METHOD:
☒ WALKED
☐ CARRIED
☐ Non-MED AIR
☐ OTHER
☐ Non-MED GND
☐ SHIP EVAC
☐ GND AMB
☐ DUSTOFF

Nation
☐ US DETAINEE
☐ Host Nation
☐ Enemy( )
☐ Coalition( )

Service
☒ Civilian
☐ Combatant
☐ Contractor
☐ USA
☐ USN
☐ USMC
☐ USAF
☐ SOF
☐ NGO ( )
☐ Other

Wound DTG: N/A

WOUNDED BY:
☐ ENEMY
☐ FRIENDLY
☐ CIVILIAN (Host Country)
☐ TRAINING
☐ SELF ACCIDENT
☐ SELF NON-ACCIDENT
☐ SPORTS-RECREATION
☐ OTHER:
☐ UNK

N/A

PROTECTION: N/A

	Not Worn	Worn	Struck	Penetrated
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

TRIAGE CATEGORY:
☒ IMMEDIATE
☐ DELAYED
☐ MINIMAL
☐ EXPECTANT

GLASCOW COMA SCALE (circle one)
3 8 12 15
UNC STUPOR LETHARGY ALERT

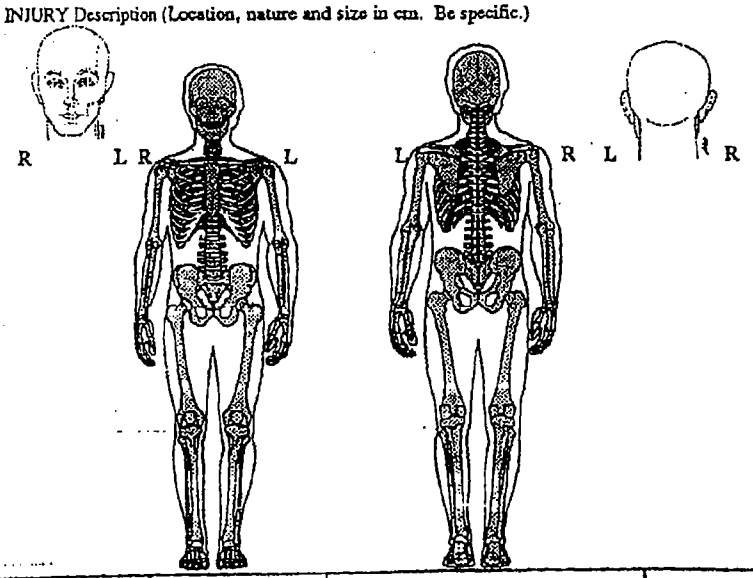
MECHANISM OF INJURY:
☐ GSW/BULLET
☐ BLUNT TRAUMA
☐ SINGLE FRAGMENT
☐ MULTI FRAGMENT
☐ MVC
☐ AIRCRAFT CRASH
☐ KNIFE/EDGE
☐ CBRNE
☐ BLAST
☐ BURN 1° 2° 3° ____ %TBSA
☐ CRUSH
☐ FALL
☐ IED
☐ OTHER ____

N/A.

VITALS:

TIME	1540	1810	1850
Pulse	103	82	96
Temp	95.9		
B/P	144/103	119/82	112/65
Resp			
SpO_2	95% RA		95%

INJURY Description (Location, nature and size in cm. Be specific.)



TX & PROCEDURES:

SEDATED/ IMMOB	Y/N
INTUBATED	Y/N
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN 4L/C 1545	Liters/min
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
HBOC	ml
Fresh Whole Bld	Units

OR Start DTG: Stop DTG:
Vent On DTG: Off DTG:
ICU in DTG: Out DTG:

DISPOSITION:
☐ RTD
☐ DECEASED
DTG: 2100 3 JUN

EVACUATED to ____
☐ URGENT
☐ URGENT SURGICAL
☐ ROUTINE
☐ MINIMAL

PROVIDER: (b)(6)-2
SPECIALTY:
DATE: DD/MMM/YYYY

MEDCOM Test Form 1381, OCT 2003

TFR → ICU

Ex 4

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0055-04-C10788-83551

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form see MEDCOM Circular 40-5

SECTION I PATIENT ASSESSMENT

DATE: 5 June 04 | PATIENT ACUITY LEVEL: | POST OP DAY: | HOSPITAL DAY: 8

TRANSFER

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

Time: 1230 To: ICU From: ICU ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time: Physician: (b)(6)-2 Anesthesia (Specify): T

Procedure/Diagnosis: CHF BP 103/76 P 83 R 16 T 98.6

LOC: Alert, oriented Neurovascular checks:

Dressing/cast: Ø Tubes: Ø

Intake (IV, po): po Output (EBL, other): Voided ☐ No ☐ Yes Amount:

Medication: see flow sheet

Other:

Report From: (b)(6)-2 LT Received By: (b)(6)-2 LTCAN -

VITAL SIGNS

TIME	1230	1400	1800	0030											
BP ARTERIAL LINE															
BP CUFF	103/76	103/81	103/72	103/70											
TEMPERATURE	98.6		97.7	97											
PULSE	83		74	80											
RESPIRATORY RATE	16		16	16											
OXYGEN (L/%)	—		—	—											
PULSE OXIMETER	95%		94%	94%											
O2 METHOD	RA		RA	RA											

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

PAIN

TIME	1230	1945						
PAIN INTENSITY (10 / 5 / 0)	0	—						
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	N	NA						

OTHER

TIME	NA							
FINGER STICK GLUCOSE	↓							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1230	1945
*Skin breakdown prevention	(b)(6)-2	(b)(6)-2
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT:

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy

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

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: CHF

DRG: ADMISSION DATE: 6-4-04

LOS: EXPECTED RELEASE:

CASE MANAGER:

PRIMARY CARE MANAGER: (b)(6)-2

ISOLATION REQUIRED (Specify):

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MCV1.00 Ex 4

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PDSS-64-CID741-93551

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1230	1945				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	R	R				
PASSIVE FLEXION	0	0				
PERIPHERAL PULSE	1	P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate, 3-severe; 4 pitting
Sensation: A-absent; N-numb; T tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal, 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1230	1945
ID band visible/legible	(b)(6)-2	(b)(6)-2
Orient to environment prn		
Side rails (2-4) up		N/
Bed position low		
Call light within reach		H

OTHER

Review & post lab results		N/
Notify MD abnormal labs		/H
Incontinent urine/stool		N/
Linen change prn		
Turn/reposition q2h		
ROM q2h if immobile		/H
Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: I Fogo
PERCENT CONSUMED: ICU	PERCENT CONSUMED: ICU	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLS

	0700-1500	1600-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: 1. Onset to ICU. Report S/S CP/SOB	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
151729	(b)(6)-2	(b)(6)-2 LTC, AN (b)(6)-2 SGT	(b)(6)-2

Ex 4

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NDSS-04-CID 285-83997

NEUROLOGICAL ASSESSMENT

		HOURS	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	3	3	3	3	3	3	3		3															
		REACTION	H	H	H	H	H	H	H		H															
	LEFT	SIZE	3	3	3	3	3	3	3		3															
		REACTION	H	H	H	H	H	H	H		H															
PUPIL SCALE			2	3	4	5	6	7 mm																		
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

C Closed by swelling

T Tube Ends
S Swelling
D Disphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the two sides

H + Brisk
H Slow
H – No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

		HOURS	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
↑ left		R	H	H	H	H	H	H	H	H	H	H	H	H	H											
		L	H	H	H	H	H	H	H	H	H	H	H	H	H											
↓ left		R	H	H	H	H	H	H	H	H	H	H	H	H	H											
		L	H	H	H	H	H	H	H	H	H	H	H	H	H											
edema ↑ left		R	–	–	–	–	–	–	–	–	–	–	–	–	–											
		L	–	–	–	–	–	–	–	–	–	–	–	–	–											
edema ↓ left		R	–	–	–	–	–	–	–	–	–	–	–	–	–											
		L	–	–	–	–	–	–	–	–	–	–	–	–	–											
		R	–	–	–																					
		L	–	–	–																					

H + Normal
H Weak
H – Absent
D Doppler
R Right
L Left

Ex 4

0089-04-CID 788-83561

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	2400	INITIALS (b)(	0-7	INITIALS (b)(6)		INITIALS
NEURO	PUPILS		PERLA		PERLA			
	SENSORIUM		CAOX3		AOX3, cooperative			
RESPIRATORY	RESPIRATION PATTERN		regular, unlabored		regular, unlabored			
	BREATH SOUNDS		clear all fields		clear B			
	SECRETIONS		ø		ø, occasional cough			
SKIN	COLOR		WNL		WNL pink			
	INTEGRITY		WNL		WNL			
IV SITE	LOCATION		(L) FA		(L) FA			
	CONDITION		wnd d/s/sq		patent, d/s/sq			
			infusion o infiltration		infusion o infiltration			
GASTRO	ABDOMEN		SNT (+) nausea		S, slightly distended			
	BOWEL SOUNDS		(+) all 4 quadrants		(+) all, normoactive			
					[illegible]			
					stomach [illegible]			
GU	URINE		voiding w difficulty		voids w difficulty			
	COLOR/CLARITY		clear yellow		clear, yellow			
CARDIOVASCULAR	CARDIACRHYTHM		1° AV Block c		1° AV block c			
			IVCD + occasional		occasional PAC			
			PAC		(-) edema BUE			

LEGEND

Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; F_1O_2 - Bicarbonate; ICP - Intracranial Pressure; $PaCO_2$ - PRESSURE OF ARTERIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2 | 16T | DEPARTMENT/SERVICE/CINC: ICU | DATE: 5 June 91

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

DA FORM 1 MAY78 4700

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

Ex 4

PATIENT'S DAY —

ACTIVITY LEVEL CLASSIFICATION: 0055-04-CID 714-80151

VITAL SIGNS	16	17	18	19	20	21	22	23
	76/45	74/51	74/53	106/74	94/46	88/61	88/62	87/65
	96.8	—	—	—	—	—	—	—
	75	76	72	77	75	91	69	74
	18	22	22	20	20	22	20	16
	94	96	94	95	95	95	98	96

INTAKE	16	17	18	19	20	21	22	23	S°T
	30	30	30	30	30	30	30	30	240
	400	20	—					300	1020

OUTPUT	16	17	18	19	20	21	22	23	
	X	650	X						1500

RESPIRATORY DATA	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	PO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA	TIME	0445								
	GLUCOSE	109								
	Na/K	134/4.1								
	$CHCO_3$	100/21								
	BUN/Cr	12/1.1								
	WBC/PLATELET	5.4/164								
	Hct/Hgb	52/17.2								
	Troponin I	Neg								

ACTIVITIES OF DAILY LIVING	TIME	0720								
	MOUTH CARE	(b)(								
	BATCH									
	SKIN CARE	(b)(6)								
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME	0730								
		(b)(6)-2								

SUCTION

24 HRS TOTALS

WT Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	720	Urine	3570
Po	3170		
TOTAL	3940	TOTAL	3570
BALANCE	+320		

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

EX 4

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MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA 0054-04-(D 785-8851

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0800	INITIALS (b)(6	1900	INITIALS (b)(		INITIALS
NEURO	PUPILS		PERLA		PERLA			
	SENSORIUM		aaox3, cooperative		CAOX3			
RESPIRATORY	RESPIRATION PATTERN		Regular, unlabored		regular & unlabored			
	BREATH SOUNDS		CTA (B)		Clear all fields			
	SECRETIONS		none					
			2 l/min O2 via NC					
SKIN	COLOR		WNL		WNL			
	INTEGRITY				WNL			
IV SITE	LOCATION		(L) FA		(D) FA			
	CONDITION		patent, good blood return; O SS infiltration		WNL; 5 x 1/5 cm infiltration in angle			
			NS @ TKO					
GASTRO	ABDOMEN		S, NT, ND		SNT (-) masses			
	BOWEL SOUNDS		BS(+)x4		(+) all 4 quadrants			
GU	URINE		Clear, yellow, low urine		abs Voiding 3 difficulty			
	COLOR/CLARITY		Urical		clear yellow			
CARDIOVASCULAR	CARDIACRHYTHM - electrode		NSR, Incidental PB Freq		1° AV Block I IVCD			
	ST WAVES		P wave S + 2/3 x 4		Ventricular ectopy			
			Cap refill < 3 sec x 4		ST ↑ & PACs			
			C. Hermann's Sign (B)					

LEGEND: Cr - Creatinine; F_iO - Fraction of inspired O_2; F_iO_2 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTERIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

DEPARTMENT/SERVICE/CINC: LCU

DATE: 4 Jun 04

(b)(6)-4

give: Name Last, First,

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

DA FORM 1 MAY78 4700

WAMC OP 375 (Redesignated) 1 APR 90 (HSXC - NU) Ex 4

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POINT OF DAY

PATIENT LABEL OR CASE NOT 0055-04-CID 715-83491

VITAL SIGNS	16	17	18	19	20	21	22	23	
						123/90	115/86	103/77	
						97.6			
						87	86	74	
						22	24	22	
						93	94	97	

INTAKE	16	17	18	19	20	21	22	23	6°T
						30	30	30	
						200		200	

OUTPUT	16	17	18	19	20	21	22	23	
				700					

RESPIRATORY DATA	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
	PCO_2								
B	PO_2								
	HCO_3								
	SAT								
G	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na:K								
	$Cl:CO_2$								
	BUN:Cr								
	WBC:PLATELET								
	Hct:Hgb								

ACTIVITIES OF DAILY LIVING	TIME								
	MOUTH CARE								
	BATCH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								
	(b)(6)-2	9	00						

TURN	TIME							
SUCTION								

24 HRS TOTALS

NURSE'S SIGNATURE

(b)(6)-2

WT Yesterday _____ WT Today _____

INTAKE		OUTPUT	
IV	90	Urine	700
Po	400		
TOTAL	490	TOTAL	700
BALANCE	210		

EX 4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
		2100	(b)(6)-				
NEURO	PUPILS	Perrla					
	SENSORIUM	A&O x3					
RESPIRATORY	RESPIRATION PATTERN	regular					
	BREATH SOUNDS	crackles/wheezing BLL					
	SECRETIONS	none					
		O2 2 NC sats					
		97%					
SKIN	COLOR	normal for race					
	INTEGRITY	intact moist					
		warm					
IV SITE	LOCATION	L forearm					
	CONDITION	CDI patent					
		NS @ KVO					
GASTRO	ABDOMEN	soft nontender					
	BOWEL SOUNDS	active x 4					
GU	URINE	voiding					
	COLOR/CLARITY	yellow/clear					
CARDIOVASCULAR	CARDIACRHYTHM	NSR					
		massive cardiac x1					
		grade 3					
		hypertension					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PaO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

(b)(6)-4

TMENT/SERVICE/CINC ICU

DATE 3 Jun 04

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700

WAMC OP 375 (Redesignated) Ex 4

0055-04-0107K-83151
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Physician's PROGRESS NOTES

DATE	NOTES
6/3/04	Admitted for CHF see HPP (b)(6)-2
6/4/04	Pt alert, fairly easy breath 99% on 2L Chest clear, heart with very heavy level of edema abdomen gen A: CHF P: ① continue Dyazide ② Begin Lasix (b)(6)-2
6/5/04	Still slightly hypotensive, HR N, BP ACE and Beta blocker were held last night, some crackles after exp Chest clear abdomen gen A: Pulmonary edema - chronic (B) and (L) added HF P: Continue to IV and adjust meds (b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | 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. 6/1999)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

Ex 4

38

Tl .ter Trauma Registry Reco

For use of this form, see AR 40-66; the proponent agency is OTSG 01SG-04-MD745-83551

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION: Number CDCFH TYPE	CASUALTY NAME: (b)(6)-4	CASUALTY SSN: (b)(6)-4

Arrive DTG: 10 June 2004 1940	Rank	Date of Birth 01 Jul 52	Gender ☒ Male ☐ Female	Unit Bisson L

ARRIVAL METHOD:
- ☐ WALKED
- ☒ CARRIED
- ☐ Non-MED AIR
- ☐ OTHER
- ☐ Non-MED GND
- ☐ SHIP EVAC
- ☐ GND AMB
- ☐ DUSTOFF

Nation
- ☐ US
- ☐ Host Nation
- ☒ Enemy (Victim)
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other

Wound DTG: Unknown

WOUNDED BY:
- ☐ ENEMY
- ☐ FRIENDLY
- ☐ CIVILIAN (Host Country)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:
- ☐ UNK

N/A

PROTECTION: NA	Not Worn	Worn	Struck	Penetrated
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASCOW COMA SCALE (circle one)

3	8	12	15
UNC	STUPOR	LETHARGY	ALERT

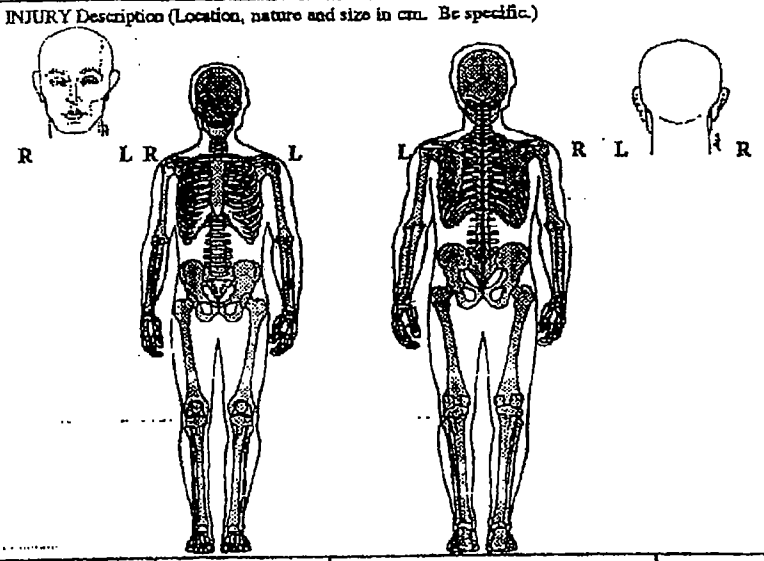
MECHANISM OF INJURY:
- ☐ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ MVC
- ☐ AIRCRAFT CRASH
- ☐ KNIFE/EDGE
- ☐ CBRNE
- ☐ BLAST
- ☐ BURN 1° 2° 3° _____ %TBSA
- ☐ CRUSH
- ☐ FALL
- ☐ IED
- ☒ OTHER Cardiac Resp arrest

VITALS:

TIME			
Pulse			
Temp			
B/P			
Resp			
SpO_2			

See Cardiac

INJURY Description (Location, nature and size in cm. Be specific.)



TX & PROCEDURES:	
SEDATED/ IMMOB	Y/N
INTUBATED	Y/N
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN	Liters/min
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
HBOC	ml
Fresh Whole Bld	Units

OR Start DTG: Stop DTG:	Vent On DTG: Off DTG:	ICU in DTG: Out DTG:

PROVIDER (b)(6)-2 SPECIALTY: ER DATE:

DISPOSITION:
- ☐ RTD
- ☒ DECEASED DTG: 2000hrs 10Jun04

EVACUATED to _____
- ☐ URGENT
- ☐ URGENT SURGICAL
- ☐ ROUTINE
- ☐ MINIMAL

MEDCOM [illegible]

Ex 4

EMERGENCY RESUSCITATION RECORD - PAT

For use of this form see MEDCOM Cir 40-5 Obs. Unit - CID 79B - 83361

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 10 June 2004

2. LOCATION OF RESUSCITATION EVENT

☐ MICU ☐ SICU ☐ CCU ☐ NICU ☒ ED ☐ PACU ☐ OR ☐ WARD: _____

☐ DIAGNOSTIC / PROCEDURE AREA: _____

☐ OUTPATIENT CLINIC: _____

☐ OTHER *(Specify)*: _____

3. WITNESSED ARREST?

☐ YES ☒ NO ☐ UNKNOWN

MONITORED AT ONSET?

☐ YES ☒ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) COMMENTS

☒ IV Access	☐ Time:	:	Inserted in field
☒ Endotrachael Tube	☐ Time:	:	Inserted in field
☐ Mechanical Ventilation	☐ Time:	:	
☐ Arterial Line	☐ Time:	:	
☐ Central Venous Line	☐ Time:	:	
☐ Pulmonary Artery Catheter	☐ Time:	:	
☐ Nasogastric Tube	☐ Time:	:	
☐ Pacing Device *(Specify type)*: _____	☐ Time:	:	
☐ Implantable Defibrillator / Cardioverter	☐ Time:	:	
☒ Other *(Specify)*: Suction	☒ Time: 1935	:	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☒ Other: Cardio-respiratory Arrest

6. RESUSCITATION ATTEMPTED

☒ YES *(Check all that were used)*
- ☒ Chest Compressions
- ☒ Defibrillation
- ☒ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS ☐ Yes ☒ No

BREATHING ☐ Yes ☒ No

PULSE ☐ Yes ☒ No

Site: _____

8. INITIAL RHYTHM

☒ Ventricular Fibrillation ☐ Pertusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☐ Returned at: ____ : ____ ☐ Never achieved

☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 19 : 58

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☒ Death

PATIENT DISPOSITION: CID

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	____ :	____
CPR Started:	____ :	____
1st Defibrillation:	____ :	____
Airway Achieved:	____ :	____
1st Dose Epinephrine:	____ :	____

Code Team Called: ☒ Yes ☐ No Time: 19 : 40

Code Team Arrived: ☐ Yes ☐ No Time: 19 : 45

10. GLASGOW COMA SCALE

(Post-resuscitation)

Circle appropriate scores, then total.

EYE OPENING
- 4 - Spontaneously
- 3 - To voice
- 2 - To pain
- 1 - No response

VERBAL RESPONSE
- 5 - Oriented, converses
- 4 - Disoriented, converses
- 3 - Inappropriate responses
- 2 - Incomprehensible sounds
- 1 - No response

MOTOR RESPONSE
- 6 - Obeys verbal commands
- 5 - Localizes painful stimulus
- 4 - Withdraws from pain stimulus
- 3 - Flexion, decorticate posturing
- 2 - Extension, decerebrate posturing
- 1 - No movement

SCORE: 3

PATIENT IDENTIFICATION

ISN: (b)(6)-2

Camp Bissiri 4

AGE: _____

GENDER: Male

HEIGHT (in): _____

WEIGHT (lbs): _____

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

Ex 4

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0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-2	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/07/26	4:00:15 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/26	12:00:00 AM

Immunizations

Medical Officer Performing Exam

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EXH 18

0107-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: Doing well on Z pack. Now w/ ABD pn and aching

O: HEENT - neg

Neck- neg

Lungs- CTA

COR-RRR

ABD- no HSM

168/98

A: HTN

P: RHD

Atenolol 50mgQD

Cimitidine 400mg BID

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EXH 18

0107-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

0000 52

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EXHIBIT 12

0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/07/12	12:30:27 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/13	12:00:00 AM

Immunizations

Medical Officer Performing Exam

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Exh 18

0107-04-C17519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-2

S: dizziness when standing- pt on PenVK, Phenergan, Atenolol

O: 142/82, p-100, r-16, SaO2 96%

A: Postural Hypotension

P: 2000 cc NS in R AC 20gu.

0000 58

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EXH 18

C 10 7-04 - C 1D 519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

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EXH 18

0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/07/10	12:13:49 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/10	12:00:00 AM

Immunizations

Medical Officer Performing Exam

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Exh 18

0107-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: reeval ekg for heart pain

O ekg attached hp 154/79 p 75

A: Rheumatic heart disease

P: refill atenelol 50 mg 5 days pheogrin 25mg once daily 5 days.

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Exh 18

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

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0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/06/28	10:51:20 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/29	12:00:00 AM

Immunizations

Medical Officer Performing Exam

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EXH 18

0107-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: F/U ONLY

RHEUMATIC HEART ON PCN 500mg QD

TENORMIN 50mg PO QD. NKDA. PAIN IN CHEST RADIATING TO BACK.

O: BP- 142/80 T-98.9 SPO2 97 % P- 87

A: RHEUMATIC HEART

P: ALLEGRA 180mg QD x 14D

ATENOLOL 50mg QD x 14D

PCN VK 500mg QD x 14D

CELEBREX 100 mg BID x 14D

F/U 14D

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EXH 19

0107-04-C1051y

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

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EXH 18

0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/06/17	10:46:45 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/17	12:00:00 AM

Immunizations

Medical Officer Performing Exam SSG (b)(6)-2

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Exh 18

0107-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: Heart Problem, Hx of Rheumatic Fever, Says this environment isn't good for him, wants to return to Abu Gharib

O: P-108, R: 34, BP: 160/62, MS Mitral Valve, LSC

A: Mitral vavle Defect

P: Cont. PCN VK 500mg qd

Tenormin 50mg p.o. qd x7d

RTC 7D, count excusal

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0107-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

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EXH 18

0107-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1974/01/01	M	67	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:24

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
(b)(6)-4	2004/05/31	7:29:17 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/08	12:00:00 AM

Immunizations

Medical Officer Performing Exam

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FXH 18

6107-04-CID514

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: heart valve problem, on long acting benzola, pcn, dizziness

O: lungs NAD, cor 2/6 sigs ao valve

A: rheumatic heart

P: Pen VK 250 mg bid, continuous

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0107-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

0007-07

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EXH 18

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 May 04	SECURITY DETAINEE
1635	S: Called to tier 1-A to see a detainee in
O: stable 95%	cell #9. MP stated to me that they heard
P 58	a loud noise from cell #9. When they checked
R 18	they found detainee (b)(6)-4 lying on his stomach
	and the R side of his face. I called out
	to the detainee and saw his eyes blink. When
	I entered the cell he refused to speak to
	me. One Amonia inhalant used to make sure
	detainee was not unconscious. He then got up
	and sat on the edge of his bed. Upon examination
	A dark red hematoma was noted on his R
	cheek that was not present during morning
	sick call. Detainee had been refusing to eat
	x 5 days. When asked why he stated that
	he could not breath while eating. Detainee
	was allowed to sit outside his cell to
	get more air. While there he was offered the
	cell directly across from #9. He got up and
	started to walk to the new cell. He was
	then told that he could go in there for
	the night if he would eat first. Detainee

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
152nd AID STATION FOB BCCF			
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.
VIGILANT ISN# (b)(6)-4 COMPOUND 1-A cell #9		

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

SECURITY DETAINEE

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Exhibit

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 May 04	SECURITY DETAINEE
	S: Then sat back down and started to eat. At 1700 when I left the tier he was eating and laughing c other detainees close to him. Lt. (b)(6)-2 was notified of the situation. Advised that weight be taken and documentation started. No weight was taken since detainee was now eating and in a better mood
	(b)(6)-2
	SPW30
	SPW30

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
152nd AID STATION FOB BCCF			
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.
VIGILANT (b)(6)-4 ISN# COMPOUND 1-A		

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

SECURITY DETAINEE

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Exhibit

PRISONER IN PROCESSING MEDICAL SCREEN

NAME (b)(6)-4 COMPOUND: ISN: (b)(6)-4
DATE: 15APR04 ~~DOB DATE:~~ 1968 AGE: 36
HISTORY BY TRANSLATOR: (YES) NO
NAME OF TRANSLATOR: (b)(6)-2

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?
None

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN & HOW WERE YOU TREATED? No

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES (NO)
B) HAVE YOU BEEN COUGHING BLOOD? YES (NO)
C) HAVE YOU BEEN LOSING A LOT OF WEIGHT? YES (NO)

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE): none

4) MEDICATION:
none

5) ARE YOU ABLE TO WALK UNASSISTED? (YES) NO
6) ARE YOU ABLE TO FEED YOURSELF? (YES) NO

8) PULSE: 65 BLOOD PRESSURE: 116/78 RESPIRATORY RATE: 18

WEIGHT: 218lbs HEIGHT: 60"

ALLERGIES?
none

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO BN MD OR PA, UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTIONS 6 OR 7 ALSO REQUIRE MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE

DATE:

ASSESMENT:

RECCOMENDATIONS:

(b)(6)-4

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Exhibit 4
ENC 4

7/20 0930

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 May 04	SECURITY DETAINEE
1635	S: Called to Tier 1-A to see A detainee in
O: stats SSR	cell #9. MP stated to me that they heard
P 58	A loud noise from cell #9. When they checked
R 18	they found detainee (b)(6)-4 lying on his stomach
	and the R side of his face. I called out
	to the detainee and saw his eyes blink. When
	I entered the cell he refused to speak to
	me. One Ammonia inhalant used to make sure
	detainee was not unconscious. He then got up
	and sat on the edge of his bed. Upon examination
	A dark red hematoma was noted on his R
	cheek that was not present during morning
	sick call. Detainee had been refusing to eat
	X 5 days. When asked why he stated that
	he could not breath while eating. Detainee
	was allowed to sit outside his cell to
	get more air. While there he was offered the
	cell directly across from #9. He got up and
	started to walk to the new cell. He was
	then told that he could go in there for
	the night if he would eat first. Detainee

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
152nd AID STATION FOB BCCF			
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.

VIGILANT
ISN# (b)(6)-4
COMPOUND 1-A cell #9

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

SECURITY DETAINEE

For Official Use Only
Law Enforcement Sensitive

Exhibit _____

7/20 0930

DO 1 NOV 04 (ID 239-0293)
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 May 04	SECURITY DETAINEE
	S: then sat back down and started to eat. At 1700 when I left the tier he was eating and laughing c̄ other detainees close to him. Lt. (b)(6)-2 was notified of the situation. Advised that weight be taken and documentation started. No weight was taken since detainee was now eating and in a better mood (b)(6)-2
	21W30
	21W30

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
152nd AID STATION FOB BCCF			
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.
VIGILANT ISN# (b)(6)-4 COMPOUND 1-A		

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PRISONER IN PROCESSING MEDICAL SCREEN

NAME: (b)(6)-4
DATE: 15APR04
HISTORY BY TRANSLATOR: YES NO
NAME OF TRANSLATOR: (b)(6)-4

COMPOUND:
~~DOB DATE:~~ 1968

ISN: (b)(6)-4
AGE: 36

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?
None

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN & HOW WERE YOU TREATED? No

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES NO
B) HAVE YOU BEEN COUGHING BLOOD? YES NO
C) HAVE YOU BEEN LOSING A LOT OF WEIGHT? YES NO

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE): none

4) MEDICATION:
none

5) ARE YOU ABLE TO WALK UNASSISTED? YES NO
6) ARE YOU ABLE TO FEED YOURSELF? YES NO

8) PULSE: 65 BLOOD PRESSURE: 116/78 RESPIRATORY RATE: 18

WEIGHT: 218 lbs HEIGHT: 60"

ALLERGIES?
none

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO BN MD OR PA, UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTIONS 6 OR 7 ALSO REQUIRE MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE DATE:

ASSESMENT:

RECCOMENDATIONS:

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Exhibit
ENCL 4

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-4
SSAN: (b)(6)-4
Date of Birth: Unknown
Date of Death: 24 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 1 June 2004

Autopsy No.: ME04-388
AFIP No.: Pending
Rank: Civ
Place of Death: Balad, Iraq
Place of Autopsy: BIAP Morgue

Circumstances of Death: By verbal report, this Iraqi male was shot in a firefight and lived to be transported to a US hospital where he underwent multiple surgeries but died due to complications of his wounds.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By prisoner number only, DNA sample obtained

CAUSE OF DEATH: Gunshot wound of the abdomen

MANNER OF DEATH: Homicide

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

PRELIMINARY AUTOPSY DIAGNOSES:

I. History of remote gunshot wound of the abdomen
   A. No gunshot wound defect or tract evident due to multiple surgical interventions
   B. Direction of wound indeterminate
   C. Status post small bowel resection and anastamosis with sigmoid colostomy, and rectal stump
   D. Feculent peritonitis (300 ml of pus and feces) and fibrinous adhesions
   E. Right pleural adhesions and bilateral purulent pleural effusions, status post chest tube placement
   F. Pulmonary edema and bilateral pneumonia (right lung 1150 grams, left lung 1000 grams)
   G. Purulent pericardial effusion (50 ml)
   H. Minute radiopaque fragments visible on sub optimal radiographs, no projectiles recovered

II. No other significant trauma
III. Toxicology and histology pending

(b)(6)-2

(b)(6)-2 MD
MAJ, MC, USA
Deputy Medical Examiner

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

(b)(6)-4 D (Last, First, Middle) Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation	NATION (e.g., United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe ☐ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier)
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le suivant
STREET ADDRESS Domicile à (Rue)	CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only one cause per line) Causes du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	Cardiac Arrest	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	GSW Abd s/p multiple Ex-lap (B) chest tube	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort résultant des causes extérieures
NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH (Hour, day, month, year) Date du décès (l'heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire (b)(6)-2	LPT, MC	TITLE OR DEGREE Titre ou diplôme MD
GRADE Grade O3	INSTALLATION OR ADDRESS Installation ou adresse (b)(3)-1 Balad	
DATE Date 24 May 04	SIGNATURE (b)(6)-2	

(State disease, injury or complication which co... heart failure, etc.
... contributing to the death but ... ing death.

NEUROLOGICAL ASSESSMENT

COMMAS SCALE		HOURS	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	EYES OPEN	SPONTANEOUSLY 4			✓					✓	✓															
		TO SPEECH 3				✓	✓	✓	✓			✓														
		TO PAIN 2	✓	✓									✓	✓	✓	✓										
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5																								
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6			✓						✓															
		LOCALIZES PAIN 5	✓	✓		✓				✓	✓															
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO RESPONSE 1										✓	✓	✓	✓	✓										
LIMB MOVEMENT	ARMS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	4	4	4	4	4	4	4		4				4											
		REACTION	+	+	+	+	+	+	+		+				+											
	LEFT	SIZE	4	4	4	4	4	4	4		4				4											
		REACTION	+	+	+	+	+	+	+		+				+											
PUPIL SCALE			2			3			4			5			6			7 mm								
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Tracheotomy
- S Stuttering
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record Separately if there is a Difference between the tow sides
- + + Brisk
- + Slow
- − No Response
- + Intact
- − Abnormal

VASCULAR ASSESSMENT

	HOURS	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
↑ left	R	+	+	+	+	+	+	+	+	+	+	+	+	+	+										
	L	+	+	+	+	+	+	+	+	+	+	+	+	+	+										
↓ left	R	+	+	+	+	+	+	+	+	+	+	+	+	+	+										
	L	+	+	+	+	+	+	+	+	+	+	+	+	+	+										
	R																								
	L																								
	R																								
	L																								
	R																								
	L																								

- + + Normal
- + Weak
- − Absent
- D Doppler
- R Right

DAILY PATIENT LAB VALUES

	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
CHEM	5/20 1350	21 May 2008							
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
ALB		1.6		1.8					3.3-5.5 g/dL
ALP		87							53-128 U/L
ALT		76		65					10-47 U/L
AMY		40							14-97 U/L
AST		99		75					11-38 U/L
Tbil		7.4		7.8					0.2-1.6 mg/dL
BUN		23		26					7-22 mg/dL
Ca		8.3							8.0-10.3 mg/dL
Chol		109		116					100-200 mg/dL
CK									39-380 U/L
CL									98-108 mmol/L
TCO2		13							18-33 mmol/L
Creat		1.0 (stat)							0.6-1.2 mg/dL
GGT				29					5-65 U/L
Glu		87		98					73-118 mg/dL
K		2.4		4.4					3.3-4.7 mmol/L
TProtein		4.2		4.1					6.4-8.1 g/dL
Na		153		153					128-145 mmol/L
	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
HEME									
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
WBC		13.4							4.8-10.8 x10(3)/uL
RBC		3.46							4.2-6.1 x10(6)/uL
Hgb		10.2							12.0-18.0 g/dL
Hct		32.3							35.0-60.0%
MCV		93.2							80.0-99.0 fl
MCH		29.4							27.0-31.0 pg
MCHC		31.5							33.0-37.0 g/dL
Plt		119							130-400 x10(3)/uL
LY%		6.9							15.0-50.0%
LY#		0.9							0.7-4.3 x10(3)/uL
	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
UA									
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
Color	AMBER	~~AMBER~~							Straw/Yellow
Clarity	HAZY	~~[illegible]~~							Clear
Glucose	NEG.	~~pH: [illegible]~~							Negative
Bilirubin	2+	~~PCO2: [illegible]~~							Negative
Ketone	NEG.	~~PO2: [illegible]~~							Negative
SG	1.030	~~HCO3: 13~~							1.010-1.025
Blood	3+	~~BEcf: -11~~							Negative
pH	5.0	~~Sat: 98%~~							5.0-8.0
Protein	1+								Negative-Trace
Urobili	0.2								Negative
Nitrite	NEG.								Negative
Leuko	NEG.								Negative

WBC- 0-1
RBC 4-6
EPITH 0-1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20May2004 0900	Surgery POD #10/19
	Still having ↑RR throughout night ↑ rate
Zosyn 1g/c this a.m.	
	Afebrile BP - 90-40's O.P. - 121/70
	I 4888 O: 4865 NET - 1980
	Lungs Coarse BS throughout Drain 650
	C_2 SAT - 92-100%
	Con - 115 - 130's
	ABd - ⊕ drainage - old blood - tinged fluid
	⊕ penrose withdrawn
	L ABG
	12.6 / 12.1 / 39.0 / 332
	(A) Respiratory status continues to be borderline with his persistent work of breathing. Oxygenation has improved but I am concerned that his increased effort may be burning calories and delaying healing. It did have some improvement with aggressive pulmonary toilet.
	H/H - It is not clear why pt is draining blood tinged fluid
	ID - WBC has remained stable but pt does have bandemia possibly representing pulmonary source of infection
	(P) ① last dg of Zosyn
	② T&C
	③ ✓ H/S

(b)(6)-2

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

21 May 2004 0855

Surgery POD#1/11/20
Breathing over the vent throughout the night
T: 101.2 HR: 128-139 BP: 116/73
I: 2740 O: 1165
Lungs: ↓ BS (R) base. Clear in other fields RR 30's
7.43/(19)/91/13/(-11)
Cor - Rg Tachy
Abd - (+) drainage of stool fr. ileostomy
Ext - Ø edema

LABS

153 | 13 | 23 / 2.4 | 1.0 — 13.1 | 32.3 | 10.2 / 119

(A) Pt is overbreathing vent and is essentially blowing off CO_2. Given possible transport today we will paralyze him for better control
Hemodynamically we appear to be behind given the ↑ base deficit and tachycardia
I/D - Will continue on Zosyn but since we have little bacteriology information a short course should suffice.

(P) ① Vecuronium
② Deep suction
③ Volume
④ Stat repeat labs

OSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PONSOR'S NAME	SSN.ID NO.	RELATIONSHIP TO SPONSOR	
ATIENT'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)-2

AL RECORD OF MEDICAL CARE
Medical Record
FORM 600 (REV. 6-97)
SA/ICMR
RI 201-9.202-1 USAPA V2.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				21 May 04	1150 HOURS	
				D Transfer to 3rd CSH		
				20 Baladi		
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 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1986—408-824

CLINICAL RECORD - DOCTOR'S ORDERS
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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: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 20 May 2004 | TIME OF ORDER: 2205 HOURS | LIST TIME ORDER NOTED AND SIGN

Post Op Orders
- Dx: Rectal stump dehiscence
- Intra abdominal Sepsis
- Ileal perforation
- Guarded condition
- IVF - LR @ 200 cc/h
- Labs: ABG, MA-7, CBC - Now

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: | TIME OF ORDER: HOURS

- Versed 5mg IV q 2h PRN
- Versed drip 2-4mg/h Titrate to effect
- Demerol 75mg IM q 3h PRN
- Zofran 3.37mg IV q 6h
- Portable CXR Now

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: | TIME OF ORDER: HOURS

- Vent Settings
- IMV - 14
- TV - 500
- FiO2 titrate to 50 F O2 SAT ≥ 95%
- ABG Now AND in AM labs
- Vent [illegible]

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 20 May 2004 | TIME OF ORDER: 2325 HOURS

AM Labs: @ 0500
- CBC
- SMA-7
- ABG

Portable CXR @ 0500

Bolus 1 L LR Now

Noted @ 0500 [illegible]

(b)(6)-2

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

24° CC @ 0830 on 21 May 04

(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

DATE OF ORDER: 18 May 2004 TIME OF ORDER: 1100 HOURS

1. Albuterol Neb q 4° PRN
2. ABG Now
3. Port CXR - Done
4. Red Rubber Catheter Lactomy q 4°

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 18 May 2004 TIME OF ORDER: 1510 HOURS

1. Transfuse 2u PRBC's over 4 hrs
   ↓ IVF when running transfusion
2. ✓ CBC 2 hours P transfusion

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 May 2004 TIME OF ORDER: 2345 HOURS

1. Transfuse 2u PRBC's over 4 hrs
2. ✓ CBC in AM P transfusion

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19 May 2004 TIME OF ORDER: 1610 HOURS

1. ~~ABG Now~~ - Done
2. ~~Portable CXR~~ - Done
3. Check
4. Chest PT q 2°
5. ✓ ABG @ 1630

(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.

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: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 18-May-04 | TIME OF ORDER: 0645 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Albuterol neb q 4 x 3 Now (b)(6)-2

Metal @ 0800 on 18 May 04 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 18 May 2004 | TIME OF ORDER: 0850 HOURS

1. Portable CXR thru an r/o ate lectasis
2. Chest Physiotherapy TID
3. see TPN order
4. AM Labs 19 May 2004:
   1. SMA-7, Amy, LFTs
   2. CBC (b)(6)-2
   3. ~~ALBUMIN~~

Metal @ 0850 on 18 May 04

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 18 May 2004 | 0850 HOURS

1. ALBUMIN 25% Bolus Now (b)(6)-2

18 May 04 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 18 May 2004 | TIME OF ORDER: 1010 HOURS

Chest tube placement

1. Pleurovac, Chest tube bedside
2. Ativan 1 g IV x 1 @ start
3. Lidocaine 1% SQ, 25 gauge needle
4. Betadine solution
5. 0-silk suture (b)(6)-2
6. Sterile gloves

Metal @ 1010 on 18 May 04 (b)(6)-2

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

(b)(6)-4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
ADULT PARENTERAL (TOTAL AND PERIPHERAL) NUTRITION ORDER FORM

OTSG APPROVED (Date)

CHECK (✓) AND COMPLETE APPROPRIATE ORDERS WHERE INDICATED

VOLUME (✓):	50% DEXTROSE (3.4 kcal/g) (✓):	LIPIDS (✓):	8.5% AMINO ACIDS (✓): (4.0 kcal/g)
1 Liter / day = 42 mL/hr (initial rate)	☐ Standard Central = initial dose (150 gm/L; 510 kcal)	☐ 10% at 21mL/hr (550 kcal; standard)	☑ Standard Central (45 gm/L (180 kcal)
2 Liters / day = 83 mL/hr (adult; maintenance)	☑ Standard Central = maintenance (200 gm/L; 680 kcal)	☑ 20% at 21mL/hr (1110 kcal)	☐ Standard Peripheral (30 gm/ (120 kcal)
3 Liters / day = 125 mL/hr	☐ Standard Peripheral * = maintenance (85 gm/L; 289 kcal)	☐ 20% at 41mL/hr (2016 kcal)	Other = ____ gm/L
Other = _____mL/hr	Other = _____ gm/L	☐ 10% at _____mL/hr ☐ 20% at _____ mL/hr	

* May not want to exceed 100 gm/L of dextrose in PPN due to increased risk of phlebitis

ELECTROLYTES (✓):	DAILY REQUIREMENTS	☑ STANDARD	INDIVIDUAL
Sodium Chloride	Sodium: 60 - 160 mEq	40 mEq/L	____ mEq/L
Sodium Acetate		0	____ mEq/L
Potassium Chloride	Potassium: 60 - 120 mEq	20 mEq/L	____ mEq/L
Potassim Acetate		0	____ mEq/L
Calcium Gluconate	Calcium: 10 - 15 mEq**	5 mEq/L	____ mEq/L
Magnesium Sulfate	Magnesium: 10 - 20 mEq	8 mEq/L	____ mEq/L
Potassium Phosphate	Phosphate: 15 - 40 mM **	7.5 mM/L	____ mM/L
Trace Elements	2 mL	2 mL/day	____ mL/day
MVI - 12	10 mL	10 mL/day	____ mL/day
Sterile H20 For Injection	QSAD	QSAD	QSAD

SPECIAL INSTRUCTIONS: TPN must be filtered using a 0.22 micron filter. Lipid infusions must be filtered using the 1.2 micron filter. ** Amounts of Calcium Phosphorus will be dependent upon solubility. *See reverse side for how to calculate a TPN.*

ADDITIONAL MEDS (✓):	ADDITIVES (✓):
Vit K. 5 mg SQ weekly or ____IM now	☐ Insulin: _____U/Day
✓ Folic Acid: 1 mg / day or ____ mg / day	☐ Ranitidine: 150 mg or ____mg/day
Hydrocortisone: 5 mg/L (for PPN only)	☑ Cimetidine: 800 mg or ____mg/day
Heparin:____U/Liter	☐ Other: _____
Other:_____	

Standard Orders To Be Transcribed:

1. If Central (TPN), check for central line placement – STAT CXR.
2. Consult to Registered Dietitian AND Pharmacy; forward copy of TPN orders to Pharmacy.
3. Use TPN line (distal port) for TPN only.
4. If TPN interrupted, hang D10W at the same rate for 4 hours or until TPN is re-started.
5. Strict I & O's, daily weights. VS a minimum of q 8 hours, call physician if Temp ≥ 101.
6. Fingerstick glucose q 6 hours; call physician if ≥ 200.
7. Triglycerides on day 1; and then q 7 days.
8. Chem 12, P04, Mg ++ on days 1,2,and 3; and then q 7 days; do c draw from tube site.
9. CBC/Diff (automatic), PT/PTT on day 1; and then q 7 days
10. 24-hour UUN on day 7; and then q 7 days
11. Other:

START TIME: New orders or changes to existing orders should be received by 1300 hours. In extreme cases, changes will be made other than on the day shift as practical.

(b)(6)-2

PREPA

DEPARTMENT/SERVICE/CLINIC: Surgery

DATE: 19 May 2004

e: Name – last,

☐ HISTORY/PHYSICAL

☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☐ OTHER

☐ DIAGNOSTIC STUDIES

(b)(6)-4

DAILY PATIENT LAB VALUES

	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
CHEM	5/18 1000	5/17 0700	5/18 1515	5/18 2327	5/19 0731	5/19 1540	5/19 1756	5/20 0600	
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
ALB									3.3-5.5 g/dL
ALP									53-128 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	21	23							7-22 mg/dL
Ca	7.9	7.9	iCa 1.11			iCa 1.12	1.14	1.15	8.0-10.3 mg/dL
Chol									100-200 mg/dL
CK									39-360 U/L
CL	99	103							98-108 mmol/L
TCO2	27	25				30	29	28	18-33 mmol/L
Creat	0.5	0.8							0.6-1.2 mg/dL
GGT									5-65 U/L
Glu	221	156							73-118 mg/dL
K	3.3	3.9	3.5			3.4	3.2	3.4	3.3-4.7 mmol/L
TProtein									6.4-8.1 g/dL
Na	145	146	146			148	147	148	128-145 mmol/L
	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
HEME									
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
WBC	13.2	13.7		14.1	12.5			12.6	4.8-10.8 x10(3)/uL
RBC	3.08	2.42		3.4	3.31			4.10	4.2-6.1 x10(6)/uL
Hgb	9.1	7.2	17	8.8	10.1	11	12	12.1	12.0-18.0 g/dL
Hct	29.8	23.4	49	28.6	31.4	33	34	39.0	35.0-60.0%
MCV	96.9	96.7			94.9	pH 7.56	pH 7.57	95.1	80.0-99.0 fl
MCH	29.4	29.7	pH=7.57	28.4	30.5	PO_2 32.2	PO_2 31.7	29.6	27.0-31.0 pg
MCHC	30.4	30.7	PO_2 30.5	30.9	32.2	PO_2 39	PO_2 47	31.1	33.0-37.0 g/dL
Plt	380	339	PO_2 85	342	275	HCO3 29	HCO3 28	332	130-400 x10(3)/uL
LY%	6.5	6.4	HCO3 24	5.8	5.6	BE 6	BE 5	6.5	15.0-50.0%
LY#	0.9	0.9	SO_2 93	0.8	0.7	SO_2 91%	SO_2 88%	0.8	0.7-4.3 x10(3)/uL
	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	DATE/TIME	
UA			BE 6						
TEST	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*RESULT*	*REF. RANGE*
Color								SG	Straw/Yellow
Clarity									Clear
Glucose								15	Negative
Bilirubin								12	Negative
Ketone								SG	Negative
SG								>7	1.010-1.025
Blood								ADG	Negative
pH								pH 7.588	5.0-8.0
Protein								PCO_2 34.3	Negative-Trace
Urobili								PO_2 64	Negative
Nitrite								HCO3 27	Negative
Leuko								BE 5	Negative

SO_2 96%

(b)(6)-4

-STAT EG7+

(b)(6)-4

t Name:_____

a_____149 mmol/L
_____4.5 mmol/L
CO2_____30 mmol/L
Ca_____1.19 mmol/L
ict_____24 %PCV
ib*_____8 g/dL
*via Hct

at 37C
pH_____7.103
pCO2_____86.9 mmHg
PO2_____82 mmHg
HCO3_____27 mmol/L
BEecf_____-2 mmol/L
sO2*_____90 %
*calculated

Sample Type_:

21FEB04 10:04

Oper: 3771

Physician:_____

Ser# 24620

Ver: JAMS047A
CLEW A94

---

i-STAT EG7+

(b)(6)-4

Pt Name:_____

Na_____149 mmol/L
K_____4.5 mmol/L
TCO2_____29 mmol/L
iCa_____1.17 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.118
PCO2_____81.4 mmHg
PO2_____76 mmHg
HCO3_____26 mmol/L
BEecf_____-3 mmol/L
sO2*_____89 %
*calculated

Sample Type_:

21FEB04 10:09

Oper: 3771

Physician:_____

Ser# 24620

Ver: JAMS047A
CLEW A94

---

i-STAT EG7+

(b)(6)-4

Pt Name:_____

Na_____148 mmol/L
K_____4.1 mmol/L
TCO2_____28 mmol/L
iCa_____1.13 mmol/L
Hct_____20 %PCV
Hb*_____7 g/dL
*via Hct

At 37C
pH_____7.242
PCO2_____60.4 mmHg
PO2_____79 mmHg
HCO3_____26 mmol/L
BEecf_____-1 mmol/L
sO2*_____93 %
*calculated

Sample Type_:

21FEB04 11:12

Oper: 3771

Physician:_____

Ser# 24620

Ver: JAMS047A
CLEW A94

TEST	RESULT	DATE/TIME
GGT		
Glu	83	
K	8.4	
TProtein	4.2	
Na	153	
HEME		
WBC		
RBC		
Hgb		
Hct		
MCV		
MCH		
MCHC		
Plt		
LY%		
LY#		
UA		
TEST	RESULT	DATE/TIME
Color		
Clarity		
Glucose		
Bilirubin		
Ketone		
SG		
Blood		
pH		
Protein		
Urobili		
Nitrite		
Leuko		

GGT	0.6-1.2 mg/dL
Glu	5-65 U/L
K	73-118 mg/dL
TProtein	3.3-4.7 mmol/L
Na	6.4-8.1 g/dL
	128-145 mmol/L

NSN 7540-01-189-7284

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CHEST CT W/IV CONT.		M	1251		
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	(b)(6)-2				DATE REQUESTED 21 MAY 04

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

POST SURG.

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
21 MAY 04		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION (Type or write entries given: Name — last, first, middle, Medical Facility)	LOCATION OF MEDICAL RECORDS
1251	LOCATION OF RADIOLOGIC FACILITY

DEPARTMENT OF THE ARMY
TASK FORCE ALCATRAZ
PRISON HOSPITAL
ABU-GHRAIB, APO-AE 09342

22 MARCH 2004

SUBJECT: Check-off list for patient transfers

Below is a list of items that **MUST** be completed in order for the TOC to get a patient transferred. Once these steps have been completed TOC personnel will make the proper arrangements for the transfer to take place.

Patient identification: (b)(6)-4 _____

Discharge or transfer order complete: Dr. signature/date/time (b)(6)-2 5/21/ 11.45

Doctor-Doctor update complete: Dr. signature/date/time (b)(6)-2 5/21 - 1145

Nurse-Nurse update complete: Nurse signature/date/time _____

Mode of transportation requested: Air ✓ Ground _____

Priority level of patient: Urgent ✓ Non-urgent _____

MP Guard required: Yes _____ No ✓

****If any item above is not applicable place N/A in the box and initial.****

If any special equipment is needed for the transport please list items required below
Portable Oxygen
Portable ventilator.

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

TOC Personnel to complete items below this line:

Patients records copied: signature/date/time: _____

Transportation requested: signature/date/time: _____

Time patient left Alcatraz: _____ Fragile fracture fixation

Central line
Art. line
Ventilator

possible [illegible] of [illegible] stay
[illegible]

Hot [illegible]
[illegible]

DATE 21 May 04 DX Intraabdominal Abscess, Necrotic Rectal Stump HOSPITAL DAY 21

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line	101/58	114/60	99/61	90/61	106/66	101/64	107/67	100/60		111/67		134/68	143/81	132/72	134/69			
	BP Cuff	101/61	114/71	107/62	104/50	109/63	104/65	109/71	107/62		116/63	40/31	105/61	147/81	134/79	124/72			
	Temperature		101.0				101.2				101.4	—	—	-	97.8	—			
	Pulse	116	122	136	132	139	136	132	128		128	122	122	119	117	113			
	Respiratory Rate	30	30	34	36	44	38	36	37		37	10	10	18	20	30			
	sat	100	99	96	97	95	97	99	97		98	95	96	96	98	98			

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	MIV	200	200	200	200	200	200	200	200	1600	200	200	250	250	250	250			
	Versed	4	5	5	5	6	5	5	5	40	5	5	5	5	5	5			
	Bolus	—	—	1000	—	—	—	—	—	1000	—	—	1000	-	—	—			
	Zosyn	50	-	-	—	-	—	50	—	100	—	—	—	—	50	—			
	Vecuronium											10	10	10	10	—			
	Albumin													100	—	—			
	TOTALS	254	205	1205	205	206	205	255	205	2740	205	215	1265	365	315	255			

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		60/60	70/130	30/160	110/270	10/280	45/325	45/370	90/460	460	70		105/175	120/295	110/405	130/535			
		SP gr																		
		S/A																		
	NG	OUTPUT							500		500									
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Ileostomy													25					
	TOTALS										1165									

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
mar 04 0830	NRSG: ↑ in Pt agitation from 0730-0800. Pt given 75 mg Demerol @ 0800. Pt now resting peacefully in bed. Pt sedated c̄ versed @ 5 mg/hr. Pt on vent - SIMV mode. TV @ 500, FiO2 @ 50%, RR 10. ETT checked @ 24 cm. BS to all lung fields, CTA. ↓ to (R) base. ~~HR tach~~ Pt breathing against vent - RR mid 30's. HR - tachy ranges 120-135 bpm. Cap refill < 3 sec x 4 ext. Pulses +2/4 x 4 ext. Pt has arterline to (L) radial artery. Good wave form & pressures coincide c̄ BP cuff. ~~BS~~ 4+ pitting edema to all extremities. (+) BS x 4, abd s, ND, appropriately tender. Midline abd incision covered c̄ 4x4's & ABD pad. Serosanguinous drng noted to inferior 1/2 of drg. Pt has ileostomy to RLQ. Stoma appears moist & pink, draining small amt bloody fluid into colostomy bag. Colostomy to LLQ. Stoma pink & moist, covered c̄ moist 4x4, mucous drng present. Foley to gravity draining dark amber urine. NGT to (L) nare ~~[illegible]~~ ~~[illegible]~~ to LCS draining dark brown fluid. CL to (R) SC. Patent & good blood return x 3. LR @ 200 cc/hr infusing c̄ difficulty. Will continue to monitor & assess - (b)(6)-2

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

PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

(b)(6)-4

VENT CHECK SHEET

VENT START DATE 21 MAY 04

DATE/TIME	MODE	VT	RR	FIO2	TOTAL RR	PEEP	ALARM	SpO2	PIP	COMMENT	INT
21MAY@1400	SIMV	750	12	40	20	5	50 1 5	100	28	PT ARRIVED FROM EMT & R.DETT@22@LIP.BBS DIMINISHED	
0015	SIMV	750	12	50	20	5	50 1 5	100	30	FiO2 ↑ UNKNOWN TIME	
0440	SIMV	750	12	50	16	5	50 1 5	100	31	SX SMALL AMOUNT OF MOD THICK YELLOW+WHITE	
0750	SIMV	750	12	50	22	5	50 1 5	100	31		
1200	SIMV	750	12	50	24	5	50 1 5	100	33	SX: frothy small white	
1505	SIMV	750	12	50	16	5	50 1 5	96	26	SX ↓ mucous	
1800	SIMV						1			PX TX XQ 4° started. SX: Lg thick pus like	
2000	SIMV	750	12	50	26	5	50 1 5	98%	35	PX TX given SX: Med thick clear	
0020	SIMV	750	12	50	12	5	50 1 5	95%	30	PX TX given SX: small Fr. Tube; lg fr mouth	
0440	SIMV	750	12	60	24	5	50 1 5	95	25	PX TX given SX: small. Tube repositioned	
0810	SIMV	750	12	50	14	5	50 1 5	95	14	TX given SX: Small white (chest tube placed in)	
1200	SIMV	750	12	60	12	5	50 1 5	97	31		
1500	SIMV	750	12	60	12	5	50 1 5	93	28		
1800	SIMV	750	12	60	12	5	50 1 5	92	29		
0405	PT	dead					1				

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
~~20 MAY 06~~	
0930	NURSING: Lower 1/2 of incision - sutures intact, edges open, dressing soaked to brown foul smelling fluid. Penrose drain in place. Dressings changed, dilution by over penrose area. Stoma pink, mucus drainage present. Tissues at open area of incision pink. (b)(6)-2 RN
1030	Pastural drainage/percussion per RT. Breath sounds coarse throughout. Albuterol nebs (b)(6)-2 RN
1200.	Respirations regular, breath sounds less coarse (b)(6)-2 RN
5/20/99	M Davis Pt suddenly became likely BP out of Penrose drain to abdomen. Called to OR of patient for about 45 min. HR 121 then PM. P 144 BP 87/54 SpO2 95 (1) attend likely found no DIC P. to contact surgeon to consider exploration no Transfer (2) Fluid support (3) FFP (4) Blood type crossed and on hold (b)(6)-2

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

'ART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTE
DATE	NOTES

1 May 04 1200 NRSG: Administered 10mg Vecuronium IVP @ 0900, 1000 & 1100 for PT agitation & to ↓ Pt's RR. Δ'd vent RR setting to 18 bpm @ 1030 d/t Pt's ↑ PCO_2. ↑'d RR again @ 1135 d/t ABG. RR now @ 20 bpm on vent. Will draw another ABG to ✓ effects of vent Δ. TV 500, FiO_2 @ 50%. PT appears relaxed. Will continue to monitor & prepare PT for transfer to 31st CSH- (b)(6)-2

1 May 04 1200 NRSG: Pt remains sedated. 10mg Vecuronium given @ 1230 for ↑ RR. 425cc dumped from NGT drng, dark brown in color. 25cc drained from colostomy bag - bloody drng. Foley emptied. All meds prepared for transfer. (b)(6)-2 Nodr dose of Zosyn given. ↑'d Tidal Volume on vent to 1200. Will continue to monitor— (b)(6)-2

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	WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 May 04	Received pt alert & orient O2 sat 89-91 on 12lt air concentrater, lungs congested thruout foley to gravity amber but clear. bloody stool bright red small liquid LR 50cc/hr TPN @ 125cc/hr, Lipid 21cc/hr, NJ dark green drainage; ~~[illegible]~~ cont. suction. see flowsheet for ~~assessment~~ vitals
9 May 04 2200	Neb given chest pt conducted & nasopharyn suction conducted, scant withdrawal O2 sat >94%. [b)(6)-2]
20 May 04 0200	FS 164 neb treatment given chest pt conducted pt unable to rough up sputum, perform T.S. well [b)(6)-2]
20 May 04 0500	Dressing change pt sat up on side of bed & staff assistance perrose drain 550cc blood tinged brownish drainage. bright red blood noted to rectum. [b)(6)-2]
20 May 0100	neb treatment given chest pt conducted, blood work drawn see flowsheet for vitals & finger stick [b)(6)-2]

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

[b)(6)-4]