DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
48TH MILITARY POLICE DETACHMENT (CID) (FWD) (-)
11TH MILITARY POLICE BATTALION (CID) (FWD)
BAGHDAD CENTRAL CONFINEMENT FACILITY
ABU GHRAIB, IRAQ APO AE 09342

CIRFR-PIT

20 JUL 05

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – CORRECTED FINAL - 0238-04-CID789-83999-5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 15 NOV 04/2015 – 15 NOV 04/2041: INTERMEDIATE CARE WARD (ICW); BAGHDAD CENTRAL CONFINEMENT FACILITY (BCCF) HOSPITAL; BCCF; GRID: 38S MB 131 837; ABU GHRAIB, IZ, APO AE 09342

DATE/TIME REPORTED: 15 NOV 04, 2045

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

SUBJECT: 1. NONE; NATURAL DEATH

VICTIM: 1. FAHAD, MOBASS (DECEASED); CIV; INTERNMENT SERIAL NUMBER (ISN) (b)(6), (b)(7)(C) UNKNOWN; UNKNOWN, IZ; M; WHITE; DETAINEE; BCCF, ABU GHRAIB, IZ APO AE 09342 (AGI); (NFI); XZ; NATURAL DEATH

This is an "Operation Iraqi Freedom" investigation.

This report was generated to correct an administrative error. During an administrative review of the file, it was noted that an exhibit was inadvertently omitted from the final report.

This investigation was initiated upon notification from the BCCF Hospital, Abu Ghraib, IZ that Detainee FAHAD had died.

Investigation revealed Detainee FAHAD died while hospitalized at the BCCF as a result of Acute Myocarditis.

10-L-0126 ACLU DDII CID ROI 15703

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 18 Nov 04, pertaining to initial notification, medical coordinations, interview of medical personnel, and other coordinations.

2. Medical Records pertaining to Detainee FAHAD.

3. Death Certificate pertaining to Detainee FAHAD.

4. Copy of ICW#2 Log Book pertaining to Detainee FAHAD.

5. Copy of ICU Log Book pertaining to Detainee FAHAD.

6. Copy of ER Log Book pertaining to Detainee FAHAD.

7. Dossier pertaining to Detainee FAHAD.

8. AIR of SA (b)(6),(b)(7)(C) 29 Nov 04, pertaining to Detainee FAHAD's autopsy.

9. Compact Disk ME 04-969 containing images of Detainee FAHAD. (USACRC and file copy only).

10. Fingerprints of Detainee FAHAD.

11. AIR of SA (b)(6),(b)(7)(C) 31 Mar 05, pertaining to medical coordination.

12. Final Autopsy Report #ME04-969, 14 Mar 05, pertaining to Detainee FAHAD which listed the cause of death as Acute Myocarditis and the manner of death as Natural.

13. Compact Disc #040238.789 containing images of Detainee FAHAD. (USACRC and file copy only).

NOT ATTACHED: None.

The original of Exhibits 1, 8-11 and 13 were forwarded with the USACRC copy of this report. The original of Exhibits 2 through 6 were retained in the files of the BCCF Hospital, Abu Ghraib, IZ. The original of Exhibit 7 was retained in the digital files of the In-processing

ACLU-RDI 5484 p.2

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

ACLU DETAINEE DEATH 2 CID 90

Holding Area, Abu Ghraib, IZ. The original of Exhibit 12 is retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Blvd., Building 102, Rockville, MD 20850.

STATUS: This is a Final Report. Commander's Report of Disciplinary Action Taken (DA Form 4833) is not required.

Report Prepared By:

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

Special Agen (b) (7)(F)

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
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1 - File

10-L-0126 ACLU DDII CID ROI 15705

ACLU-RDI 5484 p.3

000003

DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
48TH MILITARY POLICE DETACHMENT (CID) (FWD) (-)
11TH MILITARY POLICE BATTALION (CID) (FWD)
BAGHDAD CENTRAL CONFINEMENT FACILITY
ABU GHRAIB, IRAQ APO AE 09342

CIRC-PIT

15 Apr 05

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL - 0238-04-CID789-83999-5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 15 NOV 04/2015 – 15 NOV 04/2041: INTERMEDIATE CARE WARD (ICW); BAGHDAD CENTRAL CONFINEMENT FACILITY (BCCF) HOSPITAL; BCCF; GRID: 38S MB 131 837; ABU GHRAIB, IZ, APO AE 09342

DATE/TIME REPORTED: 15 NOV 04, 2045

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

SUBJECT: 1. NONE: [NATURAL DEATH]

VICTIM: 1. FAHAD, MOBASS (DECEASED); CIV; INTERNMENT SERIAL NUMBER (ISN) (b)(6), (b)(7)(C) UNKNOWN; UNKNOWN, IZ; M; WHITE; DETAINEE; BCCF, ABU GHRAIB, IZ APO AE 09342 (AGI); (NFI); XZ; [NATURAL DEATH]

This is an "Operation Iraqi Freedom" investigation.

This investigation was initiated upon notification from the BCCF Hospital, Abu Ghraib, IZ that Detainee FAHAD had died.

Investigation revealed Detainee FAHAD died while hospitalized at the BCCF as a result of Acute Myocarditis and the manner of death as Natural.

STATUTES:

N/A

10-L-0126 ACLU DDII CID ROI 15706

EXHIBITS/SUBSTANTIATION: 0238-04-CID789-83999

ATTACHED:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 18 Nov 04, pertaining to initial notification, medical coordinations, interview of medical personnel, and other coordinations.

2. Medical Records pertaining to Detainee FAHAD.

3. Death Certificate pertaining to Detainee FAHAD.

4. Copy of ICW#2 Log Book pertaining to Detainee FAHAD.

5. Copy of ICU Log Book pertaining to Detainee FAHAD.

6. Copy of ER Log Book pertaining to Detainee FAHAD.

7. Dossier pertaining to Detainee FAHAD.

8. Preliminary Autopsy Report, #ME04-434, 13 Oct 04, pertaining to Detainee FAHAD which listed the cause of death as Undetermined and the manner of death as Natural.

9. AIR of SA (b)(6),(b)(7)(C) 31 Mar 05, pertaining to medical coordination.

10. Final Autopsy Report #ME04-969, 14 Mar 05, pertaining to Detainee FAHAD which listed the cause of death as Acute Myocarditis and the manner of death as Natural.

11. Compact Disc #040238.789 containing images of Detainee FAHAD. (USACRC and file copy only).

NOT ATTACHED: None.

The original of Exhibits 1, 9, and 11 were forwarded with the USACRC copy of this report. The original of Exhibits 2 through 6 were retained in the files of the BCCF Hospital, Abu Ghraib, IZ. The original of Exhibit 7 was retained in the digital files of the In-processing Holding Area, Abu Ghraib, IZ. The original of Exhibits 8 and 10 are retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Blvd., Building 102, Rockville, MD 20850.

STATUS: This is a Final Report. Commander's Report of Disciplinary Action Taken (DA Form 4833) is not required.

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

0238-04-CID789-83999

Report Prepared By:

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

Special Agent (b) (7)(F)

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
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1 - File

10-L-0126 ACLU DDII CID ROI 15708

ACLU-RDI 5484 p.6

000006

Basis of Investigation: On 15 Nov 04, SA (b)(6), (b)(7)(C) was notified by the Baghdad Central Confinement Facility (BCCF) Hospital, Abu Ghraib, Iraq (AGI), that Detainee Mobass FAHAD, Internment Serial Number (ISN) (b)(6), (b)(7)(C) died as a result of complications during a seizure.

About 2045, 15 Nov 04, SA (b)(6), (b)(7)(C) coordinated with LTC (DR) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Deputy Commander, BCCF Hospital, AGI, who reported that FAHAD had died. He stated FAHAD arrived at the hospital on 12 Nov 04 from another hospital in Fallujah. LTC (b)(6), (b)(7)(C) stated FAHAD came into the hospital seizing. Once recovered, FAHAD told doctors he had a history of seizures and asthma. FAHAD explained that he was in a civilian hospital in Fallujah for his condition. LTC (b)(6), (b)(7)(C) explained that FAHAD had had several seizures while in the hospital, but had improved enough to be discharged. FAHAD was actually walking around about one hour before, but shortly after lying down, about 2010, he started having a seizure and stopped breathing. LTC (b)(6), (b)(7)(C) stated emergency CPR, breathing tubes, and medications used to restart the heart, were given to FAHAD, but he did not recover. LTC (b)(6), (b)(7)(C) pronounced FAHAD deceased at 2141, 15 Nov 05, from Generalized Tonic Clonic Seizure with Anoxia.

AGENT'S COMMENT: About 2015, 15 Nov 04, while photographing a previously deceased detainee, this agent observed several medical personnel running towards the Intermediate Care Ward (ICW). After completing the photographs, a few minutes later, this agent went to observe the activity. This agent observed emergency life saving measures and Cardio Pulmonary Resuscitation (CPR) being performed on FAHAD. This agent returned to release the previous detainee's body and upon return observed emergency medical treatment still being provided. This agent observed this care being given for approximately 15 minutes longer, until medical personnel stopped medical care.

About 2100, 15 Nov 04, SA (b)(6), (b)(7)(C) observed FAHAD's body and found no obvious signs of abuse or mistreatment. SA (b)(6), (b)(7)(C) exposed photographs of body, using a Sony Cybershot Digital Camera. (See Photographs)

AGENT'S COMMENT: Due to the fact that the death occurred while in the hospital, while under Doctor's care, and the detainee had never been in the detainee camps, no crime scene exam was conducted nor were any canvass interviews conducted of detainees.

About 2130, 15 Nov 04, SA (b)(6), (b)(7)(C) coordinated with COL (DR) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Commander, 115th Field Hospital, BCCF, AGI, who advised FAHAD was actually a civilian who was being treated at a civilian hospital in Fallujah, but when the combat operations began, he was transferred to a Mosque for continued care, where he was found by US Marines and transported to BCCF for treatment. This information was obtained by a separate patient who explained was brought in with FAHAD. He stated as he understood it, FAHAD was not actually a combatant, but due to guidance from MG (b)(6), (b)(7)(C) (NFI), he was given an ISN and treated as a detainee.

SA (b)(6), (b)(7)(C) Special Agent, (b) (7)(F)	75th MP Det (CID)(-)(PIT) BCCF, Abu Ghraib, Iraq
Signature (b)(6), (b)(7)(C)	Date: 18 Nov 04

ACLU DDII CID ROI 15709

About 1000, 15 Nov 04, SA (b)(6), (b)(7)(C) coordinated with SSG (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Patient Administration (PAD), BCCF Hospital, AGI, who provided a copy of the medical records and death certificate pertaining to FAHAD. (See Medical Records and Death Certificate)

About 1030, 15 Nov 04, SA (b)(6), (b)(7)(C) coordinated with MAJ (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) 91st Military Police (MP) Battalion (BN), BCCF, AGI, who stated the detainee had no capture documents and was only given an ISN per MG (b)(6), (b)(7)(C) guidance, resulting from the large influx of injured detainees and Iraqi civilians from the Fallujah area. MAJ (b)(6), (b)(7)(C) could not comment on the circumstances of FAHAD's situation. He stated FAHAD;s basic information was obtained and recorded in the Biometric Automated Toolset (BATS).

About 1110, 16 Nov 04, SA (b)(6), (b)(7)(C) briefed CW3 (b)(6), (b)(7)(C) Assistant Operations Officer (AOPS) and Forensic Science Officer (FSO), 22nd MP BN (CID) on the death.

About 1130, 16 Nov 04, SA (b)(6), (b)(7)(C) queried BATS and obtained the Personal Data Report (PDR), which contained the date of birth and place of birth for FAHAD. (See PDR)

AGENT'S COMMENT: There is a slight difference in the name provided in medical records and the one provided in BATS. This is not uncommon with different translators being used at different times. The name recorded on the death certificate will be considered as the official name.

About 1030, 18 Nov 04, SA (b)(6), (b)(7)(C) interviewed CPT (b)(6), (b)(7)(C) ICW Head Nurse, 115th FH, AGI, who stated FAHAD was transferred to ICW at 2100, 12 Nov 04. CPT (b)(6), (b)(7)(C) stated that FAHAD was alert, mobile and a good patient while in the ICW. He stated FAHAD was even talking with other patients saying bye because he was being discharged the following day. CPT (b)(6), (b)(7)(C) stated FAHAD had no visitors or interrogations while in ICW. He stated FAHAD was prescribed and taking Dilantin, a seizure medication. He stated FAHAD had no other seizures while in ICW, other than the one when he died. CPT (b)(6), (b)(7)(C) provided a copy of the ICW#2 Log Book, showing FAHAD's arrival and death. (See Copy of ICW#2 Log Book)

About 1045, 18 Nov 04, SA (b)(6), (b)(7)(C) interviewed MAJ (DR) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) 115th FH, BCCF, AGI, who stated FAHAD was transferred to the Intensive Care Unit (ICU) at 0700, 12 Nov 04, for a asthmatic condition and a history of seizures. MAJ (b)(6), (b)(7)(C) stated FAHAD told him, through a linguist, that he had been taking a seizure medicine, Tegretol, but had not taken it for two or three days. MAJ (b)(6), (b)(7)(C) re-prescribed the Tegretol and placed FAHAD on oxygen. While in ICU, FAHAD had two additional seizures, at which times MAJ (b)(6), (b)(7)(C) additionally prescribed Dilantin. After stabilizing, FAHAD was transferred to ICW#2. MAJ (b)(6), (b)(7)(C) also stated that FAHAD stated he had had several seizures while in the hospital in Fallujah. MAJ (b)(6), (b)(7)(C) could not confirm whether FAHAD actually arrived at the BCCF Hospital seizing or if the seizure occurred before he arrived. MAJ (b)(6), (b)(7)(C) stated

SA (b)(6), (b)(7)(C)
Special Agent (b)(7)(F)
75th MP Det (CID)(-)(FIT)
BCCF, Abu Ghraib, Iraq

Signature: (b)(6), (b)(7)(C) Date:

FAHAD had no visitors or interrogations while in ICU. He provided a copy of the ICU Log Book, showing FAHAD's arrival and discharge from ICU. (See Copy of ICU Log Book)

About 1055, 18 Nov 04, SA (b)(6), (b)(7)(C) interviewed 2LT (b)(6), (b)(7)(C) Emergency Room (ER) Nurse, 115th FH, AGI, who stated FAHAD came in at 0315, 15 Nov 04, with an asthmatic condition and a fresh trachea, which had been cut in Fallujah. She stated FAHAD stated he had a history of seizures. 2L(b)(6), (b)(7)(C) stated FAHAD did not have any seizures in the ER nor did he have any visitors. She provided a copy of the ER Log Book, showing FAHAD's arrival and discharge from the ER. (See Copy of ER Log Book)

About 1115, 18 Nov 04, INV (b)(6), (b)(7)(C), this office, coordinated with SFC (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) 391st MP BN, Detainee In-Processing Section, BCCF, AGI, who provided a copy of the dossier pertaining to FAHAD. (See (b)(6), (b)(7)(C)
///Last Entry///

SA (b)(6), (b)(7)(C)	75th MP Det (CID)(-)(PIT)
Special Agent (b) (7)(F)	BCCF, Abu Ghraib, Iraq
Signature: (b)(6), (b)(7)(C)	Date: 18 Nov 04

ACLU DDII CID ROI 15711

(b)(6)

0238-04-CID789-83999

I/O's & Vital Signs

Date	B/P	HR	T	Pox	RR				
14NOV 0600	116/78	92	97.8	92	18				
14NOV 1700	116/78	105	96.1	87	17				
15NOV 1700	102/64	107	97.8	95	18				

10-L-0126 ACLU DDII CID ROI 15713

FOR OFFICIAL USE ONLY

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

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

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

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

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

Procedure/Diagnosis ______ B/P ______ P ______ R ______ T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

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

Medication ______

Other ______

Report From ______ Received By ______

TIME:	110															
BP ARTERIAL LINE																
BP CUFF	[illegible]															
TEMPERATURE	97.5															
PULSE	98															
RESPIRATORY RATE	—															
OXYGEN (L/%)	—															
PULSE OXIMETER	97															
O2 METHOD																

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

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

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

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

YESTERDAY'S WEIGHT: ______

TODAY'S WEIGHT: ______

WEIGHT CHANGE: ______

*Per hospital policy.

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

PATIENT IDENTIFICATION

DIAGNOSIS: ______

DRG: ______ ADMISSION DATE: ______

LOS: ______ EXPECTED RELEASE: ______

CASE MANAGER: ______

PRIMARY CARE MANAGER: ______

ISOLATION REQUIRED (Specify): ______

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10-L-0126 ACLU DDII CID ROI 15714

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

TITLE	OTSG APPROVED (Date) (YYYYMMDD)
115th Field Hospital Intensive Care Flow Sheet	

NURSING NOTES

PATIENT EDUCATION/PSHCYOSOCIAL

TIME	SUBJECT	RESPONSE/SUPPORT/REFERRALS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	DAYS	EVENINGS	NIGHTS
② AC 18	12NOV04	12NOV04	PATENT		

(Continue on reverse)

PREPARED BY (b)(6)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
	ICU	20041112

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle ... (b)(6)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

0238-04-CID789-8399

DATE 12MW | DIAGNOSIS: S/P CRICOTOMY; S/P STATUS ASTHMATICUS | HOSPITAL DAY 1

Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22
NIBP/ ABP	111/56	113/54	115/59	110/59	113/58		128/68	108/55		98/47	99/51	105/54	122/72				
Pulse	109	105	97	106	94		109	115		103	106	104	95				
Respirations	26	28	26	24	24		23	22		24	21	28	21				
Temperature	99.4	/	/	/	/	/	/	98.7		/	/	/	/				
SaO2	94	98	99	97	97		98	95		98	97	98	96				
%O2 12L	~~94~~ FM	8L FM	4L ~~FM~~ NC	6L NC	6L NC		4L NC	6L NC		12L NRB	12L FM	12L FM	12L FM				
CVP																	
Pain Scale	0	0	0														
Pain Med	N	N	N														
Pt Position	S	S	S														

HOB↑45°

Time	07	08	09	10	11	12	13	14	Total	15	16	17	18	19	20	21	22	Total
IV	2000		70	70	70	70	70	70		100								
IVPB			~~50~~			50				100								
PO																		
Other																		
TOTAL																		

TIME	07	08	09	10	11	12	13	14	Total	15	16	17	18	19	20	21	22	Total
Urine output Hour/Total	1000 / in ER					1400 / 2400				625			425					
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care		
Oral Care		
Foley Care		
Trach Care		
Range of Motion		

Safety	D	E	N
High risk for falls	Y (N)	Y N	Y N
Call bell in reach	Y (N)	Y N	Y N
Bed position/Locked	(Y) N	Y N	Y N
Protective device	(Y) N	Y N	Y N
Cardiac Monitor	(Y) N	Y N	Y N

10-L-0126 ACLU DDII CID ROI 15716

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POST OPERATIVE DAY NA | PHYSICIAN (b)(6)

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
CVP								
Pain Scale								
Pain Med								
Pt Position								

TIME				
RESPIRATORY				
Mode				
FiO2				
Rate				
PEEP				
CPAP				
Pressure Support				
ABG				
pH				
pCO2				
Sat				
HCO3				
BE				
LAB VALUES				
NA+				
K+/ Cl-				
CO2				
BUN/ Cr				
Glu				
WBC				
Hgb/Hct				
PT/PTT				
Ca/Mg				
CPK/CKMB				
Troponin				

TIME	23	24	01	02	03	04	05	06	Total
IV									
IVBP									
PO									
Other									
TOTAL									

TIME	23	24	01	02	03	04	05	06	Total
Urine output Hour/Total									
NG Output									
Emesis									
Stool									
Chest Tube #1 / #2									
Jackson Pratt #1/ #2									
TOTAL									

TIME OUT	TIME IN	Place/Mode, Comments

24 Hr Totals	Yesterday	Today
INTAKE		
OUTPUT		
DIFFERENCE		

Legend

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

Name	Signature	Init
(b)(6)		

10-L-0126 ACLU DDII CID ROI 15717

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SYSTEM	DAYS	EVENINGS	NIGHTS
NEURO	12NOV04 @ 07CO		
Level of consciousness	AAO x 3		
Extremities: Movement	MAE		
Strength	NORMAL		
PAIN ASSESSMENT	ϕ		
CARDIOVASCULAR			
Rhthym/Lead	NSR		
Heart Sounds	S1 S2		
Skin	INTACT		
Edema	ϕ		
JVD/ Capillary refill	ϕ, < 3 SEC		
Pulses: Radial	(R) ++ (L) +		
Posterior Tibial	++ ++		
Dorsalis Pedis	++ ++		
RESPIRATORY			
Breath Sounds	~~CTA~~ c EXP WHEEZE		
Suctioning/Frequency	NA		
Endotracheal Tube:	↓		
Size: Placement:	↓		
Cough:	PRODUCTIVE		
Treatments:	ALBUTEROL NEB		
GASTROINTESTINAL			
Bowel Sounds	NORMOACTIVE		
Abdomen	ROUND, SOFT, NT, ND		
NG tube:Placement	NA		
Suction	↓		
Drainage	↓		
GENITORUINARY			
Urine: Color	CLEAR YELLOW		
Void/Foley	FOLEY 16F		
INTEGUMENTARY			
Integrety	INTACT		
Dressings	NA		
Dressing Condition	↓		
Drains/Tubes	↓		
Drainage	↓		
Signature	(b)(6)		

(b)(6)

ACLU DDII CID ROI 15718

~~FOR OFFICIAL USE ONLY~~

0238-04-CID789-8399

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
5NOV04	procedure note for code.
@2105	24 y/o ♂ ē known H/O of ... seizures.
	pt found to be seizing, tx ē 4mg Ativan x2,
	pt's seizure stopped. pt became hypoxic
	ē O2 sats to 50%. pt was immediately
	intubated ē 8.0 ETT, sats improved from 50%
	to 88%, ⊕ condensation of ETT, Ⓑ breath sounds,
	⊕ CO2 color change. pt also lost his
	pulse, compressions ē started ā palp carotid
	pulse. placed on cardiac monitor ē
	ventricular escape rhythm, wide complex,
	ⓒ rate of 20. pt in PEA and
	pt coded per nursing sheet, started EPI
	via ETT, then Ⓛ femoral central line
	placed (7.0 cordis) ē good flow and
	this line was used for further PEA
	code. bedside US of heart showed
	no cardiac activity. Pt was coded for
	more than 15 minutes without further
	improvement. Pt pronounced at 2 [illegible]

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST FIRST

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

REGISTER NO. | WARD NO.

(b)(6)

PROGRESS NOTES
Medical Record

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

10-L-0126 ACLU DDII CID ROI 15719

FOR OFFICIAL USE ONLY

NSN 7540-00-634-4176

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2024	CPR started
2025	8 mg Ativan given
2029	Epi 1ml ET tube
2030 –	1ml more Epi
2031	CPR stopped 62% 122, Ø cards
2035	1 ml Atropine
2036	Ambu bag CPR resumed
2037	LR infusing
2039	1ml Epi ET Tube
2041	Code Completed pronounced dead

(b)(6)

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

(b)(6)

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial) | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

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

L-0126 ACLU DDII CID ROI 15720

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

USE ONLY

MEDICAL RECORD | PROGRESS NOTES

DATE	
	DEATH NOTE
13 NOV 04	24 YO ♂ ɪ KNOWN H/O TONIC
2115	CLONIC ~~[illegible]~~ SEIZIURE D/O AND
	SEVERE REACTIVE AIRWAYS DX. 12 NOV 04
	PRESENTED TO 115TH FH FROM CAMP
	FALLUJAH AFTER HAVING SEIZIURE
	AND AIRWAY EMERGENCY REQUIRING
	TRACHEOSTOMY. PATIENT HAD STABILIZED
	ON WARD AND TRACHEOSTOMY WAS REMOVED
	PATIENT PLACED ON HIS SEIZURE
	PROPHYLAXIS, WAS TOLERATING REGULAR
	DIET, AMBULATING, AND APPEARED
	APPROPRIATE AND WITHOUT EVIDENCE OF
	ONGOING SEIZIURES. WAS PREPARING
	TO BE TRANSFERED TO CAMP WHEN HE HAD
	A SEIZURE ON ICW 2. NURSES WENT TO
	ATTEND TO PATIENT WHILE (b)(6) WAS
	RETRIEVED FROM ICU. NOTED BY (b)(6)
	ɪ GENERALIZED TONIC-CLONIC SEIZIURE
	ATIVAN 4mg IM GIVEN THEN REPEATED 1
	MIN LATER. AMBU BAG BROUGHT
	WHEN PATIENT NOTED TO HAVE RESPIRATORY
	EMBARASSMENT ɪ O_2 ADDED SUPPLEMENTAL.

(Continue on reverse side)

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

(b)(6)

PROGRESS NOTES
Medical Record

10-L-0126 ACLU DDII CID ROI 15722 -04-CID789-83999

PROGRESS NOTES

DATE	
15 NOV 04 (CONT'D)	CODE WAS CALLED AND PATIENT WAS INTUBATED. EPI 1 cc GIVEN BY ET TUBE. CPR STARTED THEN STOPPED AFTER 1 MIN CIRC. QUICK LOOK SHOWED WIDE VENTRICULAR ESCAPE RHYTHM - NO CARDIAC MOTION NOTED. NO PULSE. 1 mg ATROPINE GIVEN BY ET TUBE. (L) FEM VC LINE STARTED ~~AND~~ BUT ATROPINE AGAIN GIVEN (BY LINE). EPI GIVEN AGAIN, THIS TIME BY IV. IT WAS REPEATED AND RECIRCULATED. PATIENT NEVER ENTERED A SHOCKABLE RHYTHM. PUPILS BECAME FIXED AND DILATED. CHEST COMPRESSIONS WERE STOPPED. PATIENT WAS ASYSTOLIC AND SONOSITE DEMONSTRATED NO CARDIAC MOTION.
	CODE START 2024
	CODE FINISH 2041
	PROXIMATE CAUSE OF DEATH
	ANOXIA 2° TO GENERALIZED TONIC SEIZURE COMPLICATED BY REACTIVE AIRWAYS DISEASE.
	MDs: (b)(6) (b)(6) (b)(6)
	CID NOTIFIED IMMEDIATELY. (b)(6)

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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12NOV	(b)(6)	SOLUMEDROL 60MG	04	(b)(6)													
		IV Q8°	12														
			20	(b)(6)													
12NOV		ALBUTEROL SOLN	02														
		2.5 MG IN 3cc NS	06				D'ed 15 NOV 04										
		VIA NEBULIZER Q4°	10														
			14														
			18														
			22														
12NOV		ROCEPHIN 1.0 GM IV QD°	09	(b)(6)			DIC'd 12NOV04 1405							(b)(6)			
12NOV		~~ATIVAN~~ TEGRETOL	09	(b)(6)													
		200MG PO BID	21	(b)(6)													
12NOV		NS @ 70 ML/HR	07	(b)(6)													
			19	(b)(6)													
12NOV		DILANTIN 300 MG IV QPM, 1ST DOSE TONIGHT	20	(b)(6)													
14NOV		Prednisone 60mg PO qd	08	/	/	/											
		~~MAGNESIUM 2GM IV~~															

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: (b)(6) STABLE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: (b)(6)

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

ACLU DDII CID ROI 15723

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. NOV Yr. 04			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
12 NOV	(b)(6)	DILANTIN 900MG IV PUSH AT	12 NOV	NOW	1420 ~~1410~~	(b)(6)
		RATE OF 50MG/MIN				
12 NOV		MAGNESIUM 2GM IV OVER 20	12 NOV	NOW	1500	
		MIN				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
12NOV	(b)(6)	ATIVAN 4MG IV	(b)(6)
		X1 FOR SEIZURE,	
		MAY REPEAT	
		Q 10 MIN	

~~FOR OFFICIAL~~

10-L-0126 ACLU DDII CID ROI 15724

USAFA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	12	13	14	15	16	17	18	19	20	21	22	23	24	25
12NOV	(b)	ATROVENT UNIT	02	/													
		DOSE NEB Q4°	06	/													
			10	/					unavailable								
			14	/													
			18	/					from pharmacy								
			22	/													
15Nov04	(b)(6)	Albuterol/Atrovent	06	/	—	/	(b)(6)										
		Neb q8°	14	/	—	/											
			22	/	—	/											
15NOV	(b)(6)	Δ ALBUTEROL/	06	/	/	/	/										
		ATROVENT TO	14	/	/	/	/										
		MDI'S 2PUFFS	22	/	/	/											
		Q 8°															

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:
S/P CRICOTOMOY
S/P STATUS ASTHMATICUS STABLE

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

PATIENT IDENTIFICATION:
(b)(6)
(b)(6)

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 71 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

10-L-0126 ACLU DDII CID ROI 15725
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CLINICAL RECORD

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

Mo. 11 Yr. 04

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12NOV	(b)(6)	CLEAR LIQUIDS AS	B	(b)(6)			D/C'ed 14 NOV 04										
		TOLERATED	L														
			D														
12NOV	(b)(6)	VITALS PER ROUTINE	07	(b)(6)													
			19														
12NOV	(b)(6)	ACTIVITY AD LIB	07	(b)(6)													
			19														
12NOV	(b)(6)	DAILY CBC	06	/	(b)(6)												
14 NOV	(b)(6)	DIET: Advance	B	/	—	/	(b)(6)										
		AS TOLERATED	L	/	—	/											
			D	/	—	/											

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P CRICOTOMY
S/P STATUS ASTHMATICUS STABLE

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

PATIENT IDENTIFICATION:
(b)(6)

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

DA FORM 4677, 1 OCT 83 — EDITION OF 1 DEC 77 MAY BE USED.

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0238-04-CID789-83999

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)	Mo MW Yr 04			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12 MW	(b)(6)	ADMIT ICU	12 MW	MW	0720	(b)(6)

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

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10-L-0126 ACLU DDII CID ROI 15727

*U.S. Government Printing Office: 19__-__0-727/10397

0238-04-CID789-83999

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 NOV 04 TIME OF ORDER: 0520 HOURS

Admit ICU Dx: S/P Cricotomy
Stable S/P Sinus Admin
Allergies: NKDA
Diet: Clear liquids as tolerated
Vitals: Per Routine
Activity: no lib

LIST TIME ORDER NOTED AND SIGN: 12 Nov 04

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

Meds:
1. Solumedrol 60mg IV q8°
2. Albuterol soln 2.5mg in 3cc Normal Saline via Nebulizer q4°
3. Rocephin 1.0gm IV qD

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

4. Ativan 4mg IV x1 for seizures may repeat every 10 minutes
5. Tegretol 800mg PO BID

Daily CBC

PATIENT IDENTIFICATION

(b)(6)

(b)(6) OF ORDER TIME OF ORDER 0900 HOURS

11/12/04 (b)(6)

1) NS @ 70cc/hr

(b)(6)

NOTED

NURSING UNIT | ROOM NO. | BED NO.

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10-L-0126 ACLU DDII CID ROI 15728

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

0238-04-CID789-83999

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER: 15NOV 04 | TIME OF ORDER: 0400 HOURS | LIST TIME ORDER NOTED AND SIGN

Albuterol / Atrovent nebs
Q 8h (b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 15NOV 0620 (b)(6)

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER: 11/15/04 | TIME OF ORDER: 1715 HOURS

Δ Albuterol / Atrovent
to MDIs / 2 Puffs

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 11/15/04 | TIME OF ORDER: 1800 HOURS

D/c to Cdr

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

10-L-0126 ACLU DDII CID ROI 15729

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0238-04-CID789-83999

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 Jun 04 TIME OF ORDER 2000 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Albuterol / Atrovent Neb TID now Please
2) Prednisone 60mg PO QD
3) May advance diet to regular as tolerated (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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10-L-0126 ACLU DDII CID ROI 15730

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

2

0238-04-CID789-83999

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER 11/12/04 TIME OF ORDER 1405 HOURS | LIST TIME ORDER NOTED AND SIGN

1) Ativan 4mg IV
2) Dilantin 900mg IV push at rate of 50mg/min
3) Dilantin 300mg IV QPM, 1st dose tonight

(b)(6)

DATE OF ORDER TIME [illegible] HOURS

1) D/C Rocephin
2) Magnesium 2gm IV over 20 minutes.
3) Atrovent unit dose neb Q4°.

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER 11/12/04 TIME OF ORDER 1842 HOURS

1) Transfer to ICW2
Resume all orders from ICU

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER TIME OF ORDER HOURS

10-L-0126 ACLU DDIT CID ROI 15731

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

0238-04-CID789-83999

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11/15/04	[illegible]
[illegible]	[illegible]
	[illegible] 86 R 16
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible] RTXS [illegible]
	[illegible]
	[illegible]
	A/P [illegible]
	[illegible]
	[illegible] D/C [illegible]
	[illegible]
	— △ [illegible]
	— [illegible]
	— ? D/C [illegible]

(b)(6)

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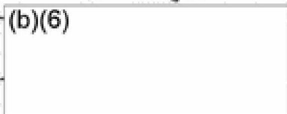
10-L-0126 ACLU DDII CID ROI 15732

0238-04-CID789-83999

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3/16/2004 1900	S: PT Still c/o severe difficulty Breathing no seizures Today
	O: 98.5 120/70 98 14 97% RA
	Lungs: mod Wheezing Bilaterally
	CV: RRR s (m)
	ABD: ND (+)BS Nontender
	EXT: Good [illegible] Pulses
	A/P:
	1) S/p Status Asthmaticus
	- Emergency [illegible] Contrary to Health
	- Continue ABx / Steroids
	- Will Order Neb Tx Tonight
	2) Seizures
	- Started on Dilantin [illegible]
	-



(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.

(b)(6)

PROGRESS NOTES
Medical Record

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

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0238-04-CID789-83999

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Mg 2gm IV x 1.
	2) Seizure d/o - We have restarted tegretol, but it will take a few days to reach therapeutic levels. Therefore, given 2 seizures (tonic-clonic) today, will load c phenytoin 900mg IV over 18mins → 300mg PO QD in addition.
	3) Crycothyroidotomy - xeroform dressg QD will close on its own c time. Keep occluded (b)(6)
12Nov04 1950	NSG: PT c SECOND SEIZURE AT 1410. SAME SYMPTOMS AS BEFORE, DIAPHORETIC, PUPILS 3/4 MM, SLOW REACTION (B) 4MG ATIVAN IV GIVEN. (b)(6) NOTIFIED. NEW ORDERS RECEIVED AND INITIATED. PT ON 10L NRB, SaO_2 99%, ORAL AIRWAY IN PLACE. VSS. WILL CONTINUE TO MONITOR. —— (b)(6)

10-L-0126 ACLU DDII CID ROI 15734

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STANDARD FORM 509 (REV. 5/1999) BACK

0238-04-CID789-83999

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | ICU Note | PROGRESS NOTES

DATE: 11/12/04 1446

NOTES

This AM, pt was doing well, titrated down to 4L NC. He was talking + interacting. At 1330, pt had generalized tonic clonic sz + was given 4mg Ativan IV c̄ cessation of seizure. At 1410, pt had 2nd generalized tonic clonic sz. that was again broken c̄ Ativan. Hx obtained prior to sz is that he has hx epilepsy + has been out of carbamazepine x 2 days. Pt started on Tegretol 200mg BID last at.

O/ BP 135/72 HR 123 R 21 O2 sat 99% on 100% NRB
Gen - post ictal
HEENT - oral airway in place
Pulm - diffuse rhonchi (B), cricothyroidotomy wound c/d/i
CV - Tachycardic ⊖m
ABD - NT/ND ⊕BS
EXT - ⊖edema
CXR: SQ emphysema in neck, ⊖ infiltrate
Labs: 14.2 > 36 < 442 138|106|14 / 4.2|17|1.3 < 146 Ca 8.1
UA ⊖

A/P 1) Asthma Exacerbation - Cont Solumedrol 1mg/kg QD convert to Prednisone once taking PO. Q4° Alb/Atrovent nebs.

RELATIONSHIP TO SPONSOR (b)(6) | SPONSOR'S NAME (b)(6) FIRST | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | WARD NO.

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

(b)(6)

PROGRESS NOTES
Medical Record

10-L-0126 ACLU DDII CID ROI 15735

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

USE ONLY

0238-04-CID789-83999

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	CONTINUED
	DOWN TO 4L NC. PT c̄ EXPIRATORY WHEEZING.
	NEB TREATMENT GIVEN. PT STATES GENERAL
	SEIZURES, HAS NOT TAKEN MEDS x 3 DAYS.
	PT c̄ PRODUCTIVE COUGH - BLOODY SPUTUM.
	VSS. WILL CONTINUE TO MONITOR. (b)(6)
12NOV04	VS: HR 134 SaO_2 99% 15L FM, RR 42 BP 124/52
1330	PT HAVING SEIZURE - SUDDEN ONSET TONIC CLONIC -
	WHOLE BODY SHAKING, JAW CLENCHED. MD
	INFORMED. 4 MG ATIVAN IV GIVEN. SUCTION AT
	BEDSIDE. ——— (b)(6)
12NOV04	NSG: PT IN POST ICTAL PHASE, SLEEPING, SNORING.
1400	PT SWITCHED FROM FACE MASK TO 6L NC. SOFT
	RESTRAINTS APPLIED USING KERLEX. QUICK
	RELEASE KNOT IN PLACE. PT DIAPHORETIC. VSS.
	WILL CONTINUE TO MONITOR. ——— (b)(6)
11/12/04	ICU Note
	S/ Detainee admitted last nt from Fallujah FST Bravo. Pt apparently was having an asthma exacerbation yesterday, then developed seizure, hypoxia, failure to intubate, + had emergent cricothyroidotomy. Pt then transferred to 115th FH ^given aminophylline / Albuterol. At Abu Ghraib, pt ^after noted to be hypoxic, but impr[illegible] [illegible] includes
	SO [illegible] emergent crich - kit removed.

10-L-0126 ACLU DDII CID ROI 15736

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STANDARD FORM 509 (REV. 5/1999) BACK

0238-04-CID789-83999

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0320	PT arrived to ETR via litter. Cric in place, foley draining yellow urine, 18 g (R) AC ē LR infusing. BP 105/61, P 126, SPO2 99% 10L facemask R-16 T 98.4 ——— (b)(6)
0345	BP 101/50, P 128, SPO2 93 10L FM, R 16, T 97.8 PT alert, ABG drawn & sent to lab, 125 mg Solumedrol administered per (b)(6)
0400	BP 95/57, P 120, SPO2 100%, pt suctioned — (b)(6)
0430	10mg Versed administered, 119/90, P 128, SPO2 90%
0440	1000cc LR infused, 2nd bag of NS infusing TKO, BP 91/47, P 121, SPO2 100% 10L face mask,
0450	5mg Versed administered, UA, CBC BMP sent to lab ——— (b)(6)
0500	P 113 SPO2 99% ———
0520	P 120, SPO2 97% 10L FM, BP 97/60, T 97.9 (b)(6)
0545	1000cc emptied from foley, BP 108/61, R 22 SPO2 90% P 119 T 98.7 ——— (b)(6)
0615	BP 108/61, P 116, SPO2 93% R 20
12MW 0915	NSG: REPORT RECEIVED FROM ER. PT TRANSFERRED VIA STRETCHER. REFER TO ICU FLOW SHEET FOR ASSESSMENT. PT ON FACE MASK 12L, TITRATED →

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.
(b)(6)		

PROGRESS NOTES
Medical Record

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

ACLU DDII CID ROI 15737
ACLU-RDI 5484 p.34

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** 0238-04-CID789-83999

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Jan 04 0554	HPI 24 y/m presents transfer Camp [illegible] Detainee had emergency Trac for status Asmaticus [illegible] hospital here has a urgent surgical [illegible] through emergency Trac Tube but significant air leak and we were unable to suction tube otherwise respiratory status stable SATS 95-100% patient attempting to talk however had significant amounts mucus plugging. Contacted surgery stated no need for any surgical intervention. Patient continued to have copious amounts secretions and was being transported to xray has "seizure activity" given Ativan 10mg decreased activity somewhat during assessment airway patency contacted Anesthesiology thought best to give trial of removal tracheostomy airway removed patient significantly better able to ventilate on own c 10L O2.
	(b)(6)
	PMHx: 1) Asthma - lifelong
	2) Seizure Disorder - Post [illegible] 14 / 11.9 / 36 \ 442
	Surg: Ø
	Exam - See Exam Sheet 138 / 106 / 14 / 4.2 / 17 / 1.3 UA neg
	A/P: 1) S/P Status Asthmaticus - now stable
	2) S/P Emergency Cric - now stable Continue monit

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
115th FIELD HOSPITAL, FT. POLK, LA 71459			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR

0126 ACLU DDII CID ROI 15738

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ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE (YYYYMMDD): 2004 NOV 12

0238-04-CID789-83999

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

24 y/o m S/P states asthmatic S/P emergency Cr...

PMHx - Seizure Disorder Takes Tegretol

3. PHYSICAL EXAMINATION (including pertinent positives and negatives)

HEENT: PERRLA EOMI TMs clear Neck: no LAD Lungs: BCTA
COV: RRR ... ABD: NO H/BS ...
EGT: Grossly Benign Pul

4. IMPRESSION (Enter admission note with plan on progress notes)

S/P Emergency ... - Now Stable
S/P Asthmatic - Now Recovering

5. ADMITTING OFFICER

a. SIGNATURE: (b)(6)

b. DATE SIGNED (YYYYMMDD): 2004 Nov 12

6. DISCHARGE NOTE (Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)

7. DISCHARGE DATE (YYYYMMDD)

8. DISCHARGING OFFICER

a. NAME (Last, First, Middle Initial)	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION (For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)

(b)(6)

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD (Initials) ...

DD FORM 2770, APR 1998 (EG)

10-L-0126 ACLU DDII CID ROI 15739

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2

(b)(6)

0238-04-CID789

Trauma Record

For use of this form, see DoD Memo Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF D (b)(6) Number (b)(6) CASUALTY NAME: FIRST LAST (b)(6) CASUALTY SSN: (b)(6)

Arrive Date-Time Group (DTG): 0320 / 12 Nov 04 | Rank Ø | Date of Birth (b)(6) | Gender (b)(6) | Unit Ø

ARRIVAL METHOD: ☐ WALKED ☐ CARRIED ☐ Non-MED AIR ☐ OTHER Air / Traumateam ☐ Non-MED GND ☐ SHIP EVAC ☐ GND AMB ☐ AIR AMB

Nation: ☐ US ☐ Host Nation ☒ Enemy( ) ☐ Coalition( )

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

Wound DTG: ∅

WOUNDED BY: ☐ US/COALITION(Nation____) ☐ ENEMY ☐ NonENEMY ☐ CIVILIAN (Nation____) ☐ TRAINING ☐ SELF ACCIDENT ☐ SELF NON-ACCIDENT ☐ SPORTS-RECREATION ☐ OTHER: N/A

PROTECTION: ☒ UNK

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

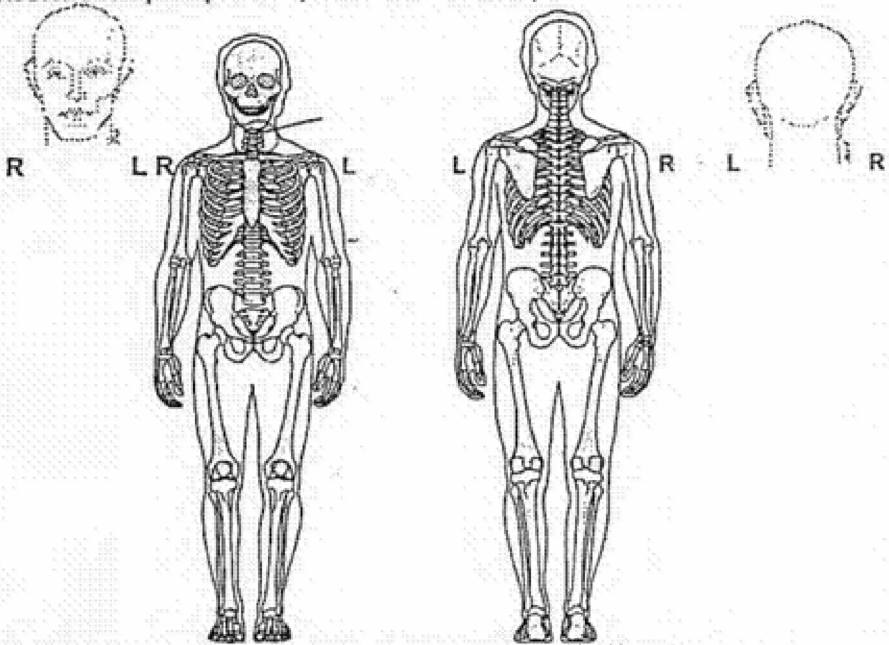
TRIAGE CATEGORY: ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL ☐ EXPECTANT

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

MECHANISM OF INJURY: ☐ GSW/BULLET ☐ BLUNT TRAUMA ☐ SINGLE FRAGMENT ☐ MULTI FRAGMENT ☐ KNIFE / EDGE ☐ BLAST ☐ CRASH(a/c, veh, ped) ☐ Chem/Rad/Nucl ☐ BURN (thermal, flash) ☐ CRUSH ☐ FALL ☐ SMOKE Inhalation ☐ HEAT ☐ COLD ☐ BITE / STING ☐ OTHER ____ NA

TIME	0320
Pulse	126
Temp	98.4
B/P	135/61
Resp	16
SpO_2	99%

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:

SEDATED	
CHEM PARALYZED	
INTUBATED	
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	(LR)/NS/HTS ml
TOURNIQUET	Time on / Time off
Collar / C-spine Back board	
HEMOSTATIC DEVICE	
OXYGEN	Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splnt	Extremity

OR Start DTG: Stop DTG: | Vent On DTG Off DTG: | Out DTG: (b)(6)

DISPO (b)(6) SPECIALTY (b)(6)

O DETAINEE

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Theater Trauma Registry Record

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

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

0238-04-CID789-83999

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

CHIEF COMPLAINT:

fresh cric, status asthmaticus

CURRENT MEDICATION

CONDITION UPON RELEASE:
_IMPROVED
_UNCHANGED
_DETERIORATED

DISCHARGE INSTRUCTION:

NOTES:

Anesthesia Note

Called to see pt with cricothyroidotomy, ? status asthmaticus, ? seizure d/g forewal of airway. Pt hemodynamically stable, breathing around & thru cricothyroidotomy hole/tube. BBS= Tube apparently occluded & removed. Pt breathing & ~~talking~~ nc mouthing words okay and improved. Continue asthma +/- seizure treatments. Treat airway as healing trach. Re-insert tube as needed. Advance diet as tolerated. Continue to follow as needed.

(b)(6)

(b)(6)

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SSN/ISN #11

0238-04-CID789-83999

Trauma Record
DISCHARGE SUMMARY

MEDICATIONS:	LABS:	XRAYS:	PMH:
Ativan 15mg total Solumedrol 125mg IV x1	CBC, Chem	CXR	PMH: Seizure Disorder Allergies: NKDA

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	PERRLA EOMI TMs Clear
Head & Neck (incl C-spine)	⊘ LAD
Chest (incl T-spine)	BCTA
Abdomen (incl L-spine)	ND (+) BS ⊘ Tender
Pelvis	⊘ Tend
UPPER /LOWER Extremities	Good Periph Pulses
Skin	[illegible]

DISPOSTION		Evacuation Priority
DTG:	☐ EVAC to ______ ☐ RTD ☐ RT CAMP ☐ DECEASED (see below)	☐ ROUTINE ☐ PRIORITY ☐ URGENT

Damage Control Procedures? Y / N   Hypothermic (< 34°C)? Y / N   Coagulopathy? Y / N

Cause of Death at DTG ______

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

PHYSIOLOGIC:
☐ Breathing ☐CNS ☐Hemo[...] Total Body Disruption ☐Sepsis ☐Multi-organ failure

CO[...] (b)(6)   SURGEON: (printedName)

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MEDCOM [...]

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

0238-04-CID789-83999

OPERATION PERFORMED

AGENTS AND TECHNICS OF ANESTHESIA

HOURS(S) 0155 0200 0210 0225 0245 15 30 45 15 30 45 15 30 45

TEMPS: ●PULSE CVP: 98% 99% 99% 99% 99%

×B.P. 220 200 180 160 140 120 100 80 60 40 20

AT 98.8 A

RESP. RATE 21 23 24

NUMBERS FOR REMARKS ①

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L		✓	
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5%	BLOOD	SALINE	OTHER
OPERATING ROOM				
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: ______ CC

WARD PRE-OP B / mmHg

TUBES: ☐ N/G ☑ FOLEY

IV IN ______ c ______ cc
OF ______ AT ______ cc/hr

IV IN ______ c ______ cc
OF ______ AT ______ cc/hr

ART. LINE IN ______

T-TUBES, HEMOVAC IN ______

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD
DATE 11/12 HRS 0150	DATE HRS
DRESSINGS/LOCATIONS STATUS: DCC	STATUS
ENDOTRACHEAL TUBE - ORAL OR NASAL ☐ YES ☐ NO	☐ YES ☐ NO
AIRWAY ☐ CLEAR ☒ PLAST AIRWAY ☐ OBSTRUCTS EASILY	STATUS:

URINARY OUTPUT

TIME						
CC						
TOTAL						
SP. GR						
S/A						

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES

① urinary cath put in @ 0225 650ml

(CONT'D ON REVERSE)

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

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ______ HRS
SENSATION PRESENT AT ______ HRS

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

RECOVERY: ☐ COMPLICATED ☐ UNEVENTFUL

PATIENT'S IDENTIFICATION
(b)(6)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

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

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AD (b)(6)
TOW (b)(6)

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NAVMED 6320/16 (BACK)

HOURS(S)	15	30	45	15	30	45	15	30	45	15	30	45	15

TEMPS:
●PULSE
CVP:

X B.P.

220
200
180
160
140
120
100
80
60
40
20

RESP. RATE →

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
0230	Versed	3mg		

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES (CON'T FROM FRONT)

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Status Asthmaticus

Theater Medical Registry Record

MTF Designation: B SURG CO	Location: CAMP FALLUJAH, IRAQ	Facility Type: ☐ Base-X ☐ GP ☐ CBPS ☒ Hard Bldg	(b)(6)	Casualty SSN: (b)(6)
MTF Casualty Received From:		Rank:	Date of Birth: 28 AUG 79	Gender: (b)(6) / Unit:
Date/Time of Injury: N/A DDMMMYY/TIME	Date/Time Arrived: 12NOV04 0045 DDMMMYY/TIME	Nation: ☐ US ☐ Host Nation ☒ Enemy (EPW) ☐ Coalition ( )	Category: ☒ Civilian ☐ Combatant ☐ Contractor	☐ USA ☐ USN ☐ USMC ☐ USAF ☐ SOF ☐ NGO (____) ☒ Other (EPW)

Arrival Method: ☐ Walked ☐ Carried ☒ USMC CASEVAC ☐ Non-MED GND ☐ Ship EVAC ☐ GND AMB ☐ DUSTOFF

Transit Duration Time ______

Wounded By: N/A ☐ Enemy ☐ UNK ☒ Friendly ☐ Civilian (Host Country) ☐ Training ☐ Self Accident ☐ Self Non-Accident ☐ Sports Recreation ☐ Other: (____)

Protection: ☒ UNK

	Not Worn	Worn	Struck	Penetrated
Helmet	☐	☐	☐	☐
Eyewear: Wiley-X ☐ / ESS ☐	☐	☐	☐	☐
Flak vest	☐	☐	☐	☐
Ceramic plate	☐	☐	☐	☐
Axillary/Deltoid protection	☐	☐	☐	☐
Lower extremity protection	☐	☐	☐	☐
Other: _____(Face, Ear, etc.)	☐	☐	☐	☐

Triage Category: ☒ Immediate ☐ Expectant ☐ Delayed ☐ Minimal

Glasgow Coma Scale

Eye Opening	Verbal Responsiveness	Motor Response
1-None	1-None	1-None
2-To pain	2-Incomp sounds	2-Extend pain
3-To command	(3)-Inapprop words	3-Flex to pain
☒ 4-Spont	4-Confused	4-Withdraws
	5-Oriented	(5)-Localize pain
		6-Obeys

UNK eyes closed

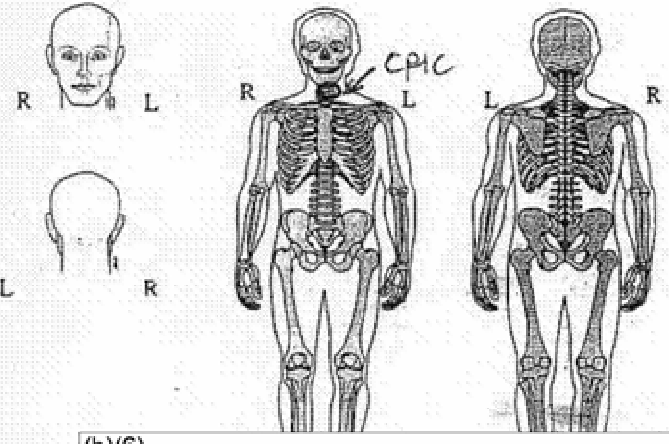
Glasgow Score 8? (Enter total number)

Mechanism of Injury: N/A ☐ GSW/Bullet ☐ Blunt Trauma ☐ Single Fragment ☐ Multi Fragment ☐ Motor Vehicle Crash ☐ Aircraft Crash ☐ Knife/Edge ☐ CBRNE ☐ Blast ☐ Burn 1^0☐ 2^0☐ 3^0☐ ____ %TBSA ☐ Crush ☐ Fall ☐ IED ☐ Mine ☐ Other: (____)

Vitals:

Time	0045		
Pulse	121		
Temp	99.8		
B/P	125/45	/	/
Resp			
SpO2	84 %	%	%

INJURY Description (Location, nature and size in cm.) Be specific – Enter free text type in gray box, 500 character maximum.



Code	Meaning
AB	Abrasion
AMP	Amputation
AV	Avulsion
BL	Bleeding
B	Burn
Deform	Deformity
ECC	Ecchymosis
FB	Foreign Body
H	Hematoma
LAC	Laceration
PW	Puncture Wound
P	Pain
FX	Fracture
SS	Seatbelt Sign
SW	Stab Wound
GSW	Gun Shot Wound

(b)(6)

Tx & Procedures:

Procedure	
Sedated	0110 & 0225
Chem Paralyzed	____
Intubated	____
CRIC arrived with	____
Needle Decomp	____
Chest Tube	☐ L side ☐ R side ☐ air ☐ blood
IO Line	____
Colloid (HTS/Albumin)	____ ml
Crystalloid (LR/NS) Other: ____	____ ml
Tourniquet	Time on ____ Time off ____
Collar/C-Spine	____
Hemostatic (e.g. Quick Clot)	
Oxygen	15 Liters/min.
RBC	____ Units
FFP	____ Units
CRYO	____ Units
Plts	____ Packs
HBOC	____ ml
Walking Blood Bank	____ Units
EXT Fixation (Location)	____
Long Bone Splint	____

OR Start / Stop	DDMMMYY/TIME / DDMMMYY/TIME	Vent On / Off	DDMMMYY/TIME / DDMMMYY/TIME	ICU In / Out	DDMMMYY/TIME / DDMMMYY/TIME

Provider: (b)(6) Specialty: Peds Date: 12NOV04 DDMMMYY

Medical Visit: ☒ Sick Call ☐ Trauma Treatment: ☒ Initial ☐ Follow-Up

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ACLU-RDI 5484 p.42

3mg versed @ [redacted] 25
aminophylline 350mg done @ 02[redacted]

0238-04-CID789-83999

Casualty Name (Last, First MI):	(b)(6)	SSN:
2mg versed 0110.		

Medications:	Labs:	X-Rays:	PMHx: unk.
albuterol neb 0045 125mg solumedrol		AP CXR	Allergies: unk

☒ SOAP Note

0050 (∅ mag sulfate available here.)
∅ pneumothorax
∅ definite infiltrate.

Cric'd 24 yo adult male brought in on vehicle, unk. referral source. ∅ hx available. has a hx of "small seizures in his eyes" (? absence sz Petit mal sz?)

- p̄ neb #1, begins talking.
- asking to have hand released.

responds to pain when cric. manipulated

Region	☐ Discharge Summary Information (Diagnosis, Procedures and Complications)
Head & Neck (incl. C-Spine)	cric, fresh, in place. eyes covered.
Chest (incl. T-Spine)	diffuse Ⓑ wheezes, ↑↑ exp phase, O2 sat 92%, resp distress c̄ mild clinical cyanosis
Abdomen (incl. L-Spine)	soft NT obese. IV & restraints in place.
Upper Extremities	IV & restraints
Pelvis	stable.
Lower Extremities	∅ apparent trauma.
Skin	∅ signs trauma.

Damage Control Procedures? ☐ Y ☐ N Hypothermic? ☐ Y ☐ N Coagulopathy? ☐ Y ☐ N Class of Hemorrhage: I ☐ II ☐ III ☐ IV ☐ Shock? ☐ Y ☐ N

DNBI Category:			
☐ Dermatologic	☐ Heat/Cold	☐ Injury, Other	☒ Respiratory
☐ GI, Infectious	☐ Injury, Rec./Sports	☐ Ophthalmologic	☐ STDs
☐ Gynecologic	☐ Injury, MVA	☐ Psychiatric, Mental	☐ Fever, Unexplained
	☐ Injury, Work/Training	☐ Psychiatric, Stress	☐ All Other Medical/Surgical

Disposition Date/Time:		Evacuation Priority:	
12 NOV 04 0915 DDMMMYY/TIME	☒ Evacuated to ______ ☐ Light duty x ____ days ☐ RTD ☐ SIQ x ____ days ☐ Deceased - ☐ DOA ☐ DOW (see below)	xo ICU.	☐ Routine ☐ Urgent Surgical ☐ Priority ☐ Convenience ☒ Urgent non surgical

Date/Time of Death: ________ DDMMMYY/TIME

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

PHYSIOLOGIC:
☐ Breathing ☐ CNS ☐ Hemorrhage ☐ Total Body Disruption ☐ Sepsis ☐ Multi-organ Failure ☐ Other, specify: (________)

Comments: D/C to ICU.

Surgeon: (b)(6)

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

(b)(6) 3-04-CID789-83999

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI (b)(6) (b)(6) SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: Ward: 2002 STAT
Drawn by: Bed: (b)(6) ✓ Routine

Specimen Date and Time:

Reported by: (b)(6) Date and Time: 15 NOV 0833

Chemistry (i-STAT) / Green Top / Syringe
Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-26 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

TEST	RESULT	REF. RANGE
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top
Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Rapid Tests

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative

Microbiology

TEST	RESULT	REF. RANGE
KOH		No Fungal Elements
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Parasite Panel		Presumptive Negative
Chlamydia		Presumptive Negative
OccBld		Negative
O&P		No Ova/Parasite
Strep A		Negative
Leishmania		Presumptive Negative
S. pneumoniae		Presumptive Negative
Flu		

Hematology / Purple Top
(CBC) Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	11.2	4.8-10.8 x10(3)/uL
	RBC	4.97	4.2-6.1 x10(6)/uL
	Hgb	13.5	12.0-18.0 g/dL
	Hct	42.7	M: 42.0-52.0%
		[illegible]	F: 37-47%
	MCV	85.7	80.0-99.0 fl
	MCH	27.1	27.0-31.0 pg
	MCHC	31.6	33.0-37.0 g/dL
	Plt	350	130-400 x10(3)/uL
	LY%	21.7	20.0-44.0%
	LY#	2.4	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple

TEST	RESULT	REF. RANGE
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

TEST	RESULT	REF. RANGE
Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

TEST	RESULT	REF. RANGE
PT		7.0-14.0 sec
PTT		
INR		0.7-1.4/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top

TEST	RESULT	REF. RANGE
Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Body Fluid Panel - Sterile Cont.
Panel includes: Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)

Other lab request:

10-L-0126 ACLU DDII CID ROI 15747

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ACLU-RDI 5484 p.44

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)
SSN or ISN: (b)(6)
Signs and Symptoms: AM LABS.
Physician: (b)(6)
Drawn by: (b)(6)
Ward: ICU-4
Bed: (b)(6)
STAT
X Routine
Specimen Date and Time: 0500 14 Nov BP
Reported by: (b)(6)
Date and Time: 14 Nov 04 0545

Chemistry (i-STAT) / Green Top / Syringe
Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-26 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry (Piccolo Analyzer) / Green Top
Chem 12 | MetLyte8 | BMP | Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology / Purple Top
(CBC) | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC	10.5	4.8-10.8 x10(3)/uL
	RBC	4.37	4.2-6.1 x10(6)/uL
	Hgb	12.0	12.0-18.0 g/dL
	Hct	37.9	M: 42.0-52.0% F: 37-47%
	MCV	86.7	80.0-99.0 fl
	MCH	27.4	27.0-31.0 pg
X	MCHC	31.6L	33.0-37.0 g/dL
	Plt	350	130-400 x10(3)/uL
	LY%	20.3	20.0-44.0%
	LY#	2.1	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)		Mono(4-10%)	
Bands(1-10%)		Eos(0-4%)	
Lymph(20-44%)		Baso(0-2%)	
Atyp Ly		Immature cells	

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

TEST	RESULT	REF. RANGE
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

Misc. Rapid Tests

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori		Negative

Microbiology

TEST	RESULT	REF. RANGE
Gram Stain		
KOH		No Fungal Elements
Directogen		Presumptive Negative
Legionella		Presumptive Negative
Parasite Panel		Presumptive Negative
OccBld		Negative
O&P		No Ova/Parasite
Strep A		Negative
Leishmania		Presumptive Negative
S. pneumo		Presumptive Negative
Flu A&B		Negative

Malaria / Purple

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (waiting for analyzer)

PT		
PTT		
INR		
D Dimer		Negative

Cardiac Panel

Myoglobin		
CK-MB		
Troponin		

Blood Bank/ Purple Top

ABO/Rh		
T/C		

Other

10-L-0126 ACLU DDII CID ROI 15748

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115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

(b)(6) | (b)(6) | SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: (b)(6) Ward: ETR X STAT
Drawn by: Bed: Routine

Specimen Date and Time: 0500/12NOV04

Reported by (b)(6) Date and Time: 12Nov/04 0536

Chemistry (i-STAT) / Green Top / Syringe — Bld Gas, Bld Gas w/ lytes, Glu, Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-26 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Test	Result	Ref. Range
Color	Lt yellow	Straw/Yellow
Clarity	Clear	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	40	Negative
SG	1.010	1.010-1.025
Blood	Trace-Lysed	Negative
pH	5.0	5.0-8.0
Protein	Neg	Negative-Trace
Urobili	0.2	0.1-1.0 Ehrlich U/dL
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC		Epi	0-5/hpf
RBC	0-5/hpf	Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:	Acetest: Small		

Chemistry (Piccolo Analyzer) / Green Top — Chem 12, MetLytes, BMP (circled), Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
	Ca	8.1	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L; F: 30-190 U/L
	CL	106	98-109 mmol/L
X	TCO2	17L	18-33 mmol/L
	Creat	1.3	0.6-1.3 mg/dL
	GGT		5-65 U/L
X	Glu	146H	73-118 mg/dL
	K	4.2	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	138	138-145 mmol/L

Misc. Rapid Tests

Test	Result	Ref.
Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative

Microbiology

Test	Result	Ref.
KOH		No Fungal Elements
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Parasite Panel		Presumptive Negative
Chlamydia		Presumptive Negative
OccBld		Negative
O&P		No Ova/Parasite
Strep A		Negative
Leishmania		Presumptive Negative
S. pneumoniae		Presumptive Negative
Flu A&B		Negative

Hematology / Purple Top — CBC (circled), Malaria, H/H

X	TEST	RESULT	REF. RANGE
X	WBC	14.2H	4.8-10.8 x10(3)/uL
	RBC	4.24	4.2-6.1 x10(6)/uL
X	Hgb	11.9L	12.0-18.0 g/dL
X	Hct	36.4L	M: 42.0-52.0%; F: 37-47%
	MCV	85.8	80.0-99.0 fl
	MCH	28.1	27.0-31.0 pg
X	MCHC	32.8L	33.0-37.0 g/dL
X	Plt	442H	130-400 x10(3)/uL
X	LY%	4.6L	20.0-44.0%
	LY#	0.7	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)		Mono(4-10%)	
Bands(1-10%)		Eos(0-4%)	
Lymph(20-44%)		Baso(0-2%)	
Atyp Ly		Immature cells	

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top

Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Body Fluid Panel - Sterile Cont.

Panel includes: Gram Stain, Cell Count, WBC Diff, ... (CSF only)

Other lab request:

10-L-0126 ACLU DDII CID ROI 15749

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0238-04-CID789-83992

115th Field Hospital
Bagndad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI (b)(6)	(b)(6)	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician (b)(6) Ward:	STAT	Specimen Date and Time:	Reported b (b)(6) Date and Time: 12NOV04 0352
Drawn by: Bed:	Routine	0340/12NOV04	

Chemistry (I-STAT) / Green Top / Syringe — Bld Gas, Bld Gas w/ lytes, Glu, Crea

X	TEST	RESULT	REF. RANGE
	Na	127	128-145 mmol/L
	K	3.7	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH	7.475 H	7.35-7.45
X	PCO2	32.9 L	35-45 mmHg
X	PO2	68 L	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	24	22-26 mmol/L
	sO2	95	95-99%
	BEecf	1	(-2) - (+3)
	AGap		8-16 mmol/L
X	iCa	0.50 L	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
X	Hct	31 L	37.0-52.0%
X	Hgb	11 L	12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

TEST	RESULT	REF. RANGE
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top — Chem 12, MetLyte8, BMP, Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc Rapid Tests

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative

Microbiology

TEST	RESULT	REF. RANGE
KOH		No Fungal Elements
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Parasite Panel		Presumptive Negative
Chlamydia		Presumptive Negative
OccBld		Negative
O&P		No Ova/Parasite
Strep A		Negative
Leishmania		Presumptive Negative
Strep pneumo		Presumptive Negative
Flu A&B		Negative

Hematology / Purple Top — CBC, Malaria, ESR

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple

TEST	RESULT	REF. RANGE
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

TEST	RESULT	REF. RANGE
Sed Rate		1hr = 0-20 mm

Coagulation (i-Stat) / Sodium Citrate

TEST	RESULT	REF. RANGE
PT		7.0-14.0 sec
PTT		
INR		0.7-1.4/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top

TEST	RESULT	REF. RANGE
Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Body Fluid Panel / Sterile Cont

Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)

10-L-0126 ACLU DDII CID ROI 15750

FOR OFFICIAL USE ONLY

0238-04-CID789-83990

NSN 7540-01-155-7394

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

chest x-ray

AGE | SEX | SSN (Sponsor) (b)(6)

WARD/CLINIC ETR

REGISTER NO.

FILM NO.

PREGNANT
☐ YES ☐ NO

TELEPHONE/PAGE NO.

REQUESTED BY (Print) (b)(6)

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

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

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

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

RADIOLOGIC REPORT

Subcutaneous emphysema in neck.
Clear lungs

(b)(6)

11/12/04

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

(b)(6)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

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L-0126 ACLU DDII CID ROI 15751

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.8

CERTIFICATE OF DEATH (OVERSEAS)
Acte de décès (D'Outre-Mer)

0238-04-CID789-83999

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER
MOBASS FAHAD	CIVILIAN	N/A	(b)(6)

ORGANIZATION Organisation	NATION (e.g., United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe
N/A	IRAQ	(b)(6)	(b)(6)

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
✓ CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier) MUSLIM
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
UNK	UNK

STREET ADDRESS Domicilé à (Rue)	CITY OF TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)
UNK	FALLUJAH

MEDICAL STATEMENT Declaration médicale

	CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)	INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	GENERALIZED TONIC CLONIC SEIZURE WITH ANOXIA	20 MIN
ANTECEDENT CAUSES / Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	KNOWN SEIZURE D/O	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	2° CAUSE REACTIVE AIRWAYS DISEASE	
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès		
✓ NATURAL Mort naturelle	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitees par des causes exterieures
ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
HOMICIDE Homicide	SIGNATURE Signature — DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès
(b)(6) 04	ICW 2, 115TH FIELD HOSP, ABU GHURAIB, IRAQ

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus.

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(6)	DOCTOR OF MEDICINE
GRADE Grade (b)(6)	INSTALLATION OR ADDRESS Installation ou adresse: FOB/ ABU GHURAIB IRAQ (115TH FH)
DATE Date (b)(6) 04	SIGNATURE Signature (b)(6)

[1] State disease, injury or complication which caused death, but not the mode of dying, such as heart failure, etc.
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou la condition qui a provoqué la mort.

10-L-0126 ACLU DDII CID ROI 15752

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DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 28 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

HOSPITAL REPORT OF DEATH

For use of this form, see AR 40400: the proponent agency is Office of The Surgeon General.

NAME AND LOCATION OF HOSPITAL

0238-04-CID789-83999

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*
(b)(6)
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)*
(b)(6) 04

3. MEDICAL EXAMINER/CORONER'S CASE
[X] YES [ ] NO

4. RELIGION
ISLAM

5. CHAPLAIN NOTIFIED
[X] YES [ ] NO

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

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)* ANOXIA	20 MIN
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) GEN. TONIC CLONIC SEIZURE	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. REACTIVE AIRWAYS DZ	
	b.	

9. DATE (b)(6) 04
10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE (b)(6)
11. SIGNATURE (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)* CID	(b)(6)			2004	(b)(6)
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* [X] YES [ ] NO
REQUESTED BY (b)(6)

21. AUTOPSY OR... (b)(6) (b)(6)

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

ICW2

NAME	ISN	DATE/ time admit	DX	MD	Discharge time/DATE
(b)(6)	(b)(6)	2300 11 NOV 04 TXFR: FROM ICU	Bronchopleural Fistula	MED	
		From ICU 11NOV04 @ 1230	S/P [illegible]		15Nov 22[illegible]
		9NOV04 @ 1200	DKA	MED	12NOV04 @ 1[illegible]
		From ICU 12NOV04 @ 1630	[illegible] Diaphragm	Surg	17NOV04 @ [illegible]30
		From ICU 12NOV04 1630	GSW to chest	Surg	13 NOV 04 @ 1[illegible]
		12 NOV 04 1655	mult soft tissue shrapnel	MED/Surg	15 NOV 04 @ [illegible]
		12 NOV 04 2100	(L) hip Ex. Fix	Ortho	15NOV 22[illegible]
		12 NOV 04 2100	Tib/Fib Fx	Ortho	15 NOV 22[illegible]
		(TXFR FROM ICU) 12 NOV 04 2100	S/P Craniotomy	MED	DECEASED 1[illegible] NOV 04
		(TXFR FROM ICU) 13 NOV 04 0200	Femur Fx / compartment syndrome	Ortho	
		13 NOV 04 0200	S/P EXP LAP	SURG.	
		13 NOV 04 0400	Ex Fix @ arm (L) pneumo	Surg	
		13 NOV	exp lap	Surg	15 NOV 04 @ 0[illegible]
		13 NOV	(L) PTX	MED	17 NOV 1930
		13 NOV	GSW [illegible]	SURG	15NOV 0900
		14 NOV @ 0310 -ER	GSW (L) [illegible]	ortho	15NOV 0945
		14 NOV @ 0500 from ER	GSW abd, GSV [illegible]	Surg	15 NOV 1000
		14 NOV 08	GSW @ leg		
		~~14 NOV 1050~~	[illegible]	Surg	
		14 NOV 1100	mult shrapnel	Surg	16 NOV 1220
		14 NOV 1130	mult fx	Surg/ortho	
		14 NOV 2030	scalp lac	MED	15 NOV @ 08[illegible]0
		15 NOV 0400	(L) buttock GSW	SURG	

(b)(6)

000051

10L-0126 ACLU DDH CID ROI 15754

0038-04-CID789-8

ICW2

MD	Discharge time/DATE	other	Chart @
MED			
	15 NOV 2200	Balad	PAD
MED	12 NOV 04 @ 1330	RTC	PAD
Surg	17 NOV 04 @ 1530	RTC	PAD
Surg	13 NOV 04 @ 1500	RTC	PAD
Med/Surg	15 NOV 04 @ 0900	on ward for OOS Hom 16 Nov 14:15	PAD
Ortho	15 NOV 2200	Balad	PAD
Ortho	15 NOV 2200	Balad	PAD
MED	DECEASED 15 NOV 04		
Ortho			
Surg/Ole			
Surg			
Surg	15 NOV 04 @ 0800	on ward for OOS Hom 16 Nov 14:15	PAD
MED	17 NOV 1930	RTC	PAD
Surg	15 NOV 0900	RTC	PAD
Ortho	15 NOV 0945	RTC	PAD
Surg	15 NOV 1000	RTC	PAD
Surg			
Surg	16 NOV 1220	Home	PAD
Surg/Orth			
MED	15 NOV @ 0830	RTC	PAD
Surg			

10-L-0126 ACLU DDI CID ROI 15755

USF-000052

0288-04-CID789-83995

ICU

DATE TIME IN	STATUS	ISN/ HOSP #	NAME	DIAGNOSIS	PHYSICIAN	
12Nov/0000	Detainee	(b)(6)	(b)(6)	S/p (L) hand amp. (R) hand I&D	(b)(6)	(b)(6)
12Nov 0700	DETAINEE			S/P LAPAROTOMY STATUS ASTHMATICUS		(b)(6)
12Nov	detainee			S/P ~~foot~~ BKA (R)		
12 Nov	detainee			Partial thickness burns		
~~12 Nov~~	~~detainee~~			~~GSW (L) chest~~		
12Nov	detainee			abd wd closure		
12Nov	detainee			(L) humerus dsg change		
12Nov	detainee					
12Nov	detainee			wound vac Δ (R) arm		
12Nov	detainee			amputation toe (L) foot		
12Nov	detainee			(R) thigh wound dsg chg		
12Nov	detainee			chest wound closure (R) toe amputation		
12Nov	American			Shrapnel (R) face & neck		
12Nov 1810	detainee			hemo/pneumo (R) chest		
12Nov 1750	detainee			Ex lap; hemo/pneumo (R)		
12 Nov 1835	detainee			GSW (R) chest c̄ hemo/pneumo		
12 Nov 1800	child			ex lap c̄ liver lac		
12 Nov	detainee			GSW (R) chest		
12Nov	detainee			(B) hemo PTX		
12Nov	detainee			GSW Abd & Arm + lots of sh... (L) nephrectomy		
~~12Nov~~	~~detainee~~			GSW		
				~~(B)~~ + (R) LE ex fix		

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10-L-0126 ACLU DDII CID ROI 15756

0268-04-CID789-83996

PHYSICIAN	INPATIENT/ RECOVERY	DISPOSITION ICU
(b)(6)	Recovery/Inpatient	ICW-2 12Nov 1230
	INPATIENT	ICW 2 1830 12Nov
	Inpatient #6	ICW-2 0700 14Nov
	Inpatient #7	
	Recovery	ICW 2 1030
	Recovery	ICW 1 1045
	Recovery	ICW 1 1200
	Recovery	ICW 1 1230
	Recovery	ICW 2 1436
	Recovery	ICW 1 12Nov
	Recovery	ICW-1 12Nov
	Inpt	ICW-1 1830 12Nov
	Inpatient #13	
	Inpatient Recovery	to ICW 15 Nov
	Inpatient #9	
	Inpatient Recovery #10	
	Inpt transfer from ICW #12	
	Inpatient	to ICW 15 Nov
	Inpatient	

of 5

0238-04-CID789-83990

Date	#	(b)(6)		Arrival	Time	(b)(6)	(b)(6)		Cat	Complaint
Nov 04	18			trauma team	0005			5A	2	(R Femur FX)
Nov 04	19			WALKIN	0330			62	4	R ear pain
Nov 04	20			Walk In	0340			63	4	(Nausea)
Nov 04	21			Trauma team	0400			5a	2	(Shrapnel to bilateral feet)
Nov 04	22			Trauma Team	0350			5a	2	(GSW R foot)
Nov 04	23			Trauma Team				5a	2	(Frag wound L Tib/Fib)
Nov 04	24			Trauma Team				5a	2	(Insect Bite)
Nov 04	25			Trauma Team				5a	2	(GSW buttock)
11NOV04	01			walk in				3	4	(vomiting + diarrhea x24 h)
Nov 04	02			WALK In	1450			3	4	(Rash on Neck)
Nov 04	03			Walk In	1455			4	1	(IED Explosion)
Nov 04	04			WALK IN	1459			4	1	(Ear on Hearing)
11Nov04	05			Air/litter	1900			5a	2	GSW L ft (infected)
Nov 04	06			Air/litter				5a	2	L foot GSW R leg L thigh
Nov 04	07			Air/litter	1910			5a	2	B pneumo thorax chest contusion
Nov 04	08			Air/litter				5a	2	B hand burns L thigh (femur)
Nov 04	09			Air/litter				5a	2	Burns (arms chest)
Nov 04	10			Air Litter	1905			5a	2	Shrapnel Injury R Shoulder
Nov 04	11			Air Litter	1930			5a	2	asthma/fresh circ

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10-L-0126 ACLU DDH CID ROI 15758
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0238-04-CID789-83990

4	(R) ear pain	((R) Otitis Media)	0340	11 Nov	0340
4	(Nausea)	Gastroenteritis	0353	11 Nov	24 hr Qtr
2	(Shrapnel to bilateral feet)	Shrapnel (L) foot - cellulitis	0515	11 Nov	ICW 1
2	(GSW (R) foot)	(GSW (R) Foot)	0615	11 Nov	Inpr
2	(Frag wound (L) Tib/Fib)	(Fragment Wound (L) Tib/Fib)	0615	11 Nov	Inpr
2	(Insect Bite)	(Cellulitis 2° to Insect Bite)	0630	11 Nov	ICW 2
2	(GSW buttock)	(GSW buttock)	0615 0615	11 Nov	ICU
1	(vomiting + diarrhea x24 hrs)	(Acute viral syndrome)	0820	11 Nov	RTD
1	(Rash on Neck)	(Contact dermatitis)	1100	11 Nov	RTD
1	(IED Explosion)	(Concussion from IED)	1515	11 Nov	24 HR QTRS
	(Ear for Hearing)	((L) Ear Trauma 2° to IED Explosion)	1515	11 Nov	RTD
2	GSW (L) ft (infected)	GSW (L) ft	1945	11 Nov	ICW 2
2	(L) foot GSW (R) leg (R) thigh	GSW (L) ft (R) thigh, leg	2020	11 Nov	ICU
2	(B) pneumo thorax chest contusion	(B) pneumothorax	2030	11 Nov	OR
2	(B) hand burns (L) thigh (femur)	(L) femur GSW / (B) hand burns	2030	11 Nov	OR
2	Burns (arms chest)	30% partial thickness Burns	2020	11 Nov	ICU
2	Shrapnel Injury (R) Shoulder	fx (L) hand / (R) shoulder injury shrapnel	2030	11 Nov	ICW
2	asthma / fresh cric	S/P Cric	2045	11 Nov	ICU

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0238-04-CID789-83999

10-L-0126 ACLU DDII CID ROI 15759

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

0238-04-CID789-83999

Last Name	BISBASS
First Name	FAHAD
Middle	MAHEDI
Category	CI-CIVILIAN INTERNEE
Power	IZ-Iraq
Arm of Service	
MOS	
COS	
Service No	
Grade	
Geneva Cat.	
ICRC	
Camp Name	BCF
Enclosure	04-115 CASH
Holding/Cel	115 CASH

(b)(3)

Height		Nationality	IZ-Iraq	Sex	M
Weight				Blood Type	
Hair Color		Religion		DOB	1979/01/01
Eye Color		Race		Complexion	
		Marks			

(b)(6), (b)(7)(C) CI-CIVILIAN INTERNEE

(b)(3)

Grade | Geneva Cat.

Height (in) | Weight (lbs) | Hair | Eye

Date of Birth 1979/01/01 | Blood Type | ICRC

Signature

Name BISBASS, FAHAD MAHEDI

Issuing Facility: BCF Date Issued: 2004/11/18 Issuing UIC: WYTPAA

ID Particular 34201

Marks

Left Index | Right Index

(b)(3) (b)(6), (b)(7)(C)

ID Particular 34201

BISBASS, FAHAD MAHEDI

Grade | Geneva Cat. | DOB 1979/01/01

Height (in) | Weight (lbs) | Hair | Eye

Sex M | ICRC | Blood Type

Nationality BCF | UIC WYTPAA | Date 2004/11/18

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PERSONAL DATA REPORT

GENERAL INFORMATION

Dossier: {E5B3DF2F-0E70-4284-A5EF-2C3C23C6CEB4}

Name (F.M.L): FAHAD MAHEDI BISBASS ()

Full Name:

WMD Category:

Operational Status:

Occupation:

National ID #: 164696

Gender: MALE

Race:

Hair Color:

Eye Color:

Build:

Height (in): Min: Max:

Weight (lb): Min: Max:

PHOTOGRAPH

ON ALERT? YES

ASSAULT ON COALITION

PERSONAL DATA

Birthdate: 01JAN1979

Birthplace: FALLUJAH, IRAQ, IRAQ

Death Date:

Religion: ISLAM-SUNNI

Nationality: IRAQI

Primary Citizenship: IRAQI

2nd Citizenship:

Ethnicity: ARAB

Marital Status: UNKNOWN

Personnel Status: UNKNOWN

CAPTURE INFORMATION

Capture Date: 110000ZNOV2004 Capture Unit: CASH

Place: FALLUJAH

Documents:

Circumstances:

Weapons/Equip:

INDIVIDUAL STATUS INFORMATION

JITF-CT Classification U.S. Relationship Status DoD Relationship Status

ALIASES

First Name	Middle Name	Last Name	Nickname

ID Numbers

ID Number Type	ID Number
CAP TAG	115 CASH

PASSPORT INFORMATION

Type	Number	Issue Date	Expiration Date	Country	Authority

PERSONAL TRAITS

LANGUAGE(S)

Language Name	Language Proficiency	Is Native Language
ARABIC, MODERN STANDARD	NATIVE PROFICIENCY	YES

Comments

ADDRESSES

EMPLOYMENT HISTORY

MILITARY SERVICE HISTORY

PHONE NUMBERS

Type	Intl	Area Code	Phone #	Ext

VEHICLE INFORMATION

RELATIVES

Relation	First	Middle	Last	Maiden	Birthdate

AGENT'S INVESTIGATION REPORT	ROI NUMBER (0386-04-CID112) 0238-04-CID789-83999
CID Regulation 195-1	PAGE 1 OF 1 PAGE

DETAILS

About 0700, 28 Nov 04, SA (b)(6), (b)(7)(C) was notified by Mr. (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Chief, Operational Investigations, Office of the Armed Forces Medical Examiner, Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd, Building 102, Rockville, MD 20850, that the remains of Mr. Mobass FAHAD, Detainee, Internment Serial Number (ISN), (b)(6), (b)(7)(C) Baghdad Central Confinement Facility (BCCF), Abu Grhaib, Baghdad, Iraq, had arrived at Dover Air Force Base (DAFB), DE 19902, to be autopsied. Detainee FAHAD reportedly began having seizures, stopped breathing, and never regained consciousness.

About 1030, 29 Nov 04, SA (b)(6), (b)(7)(C) attended the autopsy of Detainee FAHAD, (ME-04-969), which was conducted by Dr. (LTC) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) First Chief Deputy Medical Examiner, Office of the Armed Forces Medical Examiner, Armed Forces Institute of Pathology, Rockville, MD 20850. The preliminary Cause of Death was listed as Pending. The Manner of Death was listed as Pending. Photographers from AFIP exposed digital photographs of the autopsy and prepared a compact disk containing all images exposed. The FBI obtained a major case prints from Detainee FAHAD prior to the autopsy. (See CD-Rom and FBI Fingerprint of FAHAD)

AGENT'S COMMENT: The official results of the autopsy will be documented in the Final Autopsy Report, which will be posted when completed, to the Army Knowledge Online (AKO), by SA (b)(6), (b)(7)(C) ///LAST ENTRY///

TYPE (b)(6), (b)(7)(C), (b)(7)(F) BER SA	ORGANIZATION Aberdeen Proving Ground Resident Agency Aberdeen Proving Ground, MD 21005	
(b)(6), (b)(7)(C)	DATE 29 Nov 04	EXHIBIT 8

10-L-0126 ACLU DDII CID ROI 15763

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(b)(6), (b)(7)(C)
FOUO
CID COPY
ME 04-969

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TYPE OR PRINT ALL INFORMATION IN BLACK

LEAVE BLANK

FAHAD MOBASS [illegible]

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

FBI
DISASTER SQUAD

WARNING - BIOHAZARD

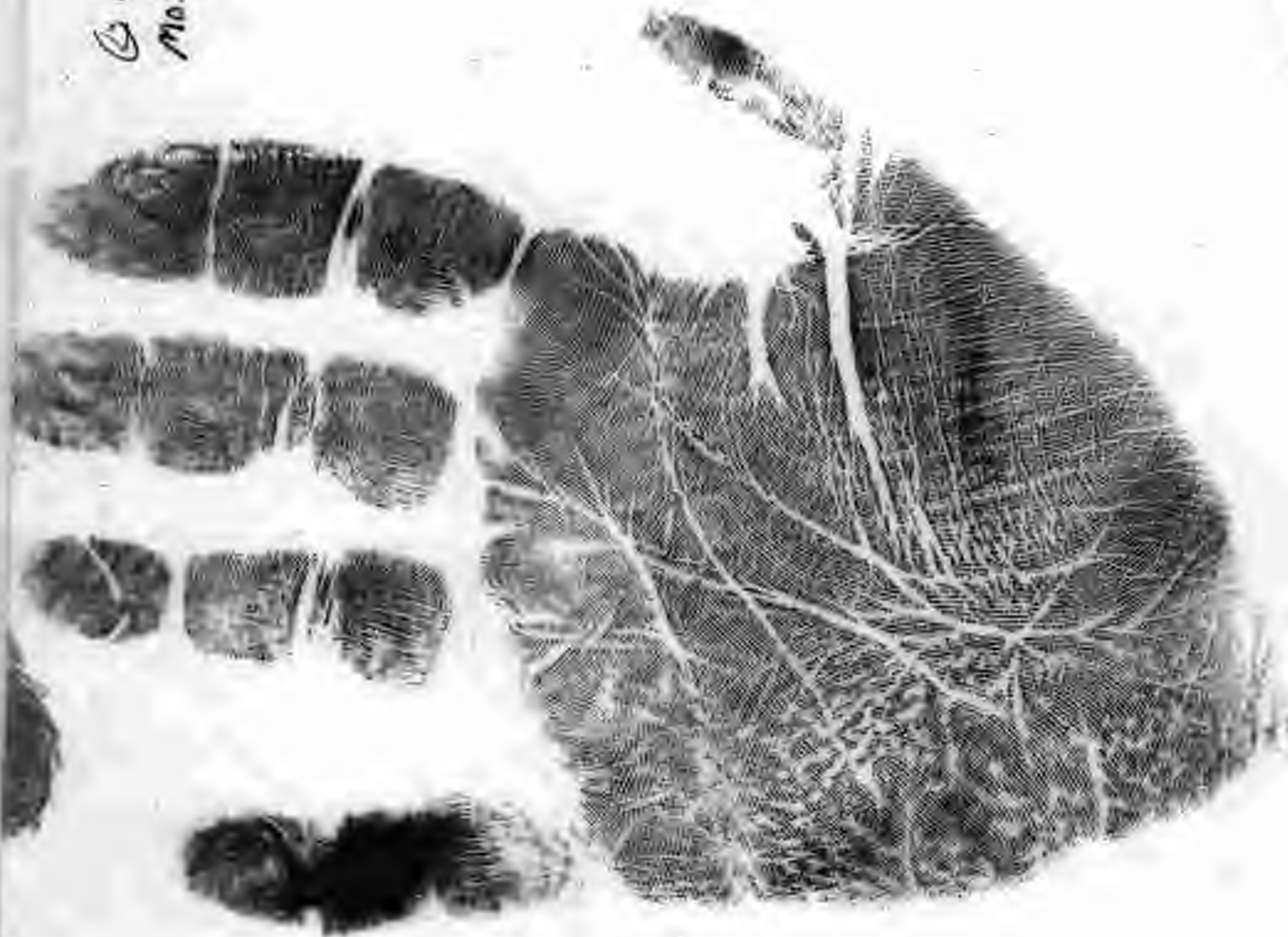
DETAINEE MOBASS FAHAD

WARNING - BIOHAZARD

EXHIBIT 10

10

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



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

10-L-0126 ACLU DDII CID ROI 15857

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TYPE OR PRINT ALL INFORMATION IN BLACK

LAST NAME NAM FIRST NAME MIDDLE NAME

FAHAD MOBASS (NMN)

FBI

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STATE USAGE

ALIASES

CONTRIBUTOR ORI

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

FBI
DISASTER SQUAD

SIGNATURE OF PERSON FINGERPRINTED

DATE OF BIRTH DOB Month Day Year

THIS DATA MAY BE COMPUTERIZED IN LOCAL, STATE AND NATIONAL FILES

DATE ARRESTED OR RECEIVED DOA

SEX RACE HGT. WGT. EYES HAIR PLACE OF BIRTH POB

DATE SIGNATURE OF OFFICIAL TAKING FINGERPRINTS

YOUR NO. OCA

LEAVE BLANK

CHARGE

FBI NO. FBI

CLASS.

SID NO. SID

REF.

SOCIAL SECURITY NO. SOC

FINAL DISPOSITION

NCIC CLASS - FPC

CAUTION

1. R. THUMB 2. R. INDEX 3. R. MIDDLE 4. R. RING 5. R. LITTLE

6. L. THUMB 7. L. INDEX 8. L. MIDDLE 9. L. RING 10. L. LITTLE

R THUMB LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY R INDEX R MIDDLE L. THUMB R. THUMB R RING RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY R LITTLE

10-L-0126 ACLU DDII CID ROI 15858

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0238-04-CID789-83999

DETAILS

About 2306, 31 Mar 05 03, the undersigned obtained a copy of Detainee FAHAD's Final autopsy report number ME04-969, 14 Mar 05, which listed the cause of death as Acute Myocarditis and the manner of death as Natural. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP DET (CID)(FWD)(-) BCCF, Abu Ghraib, Iraq APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 31 Mar 05	EXHIBIT 11

CID FORM 94
1 FEB 77

16-L-0126 ACLU DDII CID ROI 15859

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

FINAL AUTOPSY REPORT

Name: Fahad, Mobass
Alternate Reported Name: (b)(6)
SSAN: n/a
Date of Birth: (b)(6)
Date of Death:
Date of Autopsy: 28 November 2004
Date of Report: 14 March 2005

ID number: (b)(6)
Autopsy No.: (b)(6)
AFIP No.: (b)(6)
Rank: Civilian
Place of Death: Iraq
Place of Autopsy: Dover AFB, Dover, DE

Circumstances of Death: This 25 year old male civilian, presumed Iraq national, died while in US custody in Iraq. By report, he was admitted to the hospital at the Baghdad Central Confinement Facility with seizures and asthma on 12 November 2004, requiring an emergent tracheostomy for airway stabilization. He was placed on seizure prophylaxis and stabilized for several days. During preparation for transfer back to the camp, he had a generalized tonic clonic seizure and went into cardiac arrest. CPR was unsuccessful, and he was pronounced dead. By report, he had been in a Fallujah hospital for previous seizures. For complete clinical details, please refer to the medical records.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: Visual, per detention facility records; postmortem fingerprints and DNA profile obtained.

CAUSE OF DEATH: Acute Myocarditis

MANNER OF DEATH: Natural

0238-04-CID789-83999

FINAL AUTOPSY DIAGNOSES:

I. Acute myocarditis (Cardiovascular Pathology consultation)
   a. Microscopically, acute myocarditis
      i. Focal myocyte necrosis and interstitial inflammatory infiltrate, right ventricle
   b. 390 gm heart
      i. Focal moderate coronary atherosclerosis, single vessel diseae
         1. 60% luminal narrowing of proximal left anterior descending artery by pathologic intimal thickening

II. Clinical history of "Seizures" (Neuropathology consultation)
   a. Brain, 1400 gm (1385 gm fixed)
   b. Microscopically, global hypoxic-ischemic injury (Non-specific findings)
      i. Eosinophilic cytoplasm and nuclear hyperchromasia and pyknosis in basal ganglia, hippocampal formation, brain stem and cerebellum, and in a pseudolaminar distribution in the cerebral cortex
      ii. Focal petechia hemorrhage in brainstem
      iii. Meningeal congestion

III. Clinical history of "Asthma" (Pulmonary Pathology consultation)
   a. Vascular congestion of lungs; right lung 630 gm, left lung 520 gm
   b. Microscopically, mild changes suggestive but not diagnostic of asthma (reactive airway disease)
      i. Airway basement membrane thickening
      ii. Focal goblet cell metaplasia and mucus plugging
      iii. No significant eosinophilia or smooth muscle hyperplasia

IV. No evidence of significant injury
   a. Minor contusions of the right thigh
   b. Healing pustules of right arm and left buttock
   c. No internal evidence of trauma

V. No evidence of restraint

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

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000153

0238-04-CID789-83999

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished Caucasian male clad in a cut yellow one-piece jumpsuit and a pair of blue paper shorts. The body weighs 220 pounds, is 68" in height and appears consistent with the reported age of 25 years. The body is initially received frozen and is thawed prior to autopsy. Rigor has dissipated, and the body is flaccid once thawed. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure. There is early red marbling of the extremities.

The scalp is covered with dark brown hair averaging 3 cm in length. Facial hair consists of a dark mustache and dark beard. The irides are brown, and the corneae are slightly cloudy. The sclerae and conjunctivae are pale and free of petechiae. The earlobes are not pierced. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The lips are without evident injury. The teeth are natural with extensive decay and caries evident.

The neck is straight and the trachea is midline and mobile. The chest is symmetric and well developed. No injury of the ribs or sternum is evident externally. The abdomen is protuberant and soft, with numerous striae. Healed surgical scars of the abdomen are not noted. The extremities are well developed with normal range of motion. The fingernails are intact. The soles of the feet are calloused and hyperkeratotic. There is a 1 x 0.5 cm scar on the left knee. Tattoos are not noted, and needle tracks are not observed. The external genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. The pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

EVIDENCE OF THERAPY

There is a piece of white tape with gauze covering a tracheostomy incision on the lower anterior aspect of the neck. There is an endotracheal tube in place, protruding from the mouth. There are needle puncture marks with associated ecchymoses of the bilateral antecubital fossae and on the back of the left hand. There is a cluster of needle puncture marks in the left inguinal region. There is an intravenous catheter in the right inguinal region, secured with black sutures. There are five adhesive EKG tabs on the body, two on the upper right anterior aspect of the chest, one on the upper left anterior aspect of the chest, one on the lower right anterior aspect of the chest, and one on the lower left anterior aspect of the abdomen. There are two adhesive defibrillator pads on the body, one on the anterior left mid aspect of the chest and one on the mid left side of the back. There is no other evidence of medical intervention.

EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only and is not intended to imply order of infliction or relative severity.

10-L-0126 ACLU DDII CID ROI 15863
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There is a 4 x 3 cm red contusion on the lower lateral aspect of the right thigh, and there is a 4 x 3 cm red contusion with central pallor on the lower medial aspect of the right thigh. Incision of the skin over these contusions reveals a small amount of hemorrhage within the subcutaneous adipose tissue, but no deep injury.

There is a 0.3 x 0.2 cm healing crust on the back of the right upper arm, and there is a 0.5 x 0.3 cm healing pustule on the lower lateral aspect of the left buttock.

On internal examination of the head, chest and abdomen, there is no evidence of injury.

INTERNAL EXAMINATION

BODY CAVITIES:
The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. No adhesions or abnormal collections of fluid are present in any of the body cavities. All body organs are present in the normal anatomical position. The vertebral bodies are visibly and palpably intact. The subcutaneous fat layer of the abdominal wall is 8 cm thick. There is no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

HEAD: (CENTRAL NERVOUS SYSTEM)
The scalp is reflected, and there is no subgaleal hemorrhage or skull fractures found. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The brain is darkly discolored from decompositional changes. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. The brain is fixed in formalin prior to submission to Neuropathology for sectioning. The dura is stripped from the basilar skull, and no fractures are found. The atlanto-occipital joint is stable. The brain weighs 1400 grams. See "Neuropathology Report" below.

NECK:
Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, reveals no abnormalities. The anterior strap muscles of the neck are homogeneous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa and is unobstructed. The thyroid gland is symmetric and red-brown, without cystic or nodular change. There is no evidence of infection, tumor, or trauma, and the airway is patent. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury, hemorrhage, or fractures of the dorsal spinous processes.

CARDIOVASCULAR SYSTEM:
The pericardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid and adhesions. A moderate amount of epicardial fat is present. The heart is fixed in formalin prior to submission to Cardiovascular Pathology for sectioning. The aorta and its major branches arise normally, follow the usual course and are widely patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major

tributaries return to the heart in the usual distribution and are free of thrombi. The heart weighs 390 grams. See "Cardiovascular Pathology Report" below.

RESPIRATORY SYSTEM:
The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is red-purple, exuding a moderate amount of bloody fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 630 grams; the left 520 grams.

LIVER & BILIARY SYSTEM:
The liver has an intact, smooth capsule and a sharp anterior border. The hepatic capsule is smooth, glistening and intact, covering dark red-brown, moderately congested and slightly firm parenchyma with no focal lesions noted. The gallbladder contains 10 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The liver weighs 1950 grams.

ALIMENTARY TRACT:
The tongue is free of bite marks, hemorrhage, or other injuries. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 100 ml of semisolid digesting food, including rice and vegetables. The small and large bowel are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present and is unremarkable.

GENITOURINARY SYSTEM:
The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are otherwise unremarkable. White bladder mucosa overlies an intact bladder wall. The urinary bladder contains a film of cloudy urine. The prostate gland is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities. The right kidney weighs 140 grams; the left 160 grams.

RETICULOENDOTHELIAL SYSTEM:
The spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The spleen weighs 180 grams.

ENDOCRINE SYSTEM:
The pituitary, thyroid and adrenal glands are unremarkable.

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

MICROSCOPIC EXAMINATION

HEART: See "Cardiovascular Pathology Report" below.

LUNGS: See "Pulmonary Pathology Report" below.

LIVER: The hepatic architecture is intact. The portal areas show no increased inflammatory component or fibrous tissue. The hepatic parenchymal cells are well-preserved with no evidence of cholestasis, fatty metamorphosis, or sinusoidal abnormalities.

SPLEEN: The capsule and white pulp are unremarkable. There is minimal congestion of the red pulp.

ADRENALS: The cortical zones are distinctive, and the medullae are not remarkable.

KIDNEYS: The subcapsular zones are unremarkable. The glomeruli are mildly congested without cellular proliferation, mesangial prominence, or sclerosis. The tubules are well preserved. There is no interstitial fibrosis or significant inflammation. There is no thickening of the walls of the arterioles or small arterial channels. The transitional epithelium of the collecting system is normal.

BRAIN: See "Neuropathology Report" below.

CARDIOVASCULAR PATHOLOGY REPORT

(b)(6), MD:

" Diagnosis: (b)(6)

1. Acute myocarditis with focal myocyte necrosis and interstitial inflammatory infiltrate, right ventricle
2. Focal moderate coronary atherosclerosis, single vessel disease

History: Approximately 24 year old male Iraqi detainee who died in US custody; history of seizures prior to death.

Heart: 390 grams; normal epicardial fat; closed foramen ovale; normal cardiac chamber dimensions: left ventricular cavity diameter 40 mm, left ventricular free wall thickness 13 mm, ventricular septum thickness 13 mm; right ventricle thickness 4 mm, without gross scars or abnormal fat infiltrates; unremarkable valves; no gross myocardial fibrosis or necrosis; histologic sections show focal myocyte necrosis with interstitial infiltrates of lymphocytes and neutrophils in right ventricle, left ventricle is unremarkable.

Coronary arteries: Normal ostia; right dominance; focal moderate atherosclerosis: 60% luminal narrowing of proximal left anterior descending artery by pathologic intimal thickening; no other significant narrowing.

Comment: Although it is uncommon, we have seen cases of acute myocarditis limited to the right ventricle. It has also been suggested that this could represent an early phase of arrhythmogenic right ventricular dysplasia, as the etiology of this entity is not fully understood."

NEUROPATHOLOGY REPORT

Department of Neuropathology and Ophthalmic Pathology, AFIP:

"We examined the approximately 1385-gram formalin-fixed brain submitted in reference to this case. The dural fragment submitted for evaluation does not show significant pathologic findings. The brain is soft and friable and dusky in color and deformed with the right hemisphere appearing larger than the left. There is a 2 x 1.5 cm hyperemic area along the left middle frontal gyrus. The gyral pattern is normal. The brain stem and cerebellum are similarly deformed and dusky in color. Because of these extensive artefactual changes, the cranial nerves and blood vessels at the base of the brain cannot be evaluated. There is no evidence of subfalcine herniation; tonsillar and uncal herniation cannot be assessed because of the extensive artifact. Serial coronal sections of the cerebrum show overall dusky discoloration of the cortical ribbon with slight blurring of the gray-white junction. The ventricular system is distorted and difficult to evaluate. There is extensive distortion, softening and friability of the basal ganglia, hippocampal formations, thalamus, and hypothalamus. The substantia nigra and locus cereleus, and aqueduct cannot be accessed due to the artefactual changes. The spinal cord is not submitted, but the uppermost cervical cord and cervicomedullary junction are soft and distorted. The cerebellum and brainstem are dusky in color and macerated.

Summary of microscopic sections: 1. Superior/middle frontal gyrus, right. 2. Inferior parietal lobule, right. 3. Superior/middle temporal gyrus, right. 4. Cingulate gyrus, left. 5. Hippocampal formation, right. 6. Caudate/putatmen/pallidum, right. 7. Thalamus/hypothalamus at mammillary bodies, right. 8. Substanis nigra/midbrain. 9 Pons. 10. Medulla. 11. Cerebellum.

All sections were stained with H&E.

Microscopic sections demonstrate extensive neuronal changes in the form of shrunken eosinophilic cytoplasm and nuclear hyperchromasia and pyknosis in sections of basal ganglia, hippocampal formation, brain stem and cerebellum, and in a pseudolaminar distribution in sections of cerebral cortex. These features are consistent with global hypoxic-ischemic injury. There is focal petechial hemorrhage ntoed on the sections of the brainstem. Microscopic sections of the left middle frontal gyrus confirms the meningeal congestion."

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PULMONARY PATHOLOGY REPORT

Department of Pulmonary Pathology, AFIP:

"Lungs, autopsy material:

- Airway basement membrane thickening, focal goblet cell metaplasia and mucus plugging
- Vascular congestion

The sections of lung show focal mucus plugging associated with basement membrane thickening and goblet cell metaplasia (focal). We note the history of asthma, while the above changes are suggestive of asthmatic changes, they are not striking and the sections lack significant eosinophilia and muscle hyperplasia. The lungs additionally show vascular congestion. There is a mild to moderate amount of fibrin in the alveoli which may be secondary to vascular leak. Fibrin/platelet aggregates are seen in rare vessels in bronchovascular bundles as well as in the capillary bed. It is difficult to discern whether these are pre or postmortem."

ADDITIONAL PROCEDURES

- Documentary photographs are taken by OAFME photographers
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous fluid, femoral blood, heart blood, urine, bile, spleen, liver, kidney, lung, psoas muscle, gastric contents, and adipose tissue
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representative

OPINION

This adult male Iraqi detainee died in US custody of acute myocarditis, inflammation of the heart involving the right ventricle. He had a clinical history of "seizures", however, no etiology for the seizures was found on examination of the brain, and the episodes may have been cardiac in origin rather than neurologic. He also had a clinical history of asthma, and while there were microscopic changes suggestive of asthma, these pulmonary findings were not diagnostic for asthma nor significant enough to have contributed to his death. Acute myocarditis may be caused by infectious agents (bacterial, viral, fungal), connective tissue diseases, or can be idiopathic (no recognized cause).

The manner of death is natural.

(b)(6)

(b)(6) Medical Examiner

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(PHOTOGRAPHIC IMAGES)

EXHIBIT 13