DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
24th/348th MP DET (CID), 10th MP BN (CID), Camp Cropper, Baghdad, Iraq
APO AE 09342

13 Oct 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0031-2008-CID789-53213 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 06 OCT 2008, 1131 - 06 OCT 2008, 1204; INTENSIVE CARE UNIT, 115TH COMBAT SUPPORT HOSPITAL, CAMP CROPPER, IRAQ, AE 09342

DATE/TIME REPORTED: 06 OCT 2008, 1210

INVESTIGATED BY:
SA (b)(6), (b)(7)(C), (b)(7)(F)

SUBJECT:
1. NONE, ; [DEATH BY NATURAL CAUSES] (NFI)

VICTIM:
1. MOHAMMAD AL-SALHAT, KHALIL KHADIR (DECEASED); FRCIV; JORDAN; (DOB); (POB); MALE; WHITE; INTERNMENT SERIAL NUMBER US (b)(6), b(7)(C) THEATER INTERNMENT FACILITY, COMPOUND 5, CAMP CROPPER, IRAQ, ARMED FORCES AFRICA, CANADA, EUROPE & MIDDLE EAST 09342; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

THIS IS AN OPERATION IRAQI FREEDOM INVESTIGATION.

ACLU DDI CID ROI 29793

The Patient Administration Department, 115th CSH, reported the death of Detainee MOHAMMAD.

Investigation determined Mr. MOHAMMAD died as a result of Renal Carcinoma with metastases to the brain and the manner of death was natural.

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA b(6), b(7)(C) 6 Oct 08.
2. AIR of SA b(6), b(7)(C) 6 Oct 08.
3. Rough Sketch Depicting Human remains, 6 Oct 08.
4. Photographic Packet (Examination of Remains).
5. AIR of SA b(6), b(7)(C) 6 Oct 08.
6. Attending Physician's Report, 6 Oct 08.
7. CD containing medical records of Mr. MOHAMMAD.
8. Certificate of Death, 6 Oct 08.
9. CD containg orginal photographs (Examination of Remains) (USACRC, USACIDC, and file copy only)

Not Attached:

None

STATUS: This is a Final (C) Report.

CID Reports of Investigation may be subject to a Quality Assurance Review by CID higher

ACLU DDI CID ROI 29794

ACLU-RDI 5593 p.2

000002

headquarters.

Report Prepared By:

b(6), b(7)(C)

Special Agent

Report Approved By:

b(6), b(7)(C)

Special Agent in Charge

DISTRIBUTION:
Dir, USACRC, Ft Belvoir, VA
CDR, USACIDC, ATTN: CIOP-COP-CO, Fort Belvoir, VA 22060
Commander, 24th/348th Military Police Detachment, Camp Slayer, Baghdad, Iraq APO AE 09342
Operations Officer, 34th/348th MP DET (CID), Camp Slayer, Baghdad, Iraq APO AE 09342
Commander, 10th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
Commander, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
Director, Armed Forces of the Institute of Pathology, Office of the Armed Forces Medical Examiner, A
Dover Facility, Dover Air Force Base, Delaware
CID LIAISON, AFIP, ATTN: SA b(6), b(7)(C)
Special Agent in Charge, Aberdeen Proving Ground CID Office
FOB Commander, 1-114 Field Artillery, ATTN: LTC b(6), b(7)(C) Camp Cropper, Baghdad, Iraq APO AE 09
Executive Officer, 115th Combat Support Hospital, Camp Cropper, Baghdad, Iraq APO AE 09342
Command Judge Advocate, 11th Military Police Brigade, ATTN: LTC b(6), b(7)(C)
Camp Cropper, Baghdad, Iraq
PMO, VBC, IRAQ, APO AE 09342
FILE

ACLU DDI CID ROI 29795

ACLU-RDI 5593 p.3

000003

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER: 0031-08-CID789-53213

DETAILS

BASIS FOR INVESTIGATION: About 1210, 6 Oct 08, SSG b(6), b(7)(C) PAD, 115th CSH, reported Mr. MOHAMMAD died while under medical care in the ICU.

About 1241, 6 Oct 08, SA b(6), b(7)(C) arrived at the ICU, 115th CSH, and coordinated with CPT b(6), b(7)(C) b(6), b(7)(C) Registered Nurse, ICU, 115th CSH, who stated Mr. MOHAMMAD was under medical care in the ICU when at approximately 1131, 6 Oct 08, he stopped breathing. CPT b(6), b(7)(C) stated Mr. MOHAMMAD was observed to be in a state of Pulseless Electrical Activity (PEA), at which time CPR was started and Epinephrine and Atropine were administered. CPT b(6), b(7)(C) stated they were initially successful in reviving Mr. MOHAMMAD, but his vital signs were significantly reduced and in a terminal state. CPT b(6), b(7)(C) stated Mr. MOHAMMAD stopped breathing again, at which time it was observed Mr. MOHAMMAD's heart stopped. CPT b(6), b(7)(C) stated Mr. MOHAMMAD's son, Mr. b(6), b(7)(C) was bedside with Mr. MOHAMMAD and requested life saving measures be terminated, at which time Mr. MOHAMMAD was pronounced deceased by Dr. (MAJ) b(6), b(7)(C) ICU, 115th CSH, at 1204, 6 Oct 08.

About 1248, 6 Oct 08, SA b(6), b(7)(C) interviewed Dr. b(6), b(7)(C) who stated Mr. MOHAMMAD was initially diagnosed with suspected renal carcinoma (kidney cancer) during a medical evaluation following an unexplained seizure. Dr. b(6), b(7)(C) stated a CT scan of Mr. MOHAMMAD's head revealed metastases believed to be brain cancer. A CT scan of Mr. MOHAMMAD's abdominal region revealed growths on the kidney also believed to be cancer. Dr. b(6), b(7)(C) stated Mr. MOHAMMAD was admitted to the 115th CSH on 29 Sep 08, for diarrhea and altered mental status, which improved after his fluids were replenished, and he was discharged on 1 Oct 08. Dr. b(6), b(7)(C) stated Mr. MOHAMMAD was re-admitted to the ER on 4 Oct 08, after he had a seizure during visitation with his family. While in the ER, Mr. MOHAMMAD's vital signs began to decline, at which point he was transferred to the ICU on 5 Oct 08. Dr. b(6), b(7)(C) stated Mr. MOHAMMAD's condition deteriorated to the point he never awoke and became unresponsive to pain or stimuli. Dr. b(6), b(7)(C) stated he spoke to Mr. b(6), b(7)(C) and briefed him on Mr. MOHAMMAD's condition. Mr. b(6), b(7)(C) requested his father not be intebated in the event he experienced respiratory distress, but did request all other efforts be made to resuscitate him. Dr. b(6), b(7)(C) stated he was notified at approximately 1119, 6 Oct 08, that Mr. MOHAMMAD's vital signs were beginning to decline. Dr. b(6), b(7)(C) stated that at approximately 1131, Mr. MOHAMMAD stopped breathing and was observed in a state of PEA, at which time CPR was conducted until Mr. MOHAMMAD was revived. Dr. b(6), b(7)(C) stated Mr. MOHAMMAD's heart stopped again, at which time he was resuscitated. Dr. b(6), b(7)(C) stated he explained to Mr. KADAR he could continue to revive Mr. MOHAMMAD, but that his death was imminent. Mr. MOHAMMAD's heart stopped a third time, during which Mr. b(6), b(7)(C) requested all life saving measures cease. Dr. b(6), b(7)(C) stated he pronounced Mr. MOHAMMAD deceased at 1204, 6 Oct 08. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID) CAMP CROPPER, IRAQ, APO AE 09342	
SIGNATURE b(6), b(7)(C)	DATE: 6 Oct 08	EXHIBIT: 1

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(Automated)

ACLU DDI CID ROI 29796

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER: 0031-08-CID789-53213

DETAILS

EXAMINATION OF REMAINS: About 1253, 6 Oct 08, SA b(6), b(7)(C) and SA b(6), b(7)(C) conducted an examination of the remains of Mr. MOHAMMAD while at Bed 5, ICU, 115th CSH.

Characteristics of Remains: The decedent was identified, via digital retinal scan, as Mr. MOHAMMAD. The decedent appeared to be a Middle Eastern male, approximately 6'0", and weighed approximately 219 pounds. The decedent had black/gray "peppered" hair and brown eyes. The decedent was not clothed, but was covered with a bed sheet and wool blanket upon arrival. Evidence of medical intervention included a radial arterial catheter inserted in the left wrist, a Foley catheter inserted into the penis, a triple lumen catheter inserted into the femoral artery to the right groin, a nasal gastric tube inserted in his right nostril, a peripheral inter-venous catheter inserted into the right hand and left forearm, petechia to the left arm from a blood pressure cup, puncture marks to the tips of the left fingers from blood draws for glucose testing, bruising to the left thumb, hand, and right forearm from attempts to insert intra-venous catheters, and healing bruises on both legs from a previously reported fall.

Conditions of Remains: The remains were warm to the touch, with livor mortis beginning to settle in areas of the decedents back that were void of contact with the surface of the hospital bed. Rigor mortis was not present in either the large or small joints. No signs of external trauma, except for signs of medical intervention, were observed. The decedent was not wearing any jewelry.

Environmental Conditions: At the time of the examination, the temperature inside the ICU was approximately 75 degrees Fahrenheit. There were no odors out of the ordinary near the remains during the time of the examination.

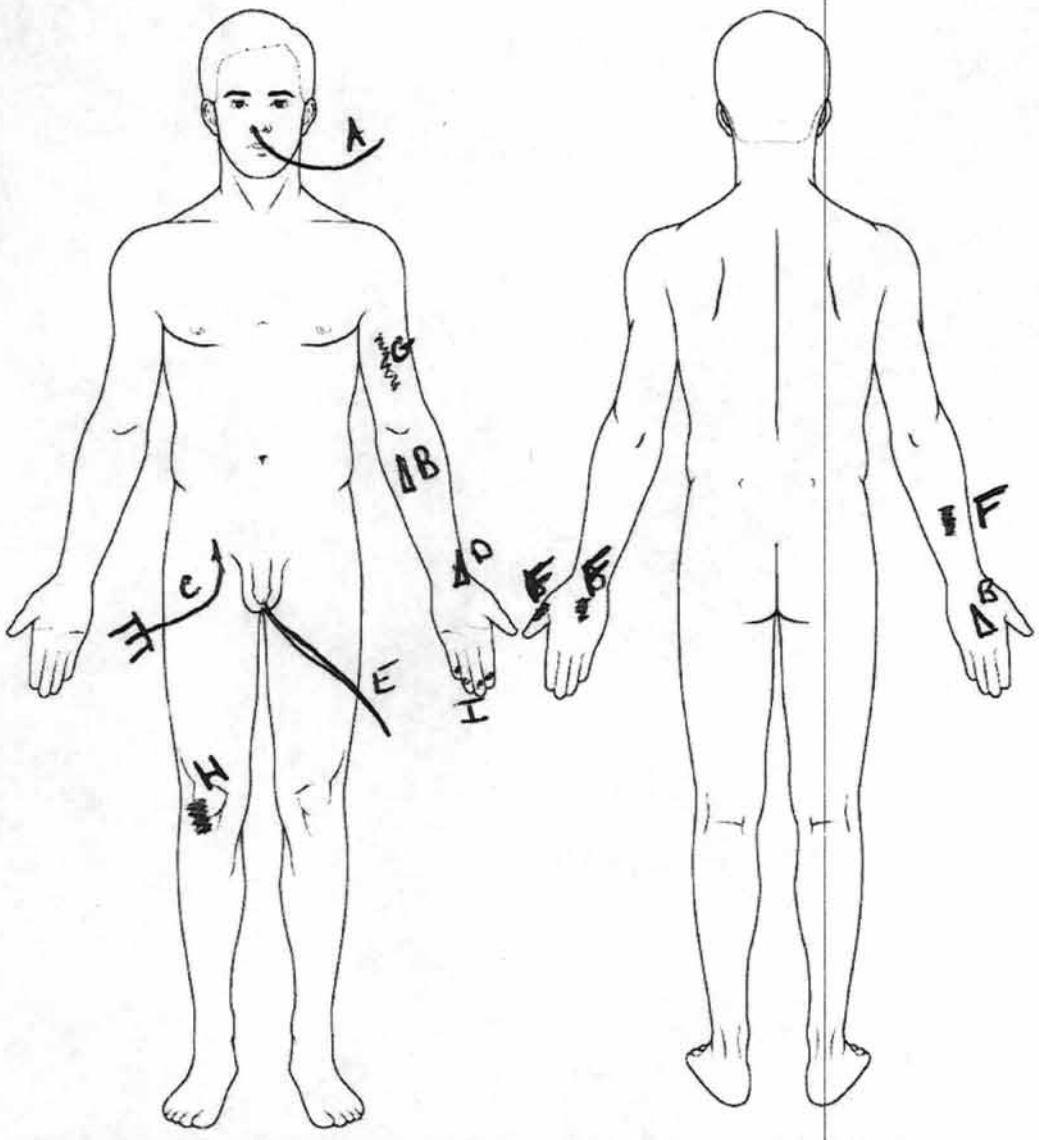
Documentation of Remains: The remains were documented by SA b(6), b(7)(C) utilizing a NIKON D80 Digital Camera with an external flash. A human remains sketch was prepared by SA b(6), b(7)(C) and verified by CPT b(6), b(7)(C)

Collection of Evidence: A collection of evidence was not performed because the decedent was treated in the 115th CSH for approximately 2 days prior to his demise and all clothing had been disposed of by hospital staff. The decedent's hands were covered with paper bags to protect and preserve possible trace evidence, and the body was released back to the ICU staff for preparation and transport to Mortuary Affairs. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIGNATU b(6), b(7)(C)	DATE: 6 Oct 08	EXHIBIT: 2

ACLU DDI CID ROI 29797

Rough Sketch Depicting Human Remains



LEGEND	TITLE BLOCK:
A: Nasal Gastric Tube	Case#: 0031-08-CID789-53913
B: Peripheral IV catheter	Offense: Undetermined Death
C: Femoral Triple lumen Catheter	Person Portrayed: Detainee ISN: [redacted]
D: Radial Arterial Catheter	Location: Bed 5, ICU, 115th CSH, CCIZ
E: Foley Catheter	Victim: Mr. Khalil Khadir Mohammad Al-Salhat
F: Bruise (IV stick)	Date/Time: 6 Oct 08/ 1347
G: Petechia (Blood Pressure cuff)	Sketched By: SA [redacted]
H: Bruise (unknown cause)	Verified By: [redacted]
I: Puncture marks (blood sugar testing)	ISN: [redacted]

ACLU DDI CID ROI 29798
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LAW ENFORCEMENT SENSITIVE
EXHIBIT 3

EXHIBIT 4

MISSING

ACLU DDI CID ROI 29799

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0031-08-CID789-53213

DETAILS

About 1350, 6 Oct 08, SA b(6), b(7)(C) coordinated with Dr. b(6), b(7)(C) who provided his report pertaining to the death of Mr. MOHAMMAD.

About 1445, 6 Oct 08, SA b(6), b(7)(C) coordinated with SGT b(6), b(7)(C) PAD, and submitted a Request For Private Medical Information.

About 1745, 6 Oct 08, SA b(6), b(7)(C) coordinated with SGT b(6), b(7)(C) and obtained the medical records and Certificate of Death pertaining to Mr. MOHAMMAD. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIGNATURE b(6), b(7)(C)	DATE 6 Oct 08	EXHIBIT 5

ACLU DDI CID ROI 29800

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

eport requested by: (b)(6) [illegible]

06 Oct 2008@1323 INPT Register #(b)(6) PHYSICIAN
DISCHARGE NOTE
DEATH NOTE DEATH NOTE

Attending Physician: (b)(6)
HN: 900 00-0018

Admission Date: 04 OCT 2008 Date/Time of Death: 06 OCT 2008, 1204hrs

ICD Operations/Procedures: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Enter Principal Diagnosis: Renal cell carcinoma

Enter Secondary Diagnosis: Brain metastases secondary to renal cell carcinoma

Enter Principal Procedures/Operations: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Discharge Summary: This is a 51yo male detainee from Compound V with history of presumed presumed renal cell carcinoma with metastatic disease involving the brain. The detainee was recently admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status but improved with fluid resuscitation and demonstrated no significant changes in CT of the head. He was subsequently re-admitted on 04 OCT 2008 for increasing somnolence. At time of admission, he had a GCS score of 5-6 and was admitted to the ICW. On the morning after admission, though, his condition worsened after having two additional seizures. He was subsequently transferred to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 103, tachycardic with a heart rate as high as 180 and low oxygen saturations necessitating placement on 100% NRB (face mask oxygen). He also had a-line and femoral central line placed. Broad spectrum antibiotic coverage with piperacillin/tazobactam and vancomycin was initiated. His family came to visit and end of life issues and code status were discussed with the ICU physician.

His condition continued to deteriorate throughout the course of his second day. The decision was made by family members that the detainee would not be intubated but would receive ACLS (Advanced Cardiac Life Support) to include chest compressions, direct current cardioversion (electric shocks) if indicated and cardiac support medications. By his second night in the hospital, he was no longer producing urine and required additional intravenous fluid support. He also was started on a continuous infusion of diltiazem to control his heart rate which had climbed as high as the 180's range. His mental status remained extremely poor and he was unresponsive to painful or verbal stimuli. By the morning of the third hospital day, he was noted to have a disconjugate gaze (his eyes were pointing in different directions from one another). He had developed pronounced Kussmaul breathing (deep and fast respirations) which continued through much of the morning. His tachycardia had improved somewhat with the use of the diltiazem infusion.

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20/900-20-0018 DETAINEE,ISN200018 FOREIGN NATIONAL - POW/INTERNE
03 Jan 1967 / Male H: not on file
Reg #: (b)(6) Loc: ICU 1 W: not on file
Spon: DETAINEE,ISN200018 Rank:
Unit: RR:
Automated version of SF509

ACLU DDI CID ROI 29802

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LAW ENFORCEMENT SENSITIVE

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

Progress Notes

Report requested by: (b)(6) 0031-08-CID789-53213

I spoke with detainee's son on multiple occasions regarding the status of his father and allowed him to remain present in the ICU. I gave my opinion that I believed advanced life support could be futile, particularly if mechanical ventilation was not an option. The son remained steadfast in his desire for us to do everything "but put him on a breathing machine."

Thirty minutes after my conversation with the son, the detainee heart rate and respiratory rate dropped precipitously. Soon after he developed PEA (pulseless electrical activity) and CPR was initiated. An oral airway was placed and the detainee was ventilated using an Ambu bag. He was noted to have ZERO spontaneous ventilations during the code process. We were able to regain a pulse after 10 minutes of CPR with epinephrine, atropine and Levophed (medications to stimulate the heart and elevate the blood pressure) and CPR was stopped. I explained to the son that his father's clinical situation had worsened significantly and that his death was imminent. I also explained that his father would continue to develop PEA because of his inability to breathe on his own. I also explained that I suspected the cause of impending death to be the herniation of his father's brain stem because of high intracranial pressures (because of the brain swelling from the metatastases and the blockage of free flow of cerebrospinal fluid out of the brain). The son expressed understanding but asked that we continue with our treatment. Ten minutes later his father went into PEA again. The ICU team again initiated CPR and provided cardiac medications with a return of the pulse, albeit weaker and slower than on the initial resuscitation. I again asked the son if he wished for us to continue. At this time, he expressed his desire for the team to stop resuscitation. I ordered cessation of CPR and bag-mask ventilation. His cardiac rhythm quickly degenerated into PEA and he expired shortly thereafter. The detainee's son was present at bedside at the time of death.

(b)(6)

20/900-20-0018 DETAINEE,ISN200018 FOREIGN NATIONAL - POW/INTERNE
03 Jan 1967 / Male H: not on file
Reg #: (b)(6) Loc: ICU 1 W: not on file
Spon: DETAINEE,ISN200018 Rank:
Unit: RR:
Automated version of SF509

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LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29803

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

* * * ADMISSION COVER WORKSHEET * * *

Reg No: (b)(6) Name: DETAINEE,ISN200018 FMP/SSN: 20/900-20-0018

ADMISSION

Date/Time: 29 Sep 2008@2248 Source: ERA MEPRS: ABAA
Sex: MALE Age: 41 DOB: 03 Jan 1967 Ward: ICW1

Patient Category: FRGN NAT POW/INTERNEE Pay Grade: Fly Status:
Marital Status: UNKNOWN Race: OTHER
Duty Zip: Ethnic: OTHER
Sponsor Name: DETAINEE,ISN200018 Religion:

MTF Trans from:
MTF of Initial Adm: Init Adm Date:
Disposition Date: 01 Oct 2008@1228 Type of Disposition: HOME

Sponsor Name: DETAINEE,ISN200018
Adm Physician: (b)(6)
Adm Diagnosis: DIARRHEA (787.91)
Adm Proc1:
Adm Proc2:

Administrative Remarks:

Cause of Injury:

Principle Dx:

Other Dx:

Principle Procedure:

Other Procedure:

Patient has a Living Will/Advance Directive on file at MTF. Yes___ No___

Signature Attending Medical Officer

*** End of Report ***

ACLU DDI CID ROI 29804

MTF: CAMP CROPPER

PERSONAL DATA - PRIVACY ACT OF 1974

RECORD OF INPATIENT TREATMENT

REGISTER: (b)(6) NAME: DETAINEE,ISN200016 FMP/SSN: 20/900-20-0018

A D M I S S I O N

DATE/TIME: 29 Sep 2008@2248 SOURCE: ERA CLIN SVC: GEN SUR/ABAA
DOB: 03 Jan 1967
SEX: M

D I S P O S I T I O N

DATE/TIME: 01 Oct 2008@1228 TYPE: HOME CLIN SVC: GEN SUR/ABAA
AGE : 41

D I A G N O S E S

DX 1. Principal DX: 78791
DIARRHEA

P R O C E D U R E S

PR 1. Principal PR: NO PROCEDURES ON FILE

I CERTIFY THAT THE IDENTIFICATION OF THE PRINCIPAL AND SECONDARY DIAGNOSES
AND PROCEDURES PERFORMED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

ATTENDING PROVIDER _____

Provider Taxonomy:

DRG: RECORD NOT GROUPED

MDC:

S E L E C T E D A D M I N I S T R A T I V E D A T A

ADMISSION:

PATIENT CATEGORY: FRGN NAT POW/INTERNEE
MARITAL STATUS: UNKNOWN
DUTY ZIP:
MTF TRANS FROM:
MTF OF INITIAL ADM:
PAY GRADE:
RACE: OTHER
ETHNIC: OTHER
RELIGION:
INIT ADM DATE:

* * * * * * * * * * * * *

DISPOSITION:

MTF TRANS TO:
ICU CLINICAL SVC:
LED DAYS OTHER FEDERAL FACILITIES:
AUTOPSY:
ICU DAYS SPENT: 0
MEDICAL HOLD DAYS:

REPLACES AF FORM 565, DA FORM 3647, NAVMEDCOM 6300/5

*** CONTINUED ON PAGE 2 ***

ACLU DDI CID ROI 29805

MTF: CAMP CROPPER

PERSONAL DATA - PRIVACY ACT OF 1974

RECORD OF INPATIENT TREATMENT

REGISTER: (b)(6) NAME: DETAINEE,ISN200018 FMP/SSN: 20/900-20-0018

BED DAYS CIVILIAN HOSPITALS:
BED DAYS THIS MTF: 2
TOTAL SICK DAYS THIS MTF: 2
CONVALESCENT LEAVE TAKEN: 0

COOPERATIVE CARE DAYS: 0
SUPPLEMENTAL CARE DAYS: 0

RECOMMENDED: 0

* * * * * * * * * * * * *

OTHER:

SPONSOR NAME: DETAINEE,ISN200018
DUTY ADDRESS:

MATERNAL/NEWBORN REGISTER:

EMERGENCY ADDRESSEE:
RELATIONSHIP:
NAME:
ADDRESS:

PHONE:

PATIENT ADDRESS:

BLOOD USED (Y/N): N
BLOOD PRODUCTS:
TRAUMA CODE:
CAUSE OF INJURY:

PREV ADMISSION THIS MTF: N
UNITS:

INJURY REMARKS:

CLINICAL RECORDS APPROVAL SIGNATURE BLOCK:

_____ _____
Medical Record Approved by Date

REGISTER: 0005332 NAME: DETAINEE,ISN200018 FMP/SSN: 20/900-20-0018

REPLACES AF FORM 565, DA FORM 3647, NAVMEDCOM 6300/5

*** End of Report ***

ACLU DDI CID ROI 29806

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

Progress Notes

For: 01 Oct 08

Report requested by: (b)(6)

01 Oct 2008@1005 INPT Register # (b)(6) PHYSICIAN

DISCHARGE NOTE

Attending Physician: (b)(6)

HN: 900 20 0018

Admission Date: 29 September 2008 Discharge Date: 1 October 2008

ICD Operations/Procedures: None

Allergies: NKDA

Enter Principal Diagnosis: Metastatic renal cell carcinoma

Enter Secondary Diagnosis: Diarrhea with mental status changes

Enter Principal Procedures/Operations: None

Enter patient's condition at time of discharge: Improved

Diet: Regular

Discharge Summary:

This is a Compound 5 detainee who is well known to me from a June 2008 admission for new onset seizure. Work then was remarkable for probable renal cell carcinoma with mets to the brain which causes the seizures. Since then the patient has been on oral steroids and anti convulsants. Per the compound 5 provider, over the past 7 days or so, the patient has become more debilitated, fatigued, and weak to the point where he could not even get up from his bed. He also suffered a fall on the day of admission due to his weakness. His mental status although not significantly changed was notable for more aphasia. The patient was brought to the ER and admitted for further evaluations. CT scan of the head was done and initial labs were done also. He was placed on the ward for further care and treatment as indicated. This am, patient was alert, and able to communicate although he was not able to speak/articulate. He was able to answer questions appropriately and make his requests known. He also was able to get up from bed and go to the restroom with nursing assistance.

Patient had an unremarkable hospital course. He was afebrile with normal VS, and was able to converse with the staff through the linguists. Work up with negative. CT of head was essentially unchanged from Jun 2008. CBC and chemistry panel was benign. PSG were also normal during stay (PSG was 125 on am of d/c). In addition stool studies were ordered but he did not have any further stool to collect for studies. He had one episode of diarrhea day prior to d/c and none the day of d/c. Metamucil was added to

20/900 20 0018 DETAINEE, ISN200018 FOREIGN NATIONAL POW/INTERNE
03 Jan 1967 / Male H: not on file
Reg #: (b)(6) Loc: CW 1 W: not on file
Spon: DETAINEE, ISN200018 Rank:
Unit: RR:

Automated version of SF509

ACLU DDI CID ROI 29807

115TH CSH CROPHVR
Personal Data - Privacy Act of 1974 (Pl 93 579)
Progress Notes
For: 01 Oct 08

Report requested by: (b)(6)

regimen to give bulk to stools. Patient desired to return to compound on day of discharge and was awake and conversant although with slowing of speech, likely due to known brain metastases from presumed renal cell carcinoma.

Discharge Medications: Continue all of outpatient medications; added Metamucil 1 packet with juice TID

Follow up: F/U with compound 5 providers as per routine

(b)(6)

ICU/ICW Attending

Signed: (b)(6)

*** END OF REPORT ***

20/900-20-0018 DETAINEE, ISN200018
01 Jan 1967 / Male
Loc: ICW 1
Spon: DETAINEE, ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
R: not on file
W: not on file
Rank:
ER:

Reg #: (b)(6)

Automated version of Sr509

ACLU DDI CID ROI 29808

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

Progress Note

Report requested by: (b)(6)

---

01 Oct 2008@1005 INPT Register # (b)(6) PHYSICIAN

DISCHARGE NOTE

Attending Physician: (b)(6)

HN: 900-20-0018

Admission Date: 29 September 2008 Discharge Date: 1 October 2008

ICD Operations/Procedures: None

Allergies: NKDA

Enter Principal Diagnosis: Metastatic renal cell carcinoma

Enter Secondary Diagnosis: Diarrhea with mental status changes

Enter Principal Procedures/Operations: None

Enter patient's condition at time of discharge: Improved

Diet: Regular

Discharge Summary:

This is a Compound 5 detainee who is well known to me from a June 2008 admission for new onset seizure. Work then was remarkable for probable renal cell carcinoma with mets to the brain which causes the seizures. Since then the patient has been on oral steroids and anti-convulsants. Per the compound 5 provider, over the past 7 days or so, the patient has become more debilitated, fatigued, and weak to the point where he could not even get up from his bed. He also suffered a fall on the day of admission due to his weakness. His mental status although not significantly changed was notable for more aphasia. The patient was brought to the ER and admitted for further evaluations. CT scan of the head was done and initial labs were done also. He was placed on the ward for further care and treatment as indicated. This am, patient was alert, and able to communicate although he was not able to speak/articulate. He was able to answer questions appropriately and make his requests known. He also was able to get up from bed and go to the restroom with nursing assistance.

Patient had an unremarkable hospital course. He was afebrile with normal VS, and was able to converse with the staff through the linguists. Work up with negative. CT of head was essentially unchanged from Jun 2008. CBC and chemistry panel was benign. PSG were also normal during stay (FSG was 125 on am of d/c). In addition stool studies were ordered but he did not have any further stool to collect for studies. He had one episode of diarrhea day prior to d/c and none the day of d/c. Metamucil was added to regimen to give bulk to stools. Patient desired to return to compound on day of discharge and was awake and conversant although with slowing of speech, likely due to known brain metastases from presumed renal cell carcinoma.

20/900-20-0018 DETAINEE,ISN200018 FOREIGN NATIONAL POW/INTERNE

Reg #: (b)(6) 03 Jan 1967 / Male H: not on file

Loc: ICW 1 W: not on file

Spon: DETAINEE,ISN200018 Rank:

Unit: RR:

Automated version of SF509

ACLU DDI CID ROI 29809

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

Report requested by: (b)(6)

Discharge Medications: Continue all of outpatient medications; added Metamucil 1 packet with juice TID

Follow-up: F/U with compound 5 providers as per routine

(b)(6)

ICU/ICW Attending

Signed: (b)(6)

20/000-20 0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Loc: ICW 1
Spon: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Reg #: (b)(6)

Automated version of SF509

ACLU DDI CID ROI 29810

115TH CSH CROPPER

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

Progress Notes

Report requested by: (b)(6)

---

01 Oct 2008@0408 INPT Register # (b)(6) MEDICAL SPECIALIST

PROG NOTES

Pt slept through night with no c/o pain. Blood sugar @ 2200 was 255 and was covered with 6 units of Reg Insulin. When giving meds, pt was able to respond with yes's and no's. Pt was also able to give self PO meds rather than have them fed to him. IV access was discontinued per MD order. No other pertinent information at this time. Will continue to assess and monitor

Signed: (b)(6)

(b)(6)

==========

20/900-20-0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Loc: JCW 1
Spon: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Req #: (b)(6)

Automated version of SF509

H-2

ACLU DDI CID ROI 29811

115TH CSH CROPPER

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

Progress Notes

Report requested by: (b)(6)

---

30 Sep 2008@1336 INPT Register # (b)(6) CLINICAL NURSE

PROG NOTES

Lungs cta. Skin intact, no wounds or ducubitis areas noted. Pt able to understand when spoken to but cannot form words to speak. Was able to communicate his desires when assisted with meals. Pt has some dexterity deficit, is able to eat drink and take meds if placed in his hands but has to use very deliberate movements and concentration to line up accurately with his mouth. Pt had one loose BM. Was able to ambulate to w/c c asst. FS 162 with no coverage.

Signed: (b)(6) (b)(6)

20/900-20-0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Loc: ICW 1
Spon: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Reg #: (b)(6)

Automated version of SF509

ACLU DDI CID ROI 29812

115TH CSH CROPPER

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

Progress Notes

Report requested by: (b)(6)

---

30 Sep 2008@0505 INPT Register #(b)(6) OPERATING ROOM

PROG NOTES

Arrived to ICW @ 2230 with c/o diarrhea and AMS. Pt does not respond appropriatley to simple verbal commands, if they respond at all. Pt has stable but sluggish gait and moves very slowly. Has 16ga in Lt AC and is recieving 100ml/hr NS. Pt urinated in bed this AM. No other pertinent information at this time. Will continue to assess and monitor.

(b)(6)

20/900-20-0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Loc: ICW 1
Spcu: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Reg #: (b)(6)

Automated version of SF509

ACLU DDI CID ROI 29813

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION C[redacted] J[redacted]ION-MEDICATION)

For use of this form, see AR [redacted]; the proponent agency is the Office of The Surgeon General

Mo. 09 Yr. 08

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2
29SEPT	(b)(6)	DIET: ~~REGULAR~~ Reverse Schedule for Ramadan) Diabetic	B	/	(b)(6)		
			L	/	(b)(6)		
			D	/			
29SEPT	(b)(6)	Vital Signs Q Shift ICW protocol	06	/	(b)(6)		
			14	/	(b)(6)		
			22	CS			
29SEPT	(b)(6)	Activity Perdetamee protocol	D	/	(b)(6)		
			N		(b)(6)		
29SEPT	(b)(6)	Weight Bearing Status: assistance only	D	/	(b)(6)		
			N		(b)(6)		
29SEPT	(b)(6)	Fingersticks QAC & HS	06	/	(b)(6)		
			FS	/			
			11	/	(b)(6)		
			FS	/			
			16	/	(b)(6)		
			FS		(b)(6)		
			22				
			FS				

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Diarrhea, Altered Mental Status, Known cancer & brain mets

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

PATIENT IDENTIFICATION: [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

ACLU DDI CID ROI 29814

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo 09 Yr 08

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	01
29SEPT	(b)(6)	NS @ 100 ml/hr	D	/	(b)(6)	
			N		(b)(6)	
29SEPT	(b)(6)	Tegretol 200mg PO QAM	10	/	(b)(6)	
29SEPT		Tegretol 100mg PO QPM	22		(b)(6)	
29SEPT		Dilantin 900mg PO QAM	10	/	(b)(6)	
29SEPT		Dilantin 400mg PO QPM	22		(b)(6)	
29SEPT		Toprol XL 50mg PO Qday	10	/	(b)(6)	
29SEPT		Isosorbide 10mg PO BID	10	/		
			22	/	(b)(6)	
29SEPT	(b)(6)	Nexium 20mg PO Qday	10	/	(b)(6)	
29SEPT		Decadron 2mg PO Q6hrs	00	/	(b)(6)	
			06	/	(b)(6)	
			12	/	(b)(6)	
			18	/		
29Sep	(b)(6)	Metamucil Packet in Juice TID	06	/	(b)(6)	
			14	/		
			22	/	(b)(6)	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Diarrhea, Altered Mental Status, Known Cancer with Brain Mets

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: 900 20 0018 / 72008

DISPENSING TIMES

D 7 8 9 10 11 12 13 14

ACLU DDI CID ROI 29815

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General	Mo 01 Yr 08

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3	4	5
29SEP08	(b)(6)	Target Glucose 70-180mg/dL	06	/	(b)(6)					
	------	<70mg/dL=give 1 Amp D50 &	FS	/						
	------	call MD	INS	/	Ø	Ø				
	------	70-180 mg/dL = No Action	11	/	(b)(6)					
	------	181-200 mg/dL = 2 units regular	FS	/						
	------	201-250 mg/dL = 4 units regular	INS	/	Ø					
	------	251-300 mg/dL = 6 units regular	16	/	(b)(6)					
	------	301-350 mg/dL = 8 units regular	FS	/						
	------	351-400 mg/dL = 10 units regular	INS	/						
	------	>400 mg/dL = CALL MD	22	(b)(6)						
	------		FS							
	------		INS							

ALLERGIES ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS — Diarrea, Altered Mental Status, Hypoxia on CA 2 brain mets

ADDITIONAL PAGES IN USE ☐ YES ☐ NO — PAGE NO

PATIENT IDENTIFICATION: [illegible]

DISPENSING TIMES

USE PENCIL FOR ALL ENTRIES

D 7 8 9 10 11 12 13 14

ACLU DDI CID ROI 29816

ICW Vital Sign Record

Date	Time	Temp	Pulse	Resp	B/P	O2 Sat	URINE	Drain # 1	Drain # 2	Drain # 3
29 Sept 08	2300	98.6	75	18	140/99	99%	1/ Nil	Admit	—	11
30 SEPT 08	0600	98	74	16	146/100	97%	300			
30 Sept 08	1400	98.1	75	18	125/80	97%	NC			
30 Sept 08	2300	98.2	81	16	124/85	95%	Incontinent			
1 OCT 08	0600	97.1	76	16	131/85	95%				

PREPARED BY (Signature & Title)
Intermediate Care Ward

DEPARTMENT/SERVICE/CLINIC
Department of Nursing

DATE (YYYYMMDD)
20080129

PATIENT'S IDENTIFICATION

MILITARY SSN: 901200[illegible]

PSEUDO ISN:

ISN:

ICW Bed# 2

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☒ FLOWCHART
☐ OTHER

RM 4700, FEB 2003

ACLU DDI CID ROI 29817

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: **PROVIDER ORDERS**

OTSG APPROVED (Date)

DATE: 29 Sep 08 Time: 2210

SERVICE (✓) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: Fracture, R Ulnar Styloid, Known CAD

CONDITION: (✓) STABLE ( ) CRITICAL ( ) GUARDED

Vital Signs: (✓) ICW Protocol ( ) ICU Protocol

Allergies: _____ (✓) NKDA

Activity: As tolerated

Weight Bearing Status: Can weight bear

Diet ( ) NPO ( ) Regular ( ) Soft ( ) Clear Liquid (✓) Diabetic ( ) NPO after midnight for surgery DOS: _____

~~Dressing Change~~ ( ) POD # _____ ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 150 mmHg

Drains ( ) NGT to LWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record output q 8hrs

Labs: (✓) CBC ( ) CRP ( ) ESR ( ) Coags ( ) ABG (✓) CMP ( ) BMP ( ) Other _____

( ) NOW (✓) 4 AM ( ) q AM ( ) q AM x 3 days

+ Creatinine

X-Rays: _____

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs (✓) NS ( ) LR @ 100 ml/hr ( ) D5 1/2 NS @ _____ ml/hr

( ) Other IV Fluid: _____

( ) Lovenox 40mg SQ daily ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before

( ) Zosyn 3.375 grams IV q 6 hours

( ) Zosyn 4.5 grams IV q 8 hours

( ) Unasyn 3 grams IV q 6 hours

( ) Ancef 1 gram IV q 8 hours

( ) Ancef 1 gram IV x 1 on chart for OR

( ) Vancomycin 1 gm IV q 12 hours

( ) Levofloxacin 500 mg daily ( ) PO ( ) IV

( ) Cefoxitin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 8 hours

( ) MS Contin _____ mg PO q 12 hours

( ) Zantac ( ) 150 mg PO BID ( ) 50 mg IV q 8 hours

( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID

( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other _____

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain

( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO

( ) Tylenol 650 mg ( ) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give if within 4 hrs of Percocet

( ) Motrin ( ) 400 mg ( ) 600 mg PO q 8 hours PRN for pain, fever, headache

( ) Benadryl ( ) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours ( ) q 8 hours PRN itch or insomnia

( ) Reglan 10 mg IV / PO q 6 hours PRN nausea

(✓) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent

(✓) Transfer to Surgical Ward

(✓) Admit to Dr. [redacted]

(✓) Consult Social Work

(✓) Physical Therapy

(b)(6)

PREPARED BY (Signature & Title)

115th Combat Support Hospital

DEPARTMENT/ SERVICE/ CLINIC

DCCS

(b)(6)

(b)(6)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name (Last, First, Middle), Grade, Date, Hospital or Medical Facility)

PSUEDO ISN _____ ISN: 20018

LOCATION ( ) ICU (✓) ICW BED # 2

( ) HISTORY / PHYSICAL ( ) FLOW CHART

( ) OTHER EXAMINATION (X) OTHER (Specify)

( ) DIAGNOSTIC STUDIES *Provider Orders*

( ) TREATMENT

MEDCOM FORM 4700 FEB 2003

Transmitted 29 SEPT 08 2210

(b)(6)

ACLU DDI CID ROI 29818

MEDICAL RECORD - SUPPLEMENTAL DATA

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

REPORT TITLE	ICW REASSESSMENT	OTSG APPROVED (Date)

	Date: 1 Oct 09	Time: 0835	Initials: (b)(6)	Time:	Initials:
1 NEUROLOGICAL. Alert and oriented to person, place, time, and situation. Responds appropriately. PEARL. Communicates adequately to express needs.	PT is alert and understand verbal commands. PT able to speak. (X)		( )		
2 CARDIOVASCULAR. Pulse RRR and WNL for age, no dependant edema, nailbeds pink, cap refill < 3 sec. No calf tenderness or chest discomfort.	(✓)		( )		
3 PULMONARY. Respirations within [illegible], quiet and regular. Depth is regular, no cough, lungs CTA bilateral with symmetrical chest movement.	(✓)		( )		
4 G I. Abdomen soft NT/ ND, +BS x4 quads, no N/V/D, constipation or rectal bleeding. No change in appetite or difficulty chewing or swallowing.	⊖ Distance (X)		( )		
5 G U / REPRODUCTIVE. No S/S of dysuria, retention, urgency, frequency or nocturia. Urine clear yellow / amber. No unusual vaginal / penile / breast discharge.	(✓)		( )		
6 MUSCULOSKELETAL. Normal muscle development and mass for age, no deformities, no assistive devices needed. Normal ROM without pain, no joint swelling, tenderness, weakness or paresthesia.	General weakness (X)		( )		
7 SKIN. Warm, dry, intact, turgor good, no rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences, mucous membranes moist and intact.	(✓)		( )		
8 PYSCHOSOCIAL. Behavior is appropriate to the situation, anxiety is controlled or mild and appropriate. Interacts appropriately with others.	Sleeps. Appears calm (*)		( )		
9 PAIN. 0-10, location, description, to include what makes it better and what makes it worse. If medication required, document intervention and reassessment.	(✓)		( )		

PRINTED NAME/GRADE/TITLE (Supervisor) (Last, First, MI)

IDC 4 TREATMENT SERVICE/CLINIC

DATE (yyyymmdd)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION

( ) FLOW CHART
(X) OTHER (Specify)
ICW Reassessment

MEDICAL RECORD 4700 FLOW SHEET Page

ACLU DDI CID ROI 29819

MEDICAL RECORD - SUPPLEMENTAL SHEET

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

REPORT TITLE	ICW REASSESSMENT	OTSG APPROVED (yyyymmdd)

Date: 30 SEPT2008 Time: 0800 Initials: (b)(6) Time: 2000 Initials: (b)(6)

1. NEUROLOGICAL. Alert and oriented to person, place, time, and situation. Responds appropriately. PEARL. Communicates adequately to express needs.	Pt able to follow directions since last Debride Treatment (✓) & ✓ hands	Pt UNDERSTANDS VERBAL COMMANDS BUT IS UNABLE TO SPEAK (✓)
2. CARDIOVASCULAR: Pulse RRR and WNL for age, no dependant edema, nailbeds pink, cap refill < 3 sec. No calf tenderness or chest discomfort.	(✓)	(✓)
3. PULMONARY: Respirations within normal rate for age group, quiet and regular. Depth is regular, no cough, lungs CTA bilateral with symmetrical chest movement.	(✓)	(✓)
4. G.I. Abdomen soft NT/ ND, +BS x4 quads, no N/V/D, constipation or rectal bleeding. No change in appetite or difficulty chewing or swallowing.	A/D noted Urine in depends (✓)	NEEDS ASSISTANCE EATING (✓)
5. G.U. / REPRODUCTIVE: No S/S of dysuria, retention, urgency, frequency or nocturia. Urine clear yellow / amber. No unusual vaginal / penile / breast discharge.	( )	INCONTINENT OF URINE (✓)
6. MUSCULOSKELETAL: Normal muscle development and mass for age; no deformities, no assistive devices needed. Normal ROM without pain, no joint swelling, tenderness, weakness or paresthesia.	keep wrists splinted (✓)	GEN. WEAKNESS (✓)
7. SKIN: Warm, dry, intact, turgor good; no rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences, mucous membranes moist and intact.	(✓)	(✓)
8. PYSCHOSOCIAL: Behavior is appropriate to the situation, anxiety is controlled or mild and appropriate. Interacts appropriately with others.	Mostly nonverbal stares ~~at~~ ~~times~~ pleasant (✓)	SLEEPS THROUGH SHIFTS (✓)
9. PAIN 0-10, location, description, to include what makes it better and what makes it worse. If medication required, document intervention and reassessment.	( )	( )

PREPARED BY (Signature & Title)	DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
3 Fel Combat Support Hospital	DCCS	

PATIENT'S IDENTIFICATION (Last, First, Middle); Grade; Date; Hospital or Medical Facility)

PSEUDO SSN [redacted] (ST) [redacted]

LOCATION: ( ) MCU ( ) ICW (X) ACE

( ) HISTORY / PHYSICAL ( ) FLOW CHART
( ) OTHER EXAMINATION (X) OTHER (Specify)
( ) DIAGNOSTIC STUDIES ICW Reassessment
( ) TREATMENT

ACLU DDI CID ROI 29820

MEDICAL RECORD - SUPPLEMENTAL MEDICAL D...

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

REPORT TITLE: **ICW INITIAL ASSESSMENT** | OTSG APPROVED (Date)

Date: 29Sep05 Time of Admission: 2300 Age: 58 (CIRCLE ALL THAT APPLY)

T: 96 P: 76 R: 18 B/P: 160/69 O2 Sat: 99% Height: ____ Weight: 202

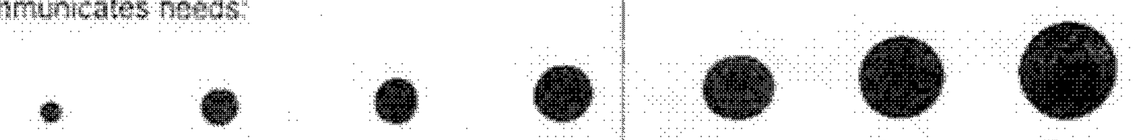
1. NEUROLOGICAL

LOC: Alert & Oriented Person (Place) Time Facial symmetry (R) droop (L) droop GCS 1-15 ____

Responds to: (Verbal) Tactile Painful Unresponsive Communicates needs:

Pupil size: (R) 3 mm (L) 3 mm Scleredema

Reaction to light: Brisk (Sluggish) Non-reactive



2. Cardiovascular

Tachycardia Bradycardia Arrhythmia: Ectopy on Monitor:

Heart Sounds: (Normal S1-S2) Irregular Distant Abnormal S3 S4 Murmur Gallop Click Rub Pacemaker: *(type)*

Pulses: 0 (absent) 1+ (thready) 2+ (weak) 3+ (normal) 4+ (bounding) JVD Carotid Bruits/Thrills

Edema: **0** *(none)* **1+** *(trace)* **2+** *(moderate)* **3+** *(deep)* **4+** *(very deep)* Location: Pitting / Non Pitting

Cap Refill < 3 sec R Upper ____ R Lower ____ L Upper ____ L Lower ____

Mucous membranes: (Pink) Pale Cyanotic

3. PULMONARY

Symmetrical Movement Regular Rate/Depth Accessory muscle use 02: Liters____ via NC____ Mask____ NRB____

Shortness of breath Orthopnea Dyspnea Night Sweats Tracheotomy: Size____ Type____ Trach Mask____

Cough: (None) Non-productive Sputum: (Clear) White Yellow Green Hemoptysis PE confirmed

Lungs: CTA Bilaterally Wheezes Rhonchi Rales Location: RUL RML RLL LUL LLL UNABLE TO ASSESS

4. G.I.

Abdomen: Flat (Round) Distended (Soft) Firm Rigid (Non-tender) Tender Painful Guarding Present

Bowel Sounds Absent Hypoactive (Normoactive) Hyperactive Location: *(quadrants)* *RUQ RLQ LUQ LLQ*

Flatus Heartburn Hemorrhoids Rectal Bleeding LBM:____ Colostomy: Location ____ Appearance:____

Stool (describe):____ G-Tube NGT OG Suction____ Placement____ Verified via Air Bolus Residuals____

Oral mucosa: Moist No Lesions Lesions Leukoplakia Appetite: Normal Decreased Diet: Regular Clears NPO Special____

Swallow and Gag Intact Absent Nausea Emesis (describe):____ Tube Feeding: Type____ Rate____

5. G.U.

Voids: (Urinal) BR Incontinent Foley: Size____ Suprapubic Dysuria Retention Urgency Frequency Nocturia

Urine: Clear Concentrated Cloudy Yellow Amber Tea Colored Blood Tinged Sediment

Vaginal/Penile Lesions: Ureitheral Discharge: Breast/Testicular Lumps

6. MUSCULOSKELETAL

Normal muscle development and mass for age (No deformities)

Amputations: ~~BKA~~ ~~AKA~~ Finger Toe:____ Arm Right ~~Left~~ Weakness: Paralysis:

(Ambulatory) ~~Gait Steady~~ ~~Unable~~ Assistive Devices:

Joints: Stiffness Swelling Tender Painful with ROM Hx of DVT

Muscle Strength: R Upper ____ R Lower ____ L Upper ____ L Lower ____

0 *(no movement)* 2+ *(moves but NOT against gravity)* (4+) *(moves against resistance)*

1+ *(trace movement)* 3+ *(moves against gravity)* 5+ *(normal strength)*

7. INTEGUMENTARY

Color: (Pink) Pale Flushed Cyanotic Jaundiced Mottled IV: Size 18G Location: (L AC)

(Dry) Moist Diaphoretic (Warm) Cool Turgor: (Good) Fair Poor Dressing: Location____ Type____

Redness: Location: Rash: Location: Abrasions: Location: Burns: Location:

Lacerations: Location: Inflammation: Location: Trauma: Location: Ulcer: Location:

	DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
31st Combat Support Hospital	DCCS	

PATIENT'S IDENTIFICATION (Type or write in ink) Name (Last, First, MI)

( ) HISTORY ( ) PHYSICAL ( ) ICW CHECK

( ) OTHER EXAMINATION (X) OTHER (Specify)

( ) DIAGNOSTIC STUDIES ICW Initial Assessment

( ) TREATMENT

LOCATION ( ) ICU (X) ICW BED # 2 AGE 58

ACLU DDI CID ROI 29821

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

OLD OLD OLD OLD OLD

ACLU DDI CID ROI 29822

CAMP CROPPER

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 28 Sep 08 - 29 Sep 08

Report requested by: (b)(6)

DETAINEE,ISN200018 20/900-20-0018 M/41 Reg #:
Ph: Military Unit: UNKNOWN

BLOOD
Col: 29Sep08@2022 Req Loc: EMT
080929 HE 95 Hcp: (b)(6) C:JR29Sep08@2039
STAT

WBC	11.5	H	(4.8-10.8)	x10 3/uL
RBC CNT	4.89		(4.20-6.10)	x10 6/uL
HGB	13.7		(12.0-18.0)	g/dL
HCT	42.2		(42-52)	%
MCV	86.3		(80.0-99.0)	fl
MCH	28.1		(27.0-31.0)	pg
MCHC	32.6	L	(33.0-37.0)	g/dL
PLATELETS	283		(130-400)	x 10(3)/u
LYMPH%	25		(20.0-44.0)	%
LYMPH#	2.8		(0.7-4.3)	x10 3/uL

SERUM
Col: 29Sep08@2022 Req Loc: EMT
080929 CH 22807 Hcp: (b)(6) C:JR29Sep08@2041
STAT

NA+	141		(128-145)	mmol/L

Result Comment: HEM 2+
Interpretations:
PERFORMED ON PICOLLO ANALYZER

K	4.2		(3.3-4.7)	mmol/L
CO2	25		(18-33)	mmol/L
CL-	97	L	(98-108)	mmol/L
GLUCOSE	194	H	(73-118)	mg/dl

Interpretations:
PERFORMED ON PICOLLO CHEMISTRY ANALYZER

CA	9.4		(8.0-10.3)	mg/dL
BUN	13		(7-22)	mg/dL
CREAT	0.6		(0.6-1.2)	mg/dL
ALK PHOS	68		(26-184)	U/L

Interpretations:
PERFORMED ON PICCOLO CHEMISTRY ANALYZER

ALT	20		(10-47)	U/L
AST	21		(16-55)	U/L
TBILI	0.5		(0.2-1.6)	mg/dL
ALBUMIN	3.9		(3.3-5.5)	g/dL
PROTEIN TOTAL	7.4		(6.4-8.1)	g/dL

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

ACLU DDI CID ROI 29823

29 Sep 06 Nutrition Risk Screening

S/O: 29 Sep 06

(b)(6)

Active Duty Coalition Force Contractor (Detainee) Civilian

Ward: Icon Bed Number 2

Diagnosis: Diarrhea, Fever, Known CA, Dizziness

Nausea: Y / (N) Vomiting: Y / (N) Diarrhea: (Y) / N Recent Weight Loss: Y / (N)

Amputee: (NO) YES (list)

Age: 58 Gender: M Ht: Wt: 202 BMI: UBW:

Diet: NPO

American Food (if authorized): YES (NO)

Special Dietary Needs:

Meds:

Labs: Glucose 194 NA+ 141 K+ 4.2 Albumin 3.9 Total Pro 7.4

BUN 13 Creatine 0.6

A/P:

Nutrition Risk:

(Patient determined to be at low nutrition risk; will be re-screened in one week)

Patient determined to be at nutrition risk secondary to :

Further intervention by RD needed within 72 hours

Re-Screen Date: 7 Oct 06

(b)(6)

PATIENT'S RECORD AND HEALTH DATA (Read Instructions for Maintaining)

SELECTIVE MAINTAINED AT

PATIENT'S NAME (Last, First, Middle Initial) SEX

RELATIONSHIP TO SPONSOR STATUS RANK/GRADE

SPONSOR'S NAME ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO. DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE (STANDARD FORM 600)

ACLU DDI CID ROI 29824

000032

ACLU DDI CID ROI 29825

TF 115 MED ICW Shift Duties Checklist:

Night shift (Charge Nurse)

Name: _____

Date: _____

Night shift (Charge Nurse)	✓
Arrive 15 minutes before report to make assignments, complete Nursing Assignments sheet. Assignments based on skill level, patient acuities.	
Ensure narcotic count is correct. Must be 2 RNs or 1 RN, 1 LVN.	
Release the day shift after report and ward rounds have been made.	
Check crash cart.	
Document refrigerator temperature if it's not done.	
Do narcotic and bulk drug order, turn into Pharmacy.	
Check front board, verify thru MPs that all ISN and PISNs are current, valid. Request ISNs for those who have not yet been processed.	
Do patient acuities, update on front board and report sheet.	
Patient tracker updated: Patient Tracker, Running Calendar, Daily Surgery List, NCH	
24 Hour Report updated, start new sheet for the next day.	
Patient Log Book up to date.	
Do 24-hour review of MD orders for complete and accurate transcription. Date, time and initial the review.	
Update the Diet Roster for the following morning NLT 0400.	
Identify patients with morning labs. Note on front board and put orders in CHCS.	
Check with PAD for planned air evacs, complete Transfer Sheet when indicated.	
When discharging patients, complete all steps of Discharge Note that apply.	
Manage patient flow, bed assignments, new nursing assignments. Coordinate with ER and ICU on admissions, transfers. Activate in CHCS.	
Coordinate coverage so all staff members get meal breaks.	
Ensure staffing is adequate for the following shifts (day, the following night).	
All green sheets and white sheets signed off.	
Make sure staff members complete items on Shift Duties Checklist.	
Report Sheet updated, saved to the S-drive and copies printed.	
Communicate directly with Head Nurse and appropriate chain of command on any staffing or patient care issues.	
Ensure appropriate military courtesy and professional conduct is exhibited at all times.	

THERAPEUTIC DOCUMENTATION CARE PLA..

(MEDICATIONS)

Mo _____ Yr _____

Verify by Initialing		SINGLE ORDER PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
Order Date	Clerk/ Nurse					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

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

ACLU DDI CID ROI 29826

Verify by initialing		THERAPEUTIC DOCUMENTATION CARE PLA... (MEDICATIONS)			Mo ______ Yr ______	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
29SEPT	(b)(6)	Zofran 4mg IV Q 6hours PRN Nausea	

ACLU DDI CID ROI 29827

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

(b)(6)

(b)(6)

(b)(6)

(b)(6)

ACLU DDI CID ROI 29828

000036

ACLU DDI GID ROI 29829

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

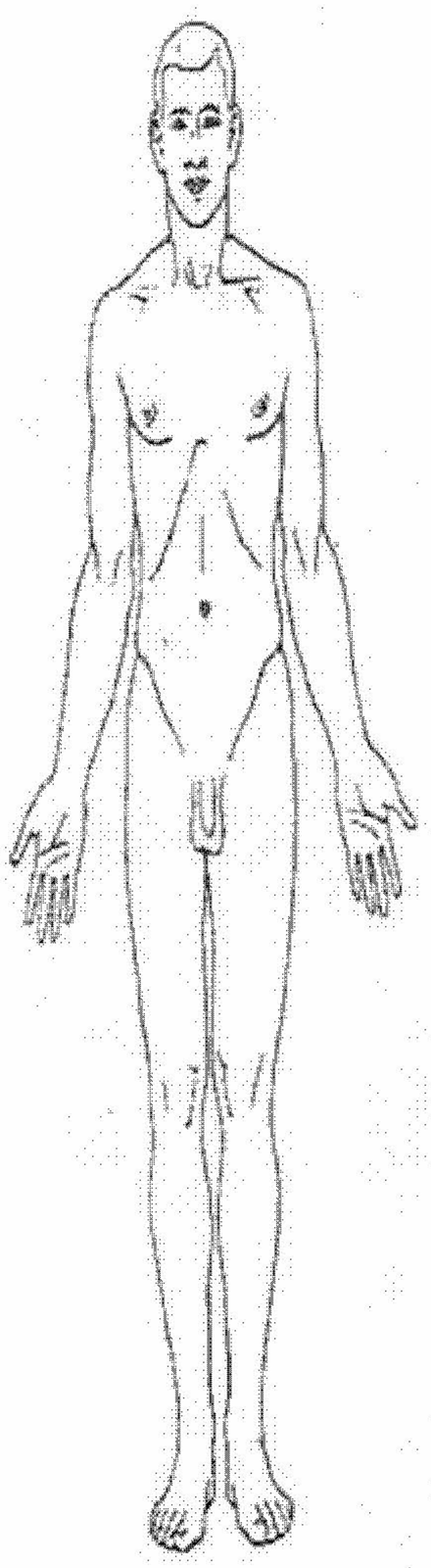
REPORT TITLE: ICW INITIAL ASSESSMENT Continuation

OTSG APPROVED (Date)

DATE: 29 Sep 08

8. PSYCHOSOCIAL
Behavior is appropriate to situation | Anxious | Uncooperative | Belligerent

9. PAIN
Location: [illegible] | Scale of 1-10 (Wong Baker): | Description:
What makes it better?
What makes it worse?



EXAMINER A

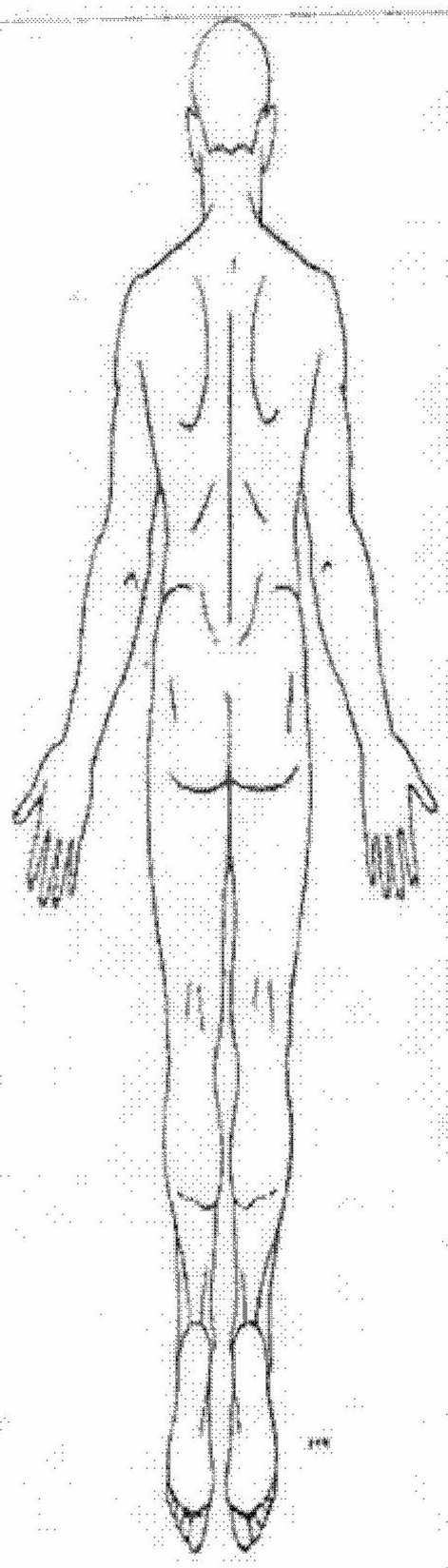


Figure 2 (B)

SEE PROGRESS NOTE

(b)(6)

PREPARED BY (Signature & Title)
31st Combat Support Hospital

DEPARTMENT/ SERVICE/ CLINIC
DCCS

DATE (yyyymmdd)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT
( ) FLOW CHART
(X) OTHER (specify)
ICW Initial Assessment

ACLU-RDI 5593 p.36

000037

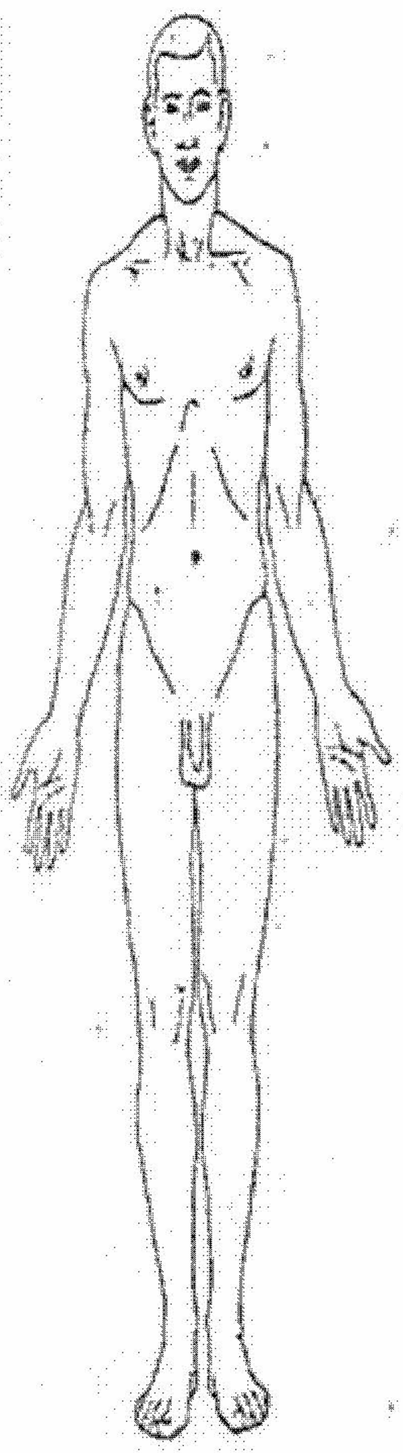
ACLU DDI CID ROI 29830

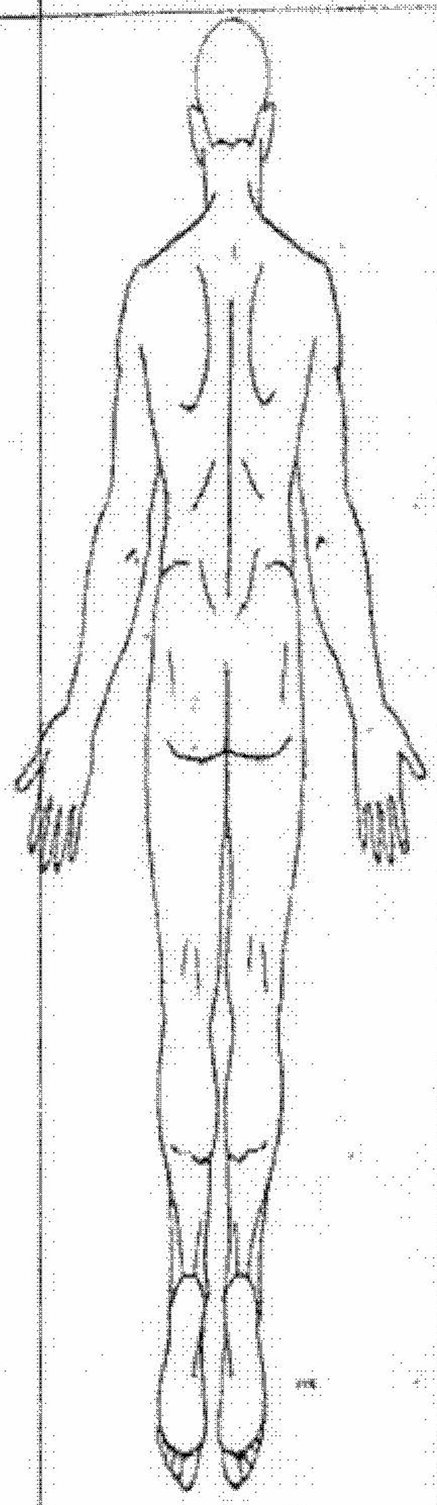
MEDICAL RECORD — CONTINUATION SHEET — FOR OFFICIAL MEDICAL DATA

REPORT TITLE: ICW REASSESSMENT Continuation

DATE: 23SEP08

Time: 0700	Initials: (b)(6)	Time: 2000	Initials: [illegible]
IV Insertion Date:	23 Sep 08	IV Insertion Date:	Dc'd
Catheter Size:	18 G	Catheter Size:	
Location:	(R) AC	Location:	
S/S of Infection/ Infiltration:	∅	S/S of Infection/ Infiltration:	
Due To Change:	4 Oct 08	Due To Change:	
Fluid / Rate:	NS @ 100	Fluid / Rate:	





0800 Pt sleepy, able to respond to directions when asked to change position. Pt's hips to help change. Depends. Skin on back, buttocks open. Pt's heels intact. Pt's care during depends change. Skin clean. (b)(6)

Pt to follow directions, dc'd to Flat bed. Pt self was able to take his meds & maintained assist & depends (b)(6)

Urine Rec care. 9D (b)(6)

1830 (b)(6)

SEE PROGRESS NOTE (b)(6)

DEPARTMENT/ SERVICE/ CLINIC: DCCS | DATE (yyyymmdd):

( ) HISTORY / PHYSICAL ( ) FLOW CHART
( ) OTHER EXAMINATION (X) OTHER (specify)
( ) DIAGNOSTIC STUDIES ICW Reassessment
( ) TREATMENT

MEDCOM FORM 4700 FEB 2003 Page 2 of 2 — 31 CSH OP 08-05 (29 Jan 08)

ACLU-RDI 5593 p.37

000038

ACLU DDI CID ROI 29831

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

Office of The Surgeon General

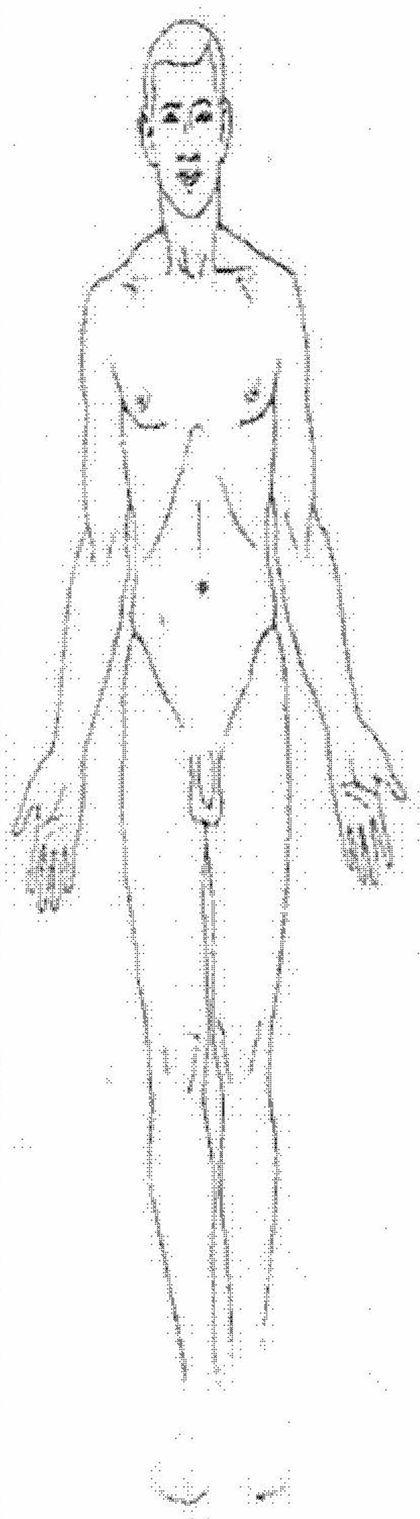
REPORT TITLE: ICW REASSESSMENT Continuation

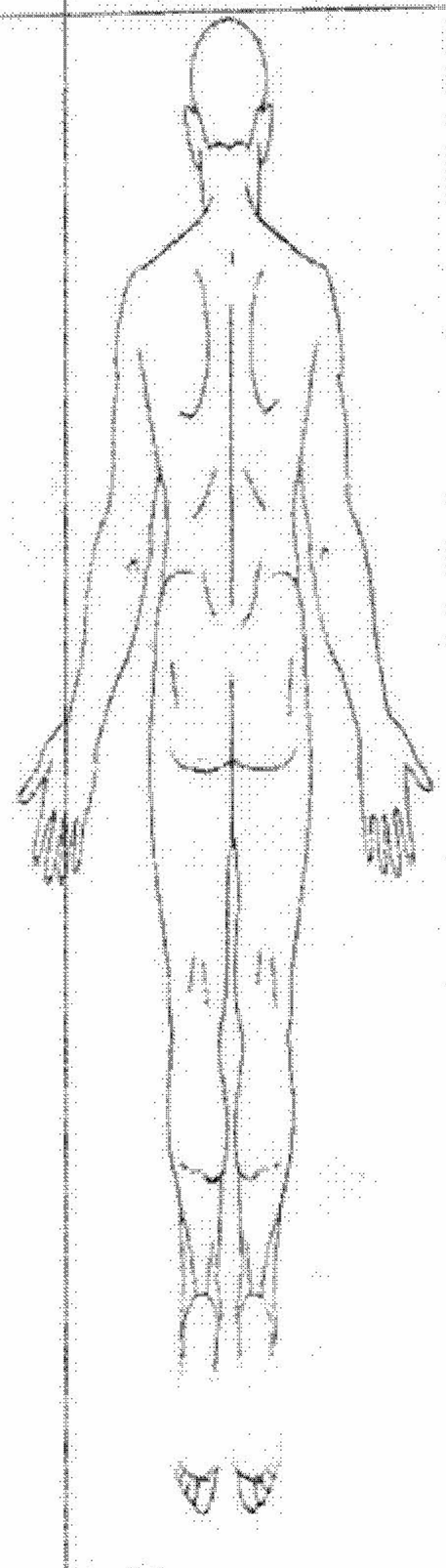
OTSG APPROVED (Date)

DATE: [illegible] Oct 08

Time: 2035 Initials: (b)(6)

Time:	Initials:
IV insertion Date:	
Catheter Size:	
Location:	
S/S of Infection/ Infiltration:	
Due To Change:	
Fluid / Rate:	





Pt resting in bed with no complaints at this time. Pt states feels good than interpreter. VSS. WNL. Will continue monitoring.

(b)(6)

ILLINOIS

Page 3 (1)

DEPARTMENT/ SERVICE/ CLINIC: DCCS

DATE (yyyymmdd)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

( ) FLOW CHART
(X) OTHER (specify)
ICW Reassessment

31 CSH DP 08-05 (29 Jan 08)

MEDCOM FORM 4700 FEB 2003 Page 2 of 2

Date: _____

115th, ICW Discharge No

Initials

(b)(6)

Discharge order written by MD

D/C prescriptions to pharmacy___

Pharmacy notified of discharge

D/C meds received from pharmacy

Detainees
Manilla Copy Physician's Order to MP ✓

US/Coalition/Contractors:
Unit Called ___
Transportation Arranged ___
2 Copies Discharge Summary to patient

D/C'd from ICW Admissions/Discharges Book

Patient Tracker Updated

D/C'd from CHCS

D/C'd off Patient Status Board, Placed D/C summary in blue bin in the ER

Discharge Summary to future consults as needed

Wire Medical Team e-mailed (b)(6)

(b)(6)

Transferred to another facility: _____

Physician's Transfer Summary on chart ___ A/E Handoff Communication on Chart ___

Report to receiving unit called ___ e-mailed ___

D/C meds w/ PT: _____, _____,

_____, _____

Medication and d/c teaching completed

X With Without Translator

Verbalized understanding: Yes No Unable to verbalize

All lines and drains d/c'd unless instructed otherwise.

IV: Location: _____ Size: ___ Time d/c'd: _____

Condition of catheter tip: _____

Foley: _____ Time d/c'd: _____ Time Due to Void: _____

JP #1: _____ Time d/c'd: _____ JP #2: _____ Time d/c'd: _____

Wound Vac: _____ Time d/c'd _____ Wet-Dry Dsg applied: Yes No

Location _____

Dressings:

Location _____ Type _____ Last Changed _____

Location _____ Type _____ Last Changed _____

Location _____ Type _____ Last Changed _____

Last Set of VS: T: 95.7 P: 68 R: 18 BP: 138/72 SpO_2 95%

Time Departed ICW:

Method of transportation: Wheel Chair Ambulatory W/Crutches

Accompanied by:

Additional Note:

ICW Personnel Signature

IN: 401 20 0018

ACLU DDI CID ROI 29832

DIRECTIONS: The provider will DATE, TIME and SIGN each order or set of orders recorded. Only one order is allowed per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other ITR forms.

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE. PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME)
2245	**Sliding Scale Insulin:**
29SEP09	( ) Target Glucose Range 70-120 mg/dL
	<70 mg/dL = give 1 Amp D50 IVP & call MD
	70-120 mg/dL = no action
	121-150 mg/dL = 2 units Regular Insulin SC
	151-200 mg/dL = 4 units Regular Insulin SC
	201-250 mg/dl = 6 units Regular Insulin SC
	251-300 mg/dL = 8 units Regular Insulin SC
	301-350 mg/dL = 10 units regular Insulin SC
	>350 mg/dL = call MD
	(✓) Target Glucose Range 70-180 mg/dL
	<70 mg/dL = give 1 Amp D50 & call MD
	70-180 mg/dL = no action
	181-200 mg/dL = 2 units Regular Insulin SC
	201-250 mg/dL = 4 units Regular Insulin SC
	251-300 mg/dL = 6 units Regular Insulin SC
	301-350 mg/dL = 8 units regular Insulin SC
	351-400 mg/dL = 10 units Regular Insulin SC
	>400 mg/dL = call MD
	(✓) Fingersticks AC & HS
	( ) Draw HbA1c
	( )
	( )
	( )

Transcribed 29SEP09 2245 (b)(6)

(b)(6)

PATIENT IDENTIFICATION (If typed or written entries note: Name - last, first, middle and grade; DOB; hospital or medical facility)

Complete the following information on page 1 of provided order. Verify. Note any changes on subsequent pages.

Diagnosis:

Height: Weight (lbs): Diet:

Allergies:

Nursing Unit	Room No.	Bed No.	Page No.

MEDCOM FORM 688-R (TEST) (MCHO)JUN 03 PREVIOUS EDITIONS ARE OBSOLETE. Rev 2/

ACLU DDI CID ROI 29833

CAMP CROPPER 30 Sep 2008@0255 Page 1

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

PATIENT LAB INQUIRY

For: 29 Sep 08 - 30 Sep 08

Report requested by: (b)(6)

DETAINEE,ISN200018 20/900-20-0018 M/41 Reg #: 5332

Military Unit: UNKNOWN

Ph:

SERUM

30 Sep 08 @ 0214 (Coll)

STAT PHENYTOIN . . . . . 11.3 (10.0-20.0) ug/mL

Interpretations:

Performed on Vitros 350 analyzer

CARBAMAZEPINE . . . . . <3.0 L (4-12) ug/mL

L-Low H-Hi *-Critical R-Resist S-Susc M-Mod Susc I-Intermed

(1)-Orig /A-Amended Comments- (O)rder, (I)nterpretation, (R)esult

ACLU DDI CID ROI 29834

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT

LOC NUMBER: 24

RECORDS MAINTAINED AT

CHIEF COMPLAINT: Diarrhea

ARRIVAL

DATE (Day, Month, Year): 29 Sept 08 | TIME: 2014

☐ WALK IN ☐ AMB ☐ MEDEVAC ☐ OTHER

TRANSPORTATION TO FACILITY CARE ENROUTE

AIRWAY: ☒ PATENT ☐ OBSTRUCTED

BREATHING: ☒ UNLABORED ☐ LABORED ☐ ABSENT

LMP | TETANUS | AGE: 21 | ☒ MALE ☐ FEMALE

MENTAL STATUS: ☐ ALERT ☒ VERBAL ☐ PAINFUL ☐ UNRESPONSIVE

CIRCULATION: ☐ NORMAL
PULSES ☐ STRONG ☐ WEAK ☐ ABSENT
CAP REFILL ☐ <2 SEC (BRISK) ☐ >2 SEC (SLOW)
BLEEDING ☐
☐ TOURNIQUET

NEUROVASCULAR DEFICITS

LUE | RUE

LLE | RLE

CURRENT MEDICATIONS

IMMEDIATE INTERVENTIONS ☐ NONE
☐ O2 ☐ CARDIAC MONITOR ☐ EKG ☒ FSBG 199 @ 2027
☒ IV
☐ C-SPINE PRECAUTION
☐ BACK BOARD REMOVED @ ____
☐ PRESSURE DRESSING ☐ TOURNIQUET

☐ C-SPINE IMMOB

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

MEDICATION	DOSE	ROUTE	TIME	INT	RESPONSE

ALLERGIES

NKA

☐ TAGS

CATEGORY OF TREATMENT

☐ EMERGENT | TIME

☐ URGENT | RN

☒ NON-URGENT

IV SITE	SIZE	TIME	INT	D/C'D	INT
L/AC	18g	2005		☐	
				☐	

(b) (6)

ORDERS

NS IL IVF
O2 C Cnx
CT Head w/o Cont
EKG
FT in Clinic
Pt to Tylenol/Motrin

VITAL SIGNS

				HT	WT
TIME	2046	2126	2219		
BP	154/95	142/83	158/96		
PULSE	91	79	72		
RESP	18	18	18		
TEMP	97.4	—	97.1		
SpO2	99	99	99		
PAIN	Unk	Unk	Unk		

MEDIC NOTE

52 MED Hx Low back pain

SURG Hx

SOCIAL Hx

COLLECTION INFORMATION

IV FLUID INTAKE: NS IVF 2 3rd

OUTPUT

900200613

ACLU DDI CID ROI 29835

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: ER

FROM: (Requesting physician or activity)

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

Progressive weakness x 1 day. ⊕ Diarrhea x +5/7 x 4-7 days, partially controlled on Imodium.

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE

(b)(6)

APPROVED

PLACE OF CONSULTATION
☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY
☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

This morning was weak, having a fall this afternoon.

Dx: Ca kidney ⓒ mets to Brain.
Diarrhea - Possible dehydration?
Fasting (Ramadan) in the morning
DM
Please check Electrolyte problem.
On dobantin + Tegretol
Confusion

Daily glucoses
range 80 - 150
SEE SHEET

(Continued on reverse side)

SIGNATURE AND TITLE

DATE

IDENTIFICATION NO. | ORGANIZATION | REGISTER NO. | WARD NO.

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

USAPPC V1.00

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-97)
Prescribed by GSA/ICMR, FPMR (41 CFR) 201-9.202-1

DDOO18

ACLU DDI CID ROI 29836

NUMBER	ONSET	ENTER	PROBLEM	DATE RESOLVED
1		06/2008	RENAL CELL CA E METS	
2		06/08	METS TO BRAIN + LUNG	
3			NODULES	
4			R KIDNEY	
5			SPINE S/P METS	
6			RETROPERITONEAL ADENOPATHY	
7			EDEMA	
8			ENCEPHALOPATHY	
9			RETROPERITONEAL ADENOPATHY	
10			SCABIES	
11			ANXIETY.	
12				

TEMPORARY (MINOR) PROBLEMS

PROBLEM LETTER	PROBLEM	DATES OF OCCURRENCES
A	OLECRANON BURSITIS	
B	PERIORITIS	
C		
D		
E		
F		
G		
H		

PATIENT'S IDENTIFICATION (Use mechanical imprint if available; or typed or written entries give: Name, SSN, Unit, Sex, Birthdate, and Duty Phone)

200018

SUMMARY OF PROBLEMS, ALLERGIES, MEDICATIONS, SURGERIES AND TRAUMAS:

NOTE: DO NOT DISCARD FROM CHART

ACLU DDI CID ROI 29837

(b)(6)

HVD # 200018 BLOCK # 5A MONTH Sept. 2008 AM/PM 4 bags for Decadron

Medication / Dose / Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tegritol 200mg QAM 100mg QPM																						T	FG	G	T	G	T	G	T		
Glyburide 10mg BID (Glynase)	Dc 22 Sept 08																					T	FG	D	C		T		X		
Glucophage 1000mg QAM (metformin)																						T	FG	G	T	G	T	G	T		
Glucophage 1000mg QPM (metformin)	22 Sept 08																			1500mg		T	FG	G	T	G	T	G	T		
Dilantin 300mg(3) QAM 200mg QPM																						T	FG	G	T	G	T	G	T		
Toprol XL 50mg QD (metoprolol)																						T	FG	G	T	G	T	G	T		
Avandia 8mg QD (rosiglitazole)																						T	FG	G	T	G	T	G	T		
Nexium 20mg QD																						T	FG	G	T	G	T	G	T		
Isosorbide 10mg BID																						T	FG	G	T	G	T	G	T		
Decadron 4mg (2mg) = 1/2 tabs Q6 hrs.																						T	FG	G	T	G	T	G	T		
Imodium 1PO QD																						T	Hold ORTIZ				RESTART T	G	T		
Vitamin C QD	Dc 22 Sept 08																					T	D	C							
Fioricet 1 PO BID																						T	FG	G	T	G	T	G	T		
Doxycycline 100mg BID x 10 days																						T	FG	G	T	G	T	G	T		
Immodium 1PO BID x5 days																						T	G	T	Hold.						
Insulin 25u Lantus AM																															

Updated MAR 9/21/08 RB

#8 Imodium in Rou

ACLU DDI CID ROI 29838

000045

115th CSH GENERAL Master List ISN # ABDJBDD 20018

DATE:	Aug 04	Aug 11	Aug 18	Aug 25	Sep 01	Sep 08	Sep 15
Weight	225	209	211	211	210	212	211
Blood Pressure:	134/80	130/89	135/76	140/87	138/88	136/85	143/89
WBC 06/2008	18.1	11.1					
Hb/Ht	13/40	12.6/37					
Platelets	347	239					
1. BUN/Cr 06/08	14/1.2	18/.5					
2. AST//ALT	19/21	15/23					
3.							
A1C 06/2008	7.1						
Random glucose	266	203					
Random range.	124-256	115-240	131-338	90-295	(60-238)	(122-320)	(231-332)
CXR 08/2008	- RML OPACITY - POSSIBLE NODE						
Micro-albumin	+						
TSH 1.1 (1/2007)							
EKG							
Cholesterol 06/08	232						
Triglycerides	380						
HDL	28						
LDL	127						
8/08 Med level Dilantin	4.8		4.0				13.9
8/08 Med level Tegretol	3.2		3.5				3.1
Foot test	2008		OK				
Date dental exam	07/2008						
Date eye exam							
NOTES/PLANS:							
Cancer test PSA	1.19.						
Cancer test							
Cancer test							
Diagnostic test:							
MEDICATIONS:							
1. Dilantin	200 BID	"	"	"	300 AM 200 PM		
2. Glyburide	10	"					
3. Glucophage	1000 BID	"					
4. Depakote ER	500 qd	"					
5. Avandia	8 qd	"					
6. Risperidone	10 BID	"					
7. Darvocet	2 q 6h	"	"	"	"	"	
8. Lantus Insulin 25 AM		"	"	25U	20U	15U	25U
9. Tegretol	100 TID	"	"	"	"	100 TID	
10. KCL	50 (PRN)	"					
11. Lovenox 5							

MED. NON-COMPLIANT

ACLU DDI CID ROI 29839

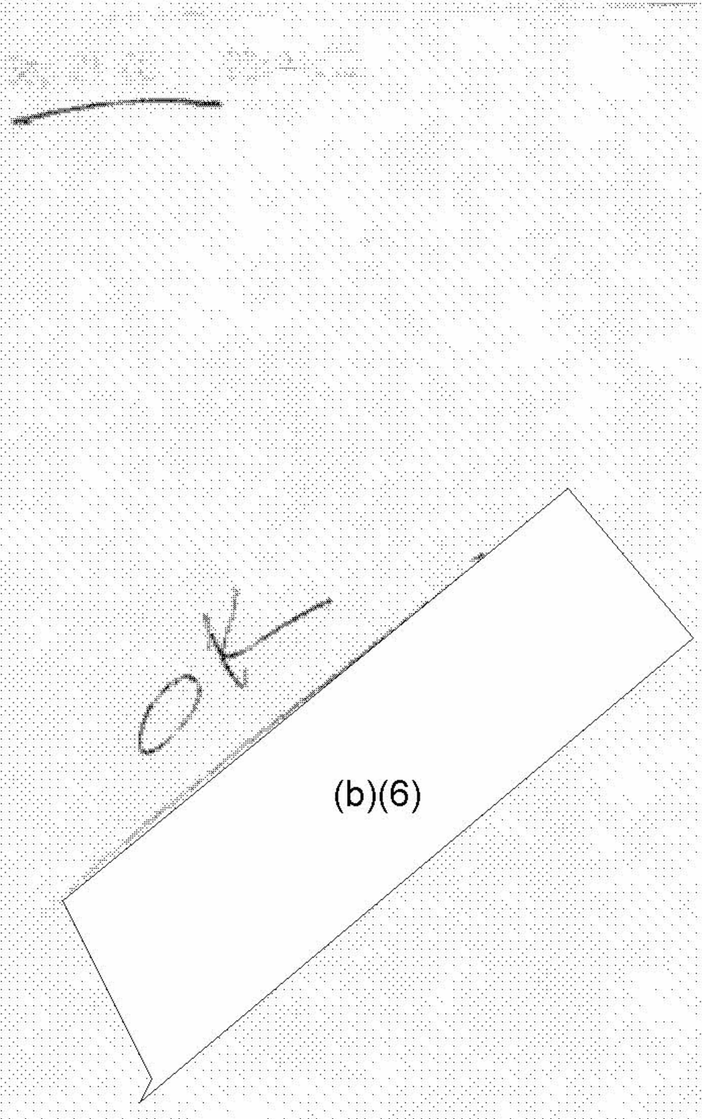
Task Force 31 Med
Camp Cropper, Iraq

Microbiology Laboratory Report

Accession #	(b)(6)
Collection Date	9/20/2006
Patient Name	Detainee200018
SSN or ID	200018
Sample Type	Stool, loose
Sample Site	
Patient Location	Area 51
Provider	(b)(6)
Result Type	FINAL
[ ] Fecal Leukocytes	
[ ] Occult Blood	
[ ] Campylobacter Antigen	
[X] C difficile Toxin	Negative
[ ] Shiga Toxin	
[ ] Giardia/Cryptosporidium/ E histolytica Antigens	
[X] Ova and Parasite Exam	No Ova or Parasites seen
[X] Culture	No E coli O157 H7, Salmonella, Shigella, Yersinia, Aeromonas, Campylobacter or Vibrio isolated
Qty Isolate #1	
Isolate #1	
Qty Isolate #2	
Isolate #2	
Qty Isolate #3	
Isolate #3	
Comments	
Report Date	09/22/2006
Tech	(b)(6)
Reviewed By	(b)(6)

Isolate 1	Isolate 2	Isolate 3
Amikacin	Amikacin	Amikacin
Amox/K Clav	Amox/K Clav	Amox/K Clav
Amp/Sulbactam	Amp/Sulbactam	Amp/Sulbactam
Ampicillin	Ampicillin	Ampicillin
Azithromycin	Azithromycin	Azithromycin
Aztreonam	Aztreonam	Aztreonam
Cefazolin	Cefazolin	Cefazolin
Cefepime	Cefepime	Cefepime
Cefotaxime	Cefotaxime	Cefotaxime
Cefotetan	Cefotetan	Cefotetan
Cefoxitin	Cefoxitin	Cefoxitin
Ceftazidime	Ceftazidime	Ceftazidime
Ceftriaxone	Ceftriaxone	Ceftriaxone
Cefuroxime	Cefuroxime	Cefuroxime
Cephalothin	Cephalothin	Cephalothin
Chloramphenicol	Chloramphenicol	Chloramphenicol
Ciprofloxacin	Ciprofloxacin	Ciprofloxacin
Clindamycin	Clindamycin	Clindamycin
Erythromycin	Erythromycin	Erythromycin
Gatifloxacin	Gatifloxacin	Gatifloxacin
Gentamicin	Gentamicin	Gentamicin
Imipenem	Imipenem	Imipenem
Levofloxacin	Levofloxacin	Levofloxacin
Linezolid	Linezolid	Linezolid
Meropenem	Meropenem	Meropenem
Moxifloxacin	Moxifloxacin	Moxifloxacin
Nitrofurantoin	Nitrofurantoin	Nitrofurantoin
Norfloxacin	Norfloxacin	Norfloxacin
Ofloxacin	Ofloxacin	Ofloxacin
Oxacillin	Oxacillin	Oxacillin
Penicillin	Penicillin	Penicillin
Pip/Tazo	Pip/Tazo	Pip/Tazo
Piperacillin	Piperacillin	Piperacillin
Rifampin	Rifampin	Rifampin
Synercid	Synercid	Synercid
Tetracycline	Tetracycline	Tetracycline
Ticar/K Clav	Ticar/K Clav	Ticar/K Clav
Tobramycin	Tobramycin	Tobramycin
Trimeth/Sulfa	Trimeth/Sulfa	Trimeth/Sulfa
Vancomycin	Vancomycin	Vancomycin

ACLU DDI CID ROI 29840



ACLU DDI CID ROI 29841

glucoses

HVD # 200018 BLOCK # 6A MONTH Sept. 2008

Blood Glucose Results	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Insulin 25u Lantus q AM															x	(b)(6)	136	193	127	221	175	106	103	82	93	130	98	83	135		
AM BS results															x	216	(b)(6)														
Sliding scale Insulin if given															x	0															
PM BS results (Bedtime)																275	259	285	232	264	125	198	302	255	244	148	321	188	173		
Sliding scale Insulin if given																(b)(6)	6u	6u	H		FG	H	8u	6u	H	H	8u	6	FG		

Sliding Scale Chart
250 - 299 = 6 units
300 - 350 = 8 units
351 - 400 = 10 units
>400 = 12 units

Initial for insulin given and BS results
H = held insulin

Do not mix Lantus and Regular Insulin

Aug BS

Br	179	128	124	131	205	131	247	113	142	163	338	220	235	116	127	149	90	114	158	204	83	120	64	173	171	229	69	120	96	189	99
Dinner	172	x	256	184	195	260	220	303	318	290	296	277	184	295	314	288	299	310	116	204	135	296	132	175	194	156	112	196	240	228	148

July BS

274	334	277	156	239	276	251	258	312	303	330	147	250	203	239	165	189	181	128	250	186	242	154	227	149	203	179	281	107	128	95
408	361	59	322	418	395	457	H	316	464	288	312	397	265	307	325	369	360	351	226		289	321	201	228	271	232	182	100	194	155

ACLU DDI CID ROI 29842

000049

AUTHORIZED

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 Sep 03	WT: BP 134/83 P 102 02SAT 97%
	[illegible]
	[illegible]
	[illegible]
1900hrs	As per bystanders through translation, pt became
	dizzy and fell. No "shaking" or seizure-like activity. No
	loss of consciousness. Upon initial exam, pt still c/o dizziness,
	[illegible] by [illegible] [illegible] of [illegible]. No [illegible]
	Lungs clear and = bilat. (+) [illegible] alert [illegible]. No
	[illegible] deficits. Pt slightly slow to answer questions,
	however this has been his normal state for some time
	now. He's also recently been treated for diarrhea,
	which has been on and off for 4-7 days.
	3 lead EKG (2 much artifact) showing ST at
	102. (b)(6) arrived and assumed care of pt. CSH
	ER contacted by (b)(6) pt transported to ER
	CSH ER [illegible] (b)(6)
1920hrs	Small dime size abrasion on (R) knee (also dirt) [illegible]
	around (R) knee as well). No active bleeding, bruising or
	swelling. Area cleaned [illegible] and [illegible] applied. (b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART[MENT/SERVICE] | [RECORDS MAINTAINED AT] | [DATE]

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

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

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

ACLU DDI CID ROI 29843

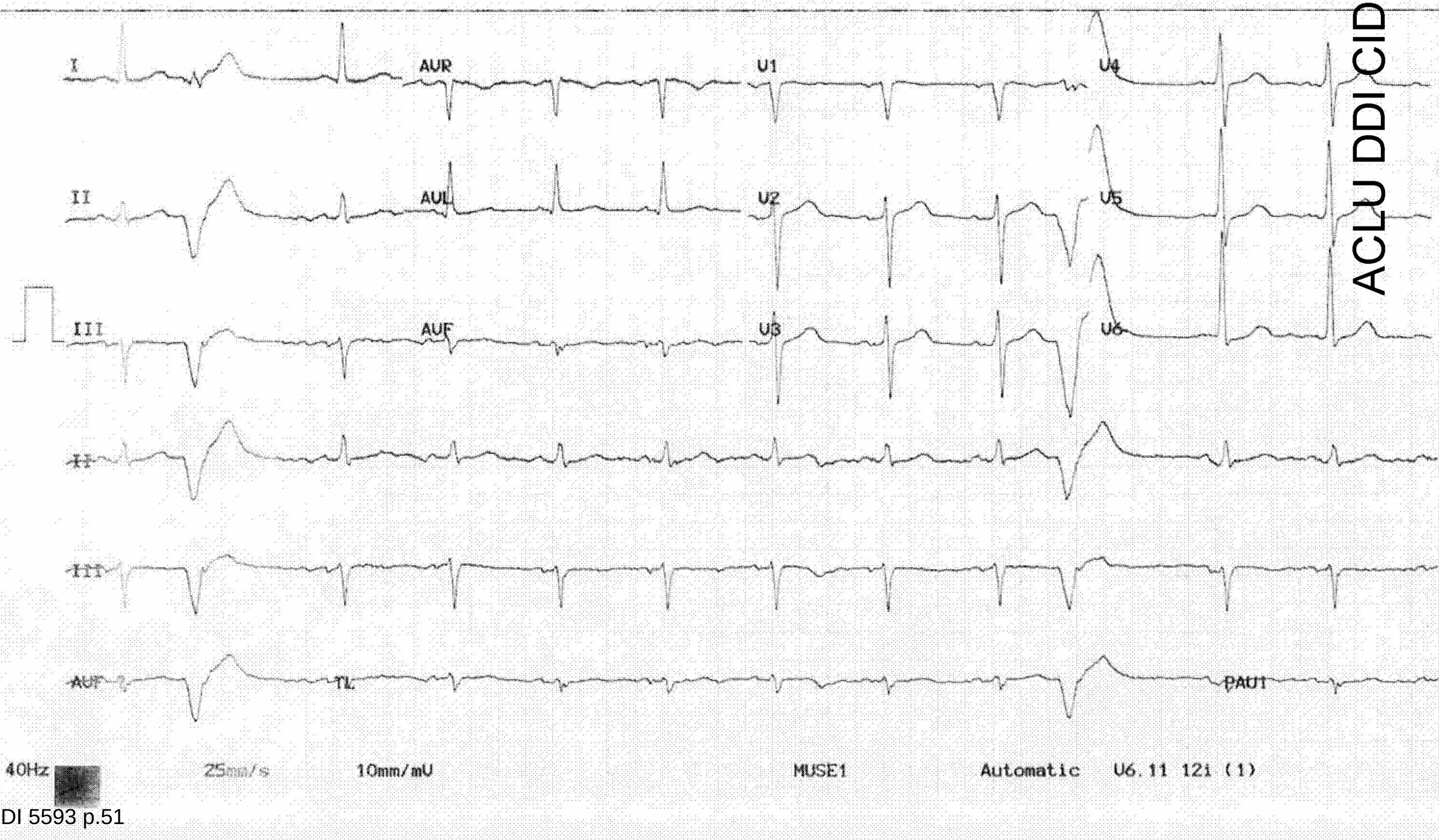
Sep/29/2008 22:32:04

HR	68 bpm	Interpretation:
PR interval	154 ms	
QRS duration	114 ms	suspected left ventr. hypertrophy
QT/QTc	412/ 462 ms	sinoatrial arrest
P-R-T axes	35 -15 20	minor left axis deviation
BP		probably abnormal ECG

(b)(6)

Meds:

Unconfirmed report.



ACLU DDI CID ROI 29844

000051

ACLU-RDI 5593 p.51

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: 900 20 0018

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 2

DATE OF ORDER: 30 Sept 08 TIME OF ORDER: 1620 HOURS

LIST TIME ORDER NOTED AND SIGN

1. C. difficile toxin
2. Stool Culture
3. Fecal leukocytes
4. Stool O & P
5. Metamucil 1 packet in juice TID

PATIENT IDENTIFICATION: 900 20 0018

DATE OF ORDER TIME

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 2

PATIENT IDENTIFICATION: 900 20 0018

DATE OF ORDER: 1 Oct 08 TIME OF ORDER: Now HOURS

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 2

PATIENT IDENTIFICATION: 900 20 0018

(b)(6)

1 Oct 08 1020

DATE OF ORDER: 1 Oct 08 TIME OF ORDER: 0850 HOURS

1. D/C to Compound 5
- once D/C Summary completed

(b)(6)

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 2

ACLU DD

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

ACLU-RDI 5593 p.52

000052

31st Combat Support Hospital
ICW Vital Sign Record

Drain # 1 BCLS Drain # 2 Drain # 3 Other

Date	Time	Temp	Pulse	Resp	B/P	O2 Sat	URINE				
5 OCT 08	1227	103.1 tm 102.9 AX	149	35	135/77	98%	15L NRB				
	1233		137	33	138/96	100%	0 mL				
	1238		133	32	143/93	100%					
	1243		132	32	163/99	99%					
	1248		132	36	153/96	100%					
	1250		130	31	155/93	100%					
	1255		131	31	151/92	99%					
	1300	102.9	131	33	151/94	99%					
	1305		134	38	181/100	100%	450 mL CLR YLW				
	1310		131	30	167/91	99%				2000	
	1315		136	34	159/98	96%					
	1320		133	30	168/95	96%					
	1325	102.3	130	29	A-LINE 141/94	97%	CLR YELLOW 380 mL				
	1330		130	30	174/94	95%					
	1335		129	30	205/79	96%	CLR YLW 400 mL				
	1340		131	30	174/87	95%					
	1343		131	28	188/80	95%	5mg LOPRESSOR IVP				
	1345		111	33	140/60	96%					
	1350	103.2	110	30	179/93	97%					

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
Intermediate Care Ward	Department of Nursing	20080128

PATIENT'S IDENTIFICATION

COALITION SSN: 90-20-0018

PSEUDO ISN:

ISN:

ICW Bed#

- ☐ HISTORY/PHYSICAL
- X FLOWCHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

ACLU DDI CID ROI 29846

31st Combat Support Hospital
ICW Vital Sign Record

Date	Time	Temp	Pulse	Resp	BP	O2 Sat	UR[illegible] Drain # 1	Drain # 2	Drain
5 oct 08	1353		115	35	173/84	97%	360 ml	Tylenol	175 mg Keflex 500 mg - Ice packs to Right Knee
	1355		115	34	150/70	98%			
	1400		118	33	150/80	97%			
	1430	102.6	117	33	175/94	99%			
			End of Record Ecc Icu						
			Eloc Shift						

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
Intermediate Care Ward	Department of Nursing	20080128

PATIENT'S IDENTIFICATION

COALITION SSN:

PSEUDO ISN:

ISN:

ICW Bed#

- ☐ HISTORY/PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- X FLOWCHART
- ☐ OTHER

FORM 4700, FEB 2003

ACLU DDI CID ROI 29847

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

900200018
200018

NURSING UNIT: 1CW | ROOM NO. | BED NO.: 2

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

Vs Hm 5 > Iv, 5 Sm, in Sig

Transcribed Orders

(b)(6)

(b)(6)

1600 SBch

PATIENT IDENTIFICATION

900200018
200018

NURSING UNIT: 1CW | ROOM NO. | BED NO.: 3

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

900200018
200018

NURSING UNIT: 1CW | ROOM NO. | BED NO.: 4

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

900200018
200018

NURSING UNIT: 1CW | ROOM NO. | BED NO.: 5

DATE OF ORDER | TIME OF ORDER ____ HOURS

DA FORM 1 APR 79 4256

PREVIOUS EDITION MAY BE USED.

USAPPC V1.00

ACLU DDI CID ROI 29848

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

900-20-0018.

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008 TIME OF ORDER 1531 HOURS

LIST TIME ORDER WAS PER SIGNED

- NS maintenance @ 125 ml/hr ✓
per (b)(6)

- 12 Lead EKG now per (b)(6)

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008 TIME OF ORDER 1541 HOURS

- 5mg IV Lopressor now ✓
per (b)(6)

- Vancomycin 1000mg IV q 12 hrs ✓

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5 Oct 08 TIME OF ORDER 1450 HOURS

(b)(6)

1) Zosyn 4.5 mg IV q 8 hours ✓
2) Zantac 50 mg IV q 8 hours ✓
3) Diuretic 300 mg qam & 200 mg q pm ✓ IV
4) Tylenol 650 mg PO/NGT BID ✓ IV
5) Dexamethasone 2 mg IV q 6 hours
6) Pert CXR x 1

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

7) SCDs bilaterally HOURS
8) FSG q 6 hours, cover w SSI ✓

(b)(6)

9) Diltiazem 15 mg IV push then

of < 90

(b)(6)

ACLU DDI CID ROI 29849

ACLU-RDI 5593 p.56

CLINICAL RECORD - DOCTORS 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

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008 TIME OF ORDER 0:38 HOURS

LIST TIME ORDER NOTED AND SIGN

- Hang Zosyn IV 3.375gm now per (b)(6) ✓

- Code Status: DNI but Full ✓ Code.

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008 TIME OF ORDER 1234. HOURS

- Hang 1 Liter of NS wide open now per (b)(6) ✓

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008 TIME OF ORDER 1305 HOURS

- Hang 1 Liter of NS Now per (b)(6) ✓

- Get Blood Cultures X2 & urine Culture now per (b)(6) ✓

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/05/2008. TIME OF ORDER 1255. HOURS

- Send (b)(6) to lab now per (b)(6) ✓

- Obtain Respiratory Culture now per (b)(6) ✓

(b)(6)

ACLU DDI CID

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

200018

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

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

6 Oct 03 0142

1) DIC Diet, ESL

2) Fosphenytoin 400 PE's IVPB. First dose

(b)(6)

PATIENT IDENTIFICATION

200018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

200018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

200018

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 74, WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1979 O-281-524

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

ACLU DDI CID ROI 29851

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

900-20-0018

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

DATE OF ORDER | TIME OF ORDER 1400 HOURS | LIST TIME ORDER NOTED AND SIGN

VO: Per (b)(6)

975mg Tylenol per NGT

x1 dose (b)(6)

12hrl. (b)(6)

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

NURSING UNIT: ICU | ROOM NO. | BED NO. 5

DATE OF ORDER 6 Oct 08 | TIME OF ORDER 0810 HOURS

500ml NS Bolus over 1 hour

V.O. (b)(6)

(b)(6)

2400 6 Oct 08 0900

PATIENT IDENTIFICATION

900-20-0018

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 Oct 08 | TIME OF ORDER 0735 HOURS

500cc NS 1L Fluid Bolus

(b)(6)

PATIENT IDENTIFICATION

900-20-0018

(b)(6)

NURSING UNIT | ROOM NO. | BED

DATE OF ORDER 6 Oct 08 | TIME OF ORDER 0842 HOURS

1. D5W 500cc bolus x 1 now and q6hrs x 2 litres

2. Maintenance fluids to D5 ½ NS

(b)(6)

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72, WHICH MAY BE USED

ACLU DDI CID ROI 29852

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
10/15/08	Pt is transported to the Medical Surgical unit escorted by Security Officers for admission to bed 1740

10/05/08 16:03:24 HR=136 P1 =135/86(105) P2 =OFF RR=39 SaO2=92% NIBP=158/95(120) T1=OFF T2=OFF Δ1=OFF
II
NORM
1.0mV/cm
PACER DISPLAY ON

10/05/08 17:09:44 HR=144 P1 =147/93(113) P2 =OFF RR=46 SaO2=91% NIBP=153/96(117) T1=OFF T2=OFF Δ1=OFF
II
NORM
1.0mV/cm
PACER DISPLAY ON
I (NORM)
130
105 P1

DATE	NOTES
10/15/08	Pt is from returns escorted by Security Officers
1740	Pt bedside

(b)(6)

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

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

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

PROGRESS NOTES
Medical Record

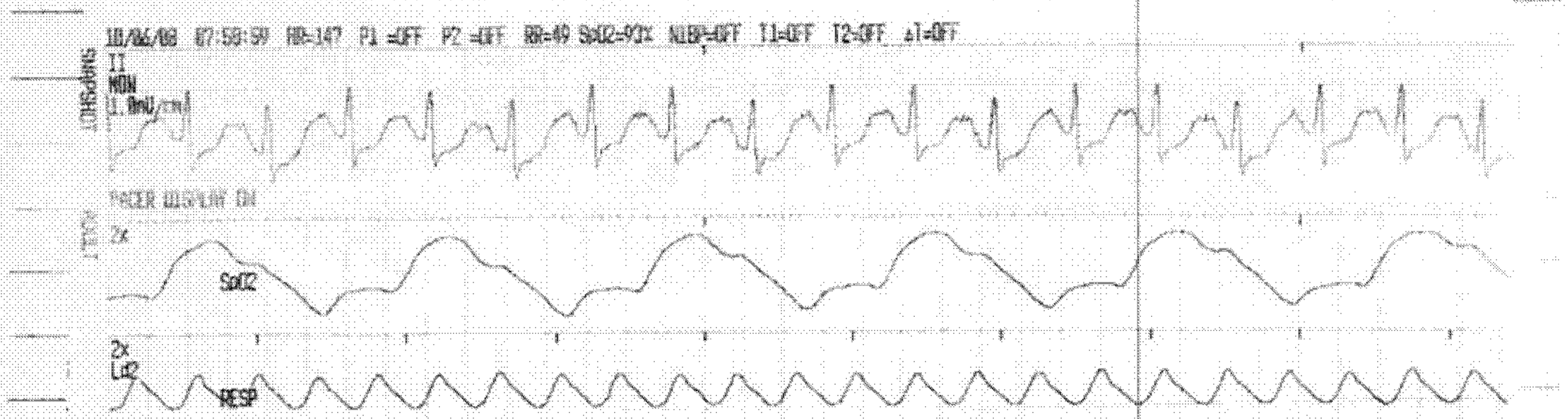
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

900-20-0018

ACLU DDI CID ROI 29853

MEDICAL RECORD

PROGRESS NOTES



RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
		REGISTER NO.		WARD NO.

SHARP/CID FORM 509 (REV. 5/1999)

ACLU DDI CID ROI 29854

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

10/05/08 13:43:03 HR=131 P1 =179/79(102) P2 =OFF RR=29 SpO2=95% NIBP=135/92(108) T1=OFF T2=OFF ΔT=OFF

II
MON
1.0mV/cm

PACER DISPLAY ON

200
135 P1
70

2x
Fm2

RESP

10/05/08 13:58:42 HR=111 P1 =179/82(107) P2 =OFF RR=38 SpO2=98% NIBP=153/94(117) T1=OFF T2=OFF ΔT=OFF

II
MON
1.0mV/cm

PACER DISPLAY ON

200
135 P1
70

2x
Fm2

RESP

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
13:15	135	96	159 / 98 [illegible]	34
13:10	129	99	167 / 91 [illegible]	30
13:06	139	99	171 / 98 [illegible]	34
13:05	131	100	181 / 100 [illegible]	37
13:00	133	98	151 / 94 114	31
12:55	131	99	151 / 92 114	30
12:50	132	100	155 / 93 117	31
12:45	131	100	153 / 96 119	33
12:40	138	100	163 / 99 [illegible]	33
12:35	136	100	147 / 92 113	33
12:25	[illegible]	98	138 / 96 • 113	[illegible]
12:21	[illegible]	95	125 / 79 98	[illegible]

Will continue to monitor patient for any changes.

(b)(6)

STANDARD FORM [illegible] BACK

ACLU DDI CID ROI 29855

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

Sept 25 08: Pt transferred to ICU from (b)(6) at 1430. ICU @ 12:16. At bedside. Pt placed on monitor. R) Fem triple lumen placed and C) Radial A-line see CHCS note for detailed event record.

(b)(6)

10/05/08 12:16:26 HR=1558 P1 =OFF P2 =OFF RR=30 SpO2=OFF NIBP=OFF T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm

PACER DISPLAY ON

10/05/08 13:15:56 HR=145 P1 =OFF P2 =OFF RR=33 SpO2=95% NIBP=159/98(121) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm

PACER DISPLAY ON
2x

10/05/08 13:28:23 HR=130 P1 =201/85(140) P2 =OFF RR=34 SpO2=99% NIBP=159/98(118) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm

PACER DISPLAY ON
140

10/05/08 13:34:58 HR=129 P1 =[redacted] P2 =OFF RR=31 SpO2=96% NIBP=146/88(111) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm

PACER DISPLAY ON
140

PROGRESS NOTES
Medical Record

10-28-08

ACLU DDI CID ROI 29856

ACLU-RDI 5593 p.63

000063

O ST ,

900-20-0018

HR 129 bpm

nt Results:

Interpretation:

1341 Rd #5

: ms
: / ms
: ms
: ms
: / ms
: / / degrees
: ms
: mU
:

Unconfirmed report.

AUR U1 U4

AUL U2 U5

AUF U3 U6

ACLU DDI CID ROI 29857

000064

05 Oct 2008 15:59:28 25mm/s 10mm/mV ADS 50Hz 0.08 - 40Hz 4x2.5R3 Automatic U6.2 (1)

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

Progress Note

Report requested by: (b)(6)

---

06 Oct 2008@1323 INPT Register # (b)(6) PHYSICIAN

DISCHARGE NOTE

DEATH NOTE

DEATH NOTE

Attending Physician: (b)(6)

HN: 900-00-0018

Admission Date: 04 OCT 2008 Date/Time of Death: 06 OCT 2008, 1204hrs

ICD Operations/Procedures: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Enter Principal Diagnosis: Renal cell carcinoma

Enter Secondary Diagnosis: Brain metastases secondary to renal cell carcinoma

Enter Principal Procedures/Operations: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Discharge Summary: This is a 51yo male detainee from Compound V with history of presumed presumed renal cell carcinoma with metastatic disease involving the brain. The detainee was recently admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status but improved with fluid resuscitation and demonstrated no significant changes in CT of the head. He was subsequently re-admitted on 04 OCT 2008 for increasing somnolence. At time of admission, he had a GCS score of 5-6 and was admitted to the ICW. On the morning after admission, though, his condition worsened after having two additional seizures. He was subsequently transferred to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 103, tachycardic with a heart rate as high as 180 and low oxygen saturations necessitating placement on 100 NRB (face mask oxygen). He also had a-line and femoral central line place . Broad spectrum antibiotic coverage with piperacillin/tazobactam and vancomycin was initiated. His family came to visit and end of life issues and code status were discussed with the ICU physician.

His condition continued to deteriorate throughout the course of his second day. The decision was made by family members that the detainee would not be intubated but would receive ACLS (Advanced Cardiac Life Support) to include chest compressions, direct current cardioversion (electric shocks) if indicated and cardiac support medications. By his second night in the hospital, he was no longer producing urine and required additional intravenous fluid support. He also was started on a continuous infusion of diltiazem to control his heart rate which had climbed as high as the 180's range. His mental status remained extremely poor and he was unresponsive to painful or verbal stimuli. By the morning of the third hospital day, he was noted to have a disconjugate gaze (his eyes were pointing in different directions from one another). He had developed pronounced Kussmaul breathing (deep and fast respirations) which continued through much of the morning. His tachycardia had improved somewhat with the use of the diltiazem infusion. I spoke with detainee's son on multiple occasions regarding the status of his father and allowed him to remain present in the ICU. I gave my opinion that I believed advanced life support would be futile, particularly if

---

20/900-00-0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Loc: ICU 1
Spon: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Reg #: (b)(6)

Automated version of SF509

ACLU DDI CID ROI 29858

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

Report requested by: (b)(6)

---

mechanical ventilation was not an option. The son remained steadfast in his desire for us to do everything "but put him on a breathing machine".

Thirty minutes after my conversation with the son, the detainee's heart rate and respiratory rate dropped precipitously. Soon after he developed PEA (pulseless electrical activity) and CPR was initiated. An oral airway was placed and the detainee was ventilated using an Ambu bag. He was noted to have ZERO spontaneous ventilations during the code process. We were able to regain a pulse after 10 minutes of CPR with epinephrine, atropine and Levophed (medications to stimulate the heart and elevate the blood pressure) and CPR was stopped. I explained to the son that his father's clinical situation had worsened significantly and that his death was imminent. I also explained that his father would continue to develop PEA because of his inability to breathe on his own. I also explained that I suspected the cause of impending death to be the herniation of his father's brain stem because of high intracranial pressures (because of the brain swelling from the metatastases and the blockage of free flow of cerebrospinal fluid out of the brain). The son expressed understanding but asked that we continue with our treatment. Ten minutes later his father went into PEA again. The ICU team again initiated CPR and provided cardiac medications with a return of the pulse, albeit weaker and slower than on the initial resuscitation. I again asked the son if he wished for us to continue. At this time, he expressed his desire for the team to stop resuscitation. I ordered cessation of CPR and bag-mask ventilation. His cardiac rhythm quickly degenerated into PEA and he expired shortly thereafter. The detainee's son was present at bedside at the time of death. (b)(6)

(b)(6)

Signed: (b)(6)

20/000-20-0018 DETAINEE, ISN200018
03 Jan 1967 / Male
Loc: ICU 1
Spon: DETAINEE, ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Reg #: (b)(6)

Automated version of SF509

ACLU DDI CID ROI 29859

CAMP CROPPER

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

Report requested by: (b)(6)

04 OCT 2006:1021 INPT Register #(b)(6) CLINICAL NURSE

PROG NOTES

At approx 1110, summoned to bedside pt w/agonal respirations HR decreased to 65 from 110. Pt bagged with 100% O2 with oral airway (b)(6) present @ bedside. Pt went to PEA @ 1111, see code record for code summary. ROSC achieved, but subsequently went back into PEA. Pt zoo @ bedside during resuscitation and frequently updated by (b)(6) with interpreter. Decision made by zoo to cease resuscitation. Time of death called @ 1204 by (b)(6) Additional family arrived and were given time with pt and updated by (b)(6) and compound S officials. CID present for evaluation. Right toe tag placed, pt placed in bag with ID tag on outside. S4 notified. Death packet released to PAD. (b)(6)

Signed: (b)(6)

26/Aug 2:[illegible] [illegible]
01 Jan 1997 / Male
Reg #: 5[illegible] Loc: ICU 1
Sptm: [illegible]
0.15
Automated Version of [illegible]

ACLU DDI CID ROI 29860

Cle		
Eye		
2 – To Pain	4 – Moves against resistance	
1 – None	3 – Moves against gravity	
Verbal Response:	2 – Moves not against gravity	
5 – Oriented	1 – No movement	
4 - Confused		
3 – Inappropriate Words		
2 – Incomprehensible Sounds		
1 – None (Note – "T" = tube)		
Motor Response:	**Pupil Scale**	
6 – Obey Commands		
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm	
4 – Withdraws to Pain		
3 – Flexion to pain		
2 – Extension to pain		
1 - None		

RESTRAINTS:

0700 site	pulse	cap. ref.	edema	**1900**	Site	pulse	cap. ref.	edema
0900 site	pulse	cap. ref.	edema	**2100**	Site	pulse	cap. ref.	edema
1100 site	pulse	cap. ref.	edema	**2300**	Site	pulse	cap. ref.	edema
1300 site	pulse	cap. ref.	edema	**0100**	Site	pulse	cap. ref.	edema
1500 site	pulse	cap. ref.	edema	**0300**	Site	pulse	cap. ref.	edema
1700 site	pulse	cap. ref.	edema	**0500**	Site	pulse	cap.ref	edema

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
L Fem Tes	5 Oct 08		DT		
L Radial Line	5 Oct 08		DT		
L Rad 22g	5 Oct 08		DT		
LFA 20g	5 Oct 08		DT		

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)	ICU	6 Oct 08

PATIENT'S IDENTIFICATION

900-20-0018

- ☐ HISTORY/PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☐ FLOWCHART
- ☐ OTHER

ACLU DDI CID ROI 29861

NIBP/ ABP (MAP)										
Pulse										
Respirations										
Temperature										
SaO2										
%O2										
O_2 Delivery										
Mode										
Rate										
Tidal Vol.										
Peep										
PS										
Pain Scale										
Pain Med										
Pt Position										
CVP										

24 Hour Totals	Yesterday	Today
INPUT	3692	
OUTPUT	2207	
DIFFERENCE	1485	

Overall Fluid Status: +/-
(Running Total Fluid balance)

+1485

(INTAKE) TIME	23	24	01	02	03	04	05	06	**Total 8 HRS**	**24 HOUR TOTAL**
IV										
IVPB										
PO/ TF										
Other										
TOTAL										

OUTPUT

TIME	23	24	01	02	03	04	05	06	**Total 8 HRS**	**24 HOUR TOTAL**
Urine output /Total										
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend	
Init= initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2= Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	S= Supine
N= No	ABP= Arterial Blood Pressure
Y= Yes	PS=Pharmacologically Sedated
+2= strong +1=weak	

Name	Signature	Init.

ACLU DDI CID ROI 29862

EMERGENCY RESUSCITATION RECORD

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

PART 1 - Complete this report immediately following the event. Place the original in the patient's record and provide a copy to the nursing supervisor/OIC.

1. DATE: 6 Dec 09

2. LOCATION OF RESUSCITATION: ☒ Ward: ED

☐ MICU ☐ SICU ☐ CCU ☐ NICU ☐ PICU ☒ ED ☐ PACU ☐ OR

☐ Diagnostic/Procedure Area:

☐ Outpatient Clinic:

☐ Other (Specify):

3. PATIENT STATISTICS:

Age: ____ Gender: M

Height (in): ____

Weight (lbs): 94 Weight (kg): ____

4. INITIAL CONDITION:

CONSCIOUS? ☐ Yes ☒ No

BREATHING? ☒ Yes ☐ No

PULSE? ☐ Yes ☒ No Pulse Site: Right

WITNESSED ARREST? ☒ Yes ☐ No ☐ Unknown

MONITORED AT ONSET? ☒ Yes ☐ No

5. INITIAL RHYTHM:

☐ Asystole ☒ Pulseless Electrical Activity ☐ Other:

☐ Bradycardia ☐ Ventricular Fibrillation

☐ Perfusing Rhythm ☐ Ventricular Tachycardia

RETURN OF SPONTANEOUS CIRCULATION (ROSC):

☐ Returned at: 1140 → 1149 ☐ Never Achieved

☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

* SEE NOTE on back

TIME CPR STOPPED: 1149 DUE TO: ☐ ROSC ☒ DNR ☐ Death

6. IMMEDIATE CAUSE OF ARREST/EVENT: (Check One)

☐ Hypotension/Hypovolemia

☒ Lethal Arrhythmias

☐ Metabolic

☐ Myocardial Infarction or Ischemia

☐ Respiratory Depression

☐ Trauma

☐ Unknown

☐ Other:

7. RESUSCITATION ATTEMPTED:

☒ YES (Check all that apply) BVM Oral Airway

☒ Airway Management ☐ Cardiac Massage

☒ Chest Compressions ☐ Defibrillation

☐ NO (Check one)

☐ False Alarm/Arrest (BLS/ALS not needed)

☐ Do Not Resuscitate (DNR)

☐ Pronounced Dead Prior to Resuscitation

☐ Other:

8. EVENT TIMES: (The times below are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	Time (Military)
Collapse/Arrest Onset:	1131
CPR Started:	1131
1st Defibrillation:	
Airway Achieved:	DNT
1st Dose Epinephrine:	1132
Code Team Called: ☐ Yes ☐ No	Prior
Code Team Arrived:	Prior

9. INTERVENTIONS:

(CHECK THOSE IN PLACE AT START OF RESUSCITATION)	(CHECK THOSE INITIATED DURING RESUSCITATION. NOTE TIME)	COMMENTS
☒ IV Access Gauge: 20, 22 Site: R & L Hand	☐ Time(s) ____ / ____	
☐ Endotracheal Tube Size: ____	☐ Time(s) ____ / ____	
☐ Mechanical Ventilation	☐ Time(s) ____ / ____	
☒ Arterial Line	☐ Time(s) Bradick	
☒ Central Venous Line	☐ Time(s) K Fuller	
☐ Pulmonary Artery Catheter	☐ Time(s) ____ / ____	
☒ Nasogastric Tube Levin	☐ Time(s) ____ / ____	
☐ Pacing Device (Specify): ____	☐ Time(s) ____ / ____	
☐ Implantable Defibrillator/Cardioverter	☐ Time(s) ____ / ____	
☐ Other (Specify): ____	☐ Time(s) ____ / ____	

PATIENT DISPOSITION FOLLOWING RESUSCITATION:

Morgue

PATIENT IDENTIFICATION (Pen typed or written entries note: name-last, first, middle initial; grade; DOB; hospital or medical facility)

10-20-1978

10. GLASGOW COMA SCALE: (Post-resuscitation)
Circle appropriate score for each parameter, then total score.

EYE OPENING	MOTOR RESPONSE
4 - Spontaneously	6 - Obeys verbal commands
3 - To voice	5 - Localizes painful stimulus
2 - To pain	4 - Withdraws from pain stimulus
1 - No response	3 - Flexion, decorticate posturing
VERBAL RESPONSE	2 - Extension, decerebrate posturing
5 - Oriented, converses	1 - No movement
4 - Disoriented, converses	
3 - Inappropriate responses	SCORE: 2
2 - Incomprehensible sounds	
1 - No response	

ACLU DDI CID ROI 29863

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Military)	1131	1132	1134	1135	1136	1138	1139	1140	1141	1144	1204	
VITALS	BLOOD PRESSURE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	↑	↑	
	HEART RATE	30	0	20					Y 155	N	↑	↑	
	PULSE PALPABLE (Y/N)	N	N	N	N	N	N	N	Y	Y	→	→	
	COMPRESSION (* = CPR)	*	*	*	*	*	*	*		*	Start CPR	Stop CPR	
	EKG/ECG	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SR	[illegible]			
	DEFIBRILLATION (Joules: 200, 300, 360)												
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)												
	PACING PERFORMED (✓)												
	RESPIRATIONS	BVM	BVM	BVM	BVM	BVM	BVM	BVM	BVM	BVM			
	TEMPERATURE	100.3											
AIRWAY	VALVE MASK ~100% O_2 (✓)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	INTUBATED (✓)												
	MASK (Specify)												
	% OXYGEN (O_2)												
	PULSE Ox / O_2 SATS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	98%				
MEDICATIONS	*Note dose and route.*												
	AMIODARONE												
	ATROPINE				✓			✓					
	DOPAMINE												
	EPINEPHRINE		✓	✓		✓				✓			
	LIDOCAINE												
	~~PROCAINAMIDE~~ CaCl						✓			✓			
	VASOPRESSIN												
LABS	POTASSIUM (K)								4.5				
	GLUCOSE								444				
	CALCIUM (Ca)								13.6				
	MAGNESIUM (Mg)												
ABGS	PH								6.87				
	pCO_2								88.7				
	pO_2								55		↓	↓	
	HCO_3								16				

COMMENTS: (13) pt c agonal resp(5), pulse 35 w/ palpable pulse CPR started. RSC obtained & CPR subsequently HR ↓ 135 ↓ 125 ↓ 105 ↓ ↓ of BP and respirations w/ BVM. ETT secured & BBS completed started prior to pt #2 arriving. Pt-(b)(6) deceased. Soc. Worker notified. Decision to stop resuscitation made. Pt's parents present. Time of death @ 1204 per (b)(6). Additional staff entered room to offer support. Pt left in room with parents. Corpsman S. Hargett S. USN. Efforts to remove ETT to maintain cleanliness of body.

(b)(6) (b)(6) (b)(6) (b)(6) NURSE (b)(6)

ACLU DDI CID ROI 29864

ACLU-RDI 5593 p.71

000071

NIBP/ ABP (MAP)																			
Pulse																			
Respirations																			
Temperature																			
SaO2																			
%O2																			
O_2 Delivery																			
Mode																			
Rate																			
Tidal Vol.																			
Peep																			
PS																			
Pain Scale																			
Pain Med																			
Pt Position																			
CVP																			

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV																		
IVPB																		
PO/ TF																		
Other																		
TOTAL																		

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total																		
NG output																		
Emesis																		
Stool																		
Chest tub #1/ #2																		
Jackson Pratt #1/ #2																		

Bath/Skin Care			
Oral Care			
Foley Care			

Cardiac Monitor	Y N	Y N	Y N
Bed position/Locked	Y N	Y N	Y N
Call bell in reach	Y N	Y N	Y N
	Y N	Y N	Y N
High risk for falls	Y N	Y N	Y N

ACLU DDI CID ROI 29865

NURSING STANDARDS OF CARE PI PILOT

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION/CARE PLAN (NON-MEDICATION)

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

Mo. Yr.

INITIAL PROPER COLUMN FOLLOWING EACH ENTRY

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	SHIFT	5 6 7	DATE COMPLETED
5oct 08	(b)(6)	EMERGENCY EQUIPMENT OUTSIDE ROOM, BED ALARM ON/OFF	D	(b)(6)	
			1	(b)(6)	
			X		
5oct 08		GREEN AND WHITE SHEETS REVIEWED, ORDERS COSIGNED MEDS CHARTED	D	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		BATH	QD		
			X		
5oct 08		IV LINES CHECKED AND DATED Q96HR STANDARD LINES, Q24HR TPN, Q12HR PROPOFOL	07	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		HIGH ALERT MED DOSAGES VERIFIED @ CHANGE OF SHIFT AND WITH DOSAGE CHANGE	07	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		CRITICAL CARE ASSESSMENT DONE Q4HR W/ EKG STRIP INTERPRETATION	07	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		PAIN DOCUMENTED W/ EACH ASSESSMENT AND WITH PAIN MED INTERVENTION	07	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		PT TURNED Q2 HR IF UNABLE TO TURN SELF	07	(b)(6)	
			19	(b)(6)	
			X		
5oct 08		MOUTHCARE / FOLEY CARE DONE AND DOCUMENTED Q8 HR	07	(b)(6)	
			19	(b)(6)	
			X		

ALLERGIES ☐ YES ☐ NO: NKDA

PRIMARY DIAGNOSIS: Lt Med Shins

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION

900-10-0018

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

ACLU DDI CID ROI 29866

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo Yr

VERIFY WRISTBAND

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5 6 7
5Oct 08	(b)(6)	WOUND CARE DRESSINGS DATED, BRADEN SCALE DAILY & WHEN CHNG	07	(b)(6)
			19	(b)(6)
			X	
5Oct 08		RESPIRATORY/VENTILATOR DAILY VAP BUNDLE COMPLETED	07	NP
			19	NP
			X	
5Oct 08		DOCUMENTED MOUTHCARE AND ETT CARE Q8 HOURS AND PRN	07	NP
			19	NP
			X	
5Oct 08		IS Q1 AS CLINICALLY INDICATED	07	NP (b)(6)
			19	NP
			X	
5Oct 08		CENTRAL LINE CARE/BUNDLE EMERGENT LINES CHANGED WITH 24 HOURS	07	(b)(6)
		NEED FOR LINE ASSESSED DAILY	19	
			X	
5Oct 08		CENTRAL LINE DSG CHANGE Q96HR AND PRN USE OF BIOPATCH IF AVAILABLE	07	(b)(6)
			19	
			X	
5Oct 08		ALINE/CVP TRANSDUCERS ZEROED AND LEVELED Q SHIFT AND WITH PT REPOSITION	07	(b)(6)
			19	
			X	

ALLERGIES ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS

Pediatric ICU Status

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO

PATIENT IDENTIFICATION

Yoo Zo-008

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

ACLU DDI CID ROI 29867

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-66; 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	
SCD 22	(b)(6)	INF @ 125cc/	01	(b)(6)
		hr	15	(b)(6)
			23	
SCD 28	(b)(6)	Vancomycin 1 gm	02	(b)(6)
		IVPB 12 hours	14	(b)(6)
SCD 28	(b)(6)	Zosyn 4.5mg IV	06	(b)(6)
		q 8 Hours	14	
			22	(b)(6)
SCD 28	(b)(6)	Pantac 50mg IV	07	(b)(6)
		q 8 hours	03	
			16	(b)(6)
SCD 28	(b)(6)	Dilantin 300 mg	10	
		q AM PO/NGT		
SCD 28	(b)(6)	Dilantin 200 mg	22	(b)(6)
		q PM PO/NGT		
SCD 28	(b)(6)	Tegretol 100 mg	10	(b)(6)
		PO/NGT BID	22	(b)(6)
SCD 28	(b)(6) (b)(6)	Diltiazem ~~25 (4H~~	07	(b)(6)
		Nitrate Ointment	15	(b)(6)
		< 9C	23	

ALLERGIES ☐ YES ☐ NO | PRIMARY DIAGNOSIS: Alt Ment Status

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION

900-20-0018

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 ... EDITION OF ... MAY BE USED ... PAGE 1 OF 2

ACLU DDI CID ROI 29868

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
5Oct 05	(b)(6)	IVPB Zosyn 3.375 mg x 1 now	Oct	Now	1240	(b)(6)
5Oct 05		1 Liter NS Bolus	5Oct	Now	1240	
5/10/05		1 Liter NS Bolus x 1	5Oct	Now	1305	
5/10/05		5 mg Lopressor x 1 now IV	5Oct	Now	1245	
5/10/05		Tylenol 975mg Per PGT x 1 now	5Oct	Now	1445	
9 Oct		500cc NS Bolus over 5 min Now	6Oct	Now	0015	
6Oct 1200		500ml NS Bolus	6Oct	Now	0600	0605
6Oct 0400		5th 500ml bolus x 1 now and (6p x 2)	6Oct	Now	0900	0902
			6Oct	0500		
				2100		
			7Oct	0500		

D/C Acd

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
5Oct 05	(b)(6)	Tylenol 650 mg PO q4 hrs for Pain, HA or Fever	5Oct 0500 5Oct 1010

ACLU DDI CID ROI 29869

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-66; 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
5oct	(b)(6)	Dexamethasone 2mg IV	6	/
		q6 hours	14	/ Rewritten
			22	Dc'd
				X
6 oct	(b)(6)	Dexamethasone 2mg IV	04	/ Dc'd
		q6°	10	/ Dc'd
			16	/
			22	/ Dc'd
				X
10 oct	(b)(6)	Ds 1/2 NS MIV @ 125	12	X / X
		x 2 L	18	X
			16	X
			21	/ X
10 oct	(b)(6)	Ds 1/2 NS MIV @ 125	02	X / X
			05	X
			22	X
				X
10 oct	(b)(6)	Ecophenotrin-Rotenone SV	10	/ X
		Other IS dose now		X / X
				X

ALLERGIES: ☐ YES ☐ NO — PRIMARY DIAGNOSIS: Acute Nasal Sinus

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PATIENT IDENTIFICATION: 90-20-0018

DOSING TIMES

USE PENCIL — CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF [illegible] WILL BE USED. — PAGE 1 OF 2

ACLU DDI CID ROI 29870

VERIFY & INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION		
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6
	- - - - - -	Target Glucose Range 70-180 mg/dL	LU	/	ADG
	- - - - - -	<70 mg/dL = give 1 Amp D50 IVP & call MD	FS	/	305
		70-180 no action	Coverage	/	5u
		181-200 2 units R	06	/	ADG
		201-250 4 units R	FS	/	245
		251-300 mg/dL = 6 units [illegible]	Coverage	/	4u
		[illegible]	12	/	
		351-400 10 units R	FS	/	
	- - - - - -	>400 mg/dL = call MD	Coverage	/	
	- - - - - -		18	ADG	
	- - - - - -		FS	316	
	- - - - - -		Coverage	5u	

ALLERGIES ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS

Mets Brain CA

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO ____

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

[illegible] 7 8 9 10 11 12 13 14

[illegible] 16 [illegible] 17 18 19 20 [illegible] [illegible]

[illegible] [illegible] [illegible] 01 02 03 04 [illegible] [illegible]

900-20-0018

ACLU DDI CID ROI 29871

ACLU-RDI 5593 p.78

000078

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ____ Yr ____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5 Oct 08	(b)(6)	Blood cultures x 2 DNU	5 Oct 08	DNU	1300	(b)(6)
5 Oct 08		Labs: Routine	5 Oct 08	DNU	1300	
5 Oct 08		Labs: Sputum culture x 1	5 Oct 08	DNU	1500	
5 Oct 08		12 Lead EKG x 1	5 Oct 08	DNU	1500	
5 Oct 08		Portable CXR x 1 DNU	5 Oct 08	DNU	1500	
5 Oct 08		Admit to ICU from ICU	5 Oct 08	1220	1220	
5 Oct 08		Dx: Alt. Mental Status (b)(6)	05 Oct 2008	1200	1220	
5 Oct 08		Urine Cultures	05 Oct 2008	DNU 1300	1300	

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

ACLU DDI CID ROI 29872

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
Sep 08	(b)(6)	Code Status:	07	/	(b)(6)		
		DOI Dx Fx	15	(b)(6)			
		Code	23				
			/				
Sep 08	(b)(6)	SD Bolus	07	/	(b)(6)		
			15	(b)(6)			
			23				
			/				
Sep 08	(b)(6)	Vitals Per ICU Protocol	07	/	(b)(6)		
			15	(b)(6)			
			23				
			/				
Sep 08	(b)(6)	NGT	07	/	(b)(6)		
			15	(b)(6)			
			23				
			/				
Sep 08	(b)(6)	Labs q AM: CBC, ABG, Comp	06	/	(b)(6)		
			/				
			/				
Sep 08	(b)(6)	Diet: DPO	06	/	(b)(6)		
			12	/			
			17	(b)(6)			
			/				
Sep 08	(b)(6)	Activity: Bedrest	07	/	(b)(6)		
			15	(b)(6)			
			23				
			/				

ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS: AH Mental Status

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO

PATIENT IDENTIFICATION

400-20-0085

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 3077, 1 OCT 1978 EDITION OF 1 DEC 77 MAY BE USED APD LITHO

ACLU DDI CID ROI 29873

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
5-25-18	(b)(6)	Follow to Q4hr.ly

1545

07 (b)(6)

115 (b)(6)

22

PRIMARY DIAGNOSIS:

All Meds States

ADDITIONAL PAGES IN USE.

☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

900-20-0018

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

OCT 1978 EDITION OF 1 DEC 77 MAY BE USED. APD PE V1 00

ACLU DDI CID ROI 29874

Personal Data Privacy Act of 1974 (PL 93 579)

PATIENT LAB INQUIRY

For: 05 Oct 08 06 Oct 08

Report requested by: (b)(6)

DETAINEE,ISN200018 20/900 20 0018 M/41 Reg #: (b)(6)

Ph: Military Unit: UNKNOWN

06 Oct 08 @ 1148 (Coll) BLOOD

STAT WBC	18.7	H	(4.8 10.8)	x10 3/ul
RBC CNT	4.44		(4.20 6.10)	x10 6/ul
HGB	12.2		(12.0 18.0)	g/dL
HCT	39.0	L	(42 52)	%
MCV	87.8		(80.0 99.0)	fl
MCH	27.5		(27.0 31.0)	pg
MCHC	31.3	L	(33.0 37.0)	g/dL
PLATELETS	141		(130 400)	x 10(3)/ul
LYMPH%	31		(20.0 44.0)	%
LYMPH#	5.7	H	(0.7 4.3)	x10 3/ul

06 Oct 08 @ 1148 (Coll) ARTERIAL BLO

STAT PH BG	6.87	L*	(7.35 7.45)	

Result Comment:

Immediately reported results to (b)(6) 1200hrs on 6Oct2008.

PCO2	89	H*	(35.0 45.0)	mmHg
PO2	55	L	(80 100)	mmHg
HCO3 POCT	16	L	(22 26)	mmol/L

Interpretations:

PERFORMED ON ISTAT ANALYZER

BASE EXCESS	17	L		mmol/L
O2 SAT %	60	L	(95 98)	%
TCO2	19		(18 32)	mmol/L

Interpretations:

PERFORMED ON BLK I STAT

IONIZED CA	2.16	H	(1.12 1.32)	mmol/L

Interpretations:

PERFORMED ON I STAT

ACLU DDI CID ROI 29875

TO: ☐ PATIENT ADMINISTRATOR
☐ ADMINISTRATIVE OFFICER OF THE DAY

PERSON TO BE NOTIFIED
5. RELATIONSHIP

1. DATE	2. HOUR	6. NAME AND ADDRESS
5 Oct 08	1500	
3. RELIGION OF PATIENT	4. WARD	
	ICU	

ACTION TAKEN BY MEDICAL OFFICER

7. BRIEF DIAGNOSIS *(Use lay terminology)*

Metastatic Cancer (to brain) with altered mental status

8. STATUS OF PATIENT

PLACED ON ROSTER — PROGNOSIS: RECOVERY IS -

a. ☒ VERY SERIOUSLY ILL — ☒ NOT EXPECTED — ☐ QUESTIONABLE

b. ☐ SERIOUSLY ILL — ☐ QUESTIONABLE — ☐ EXPECTED

c. ☐ NON SERIOUSLY ILL — EXPECTED LENGTH OF HOSPITALIZATION ____ DAYS

d. ☐ SPECIAL CATEGORY *(Specify)*

CHANGE OF STATUS

e. ☐ SI TO VSI — g. ☐ RECOVERED — i. ☐ DIED

f. ☐ VSI TO SI — h. ☐ TRANSFERRED — j. ☐ ADDITIONAL SPECIAL CATEGORY *(Specify in remarks)*

9. REMARKS

10. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN (b)(6)

11. SIGNATURE OF ATTENDING PHYSICIAN (b)(6)

ACTION TAKEN BY PATIENT ADMINISTRATOR OR ADMINISTRATIVE OFFICER OF THE DAY

NOTIFIED	ACTION	DATE	HOUR	METHOD OF NOTIFICATION *(Initial one)* TELEPHONE	TELEGRAM	LETTER	IN PERSON
	12. REPORT RECEIVED						
	13. PERSON *(Same as Item 6)*						
	14. INFORMATION OFFICE						
	15. RED CROSS						
	16. CHAPLAIN						
	17. UNIT COMMANDER						
	18. OTHER *(Specify)*						

9. REMARKS

PATIENT'S IDENTIFICATION *(Place label or write entries given below. Name: last, first, middle, grade, Social Security Number, and unit)*

10-20-2008

20. TYPED OR PRINTED NAME OF PATIENT ADMINISTRATOR OR ADMINISTRATIVE OFFICER OF THE DAY (b)(6)

21. SIGNATURE (b)(6)

DA FORM 2054, AUG 2007 — PREVIOUS EDITION IS OBSOLETE. — APD PE v1.00ES

ACLU DDI CID ROI 29876

======= PICCOLO =======
10/06/08 12:01 PM
PATIENT TYPE: MALE
PATIENT #: 900200018
COMPREHENSIVE METABOLIC
DISC LOT #: 8272AA4
OPERATOR #: (b)(6)
DOCTOR #:
SERIAL #: 0000100604

NA+	162*	128-145	MMOL/L
K+	4.5	3.6-5.1	MMOL/L
tCO2	18	18-33	MMOL/L
CL-	118*	98-108	MMOL/L
GLU	444*	73-118	MG/DL
CA	13.5*	8.0-10.3	MG/DL
BUN	19	7-22	MG/DL
CRE	2.5*	0.6-1.2	MG/DL
ALP	42*	53-128	U/L
ALT	91*	10-47	U/L
AST	149*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
ALB	2.5*	3.3-5.5	G/DL
TP	5.6*	6.4-8.1	G/DL

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

---

i-STAT EG7+

Pt: 900200018

Pt Name:_____

Na_____156 mmol/L
K_____4.0 mmol/L
TCO2_____19 mmol/L
iCa_____2.16 mmol/L
Hct_____33 %PCV
Hb*_____11.2 g/dL
*via Hct

At 37C
pH_____6.865
PCO2_____88.7 mmHg
PO2_____55 mmHg
HCO3_____16.0 mmol/L
BEecf_____-17 mmol/L
sO2*_____60 %
*calculated

Sample Type_:

06OCT08 11:43

Oper: 9945

Physician:_____

Ser#: (b)(6)
Ver: (b)(6)

ACLU DDI CID ROI 29877

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

CHIEF COMPLAINT

Tetanus

ARRIVAL

DATE (Day, Month, Year) | TIME

AIRWAY
☐ PATENT
☐ OBSTRUCTED

BREATHING
☐ UNLABORED
☐ LABORED
☐ ABSENT

LMP | TETANUS | AGE | ☐ MALE ☐ FEMALE

☐ WALK-IN ☐ AMB ☐ MEDEVAC ☐ OTHER

MENTAL STATUS
☐ ALERT ☐ VERBAL ☐ PAINFUL ☐ UNRESPONSIVE

TRANSPORTATION TO FACILITY
CARE ENROUTE

CIRCULATION ☐ NORMAL
PULSES ☐ STRONG ☐ WEAK ☐ ABSENT
CAP REFILL ☐ <2SEC (BRISK) ☐ >2 SEC (SLOW)
BLEEDING ☐
☐ TOURNIQUET

NEUROVASCULAR DEFICITS

LUE | RUE

LLE | RLE

CURRENT MEDICATIONS

D. Lemon
Tdap
Tegretol

IMMEDIATE INTERVENTIONS ☐ NONE
☐ O2 ☐ CARDIAC MONITOR ☐ EKG ☐ FSBG
☐ IV
☐ C-SPINE PRECAUTION
☐ BACK BOARD REMOVED @ ____
☐ PRESSURE DRESSING ☐ TOURNIQUET

☐ C-SPINE IMMOB

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

MEDICATION	DOSE	ROUTE	TIME	INT	RESPONSE

ALLERGIES

NKA

☐ TAGS

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 2100

RN:

IV SITE	SIZE	TIME	INT	DCD	INT
LFA	20 L	2100	Tc	☐	
				☐	

ORDERS

Cbc, cmp
Diff, Blood Cult
Dc Diff, Blood Cult
Cxr
Xray L Hand
Ivf Tub - @ 85
Foley - 2

VITAL SIGNS

				WT	WT
TIME	0200	0230			
BP	111/92	126/80			
PULSE	74	73			
RESP	16	16			
TEMP	98.2 (F)				
SpO2	98%	98%			
PAIN					

MEDIC NOTE

4 Person Team Carry
2 IV 18G Hand + Right AC
Ua, Upon arrival pt A+O x 0
Intermittent

(b)(6)

MED Hx

SURG Hx

SOCIAL Hx

CONTACT ME THIS INFORMATION

PATIENT IDENTIFICATION (Name, Address, Phone, MEDIC ID, Social Security Number)

5-200 018

IV FLUID INTAKE | OUTPUT

ACLU DDI CID ROI 29878

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT

NURSING NOTE

0207 Entry into unit. Face to ur yellow line
0215 NG tube placed for feeding tube placement
confirmed by Aussie + X-ray
0225 Report to (b)(6)
[illegible]

TIME SEEN BY PROVIDER

NURSE SIGNATURE AND STAMP

PROVIDER HISTORY/PHYSICAL

CONSULT WITH	TIME	ACTION

DISPOSITION MODIFIED DUTY UNTIL

☐ RTD ☐ RTC ☐ QTRS 24 ☐ QTRS 48 ☐ QTRS 72

ADMIT | TIME OF RELEASE | CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

DIAGNOSIS

PROVIDER SIGNATURE AND STAMP

PATIENT DISCHARGE INSTRUCTIONS

PATIENT'S SIGNATURE

I have received and understand these instructions

ACLU DDI CID ROI 29879

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

REPORT TITLE

PROVIDER ORDERS

OTSG APPROVED (Date)

DATE: 5 Oct 05 TIME: 1430 SERVICE: (X) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: Metastatic Cancer/Altered Mental Status CONDITION: ( ) STABLE ( ) CRITICAL ( ) GUARDED

Vital Signs: ( ) ICW Protocol (X) ICU Protocol Allergies: 2 KDT ( ) NKDA

Activity: Bedrest Weight Bearing Status: _____

Diet: (X) NPO ( ) Regular ( ) Soft ( ) Clear Liquid ( ) Diabetic ( ) NPO after midnight for surgery DOS: _____

Dressing Change: ( ) POD # _____ ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 150 mmHg

Drains: (X) NGT ~~to WIWO~~ ( ) Chest Tube to _____ ( ) Hemovac ( ) JP (X) Foley ( ) Record output q 8hrs

Labs: (X) CBC ( ) CRP ( ) ESR ( ) Coags (X) ABG (X) CMP ( ) BMP ( ) Other _____
( ) NOW ( ) in AM (X) q AM ( ) q AM x 3 days

X-Rays: _____

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs (X) NS ( ) LR @ 125 ml/hr ( ) D5 1/2 NS @ _____ ml/hr
( ) Other IV Fluid: _____
( ) Lovenox 40mg SQ daily ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before surgery
( ) Zosyn 3.375 grams IV q 6 hours
( ) Zosyn 4.5 grams IV q 8 hours
( ) Unasyn 3 grams IV q 6 hours
( ) Ancef 1 gram IV q 8 hours
( ) Ancef 1 gram IV x 1 on chart for OR
( ) Vancomycin 1 gm IV q 12 hours
( ) Levofloxacin 500 mg daily ( ) PO ( ) IV
( ) Cefoxitin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 8 hours
( ) MS Contin _____ mg PO q 12 hours
( ) Zantac ( ) 150 mg PO BID ( ) 50 mg IV q 8 hours
( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID
( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other: _____

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain
( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO
(X) Tylenol 650 mg (X) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give it within 4 hrs of Percocet
( ) Motrin ( ) 400 mg ( ) 800 mg PO q 8 hours PRN for pain, fever, headache
( ) Benadryl ( ) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours ( ) q 8 hours PRN itch or insomnia
( ) Reglan 10 mg IV / PO q 6 hours PRN nausea
( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent
( )
( )
( )

(b)(6)

PREPARED BY (Typed name & title) SERVICE/CLINIC DATE (YYYYMMDD) 20060

PATIENT'S IDENTIFICATION (For typed or written entries, enter Name (Last, First, Middle), Grade, Date, Hospital or Medical Facility)

PSEUDO SSN: 000-29-0018 SSN:

LOCATION: (X) ICU ( ) ICW BED # 2 AGE:

( ) HISTORY / PHYSICAL ( ) FLOW SHEET
( ) OTHER EXAMINATION (X) OTHER (Specify)
( ) DIAGNOSTIC STUDIES *Provider Orders*
( ) TREATMENT

MEDCOM FORM 4700 FEB 2003

ACLU DDI CID ROI 29880

MEDICAL RECORD - PROVIDER ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other ITR forms.

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE. PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME.)	
	Sliding Scale Insulin:	
	( ) Target Glucose Range 70-120 mg/dL	
	<70 mg/dL = give 1 Amp D50 IVP & call MD	
	70-120 mg/dL = no action	
	121-150 mg/dL = 2 units Regular Insulin SC	
	151-200 mg/dL = 4 units Regular Insulin SC	
	201-250 mg/dl = 6 units Regular Insulin SC	
	251-300 mg/dL = 8 units Regular Insulin SC	
	301-350 mg/dL = 10 units regular Insulin SC	
	>350 mg/dL = call MD	
	☒ Target Glucose Range 70-180 mg/dL	
	<70 mg/dL = give 1 Amp D50 & call MD	
	70-180 mg/dL = no action	
	181-200 mg/dL = 2 units Regular Insulin SC	
	201-250 mg/dL = 4 units Regular Insulin SC	
	251-300 mg/dL = 6 units Regular Insulin SC	
	301-350 mg/dL = 8 units regular Insulin SC	
	351-400 mg/dL = 10 units Regular Insulin SC	
	>400 mg/dL = call MD	
	(☒) Fingersticks AC & HS	
	( ) Draw HbA1c	
	( )	
	( )	
	( )	

(b)(6)

PATIENT IDENTIFICATION (Typed or stamped name: last, first, middle initial; grade; DoB; SSN; unit or medical facility)

9 00 20001 8

Complete the following only to make changes on page 1 of provided orders. Do not use for new orders. Note any changes on subsequent pages.

Diagnosis:

Height: Weight (lbs): Diet:

Allergies:

Nursing Unit	Room No.	Bed No.	Page No.

ACLU DDI CID ROI 29881

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	OTSG APPROVED (Date)
PROVIDER ORDERS	

(b)(6)

DATE: 15 Feb 08 TIME: 2300

SERVICE: ( ) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: GSW Right Femur & Arm

CONDITION: ( ) STABLE ( ) CRITICAL ( ) GUARDED

Vital Signs: ( ) ICW Protocol ( ) ICU Protocol

Allergies: _____ ( ) NKDA

Activity: Up IC as tolerated

Weight Bearing Status: _____

Diet: ( ) NPO ( ) Regular ( ) Soft ( ) Clear Liquid ( ) Diabetic ( ) NPO after midnight for surgery DOS: _____

Dressing Change: ( ) POD # _____ ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 150 mmHg

Drains: ( ) NGT to LIWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record output q 8hrs

Labs: ( ) CBC ( ) CRP ( ) ESR ( ) Coags ( ) ABG ( ) CMP ( ) BMP ( ) Other _____
( ) NOW ( ) in AM ( ) q AM ( ) q AM x 3 days

X-Rays: _____

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs ( ) NS ( ) LR @ _____ ml/hr (X) D5 1/2 NS @ 150 ml/hr

( ) Other IV Fluid: _____

( ) Lovenox 40mg SQ daily ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before

( ) Zosyn 3.375 grams IV q 6 hours

( ) Unasyn 3 grams IV q 6 hours

( ) Ancef 1 gram IV q 8 hours

( ) Ancef 1 gram IV x 1 on chart for OR

( ) Vancomycin 1 gm IV q 12 hours

( ) Levofloxacin 500 mg daily ( ) PO ( ) IV

( ) Cefoxitin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 6 hours

( ) MS Contin _____ mg PO q 12 hours

( ) Zantac ( ) 150 mg PO BID ( ) 50 mg IV q 8 hours

( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID

( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other _____

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain

( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO

( ) Tylenol 650 mg ( ) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give it within 4 hrs of Percocet

( ) Motrin ( ) 400 mg ( ) 800 mg PO q 8 hours PRN for pain, fever, headache

( ) Benadryl ( ) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours ( ) q 8 hours PRN itch or insomnia

( ) Reglan 10 mg IV / PO q 6 hours PRN nausea

( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent

( ) D5 1/2 NS 1000 ml IV @ 150 ml/hr

( ) Tylenol 650 mg PO q 6 hrs

( ) Percocet 5/325 1-2 tabs PO q 4 hrs PRN pain

( ) Toradol 30 mg IV q 6 hrs PRN pain

( ) Flagyl 500 mg IV q 8 hrs

RECORDER (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (yyyymmdd)
115th Combat Support Hospital (b)(6)	DCCS	20080701

PATIENT'S IDENTIFICATION (For typed or written entries give: Name (Last, First, Middle), Grade, Date, Hospital or Medical Facility)

( ) SUBJECTIVE _____ (SN _____

( ) HISTORY / PHYSICAL ( ) FLOW CHART
( ) CONSULTATION (X) OTHER (specify)
( ) DIAGNOSES / PROBLEMS *Provider Orders*
( ) TREATMENT

LOCATION ( ) ICU ( ) ICW BED # _____ AGE

MEDCOM FORM 4700 FEB 2003

ACLU DDI CID ROI 29882

Name: [redacted]

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

Progress Notes

Report requested by: (b)(6)

[redacted] Register # (b)(6) CLINICAL NURSE

Neuro:Cognitive:

Left Pupil: See Note Size: 3 mm

Right Pupil: See Note Size: 3 mm

LOC: See Note

Motor: See Note

Speech: Clear

Memory: See note

Corneal reflex: See Note

GCS:

Eye Opening 1- None

Verbal 1- None

Motor 1- None

Total GCS 3

RASS Score: N/A

Respiratory:

Sounds: RUL: Clear Throughout Auscultation RLL: See Note

Sounds: LUL: Clear throughout auscultation LLL: See Note

Secretions: N/A Color: N/A

ETT: N/A Position: N/A

Trach: N/A Type: N/A

Oxygen: Non-Rebreather Rate: Tachypnea

CT: N/A Pleura VAC: N/A

CT: N/A Pleura VAC: N/A

Cardiac:

Rhythm: Sinus Tachycardia

Sounds: Audible S1/S2

Neck Veins flat at 45 degrees Yes

Capillary Refill < 2 sec

Left peripheral pulses +1 Edema: +1

Rt/L peripheral pulses +1 Edema: +1

Gastrointestinal:

Abdomen: Soft Non-Tender

Bowel Sounds: Diminished

Diet: NPO

BM: N/A Color:None

Colostomy: N/A

NG: Right To: Clamped

OG: N/A To: N/A

DHT: N/A

PEG: N/A

Genitourinary:

Void: Foley Catheter Size:14 Fr

Color: Yellow

Character: Sediment

Skin:

General Appearance: See Note

Color and Temperature: See Note

[redacted]

Reg # (b)(6)

[redacted]

Attempted collection of Urine

ACLU DDI CID ROI 29883

CMN: [illegible]

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

Visit requested by: (b)(6)

Temperature: Warm
Weight: WNL
Moisture: Clammy
Integrity: Intact

Central Lines:
Location: R FEM Type: TLC
Location: N/A Type: N/A
Access necessity daily with MD: N/A
Arterial Line: L Radial Access: See Note
IV Lines:
Site Left: N/A Site Right: Wrist Peripheral IV Line in Place Status:
Patient Hx S/S of Infection
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A
Signed: (b)(6)

Reg # (b)(6)

ACLU DDI CID ROI 29884

CAMP CROPPER

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

Progress Notes

Records requested by (b)(6)

24 Oct 2004@0751 :NPT Register # (b)(6) CLINICAL NURSE

PROG NOTES

Addendum to 0700 assessment.Notes:

Received pt @ 0700, diaphoretic, HR 155, RR 50-55, (b)(6) aware. Neuro:Pt with occ disconjugate gaze?roving and fixed @ 3cm. No spontaneous mvmnt noted, unable to elicit mvmnt with deep pain stim, corneal reflex present. Resp: MAS tachypneic BBS crackles to BLL clear BUL. CV: S NR 155 cardizem @ 11 increased to 15mg/hr, pale, clammy skin T 104. Lines/IVF: 0 NS @ 125ml/hr, cardizem @ 15mg/hr. NS fluid bolus given per Dr Samsey for decreased UOP of 0ml. GI: @ WNL clamped GU: Foley as noted above Integ: scattered ecchymosis t/o, back not yet visualized. 650mg Tylenol given for T of 104. PS: Son present @ bedside updated on plan of care with interpreter. Plan: 1-Cont to titrate cardizem to decrease BP 2-Cont to monitor UOP 3-Provide pain control/comfort care.

Signed: (b)(6)

(b)(6)

ACLU DDI CID ROI 29885

CLINICAL RECORD

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

Mo. [illegible] Yr. [illegible]

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	5	6	7	8	9	10	11	12	13	14	15	16	17	18
[illegible] 07	(b)(6)	Target Glucose Range 70-180 mg/dL	0600	(b)(6)													
		<70 mg/dL = give 1 Amp D50 IVP & call MD	FS														
		70-180 mg/dL = no action	Ins														
		181-200 mg/dL = 2 Units Regular Insulin SC	1100														
		201-250 mg/dL = 4 Units Regular Insulin SC	FS														
		251-300 mg/dL = 6 Units Regular Insulin SC	Ins														
		301-350 mg/dL = 8 Units Regular Insulin SC	1600														
		351-400 mg/dL = 10 Units Regular Insulin SC	FS														
		>400 mg/dL = call MD	Ins														
		Continue in ICU	2200														
			FS														
			Ins														

ALLERGIES ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS
CA of kidney c̄ mets to brain

ADDITIONAL PAGES IN USE ☑ YES ☐ NO
PAGE NO

PATIENT IDENTIFICATION
900 200018
200018
ICW, Bed 2

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

DA FORM 4678, 1 FEB 1979 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED PAGE 1 OF 2

Progress Note

Report requested by: (b)(6)

05 Oct 2008@1449 INPT Register #(b)(6) PHYSICIAN

ADMISSION NOTE

Attending Physician: (b)(6)
HN: 900 00 0018
Admission Date: 4 October 2008

Allergies: NKDA

HPI: This is a detainee from Compound V known to me with hx of metastatic presumed renal cell carcinoma (to brain). Patient was admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status. Patient was recently admitted 29 Sept and d/c on 1 Oct after patient improved with NS IVF and demonstrated no change in CT of head (same 4 predominant lesions overall unchanged since June 2008 initial diagnostic CT scan). Patient re-admitted overnight for increasing somnolence. At time of admission, patient was at about a GCS of 5-6. This am, he worsened after seizure x 2. He was brought to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 103, tachycardic to HR as high as 180. He was placed on 100% NRB as his pulse oximeter reading was low 90's. He also had a line and femoral central line placed. Family came to visit patient and discussed end of life issues and code status with son and wife.

PMHx: Renal cell carcinoma with brain metastasis, HTN, Type II DM, GERD

PSHx: None

SOCHx: No tobacco/ETOH

MEDS: Decadron 2 mg IV q6 hrs, Dilantin 300 mg qam/200 mg qpm, Tegretol 100 mg BID, Zantac 50 mg IV q8 hrs, Zosyn 4.5 grams IV q8 (D#1), Vancomycin 1 gram q12 hours, Tylenol 650 mg PO q4 6 hours prn

PE: BP 175/95 HR 139 RR 35 Temp 103.1 O2sat 97% on 100% NRB
Neuro/psych GCS 6, +Babinski, on no sedation, seizure x2 since admit, cont Dilantin/Tegretol; only responds to pain; cont monitoring

CV tachy S1/S2, EKG with ST segment depression in lateral leads, likely demand ischemia; cont BB and prn IV lopressor for rate control; will start drip for HTN and tachycardia if needed (diltiazem, or Nitroprusside; will look to hold off on BB in case of decreased inotropic affects but if not efficacious will consider Labetolol drip instead).

Pulm rhonchi bilaterally, patient DNI, will check CXR, cont antibiotics, pulm toilet

GI/Liver/nutrition LFT's normal, abdominal exam benign; hold off on feeding right now; will reassess tomorrow for possible dovity/enteral feeds

---

20/[illegible] DETAINEE,ISN200[illegible] FOREIGN NATIONAL POW/INTERNEE
03 Jan 1947 / Male H: not on file
Reg #: (b)(6) [illegible]: ICU 1 W: not on file
Spon: DETAINEE,ISN200[illegible] Rank:
Unit: KR:

Automated version SF509

ACLU DDI CID ROI 29887

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

Report requested by: (b)(6)

Renal/electrolytes Na 133 K 3.8 Cl 91 HCO3 25 B/C 7/0.2 Gra 238; Mg 2.1;
renal function normal; continue IV fluid resuscitation; already 2 liters in of NS; urine output excellent, 1400 ml since this am; cont to monitor

Hem/Onc WBC 11.7 Plts 324; metastatic cancer to brain; hold off on Lovenox; DVT with TEDS/SCD's; cont to monitor CBC daily

ID Tm 103.1 this am; started empiric Zosyn and Vancomycin; blood cx and urine cx done; will f/u on studies

Skin As per unit/nursing protocol

Prophylaxis SCD's, Zantac

Tubes/lines L radial A line placed; R femoral central line placed; 2 PIV, Foley, NGT

Disposition: Discussed with family and do not wish for patient to intubated or placed on mechanical ventilation. Discussed with them in presence of compound V provider, (b)(6) and MP commander, (b)(6) explained to family the difficulty of a DNI order in setting of this patient's condition. Son still did not want intubation or mechanical ventilation. Therefore, will continue with antibx, IV fluid support, BP control, and potentially DCCV and IV pressor support.

(b)(6)

Signed: (b)(6)

20/ ID: 00 A PI:AINEY, LENNOX012
Loc: ICU I
Spec: DETAINEE, ISN: 018
Unit:
Req #: (b)(6)
Automated version of SP509

POSITION: NATIONAL Pow/INTERNE
D: not [illegible]
W: not [illegible]
Rank:
PRI:

ACLU DDI CID ROI 29888

Camp Cherries

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

Progress Notes

Report requested by: (b)(6)

05 Oct 2006@1410 INMT Register # (b)(6) CLINICAL NURSE

PROG NOTES

Rapid Response Team Note. Patient is an elderly detainee with who was visiting family in the private PACT room when patient began to seize. (b)(6) responded immediately and (b)(6) was notified. Patient was transferred to ICU status and moved into bed 4. (b)(6) assisted upon transfer into the ICU. The following is the timeline of events that transpired during the event. 12:14: IV NS hung wide open. 100% O2 applied via NRB. 12:38: Versed 3.175mg started. INM Status verified by power of attorney, mechanical and chemical code authorized. 12:41: Right femoral central venous access attempted. 12:55: Right femoral TLC inserted successfully by (b)(6) Rainbow lab sent. 2nd liter of NS hung (1st liter was hung at the start of the transfer process). Respiratory culture attempted but was unsuccessful. 13:05: Left A line insertion attempted. Urimeter attached to foley. Blood cultures and Urine cultures being collected. 13:08: A line in place in left Radial artery. 13:28: ST depression noted. O2 sats 96-97%. 1331: NS maintenance @125 ml/hr. 12 lead EKG obtained. 1 blood culture X2 and urine sent. Blood obtained from "a" forearm and "L line. 5mg lopressor given. Ice packs applied to arm pits. 14:55: Resp. ry pattern change, belly breathing and agonal breathing noted at times with audible crackles.

Signed (b)(6)

Req # (b)(6)

ACLU DDI CID ROI 29889

MEDICAL RECORD - SUPPLEMENT

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

REPORT TITLE

ICW INITIAL ASSESSMENT

OTSG APPROVED (Date)

Date: 05 Jan 21 Time of Admission: 0830 Age: ___ (CIRCLE ALL THAT APPLY)

T: 97.3 P: 71 R: 20 B/P: 179/101 O2 Sat: 100% Height: ___ Weight: ___

1. NEUROLOGICAL A&O x 2

LOC: Alert & Oriented Person Place Time Facial symmetry (R) droop (L) droop GCS 1-15 15

Responds to: Verbal Tactile Painful Unresponsive Communicates needs:

Pupil size: (R) 3 mm (L) 3 mm Scleredema

Reaction to light: Brisk Sluggish Non-reactive

2mm 3mm 4mm 5mm 6mm 7mm 8mm

2. Cardiovascular

Tachycardia Bradycardia Arrhythmia: Ectopy on Monitor:

Heart Sounds: Normal S1-S2 Irregular Distant Abnormal S3 Murmur Gallop Click Rub Pacemaker: *(type)*

Pulses: 0 (absent) 1+ (thready) 2+ (weak) 3+ (normal) 4+ (bounding) JVD Carotid Bruits/Thrills

Edema: 0 *(none)* 1+ *(trace)* 2+ *(moderate)* 3+ *(deep)* 4+ *(w... deep)* Location: Bilateral hands, feet Pitting / Non Pitting

Cap Refill < 3 sec R Upper < 3 R Lower < 3 L Upper < 3 L Lower < 3

Mucous membranes: Pink Pale Cyanotic

3. PULMONARY

Symmetrical Movement Regular Rate/Depth Accessory muscle use 02: Liters____ via NC____ Mask____ NRB____

Shortness of breath Orthopnea Dyspnea Night Sweats Tracheotomy: Size____ Type____ Trach Mask____

Cough: None Non-productive Sputum: Clear White Yellow Green Hemoptysis PE confirmed

Lungs: CTA Bilaterally Wheezes Rhonchi Rales Location: RUL RML RLL LUL LLL

4. G.I.

Abdomen: Flat Round Distended Soft Firm Rigid Non-tender Tender Painful Guarding Present (b)(6)

Bowel Sounds Absent Hypoactive Normoactive Hyperactive Location: *(quadrants)* *RUQ* *RLQ* *LUQ* *LLQ*

Flatus Heartburn Hemorrhoids Rectal Bleeding LBM Unknown Colostomy: Location ____ Appearance: ____

Stool (describe): ____ G-Tube NGT OG Suction ____ Placement (b)(6) Verified via Air Bolus Residuals 0

Oral mucosa: Moist No Lesions Lesions Leukoplakia Appetite: Normal Decreased Diet: Regular Clears NPO Special ____

Swallow and Gag Intact Absent Nausea Emesis (describe): ____ Tube Feeding: Type ____ Rate ____

5. G.U.

Voids Urinal BR Incontinent Foley: Size ____ Suprapubic Dysuria Retention Urgency Frequency Nocturia

Urine: Clear Concentrated Cloudy Yellow Amber Tea Colored Blood Tinged Sediment

Vaginal/Penile Lesions: Urethoral Discharge: Breast/Testicular Lumps

6. MUSCULOSKELETAL

Normal muscle development and mass for age No deformities

Amputations: BKA AKA Finger Toe: ____ Arm Right Left Weakness: generalized Paralysis:

Ambulatory Gait Steady Unable Assistive Devices:

Joints: Stiffness Swelling Tender Painful with ROM Hx of DVT

Muscle Strength: R Upper 0 R Lower 0 L Upper 0 L Lower 0

0 *(no movement)* 2+ *(moves but NOT against gravity)* 4+ *(moves against resistance)*

1+ *(trace movement)* 3+ *(moves against gravity)* 5+ *(normal strength)*

Does not move on own.

7. INTEGUMENTARY

Color: Pink Pale Flushed Cyanotic Jaundiced Mottled IV: Size 20g Location (L) FA (5)

Dry Moist Diaphoretic Warm Cool Turgor: Good Fair Poor Dressing: Location ____ Type ____

Redness: Location: ____ Rash: Location ____ Abrasions: Location: ____ Burns: Location: ____

Lacerations: Location: ____ Inflammation: Location: ____ Decubitis: Location: ____ Ulcers: Location: ____

Bruises: Location: ____

PREPARED BY (Signature and Title)
31st Combat Support Hospital

DATE (yyyymmdd)
[redacted]

PATIENT IDENTIFICATION (For typed or written entries, include Name, ...)

PSEUDO SSN: 9L2000J8 SSN: 2000J8

LOCATION ( ) ICU (✓) ICW BED # 2 AGE

ORDER EXAMINATION
( ) LABORATORY STUDIES
( ) MEDICATION

FLOW SHEET
(X) OTHER (specify)
ICW Initial Assessment

MEDCOM FORM 4700 FEB 2003 PAGE 1 OF 2

ACLU DDI CID ROI 29890

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: ICW INITIAL ASSESSMENT Continuation

OTSG APPROVED (Date)

DATE 07OCT2008

8. PSYCHOSOCIAL

Behavior is appropriate to situation Non-responsive x to Pain Stimuli Anxious Uncooperative Belligerent

9. PAIN

Location: N/A Scale of 1-10 (Worst Ever): N/A Description: N/A

What makes it better? What makes it worse?

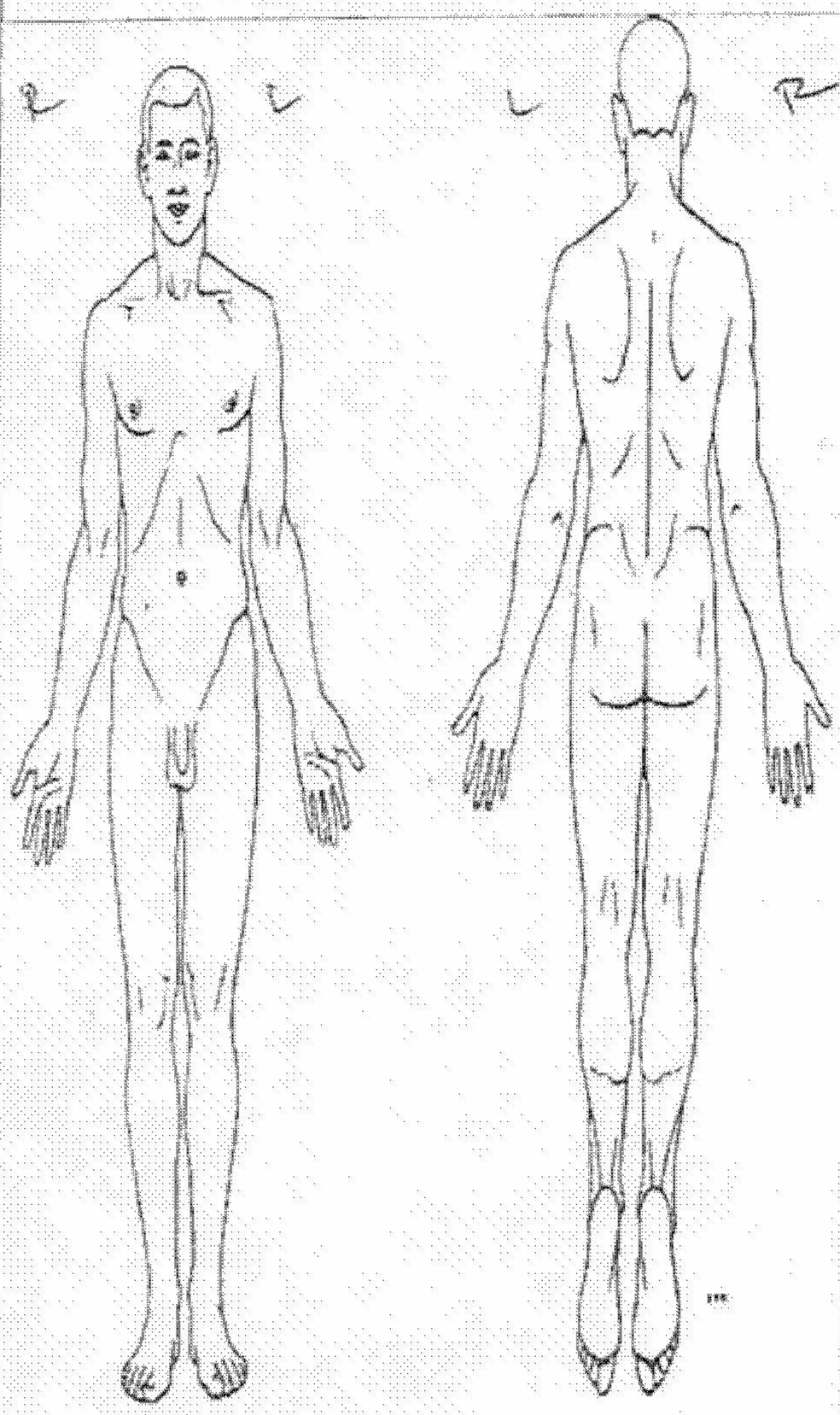


DIAGRAM A

Figure 2-10

0300 See CHCS progress note

(b)(6)

PREPARED BY (Signature & Title)
31st Combat Support Hospital

DEPARTMENT/ SERVICE/ CLINIC
DCCS

DATE (yyyymmdd)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT
( ) FLOW CHART
(X) OTHER (specify)
ICW Initial Assessment

ACLU DDI CID ROI 29891

ACLU-RDI 5593 p.98

000098

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

REPORT TITLE	ICW REASSESSMENT		
Date: 15 Oct 2016	Time: 0745 Initials (b)(6)	Time:	Initials:
1. NEUROLOGICAL: Alert and oriented to person, place, time, and situation. Responds appropriately. PEARL. Communicates adequately to express needs.	Pt is awake at this time responds to simple commands.		
2. CARDIOVASCULAR: Pulse RRR and WNL for age, no dependant edema; nailbeds pink, cap refill < 3 sec; No calf tenderness or chest discomfort.	Pt heart sounds as above. Pt is asymptomatic.		
3. PULMONARY: Respirations within normal rate for age group, quiet and regular. Depth is regular, no cough, lungs CTA bilateral with symmetrical chest movement.	Pt lungs are sounds on clear, pt does occasionally intermittently when breathing deep.		
4. G.I.: Abdomen soft NT/ ND, +BS x4 quads, no N/V/D, constipation or rectal bleeding. No change in appetite or difficulty chewing or swallowing.	Pt has not taken meds that is ordered. Bowel sounds heard x4. Pt denies nausea, vomiting or rectal bleeding. Oral mucosa moist.		
5. G.U. / REPRODUCTIVE: No S/S of dysuria, retention, urgency, frequency or nocturia. Urine clear yellow / amber. No unusual vaginal / penile / breast discharge.	Pt has fully voiding to bathroom, denies any urinary issues. Urine yellow amber.		
6. MUSCULOSKELETAL: Normal muscle development and mass for age, no deformities, no assistive devices needed. Normal ROM without pain, no joint swelling, tenderness, weakness or paresthesia.	Unable to assess. Pt in bed.		
7. SKIN: Warm, dry, intact, turgor good, no rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences, mucous membranes moist and intact.	Pt has refused to shower as pt has trouble getting up due to the fact it has IVs and heel protectors in place.		
8. PYSCHOSOCIAL: Behavior is appropriate to the situation, anxiety is controlled or mild and appropriate. Interacts appropriately with others.	Pt is unresponsive. Unable to assess.		
9. PAIN: 0-10, location, description, to include what makes it better and what makes it worse. If medication required, document intervention and reassessment.	Unable to assess. Pt only responds to painful stimuli.		

PREPARED BY (Signature & Title)	DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
[illegible] Combat Support Hospital	DCCS	

PATIENT IDENTIFICATION (Typed or written name, grade, unit, Name (Last, First, Middle), Grade, Unit, Home Unit or Medical Facility)

SECTION [illegible] ISN 20101[illegible]

( ) HISTORY / PHYSICAL ( ) FLOW CHART
( ) OTHER EXAMINATION (X) OTHER (specify)
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

[illegible] WEIGHT 2 AGE

DD FORM 4700, JUN 2003 Page 1 of 2 ... CHCO OP 08.06 (2nd Jan 08)

ACLU DDI CID ROI 29892

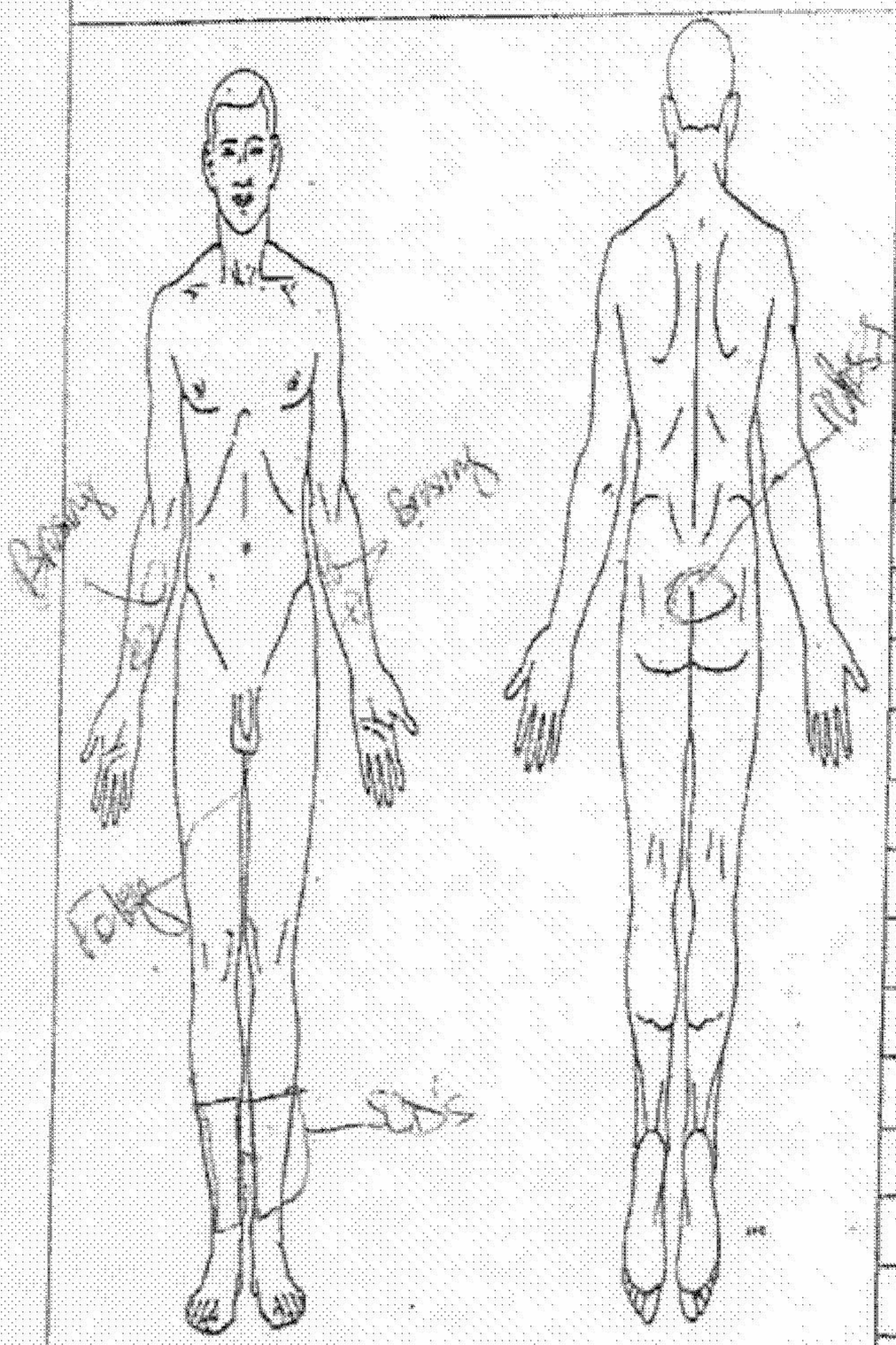
MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: ICW REASSESSMENT Continuation

DATE: 12 Oct 12

Time: 2145	Initials: (b)(6)	Time:	Initials:
IV Insertion Date:		IV Insertion Date:	
Catheter Size:	18g / 22g	Catheter Size:	
Location:	R hand / LFA	Location:	
S/S of Infection/ Infiltration:	none / none	S/S of Infection/ Infiltration:	
Due To Change:	20 Oct 12 / 9 Dec 12	Due To Change:	
Fluid / Rate:	NS @ 75cc/hr	Fluid / Rate:	See LDA's



(b)(6)

DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
DCCS	

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT
( ) FLOW CHART
(X) OTHER (specify)
ICW Reassessment

ACLU DDI CID ROI 29893

LSOAT ICE 0400 Admin progress note in chart, not printed off printer d/t printer difficulty (system-wide) Pt had tonic clonic seizure, ED MD came to bedside and Valium 5mg IV administered. Seizure lasted approximately 2 minutes. VS taken, BP 202/119, now down to 159/100. MD said this is expected for patient. Informed MD that pharmacy did not return page, stated it is okay to give Meds once pharmacy arrives at 0800. FS 200, 2u Reg. insulin administered. No other issues

SOAP ICE 1210 Transfer Note: Pt was allowed to have visitation with his family in the PACU. Pt HR was between 140-150. Pt was on 6L NC @ 50% via a venti mask. During the visit Pt had a low grade temp and blood pressure was 157/108. While family was visiting Pt began to have a seizure. Pt was placed on a NRB @ 1545. Pt O2 sats were 75%. Pt was suctioned & O2 sats went to 92%. MD was immediately notified. Pt was moved from PACU area to ICU floor for further care by ICU nurses. Pt did not receive the scheduled PCA Dilaudid because of active seizure activity and desating. This

(b)(6)

(b)(6)

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

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

PATIENT IDENTIFICATION: If typed or written entries, give: Name - last, first, middle; Hospital No.; Sex; Date of Birth; Ward or Unit | REGISTER NO. | WARD NO.

WITNESS NOTED
Medical Record

STANDARD FORM 509 (REV. 2/1
PRESCRIBED BY GSA/ISOO (32 CFR) 103-11 2E91

90% c.i.f
3 c.c.i.f
100% f.i.f.?

ACLU DDI CID ROI 29894

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

is ordered to the nurses assigned the patient

(b)(6)

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)

ACLU DDI CID ROI 29895

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

Report requested by: (b)(6)

---

05 Oct 2008@0453 INPT Register # (b)(6) OPERATING ROOM
PROG NOTES
Nursing: Received report and pt from ED around 0300. Pt arrived to ward with GCS of 6. Does not open eyes, does not verbalize. Responds to pain stimuli only, flexing and withdrawing. Hx of seizures, bed rails padded for seizure precautions. Pharmacy paged so pt may receive seizure medications, awaiting response to page. BP 170/106, will give Toprol XL when medications arrive as well. NGT to R nare, placement verified c Xray in ED and stethescope on ward. Lungs c coarse breath sounds to bilateral upper lobes. Pt incontinent of urine, foley catheter placed in ED. Incontinent brief placed for BMs as well. Reddened sacrum noted, turned to side and will turn q2hrs. Head elevated d/t aspiration risk. Heel protectors and SCD pump applied. D51/2NS @ 50cc/hr started. Pt diabetic, FS ordered with insulin sliding scale. Compound 5 guard at bedside. No other issues.
Signed: (b)(6)

20/900-20-0018 DETAINEE,ISN200018 FOREIGN NATIONAL - POW/INTERNE
03 Jan 1967 / Male H: not on file
Reg #: (b)(6) Loc: ICW 1 W: not on file
Spon: DETAINEE,ISN200018 Rank:
Unit: RR:
Attending Physician at Sick

ACLU DDI CID ROI 29896

BAND CHECKLIST

9002cc018

Date:

	Yes	No
IDENTIFICATION BANDS		
Is the band present and properly attached around ankle or wrist?	✓	
DETAINEES		
Is the ISN:		
Present	✓	
Correct	✓	
Legible	✓	
Is the PISN:		
Present	✓	
Correct	✓	
Legible	✓	
US SOLDIER /CONTRACTOR/ COALITION		
Is the date of birth:		
Present		
Correct		
Legible		
Is the name:		
Present		
Correct		
Legible		
IRAQI CIVILIAN		
Is the hospital number:		
Present		
Correct		
Legible		
Is the name:		
Present		
Correct		
Legible		

N/A

N/A

Comments:

ACLU DDI CID ROI 29897

Date	Time	Temp	Pulse	Resp	B/P	O2 Sat	URINE	Drain #1	Drain #2	Dr...
05OCT08	0300	97.8	71	20	170/104	100%	Foley	100 cc/hr		
05 OCT	0600	100.1	98	22	180/102	98%	1600			
05OCT	1400									

PREPARED BY (Signature & Title)
Intermediate Care Ward

DEPARTMENT/SERVICE/CLINIC
Department of Nursing

DATE (YYYYMMDD)
20080129

PATIENT IDENTIFICATION

PSEUDO ISN: 0[illegible]200018

[illegible]

(b)(6)

[illegible]

HISTORY/PHYSICAL

OTHER EXAMINATION OR EVALUATION

DIAGNOSTIC STUDIES

TREATMENT

FLOWCHART

OTHER

SITE SH OF 08-02 (28 Jan 08)

DA FORM 4700, FEB 2003

ACLU DDI CID ROI 29898

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Month Yr 2[illegible]

VERIFY & INITIAL ENTRY

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13	14	15	16	17	18
05OCT06	(b)(6)	D5 1/2NS @ 50 ml/hr	D	(b)(6)													
			N														
05OCT06		Dilantin 300mg q am per NGT	10	(b)(6)													
			1														
05OCT06		Dilantin 200mg qhs per NGT	22														
			1														
05OCT06		Tegretol XL 50mg q am per NGT	10	(b)(6)													
			1														
05OCT06		Decadron 2mg BID per NGT	06	(b)(6)													
			12														
			18														
			24														
05OCT06		Tegretol 100mg TID per NGT	06	(b)(6)													
			14														
			22														

ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS

Acute Kidney Failure

ADDITIONAL PAGES IN USE ☑ YES ☐ NO

1 2 NO

DISPENSING TIMES

USE PENCIL CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF [illegible] IS OBSOLETE DA Form 4

ACLU DDI CID ROI 29899

THERAPEUTIC DOCUMENTATION CARE PLA...
(MEDICATIONS)

Verify by Initialing

Mo. ______ Yr. ______

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
05 [illegible] 06 12 Oct 06	(b)(6)	Valium 5mg IV x 5min PRN Seizures	(b)(6)

DA FORM 4678, 1 FEB 79

USAPA V1.01
PAGE 2 OF 2

ACLU DDI CID ROI 29900

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
5/13/13	(b)(6)	DIET KHODJOR (Reverse Schedule for Ramadan)	0	(b)(6)
			2	
			4	
5/13/13	(b)(6)	Vital Signs Q Shift	06	(b)(6)
			14	
			22	
5/13/13	(b)(6)	Activity	D	(b)(6)
			N	
5/13/13	(b)(6)	FS AC+HS	06	(b)(6)
			11	
			16	
			22	

ALLERGIES: ☐ YES ☒ NO

NKA

PRIMARY DIAGNOSIS:

Cellulitis of buttock

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION

(b)(6)

Tiw Tuc 2

ADMINISTRATION TIMES

UCR CODE | ADMINISTRATION TIMES

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

DA FORM 4677, 1 OCT 1978 EDITION OF 1 DEC 77 MAY BE USED. APD PE v1.00

ACLU DDI CID ROI 29901

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr ~~2007~~ 2004

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5 Oct 07	(b)(6)	ADMIT TO ICW DR Phillips DR Williams DR Abel CONDITION ~~STABLE~~ Guarded				
5 Oct 07		ADMITTING DIAGNOSIS: r/o kidney & liver failure DX:				
		LABS:				

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

ACLU DDI CID ROI 29902

CAMP CROPPER 06 Oct 2008e0547 Page 1

Personal Data Privacy Act of 1974 (PL 93 579)

PATIENT LAB INQUIRY

For: 05 Oct 08 06 Oct 08

Report requested by: (b)(6)

DETAINEE,ISN200018 20/900 20 0018 M/4 Req #: (b)(6)

Ph:

Military Unit: UNKNOWN

06 Oct 08 @ 0517 (Coll) BLOOD

STAT WBC	14.2	H	(4.8 10.8)	x10 3/ul
RBC CNT	5.49		(4.20 6.10)	x10 6/ul
HGB	15.8		(12.0 16.0)	g/dL
HCT	47.1		(42 52)	%
MCV	86.0		(80.0 94.0)	fl
MCH	28.7		(27.0 31.0)	pg
MCHC	33.4		(33.0 37.0)	g/dL
PLATELETS	215		(130 400)	x 10(3)/uL
LYMPH%	17	L	(20.0 44.0)	%
LYMPH#	2.5		(0.7 4.3)	x10 3/ul

06 Oct 08 @ 0517 (Coll) ARTERIAL BLO

STAT PH BO	7.55	H	(7.35 7.45)	

Result Comment: pco2 critical

PCO2	16	L*	(35.0 45.0)	mmHg
PO2	56	L	(80 100)	mmHg
HCO3 POCT	14	L	(22 26)	mmol/L

Interpretations:

PERFORMED ON ISTAT ANALYZER

BASE EXCESS	-8	L		mmol/L
O2 SAT %	93	L	(95 98)	%
TCO2	15	L	(18 33)	mmol/L

Interpretations:

PERFORMED ON THE I STAT

IONIZED CA	1.15	L	(1.12 1.32)	mmol/L

Interpretation:

PERFORMED ON I STAT

06 Oct 08 @ 0517 (Coll) SERUM

STAT NA	158	H	(128 145)	mmol/L

Interpretations:

PERFORMED ON PICCOLO ANALYZER

K	3.6		(3.3 4.7)	mmol/L
CO2	21		(18 33)	mmol/L
CL	116	H*	(98 108)	mmol/L
GLUCOSE	244	H	(73 118)	mg/dl

Interpretations:

PERFORMED ON PICCOLO CHEMISTRY ANALYZER

CA	8.7		(8.8 10.3)	mg/dL
BUN	13		(7 22)	mg/dL
CREAT	1.3	H	(0.6 1.2)	mg/dL
ALK PHOS	55		(26 137)	U/L

Interpretations:

PERFORMED ON PICCOLO CHEMISTRY ANALYZER

==

Indicate if: A (Addition) R Result S Susp. Pt Ref Susp. F Performed

I Incorrect C Corrected Comments: (C) Corr, (I)Interpretations, (D)Comm

==

ACLU DDI CID ROI 29903

Personal Data Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
Per: 05 Oct 08 - 06 Oct 08

Report requested by: (b)(6)

DETAINEE, ISN200018 20/900 20 0018 M/4I Reg #: (b)(6)
Ph: Military Unit: UNKNOWN

06 Oct 08 @ 0547 (Cell)

				SERUM
ALT	14		(10 45)	U/L
AST	25		(15 50)	U/L
TBILI	0.9		(0.2 1.6)	mg/dl
ALBUMIN	3.3	L	(3.3 5.5)	g/dl
PROTEIN TOTAL	7.4		(6.4 8.1)	g/dl

Result Comment: critical chloride

ACLU DDI CID ROI 29904

PATIENT:

DATE: 8 Oct 03

TIME	23	24	01	02		04	05	06
NIBP/ ABP (MAP)	104/72	102/73	108/77	112/80	110/80	128/86	107/77	93/59
Pulse	131	131	129	130	129	126	142	153
Respirations	40	41	39	39	40	40	40	48
Temperature	97.4	97.4		98.2	98.3	98.7	98.7	98.9
SaO2	93	91	96	96	96	95	94	92
%O2	15L	15L	15L	15L	15L	15L	15L	15L
O2 Delivery	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale	2/10	2/10	0/10	0/10	0/10	0/10	0/10	0/10
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Yesterday	Today
INPUT	3692	
OUTPUT	2207	
DIFFERENCE	1485	

Overall Fluid Status: +/-
(Running Total Fluid balance)

+1485

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV	125	125	125	125	125	125	125	125		
IVPB		50		250				100		
	15	15	13	13	13	13	13	13		
		500								
PO/ TF										
Other										
TOTAL										3692

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	40	20	40	45	15	5	35	7		2207
NG output										
Emesis										
Stool										
Chest tube #1 / #2										
Jackson Pra... #1 / #2										

Legend	
Init=initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2=Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	S= Supine
N=None	ABP= Arterial Blood Pressure
+2= strong +1=weak	PS=Pharmacologically Sedated

Name	Signature	Init.
(b)(6)		

ACLU DDI CID ROI 29905

Glasgo

Eyes Open:		
4 - Spontaneously		
3 – To speech		
2 - To pain	4 – Moves against resistance	
1 – None	3 – Moves against gravity	
Verbal Response:	2 – Moves not against gravity	
5 – Oriented	1 – No movement	
4 - Confused		
3 – Inappropriate Words		
2 – Incomprehensible Sounds		
1 – None (Note – "T" = tube)		
Motor Response:	**Pupil Scale**	
6 – Obey Commands		
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm	
4 – Withdraws to Pain		
3 – Flexion to pain		
2 – Extension to pain		
1 - None		

RESTRAINTS:

0700 site	pulse	cap. ref.	edema	**1900**	Site	pulse	cap. ref.	edema
0900 site	pulse	cap. ref.	edema	**2100**	Site	pulse	cap. ref.	edema
1100 site	pulse	cap. ref.	edema	**2300**	Site	pulse	cap. ref.	edema
1300 site	pulse	cap. ref.	edema	**0100**	Site	pulse	cap. ref.	edema
1500 site	pulse	cap. ref.	edema	**0300**	Site	pulse	cap. ref.	edema
1700 site	pulse	cap. ref.	edema	**0500**	Site	pulse	cap.ref	edema

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS

PREPARED BY: (signature & Title) | DEPARTMENT/SERVICE/CLINIC (b)(6) | DATE 5 Oct 05

900-20-0018

- ☐ HISTORY/PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☐ FLOWCHART
- ☐ OTHER

ACLU DDI CID ROI 29906

DATE:		DIAGNOSIS:									HOSPITAL DAY:								
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22			
NIBP/ ABP (MAP)									176/82	154/80	122/85	114/	122/81	122/81	126/87				
Pulse									121	93				105	102	152			
Respirations									26	18				42	42	42			
Temperature									102	98.4	101			99.1	98.2	100.4			
SaO2									96	94				91	92	92			
%O2									28	28				RA	RA	RA			
O2 Delivery									RA	RA									
Mode																			
Rate																			
Tidal Vol.																			
Peep																			
PS																			
Pain Scale									0/10	0/10	0/10	0/10	0/10	0/10	0/10	0/10			
Pain Med																			
Pt Position																			
CVP																			

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV										125	125	125	125	125	125	125	125	
IVPB										350	50	50	50				100	
Bolus								200										
Dilt										5	7	12	15	15	15	15	15	
PO/ TF																		
Other																		
TOTAL																		

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total										150	200	200	175	150	80	100	40	
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		

BATH/MEALS		
Bath/Skin Care		
Oral Care		
Foley Care		

SAFETY	D	E	N
Cardiac Monitor	Y N	Y N	Y N
Bed position/Locked	Y N	Y N	Y N
Call bell in reach	Y N	Y N	Y N
Protective Device	Y N	Y N	Y N
High risk for falls	Y N	Y N	Y N

ACLU DDI CID ROI 29907

CAMP CROPPER

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

Report requested by (b)(6)

28 Oct 2006@1630 (MST Register # (b)(6) CLINICAL NURSE
PROG NOTES:
At approx 1330 summoned to bedside pt w/acute respirations HR decreased to 40's from 130's pt noted with LOC's w/o oral airway. (b)(6) present @ bedside. Pt went to PEA x 1min, one code record for code summary #0320 achieved, pt subsequently went back into PEA. Pt was @ bedside during resuscitation and frequently updated by (b)(6) with interpreter. Decision made by MAJ to cease resuscitation. Time of death called @ 1204 by (b)(6) Additional family arrived and were given time with pt and updated by (b)(6) (b)(6) and command's officials. TOD present for evaluation. Right toe tag placed. Pt placed in bag with ID tag on outside. SA notified. Death packet reviewed by PA.
Signed: (b)(6)

DETAINEE, [illegible]
03 Jan 1961 / Male
Loc:
Spec: DETAINEE,1ND000[illegible]
Unit:
Automated version of CPS09

ACLU DDI CID ROI 29908

CAMC Network

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

Report requested by: (b)(6)

06 Oct 2008@1123 [MST] Register # (b)(6) PHYSICIAN
DISCHARGE NOTE

DEATH NOTE DEATH NOTE

Attending Physician: (b)(6)
MR# 900 66 0814

Admission Date: 04 OCT 2008 Date/Time of Death: 06 OCT 2008, 1204hrs

ICU Operations/Procedures: Right femoral vein triple lumen catheter, left radial arterial line, ACLS

Enter Principal Diagnosis: Renal cell carcinoma

Enter Secondary Diagnosis: Brain metastases secondary to renal cell carcinoma

Enter Principal Procedures/Operations: Right femoral vein triple lumen catheter, left radial arterial line, ACLS

Discharge Summary: This is a 51yo male detainee from Compound V with history of presumed primary renal cell carcinoma with metastatic disease involving the brain. The detainee was recently admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status but improved with fluid resuscitation and demonstrated no significant changes on CT of the head. He was subsequently re-admitted on 04 OCT 2008 for increasing somnolence. At time of admission, he had a GCS score of 5-6 and was admitted to the ICW. On the morning after admission, though, his condition worsened after having two additional seizures. He was subsequently transferred to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 103, tachycardic with a heart rate as high as 180 and low oxygen saturations necessitating placement on 100% NRB face mask oxygen. He also had a line and femoral central line placed. Broad spectrum antibiotic coverage with piperacillin/tazobactam and vancomycin was initiated. His family came to visit and end of life issues and code status were discussed with the ICU physician.

His condition continued to deteriorate throughout the course of his second day. The decision was made by family members that the detainee would not be intubated but would receive ACLS (Advanced Cardiac Life Support to include chest compressions, direct current cardioversion electric shocks if indicated and cardiac support medications). By his second night in the hospital, he was no longer producing urine and required additional intravenous fluid support. He also was started on a continuous infusion of diltiazem to control his heart rate which had climbed as high as the 160's range. His mental status remained extremely poor and he was unresponsive to painful or verbal stimuli. By the morning of the third hospital day, he was noted to have a dysconjugate gaze (his eyes were pointing in different directions from one another). He had developed pronounced Kussmaul breathing (deep and fast respirations) which continued through much of the morning. His tachycardia had improved somewhat with the use of the diltiazem infusion.

I spoke with detainee's son on multiple occasions regarding the status of his father and allowed him to remain present in the ICU. I gave my opinion that I believed advanced life support would be futile, particularly if

20/900 20 0814 DETAINEE,ISN#00814
01 Jan 1957 / Male
Loc:
Spec: DETAINEE,ISN#00814
Unit:
Automated version of SF509

ACLU DDI CID ROI 29909

Report requested by (b)(6)

mechanical ventilation was not an option. The son remained steadfast in his desire for us to do everything "but put him on a breathing machine".

Thirty minutes after my conversation with the son, the detainee's heart rate and respiratory rate dropped precipitously. Soon after he developed PEA pulseless electrical activity and CPR was initiated. An oral airway was placed and the detainee was ventilated using an Ambu bag. He was noted to have ZERO spontaneous ventilations during the code process. We were able to regain a pulse after 10 minutes of CPR with epinephrine, atropine and levophed medications to stimulate the heart and elevate the blood pressure and CPR was stopped. I explained to the son that his father's clinical situation had worsened significantly and that his death was imminent. I also explained that his father would continue to develop PEA because of his inability to breathe on his own. I also explained that I suspected the cause of impending death to be the herniation of his father's brain stem because of high intracranial pressure because of the brain swelling from the anticoagulants and the blockage of the flow of cerebral spinal fluid out of the brain. The son expressed understanding but asked that we continue with our treatment. Ten minutes later his father went into PEA again. The ICU team again initiated CPR and provided cardiac medications with a return of the pulse, albeit weaker and slower than on the initial resuscitation. I again asked the son if he wished for us to continue. At this time, he expressed his desire for the team to stop resuscitation. I ordered cessation of CPR and bag mask ventilation. His cardiac rhythm quickly degenerated into PEA and he expired shortly thereafter. The detainee's son was present at bedside at the time of death.

(b)(6)

Signed (b)(6)

20/SEP 20 0918 DETAINEE,ID#200018
01 Jan 1957 / Male
Loc:
Spec: DETAINEE,ID#200018
Unit:
Automated version of SF509

ACLU DDI CID ROI 29910

CASE CHRONOLOGY

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

Progress Notes

Report requested by: (b)(6)

06 Oct 2018@0751 (MST) Register #: (b)(6) CLINICAL NURSE

PROGRESS NOTES

Addendum to Triage Assessment Note:

Received pt @ 0700. Diaphoretic, GR 155, RR 50 SR (b)(6) aware. Neuro PE with occ disconjugate gaze/moving and fixed @ 1cm. No spontaneous vomit noted. Unable to elicit vomit with deep pain stim, corneal reflex present. Resp: Non tachypneic RRS cracklies to BL clear AOL. CV: S NR 155 cardizem @ 11 increased to 15mg/hr, pale, clammy skin T 104. Lined/IVF: 0 NS @ 125ml/hr. Cardizem @ 15mg/hr. NS fluid bolus given per (b)(6) for decreased UOP of 6ml. At 0 MST Crumpet MD policy as noted above Temp: scattered ecchymosis L/S. Back not yet visualized. Shows Tylenol given for T of 104. PE: Sat

Signed: (b)(6)

20/NOV/18 0818 DETAINEE,ISN#000018

01 Jan 1967 / Male

Loc:

Spec: DETAINEE,ISN#000018

Unit:

Automated version of SF509

ACLU DDI CID ROI 29911

Camp Cropper

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

Progress Note

Report requested by: (b)(6)

05 Oct 2006@1745 INPT Register #: (b)(6) CLINICAL NURSE

PROG NOTES:

Neurological:

Left Pupil: See Note Size: 3 mm

Right Pupil: See Note Size: 3 mm

LOC: See Note

Motor: See Note

Speech: Clear

Memory: See note

Gag reflex: See Note

EOM:

Eye Opening: 1 None

Verbal: 1 None

Motor: 1 None

Total GCS: 3

PERRLA Screen: N/A

Respiratory:

Sounds: R&L Clear Throughout Auscultation R&L: See Note

Sounds: L&L Clear throughout auscultation L&L: See Note

Secretions: N/A Color: N/A

ETT: N/A Position: N/A

Trach: N/A Type: N/A

Oxygen: Non-Rebreather Rate: Tachypnea

CT: N/A Pleura VAC: N/A

CT: N/A Pleura VAC: N/A

Cardiac:

Rhythm: Sinus Tachycardia

Sounds: Audible S1/S2

Neck Veins flat at 45 degrees Yes

Capillary refill < 2 sec

Rt peripheral pulses +1 Rt. Edema: +1

Lt peripheral pulses +1 Lt. Edema: +1

Gastrointestinal:

Abdomen: Soft Non Tender

Bowel Sounds: Diminished

Diet: NPO

BM: N/A Color: None

Colostomy: N/A

Rt: Right Tx: Clamped

Lt: N/A Tx: N/A

Ileo: N/A

Jej: N/A

Genitourinary:

Void: Foley Catheter Size: 16 Fr

Color: Yellow

Character: Sediment

Skin:

General Appearance: See Note

Color and Pigmentation: Pale

Temperature: Warm

Turgor: Wha

Moisture: Clammy

2c/90c 2c Acip DETAINEE,ISN#800018

03 Jan 19?? / Male

Loc:

Spec: DETAINEE,ISN#800018

Unit:

Automated version of AF500

ACLU DDI CID ROI 29912

CAMP CROPPER

Personal Data - Privacy Act of 1974 (P.L. 93-579)
Progress Note

Report requested by: (b)(6)

Integrity: Intact

Central lines:
Location: R FEM Type: TLC
Location: N/A Type: N/A
Assess necessity daily with MD: N/A
Arterial Line: L Radial. Assess: See Note
IV Lines:
Site Left: N/A Site Right: Wrist peripheral IV Line In Place Status:
Patient NO S/S of Infection
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A
Comment: (b)(6)

20/900 ab 0018 DETAINEE, IRNZ00018
01 Jan 1967 / Male
Loc:
Spon: DETAINEE, IRNZ00018
Unit:
Automated version of SF509

ACLU DDI CID ROI 29913

XXX Checklist

Personal Data - Privacy Act of 1974 (P.L. 93-579)

Progress Note

Report requested by (b)(6)

26 Oct 2008@1311 INPT Register # (b)(6) CLINICAL NURSE

PROG NOTES:

Neurological:

Left Pupil: WNL Size: 3 mm

Right Pupil: WNL Size: 3 mm

LOC: Oriented

Motor: No movement

Speech: See Note

Memory: LTA: Unassessed

Gag reflex: WNL

PERRLA:

Eye Opening: 1: None

Verbal: 1: None

Motor: 1: None

Total GCS: 3

MASS Score: N/A

Respiratory

Sounds: RUL: WNL no adv sounds RLL: WNL no adv sounds

Sounds: LUL: WNL no adv sounds LLL: WNL no adv sounds

Secretions: N/A Color: N/A

ETT: N/A Position: N/A

Trach: N/A Type: N/A

Oxygen: Non rebreather Rate: Tachypnea

CT: N/A Pleura VAC: N/A

CT: N/A Pleura VAC: N/A

Cardiac:

Rhythm: Sinus Tachycardia

Sounds: Audible S1/S2

Neck Veins Flat at 45 degrees Yes

Capillary Refill: < 3 sec

LUE peripheral pulses +2 WNL Edema: None

RUE peripheral pulses +2 WNL Edema: None

Gastrointestinal:

Abdomen: Soft Non Tender

Bowel Sounds: Positive

Diet: NPO

NG: N/A Color: None

Colostomy: N/A

RLL: Right Pt: Clamped

GU: N/A Dx: N/A

Diet: N/A

Foley: N/A

Genitourinary:

Voids: Yes Catheter Specific Pt

Color: Yellow

Characteristics: Clear

Skin:

General Appearance: WNL

Color and Pigmentation: NPO

Temperature: Warm

Turgor: WNL

Moisture: WNL

26/Oct/08 20:01:18 DETAINEE,ISN#00018

CC scan (PRC / Male

ACC

Spon: DETAINEE,ISN#00018

Unit:

Autocoded version of SP509

ACLU DDI CID ROI 29914

ACLU-RDI 5593 p.121

000121

CAMP CROWDER

Personal Data - Privacy Act of 1974 (P.L. 93-579)
Progress Note

Report requested by: (b)(6)

Integrity: Intact

Drain 1: N/A Drain 2: N/A
Drain 3: N/A Drain 4: N/A
Baked Pack: N/A

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Wound 3:
Location: N/A
Dressing: N/A
Drainage: None
Wound 4:
Location: N/A
Dressing: N/A
Drainage: None
Central Lines:
Location: A PICC Type: TLC
Location: N/A Type: N/A
Access necessary daily with ME: N/A
Arterial Line: 1 Radial Access: Patent and Transducing
IO Lines:
Site Left: N/A Site Right: N/A Status: N/A
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A

VAP Precautions
HOB > 30 degrees at all times: N/A
Sedation Interruption: N/A
GI Prophylaxis ordered: N/A
DVT Prophylaxis: N/A
Oral Care: N/A
Subglottic suctioning: N/A

Restraints: N/A CMS: N/A

Psych/ED:
Plan of care: Pt/family aware
Teaching done: N/A

Notes:
pt unresponsive to stimuli. Has corneal reflex in left eye, no reflex in right eye. Eating in low 90's resp rate 40-50. Tachy in 120-150. pt's mom at bedside. will continue to monitor

Signed: (b)(6)

20/20 20 Unit: DETAINEE,ICN200018
03 Jan 1967 / Male
Loc:
Spec: DETAINEE,ICN200018
Unit:

Automated version of SF509

ACLU DDI CID ROI 29915

CAMP CHAFFEE

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

Report requested by (b)(6)

05 Oct 2006@14:0 (MST Register # (b)(6) CLINICAL NURSE

PROG NOTES

Rapid Response Team Note: Patient is an elderly detainee with who was visiting family in the private PACU room when patient began to seize. (b)(6) responded immediately and (b)(6 (b)(6) was notified. Patient was transferred to ICU status and moved into bed 5. (b)(6) assisted upon transfer into the ICU. The following is the timeline of events that transpired during the event. 12:14: IV NS bung wide open. 100% O2 applied via NRB. 12:18: Zoxyn 1.175gm started. DNI Status verified by power of attorney, mechanical and chemical code authorized. 12:42: Right femoral central venous access attempted. 12:55: Right femoral TLC inserted successfully by (b)(6) Rainbow lab sent, 2nd liter of NS bung. 1st liter was bung at the start of the transfer process. Respiratory culture attempted but was unsuccessful. 13:05: Left A line insertion attempted. Transducer attached to foley. Blood cultures and Urine cultures being collected. 13:25: A line is place in left Radial artery. 13:28: PT sedation noted. O2 sats 96-97%. 1141: NS maintenance @125 ml/hr. 12 lead EKG obtained. 1141: Blood culture X2 and urine sent. Blood obtained from left forearm and central line. Dry dressing given. Ice packs applied to arm pits. 1430: Respiratory pattern change: belly breathing and apnea. breathing noted at times with audible crackles.

Signed: (b)(6)

05/Oct 20 0016 DEFAINEE,DENJOHN
03 Jan 1967 / Male
Loc:
Spec: DETAINEE,DENJOHN
Unit:
Automated version of DF509

ACLU DDI CID ROI 29916

CAMP CROPPER

Personal Data - Privacy Act of 1974 (Pl 93-579)
Progress Note

Report requested by: (b)(6)

05 Oct 2006@0700 INPT Register # (b)(6) CLINICAL NOTES

PROG NOTES

Recieved report from previous nurse and assumed care of the patient. Upon assessment pt's oxygen saturation dropped to 89%. Pt was placed on 4L of O2 via nasal cannula. O2 sats are now between 90-95%. Pt blood pressure was elevated all other vitals are stable. NGT to right nare is in proper position and was assessed with air bolus. Pt tolerated this well. Pt responds to painful stimuli only. Will continue to monitor and assess.

Signed: (b)(6)

21/Sep 20 0018 DETAINEE, [redacted]
01 Jan 1967 / Male
Loc:
Spec: DETAINEE, [redacted]
Unit:
Automated version of EPOCH

ACLU DDI CID ROI 29917

CAMP CROFTER

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

Report requested by: (b)(6)

25 Oct 2008@0453 INPT Register # (b)(6) OPERATING ROOM
PROG NOTES:

Nursing: Received report and pt from ED around 0300. Pt arrived to ward with GCS of 6. Does not open eyes, does not verbalize. Responds to pain stimuli only, flexing and withdrawing. Hx of seizures, bed rails padded for seizure precautions. Pharmacy paged so pt may receive seizure medications, awaiting response to page. BP 170/106, will give Tapros XL when medications arrive as well. NPT to R nare, placement verified x Xray in ED and stethescope on ward. Lungs x coarse breath sounds to bilateral upper lobes. Pt incontinent of urine, Foley catheter placed in ED. Incontinent brief placed for BMs as well. Reddened sacrum noted, turned to side and will turn q2hrs. Head elevated d/t aspiration risk. Heel protectors and SCD pump applied. D5 1/2NS @ 50cc/hr started. Pt diabetic, FS ordered with (name) sliding scale. Compound S guard at bedside. No other issues.

Signed: (b)(6)

20/900 20 0018 SMITA,NEE,ISN200718
01 Jan 1967 / Male
USC
Spec SMITA,NEE (ENL0103)
Unit
Automated version of SF519

ACLU DDI CID ROI 29918

CAMP CROPPER

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

Report requested by: (b)(6)

01 Oct 2008@1305 INPT Register #: (b)(6) PHYSICIAN
DISCHARGE NOTE

Attending Physician: (b)(6)
DX: sub acute

Admission Date: 29 September 2008 Discharge Date: 1 October 2008

CPT Operations/Procedures: None

Allergies: NKDA

Enter Principal Diagnosis: Metastatic renal cell carcinoma

Enter Secondary Diagnosis: Diarrhea with mental status changes

Enter Principal Procedures/Operations: None

Enter patient's condition at time of discharge: Improved

Diet: Regular

Discharge Summary:

This is a Compound 5 detainee who is well known to me from a June 2008 admission for new onset seizure. Work then was remarkable for probable renal cell carcinoma with mets to the brain which caused the seizure. Since then the patient had been on oral phenytoin and anti convulsants for the compound C provider, over the past 7 days or so, the patient has become more debilitated, fatigued, and weak to the point where he could not even get up from his bed. He also suffered a fall on the day of admission due to his weakness. His mental status although not significantly changed was notable for more aphasia. The patient was brought to the ER and admitted for further evaluations. CT scan of the head was done and initial labs were done also. He was placed on the ward for further care and treatment as indicated. This am, patient was alert, and able to communicate although he was not able to speak/articulate. He was able to answer questions appropriately and make his requests known. He also was able to get up from bed and go to the restroom with nursing assistance.

Patient had an uneventful hospital course. He was afebrile with normal VS, and was able to converse with the staff through the linguists. Work up with negative CT of head was essentially unchanged from Jun 2008. CBC and chemistry panel was benign. PSA were also normal during stay. PSA was 125 on am of d/c. In addition stool studies were ordered but he did not have any further stool to collect for studies. He had one episode of diarrhea day prior to d/c and none the day of d/c. Metamucil was added to regimen to give bulk to stools. Patient desired to return to compound on day of discharge and was awake and conversant although with slowing of speech, likely due to known brain metastases from presumed renal cell carcinoma.

Discharge Medications: Continue all of outpatient medications; added Metamucil 1 packet with juice PO

20/20M 2E 0N16 DETAINEE,ISN#000018
01 Jan 1967 / Male
Loc:
Spon: DETAINEE,ISN#000018
Unit:
Automated version of SF509

ACLU DDI CID ROI 29919

CAMP CROPSEY

Personal Data - Privacy Act of 1974 (Pl. 93-579)
Progress Note

Report requested by: (b)(6)

Follow up. F/U with compound 5 providers as per routine

(b)(6)

Signed: (b)(6)

[redacted]
01 Jan 1967 / Male
Loc:
Spec: DETAINEE,ISN200018
Unit:

Automated version of SF509

ACLU DDI CID ROI 29920

CAMP CROPPER

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

Report requested by (b)(6)

01 Oct 2006@1408 INPT Register # (b)(6) MEDICAL SPECIALIST

Read NOTES

Pt slept through night with no c/o pain. Blood sugar @ 2206 was 255 and was covered with 6 units of Reg insulin. When giving meds, pt was able to respond with yes's and no's. Pt was also able to give self PO meds rather than have them fed to him. IV access was discontinued per MD order. No other pertinent information at this time. Will continue to assess and monitor.

Signed: (b)(6)

20/DOC 20 0018 DETAINEE,ISN#000018
03 Jan 1967 / Male
Spec:
Spon: DETAINEE,ISN#000018
Unit:

Automated version of SF600

ACLU DDI CID ROI 29921

CAMP CROPPER

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

Progress Note

Report requested by: (b)(6)

20 Sep 2006 1415 INF2 Register # (b)(6) CLINICAL NURSE

PROG NOTES:

Lungs clr. Skin intact, no wounds or decubitis areas noted. Pt able to understand when spoken to but cannot form words to speak. Was able to communicate his desires when assisted with meals. Pt has some dexterity deficit, is able to eat drink and take meds if placed in his hands but has to use very deliberate movements and concentration to line up accurately with his mouth. Pt had one loose BM. Was able to ambulate to w/c & asst. to WC with to restroom.

Signed: (b)(6)

20/SEP 20 2006 DETAINEE,ISN#000119
01 Jan 1967 / Male
Race:
Spec: DETAINEE,ISN#000119
Unit:
Automated version of SF509

ACLU DDI CID ROI 29922

CAMP CROPPER

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

Report requested by: (b)(6)

10 Sep 2003@0505 INPT - Register #: (b)(6) - Operations Room

PROG NOTES:

Arrived in IOW @ 2250 with c/o diarrhea and AMS. Pt does not respond appropriately to simple verbal commands, if they respond at all. Pt has stable but agitation gait and moves very slowly. Has 16lpm in @ RA and is receiving 10ml/hr NS. Pt orientated to bed this AM. No other pertinent information at this time. Will continue to assess and monitor.

Guards: Wes Ivy

Signed: (b)(6)

20/MALE 20 Code: DETAINEE,ISN#200128
DOB: Jan 1967 / Male
LOC:
Sponsor: DETAINEE,ISN#200128
Unit:

Automated version of SF509

ACLU DDI CID ROI 29923

* Corrected Copy

HOSPITAL REPORT OF DEATH

For use of this form, see AR 40-62; the proponent agency is OTSG. The Surgeon General

Instructions - Medical Officer

Original to be forwarded with Parts I through IV and Appendix to Form 1 to Chief of the Office

NAME AND LOCATION OF HOSPITAL

TF 11 Camp Cropper

Duplicate to be retained in case history, without copy to the Register or Administrator, to whom the original and duplicate will be forwarded for preparation of required copies, the necessary action and for preservation of records of deaths

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)

Khalil Khadir Mohammed Al-Salhat

ISN 200018

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

2. TIME OF DEATH (Hour, day, month, year)

1200hrs 06 Oct 2008

3. MEDICAL EXAMINER CORONER'S CASE

☐ YES ☒ NO

4. RELIGION

5. CHAPLAIN NOTIFIED

☐ YES ☒ NO

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

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) Brain Metastases, Renal cell CA	5 months
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) Renal cell carcinoma	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE

6 Oct 2008

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER

(b)(6)

(b)(6)

SECTION B - ACTION

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

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED (If yes, give date and place)

☐ YES ☐ NO

21. AUTOPSY ORDERED BY (Signature)

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

ACLU DDI CID ROI 29924

Corrected Copy

CERTIFICATE OF DEATH

FAD

INTERNMENT SERIAL NUMBER: 2CC15

FROM: 11 115 (MED)

TO:

NAME (Last, first, MI): #11-Salhat, Khalil Khadir Mohammad

GRADE:

SERVICE NUMBER:

NATIONALITY:

POWER SERVED:

PLACE OF CAPTURE/INTERNMENT AND DATE:

PLACE OF BIRTH:

DATE OF BIRTH:

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN:

FIRST NAME OF FATHER:

PLACE OF DEATH: TCC 3.15

DATE OF DEATH: 06 October 2008

CAUSE OF DEATH: Blunt Injuries for Reattached

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):

WHERE 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)

(b)(6)

DO NOT WRITE IN THIS SPACE

CERTIFIED A TRUE COPY

DATE: 06 October 2008

SIGNATURE OF COMMANDING OFFICER

WITNESSES

SIGNATURE

ADDRESS

SIGNATURE

ADDRESS

ACLU DDI CID ROI 29925

TAB

CERTIFICATE OF DEATH

For use of this form see AR 638-5; the proponent agency is PMG

INTERNMENT SERIAL NUMBER

NE 20665

FROM

115th CSH

TO

NAME (*Last, first, MI*)

GRADE

SERVICE NUMBER

NATIONALITY

POWER SERVED

PLACE OF CAPTURE/INTERNMENT AND DATE

DATE OF BIRTH

PLACE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN

FIRST NAME OF FATHER

PLACE OF DEATH

Camp Bucca

DATE OF DEATH

06 October 2005

CAUSE OF DEATH

Blunt Force Injuries Due to Accident

DATE OF BURIAL

PLACE 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 (*Officer, Nurse, Minister of Religion, Fellow Internee*). IF CREMATED, GIVE REASON. (*If more space is required, continue on reverse side*)

(b)(6)

DO NOT WRITE IN THIS SPACE

CERTIFIED A TRUE COPY

DATE

06 October 2005

SIGNATURE OF COMMANDING OFFICER

WITNESSES

SIGNATURE

ADDRESS

SIGNATURE

ADDRESS

ACLU DDI CID ROI 29926

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-562; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will: Send form without delay to the Registrar or Administrative Officer of the Day for necessary action and certification of number of copies.

Prepare, in duplicate copy only, items 1 through 10 and 20 to 28. Print 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)

Rashed, Khaled Kudes Mohamed

ISN: 200018

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

2. TIME OF DEATH (Hour and day of month)

1204hrs 06 OCT 2003

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

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☒ NO

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

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, asphyxia, etc. It means the disease, injury or complication which caused death.)	DUE TO (or as a consequence of) Brain metastases, Renal cell Ca	5 months
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) Renal cell Carcinoma	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE

6 Oct 2003

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE

(b)(6)

(b)(6)

SECTION B - ADMINISTRATIVE ACTION

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

SECTION C - RECORD OF AUTOPSY

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

21. AUTOPSY ORDERED BY (Signature)

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

ACLU DDI CID ROI 29927

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

Report requested by: (b)(6)

06 Oct 2008@1323 INPT Register # (b)(6) PHYSICIAN
DISCHARGE NOTE
DEATH NOTE

Attending Physician: (b)(6)
HN: 900 00-0018

Admission Date: 04 OCT 2008 Date/Time of Death: 06 OCT 2008, 1204hrs

ICD Operations/Procedures: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Enter Principal Diagnosis: Renal cell carcinoma

Enter Secondary Diagnosis: Brain metastases secondary to renal cell carcinoma

Enter Principal Procedures/Operations: Right femoral vein triple lumen catheter; left radial arterial line; ACLS

Discharge Summary: This is a 51yo male detainee from Compound V with history of presumed presumed renal cell carcinoma with metastatic disease involving the brain. The detainee was recently admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status but improved with fluid resuscitation and demonstrated no significant changes in CT of the head. He was subsequently re-admitted on 04 OCT 2008 for increasing somnolence. At time of admission, he had a GCS score of 5-6 and was admitted to the ICW. On the morning after admission, though, his condition worsened after having two additional seizures. He was subsequently transferred to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 103, tachycardic with a heart rate as high as 180 and low oxygen saturations necessitating placement on 100% NRB (face mask oxygen). He also had a-line and femoral central line placed. Broad spectrum antibiotic coverage with piperacillin/tazobactam and vancomycin was initiated. His family came to visit and end of life issues and code status were discussed with the ICU physician.

His condition continued to deteriorate throughout the course of his second day. The decision was made by family members that the detainee would not be intubated but would receive ACLS (Advanced Cardiac Life Support) to include chest compressions, direct current cardioversion (electric shocks) if indicated and cardiac support medications. By his second night in the hospital, he was no longer producing urine and required additional intravenous fluid support. He also was started on a continuous infusion of diltiazem to control his heart rate which had climbed as high as the 180's range. His mental status remained extremely poor and he was unresponsive to painful or verbal stimuli. By the morning of the third hospital day, he was noted to have a disconjugate gaze (his eyes were pointing in different directions from one another). He had developed pronounced Kussmaul breathing (deep and fast respirations) which continued through much of the morning. His tachycardia had improved somewhat with the use of the diltiazem infusion.

==========

20/900-20-0018 DETAINEE,ISN200018
03 Jan 1967 / Male
Reg #: (b)(6)
Loc: ICU 1
Spon: DETAINEE,ISN200018
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
BR:

Automated version of SF509

ACLU DDI CID ROI 29928

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

Progress Notes

Report requested by: (b)(6)

I spoke with detainee's son on multiple occasions regarding the status of his father and allowed him to remain present in the ICU. I gave my opinion that I believed advanced life support would be futile, particularly mechanical ventilation was not an option. The son remained steadfast in his desire for us to do everything "but put him on a breathing machine".

Thirty minutes after my conversation with the son, the detainee heart rate and respiratory rate dropped precipitously. Soon after he developed PEA (pulseless electrical activity) and CPR was initiated. An oral airway was placed and the detainee was ventilated using an Ambu bag. He was noted to have ZERO spontaneous ventilations during the code process. We were able to regain a pulse after 10 minutes of CPR with epinephrine, atropine and Levophed (medications to stimulate the heart and elevate the blood pressure) and CPR was stopped. I explained to the son that his father's clinical situation had worsened significantly and that his death was imminent. I also explained that his father would continue to develop PEA because of his inability to breathe on his own. I also explained that I suspected the cause of impending death to be the herniation of his father's brain stem because of high intracranial pressures (because of the brain swelling from the metatastases and the blockage of free flow of cerebrospinal fluid out of the brain). The son expressed understanding but asked that we continue with our treatment. Ten minutes later his father went into PEA again. The ICU team again initiated CPR and provided cardiac medications with a return of the pulse, albeit weaker and slower than on the initial resuscitation. I again asked the son if he wished for us to continue. At this time, he expressed his desire for the team to stop resuscitation. I ordered cessation of CPR and bag-mask ventilation. His cardiac rhythm quickly degenerated into PEA and he expired shortly thereafter. The detainee's son was present at bedside at the time of death. (b)(6)

(b)(6)

Signed: (b)(6)

20/900-20-0018 DETAINEE,ISN200018 FOREIGN NATIONAL - POW/INTERNE

Reg #: (b)(6) 03 Jan 1967 / Male H: not on file

Loc: ICU 1 W: not on file

Spon: DETAINEE,ISN200018 Rank:

Unit: RR:

Automated version of SP509

ACLU DDI CID ROI 29929

CASE CRITES

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

Report Generated by (b)(6)

Oct 20 080745 EDT Registered # (b)(6) Current Unit

CASE NOTES

1 Entry

1 Oct Unit Log Note Entry Time

1 Oct Unit Log Note Entry Time

1 Oct See Note

Motor: See Note

Speech: Clear

Memory: See note

Gag reflex: See Note

GCS:

Eye Opening: 1 None

Verbal: 1 None

Motor: 1 None

Total GCS: 3

RASS Score: N/A

Respiratory:

Sounds: RUL: Clear Throughout Auscultation RLL: See Note

Sounds: LUL: Clear throughout auscultation LLL: See Note

Secretions: N/A Color: N/A

ETT: N/A Position: N/A

Trach: N/A Type: N/A

Oxygen: Non Rebreather Rate: Tachypnea

CT: N/A Pleura VAC: N/A

CT: N/A Pleura VAC: N/A

Cardiac:

Rhythm: Sinus Tachycardia

Sounds: Audible S1/S2

Neck Veins flat at 45 degrees Yes

Capillary Refill < 2 sec

ULE peripheral pulses +1 WNL Edema: +1

ALE peripheral pulses +1 WNL Edema: +1

Gastrointestinal:

Abdomen: Soft Non Tender

Bowel Sounds: Diminished

Diet: NPO

BM: N/A Color: None

Colostomy: N/A

NG: Night To: Clamped

OG: N/A To: N/A

DHT: N/A

PEG: N/A

Genitourinary:

Void: Foley Catheter Size: 14 Fr

Color: Yellow

Character: Sediment

Skin:

General Appearance: See Note

Color and Pigmentation: Pale

Temperature: Warm

Turgor: WNL

Moisture: Clammy

20/900-20-0018 DETAINEE, ISN200018

01 Jan 1967 / Male

Reg # (b)(6) Loc: ICU 1

Spon: DETAINEE, ISN200018

Unit:

ACLU DDI CID ROI 29930

Case Comments

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

Reports requested by: (b)(6)

Indentify Intact

Chief Cell Count:
Formation: % PMN Type: Tot
Count: Int N/A Type: N/A
Access Necessity Daily with PC: N/A
Arterial Line: L Radial Access: See Note
IV Lines:
Site: Left: N/A Site Right: Moist Peripheral IV Line in Place Status:
Patent No S/S of Infection
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A
Signed: (b)(6)

20/900-20-031A DETAINEE,ISN#000138
01 Jan 1967 / Male
Reg #: (b)(6) Loc: ICE 1
Spec: DETAINEE ISN#000138
Unit:
Authorized version of SF509

ACLU DDI CID ROI 29931

Report requested by: (b)(6)

Re: Dec 2016ed751 (NAT Register # (b)(6) CLINICAL NURSE

CASE NOTES:

Admission to ICU for management Ref to

[illegible] pt is 67YO Caucasian male, HR 140's, BP 80/50, on January evening [illegible] with acute hypoxemic [illegible] pneumonia and likely PE. He spontaneously [illegible] unable to obtain vascular with deep pain stim, corneal reflex present. [illegible] NAD tachypneic BBS crackles to bil clear BUL. CV S HR 150 cardizem gtt [illegible] increased to 15mg/hr, pale, clammy skin T 104. Lines/IVF 0 NS @ 125ml/hr, cardizem @ 15mg/hr NS fluid bolus given per Dr Sanabry for decreased UOP of 0ml. Cl: 0 NOT clamped CU: Foley as noted above 1mtng: scattered ecchymosis t/o, back not yet visualized 650mg Tylenol given for T of 104 PS: Sob present @ bedside updated on plan of care with interpreter Plan: 1 Cont CC titrate cardizem to decrease HR 2 Cont to monitor UOP 3 Provide pain control/comfort care

Signed: (b)(6)

[illegible] 20/Feb/16 14:02:19 CERTIFIED_LEN2000118
01 Jan 1967 / Male
Reg #: (b)(6) LOC: ICU 1
Spec: CERTIFIED_LEN2000118
Unit:
Authorized version of CP349

ACLU DDI CID ROI 29932

Case #:20250328

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

Pt is requested by (b)(6)

Pt Det 20250328 [MST] Register # (b)(6) CLINICAL VIGN

SOC NOTES

Family History:

Pt lives with: WNL Drugs: I do

Support System: WNL Drugs: I do

ETOH: See Note

Motor: No movement

Speech: See Note

Memory: UTA, intubated

Gag reflex: WNL

GCS:

Eye Opening: 1 None

Verbal: 1 None

Motor: 1 None

Total GCS: 3

RASS Score: N/A

Respiratory:

Sounds: RUL: WNL no adv. sounds RLL: WNL no adv. sounds

Sounds: LUL: WNL no adv sounds LLL: WNL no adv. sounds

Secretions: N/A Color: N/A

ETT: N/A Position: N/A

Trach: N/A Type: N/A

Oxygen: Non Rebreather Rate: Tachypnea

CT: N/A Pleura VAC: N/A

CT: N/A Pleura VAC: N/A

Cardiac:

Rhythm: Sinus Tachycardia

Sounds: Audible S1/S2

Neck Veins flat at 45 degrees Yes

Capillary Refill: < 2 sec

LLE peripheral pulses +2 WNL Edema: None

RLE peripheral pulses +2 WNL Edema: None

Gastrointestinal:

Abdomen: Soft Non Tender

Bowel Sounds: Positive

Diet: NPO

BM: N/A Color: None

Colostomy: N/A

NG: Right To: Clamped

OG: N/A To: N/A

DHT: N/A

PEG: N/A

Genitourinary:

Void: Yes Catheter Size: 16 Fr

Color: Yellow

Character: Clear

Skin:

General Appearance: WNL

Color and Pigmentation: WNL

Temperature: Warm

Turgor: WNL

Moisture: WNL

20/900 20 0015 DETAINEE,ISN#20015

21 Jan 1967 / Male

Reg #: (b)(6) Loc: CTF 1

Spec: DETAINEE,ISN#20015

Unit:

ACLU DDI CID ROI 29933

CAMP CROPPER

Personal Data - Privacy Act of 1974 (PL 93-579)
Protected When Filled In

Report requested by: (b)(6)

Integrity Inmate

Insulin 1: N/A Insulin 2: N/A
Insulin 3: N/A Insulin 4: N/A
Blood Sugar: N/A

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Wound 3:
Location: N/A
Dressing: N/A
Drainage: None
Wound 4:
Location: N/A
Dressing: N/A
Drainage: None
Central lines:
Location: R FEM Type: TLC
Location: N/A Type: N/A
Assess necessity daily with MD: N/A
Arterial Line: L Radial Assess: Patent and transducing
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A

VAP Precautions:
HOB > 30 degrees at all times: N/A
Sedation Interruption: N/A
GI Prophylaxis ordered: N/A
DVT Prophylaxis: N/A
Oral Care: N/A
Subglottic suctioning: N/A

Restraints: N/A CMS: N/A

Psych/SD:
Plan of care: Pt/family aware
Teaching done: N/A

Notes
pt unresponsive to stimuli. min corneal reflex in left eye, no reflex in right eye, resting on low 90's resp rate 40-50 tachy in 120-150 pt's mom at bedside. will continue to monitor
Signed: (b)(6)

20/900-20-0018 DETAINEE, ISN200018
03 Jan 1967 / Male
Reg #: (b)(6) Loc: ICU 1
Upon: DETAINEE ISN200018
Unit:

ACLU DDI CID ROI 29934

Report requested by: (b)(6)

Pt Name: (b)(6) INPT Medical Rec #: (b)(6) PHYSICIAN
ADMISSION NOTE
Attending Physician: (b)(6)
DOB: 1967-06-02 Age: 41
Admission Date: 10/1/2008

Allergies: NKDA

HPI: This is a detainee from Compound 5 known to me with hx of metastatic presumed renal cell carcinoma (to brain). Patient was admitted after 1-2 weeks of increasing somnolence, diarrhea, and altered mental status. Patient was recently admitted 29 dept and d/c on 1 Oct after patient improved with NS IVF and demonstrated no change in CT of head (some 4 predominant lesions overall unchanged since June 2008 initial diagnostic CT scan). Patient re-admitted overnight for increasing somnolence. At time of admission, patient was at about a GCS of 5-6. This ac. be worsened after seizure x 2. He was brought to the ICU from the ICW for further monitoring and a family visit. In the ICU, he was febrile to 101, tachycardic to HR as high as 140. He was placed on 100% NRB as his pulse oximeter reading was low 90's. He also had a line and femoral central line placed. Family came to visit patient and discussed end of life issues and code status with son and wife.

PMHx: Renal cell carcinoma with brain metastasis, HTN, Type II DM, GERD

PSHx: None

SOCHx: No tobacco/ETOH

Meds: Decadron 2 mg IV q6 hrs, Dilantin 100 mg qam/200 mg qpm, Tegretol 100 mg BID, Zantac 50 mg IV q8 hrs, Zosyn 4.5 grams IV q8 (24hr), Vancomycin 1 gram q12 hours, Tylenol 650 mg PO q4-6 hours prn

PE: BP 175/95 HR 139 RR 35 Temp 101.1 O2sat 97% on 100% NRB
Neuro/psych - GCS 6, •Babinski, on no sedation, seizure x2 since admit, cont Dilantan/Tegretol, only responds to pain, cont monitoring

CV - tachy S1/S2, EKG with ST segment depression in lateral leads, likely demand ischemia, cont BB and prn IV lopressor for rate control, will start drip for HTN and tachycardia if needed (diltiazem, or Nitroprusside), will look to hold off on BB in case of decreased inotropic affects but if not efficacious will consider Labetolol drip instead

Pulm - rhonchi bilaterally, patient DNI, will check CXR, cont antibiotics, pulm toilet

GI/Liver/nutrition - LFT's normal, abdominal exam benign, hold off on feeding right now, will reassess tomorrow for possible Jevity/enteral feeds

Renal/electrolytes - Na 133 K 3.8 CL 91 HCO3 25 B/Cr 7/0.2 Glu 238, Mg 2.1,
renal function normal, continue IV fluid resuscitation, already 2 liters in of NS, urine output excellent, 1400 ml since this am, cont to monitor

ACLU DDI CID ROI 29935

Adm Cmt/Pres

Personal Data - Privacy Act of 1974 (PL 93-579)
Dragoman 9.0

Event requested by (b)(6)

Code Stat: [illegible] patient is metastatic cancer to brain; held off on [illegible] in view of [illegible] wishes to [illegible] CMC daily

[illegible] to ICU [illegible] arterial [illegible] Key, and Valsalva, [illegible] and [illegible] time ex done; will [illegible] at midday

Data: As per unit/nursing protocol

Prophylaxis: SCDs, Zantac

Tubes/lines: L radial A line placed, R femoral central line placed, 2 PIV, Foley, NPO

Disposition: Discussed with family and do not wish for patient to intubated or placed on mechanical ventilation. Discussed with them in presence of compound V provider (b)(6) and MP commander (b)(6) Explained to family the difficulty of a DNI order in setting of this patient's condition. Son still did not want intubation or mechanical ventilation. Therefore, will continue with antibx, IV fluid support, BP control, and potentially DCCV and IV pressor support.

(b)(6)

Signed (b)(6)

20/900-20-0018 DETAINEE, ISN200019.3
03 Jan 1967 / Male
Loc: ICU 1
Spon: DETAINEE, ISN200019
Unit:
Automated version of SF509

Reg #: (b)(6)

ACLU DDI CID ROI 29936

ACLU-RDI 5593 p.143

000143

1. LAST NAME-FIRST NAME-MIDDLE INITIAL	2. GRADE
ISN# 20018 900-20-0018	3. SOCIAL SECURITY NO.
4. ORGANIZATION TF 115th MED STRYKER BDE	5. WARD ICU
6. DEATH OCCURRED HOUR: 120-1 / DAY: 6 / MO.: 10 / YEAR: 2009	7. PLACE WHERE DEATH OCCURRED Copper ICU
AUTHORIZED SIGNATURE: (b)(6)	

DEATH TAG

DA FORM 3910 1 AUG 72 REPLACES DA FORM 8-219, 1 MAR 63. WHICH WILL BE USED
For use of this form see, AR 40-400; the proponent agency is OTSG.

ACLU DDI CID ROI 29937

VERY SERIOUSLY ILL/SERIOUSLY ILL/SPECIAL CATEGORY PATIENT REPORT

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

TO: ☐ PATIENT ADMINISTRATOR
☐ ADMINISTRATIVE OFFICER OF THE DAY

PERSON TO BE NOTIFIED
5. RELATIONSHIP
6. NAME AND ADDRESS

1. UNIT: Scouts
2. WORK: None
3. RELIGION OF PATIENT:
4. WARD: ICU

PATIENT (Name, last, first, middle initial)

BRIEF DIAGNOSIS (Do not abbreviate)

Metastatic cancer (to brain) with altered mental status

8. STATUS OF PATIENT

PLACED ON ROSTER

a. ☒ VERY SERIOUSLY ILL
b. ☐ SERIOUSLY ILL
c. ☐ NON SERIOUSLY ILL
d. ☐ SPECIAL CATEGORY (Specify)

PROGNOSIS: RECOVERY IS:

☒ NOT EXPECTED ☐ QUESTIONABLE
☐ QUESTIONABLE ☐ EXPECTED

EXPECTED LENGTH OF HOSPITALIZATION ___ DAYS

CHANGE OF STATUS

e. ☐ SI TO VSI
f. ☐ VSI TO SI
g. ☐ RECOVERED
h. ☐ TRANSFERRED
i. ☐ DIED
j. ☐ ADDITIONAL SPECIAL CATEGORY (Specify in remarks)

9. REMARKS

10. (b)(6)

11. (b)(6)

ACTION TAKEN BY PATIENT ADMINISTRATOR OR ADMINISTRATIVE OFFICER OF THE DAY

NOTIFIED

ACTION	DATE	HOUR	METHOD OF NOTIFICATION (Initial one) TELEPHONE	TELEGRAM	LETTER	IN PERSON
12. REPORT RECEIVED						
13. PERSON (Same as Item 6)						
14. INFORMATION OFFICE						
15. RED CROSS						
16. CHAPLAIN						
17. UNIT COMMANDER						
18. OTHER (Specify)						

9. REMARKS

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle, grade, family member prefix, SSN)

700-20-0018

20. TYPED OR PRINTED NAME OF PATIENT ADMINISTRATOR OR ADMINISTRATIVE OFFICER OF THE DAY

(b)(6)

21. SIGNATURE

(b)(6)

DA FORM 2984, AUG 2007 PREVIOUS EDITIO APD PE v1.00ES

ACLU-RDI 29938

EXHIBIT(S) 8 & 9

Page(s) 000147 thru 000236
referred to:

CDR USAMEDCOM
ATTN: FOIA OFFICE, STOP 76
1216 STANLEY RD 2D FL
FT. SAM HOUSTON, TX 78234-5049

ACLU DDI CID ROI 29940

Corrected Copy

0031-08-CID789-53213

TAB

REFERENCE NUMBER
JCXCIS

CERTIFICATE OF DEATH

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

FROM

IT HQ (JTF D)

TO

NAME (Last, first, MI)
Al-Salhi, Khalid Khadir Mohammed

GRADE

SERVICE NUMBER

NATIONALITY

POWER SERVED

PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH

DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN

FIRST NAME OF FATHER

PLACE OF DEATH
JCX-3X S

DATE OF DEATH
06 October 2008

CAUSE OF DEATH
Blunt Trauma to the Head Cardiac 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*).

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE
06 October 2008

SIGNATURE OF COMMANDING OFFICER

(b)(6)

WITNESSES

SIGNATURE

ADDRESS

SIGNATURE

ADDRESS

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29941

EXHIBIT 8

EXHIBIT 7

MISSING

ACLU DDI CID ROI 29939